

THE ASSESSMENT OF MALINGERING

An Evidence-Based Approach

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I. KEY DEFINITIONS

- A. The word malingering derives from the Latin word “*malum*” that means bad or harmful, in this context refers to the bad intent of the offender’s actions.
- B. Key definitions
1. *Malingering*: The DSM-5 defines malingering as the “intentional production of false or grossly exaggerated physical or psychological symptoms motivated by external incentives.” External incentives can include:
 - a. avoiding military duty
 - b. avoiding work
 - c. obtaining financial compensation
 - d. evading criminal prosecution
 - e. obtaining drugs
 2. *Feigning*: the deliberate fabrication or gross exaggeration of psychological or physical symptoms without any assumptions about its goals (Rogers and Bender 2003).
 3. *Suspect effort*: describes effort-test performance that suggests the examinee is not applying his or her best effort to do well on the task. The cause of suspect-effort performance may be either intentional or nonintentional. Sometimes this presentation is also referred to as suboptimal effort, incomplete effort, or submaximal effort.
- C. Factitious disorder
1. Voluntary production of symptoms to assume the patient role.
 2. No other obvious secondary gain.
- D. Ganser’s syndrome:
1. **Approximate answers** (examples: 2+2=5, an elephant has 5 legs, etc.). Approximate answers is the symptom that has been classified as pathognomonic of Ganser’s syndrome;

2. Clouding of consciousness;
3. Somatic conversion (particularly sensory symptoms);
4. Hallucinations.

II. PREVALENCE

- A. In a study of malingered mental illness in a metropolitan emergency department, 13% of patients were suspected or considered to be malingering.
- B. Between 25-30% of individuals presenting for worker's compensation or disability claims demonstrate probable symptom exaggeration.
- C. In their survey of the American Board of Clinical Neuropsychology membership, Mittenberg et al. (2002) determined that 30% of 3,688 disability cases involved probable malingering.

III. GENERAL CLINICAL ISSUES IN THE DETECTION OF MALINGERING

Understanding real symptoms underlies distinguishing typical from atypical symptoms.

Seven validated detection strategies for feigned mental disorders are outlined below. Remember these as "The Magnificent Seven":

- A. ***Rare Symptoms.*** Malingers are often unaware of which symptoms occur infrequently among patients with genuine disorders. The rare-symptoms strategy works can be used to detect feigning patients, who endorse a substantial proportion of these highly infrequent symptoms.
- B. ***Improbable Symptoms.*** Approximately one-third of malingerers dramatically overplay their presentations and present improbable symptoms that have a very bizarre or fantastic quality. As an example, a patient's report of seeing Satan and his wife as conjoined twins would be an improbable symptom.
- C. ***Symptom Combinations.*** Many malingerers do not consider which symptoms are unlikely to occur together (i.e., symptom combinations). One approach is the use of unlikely symptom pairs in which each symptom is common by itself. For example, generalized anxiety and restful sleep are unlikely to occur together.
- D. ***Symptom Severity.*** Most genuine patients experience symptoms on a continuum from mild to moderate or even extreme. Malingers often do not appreciate this continuum and report many symptoms as severe or extreme (i.e., symptom severity).
- E. ***Indiscriminant Symptom Endorsement.*** When given a structured format covering many disorders, some malingerers endorse two-thirds or more of the symptoms presented (i.e., indiscriminant symptom endorsement). Genuine patients typically do not report such an array of diverse symptoms.

- F. **Obvious vs. Subtle Symptoms.** Malingers tend to focus on “obvious” symptoms clearly indicative of a mental disorder and overlook “subtle” symptoms that are not immediately associated with that disorder. In feigning schizophrenia, positive symptoms (e.g., hallucinations) may be emphasized and negative symptoms (e.g., avolition) entirely ignored.
- G. **Reported versus Observed Symptoms.** Many genuine patients lack insight into their own symptomatology and their presentations may be highly inconsistent with clinical observations. In using this detection strategy (Reported versus Observed Symptoms), both the type and magnitude of observed inconsistencies must be evaluated. To avoid errors, blatant inconsistencies must be evaluated for the current time only, since past symptoms are not directly observable. Some clinicians choose to mention these observed inconsistencies (e.g., reportedly poor concentration but the capacity to focus on an extended interview) to the patient. As a benchmark, genuine patients are unlikely to deteriorate suddenly in their functioning after a simple remark about observed inconsistencies.

IV. **GENERAL TESTING STRATEGIES TO ASSESS MALINGERING**

- A. **Floor effect approaches:** The concept known as the “floor effect” involves the incorporation of extremely easy questions or tasks in the testing methodology. Such items generally involve over-learned information or simple skills that are easily retained, even in those with limited intellectual functioning. Examples of such items include requests to perform simple arithmetic calculations (e.g. $2+2=?$), questions about basic common information (e.g. Who is President of the United States?), queries regarding basic autobiographical information (such as one’s age or birthday), requests to complete a simple sequence (e.g. a, b, _; 3, 4, __), or instructions to copy or recall simple diagrams or designs. Examples of Floor Effect Tests include:
1. **The Rey 15-item Test (FIT)** is an example of such an assessment. This test requires that individuals remember a set of 15 letters, numbers and geometric shapes that are in fact quite simple because of their redundancy. Various cut scores (the score that separates malingerers from non-malingerers) have been suggested although any score less than 10 is generally accepted as indicating a lack of effort. A meta-analysis of the FIT indicated that its specificity (correctly identifying a person as not feigning) was much higher than its sensitivity (correctly identifying a person as feigning; 92% compared to 43%) with an overall hit rate of 70% In an effort to improve the sensitivity, Griffin modified the FIT by increasing its redundancy, providing standardized administration instructions, and outlining a method of qualitative scoring. In a clinical population and using the qualitative scoring method, he estimated the sensitivity at 71% although the specificity dropped to 75% with this scoring system.
 2. **The b Test** (Boone et al. 2002) Key point: used to assess suspect effort in a variety of claims, to include impaired memory due to problems with attention,

focusing, or concentration. The b Test is a letter recognition and discrimination task designed to detect suspect test-taking effort in individuals **aged 17 or older**.

- a. The test consists of a 15-page Stimulus Booklet, each page of which contains an array of lowercase “b”s interspersed among other letters that serve as distractors.
- b. The examinee is asked to circle all the “b”s that are on each page, working as rapidly as possible.
- c. The error totals, along with the time required to complete the task, are needed to calculate the Effort Index (E-score), which is the primary measure of test-taking effort on the b Test.
- d. Total time required for administration and scoring is typically 15 minutes or less.

B. Symptom validity testing (SVT):

1. SVT involves asking the patient to choose one of two items relevant to their complaint. For example, if a person reports that they have impaired memory, they can be shown a series of words, pictures, or even numbers. They are then presented two items with only one of the two items having been previously presented to them. The person is then asked to make a forced-choice, i.e. identify which item they had been shown. Individuals with a genuine memory loss are expected to correctly identify approximately 50% of the items.
2. Through the use of statistics, the evaluator can determine the probability that a person with genuine amnesia would score below chance levels (76). There are numerous SVTs to assess whether a person is putting forth their best effort when their memory is tested. Because the use of multiple SVTs is more likely to detect below-chance results than a single test, the examiner should consider using multiple SVTs in forensic neuropsychological evaluations. Many commonly used tests to assess memory loss utilize this SVT approach.
3. Example SVT tests include the following:

Test of Memory Malingering (TOMM):

- The TOMM is a visual recognition test that involves presenting the individual with 50 different picture drawings.
- Two learning trials are presented followed by a retention trial. Scores below chance or based on criteria developed from head injured or cognitively impaired individuals are indicative of feigned memory impairment.

4. **Morel Emotional Numbing Test.** This instrument assesses affect recognition in a two-alternative forced-choice format. Many of the SVTs used are primarily measures of memory malingering whereas the MENT assesses primarily PTSD malingering.
 - Using the two-alternative format, the MENT was designed to give the test taker the impression that deficits in affect recognition are pathognomonic of PTSD as follows: “Some individuals with PTSD may have difficulty recognizing facial expressions.”
 - In reality, any adult who puts forth a reasonable amount of effort (except for visually impaired or those with less than a 3rd grade reading level) would complete the task with 90-100% accuracy even if they have PTSD (Morel 2008).

C. Unusual Patterns of Response Tests

1. Several psychological tests evaluate if the examinee is providing atypical responses to questions about mental health symptoms. Examples of such atypical responses include symptoms rarely presented by those with a genuine mental disorder, an unusual combination of symptoms, highly improbable or absurd symptoms, or an inconsistency in reported symptoms as compared to actual behavior observed during the evaluation or with prior reported symptoms on the test.
2. **Miller Forensic Assessment of Symptoms Test (M-FAST):**
 - Developed as a screening instrument designed to identify malingered psychopathology.
 - It is a 25-item structured interview that can be administered in approximately 5 minutes.
 - The M-FAST consists of items rationally derived from the literature on constructs useful in identifying malingerers and yields scores relevant to seven strategies: Unusual Hallucinations, Reported versus Observed, Rare Combinations, Extreme Symptomatology, Negative Image, Unusual Symptom Course, and Suggestibility.
 - A score of 6 or higher is suggested by the manual as indicative of a need for more extensive assessment. Research indicates that it is effective in identifying feigning in a variety of settings (77, 78).
3. **The Structured Inventory of Malingered Symptomatology (SIMS):**

- A 75-item true/false self-report test developed as a screening tool for malingering.
- One advantage of the SIMS is that it contains five subscales that assess malingering in areas other than psychopathology. The subscales are Low Intelligence, Amnesic Disorders, Neurological Impairment, Affective Disorders and Psychosis. Research has been mixed regarding its effectiveness in discriminating psychiatric patients from malingerers.
- Scores greater than 14 are suggest possible malingering.

4. **Structured Interview of Reported Symptoms (SIRS):**

- The most widely used assessment for the detection of feigned psychiatric symptoms using this paradigm is the Structured Interview of Reported Symptoms (SIRS). The SIRS was developed to assess a broad range of strategies in the detection of feigning.
- It is a 172-item structured interview, which requires approximately 30 to 45 minutes to administer. The original SIRS contained eight primary and five supplementary scales. The supplementary scales were used only if the respondent did not endorse symptoms in sufficient quantity to make a definitive determination. Responses on the primary scales were classified as honest, indeterminate, probable or definite. An individual was considered to be feigning psychiatric symptoms if he/she scored in the definite range on at least one primary subscale or in the probable range on three or more primary subscales. Studies indicated that these criteria optimized both sensitivity and specificity.
- The SIRS has been shown to be both a valid and reliable method for detecting malingering with very low false-positive rates, although others have found the false positive rate to be extremely high.
- Despite this criticism, the SIRS has been reported to have general acceptance among forensic experts in evaluations and is often cited as the “gold standard” or “benchmark” in the detection of feigned psychiatric symptoms. The SIRS has recently been revised (SIRS-2) although the primary scales remain unchanged.
- A new supplementary scale was added, which was developed to assess feigned cognitive deficits. The SIRS-2 provides an algorithm for decision-making that includes the use of composite scores as well as the primary scales. No information has yet been provided on the likelihood of feigning based on this algorithm.

D. Self-report tests of psychological functioning

1. Perhaps the most researched strategy in the detection of response bias is to employ self-report tests of general psychological functioning that also include validity scales.
2. The two instruments most often used in this regard are the Minnesota Multiphasic Personality Inventory (MMPI) and the more recent version, the MMPI-2 and the Personality Assessment Inventory (PAI). The MMPI-2 is a 567-item self-report instrument designed as a measure of general psychopathology. It has been cited as being “the mostly widely administered objective personality test in forensic evaluations” largely because of the extensive research conducted on its ability to detect response bias via the embedded validity scales. The three original validity scales from the MMPI included the Lie scale (L), the Infrequency scale (F) and the defensiveness scale (K).

V. EVALUATION OF MALINGERED DEPRESSION

- A. In their research, Gervais et al (2001) found that between 25-30% of patients who claimed major depression in civil litigation were probably malingering based on their performance on forced choice tests.
- B. Carefully review DSM-5 criteria to determine if individual meets criteria for a depressive disorder.
- C. Questions to clinically evaluate possible malingered depression (Scott and McDermott *in press*, 2017):
 1. Does the person have a wide range of facial expressions inconsistent with a depressed state?
 2. Does the person have a normal range of motor movements inconsistent with being very slow or very agitated?
 3. Does the person laugh and joke during the examination, inconsistent with depression?
 4. Does the person report involvement in a variety of activities that they enjoy doing?
 5. Does the person actually a change in weight that they describe?
 6. Does the person indiscriminately endorse symptoms unrelated to depression?
 7. Does the person promote their personal strengths in a positive laudatory manner inconsistent with a low self-esteem?
 8. Does the person state that others are to blame for their problems and that they are blameless?
 9. Does the person perform poorly when asked extremely easy questions about their life, such as their birthday?
 10. Does the person demonstrate a sudden worsening of reported problems in memory and concentration once informed they are going to be “tested”?

11. Does the person suddenly appear more depressed when they think they are being observed vs. unobserved?
- C. Understand that self-report instruments for depression do NOT include measures of malingering. In his study examining the use of the Beck Depression Inventory (BDI) as a measure of depression, Lees-Haley (1989) instructed 52 untrained volunteers to malingering symptoms in a manner that would be effective in the course of civil litigation. His findings demonstrated that 96% were able to feign depression and nearly 60% successfully feigned extremely severe depression.

These results emphasize that self-report questionnaires asking about mood symptoms produce results that may satisfy the diagnostic criteria of a mood disorder when in reality the person may have minimal, if any, genuine symptoms.

VI. THE “ROSENHAN” STUDY (1973)

- A. Rosenhan study (1973)-often cited to provide evidence in court that psychiatrists are unable to distinguish between the “sane” and “insane” and between “normal” and “abnormal.”
- B. In this study, **eight** normal, sane people gained admission to twelve different mental hospitals. These eight are referred to in the article as “pseudo patients.”
- C. The eight included a psychology graduate student in his 20’s, three psychologists, a pediatrician, a painter and a housewife. Three were women and five were men. None had ever suffered symptoms of serious psychiatric disorders. All were functioning well in their family, interpersonal and occupational lives.
- D. To gain admission, the pseudopatient arrived at the Admissions Office complaining that he or she had been hearing voices. When asked what the voices said, they replied that they were often unclear, but as far as they could tell they said, “Empty,” “Hollow,” and “Thud.”
- E. Immediately upon admission to the Psychiatric Ward, the pseudo-patient ceased simulating any symptoms of abnormality.
- F. All of these pseudopatients were diagnosed as schizophrenic based on this one reported symptom except for one patient who was diagnosed as bipolar disorder. There were never found out and were eventually discharged with the diagnosis of “schizophrenia in remission.”
- G. The range of stay was from 7 to 52 days with the average being 19 days.
- H. This study is often used by prosecutors to suggest that mental health professionals are very gullible and unable to recognize malingered psychotic symptoms.

VII. CLINICAL CLUES TO MALINGERED PSYCHOSIS (Resnick 1984)

- A. Malingerers' symptoms may fit no known diagnostic entity.
- B. Malingerers may overact their part. Malingerers are eager to call attention to their illnesses in contrast to schizophrenics, who are often reluctant to discuss their symptoms.
- C. Malingerers are likely to have contradictions in their accounts of their illness.
- D. Malingerers are more likely to be evasive, repeat questions or answer questions slowly, to give themselves more time to make up an answer.
- E. Malingerers are more likely to try to take control of the interview and behave in an intimidating manner.

VIII. MALINGERED VS. TRUE HALLUCINATIONS

- A. There are numerous details the evaluator should listen for when hallucinations are being described. Some characteristics of auditory hallucinations include:
 - 1. Content
 - 2. Clarity
 - 3. Loudness
 - 4. Vividness
 - 5. Duration
 - 6. Frequency
 - 7. Continuous or intermittent
 - 8. Single or multiple voices
 - 9. Male or female
 - 10. Inside or outside of the head
 - 11. Tone of voice of hallucinations
 - 12. Voices speak in second or third person
 - 13. Insight into unreality of voices
 - 14. Belief that others could hear voices
 - 15. Relationship to person speaking
 - 16. Associated hallucinations of other senses
 - 17. Patient alone or with others
 - 18. Converse back with the voices
 - 19. Ability to put the voices out of mind
 - 20. Mood during hallucinations
 - 21. Relationship to delusions
 - 22. Concomitant confusion
 - 23. Patient's reaction to the voices
 - 24. Direction to do things from voices
 - 25. Consequences for failure to obey

- 26. Effort not to obey voices
 - 27. Alternative rational motive for the acts
 - 28. What makes the better or worse
 - 29. The number of voices
- B. It is important when assessing potentially malingered hallucinations, to begin with very open ended questions in reference to what the person reports experiencing.
- 1. Describe what you are hearing.
 - 2. Is there anything else you can describe?
 - 3. Anything else about this experience you can remember?
- C. Be careful not to educate the evaluatee/patient regarding what exact signs and symptoms you are expecting to make an accurate diagnosis. Over time, the person can anticipate answers to give based on prior questioning. Some have called this education “Clinician Assisted Deception.”
- D. Auditory hallucinations
- 1. Auditory hallucinations are usually perceived as words or sentences heard by the patient as remarks or comments concerning him or her.
 - 2. Hallucinations from drugs are commonly described as unformed noises.
 - 3. In a study of 100 consecutive patients with hallucinations (61%) were schizophrenic, detailed phenomenology was studied (Nayani and David 1996)
 - a. Internal vs. external hallucinations:
 - 49% of the sample heard the voices through their ears as external stimuli.
 - 38% heard them in internal space.
 - 12% heard them in both variably.
 - b. The most common encountered hallucinated utterances were simple **terms of abuse** (60%)
 - Female subjects described words of abuse conventionally directed at women (e.g. slut).
 - Male subjects described “male” insults such as those imputing homosexuality.
 - 4. Strategies to decrease hallucinations-Ask what the person does to make the voices go away. In one study, **76%** of patients were able to identify at least one activity,

either cognitive or behavioral-which helped them in dealing with auditory hallucinations.

Frequent coping strategies in actual schizophrenics are:

- a. Specific activities (working)
- b. Changes in posture (lie down or walk)
- c. Seeking out interpersonal contact
- d. Taking medication

Activities that have been shown to make voices worse:

- a. 80% of those with hallucinations stated that being alone worsened their hallucinations (Nayani and David, 1996)
- b. The two things that made voices worse were listening to the radio or watching television (Leudar et al. 1997)

TV programs were particularly hallucinogenic. Voices sometimes comment about the program.

5. Summary of suspect auditory hallucinations:

- a. Continuous rather than intermittent
- b. Vague or inaudible hallucinations
- c. Not associated with delusions
- d. Stilted language
- e. No strategies to diminish voices
- f. Claim that all instructions are obeyed

D. Visual hallucinations

1. Visual hallucinations (46% vs. 4%) were found more often with malingerers than genuinely psychotic individuals.
2. Visual hallucinations were usually of normal-sized, animals or other objects.
3. Occasionally small (Lilliputian), especially in alcoholics, organic, or toxic psychoses, especially anticholinergic (Atropine) toxicity.

Lilliputian hallucinations are rare in schizophrenia.

4. Visual hallucinations are usually consistent with auditory hallucinations and with delusional thinking.
5. Psychotic hallucinations do not change if the eyes are open or closed.

6. Drug induced visual hallucinations are more readily seen with the eyes closed.
7. Dramatic, atypical visual hallucinations should arouse suspicions of malingering.
8. Summary of suspect visual hallucinations:
 - a. Visual alone in schizophrenia
 - b. Black and white
 - c. Dramatic, atypical
 - d. Change with eyes closed
 - e. Miniature or giant figures
 - f. Visions unrelated to delusions or auditory hallucinations

IX. MALINGERED VS. TRUE DELUSIONS

- A. Delusion-a false statement made in an inappropriate context with inappropriate justification. A fixed false belief.
- B. Most delusions involve the following general themes:
 1. Disease
 2. Nihilism, poverty, sin and guilt
 3. Grandiosity
 4. Jealousy
 5. Love (erotomania)
 6. Persecution
 7. Reference
 8. Religion
 9. Being poisoned
 10. Being possessed (Cacodemonomania)
 11. Being the descendant of royal family
 12. Having insects under the skin (delusional parasitosis)
 13. Significant others have been replaced by doubles (Capgras syndrome)
- C. Clues to malingered delusions:
 1. Abrupt onset or termination
 2. Eagerness to call attention to delusions
 3. Conduct not consistent with delusions
 4. Bizarre content without disordered thoughts
 5. Delusions with exaggerated cognitive deficit.

X. EVALUATION OF PTSD CLAIMS (Breslau 2009; Knoll and Resnick 2006)

- A. Overview (Breslau 2009):

1. The lifetime cumulative exposure to any traumatic event in a national sample of the U.S. population in 2000 was 82.8%. Despite the vast majority of the population being exposed to one or more traumatic event, only a minority of trauma victims (<10%) develop PTSD.
 2. PTSD prevalence is higher in women compared with men despite the increased likelihood of men experiencing a traumatic event.
 3. Persons with PTSD have high rates of other psychiatric disorders. For example, those people who meet criteria for PTSD after a trauma are at a markedly increased risk for major depression.
- B. Apply the duration and “clinically significant impairment” criteria. Boals and Hathaway (2010) noted the importance of reviewing the F (duration of symptoms greater than a month) and G criteria (clinically significant distress or impairment) for PTSD in addition to the reported symptoms. In particular, when F and G criteria were included in individuals reported PTSD symptoms, those meeting PTSD criteria dropped from 20% to 3%.
- C. Forensic interview of evaluatee (Knoll and Resnick 2006):
1. Take a careful history without providing verbal or nonverbal clues regarding genuine symptoms of PTSD or any skepticism of evaluatee’s report.
 2. Begin with open-ended questions and avoid leading questions regarding PTSD symptoms.
 3. Firmly request detailed illustration of symptoms. DSM criteria are readily available and therefore a malingerer may be easily able to report basic symptoms. However, malingerers may have difficulty elaborating on criteria with personal life details and are more likely to report vague symptoms with an artificial quality.
 4. Inquire as to both duration of exposure to PTSD stressor and proximity to stressor. Increased exposure and closer proximity to stressor increases the risk of acquiring PTSD symptoms.
 5. Take careful dream/nightmare history:
 - a. Disturbed sleep is a hallmark of PTSD. Up to 75% report nightmares whereas about 5% of all adults report nightmares.
 - b. Characteristics of genuine PTSD nightmares vs. malingered nightmares include increased nocturnal awakenings, awakening earlier in the evening, increase in body movements, and increase in REM abnormalities. A 2013 review of sleep disturbances found in PTSD noted that although nightmares

are primarily a REM sleep phenomenon, they may also occur during non REM sleep in patients with PTSD. Therefore, there can be disturbances in both REM and NREM sleep.

- c. Genuine posttraumatic nightmares typically ameliorate after standard treatments for PTSD.
 - d. There is mixed literature regarding whether or not reporting exact replications of nightmares is consistent with genuine vs. malingered nightmares. Wittmann, Schredl, and Kramer (2007) reviewed several studies and found that approximately 50% of participants reported replicative post-trauma nightmares, while a study of treatment seeking individuals found that only 20% of trauma-exposed individuals reported replicative nightmares (Davis et al. 2007).
6. Flashbacks: involuntary memories involving re-experiencing distressing events in the present (Brewin 2015).
 - a. 9% of veterans with genuine PTSD from the first Gulf War described flashbacks.
 - b. Flashbacks described more commonly in clinical situations and civil litigation.
 - c. Brewin et al (2012) demonstrated that flashbacks can be reported to include stimuli a person has not experienced if they have previously been presented such stimuli as part of their own trauma narrative.
 7. Look for actual evidence of concentration deficits, irritability and hypervigilance during the interview.
 8. Obtain details regarding daily activities before and after the trauma.
 9. Investigate if the patient has an ability to enjoy recreation while reporting an inability to work.
 10. Inquire into rare or improbable symptoms not typically seen in PTSD. Consider asking about symptoms not associated with PTSD such as inflated self-esteem, decreased need for sleep, increased talkativeness or impulsive spending.
 11. Consider using psychological testing to assess for malingering to include SVT tests. One such test being studies to assess malingered PTSD is the Morel Emotional Numbing Test. This instrument assesses affect recognition in a two-alternative forced-choice format. Many of the SVT's used are primarily measures of memory malingering whereas the MENT assesses primarily PTSD malingering.

12. The M-FAST (Miller Forensic Assessment of Symptoms Test) has demonstrated a significant difference between war-related PTSD and malingering participants using a cutoff score of six or higher.

15. Gather collateral information (e.g. family members, friends, or significant others).

XI EVALUATING AMNESIA CLAIMS (Scott 2012)

A. **Amnesia definition:** memory impairment while other basic cognitive functioning remains intact. Disorders that involve marked impairment in multiple cognitive domains, such as dementia or other progressive neurological disorders, are not typified by isolated memory impairments.

B. Amnesia can be divided into two main types based on how the memory loss is referenced to a particular point in time:

1. **Anterograde amnesia** involves difficulty in recalling new facts or life events *after* the onset of a particular condition or incident. Anterograde amnesia is typically global in that memory for all newly presented information (both verbal and non verbal) is impaired regardless of how the information is presented. The majority of patients suffering from anterograde amnesia have some degree of retrograde amnesia. However, this pattern is not absolute. In fact, there are reported cases of people with particular brain injuries or diseases that experience anterograde amnesia with minimal or no associated retrograde amnesia.

The term “Transient Global Amnesia” (TGA) was coined by Fisher and Adams (1964). TGA is characterized by complete anterograde amnesia, which may result in the person experiencing disorientation to time and place. Because affected persons are able to use their long-term memory, they retain knowledge about who they are and are often able to make logical interpretations of their circumstances. Common characteristics of TGA include repetitive questioning and answering, repetitive behaviors, apathy or agitation, and a transient memory loss usually lasting between 1-24 hours. The exact etiology of TGA is unclear though many cases appear triggered by precipitating events such as physical exertion, sexual intercourse, emotional stress related to arguing, or certain medical procedures. TGA is distinguished from other forms of anterograde amnesia by its short duration and memory recovery.

2. **Retrograde amnesia** occurs when a person has impaired retrieval of information that they had learned *prior* to the onset of a condition or situation (Kopelman 2002). Focal retrograde amnesia is defined as a memory loss for an isolated circumscribed period of a person’s life. Offenders who claim amnesia only for the period of their criminal behavior without other memory deficits are reporting a focal (i.e. circumscribed) retrograde amnesia.

VI. PROPOSED AMNESIA CAUSES

A. Organic:

1. A variety of circumstances may impact brain structures that relate to the encoding and consolidation of memories. For example, medical conditions (such as diabetic hypoglycemia or traumatic head injury) may interfere with the brain's ability to input and store the memory (Kopelman 2002). The list of possible medical conditions affecting memory is extensive and careful consideration of an organic etiology is important when evaluating amnesia claims.
2. Head injuries are a common proposed cause of amnesia in both civil and criminal litigation.
3. Medical causes of amnesia include:
 - Alcohol and/or substance use (see section below)
 - Aneurysm rupture of the anterior communicating artery
 - Anoxia
 - Brain disease, impairment, or injury
 - Cerebrovascular accident
 - Delirium
 - Dementia
 - Electroconvulsive therapy
 - Encephalitis
 - Hypoglycemia
 - Somnambulism
 - Transient epileptic forms of amnesia
 - Wernicke-Korsakoff Syndrome

B. Proposed psychological causes of amnesia:

1. Numerous potential emotional triggers for situation specific amnesia have been described in the literature. Suggested psychological causes center on the theory that an altered emotional state or level of consciousness results in memories being stored in some type of exceptional or alternate context (Porter et al. 2001). When the person attempts to retrieve the memory in a calmer state, the memories are theoretically not accessible because of this state-dependent memory. Emotional states that have been suggested to cause or contribute to amnesia include extreme rage, anger, psychosis, or dissociation resulting from severe trauma. In line with this theory, researchers have found that defendants with more emotionally driven and reactive murders are more likely to claim amnesia (56%) than defendants whose homicides involved planning (30%) (Merckelbach and Christianson 2007).
2. Memory loss due to a rageful state usually related to a crime of passion has been referred to as a "red out." Swihart et al. (1999) provides two cases examples to support this proposed red-out phenomena, which he reports involves a sudden

rush of anger toward a known victim resulting in homicidal violence. In this red-out scenario, the perpetrator describes a loss of memory that begins at the peak of the violent act with memory returning following the completion of the violence. These authors propose four key elements of a red-out:

- a. An intact memory for events before and after the violent attack;
- b. An unusual level of anger associated with the attack;
- c. Amnesia for the most violent part of the event; and
- d. The absence of any alcohol, drugs, or organic basis for the amnesia.

Although the authors suggested malingering was unlikely in their two case reports, no structured assessments of malingering were described in their review. A person's self-report regarding their "emotionality" prior to their claimed amnesia may need to be viewed with some skepticism. For example, one study found that murderers nearly always provided an exaggerated account of their emotionality at the time of the crime as determined by comparing their statements to official crime reports (Porter, Woodworth and Doucette 2007).

3. The Diagnostic and Statistical Manual, Fifth Edition, (DSM-5) uses the term dissociative amnesia when describing psychological states associated with memory loss. According to the DSM-5, the diagnosis of Dissociative Amnesia "is an inability to recall important personal information, usually of a traumatic or stressful nature, that is inconsistent with ordinary forgetting" (DSM-5, page 298). The DSM-5 eliminated the separate diagnosis of Dissociative Fugue from the DSM-IV-TR and this is now a modifier for Dissociative Amnesia.
4. The DSM-5 distinguishes the diagnosis of Dissociative Amnesia from other diagnoses that may include an amnesic or dissociative state as one of the diagnostic criteria. Alternate diagnoses include:
 - a. Dissociative Identity Disorder:
 - b. Posttraumatic stress disorder
 - c. Neurocognitive disorders
 - d. Substance-related disorders
 - e. Posttraumatic amnesia due to brain injury
 - f. Seizure disorders
 - g. Catatonic stupor
 - h. Factitious disorder and malingering
 - i. Normal and age-related changes in memory
5. Dissociative Identity Disorder in the DSM-5 had some alteration in the language that may make it easier to diagnose DID while at the same time wording in the text portion emphasizes the evaluation of malingering. Key aspects of this new definition include:

- a. Disruption of identity characterized by two or more distinct personality states, which may be described in some cultures as an experience of possession. The signs of symptoms may be observed by others or reported by the individual.
- b. Recurrent gaps in the recall of everyday events, important personal information, and/or traumatic events that are inconsistent with ordinary forgetting.
- c. DSM-5 recommendations of features to consider when considering malingering vs. DID include the following:
 - Those who feign DID do not report subtle symptoms of intrusion characteristics.
 - Those who feign DID tend to over report well publicized symptoms of the disorder, such as dissociative amnesia while underreporting other symptoms such as depression.
 - Those who feign tend to be relatively undisturbed by or may even seem to “enjoy” having the disorder in contrast to those with genuine DID who tend to be ashamed of and overwhelmed by their symptoms and tend to underreport or deny their condition.
 - Those who feign may present an “all-good” identity and an “all-bad” identity in hopes of gaining exculpation for a crime.

C. Malingered amnesia in criminal cases:

1. The precise prevalence rate of malingered amnesia in criminal cases is difficult to establish. However, when research subjects are asked to think of a way to defend against a hypothetical murder charge, amnesia combined with blaming the act on an internal force (such as an alternate personality) is the most commonly chosen strategy (Rabinowitz 1989, Spanos, 1986).
2. Surveys of forensic psychologists indicate the base rate of malingering in referred cases is in the range of 11-20% (Mittenberg et al. 2002). Likewise, in one of the first studies examining offenders who claim amnesia, Hopwood and Snell (1933) described that nearly 20% of offenders reporting no recollections of their criminal acts were feigning their memory loss.
3. Kopelman (2002) notes that there are at least four reasons to suggest that some amnesia claims are genuine and should not automatically be discounted. These reasons include
 - a. Different offenders’ descriptions of their memory gaps are similar to each other, with the reported memory loss for the offense period typically lasting an hour or less.

- b. Some victims or witnesses of violent crime who experience emotional arousal and/or alcohol intoxication have also claimed amnesia. Despite these associated factors (which are often present in offenders) victim and witness claims are rarely questioned.
 - c. Offenders' amnesia claims may not help in their defense or may prevent important information they know from coming forward; yet they persist in reporting a loss of memory for their actions.
 - d. Many offenders claiming amnesia have actually turned themselves into the police or failed to take steps to prevent their apprehension indicating that they are not malingering amnesia to avoid punishment.
4. Even though some offenders turn themselves into police, they may still have multiple reasons to feign memory loss. These include:
- a. Falsely claiming amnesia allows the defendant to potentially testify while remaining silent about the crime. A defendant who reports no memory for the crime can significantly evade cross-examination for his criminal actions (Merckelbach and Christianson 2007). Along these same lines, a defendant may find it easier to claim amnesia as opposed to taking the riskier approach of lying or creating a fake alibi (Porter et al. 2001).
 - b. Oorsouw and Cima (2007) demonstrated that pre-trial inmates were significantly more likely to claim amnesia for their crime compared to convicted inmates. Defendants who claim amnesia are likely to have an extensive psychiatric evaluation (Merckelbach and Christianson 2007). Because experts may not be adequately trained in assessing amnesia and/or may not conduct structured memory assessment, defendants may be inappropriately diagnosed as genuinely amnesic when they are faking. For example, one study indicated that trained forensic experts failed to identify 50% of malingerers when they relied solely on the defendant's self-report or failed to conduct or review appropriate psychological tests (Rosen and Phillips 2004).
 - c. Claiming amnesia provides the defendant a reason not to discuss the crime and thereby avoid potentially painful memories (14).
5. Suspecting that a defendant may feign memory loss is justified for several reasons as summarized by Jellicic and Merckelbach (2007). These reasons include:
- a. Complete amnesia is rare, even in situations where a person may be in a different emotional state when the crime occurs than when they are later questioned about the crime.

- b. Significant research notes that actions performed by a person are remembered better than other types of information (Engelkamp 1994) or other events witnessed (Symons and Johnson 1997).
 - c. Individuals who witness a violent crime do not typically report memory loss of the traumatic event, suggesting that emotional trauma is an unlikely explanation for complete memory loss. In particular, concentration camp survivors maintain memories of the brutal violence they experienced when examined 40 years later (Wagenaar and Grownwed 1990). Likewise, children between the ages of 5 and 10 who witness their parents being murdered maintain vivid recollections of the trauma (Symons and Johnson 1997).
 - d. Polled sexual and homicide offenders overwhelmingly report that feigning memory loss is common when charged with these offenses.
 - e. Studies of convicted offenders who claimed crime-related amnesia note that they are more likely to score in the malingering range on a self-reported instrument to assess feigned rare and bizarre cognitive and psychiatric symptoms compared to prison inmates who have not claimed amnesia.
6. The presence of psychopathy has been suggested as a factor that might increase the likelihood that an offender will malingering amnesia.
- a. Psychopathy represents a personality construct characterized by severe personality defects (e.g., lack of empathy, callousness, lack of remorse, pathological lying, conning others) and disruptive behaviors (e.g., juvenile delinquency, early childhood behavioral problems, adult arrests) (Hare 1993).
 - b. One study sometimes cited to suggest that psychopaths facing legal charges are more likely to feign amnesia for their crime involves research conducted by Lynch and Bradford (1986). In this study, 22 pre-trial defendants, all of whom reported some type of alcohol and/or drug amnesia regarding their offense, were referred for a forensic psychiatric evaluation. A polygraph was given to the defendants to evaluate the truthfulness of their amnesia claims. The authors noted that 63% of offenders with psychopathic features were deceptive in their amnesia claims compared to 50% of those without personality disorders. The study, however, did not incorporate any measure of psychopathy. Instead, all personality disorders were grouped together into one personality group. Of note, the study results did not show how any subject met diagnostic criteria for antisocial personality disorder or psychopathy.
 - c. Subsequent research indicates that contrary to what might be expected, psychopathic criminal defendants are not more likely to feign a psychiatric

disorder (Kurchaski et al. 2006) or be particularly adept at malingering (Poythress et al. 2001). At the present time, psychopathy by itself cannot be cited as a reliable indicator that the person is malingering amnesia.

- d. There is no precise feigned-amnesia profile. Research studies are mixed regarding the demographics of those who falsely claim amnesia (Grondahl et al. 2009), although some evidence indicates that older offenders more commonly claim amnesia (Cima et al. 2004).

X. AMNESIA EVALUATIONS-FORENSIC REVIEW AND HISTORY

A. Conduct a relevant medical and psychiatric examination.

1. The evaluator should first clarify that the reported problem is one of amnesia rather than memory problems associated with dementia, delirium, or a developmental disability such as mental retardation. A memory evaluation should be comprehensive and in many circumstances will be aided by neuropsychological testing. Basic components of a memory evaluation include the following:
 - a. Orientation to time and place;
 - b. Ability to recall prose;
 - c. Rote learning;
 - d. Visuospatial memory and retention;
 - e. Remote memory and fund of information; and
 - f. Autobiographic memory.
2. Potential medical contributions to memory loss must be investigated with appropriate laboratory testing, physical and neurological examinations, and imaging when indicated.
3. In cases involving retrograde amnesia resulting from severe head trauma, older memories more commonly return than more recent memories. Over time the amnesia substantially resolves with the amnesic period limited to the traumatic event and the few seconds prior to the event. Offenders claiming amnesia as a result of brain trauma whose memory recovery does not follow this pattern should be carefully screened for malingering. This pattern is sometimes referred to as “Ribot’s law.”
4. Semi-structured diagnostic assessment tools may assist in better understanding memory loss complaints. Numerous instruments are available to guide the evaluator in asking questions specific to amnesia associated with a wide variety of conditions. Semi-structured interviews that have been used to assess amnesia associated with Posttraumatic Stress Disorder (PTSD) include the Clinician-Administered PTSD Scale (CAPS), the Peritraumatic Dissociation Experiences-Rater version (PDEQ-R), and the PTSD Symptom Scale Interview.

5. Similarly, a variety of semi-structured interview instruments to assess dissociation (with related amnesic components) have also been published. One commonly used screening instrument for dissociation is the Dissociative Experience Scale (DES). The DEC consists of 28 statements that related to a range of dissociative symptoms and the person evaluated is asked to note how often they have such experiences when they are not under the influence of alcohol or drugs. Scores of 30 or higher have been noted as suggesting severe dissociation. Two other structured interviews to evaluate potential dissociative disorders include the Dissociative Disorders Interview Schedule (DDIS) and the Structured Interview for DSM-IV Dissociative Disorders (SCID-D).
6. Although semi-structured interview instruments may assist the evaluator in asking specific symptom related questions, the majority of these instruments rely on self-reports alone to code and score the responses. Therefore, in those individuals feigning memory loss, a “finding” of amnesia or dissociation does not prove that the claimed memory impairment is genuine or related to the crime. For example, McLeod et al (2004) noted that male prisoners’ high levels of dissociative symptoms were unrelated to their violent crimes (43). Furthermore, in their study of Canadian homicide offenders, Woodworth et al. (2009) found that although dissociative tendencies as measured with the DES were associated with a self-reported memory loss, objective measures of memory quality did not reflect this perceived impairment.

B. Clarify the characteristics of claimed amnesia

1. When a person claims amnesia, the evaluator should carefully determine the type (i.e., anterograde, retrograde, or both) and extent of memory deficit reported. The following symptoms of extreme specificity regarding amnesia reports have been described as consistent with malingering.
 - a. A circumscribed memory loss for the crime with recall of events before and after the crime. In one study of murderers who claimed amnesia, the majority (60%) reported that their memory loss was limited to the crime itself (Bradford 1979). This isolated pattern of memory loss contrasts with studies of memory and emotional events which generally find that people remember the event very well but have some memory loss for information before and after the emotionally arousing incident (Christianson et al. 2007).
 - b. A sharp and sudden onset and ending of the circumscribed amnesic period. Genuine amnesia more characteristically has a blurred beginning and ending (Power 1979).
 - c. A complete loss of memory for a circumscribed period. In a study of 21 convicted male offenders claiming amnesia, 20 claimed partial amnesia and only 1 claimed complete amnesia. These findings indicate that complete

amnesia for a criminal act is very rare (Gronwahl 2009) and amnesia for the complete act of killing is very unlikely (Christianson et al. 2007).

- d. An attitude by the person that nothing can possibly help their memory recovery. Schacter (1986) assessed offenders' "feeling-of-knowing" in regards to their beliefs that their memory return could be assisted by cues, reminders, reenactments, or a return to the crime scene. Offenders with low "feeling-of-knowing" ratings were dogmatic that their memory could not be helped by any assistance and this pattern was described as characteristic of malingerers.
- e. An overly dramatic presentation with reports that the symptoms experienced were *extremely severe* (Christianson et al. 2007).
- f. A report of *extremely specific* symptoms (i.e. "I can't remember anything from precisely 8:00 a.m. until 12:00 p.m.") (Christianson et al. 2007).
- g. A report that the amnesia was caused by intoxication contrary to available evidence (Christianson et al. 2007).

C. *Evaluate the relationship of alcohol and/or substance use to claimed amnesia:*

1. Alcohol use is common in violent offenders who claim amnesia. In their study of criminal offenders, Taylor and Kopelman (1994) noted that over half of those claiming amnesia were under the influence of alcohol in the hours prior to their offense. Persons who consumed the most alcohol were more likely to report amnesia. Other studies have indicated that over 85% of offenders claiming amnesia were under the influence of alcohol and/or drugs when they committed their crime (Parwatikar et al. 1985).
2. Evaluators, however, should not assume that an offender's reported alcohol or drug use has resulted in genuine amnesia. For example, Cima et al. (2004) described that although substance-abuse-disordered forensic patients were more likely than controls to claim amnesia, only a minority of them had a sufficiently high alcohol or drug level to actually produce amnesia. This finding indicates that an offender may falsely claim that their substance use caused memory loss for their crime to minimize their personal responsibility (Cima et al. 2002).

D. *Evaluate degree of offense planning*

1. Criminal behavior is often described as either instrumental or impulsive. Instrumental crimes are those that involve a degree of planning as compared to more impulsive crimes, which are typically sudden, emotionally driven with little or no preparation. In reality, there may be both instrumental and reactive

components involved in a crime. Nevertheless, this distinction is important in evaluating authenticity of memory claims.

2. Because elaborative processing and rehearsal actually *improves* memory (Brown and Craik 2000), planning and premeditation should enhance an offender's memory for the crime. As a result, genuine amnesia for instrumental criminal behavior would not be expected (Jelicic and Merckelbach 2007).
3. To evaluate an offender's memory regarding the alleged criminal act, the examiner might find it helpful to systematically follow Calhoun and Weston's proposed pathway model to homicidal violence (Calhoun and Weston 2003). Table 4 below summarizes the first six steps to violent homicides in this model pathway with two additional subsequent steps (steps seven and eight) suggested by Christianson et al. (2007).

Proposed pathway to violence

Violent crime stages	Associated feeling and action memories
Step 1: Grievance	Feelings include anger, revenge, and being wronged
Step 2: Ideation	Accepting use of violence to correct wrong or fulfill violent/sexual fantasies. May identify with other assailants and discuss fantasies with others
Step 3: Research and planning	May include gathering information to enact plan, inquiring about target, and conducting surveillance
Step 4: Preparations	May involve assembling equipment, practicing firing gun, choosing clothing, writing messages to others, making will.
Step 5: Breach	Positioning oneself close to the potential victim.
Step 6: Attack	Enacting a plan, which requires commitment and resolve.
Step 7: Realization	Actions upon the victim's body, to include additional violence or sexual acts.

Step 7: Post-crime behavior	Behaviors aimed at avoiding discovery or staging the crime scene.
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E. *Obtain relevant collateral information.*

1. Records often useful in both civil and criminal evaluations:

- Any statements or writings by defendant or plaintiff (police reports, depositions, complaint, etc.)
- Witness statements regarding crime or alleged cause of trauma
- Investigative reports regarding crime or alleged cause of trauma
- Medical records (to include neurologic workup)
- Relevant neuroimaging studies
- Psychiatric records
- Alcohol and drug treatment records
- Laboratory data associated with alcohol use (such as liver function tests)
- Occupational records
- Educational records
- Observations by others regarding prior memory functioning
- Observations by others regarding current memory functioning
- Prior exposure to media regarding amnesia cases or presentation
- General psychological testing
- Specific malingering testing
- Neuropsychological testing

2. Records specific to criminal evaluations:

- Arrest records
- Booking records
- Jail records (to include mental health screens and treatment)

3. Records specific to civil evaluations:

- Employee evaluation file
- For accidents, on site emergency care, ambulance run sheets, emergency room records, accident report
- Prior disability or workers compensation claims
- Prior litigation history
- Depositions of relevant parties to include expert witnesses

EVALUATING MALINGERED ADHD

Vignette:

You are asked to evaluate a Joe, a criminal defendant referred for a competency to stand trial evaluation. He has been charged with assault with a deadly weapon and resisting arrest after he struck his fiancée with a baseball bat across her face when she refused to sign over her monthly paycheck to him. When the police arrived at their trailer home, he swung at them with the bat as they attempted to arrest him. Joe tested positive for methamphetamine at the time of his arrest.

Joe reports that he has severe ADHD that prevents him from concentrating on his case, from consulting with his attorney, and from retaining information about the legal system. He reports that he has “fired” two past attorneys when they refuse to “just get the court to drop all my charges.” In a prior evaluation, he told the evaluating psychologist that could not remember his attorney’s name and could not recall his charges because of his impaired attention. He told this psychologist that he has used methamphetamine to “self-medicate” his severe attention problems because he could not afford a psychiatrist to obtain a prescription stimulant. This psychologist administered the Conners’ Adult Scale and the Conner’s Performance Test and opined that based on these results, the defendant “without question meets criteria for a severe ADHD diagnosis that renders him incompetent to stand trial.” This evaluator related that Joe’s firing of his attorney resulted from his “impulsive actions classic for ADHD.” The court evaluator also rendered an opinion that the jail should immediately prescribe Joe a stimulant medication.

When you question this defendant about his past mental health history and any treatment for ADHD during childhood, he quickly stands up, kicks his chair over, and leaves the evaluation room while yelling, “It’s all in my chart you asshole. I’m not going to waste my time repeating my life history to you. Look it up.”

How would you proceed in evaluating this case?

I. ADHD OVERVIEW

- A. Diagnostic criteria: The majority of DSM-5 criteria for ADHD are subjective in nature and rely heavily on self-report.
- B. ADHD is therefore easily malingered and examiners often obtain no collateral information or conduct any tests of feigning, particularly in adults.

II. CLINICAL EVALUATION

- A. A comprehensive assessment of ADHD in adults should employ multiple strategies, including a structured clinical interview, medical examination, self-report rating scales, rating scales from other reporters, structured tasks of attention, and structured tasks of impulsivity (Roy-Byrne et al.1997).
- B. Interview observations to note:
 - 1. Ask if the evaluatee learned about ADHD symptoms. Do they have a family member with ADHD, have the researched ADHD symptoms, or have they been previously diagnosed with ADHD?

2. Does the individual show ability to attend to questions asked during the examination?
3. Does the person appear easily distracted during the examination?
4. Does the person attempt to appear less intelligent than their record indicates?
5. Does the person have a dramatic change in performance when asked to perform tests of attention and concentration?

C. **Evaluator should VERIFY PAST HISTORY of ADHD because self-report for past ADHD symptoms is NOT reliable.** In a prospective study (Mannuzza, Klein, Klein, Bessler, and ShROUT, 2002), in which structured clinical interviews were administered to adults who were diagnosed with ADHD as children (based on strict research criteria) and adults who showed no evidence of ADHD in childhood. Interviewers, who were unaware of the diagnostic status of participants and the study's purpose, rated the presence of clinically significant childhood symptoms of inattention, hyperactivity, and impulsivity based on the adult interview data. Interviewers then used their ratings to form both probable and definite diagnosis of childhood ADHD. Notably, 32% of childhood ADHD symptoms were recorded as clinically significant in at least 20% of the control participants, and 11% of controls were diagnosed with ADHD in adulthood based on their retrospective symptom report, despite having been carefully screened for the absence of ADHD when they were children.

1. **Rating scales are NOT do not detect malingered ADHD symptom report.** Because self-report scales are subjective in nature and symptoms of ADHD are easily learned, there are concerns that individuals could easily feign ADHD symptoms on such scales.

III. TESTING AND ADHD

- A. Neuropsychological research has not identified consistent findings for ADHD and neurologic impairments are not specific to this disorder.
- B. Continuous Performance Tests (CPTs) are often used to assess and “validate” a diagnosis of ADHD. CPTs present stimuli to an individual and evaluate if the person is able to identify the presented stimuli (measure of attention) or if the person is able to NOT wrongly identify a stimuli (measure of impulsivity). Such tests typically measure errors of omission (lack of attention) and errors of commission (impulsivity).
 1. One commonly used CPT is known as the Conners' CPT-II. The CPT-II is a computerized attention task in which an individual is asked to respond to all letters flashing on the computer screen except for a target letter; the task includes several blocks of trials with different interstimulus intervals.
 2. Most CPT measures do *not* have embedded measures of validity and therefore do not measure whether or not the person's performance is credible.

3. In their study Suhr et al (2011) utilized archival data on Conner's Continuous Performance Test (CPT) scores to compare individuals who presented to university clinics with symptoms of potential ADHD. These young adults were divided into three groups: (1) those who failed a measure of noncredible performance (the Word Memory Test; WMT), (2) those who met diagnostic criteria for ADHD, and (3) controls with psychological symptoms who did not meet the diagnostic criteria for ADHD. More individuals who failed the WMT were also clinically impaired on the CPT than individuals diagnosed with ADHD and individuals with psychological symptoms, who could not be distinguished from each other. Results from this study demonstrate the importance of assessing for noncredible performance before interpreting neuropsychological test scores in ADHD assessment. **The study provides evidence that the CPT is vulnerable to noncredible performance and that noncredible performance on the CPT can be difficult to distinguish from actual ADHD.**
- C. Strongly consider using tests to assess level of effort and tests to evaluate non credible cognitive responding. Example tests that may assist in evaluating credible cognitive deficits include:
1. Word Memory Test
 2. Medical Symptom Validity Test
 3. b test
 4. TOMM

IV. SUMMARY POINTS ON EVALUATING MALINGERED ADHD

- A. Is there a documented history of ADHD in childhood?
- B. Is the person's presentation consistent with ADHD?
- C. Does collateral interview and/or evidence support ADHD?
- D. Has the individual failed effort tests to assess non credible performance?
- E. Even if the person meets ADHD criteria, is there evidence of actual impairment that impacts the referral question?

V. SUMMARY

- A. Carefully investigate reported symptoms and be cautious when relying on self-report alone.
- B. Look for clues of malingering during evaluation.
- C. Review collateral records to evaluate if reported symptoms are consistent with the actual record.
- D. Consider using psychological testing strategies to help evaluate reported symptoms.
- E. Remember that a diagnosis of "malingering" requires that you have sufficient evidence to link symptoms to person's intent for a secondary gain.

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