



Introduction to Malingering Research and Symptom Validity Assessment

Thomas Merten^a and Harald Merckelbach^b

^a *Vivantes Netzwerk für Gesundheit, Klinikum im Friedrichshain, Berlin, Germany*

^b *Forensic Psychology Section, Maastricht University, Maastricht, The Netherlands*

Correspondence to: Thomas Merten, PhD, Vivantes Netzwerk für Gesundheit, Klinikum im Friedrichshain, Dept. of Neurology, Landsberger Allee 49, D-10249 Berlin, Germany. Email to: thomas.merten@vivantes.de

A hundred years ago, the British physician sir John Collie was one of the few authors who wrote technical papers about the phenomenon of malingering. A recurrent theme in his publications was that “excessive illness claims” are closely related to insurance and workers compensation acts and are typical for the working classes, especially the women and the neurotics among them (Collie, 1913). Collie’s ideas were heavily inspired by his work as a medical examiner for the London County Council and other bodies. The fact that he published about malingering did not contribute in a positive way to his reputation. On the contrary, in the obituary that appeared in the *British Medical Journal* some weeks after Collie’s death (1935), the anonymous author deemed it necessary to remark that “in popular estimation he was quite wrongly regarded as a hard-hearted official devoid of all human sympathies” (Anonymous, 1935; p. 807).

Since Collie’s days, things have changed profoundly. The annual number of publications with the keyword *malingering* showed a steep increase from the beginning of the 1980s (with less than five publications per year) to the mid 2000s, exceeding the mark of 100 in 2006 (Berry & Nelson, 2010). Importantly, the overwhelming majority of these papers have been published in neuropsychological rather than medical journals. Indeed, symptom validity testing and malingering research have become a success story of neuropsychology so much so that during the past two decades, no other field has produced such a wealth of empirical studies, methodological development, and, subsequently, conceptual debate and progress related to the problem of non-authentic symptoms.

The question why neuropsychology was that much involved in breaking the long-lasting taboo in such important issues like *deception in clinical and forensic communications* and *differential diagnosis of non-authentic symptom presentations* can be answered on different levels. Firstly, the core business of neuropsychology is cognitive functioning and its measurement. Thus, clinical and forensic neuropsychology have always maintained close links with psychological assessment methods. However, psychological tests critically depend on the willingness of the patient to invest optimal effort; when this willingness is, for whatever reason, compromised and the patient exhibits a response bias during testing, the test profile obtained fails to reflect the true level of his or her cognitive functioning or impairment.

Secondly, the evaluation of claimants in injury or compensation cases has become an important branch of applied neuropsychology. Cognitive symptoms are often reported by claimants who have been given all sorts of diagnostic labels. These labels are not limited to traumatic brain injury and cerebral diseases, which are traditionally the province of neuropsychologists. Cognitive symptoms like memory and attention deficits are also reported by patients with depression, anxiety disorders, posttraumatic stress disorder, and somatoform disorder. These symptoms may be profound in some of the dissociative disorders (in particular, dissociative amnesia), and they play an important role in patients with pain conditions, fibromyalgia, whiplash injury, as well as a variety of what

came to be known as “new diseases” (such as sick building syndrome, multiple chemical sensitivity, or golf war syndrome).

Thirdly and related to the latter point, base rate estimates indicate that a considerable number of claimants who report cognitive symptoms also exhibit response biases when they are evaluated with formal tests (e.g., Mittenberg, Patton, Canyock & Condit, 2002). In some settings, the prevalence of claimants with presumably non-authentic symptom presentation may reach or even exceed the 50 percent level (e.g., Larrabee, 2007; Schmand, Lindeboom, Schagen, Heijt, Koene, & Hamburger, 1998; Sullivan, May, & Galbally, 2007). Fourthly, a number of empirically based methods have been developed, primarily by neuropsychologists, which render diagnostic decision making regarding the validity of individual test profiles and possible response biases more reliable than any other method known to date. Finally, due to its close relationship to biological and medical sciences in general, and neurology in particular, neuropsychology is one of those psychological disciplines that have always maintained a special emphasis on empirical methods, on objective measurement, and on the stringency of logical argumentation.

The above considerations help to understand why the bulk of empirical research on response bias, symptom validity and malingering has been published in journals focused on applied neuropsychological assessment, such as the *Archives of Clinical Neuropsychology* and *The Clinical Neuropsychologist* (cf. Sweet & Guidotti Breting, 2013). In little more than two decades of malingering research, this has resulted not only in a wealth of studies, but also in conceptual clarification. Modern methods of symptom validity assessment can today be considered as an indispensable, integral part of neuropsychological evaluations (e.g., Bush et al., 2005; Heilbronner et al., 2009), in particular in the forensic context where secondary gain is immanent.

So far, this development has had relatively little impact on neighbouring disciplines. While some psychiatrists have welcomed research on response validity and the new tools that came with that, others may feel threatened and maintain that their clinical judgment alone, in combination with traditional lists of malingering criteria, are sufficient to rule out malingering as a differential diagnostic option. Consequently, they maintain, symptom validity assessment has no regular place in the assessment of psychopathology (e.g., Dressing, Foerster, Widder, Schneider, & Falkai, 2011).

Numerous studies have shown that it is relatively easy to fake or exaggerate somatic, cognitive or psychological symptoms in a way that it remains undetected by medical and psychological experts when they rely on clinical intuition alone. Both in clinical and forensic contexts, the consequences of wrong diagnoses are far reaching.

Although psychopathologists have been interested in studies on the detection of deception and related issues like, for instance, psychopathy, they have not profited from broader symptom validity assessment research. This is unfortunate. For example, a popular research theme in psychopathology is posttraumatic stress disorder (PTSD). Individuals with a PTSD background are sometimes involved in litigation or disability claims and this context may give them a motive to exaggerate or even fabricate symptoms. When these individuals are included in research samples, the integrity of the data set is at stake. It is with this consideration in mind that Rosen (2006) recommended protecting the PTSD data base by paying proper attention to the possibility of malingering in individuals who claim PTSD symptoms. Of course, malingering is a diagnostic option that can just as well apply to other disorders (e.g., psychosis, depression, attention deficit hyperactivity disorder) when issues of compensation or secondary gain (e.g., stimulant medication, reduced criminal responsibility) arise. Rosen's recommendation would be futile if there were no instruments to screen for malingered psychopathology. But as a matter of fact, such instruments have been developed (e.g., Morel, 1998), although not all of them are always sufficiently accurate.

The current issue of the *Journal of Experimental Psychopathology* aims at acquainting a larger readership of clinical and experimental psychologists to the progress made in this branch of research. Collie (1913; p. 645) wrote that “to most medical men the simulation of disease presents a difficult, almost insoluble puzzle.” Things have changed considerably and neuropsychology can inform us how they have changed.

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