This is a preprint of an article published as DeClue, G. (2002). Feigning ≠ malingering: A case study. *Behavioral Sciences and the Law, 20,* 717-726. A reprint can be purchased for a reasonable fee at: http://www3.interscience.wiley.com/cgi-bin/abstract/94518034/ABSTRACT.
Wiley does not provide authors with free reprints and Wiley does not allow authors to make free reprints available on the web. Sorry for the inconvenience.

Feigning ≠ Malingering: A Case Study

In the fourth edition of *The Clinician's Handbook,* Meyer and Deitsch (1996) assert that, in the practice of assessing for malingering, the Structured Interview of Reported Symptoms (SIRS; Rogers *et al.,* 1992) "is of questionable usefulness since even its author has been consistently disinclined to offer cutoff point decision rules" (Meyer & Deitsch, 1996, p. 422). In fact, Rogers *et al.* (1992, p. 26; emphasis in original) present clear cut scores for feigning but insist, *"Feigning should be established first, and motivation for feigning second."* And, in sharp contrast to the "questionable usefulness" characterization, Rogers *et al.* (1998) consider the SIRS to be a gold standard for malingering research.[1] This case study compares the usefulness of Meyer and Deitsch's versus Rogers' assessment-of-malingering models for practicing forensic psychologists, illustrates that malingering should never be diagnosed by test score(s) alone, and offers some guidance for how practicing forensic clinicians should present assessment-of-malingering data in reports and testimony.

[1] Rogers *et al.* (1998) write, "The use of the SIRS as a gold standard requires a brief explanation. Extensive research (see Rogers *et al.,* 1992; Rogers, 1997b) with both simulation designs and known-groups comparisons has established stable and accurate cutoff scores for establishing feigners and genuine patients. Use of the combined rules (see Rogers *et al.,* 1992) has a high degree of accuracy in classifying both feigners (.98) and genuine patients (.95)."

Malingering

Both Meyer and Deitsch (1996) and Rogers (1997a) consider the recommendations of the *Diagnostic and Statistical Manual (DSM-IV;* American Psychiatric Association, 1994, p. 683*)*, which advises that

> Malingering should be strongly suspected if any combination of the following is noted:
>
> 1. Medico-legal context of presentation (e.g., the person is referred by an attorney to the clinician for examination)
>
> 2. Marked discrepancy between the person's claimed stress or disability and the objective findings
>
> 3. Lack of cooperation during the diagnostic evaluation and in complying with the prescribed treatment regimen
>
> 4. The presence of Antisocial Personality Disorder

Meyer and Deitsch (1996, p. 412) assert, “This is good advice” and advise that “it is often appropriate to broaden the concept of malingering to any type of response that distorts the production of an accurate record.”

In contrast, Rogers (1997a) is critical of DSM-IV’s approach, and summarizes data from a study (Rogers, 1990) that showed that, using DSM-IV’s guidelines, “for every malingerer correctly identified, nearly four times as many *bona fide* patients were miscategorized as malingerers” (Rogers, 1997a, p. 9). Because of the serious consequences generated by a classification of malingering, such a false positive rate is clearly unacceptable.

Definitions

In contrast to Meyer and Deitsch's suggestion to broaden the use of the concept of malingering, Rogers (1997a) presents more narrow definitions. Rogers' definitions, presented next, are used throughout the remainder of this paper. *Dissimulation* is a general term to describe an individual who is deliberately distorting or misrepresenting psychological problems. *Dissimulation* can incorporate any, or a combination, of the following: malingering, defensiveness, irrelevant responding, or random responding. *Malingering* and *defensiveness* are reserved for cases in which there is unequivocal evidence of deliberate dissimulation. In *defensive* responding, the person minimizes or denies psychological problems or symptoms. A person who is *malingering* is intentionally exaggerating or fabricating psychological problems or symptoms; this is a conscious choice, motivated for external gain. Finally, *feigning* refers to exaggerating or fabricating psychological problems or symptoms, regardless of what the intent—if any—may be.

Models for Assessing Malingering

Meyer and Deitsch (1996, p. xi) endeavor to integrate "common behavior features, … test data, and … treatment recommendations" into a practical guidebook for clinicians, including those doing forensic work. Although they make some reference to research, many—perhaps most—of their recommendations do not show a clear scientific basis. This may limit the admissibility of testimony guided by their handbook, particularly in federal cases and in states guided by *Daubert v. Merrell Dow Pharmaceuticals,* 509 U.S. 579 (1993); *General Electric v. Joiner,* 522 U.S. 136 (1997);

and *Kumho Tire Co. v. Carmichael,* 526 U.S. 137 (1999); see e.g., O'Connor and Krauss (2001).

Meyer and Deitsch's Chapter 16 presents separate 16- to 28-item checklists for hypochondriasis, factitious disorder, and malingering. These lists provide some guidance for clinical decision making, but there is no empirical support to provide a basis for testimony. Additional drawbacks of this approach are the absence of a theory to guide interpretation of data and the aforementioned over-broad conceptualization of malingering to include "any type of response that distorts the production of an accurate record" (p. 412).

According to Rogers' *adaptational model* of malingering (Rogers, 1990, 1997a; Rogers *et al.,* 1992), would-be malingerers engage in a cost-benefit analysis involving estimation of their likelihood of success in an assessment. A person would be more likely to malinger when the context of the evaluation is perceived to be adversarial and the stakes are high. The cost-benefit analysis would involve estimation of the likelihood of success if one were honest versus the likelihood of success if one attempts to malinger. In some forensic contexts, people (e.g., some criminal defendants) may estimate that they are unlikely to succeed (be found not guilty) if they are honest, have a fair chance of succeeding (be found not guilty by reason of insanity) if they successfully malinger, have a fair likelihood of pulling it off (fooling the examiner and the judge or jury), and risk little by trying (no additional penalty if caught).

Whereas DSM-IV describes when malingering should be "strongly suspected," Rogers (1997a) presents a) a *threshold model* for when clinicians should thoroughly evaluate suspected dissimulation and b) a *clinical decision model* involving "accurate

classification of 90% or more of individual persons based on extensive, cross-validated research" (Rogers, 1997a, p. 14). This provides a clear framework for a forensic clinician to report findings.

Rogers' adaptational model of dissimulation is more useful for practicing forensic clinicians than that provided by Meyer and Deitsch and the guidelines in DSM-IV because Rogers' model a) provides a coherent theory to guide investigation and report, b) provides a clear framework (with the threshold and clinical decision models) for describing the degree of certainty about whether a subject is dissimulating, and c) facilitates distinct discussion of the likelihood of, type of, and motivation for malingering.

Models for Clinical Decision Making

In a more recent publication, Rogers and Shuman (2000) present two models of clinical decision making: a *hypothesis-testing model* and a *linear best-fit* model. Forensic examiners who use a hypothesis-testing model formulate a hypothesis about the person's behavior and diagnosis near the beginning of the evaluation, and then gather data to confirm or disconfirm the hypothesis. If the hypothesis is disconfirmed, a new hypothesis is formed and tested. Borum *et al.* (1993) address potential problems with this approach and recommend that experts always test alternative hypotheses.

Although they believe that the hypothesis-testing model is the one most used by forensic experts,[2] Rogers and Shuman (2000) advocate the use of a linear best-fit model, in which the examiner conducts the assessment in two phases. First, in the data-collection phase, the examiner amasses comprehensive and relevant data, undistorted by bias and preconceptions. Second, in the decision phase, the examiner considers the relative merits of competing hypotheses, and, where possible, forms

[2] At least for insanity evaluations, the context of Rogers and Shuman's book.

opinions and conclusions. The linear best-fit model has the advantage of avoiding such biases as primacy bias, confirmatory bias, over-reliance on unique data, and premature closure. The disadvantage is that by seeking to comprehensively collect all relevant data, the linear best-fit model will typically take longer than the hypothesis-testing model.[3]

Cut Scores with the SIRS

As the SIRS was initially presented, its developers noted there was no "gold standard" or "ground truth" against which to validate a new measure of response style (Rogers *et al.,* 1992). Five years later, Rogers (1997b, p. 325) wrote, "The SIRS appears to be established as a standard method for the assessment of malingering. The SIRS has a high level of reliability and well-established validity (see Berry, Wetter, & Baer, 1995). In addition, the SIRS appears unparalleled in its ability to distinguish between feigned and genuine disorders (Rogers, 1995)." Melton *et al.* (1997, pp. 55-56) report "Research on the SIRS has…consistently reported respectable indices of *sensitivity*[4] and *specificity.*[5] … Thus, the SIRS is worthy of serious consideration by forensic clinicians investigating the malingering of symptoms of psychopathology." I concur.

In contrast to Meyer and Deitsch's (1996) criticism about the lack of cutoff point decision rules for the SIRS, Melton *et al.* (1997, p. 55) applaud that "the interpretation of

[3] The time difference is likely to be less for clinicians who follow Rogers and Shuman's (2000) guidance regarding incremental validity and psychological testing. Rather than using a test battery of multiple measures of the same construct, clinicians would use the single, best-validated instrument for measuring the relevant issue (e.g., symptom or diagnosis) and only use additional instruments for which there is evidence of incremental validity (improved accuracy by adding the less-validated instrument).

[4] Sensitivity reflects a test's capacity to select many or most of the individuals who possess the trait or exhibit the behavior that the test is designed to measure.

[5] Specificity is an index of the degree to which the test selects only those individuals possessing the trait or expressing the behavior that the test is designed to detect.

the SIRS scales is geared to minimize the risk that a respondent will be inappropriately identified as malingering."

In the SIRS manual, Rogers *et al.* (1992) present cut scores for classifying responders as *Honest, Indeterminate, Probable Feigning,* and *Definite Feigning* for each of the eight primary scales of the SIRS. A respondent is to be classified as definitely feigning if he or she a) scores in the definite range on any of the eight primary scales—99% likelihood of feigning, b) scores in the probable range on three or more of the primary scales—97% probability of feigning, or c) above 76 on the total SIRS score—100% likelihood of feigning (Rogers, 1997b). Rogers (1997b) also presents a threshold model for suspecting malingering based on a) four or fewer SIRS scales in the honest range, b) two SIRS scales in the probable range, or c) a total SIRS score of greater than 66.

It is abundantly clear that Rogers and his colleagues offer cutoff point decision rules for *feigning.* Why do they not do so for *malingering?*

> The determination of malingering is a multimethod assessment that incorporates and integrates data from unstructured interviews, psychological tests, and collateral sources. Despite the unmatched accuracy of SIRS for the classification of feigned psychopathology, such an important determination should not rely solely on single measure. Therefore, the clinical decision model requires confirmatory data in addition to the SIRS (Rogers, 1997b, p. 325).

The SIRS provides the single most accurate indication of whether a person is feigning (exaggerating or fabricating) psychopathology (particularly psychotic

symptoms), and allows the clinician to quantify the likelihood that the subject is dissimulating. Additional data, from interview and observation, other tests, records review, and collaterals, help to confirm or disconfirm the presence of feigning. *The SIRS does not identify the person's motivation for feigning—nor does any psychological test.* The person's motivation for feigning may be inferred from additional information, including the context of the evaluation and collateral sources, if enough information is available and if the evaluator considers enough hypotheses.

Case Data

SIRS Scores

This case involves a 20-year-old male referred for a forensic psychological assessment.[6] On the SIRS, no scores were in the Definite range; four scores, Rare Symptoms (RS), Blatant Symptoms (BL), Severity of Symptoms (SEV), and Reported vs. Observed Symptoms (RO), were in the Probable range; three scores, Symptom Combination (SC), Subtle Symptoms (SU), and Selectivity of Symptoms (SEL), were in the Indeterminate range; and one score, Improbable and Absurd Symptoms (IA) was in the Honest range.[7] According to the SIRS manual (Rogers *et al.,* 1992), among research samples with a 51% base rate of feigning, subjects with four or more primary SIRS scales in the Probable range have a 100% likelihood of feigning (see Table 16, p. 24). The basic interpretation recommended by the SIRS manual would be:

> *The client has moderately elevated scores on the Rare Symptoms scale, which consists of symptoms that occur very infrequently in* bona fide

[6] The SIRS scores are purposely presented before setting, referral question, and additional information, which are provided below.

[7] The score on Inconsistency of Symptoms (INC) was 6; scores greater than 6 are considered high (Rogers *et al.,* 1992; see Tables 8-12). Only one of the five criteria for suspecting malingering rather than factitious disorder was met: IA > 5. See Table 19, p. 26, in Rogers *et al.* (1992).

patients; the Blatant Symptoms scale, which consists of symptoms that untrained individuals are likely to identify as obvious signs of a major mental illness; the Subtle Symptoms scale, which consists of symptoms that an untrained individual is likely to associate with everyday problems or minor maladjustment; and the Selectivity of Symptoms scale, which indicates the non-selective or indiscriminate endorsement of psychiatric problems. This combination of elevated scores is characteristic of individuals who are feigning a mental disorder, and is rarely seen in clients responding truthfully.

The pattern of scores on the SIRS meets Rogers' criteria for a clinical decision that the subject is not responding in a reliable manner. It is very likely that the subject is feigning a mental disorder, but additional information is required for consideration of whether or not the subject is malingering.

Additional Information

Intelligence testing yielded a Verbal IQ score of 75, a Performance IQ score of 70, and a Full Scale IQ score of 70.[8] Could the person's performance on the SIRS somehow be due to low intelligence? A study of 39 mentally retarded male patients in a forensic mental hospital suggests otherwise. In this study, in which the base rate of malingering was 23%, Hayes *et al.* (1998) found that the SIRS led to 95% overall classification accuracy. This supports using standard interpretation of SIRS scores in cases where the person's IQ is low.

On the Personality Assessment Inventory (PAI; Morey, 1991, 1996), T-scores on the validity scales were as follows: Inconsistency 70, Infrequency 51, Negative

[8] The average IQ score is 100. The cut-off between the Borderline and Mentally Deficient ranges is 70.

Impression 66, Positive Impression 15; with a Malingering Index of 1. These scores do not meet PAI criteria for suspecting malingering (Rogers *et al.,* 1998); they show a) nonrandom responding, b) some inconsistency in responding but not enough to invalidate the profile, and c) more of a tendency to describe problems than virtues. This *pattern* is generally consistent with results from the SIRS, but the *degree* of overreporting is not as high.[9]

This 20-year-old male had been in the same prison for over a year. He was not prescribed any psychotropic medication and was not receiving any psychiatric treatment at the time of the assessment, but had recently started participating in group treatment for sex offenders. School records show that at various times he had been placed in special classes for children with specific learning disabilities, emotional handicaps, and severe emotional disturbances. Symptoms of Attention Deficit-Hyperactivity Disorder and one or more personality disorders had been noted in the psychiatric records. Socially, he was described as having "impaired ability to appropriately interact with others," he "saw the world in a very self-centered way," he "suffered from poor peer relationships," he "was easily upset, socially immature, and unpredictable," and he was "often telling elaborate lies."

Recalling that DSM-IV recommends that malingering should be strongly suspected when any combination of four factors is present, it is noteworthy that three of those four factors are present in this case. There was a medico-legal context to the evaluation, there was a marked discrepancy between the person's claimed stress or

[9] Multiple clinical scale elevations led to multiple diagnostic possibilities, including psychotic disorders, mood disorders, and personality disorders.

disability and the objective findings,[10] and the person meets criteria for a diagnosis of antisocial personality disorder.[11] The person's performance on the SIRS (the single best-validated instrument for assessing response style) leads to classification as feigning; people in malingering studies with comparable scores are classified as feigning, with 100% accuracy. Is there any doubt that this person is malingering? Yes, there is.

This young man was referred for evaluation under the state's civil commitment of sexually violent predators law, in anticipation of a hearing to determine whether he has a mental abnormality and/or personality disorder that makes him likely to engage in future acts of sexual violence. In this context, the presence of a psychiatric disorder would enhance the likelihood that he would be involuntarily, and indefinitely, committed to a secure treatment facility. This provided no external motivation to try to malinger psychiatric symptoms. Various possible motivations for malingering were considered,[12] but not supported by collateral information or other data. Unstructured and semi-structured interviews yielded some highly improbable accounts of past and present experiences.[13]

Although his self-report was unreliable, the subject did not meet DSM-IV criteria for a diagnosis of Malingering because there was no discernable external motivation for feigning symptoms. He did not meet criteria for a diagnosis of Factitious Disorder because his feigning did not appear to be motivated by a desire to "assume the sick

[10] Notable on the Reported vs. Observed Symptoms scale of the SIRS.
[11] Met criteria for Conduct Disorder prior to age 15, repeatedly violated the law, impulsive, irritable and aggressive, and lack of remorse.
[12] Schizophrenia is negatively weighted in some actuarial prediction instruments. An institutionalized inmate may fear freedom.
[13] He described having six children by six different mothers in six different states. He described killing several people, though he has never been charged with a crime involving death of a victim. He described personal involvements in violent deaths on three different continents.

role" (p. 474). A comprehensive view of his records and current symptom presentation clearly showed the presence of a psychiatric disturbance. He met criteria for a diagnosis of Schizoaffective Disorder, Bipolar Type, in that he had experienced both major depressive episodes with delusions and hallucinations, and a manic episode with delusions and hallucinations; both the mood episodes and the psychotic symptoms were prominent and the disturbance was not due to direct physiological effects of a substance or a general medical condition.

Contrasting Models

If a clinician approached the forensic psychological evaluation of this subject by testing alternative hypotheses with Meyer and Deitsch's (1996) handbook as a guide, it appears likely that potential diagnoses of Malingering or Factitious Disorder would be briefly considered and rejected, if considered at all. In one sense that would be correct, because the subject does not meet criteria for either of those diagnoses. But this approach would likely lead to overlooking or underemphasizing the fact that the subject's self-report was unreliable.

If, instead, Rogers' adaptational model of malingering (Rogers, 1990, 1997a; Rogers *et al.,* 1992) were utilized,[14] the evaluator would establish that the subject's self report was unreliable *and* that the unreliability was not due to malingering or an attempt to assume the sick role. An evaluator's "responsibility goes beyond the mere identification of dissimulators and extends to his or her understanding of their motivations for these deliberate distortions," (Rogers, 1997c, p. 389) which requires consideration of information beyond the test data.

[14] With either clinical decision model: either the hypothesis-testing model or the linear best-fit model.

In the present case, the examiner's opinion was that the person's self-report was unreliable, but not malingered. His report could not be taken at face value, and it was clear that he was over-reporting unusual experiences. Yet it did not appear that he was exaggerating or feigning symptoms in order to be considered more severely mentally ill than he really was. He enjoys telling stories, he enjoys getting attention, and he does not appreciate the consequences of his actions.[15]

Presenting Assessment-Of-Malingering Data In Reports And Testimony

This study illustrates that cutoff point decision rules are possible for *feigning* but not for *malingering.* No test score or combination of test scores can determine whether or not a person is malingering. Even when test scores lead to virtual certainty that a person's self-report is unreliable, that alone tells nothing about a person's motivation for giving an unreliable account. "An important guideline is that *feigning should be established first, and motivation for feigning second.* Most individuals, including clients, are motivated by external incentives" (Rogers *et al.,* 1992, p. 26). Psychological tests, even ones with excellent sensitivity and specificity, cannot replace careful investigation by the forensic examiner.

In preparing forensic reports or testimony regarding response styles, evaluators should communicate findings about unreliability of self report, direction of unreliability (e.g., overreporting, underreporting, or random reporting), and motivation for that unreliability, separately. In the present case, there was a high level of certainty about the fact that the subject's self report was unreliable, clear indication that the subject's

[15] It is likely that if he were facing criminal charges he would be found incompetent to proceed. If he were to be interrogated by police detectives, he might confess to crimes he did not commit.

self report involved overreporting psychopathology, but less certainty about the subject's reasons for overreporting symptoms.

When an expert says that test scores show a 97% or 100% likelihood of *feigning,* the judge or jury may "hear" this as a 97% or 100% likelihood of *malingering.* Forensic examiners have an affirmative obligation to take steps to ensure that their data and opinions are not misconstrued (Committee on Ethical Guidelines for Forensic Psychologists, 1991). Whenever an examiner presents data showing a near-certainty that a person's self-report is unreliable, the examiner must clearly communicate that this does not equate to a near-certainty that the person is malingering.

This last point should be kept in mind as we consider how the same clinical data from this case might be considered in different assessment contexts. This same individual was previously arrested for a serious sex offense, was interrogated, and subsequently entered a plea and was sentenced. He could very well have been referred for forensic evaluations relevant to competency to waive Miranda or other rights, competency to proceed, criminal responsibility, sentencing, or other issues. In many of those contexts, there would be clear external motivation to malinger. Imagine the same subject presenting the same symptoms in a different forensic context. With clear motivation to malinger; inconsistent, extreme, and highly improbable symptom presentation; and test scores associated with a 100% likelihood of feigning, how could a forensic examiner not conclude that the person was malingering? There are two ways that we know of, both mentioned earlier in this paper.

Borum *et al.* (1993) emphasize the importance of testing alternative hypotheses. Rogers and Shuman (2000) recommend comprehensive data collection prior to

hypothesis testing. In the present case, either of these approaches would require the examiner to gather and consider additional information, which would show that the person had been giving exaggerated and improbable descriptions of events and symptoms for years. A competent evaluation of the same person in a different forensic context would necessarily entail extensive data collection and consideration of alternatives, even though the examiner's initial hypothesis would likely be that the person was malingering.

Evaluators must also clearly communicate that the fact that a person's self report is unreliable does not answer the referral question. For example, if someone pleading insanity is found to be feigning symptoms of psychopathology, that finding does not answer questions about what his mental state was at the time of the offense. The evaluator should communicate that the person's presentation cannot be taken at face value, and it will be important for the evaluator and ultimately the factfinder to utilize other data sources to construct or reconstrunct the person's mental state.

In the context of civil commitment, the U.S. Supreme Court noted that factual issues represent only the beginning of the inquiry, and the ultimate issue "turns on the *meaning* of the facts which must be interpreted by expert psychiatrists and psychologists. Given the lack of certainty and the fallibility of psychiatric diagnosis, there is serious question as to whether a state could ever prove beyond a reasonable doubt that an individual is both mentally ill and likely to be dangerous." *Addington v. Texas,* 99 S.Ct. 1804 at 1811 (1979). The parallel here is that, using the best assessment techniques, there is potential for evaluators to say with a specifiable level of certainty that a person is feigning (exaggerating or fabricating) psychopathology, but

whether or not the person is malingering (deliberately distorting responses for external gain) requires interpretation of the *meaning* of the facts. Evaluators may be able to provide a scientific basis to support an opinion that a person is feigning psychopathology, but rely on a less certain clinical interpretation as to whether the person is malingering. Evaluators must acknowledge the decrease in the level of certainty when going from reporting about feigning to reporting about malingering, and will need to adhere to their jurisdictions' rules for admissibility.

Recommendations for Forensic Clinicians

The following recommendations are made for clinicians assessing for malingering in forensic cases:

1. Use Rogers' adaptational model of malingering (Rogers, 1990, 1997a; Rogers *et al.,* 1992) for theoretical and practical guidance.
2. Using either a hypothesis-testing model or a linear best-fit model, gather sufficient information to test multiple hypotheses.
3. Apply a multimethod assessment approach, using the best forensic assessment instruments (e.g., SIRS), clinical interview, records review, and collateral interviews.
4. Clearly explicate logical links between data and opinions (see Borum et al., 1993; Skeem & Golding, 1998).
5. Carefully distinguish opinions about whether the subject's responses are reliable, the quantitative nature of the unreliability (e.g., overreporting, underreporting, random responding), and the likely motivation for the unreliability.

6. Clearly present information about the basis for the expert's opinion about unreliability, acknowledging that error rates for detecting feigning do not equate to error rates for detecting malingering.

Researchers and academicians are making excellent progress in developing tools and techniques for assessing response style, including malingering (Rogers, 1997d). As forensic clinicians apply these tools and techniques, we must take care that our work is not the weak link in the process. It is hoped that the comments and recommendations presented here will assist forensic clinicians conduct assessments that are useful to courts.

References

American Psychiatric Association. 1994. *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition.* Author: Washington, DC.

Berry DTR, Wetter MW, Baer RA. 1995. Assessment of malingering. In JN Butcher (Ed.), *Clinical Personality Assessment: Practical approaches* (pp. 236-248). Oxford University Press: New York.

Borum R, Otto R, Golding S. 1993. Improving clinical judgment and decision making in forensic evaluation. *Journal of Psychiatry and Law* **21**: 35-76.

Committee on Ethical Guidelines for Forensic Psychologists. 1991. Specialty guidelines for forensic psychologists. *Law and Human Behavior* **15(6)**: 1991.

Hayes, JS, Hale, DB, Gouvier, WD. 1998. Malingering detection in a mentally retarded forensic population. *Applied Neuropsychology,* **5(1)**: 33-36.

Melton GB, Petrila J, Poythress NG, Slobogin C. 1997. *Psychological Evaluations for the Courts, 2nd Edition.* Guilford: New York.

Meyer RG, Deitsch SE. 1996. *The Clinician's Handbook: Integrated Diagnostics, Assessment, and Intervention in Adult and Adolescent Psychopathology, Fourth Edition.* Allyn & Bacon: Needham Heights, Massachusetts.

Morey LC. 1991. *Personality Assessment Inventory: Professional Manual.* Psychological Assessment Resources: Odessa, FL.

Morey LC. 1996. *An Interpretive Guide to the Personality Assessment Inventory (PAI).* Psychological Assessment Resources: Odessa, FL.

O'Connor M, Krauss D. 2001. Legal update: New developments in rule 702. *American Psychology-Law Society News* **21**: 1-4, 18.

Rogers R. 1990. Development of a new classificatory model of malingering. *Bulletin of the American Academy of Psychiatry and Law* **18**: 323-333.

Rogers R. 1995. *Diagnostic and Structured Interviewing: A Handbook for Psychologists.* Psychological Assessment Resources: Odessa, FL.

Rogers R. 1997a. Introduction. In R Rogers (Ed.), *Clinical Assessment of Malingering and Deception, 2nd Edition* (pp. 1-19), Guilford: New York.

Rogers R. 1997b. Structured interviews and dissimulation. In R Rogers (Ed.), *Clinical Assessment of Malingering and Deception, 2nd Edition* (pp. 301-327), Guilford: New York.

Rogers R. 1997c. Current status of clinical methods. In R Rogers (Ed.), *Clinical Assessment of Malingering and Deception, 2nd Edition* (pp. 373-397), Guilford: New York.

Rogers R., Ed. 1997d. *Clinical Assessment of Malingering and Deception, 2nd Edition.* Guilford: New York.

Rogers R, Bagby RM, Dickens SE. 1992. *Structured Interview of Reported Symptoms (SIRS): Professional Manual.* Odessa, FL: Psychological Assessment Resources.

Rogers, R., Sewell, K. W., Cruise, K. R., Wang, E. W., and Ustad, K. L. (1998). The PAI and feigning: A cautionary note on its use in forensic-correctional settings, *Assessment, 5(4),* 399-405.

Rogers R, Shuman D. 2000. *Conducting Insanity Evaluations.* Guilford: New York.

Skeem JL, Golding SL, 1998. Community examiners' evaluations of competence to stand trial: Common problems and suggestions for improvement. *Professional Psychology: Research and Practice,* **29(4):** 357-367.