

## The Case Against Abandoning the Search for Substantive Accuracy

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### I. INTRODUCTION

Professor Slobogin's new book, *Proving the Unprovable*,<sup>1</sup> is the most provocative evidence text that I have read in years. In the book, he argues in favor of a more relaxed standard for admitting psychologists' and psychiatrists' testimony about a person's prior mental state.<sup>2</sup> He contends that a person's earlier mental state is essentially unprovable<sup>3</sup> and that it is impossible to gauge the validity of such testimony<sup>4</sup> in the sense of its substantive accuracy.<sup>5</sup> He concludes that the nature of such testimony ordinarily precludes the application of the normal expert testimony standards prescribed by *Daubert v. Merrell Dow Pharmaceuticals, Inc.*<sup>6</sup> and *Kumho Tire Co. v. Carmichael*.<sup>7</sup>

Instead, he proposes generally accepted content validity as the standard for admissibility.<sup>8</sup> The proposal contemplates the creation of a database of cases in which psychiatrists' or psychologists' testimony about prior mental state was used.<sup>9</sup> The database would include information such as the reports, testimony, and verdict in the case to identify the factors that the legal decisionmaker considered relevant.<sup>10</sup> The database would be used to refine structured interview

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<sup>1</sup> CHRISTOPHER SLOBOGIN, *PROVING THE UNPROVABLE: THE ROLE OF LAW, SCIENCE, AND SPECULATION IN ADJUDICATING CULPABILITY AND DANGEROUSNESS* (2007).

<sup>2</sup> *See id.* at 18.

<sup>3</sup> *Id.* at 57 (describing the mental state as "ultimately unknowable"); *id.* at 140 (describing testimony as "inscrutab[le]," the reliability of which "we cannot know").

<sup>4</sup> *Id.* at 41.

<sup>5</sup> *Id.* at 16.

<sup>6</sup> 509 U.S. 579 (1993).

<sup>7</sup> 526 U.S. 137 (1999).

<sup>8</sup> SLOBOGIN, *supra* note 1, at 16.

<sup>9</sup> *Id.* at 63–65.

<sup>10</sup> *Id.* at 65.

instruments.<sup>11</sup> Psychiatrists and psychologists could use the instruments to ensure that their report addressed the factors that the law considers material in the specific context, such as an insanity defense in a criminal trial.<sup>12</sup>

In *Proving the Unprovable*, Professor Slobogin presents a balanced analysis. In critical passages, he adds important qualifications. For instance, he states that “scientifically verified evidence” is “usually” unavailable as a basis for expert testimony about past mental states.<sup>13</sup> He writes that “[i]n those few instances when scientifically reliable information material to [the] issue [of past mental state] is available, the expert should rely on it.”<sup>14</sup> In addition, at several points he notes the utility of malingering detection techniques.<sup>15</sup>

My fear, though, is that some may not read *Proving the Unprovable* closely enough and may lose sight of those qualifications. The book is argued so forcefully that readers may instead focus on Professor Slobogin’s broad language suggesting that the very nature of the topic precludes policing the substantive accuracy of the relevant expert testimony. Professor Slobogin professes that his deep concerns are epistemological.<sup>16</sup> In his view, “[s]peculative clinical testimony . . . is probably the best we can do for the foreseeable future.”<sup>17</sup>

Our difference of opinion may simply be one of emphasis and degree. However, I feel obliged to say that I have grave doubts about the wisdom of a general call to abandon the search for substantive accuracy in psychological and psychiatry testimony. The purpose of this short Article is to explain the source of my doubts. Part II of this Article is a descriptive survey of the state of the art of determining malingering by subjects of psychological and psychiatric interviews. Part III is a critical evaluation of the state of that art. Part IV asks what light the state of the art of malingering detection sheds on the question of whether it is necessary to abandon any attempt to ensure the substantive accuracy of testimony by psychologists and psychiatrists about a person’s prior mental state.

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<sup>11</sup> *Id.* at 66.

<sup>12</sup> *Id.* at 16, 66.

<sup>13</sup> *Id.* at 57.

<sup>14</sup> SLOGOBIN, *supra* note 1, at 59.

<sup>15</sup> See, e.g., *id.* at 65, 140; see also Dorothy Clay Sims, *The Myth of Malingering: Is It the Truth or a Lie?*, PLAINTIFF, Dec. 2007, at 1.

<sup>16</sup> SLOGOBIN, *supra* note 1, at 59.

<sup>17</sup> *Id.* at 40.

## II. A DESCRIPTION OF THE STATE OF THE ART OF DETECTING MALINGERING BY MENTAL PATIENTS

Today there are numerous methods for detecting malingering by subjects.

### A. *The Adaptation of "Lie Detector" Techniques*

The forensic and law enforcement communities use a number of techniques, including polygraphy, in order to determine whether a person is lying. Malingering is a form of lying. Therefore, it should come as no surprise that several of these techniques have been adapted to determine whether a subject is malingering.

By way of example, researchers have endeavored to use hypnosis to determine whether a person is malingering.<sup>18</sup> Suppose, for example, that the subject claims amnesia as to events involved in a civil or criminal case.<sup>19</sup> However, the use of hypnosis for this purpose is controversial.<sup>20</sup> To begin with, it can be difficult to determine the authenticity of the apparent trance:<sup>21</sup> Is the person actually in a trance, or is the subject faking?<sup>22</sup> Further, even assuming that the subject is in a trance, some memories purportedly recovered during hypnotic induction prove to be false pseudo-memories.<sup>23</sup> Unfortunately, there is no definitive test to differentiate between pseudo-memories and genuine memories of events based on historical truth.<sup>24</sup>

Likewise, researchers have employed drug-assisted interviews to detect malingering.<sup>25</sup> Psychoactive substances<sup>26</sup> such as barbiturates,<sup>27</sup> sodium amytal (amobarbital),<sup>28</sup> amphetamines,<sup>29</sup> droperidol,<sup>30</sup> and ketamine<sup>31</sup> have all been used. These drugs can induce a state of re-

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<sup>18</sup> Robert D. Miller & Lawrence J. Stava, *Hypnosis and Dissimulation*, in CLINICAL ASSESSMENT OF MALINGERING AND DECEPTION 282 (Richard Rogers ed., 2d ed. 1997) [hereinafter MALINGERING AND DECEPTION].

<sup>19</sup> *Id.* at 294–95.

<sup>20</sup> *Id.* at 282.

<sup>21</sup> *Id.* at 285, 299.

<sup>22</sup> *Id.* at 286, 293, 299–300.

<sup>23</sup> *Id.* at 289.

<sup>24</sup> Miller & Stava, *supra* note 18, at 289.

<sup>25</sup> Richard Rogers & Robert M. Wettstein, *Drug-Assisted Interviews to Detect Malingering and Deception*, in MALINGERING AND DECEPTION, *supra* note 18, at 239.

<sup>26</sup> *Id.* at 240.

<sup>27</sup> *Id.* at 239.

<sup>28</sup> *Id.*

<sup>29</sup> *Id.* at 249.

<sup>30</sup> *Id.*

<sup>31</sup> Rogers & Wettstein, *supra* note 25, at 249.

laxation<sup>32</sup> and have a disinhibitory effect on the subject's ability to manipulate the content of a self-report.<sup>33</sup> However, there has been relatively little research into these techniques.<sup>34</sup> Worse still, the available studies indicate that some patients can deceive during such interviews,<sup>35</sup> and there are no clearly established criteria for identifying such deceptions.<sup>36</sup>

*B. Unstructured Interviews*

For years clinicians have conducted unstructured interviews with patients, and over the years they have identified certain indicators of deception.<sup>37</sup> The indicators include, inter alia, the following clues<sup>38</sup>:

- The patient reports preposterous<sup>39</sup> or absurd<sup>40</sup> symptoms.
- The patient quickly accepts the interviewer's suggestion of symptoms.<sup>41</sup>
- The patient reports rare symptoms<sup>42</sup> that occur infrequently in the normative clinical group<sup>43</sup>—for example, in less than five percent of the normative group.<sup>44</sup>
- The patient reports rare combinations of symptoms.<sup>45</sup>
- The patient reports contradictory symptoms.<sup>46</sup>
- Even if the symptoms are not outright contradictory, they are inconsistent.<sup>47</sup>

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<sup>32</sup> *Id.* at 241.

<sup>33</sup> *Id.* at 242.

<sup>34</sup> *Id.* at 241, 245, 250.

<sup>35</sup> *Id.* at 247.

<sup>36</sup> *Id.*

<sup>37</sup> Richard Rogers, *Structured Interviews and Dissimulation*, in MALINGERING AND DECEPTION, *supra* note 18, at 301, 303–04.

<sup>38</sup> Dewey G. Cornell & Gary L. Hawk, *Clinical Presentation of Malingers Diagnosed by Experienced Forensic Psychologists*, 13 LAW & HUM. BEHAV. 375, 376 (1989).

<sup>39</sup> Rogers, *supra* note 37, at 304. “In one case, neon-green blood spurted from a gigantic Satan who was successfully vanquished in the patient's living room with a handy chain saw; a 60-foot Christ waited outside his small cottage to congratulate him on his accomplishment.” *Id.*

<sup>40</sup> Shayna Gothard et al., *Detection of Malingering in Competency to Stand Trial Evaluations*, 19 LAW & HUM. BEHAV. 493, 503 (1995).

<sup>41</sup> Cornell & Hawk, *supra* note 38, at 378.

<sup>42</sup> Rogers, *supra* note 37, at 303.

<sup>43</sup> Roger L. Greene, *Assessment of Malingering and Defensiveness by Multiscale Personality Inventories*, in MALINGERING AND DECEPTION, *supra* note 18, at 169, 177–79.

<sup>44</sup> Rogers, *supra* note 37, at 310.

<sup>45</sup> *Id.* at 310–11.

<sup>46</sup> *Id.* at 310 (discussing “psychomotor agitation and psychomotor retardation”); see Douglass Mossman, Daubert, *Cognitive Malingering, and Test Accuracy*, 27 LAW & HUM. BEHAV. 229, 230 (2003).

- “[T]he examinee’s demeanor changes as he enters or leaves the examination area.”<sup>48</sup>
- The subject overplays<sup>49</sup> by reporting grossly exaggerated or overblown<sup>50</sup> symptoms.
- The subject engages in global faking<sup>51</sup> and indiscriminately endorses a large number of symptoms.<sup>52</sup> If, for instance, the patient endorses more than two thirds of the possible symptoms for a mental disorder, the sheer number of symptoms gives rise to a strong suspicion that the patient is malingering.<sup>53</sup>
- Although the patient reports the blatant, obvious symptoms for the mental state, the patient does not describe any of the subtle symptoms that normally accompany the mental state.<sup>54</sup>
- The subject follows a curious pattern in endorsing symptoms suggested by the interviewer. Suppose, for example, that the subject alternates true and false answers to a series of twenty questions.<sup>55</sup>
- The subject reports the sudden,<sup>56</sup> abrupt<sup>57</sup> onset of a mental illness that ordinarily gradually emerges.<sup>58</sup>

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<sup>47</sup> Greene, *supra* note 43, at 170, 174.

<sup>48</sup> Steve Rubenzer, *Malingering of Psychiatric Disorders and Cognitive Impairments in Criminal Court Settings*, THE PROSECUTOR, Sept.–Oct. 2004, at 3.

<sup>49</sup> *Id.*

<sup>50</sup> Eric Y. Drogin, “When I said That I Was Lying, I Might Have Been Lying”: *The Phenomenon of Psychological Malingering*, 25 MENTAL & PHYSICAL DISABILITY L. REP. 711 (2001).

<sup>51</sup> Greene, *supra* note 43, at 184.

<sup>52</sup> Rogers, *supra* note 37, at 308.

<sup>53</sup> *Id.* at 303.

<sup>54</sup> *Id.*; Greene, *supra* note 43, at 191; Cornell & Hawk, *supra* note 38, at 382 (“blunted or inappropriate affect, and formal thought disorder (e.g., loose or tangential speech patterns) . . . is consistent with Resnick’s view . . . that malingerers mimic the content, but not the form, of psychotic thinking”); JOHN PARRY & ERIC Y. DROGIN, MENTAL DISABILITY: LAW, EVIDENCE, AND TESTIMONY 245 (2007) (“even a practiced malingerer ‘may omit some of the more subtle symptoms of mental illness’ . . . [such as] blunted or inappropriate affect, and formal thought disorders such as loose or tangential speech patterns”).

<sup>55</sup> Greene, *supra* note 43, at 174.

<sup>56</sup> Richard Rogers et al., *The SIRS as a Measure of Malingering: A Validation Study with a Correctional Sample*, 8 BEHAV. SCI. & L. 85, 92 (1990).

<sup>57</sup> Rogers, *supra* note 37, at 308.

<sup>58</sup> Miller & Stava, *supra* note 18, at 286.

- The subject describes unrealistically severe symptoms.<sup>59</sup> Suppose, for instance, that the subject claims that he or she has suffered from virtually unbearable symptoms<sup>60</sup> “all my life.”<sup>61</sup> The interviewer should be skeptical if the subject reports the majority<sup>62</sup> of his or her symptoms or, in the view of some researchers, four symptoms<sup>63</sup> at an intense level.

### C. *Multiscale Personality Inventories*

Some standard psychological tests have also been used to assist in the detection of malingering.<sup>64</sup> For example, there are indications that malingerers claiming a mental illness perform differently on tests such as personality inventories<sup>65</sup> than persons actually suffering from the illness.<sup>66</sup>

There are numerous standard tests that have at least occasionally been employed in the detection of deception: the Basic Personality Inventory (BPI);<sup>67</sup> the Bender-Gestalt;<sup>68</sup> the California Psychological Inventory-Revised (CPI-R);<sup>69</sup> the Inventory of Problems (IOP);<sup>70</sup> and the relatively new Personal Assessment Inventory (PAI).<sup>71</sup> In general, in searching for evidence of a malingering performance on the test, the researcher looks for tests in which the subject did not achieve the expected proportion of correct responses.<sup>72</sup> If the subject’s performance is atypically bad<sup>73</sup> even on simple tasks<sup>74</sup>—for example, two stan-

<sup>59</sup> Rogers, *supra* note 37, at 313.

<sup>60</sup> Rogers et al., *supra* note 56, at 92.

<sup>61</sup> Rubenzer, *supra* note 48, at 2.

<sup>62</sup> Richard Rogers, *Current Status of Clinical Methods*, in MALINGERING AND DECEPTION, *supra* note 18, at 373–74.

<sup>63</sup> Rogers, *supra* note 37, at 313.

<sup>64</sup> Richard Rogers et al., *Explanatory Models of Malingering: A Prototypical Analysis*, 18 LAW & HUM. BEHAV. 543, 543 (1994).

<sup>65</sup> Gothard et al., *supra* note 40, at 504; James R.P. Ogloff, *The Admissibility of Expert Testimony Regarding Malingering and Deception*, 8 BEHAV. SCI. & L. 27, 34–35 (1990).

<sup>66</sup> Glenn P. Smith, *Assessment of Malingering with Self-Report Instruments*, in MALINGERING AND DECEPTION, *supra* note 18, at 351.

<sup>67</sup> R. Michael Bagby et al., *Detection of Dissimulation with the New Generation of Objective Personality Measures*, 8 BEHAV. SCI. & L. 93, 94–95 (1990).

<sup>68</sup> Loren Pankratz & Laurence M. Binder, *Malingering on Intellectual and Neuropsychological Measures*, in MALINGERING AND DECEPTION, *supra* note 18, at 223, 231.

<sup>69</sup> Greene, *supra* note 43, at 170.

<sup>70</sup> Smith, *supra* note 66, at 366.

<sup>71</sup> Rubenzer, *supra* note 48, at 3.

<sup>72</sup> Pankratz & Binder, *supra* note 68, at 231–32.

<sup>73</sup> *Id.* at 231.

<sup>74</sup> *Id.* at 232.

dard deviations below the performance for a normative clinical group of persons suffering from the illness<sup>75</sup>—there is a strong possibility of malingering. When the subject's performance is improbably poor<sup>76</sup>—statistically significantly lower than chance<sup>77</sup>—it is a common-sense inference that the subject recognized the correct answer but deliberately chose an incorrect answer.<sup>78</sup>

There has been some malingering research with respect to the Millon Clinical Multiaxial Inventory (MCMI).<sup>79</sup> For example, there is a Validity Index for the test.<sup>80</sup> If the subject endorses an extremely rare symptom manifested by less than 0.01% of the normative clinical population, there is a justifiable suspicion of malingering.<sup>81</sup> Further, there is a Debasement scale ("Scale Z") on MCMI-III,<sup>82</sup> and some researchers have successfully used the scale to identify students who were instructed to mangle on the test.<sup>83</sup>

However, by a wide margin, the inventory used most frequently is the Minnesota Multiphasic Personality Inventory-2 (MMPI-2).<sup>84</sup> The MMPI-2 has the advantage that there is available comparative data for a normative group of 3475 patients.<sup>85</sup> Researchers have capitalized on this data to develop several scales and indices for detecting malingering:

- The Lie Scale (L):<sup>86</sup> The detection strategy underlying this scale is to identify persons who choose "items with extremely desirable but very rare human qualities. If a person endorsed a large number of these items, the probability is very high that the responses would be dishonest."<sup>87</sup>
- The F Scales:<sup>88</sup> These include the Fake Bad Scale (FBS).<sup>89</sup> Here the underlying detection strategy is based on the

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<sup>75</sup> *Id.*

<sup>76</sup> *Id.* at 227.

<sup>77</sup> *Id.* at 228–29, 230.

<sup>78</sup> Pankratz & Binder, *supra* note 68, at 230.

<sup>79</sup> Greene, *supra* note 43, at 169.

<sup>80</sup> *Id.* at 182.

<sup>81</sup> *Id.*

<sup>82</sup> *Id.* at 195.

<sup>83</sup> *Id.*

<sup>84</sup> *Id.* at 169.

<sup>85</sup> Greene, *supra* note 43, at 169; *see* Rogers, *supra* note 62, at 383.

<sup>86</sup> Greene, *supra* note 43, at 170.

<sup>87</sup> *Id.*

<sup>88</sup> *Id.* at 177.

<sup>89</sup> *Id.*

infrequency or rarity of certain symptoms.<sup>90</sup> For instance, the subject might endorse several symptoms, each reported by less than 10% of the normative sample.<sup>91</sup> Traditionally, malingering researchers have placed greatest reliance on the F scales on the MMPI-2.<sup>92</sup>

- The Gough Dissimulation Index (Ds):<sup>93</sup> In some studies, this index has been used successfully to identify 97% of the authentic profiles and 75% of the malingerers.<sup>94</sup> However, there are multiple versions of the Ds,<sup>95</sup> and there have been few studies of some of these versions.<sup>96</sup>

#### D. Screening Specialized Instruments

The techniques discussed above have applications other than the detection of malingering. We turn now to more specialized techniques, developed primarily or exclusively for detecting the subject's attempt to feign symptoms. Today there are so many such specialized instruments that there are both full-fledged tests and screening instruments.

There are numerous screening techniques. The latest generation of screens includes: the Tehachapi Malingering Scale (TMS),<sup>97</sup> a brief 20-item test;<sup>98</sup> the Malingering Detection Scale (MDS), a 29-item instrument;<sup>99</sup> the Malingering Probability Scale (MPS), a 140-item instrument in true-false format;<sup>100</sup> the Structured Inventory of Malingered Symptomatology (SIMS), which consists of 75 items organized into five scales;<sup>101</sup> and the Sentence Completion Test (SCT), which includes 136 items in 12 categories.<sup>102</sup> Although most of these instruments are relatively short,<sup>103</sup> in some studies they have been remarkably effective. For example, in one test the MPS achieved 94%

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<sup>90</sup> *Id.*

<sup>91</sup> *Id.*

<sup>92</sup> Greene, *supra* note 43, at 187.

<sup>93</sup> *Id.* at 190, 194.

<sup>94</sup> *Id.* at 190.

<sup>95</sup> *Id.* at 194.

<sup>96</sup> *Id.*

<sup>97</sup> Smith, *supra* note 66, at 360.

<sup>98</sup> *Id.*

<sup>99</sup> *Id.* at 361–62.

<sup>100</sup> *Id.* at 362–64.

<sup>101</sup> *Id.* at 364–66.

<sup>102</sup> *Id.* at 367–68.

<sup>103</sup> *See* Smith, *supra* note 66, at 352.



sensitivity and 88% specificity.<sup>104</sup> In another test, the total score for SIMS enabled researchers to identify 95.6% of the simulators.<sup>105</sup>

Nevertheless, the most popular screen is the M Test.<sup>106</sup> It has been subjected to more rigorous testing than any other screen.<sup>107</sup> The M Test is specifically designed to detect the malingering of schizophrenia.<sup>108</sup> The test consists of 33 true-false items with three scales: confusion (C), malingering (M), and schizophrenia (S).<sup>109</sup> The S scale items relate to genuine symptoms of schizophrenia. In contrast, the M scale includes 15 items related to bogus symptoms such as extremely severe symptoms and atypical delusions and hallucinations.<sup>110</sup> The essential premise of the test is that a malingerer is likely to be unable to distinguish the genuine and bogus symptoms.<sup>111</sup> The attempts to validate the M Test have yielded mixed results. In some studies, the researchers accurately classified the vast majority of subjects, for instance, 87.3%<sup>112</sup> or 95.2%.<sup>113</sup> However, in other tests the accuracy rate of the classifications has been much lower, dipping to 40%<sup>114</sup> or 30.8%.<sup>115</sup>

The consensus is that these screens should be used only as the initial level of assessment.<sup>116</sup> Rather than serving as the sole basis for a finding of malingering, a screen test ought to merely trigger a more thorough assessment.<sup>117</sup> Many of the screens have limited probative value. In some cases, the validating tests consisted of small samples.<sup>118</sup> In other cases, they have not been cross-validated with known malingerers as well as test subjects instructed to malingering.<sup>119</sup> As a result, a screening test result indicating malingering must be confirmed by a more thorough specialized instrument.

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<sup>104</sup> *Id.* at 363.

<sup>105</sup> *Id.* at 365.

<sup>106</sup> *Id.* at 352.

<sup>107</sup> *Id.* at 357.

<sup>108</sup> *Id.* at 352.

<sup>109</sup> Smith, *supra* note 66, at 352.

<sup>110</sup> *Id.*

<sup>111</sup> *Id.*

<sup>112</sup> *Id.* at 353.

<sup>113</sup> *Id.*

<sup>114</sup> *Id.*

<sup>115</sup> Smith, *supra* note 66, at 353.

<sup>116</sup> Margaret P. Norris & Mary C. May, *Screening for Malingering in a Correctional Setting*, 22 LAW & HUM. BEHAV. 315, 322 (1998).

<sup>117</sup> Smith, *supra* note 66, at 368.

<sup>118</sup> *See id.* at 359.

<sup>119</sup> *Id.* at 355.

*E. Full-Fledged Specialized Malingering Instruments*

Just as there are several malingering screens, a large number of full-fledged malingering instruments exists. The number is both large and growing.<sup>120</sup> The full-fledged instruments include: the Diagnostic Interview Schedule (DIS);<sup>121</sup> the Dot Counting Test;<sup>122</sup> the Rey Fifteen-Item Test (FIT);<sup>123</sup> the Georgia Court Competence Test-Mississippi State Hospital (GCCT-MSH);<sup>124</sup> the Structured Clinical Interview (SCID);<sup>125</sup> the Portland Digit Recognition Test (PDRT);<sup>126</sup> and the Test of Memory Malingering (TOMM).<sup>127</sup> In scoring these tests, the analyst looks for performance significantly worse than chance.<sup>128</sup> If the subject's score falls below the chance level by two standard deviations,<sup>129</sup> "it is likely that the person has some knowledge of the correct responses and is deliberately answering incorrectly."<sup>130</sup>

Although the above instruments have received some attention in the literature, two instruments have been especially popular. One such instrument is the Schedule of Affective Disorders and Schizophrenia (SADS).<sup>131</sup> While the test is "not an impenetrable shield against fabrication,"<sup>132</sup> the indications are that the subject must possess a sophisticated understanding of the mental disorder in question in order to malingering on the test without detection.<sup>133</sup> There are three sources for normative SADS data: forensic patients, patients with schizophrenia, and jail referrals.<sup>134</sup> The instrument uses several detection strategies, including whether the reported symptom or combination of symptoms is rare, whether the reported symptoms are contradictory, whether the subject has indiscriminately endorsed a

<sup>120</sup> Rubenzer, *supra* note 48, at 2.

<sup>121</sup> Rogers, *supra* note 37, at 319–20.

<sup>122</sup> Drogin, *supra* note 50, at 713; Rubenzer, *supra* note 48, at 4.

<sup>123</sup> Mossman, *supra* note 46, at 230.

<sup>124</sup> Gothard et al., *supra* note 40, at 493, 503.

<sup>125</sup> Rogers, *supra* note 37, at 319.

<sup>126</sup> Pankratz & Binder, *supra* note 68, at 228–29; Drogin, *supra* note 50, at 713.

<sup>127</sup> Drogin, *supra* note 50, at 713 (the test "has achieved positive research validation"); Mossman, *supra* note 46, at 230 (this is an "often-used test[] of malingered cognitive deficits").

<sup>128</sup> Pankratz & Binder, *supra* note 68, at 228–29.

<sup>129</sup> Grant L. Iverson et al., *Evaluation of an Objective Assessment Technique for the Detection of Malingered Memory Deficits*, 15 LAW & HUM. BEHAV. 667, 668 (1991).

<sup>130</sup> *Id.* at 674.

<sup>131</sup> Rogers, *supra* note 37, at 307.

<sup>132</sup> *Id.* at 308.

<sup>133</sup> *Id.*

<sup>134</sup> *Id.* at 309–10.

large number of symptoms, and whether the subject has rated an implausibly large number of symptoms as severe or extreme in intensity.<sup>135</sup> If the subject describes several symptoms, each of which is encountered in less than five percent of the forensic sample, there is good reason to believe that the subject is malingering.<sup>136</sup> Likewise, based on the comparative data for schizophrenic and jail referral samples, malingering is a likely hypothesis if the subject endorses more than four symptoms at severe or extreme severity.<sup>137</sup>

Probably the most specialized instrument is the Structured Interview of Reported Symptoms (SIRS). SIRS was first developed in 1985.<sup>138</sup> The current version of SIRS includes 172 items.<sup>139</sup> The test usually requires thirty to forty-five minutes to administer<sup>140</sup> and fifteen minutes to score.<sup>141</sup> The items fall into three categories: detailed inquiries about specific symptoms, repeated inquiries designed to test response consistency, and general inquiries about psychological problems.<sup>142</sup> The test is organized into eight primary scales and five supplementary ones.<sup>143</sup> In developing SIRS, experienced experts identified eight primary strategies and formulated a scale to implement each strategy.<sup>144</sup> The strategies are as follows:

- RS: the subject has endorsed a rare symptom;
- SC: the subject has endorsed an uncommon combination of symptoms;
- IA: the subject has endorsed an implausible or fantastic symptom;
- BL: the subject has endorsed a disproportionate number of blatant symptoms;
- SU: many of the “symptoms” reported are ordinarily viewed as everyday problems;
- SEL: the sheer number of symptoms reported is improbable;

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<sup>135</sup> *Id.* at 310–13.

<sup>136</sup> *Id.* at 310–11.

<sup>137</sup> Rogers, *supra* note 37, at 313.

<sup>138</sup> *Id.* at 321.

<sup>139</sup> *Id.*; see PARRY & DROGIN, *supra* note 54, at 244–45 (“[o]ne of the most promising tools”).

<sup>140</sup> Norris & May, *supra* note 116, at 316.

<sup>141</sup> Rubenzer, *supra* note 48, at 4.

<sup>142</sup> Rogers, *supra* note 37, at 321.

<sup>143</sup> *Id.*; Gothard et al., *supra* note 40, at 496 (“Eight of these scales are termed primary scales, as they have consistently been demonstrated to be the most accurate in sorting fakers from honest respondents.”).

<sup>144</sup> Rogers, *supra* note 37, at 321.

- SEV: the subject reports a large number of symptoms at an extreme or unbearable level of intensity; and
- RO: the subject's self-reporting of observable behavior is at odds with third parties' observations.<sup>145</sup>

A subject may be classified as a malingerer on one of three different bases: one exceptionally high scale, three or more scales in the probable feigning range, or an enhanced total score.<sup>146</sup> There has been little research involving SIRS testing of adolescents or mentally retarded individuals.<sup>147</sup> But with those notable exceptions, there has been extensive validation research with SIRS, and those studies "have demonstrated consistently its usefulness in classifying feigners and honest responders."<sup>148</sup> In many of the studies, the accurate hit rate was in the high eighty to ninety percentiles.<sup>149</sup>

### III. A CRITICAL EVALUATION OF THE STATE OF THE ART OF DETECTING MALINGERING

Part II described the status quo of malingering testing. In light of that data, where does malingering testing stand?

#### A. *The Limitations of the Current State of the Art*

Although there has been substantial progress in malingering testing during the past few decades,<sup>150</sup> there are still some obvious limitations to the methodology.

To begin with, malingering tests are most appropriately used in the forensic context.<sup>151</sup> Most clinicians do not utilize such tests.<sup>152</sup>

<sup>145</sup> *Id.* at 322.

<sup>146</sup> *Id.* at 325.

<sup>147</sup> *See id.* at 324.

<sup>148</sup> *Id.*; Drogin, *supra* note 50, at 713 ("Where psychopathology is concerned, the . . . SIRS . . . has fared well in follow-up studies.").

<sup>149</sup> Rogers, *supra* note 37, at 322–23, 324; Gothard et al., *supra* note 40, at 500, 502 (96.7%, 97.8%); Rogers et al., *supra* note 56, at 89.

<sup>150</sup> *See* Rogers, *supra* note 62, at 373. There has also been substantial progress in the techniques for forecasting dangerousness. Christopher Slobogin, *Dangerousness and Expertise Redux*, 56 EMORY L.J. 275 (2006).

[P]rediction methodology has significantly improved. Two decades ago, actuarial methods for predicting violent behavior were in their infancy and the dominant method of evaluating dangerousness was essentially seat-of-the-pants, "clinical" speculation. Today the development of several sophisticated, empirically validated risk assessment instruments has made prediction much more of a science.

*Id.* at 277.

<sup>151</sup> Rubenzer, *supra* note 48, at 5–6.

<sup>152</sup> Rogers, *supra* note 37, at 302.

Likewise, most treating neurophysiologists do not administer the tests to their patients.<sup>153</sup> The widespread belief is that the administration of a malingering test is incompatible with developing the sort of trusting relationship needed for effective treatment.<sup>154</sup>

Moreover, many of the tests are vulnerable to coaching.<sup>155</sup> Many, if not most, malingerers<sup>156</sup> may use relatively unsophisticated strategies, based on simplistic notions about mental states.<sup>157</sup> However, not all feigners are naive and unprepared.<sup>158</sup> On some tests, if the malingerer prepares by learning a good deal about the mental state to be faked, the malingerer has a much better chance of foiling the test.<sup>159</sup> For example, despite early claims to the contrary,<sup>160</sup> it is clear that simulators often succeed in faking on projective measures such as the Rorschach test.<sup>161</sup> Moreover, the available research indicates that it is easier to feign a cognitive deficit than a mental illness.<sup>162</sup> However, coaching and advance preparation seem to have little effect on the ability of either the MMPI-2 or the SIRS to detect malingering.<sup>163</sup>

More fundamentally, there are concerns about the extent and quality of the validation of some of the tests described in Part II. In unstructured interviews, there are no standard objective diagnostic criteria that the interviewer can rely on to detect malingering.<sup>164</sup> In

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<sup>153</sup> Pankratz & Binder, *supra* note 68, at 233.

<sup>154</sup> Rubenzer, *supra* note 48, at 1.

<sup>155</sup> Rogers, *supra* note 62, at 379.

<sup>156</sup> In forensic practice, many malingerers tend to be relatively young and poorly educated. See Gothard et al., *supra* note 40, at 498.

<sup>157</sup> *Id.* at 504.

<sup>158</sup> Rogers, *supra* note 62, at 379; see Ryan C.W. Hall & Richard C.W. Hall, *Detection of Malingered PTSD: An Overview of Clinical, Psychometric, and Physiological Assessment: Where Do We Stand?*, 52 J. FORENSIC SCI. 717, 718 (2007) (the Internet increases the accessibility of information about mental diseases and how to feign them).

<sup>159</sup> Greene, *supra* note 43, at 187.

<sup>160</sup> David J. Schretlen, *Dissimulation on the Rorschach and Other Projective Measures*, in MALINGERING AND DECEPTION, *supra* note 18, at 208, 209 (it was asserted that “the Rorschach measures processes and traits that are largely unconscious and essentially beyond volitional control”).

<sup>161</sup> *Id.* at 212–13, 215, 221; Rogers, *supra* note 62, at 374.

<sup>162</sup> See Rogers, *supra* note 62, at 375 (“Unlike the fabrication of a mental disorder (e.g. a constellation of symptoms and associated features with a convincing onset and course), feigned cognitive deficits do not require the creation of anything. Instead, malingerers simply can claim ‘not to know’ or appear to expend effort but provide an incorrect response.”).

<sup>163</sup> *Id.* at 383.

<sup>164</sup> Cornell & Hawk, *supra* note 38, at 383; see PARRY & DROGIN, *supra* note 54, at 243 (“a question exists as to whether clinicians have ‘any extraordinary ability to detect malingering’”; judges should weigh clinical evidence “cautiously. . . . [E]ven cli-

the case of many techniques, there has been little or no cross-validating research with known malingerers or persons instructed to mangle.<sup>165</sup> “[S]imulation research . . . should be validated with known-groups comparison.”<sup>166</sup> Persons suffering from factitious disorders feign symptoms out of a psychological need to assume the sick role.<sup>167</sup> In contrast, true malingerers feign symptoms due to some external incentive.<sup>168</sup> Thus, a research subject in a malingering study should not only be instructed to feign, he or she should also be provided an external incentive. For example, the subject is sometimes promised a financial reward to successfully fool the interviewer.<sup>169</sup> In the real world, though, a malingeringer such as a criminal might be much more strongly motivated to dupe the interviewer.<sup>170</sup> That is why the validation of the detection technique with a sample of known malingerers is so critical.

Finally, there is agreement that an interviewer should not rest a finding of malingering on the basis of the outcome of a single technique or instrument.<sup>171</sup> Standing alone, no individual test outcome or result is probative enough to constitute sole proof of malingering.<sup>172</sup> No matter how extreme the subject’s test on one test or instrument, the interviewer must confirm that test with an independent technique.<sup>173</sup>

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nicians working in forensic settings, who are familiar with malingering, have a high ‘misidentification rate.’”).

<sup>165</sup> Rogers, *supra* note 62, at 373 (remarking on “a paucity of research cross-validating”); *see also* Hall & Hall, *supra* note 158, at 722 (known simulators).

<sup>166</sup> Smith, *supra* note 66, at 370; *see* Rogers, *supra* note 62, at 374.

<sup>167</sup> AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (DSM-IV-TR) 513 (4th ed. 2000).

<sup>168</sup> *Id.* at 513, 516, 739.

<sup>169</sup> Gothard et al., *supra* note 40, at 495; Rogers et al., *supra* note 56, at 87 (offering “an additional \$5.00 for a convincing portrayal of mental illness”); Aldert Vrij et al., *Will the Truth Come Out? The Effect of Deception, Age, Status, Coaching, and Social Skills on CBCA Scores*, 26 L. & HUM. BEHAV. 261, 276 (2002) (offering a prize they can win).

<sup>170</sup> Vrij et al., *supra* note 169, at 263.

<sup>171</sup> Ogloff, *supra* note 65, at 35 (“there is really no method, when considered alone, that is entirely effective at identifying malingerers”); Rogers & Wettstein, *supra* note 25, at 248 (“alone”).

<sup>172</sup> Rogers & Wettstein, *supra* note 25, at 248; Smith, *supra* note 66, at 368; Hall & Hall, *supra* 158, at 723 (noting that “there is no one way to identify the malingering of PTSD”).

<sup>173</sup> Gothard et al., *supra* note 40, at 503.

*B. The Utility of the Current Techniques for Detecting Malingering*

Despite the limitations mentioned above, tremendous progress has been made.<sup>174</sup>

Although the contemporary tests are still imperfect, they can be “very accurate.”<sup>175</sup> There is impressive evidence that the use of the existing malingering detection techniques can enable interviewers to accurately classify malingerers from persons actually experiencing the claimed mental condition.<sup>176</sup> In a study involving unstructured interviews by experienced clinicians, researchers “correctly classified 37 of 39 malingerers and 20 of 25 psychotics,” achieving an “overall classification accuracy of 89.1%.”<sup>177</sup> In another test, relying on standard neuropsychological tests and batteries, the researchers attained an overall correct classification rate of 83%.<sup>178</sup> In still another SIMS test, reliance on the total score permitted the researchers to accurately identify 95.6% of the simulators.<sup>179</sup> In a research project employing specialized screening instruments for malingering, more than 90% of the feigning participants were correctly identified.<sup>180</sup> In a study investigating a malingering index for the MMPI test, “researchers accu-

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<sup>174</sup> Schretlen, *supra* note 160, at 210–11 (“The overall increase in psychometric research on response distortion and malingering is shown by the fact that more controlled studies have been reported during the past 15 years than during the preceding 40 years.”).

<sup>175</sup> Mossman, *supra* note 46, at 246.

<sup>176</sup> As Ryan C.W. Hall & Richard C.W. Hall noted in their article:

The validity of the MMPI has been confirmed by multiple studies. One of the first studies, carried out in 1985 by Fairbanks et al. . . . found that using the F scale with cutoffs of 88 allowed investigators to identify malingering of PTSD more than 90% of the time. Similar results were reported by McCaffrey and Bellamy-Campbell. Using the F scale and the PTSD subscale, they were able to correctly identify 91% of a population consisting of Vietnam veterans with PTSD, Vietnam veterans who were intentional[ly] malingering, and mental health professionals who were also Vietnam veterans who were intentionally malingering.

Hall & Hall, *supra* note 158, at 719 (internal citations omitted); *see* Cornell & Hawk, *supra* note 38, at 380.

<sup>177</sup> Cornell & Hawk, *supra* note 38, at 380. *But see* PARRY & DROGIN, *supra* note 54, at 243.

<sup>178</sup> Pankratz & Binder, *supra* note 68, at 227; *see* PARRY & DROGIN, *supra* note 54, at 244–45 (noting that “a number of psychological validity scales, used for detecting malingering while embedded in broader measures of personality functioning, have met with some qualified success”; the authors mention the MMPI/MMPI-2 scales in particular).

<sup>179</sup> Smith, *supra* note 66, at 365.

<sup>180</sup> *Id.* at 369.

rately classified 97% of the authentic profiles and 75% of the malingerers.”<sup>181</sup>

In a large number of studies, SIRS has demonstrated its validity as a method of detecting malingering.<sup>182</sup> This specialized instrument has been “extensively validated.”<sup>183</sup> Importantly, some of the empirical investigations of SIRS have entailed cross-validation, that is, testing the technique’s ability to detect both persons instructed to malingering and known malingerers.<sup>184</sup> In a 1990 validation study involving an early version of SIRS,<sup>185</sup> the overall accurate classification rate was 88%.<sup>186</sup> In a 1995 study, researchers accurately identified 96.7% of the simulators.<sup>187</sup> After the removal of one outlier, the total SIRS score enabled researchers to correctly discriminate in 99.4% of the sample.<sup>188</sup> A 1997 test indicated that when researchers used SIRS in conjunction with MMPI-2, they accurately classified 95.5% of the subjects.<sup>189</sup>

It remains true that an interviewer should not rest a finding of malingering on the outcome of any one test,<sup>190</sup> even SIRS.<sup>191</sup> A thorough,<sup>192</sup> multi-method assessment,<sup>193</sup> including psychological inventories and specialized malingering instruments, is the soundest approach. The techniques can and ought to be used in combination.<sup>194</sup> The interviewer should use SIRS to confirm suspicions of malingering raised by the other tests.<sup>195</sup> Despite the undeniable fallibility of

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<sup>181</sup> Greene, *supra* note 43, at 190.

<sup>182</sup> Rogers, *supra* note 37, at 324.

<sup>183</sup> *Id.*

<sup>184</sup> *Id.* at 327.

<sup>185</sup> Rogers et al., *supra* note 56, at 86. This version involved 150 inquiries. *Id.*

<sup>186</sup> *Id.* at 89.

<sup>187</sup> Gothard et al., *supra* note 40, at 500.

<sup>188</sup> *Id.*

<sup>189</sup> Rogers, *supra* note 37, at 323.

<sup>190</sup> Pankratz & Binder, *supra* note 68, at 228; Smith, *supra* note 66, at 368; Ogloff, *supra* note 65, at 35.

<sup>191</sup> Rogers, *supra* note 37, at 325.

<sup>192</sup> Rogers, *supra* note 62, at 396.

<sup>193</sup> Rogers, *supra* note 37, at 325. Hall & Hall explain that:

It is important to remember that there is no source of data that cannot be manipulated or faked by a determined individual. As there is no one way to identify the malingering of PTSD, it is critical to examine multiple sources of data and to use sound clinical judgment when determining if a patient’s symptoms are those of true PTSD or are malingered.

Hall & Hall, *supra* note 158, at 723.

<sup>194</sup> Smith, *supra* note 66, at 363.

<sup>195</sup> Gothard et al., *supra* note 40, at 503.



individual detection techniques,<sup>196</sup> the objective probability of malingering is high when multiple methods point to that conclusion.<sup>197</sup>

#### IV. THE USE OF CURRENTLY AVAILABLE MALINGERING DETECTION TECHNIQUES TO IMPROVE THE SUBSTANTIVE ACCURACY OF EXPERT TESTIMONY ABOUT PRIOR MENTAL STATE

As Part I noted, the essential question is whether the courts should abandon any insistence on a showing of substantive accuracy in determining the expert testimony about a subject's prior mental state. Again, the thesis of this Article is that in a significant number of cases it is unnecessary for the courts to do so. This Part initially describes the two alternative reasoning processes that an expert can rely on in drawing a conclusion as to a subject's past mental state. Then the Article demonstrates the contribution that malingering testing can make to the substantive accuracy of both reasoning processes.

##### A. *The Two Reasoning Processes an Expert May Logically Rely on in Drawing a Conclusion as to a Subject's Prior Mental State*

As a matter of logic, there are two different routes that an expert can take in order to reach a final conclusion as to a subject's prior mental state.

In one route, the starting point is the subject's present mental state. Suppose that, at trial, the focus is on the subject's mental state at the time of a prior event—for example, a confrontation one year earlier. The mental condition in question is relatively permanent in nature and could easily last one year; and during that year, there are no events such as traumatic occurrences or the administration of therapy likely to change the subject's mental state. Given these circumstances, if the expert finds that the subject presently has a certain mental state, it is a logical inference that the subject had the same mental state a year earlier.

In the second route, the starting point is the subject's symptomatology at the time of the prior event. Assume that that set of symptoms normally accompanies a certain mental state. That mental state is ordinarily the cause of that constellation of symptoms, or those symptoms are common manifestations of the mental state. If the evidence at trial establishes that the subject displayed those symptoms at the time of the event a year earlier, again it is a logical inference that the subject had that mental state a year earlier.

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<sup>196</sup> Rogers, *supra* note 62, at 392.

<sup>197</sup> Gothard et al., *supra* note 40, at 503.

B. *The Contribution that Malingering Testing Can Make to Ensure the Substantive Accuracy of the Reasoning Processes*

Whichever reasoning process the expert contemplates relying on, the malingering test can play an important role in ensuring the substantive accuracy of the expert's ultimate inference as to the subject's prior state of mind.

Consider the first route, starting with a finding as to the subject's present state of mind. Part II described various malingering detection techniques that an expert may employ to detect whether the subject is presently feigning a state of mind. As previously stated, it would be unsound for the expert to rely on a single test outcome in determining whether the subject is malingering.<sup>198</sup> However, assume that an unstructured interview discloses few, if any, indicators of malingering and that the subject has no abnormal scores on any of the malingering scales for MMPI-2 or SIRS. The expert would be rationally justified in concluding that the subject is indeed experiencing the claimed mental state.

Moreover, there is data as to the average or probable duration of many mental illnesses and states.<sup>199</sup> By way of example, that data

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<sup>198</sup> See *supra* notes 190–97 and accompanying text.

<sup>199</sup> It is true that some mental conditions are episodic and highly variable over time. However, others tend to be more chronic in nature. PARRY & DROGIN, *supra* note 54, at 227 (“those mental disorders that would justify a finding of NGRI or diminished criminal responsibility are both severe and chronic (e.g. schizophrenia, mood disorders, DID, brain injury, and mental retardation) and, thus, may not change substantially over time”).

In the case of major depressive disorder (also known as unipolar disorder), the *Diagnostic and Statistical Manual* estimates that untreated episodes typically last four months or longer. AM. PSYCHIATRIC ASS'N, *supra* note 167, at 354. Another authority puts the average duration for an untreated patient at six to nine months. DAVID H. BARLOW & MARK DURAND, *ABNORMAL PSYCHOLOGY: AN INTEGRATIVE APPROACH* 186–87 (1999). Further, the typical patient will experience multiple recurrences. At least sixty percent of those diagnosed with a single episode can expect to have a second episode. AM. PSYCHIATRIC ASS'N, *supra* note 167, at 372. Individuals who have had two episodes have a seventy percent chance of a third, and individuals who have experienced three episodes have a ninety percent chance of having a fourth. *Id.*

Similarly, in the case of bipolar disorder, many persons experience multiple mood episodes. Indeed, five to fifteen percent of the sufferers will have four or more episodes in a single year. *Id.* at 386.

In the case of schizophrenia, some signs of the disorder persist for at least six months. *Id.* at 298. This is another condition which tends to be chronic in character. BARLOW & DURAND, *supra*, at 414.

Likewise, dysthymic disorder has a chronic course. AM. PSYCHIATRIC ASS'N, *supra* note 167, at 379. This disorder cannot be diagnosed until the individual has had persistent symptoms for at least two years. EUGENE H. RUBIN & CHARLES F. ZORUMSKI, *ADULT PSYCHIATRY* 92 (2006). It can last twenty to thirty years or more. BARLOW & DURAND, *supra*, at 187.

might show that a certain mental condition is relatively permanent in nature and is likely to last indefinitely. If the mental condition is of permanent character and there is no evidence of an intervening event likely to disrupt the mental condition,<sup>200</sup> there is a permissible inference that the subject was in the same mental state earlier. That inference is far more than a guess; considered together, the outcomes of the malingering tests and the research as to the normal duration of the mental illness provide fair assurance that the inference is substantively accurate.

On a previous occasion, Professor Slobogin wrote that “conclusions about present mental state can help the evaluator gauge the validity of the defendant’s description of his or her past mental state, especially if the period between the offense and the evaluation is short.”<sup>201</sup> Especially in criminal cases, the period may be quite short. Suppose, for example, that the subject is an accused criminal, arrested on the very day of the commission of the actus reus. It is plausible that a psychiatric evaluation of the accused could be conducted within a few weeks of the incident. When the time lapse is that short, and multiple malingering techniques point to the conclusion that the accused is presently feigning, that is a solid inference that the accused did not have the claimed mental state at the time of the actus reus.

Now consider the second potential route, starting with the subject’s symptomatology at the time of the prior event. Here the underlying hypothesis is that there is a connection between those symptoms and that mental state. The research invested in the preparation of the diagnostic criteria set out in the latest version of the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders*<sup>202</sup> investigated that sort of connection. The research included literature reviews, data reanalyses, and field trials.<sup>203</sup> More specifically, there were 150 reviews, the reanalysis of 50 separate data sets,

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Cyclothymic disorder is similarly chronic. AM. PSYCHIATRIC ASS’N, *supra* note 167, at 379.

<sup>200</sup> Compare the concept of continuity of state of mind used in the application of the state-of-mind hearsay exception. 2 MCCORMICK ON EVIDENCE § 274, at 219–20 (Kenneth S. Broun et al. eds., 6th ed. 2006).

<sup>201</sup> Christopher Slobogin et al., *The Feasibility of a Brief Evaluation of Mental State at the Time of the Offense*, 8 LAW & HUM. BEHAV. 305, 309 (1984).

<sup>202</sup> AM. PSYCHIATRIC ASS’N, *supra* note 167.

<sup>203</sup> *Id.* at xxvi–xxvii.

and field trials at 88 universities and research institutions involving more than 7000 subjects.<sup>204</sup>

In future tests conducted to refine diagnostic criteria to be used in forensic cases, more extensive use can be made of malingering detection testing. In particular, the use of malingering detection techniques can improve the specificity of such criteria: To what extent will these diagnostic criteria yield false positives, that is, the conclusion that a malingerer is suffering from the mental disorder? By including malingering detection testing in the experimental design, researchers can provide a much more reliable answer to that key question.

## V. CONCLUSION

Professor Slobogin's proposed standard of generally accepted content validity will certainly help guarantee that a mental health expert's opinion represents something more than that witness's ipse dixit. I do not want to overstate either the value of malingering detection techniques or my disagreement with Professor Slobogin.

To begin with, we do not yet have established tests for detecting the malingering of every mental state that could be relevant in a legal proceeding. However, there are tests for a number of such mental states. For example, there are techniques for some Axis II disorders<sup>205</sup> as well as more serious Axis I disorders.<sup>206</sup> Thus, there are techniques for detecting malingering of psychoses<sup>207</sup> such as schizophrenia<sup>208</sup> and affective disorders.<sup>209</sup> There are also techniques for cognitive impairments<sup>210</sup> including mental retardation,<sup>211</sup> amnesia,<sup>212</sup> and memory deficits.<sup>213</sup> It would probably be fair to say that malingering detection tests currently exist for a significant minority of the mental states encountered by psychiatrists and psychologists.

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<sup>204</sup> William D. Wentzel, *Review: Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (DSM-IV)*, THE ADVOCATE, Aug. 1994, at 25-26.

<sup>205</sup> Rogers, *supra* note 37, at 319.

<sup>206</sup> *Id.* at 320.

<sup>207</sup> Schretlen, *supra* note 160, at 213; Cornell & Hawk, *supra* note 38, at 377; Drogin, *supra* note 50, at 3.

<sup>208</sup> Schretlen, *supra* note 160, at 212, 215; Smith, *supra* note 66, at 353, 362.

<sup>209</sup> Smith, *supra* note 66, at 364; Drogin, *supra* note 50, at 4.

<sup>210</sup> PARRY & DROGIN, *supra* note 54, at 123; Pankratz & Binder, *supra* note 68, at 223, 231; Rogers, *supra* note 62, at 375; Smith, *supra* note 66, at 352, 364; Drogin, *supra* note 50, at 713; Mossman, *supra* note 46; Rubenzer, *supra* note 48.

<sup>211</sup> Smith, *supra* note 66, at 358.

<sup>212</sup> Smith, *supra* note 66, at 364; Rubenzer, *supra* note 48, at 40.

<sup>213</sup> Pankratz & Binder, *supra* note 68, at 230; Rogers, *supra* note 62, at 376; *see generally* Iverson et al., *supra* note 129.

Nor do I want to overstate my difference of opinion with Professor Slobogin. As Part I noted, in *Proving the Unprovable*, he makes it clear that he is not making a categorical claim that it is never possible to test the substantive accuracy of expert testimony about past mental state.<sup>214</sup> He acknowledges that in a “few instances,” there may be scientifically reliable information about past mental state.<sup>215</sup> He specifically mentions the possibility of using malingering detection techniques.<sup>216</sup>

My primary concern is that others may cite *Proving the Unprovable* as a basis for a general call to abandon any effort to ensure that the expert’s opinion possesses a measure of substantive accuracy. In a significant number of cases, the state of the art of malingering detection makes it unnecessary to abandon that effort. Although Professor Slobogin’s proposal is a step in the right direction,<sup>217</sup> we can do better; we can improve the accuracy of mental health experts’ testimony by insisting on an appropriate use of malingering detection techniques. The existing techniques are fallible; but the use of several techniques, including the specialized instruments, provides some reliable evidence that the expert’s opinion is correct.

Moreover, I fear that such a general call would be counterproductive.<sup>218</sup> If mental health experts publicly and formally eschew any

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<sup>214</sup> SLOBOGIN, *supra* note 1, at 57.

<sup>215</sup> *Id.* at 59.

<sup>216</sup> *Id.* at 65, 140.

<sup>217</sup> Andrew E. Taslitz, *Book Review: Proving the Unprovable*, CRIM. JUST., Fall 2007, at 70, 76 (noting that “the law is likely to move in the direction [Professor Slobogin] suggests over time”).

<sup>218</sup> My hope is that in the short term, Professor Slobogin’s proposal would be directed primarily to the mental health community itself. One of the things that I respect the most about Professor Slobogin’s book is its candor. For example, he points out that the proposal is not entirely novel. A similar proposal was made roughly a decade ago by Fishman. SLOBOGIN, *supra* note 1, at 63. In the decade since, the mental health community has evidently done little to implement the proposal. Professor Slobogin explains that there will be major hurdles to overcome in order to implement the proposal. *Id.* at 67. To construct the required database, contributing clinicians will have to adopt the same terminology and criteria. Without that, it will be impossible to determine whether two cases are “similar enough to make accurate comparisons.” *Id.* at 67–68. Further, the database will be useful only if it enables users to determine that legal decisionmakers found a particular datum or approach persuasive. Unfortunately, legal dispositions are often opaque. *Id.* at 68–69. How are we to determine what factors were critical when the disposition is by plea rather than trial? For that matter, at trial how are we to probe behind a general verdict? I think it is fair to say that Professor Slobogin is hopeful that the mental health community can overcome these hurdles, but he acknowledges that they may prove to be insuperable. *Id.* at 70.

The upshot is that this proposal cannot be adopted immediately and perhaps may never be able to be implemented. If the proposal is immediately submitted to

attempt at substantive accuracy, the political reaction could be both immediate and harsh. The opponents of legal doctrines such as insanity might well argue that mental health experts have finally conceded what the opponents have long claimed, namely, that there is no assurance of the substantive accuracy of the experts' opinions and that in reality, the opinions represent ideology masquerading as expertise. Rather than leading to the reform of the relevant legal doctrines, the abandonment could well trigger the imposition of Draconian restrictions on the doctrines. As Mark Twain once remarked, "[t]ruth is the most valuable thing we have."<sup>219</sup> We should think long and hard before abandoning the pursuit of substantive accuracy.

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legal decisionmakers—courts and legislatures—as an alternative to the status quo, the most favorable possible reaction would be that the proposal is premature. Given the current political climate on law and order issues, other—decidedly less favorable—reactions are distinct possibilities.

<sup>219</sup> MARK TWAIN, PUDD'NHEAD WILSON'S CALENDAR, *quoted in* THE POCKET BOOK OF QUOTATIONS 409 (1959).