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Introducing Psychological Injury and Law

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Abstract

Psychology injury and law is a specialized forensic psychology field that concerns reaching legal thresholds for actionable negligent or related injuries having a psychological component, such as for posttraumatic stress disorder, chronic pain, and mild traumatic brain injury. The presenting psychological injuries have to be related causally to the event at issue, and if pre-existing injuries, vulnerabilities, or psychopathologies are involved at baseline, they have to be exacerbated by the event at issue, or added to in unique ways such that the psychological effects of the event at issue go beyond the *de minimis* range. The articles in this special issue deal with the legal aspects of cases of psychological injury, including in legal steps and procedures to follow and the causal question of whether an index event is responsible for claimed injuries. They deal with the major psychological injuries, and others such as somatic symptom disorder and factitious disorder. They address best practices in assessment such that testimony and reports proffered to court are probative, i.e., helping the trier of fact to arrive at judicious decisions. The articles in the special issue review the reliable and valid tests in the field, including those that examine negative response bias, negative impression management, symptom exaggeration, feigning, and possible malingering. The latter should be ruled in only through the most compelling evidence in the whole file of an examinee, including test results and inconsistencies. The court will engage in admissibility challenges when testimony, reports, opinions, conclusions, and recommendations do not meet the expected standards of being scientific, comprehensive, impartial, and having considered all the reliable data at hand. The critical topics in the field that cut across the articles in the special issue relate to (a) conceptual and definitional issues, (b) confounds and confusions, (c) assessment and testing, (d) feigning/malingering, and (e) medicolegal/legal/court implications. The articles in the special issue are reviewed in terms of these five themes.

Keywords Psychological injury · Law · Egg shell · Crumbling skull · Posttraumatic stress disorder · Chronic pain · Mild traumatic brain injury · Persistent postconcussion disorder · Somatic symptom disorder · Fictitious disorder · Assessment · MMPI-2-RF · PAI · Feigning · Malingering

The area of psychological injury and law constitutes a specialized area of practice in forensic psychology. It is an area that is replete with controversies and opposing views, such that it is highly contested in court and related venues. Introducing the complex area of psychological injury and law takes a whole special issue devoted to the law in the area and the major psychological injuries that assessors and the court are likely to encounter—posttraumatic stress reactions and disorders, chronic pain, and traumatic brain injury (mild severity, more serious injuries are less contested). All these areas are greatly contested in court because they are invisible injuries that are subject to purposeful exaggeration or even outright fabrication for monetary gain in court action. Leading experts weigh in on these topics in the special issue, and this paper considers major themes that cut across them. The main conclusion that it reaches is that experts and forensic practitioners should always strive to be scientific, comprehensive, and impartial in assessments and in dealing with court and related legal venues.

This special issue has brought together leading experts in law, psychology, and medicine to explain at the introductory level what the term psychological injury represents and how it is presented to and dealt with in legal settings. The articles in the special issue turned out to be more than simple descriptive exercises, which is consistent with the complexity in the field.

Psychological injuries refer to psychiatric or psychological conditions induced by negligent actions, such as in motor vehicle collisions and workplace injuries (causes of action in

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tort also are referred to as intentional, or having strict liability; Kohutis & McCall, 2020). The psychological injuries are serious enough to lead to claims for damages by the injured person against the persons or agents responsible, such as the negligent driver in a motor vehicle accident or the negligent workplace that had put worker safety at risk. The main psychological injuries relate to trauma reactions, such as posttraumatic stress disorder (PTSD), pain conditions that become chronic, and psychological sequelae of mild traumatic brain injury (MTBI). The special issue includes papers on all three topics (respectively, Kerig, Mozley, & Mendez, 2020; Mailis, Tepperman, & Hapidou, 2020; and Young, 2020a).

The two legal articles introduce the special issue and were written by Foote, Goodman-Delahunty, and Young (2020) and Kohutis and McCall (2020). The former describes the procedures that take place legally in cases of personal injury, and the latter describes causality for injuries that have a pre-existing component. According to Foote et al. (2020), there are legal and ethical constraints in undertaking psychological injury assessments. The legal steps and procedures are onerous and require diligence and adhering to expected legal standards. The ethical sources for conducting these types of evaluations are presented in the American Psychological Association's ethics code and its forensic specialty guidelines (American Psychological Association, 2013, 2017). The Foote et al. (2020) paper constitutes a rich resource for the fundamentals in working in the field, and it deserves careful scrutiny, but presentation of its details is beyond the scope of the present work.

According to Kohutis and McCall (2020), the courts have given these types of cases colorful terms, such as eggshell and thin skull cases (with crumbling skull cases having much preexisting vulnerabilities). In these types of cases, the psychiatric psychological and legal task is to determine the degree to which the prior psychiatric/psychological state, even if only latent and not fully expressed, as in schizophrenia, can explain in full or at least mostly the reported psychological reaction to the index, subject event at issue in the legal actions undertaken. These authors also examine the difficult cases legally of somatic symptom disorder and fictitious disorder.

The assessment article by Fokas and Brovko (2020) reports on the reliability and validity results of two widely used broadband personality and psychopathology inventories used in forensic assessments, the Minnesota Multiphasic Personality Inventory-2 Restructured Form (MMPI-2-RF; Ben-Porath & Tellegen, 2011) and the Personality Assessment Inventory (PAI, Morey, 2007). Both tests have scales that address that the likelihood of the results of the tests are invalid due to overreporting (referred to as respondent validity, not to be confused with test validity).

The articles in the special issue were found to have common themes that cut across them and that illustrate the complexities in the field and the practical and legal expertise required to assess patients expressing psychological injuries. The court expects a sound scientific basis for testimony, including reports, proffered to court, and using reliable and valid procedures that allow for admissibility of the material and respect for their contents. These common themes in the articles in the special issue reveal that, even for basic concepts and definitions, there is no consensus on acceptable terminology and classification. There are multiple confusions, confounds, and conundrums that assessors in the field will confront for each of the major psychological; its high-stakes and court nature renders it a minefield for the unprepared assessor who is not familiar with the best state-of-the-art assessment practices. Assessors who do not consider the possibility of feigning, or malingering, for example, will quickly find that their work is deemed inadmissible to court or, if admitted, will be exposed to withering cross-examination with the weight of their evidence reduced or nullified.

With this preamble, the authors proceed to examine their articles for the special issue from the point of view of five key themes. They show the challenges inherent in working in the field of psychological injury and law, both for the psychological injury component and the law component of the field. The specific themes covering the articles in the special issue involve: (a) conceptual and definitional issues, (b) confounds and confusions, (c) assessment and testing, (d) feigning/malingering, and (e) medicolegal/legal/court implications. For each of the five themes, this paper gives an introduction, including what the themes concern and how each of the articles in the special issue deals with them. Also, this paper gives examples of what the articles in the special issue do not consider. These lacunae within the articles of the special issue serve as recommendations for further work in the area. That said, the primary recommendation of the paper is that each of the five major themes in psychological injury and law should be given due consideration toward arriving at consensus statements for best practices and for further research required.

Five Themes Cutting Across the Special Issue Articles

Conceptual and Definitional Issues

Entering the field of psychological injury and law will lead to a labyrinth of confusing concepts, terms, classification systems, and approaches. The legal terminology is complex and sometimes at odds with psychiatric psychological terms, such as the case for reliability in law, which refers to validity for the court, yet which had a different meaning in science (consistency of data or diagnosis). This is one example of the difficulties confronting workers in the area of psychological injury

and law, and it gets worse as we enter the psychiatric/psychological arena. One the one hand, at times, psychologists and psychiatrists have to translate their terminology and diagnoses into legal language. For example, the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Statistical Classification of Diseases and Related Health Problems (ICD) diagnostic systems might have one range of definitions for terms such as "impairments" and "disability," but the legal definitions in one's jurisdiction might be quite different. Or, the assessor might be comfortable with one diagnostic system of the major ones available, but the court might expect use of another. On the other hand, the terminology and its definitions in the area of psychological injury and law might be hotly debated and subject to conceptual, practice, research, and empirical debates that have not been resolved. Finally for present purposes, the area of psychological injury and law is a legally contested one, with plaintiff and defense having different theories of the case and approaches to what constitutes valid assessment procedures, base rates of malingering, and so on. In all these areas, one will find differences in conception, definition, and terminology. Science offers the best remedy to deal with these concerns, and the present special issue is dedicated to presenting the differences in concepts, definitions, terminology, and classification of the major psychological injuries in order to have assessors be fully aware of them, and in order that they conduct their assessments reliably and validly and to meet the expectations of court.

One common concern for the psychological injuries discussed in the special issue with respect to terms and labels relates to the extreme heterogeneity in patient presentation even within the most common definitions and nosological classifications. The authors hint at this heterogeneity and here we expand on it. Young, Lareau, and Pierre (2014) had shown that the classification strategy in the DSMs (polythetic criteria, with several sub-categories and each allowed to have some minimal number of symptoms present from a longer list of symptoms within each sub-category) allows for an incomprehensible amount of individual variation in symptom expression for certain disorders. In the case of PTSD, for example, when possible comorbidities are considered, the several hundred thousand ways of expressing PTSD jump to over one quintillion ways of expressing the disorder complex. If one were to examine the permutations and combinations for expressing concussion symptoms, with the multiple physical, cognitive, and socioemotional symptoms involved, as well as the neurological, the variations would be endless, as well. Certainly, pain complaints can be equally daunting to narrow down into diagnostic categories when so much individual variation abounds.

Regarding PTSD, Kerig et al. (2020) point out that these concerns are particularly acute given that there are now two distinctly different sets of diagnostic criteria for the disorder. Among the sharp distinctions between the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5; American Psychiatric Association, 2013) and the International Statistical Classification of Diseases and Related Health Problems, 11th Ed. (ICD-11; World Health Organization, 2020) criteria are their contrasting definitions of what comprises a traumatic event, inconsistent numbers and types of symptoms needed to qualify for the diagnosis, the presence of subtypes (i.e., the dissociative subtype in DSM-5) that are not taken into account in the other system, and the inclusion of additional diagnoses (i.e., the complex PTSD (CPTSD) diagnosis in ICD-11) that were not only omitted but were positively refuted by the developers of the other system (Resick et al., 2012). These concerns cannot be dismissed with the commonly held notion that the ICD-11 is a European system, whereas the DSM-5 holds sway in North America, given that HIPAA (Health Insurance Portability and Accountability Act, 1996) and many health insurance companies are beginning to require ICD-11 codes for reimbursement. Moreover, especially given the newness of ICD-11, which was released only last year, few empirically rigorous studies are available to provide evidence of either system's reliability, validity, and predictive value.

In their chronic pain article, Mailis et al. (2020) address the evolution of the multiple definitions of chronic pain within a historical context. They present the most recent approaches to pain terminology and definitions, and what these definitions mean as applied to clinical and medicolegal practice. Also, they review how pain is handled in the two most widely used systems of classification of mental disorders (including classification of pain conditions), the DSM and the ICD. They discuss the disparities in the two most recent versions of DSM, pointing out similarities and differences in how pain is diagnosed. They elaborate on the new IASP (International Association for the Study of Pain) definition of chronic pain and the novel ICD-11 classification of chronic pain. With respect to conceptual and definitional issues, they find that there is a plethora of divergent approaches, and even the most recent ones have inconsistencies and cannot cover all the examples that they provide. They call for further work on specifying the definition and classification of chronic pain from a medical and psychological point of view.

The articles on PTSD and chronic pain in this special issue underscore the myriad problems in dealing with the major definitions, terms, and classificatory systems in their areas, but the article by Young (2020a) on MTBI calls for a total revamping of the area. It calls for a new roadmap in the conceptualization, study of, and practice and assessment procedures related to MTBI and also for its consequences, which in the present arena concern persistent postconcussion syndrome (PPCS). On the one hand, MTBI has no commonly accepted definition, and Young (2020a) proposes avenues for a new one based on several sources that he integrates, including the

upcoming revision of the American Congress of Rehabilitation Medicine (ACRM) definition of MTBI (Silverberg, Iverson, Silverberg, on behalf of the ACRM Mild TBI Definition Expert Consensus Group, ACRM Brain Injury Special Interest Group Mild TBI Task Force, 2020). On the other hand, for PPCS, he advocates for abolishing the use of the term, and he created another one to replace it—somatic symptom disorder with predominant PPCS-like symptoms. Young (2020a) makes an integrated list of the subjective symptoms of MTBI. His SSD variation to replace PPCS is very detailed and is organized to fit the structure of the general SSD category in the DSM-5, but with additions to improve its quality.

In terms of assessment, there have been issues in definitions of key terms and their interpretations. For example, to clarify their different uses, terminologically, performance validity tests (PVTs) were branched off from symptom validity tests (SVTs). The names of some of the scales were changed (e.g., the FBS kept its label, but now is referred to as symptom validity). Cut scores for different tests change with research findings. In addition, the conceptual basis for these types of tests differs (Fokas & Brovko, 2020).

The legal articles by Foote et al. (2020) and by Kohutis and McCall (2020) review special legal terminology in the field of psychological injury and law. There is little controversial in these regards, because the law works from standard procedures. The problems with the legal terms in the field are that psychologists and psychiatrists have to change their mindset and translate them into their usual language. Moreover, there are jurisdictional differences that the two law articles do not address, with some terms in the civil law involved emanating from different countries. Moreover, there are criminal and civil law differences to consider, as described to some degree in Foote et al. (2020).

One topic for which the articles in the special issue on psychological injury and law could have been amplified is the nature of impairments, disabilities, and limitations and restrictions that are intrinsic both to attributing psychiatric disorders in nosological systems and to discerning the losses of evaluees for court purposes. Evaluating these impairments and disabilities is context-dependent and depends on the individual's pre-existing roles (work, caregiving, studying, as the case may be), capacities, coping mechanisms, support network, and so on. These types of assessments should be interdisciplinary, for example, with occupational therapy in-home and outing assessments.

Confounds and Conundrums

The area of psychological injury and law is not straightforward, not only in terms of the complexity of the law but also in terms of the complexity of the assessment process. Furthermore, each of the major psychological injuries—chronic pain, PTSD, and psychological sequelae of MTBI—has their controversies that complicate the assessment and diagnostic tasks involved. Furthermore, the issues of negative response bias/negative impression management, symptom exaggeration, and feigning/malingering are involved in every case. Can assessors be certain of their opinions, conclusions, and recommendations in light of these issues? Perhaps the pre-injury status of the person can explain everything psychiatric/psychological about them, and the injury has not contributed further to their presenting psychiatric/psychological condition, despite claims to the contrary.

Kerig et al. (2020) note that there are many opportunities for subjectivity to enter into the diagnosis of PTSD. For example, the ICD-11 criteria use phrases such as "extremely threatening or horrific" to define a traumatic event, which may be interpreted differently by various evaluees and evaluators; what is "extremely threatening" to one person may be viewed as merely uncomfortable to another. Similarly, time frames defined as "a few weeks" leave the criteria open to individual interpretation. Perhaps the biggest conundrum in the case of PTSD, however, is that the two different diagnostic systems comprise distinctly different sets of symptoms, with the DSM-5 encompassing a broad spectrum of indicators across four clusters, which incorporate a number of signs that in previous versions of the DSM were considered to be "associated features" (e.g., negative cognitions, externalizing behaviors); in contrast, the ICD-11 parsimoniously limits itself to only three core features. The conundrum regarding "what is PTSD" is highlighted even more clearly by the inclusion in ICD-11 of a separate diagnosis of CPTSD (complex PTSD), which places within the scope of stressor-related disorders symptoms that might otherwise be seen as signs of personality disorders and diagnosed as such. Moreover, neither of the diagnostic compendia has incorporated the proposed new diagnosis of developmental trauma disorder (DTD; van der Kolk et al., 2009), despite its positive reception in the popular and clinical literatures, which may lead attorneys and courts to call for DTD to be given consideration despite its lack of status as an official diagnosis.

Structured interviews might be more valid, but we still need a range of assessment strategies to rule out malingering. These strategies include searching documents for compelling inconsistencies, finding compelling inconsistencies in the interviews, and using the F scales on the MMPIs.

Possible confounds include pre-existing psychopathology present to the point that they preclude the index event from adding more than little to the psychological profile, such as pre-existing schizophrenic paranoia or serious borderline personality disorder or antisocial personality disorder and criminal history of a serious nature. All this can cast doubt both on the validity of the claim in the first place (e.g., the malingering

factor) and/or the claimed additional trauma experienced to the index event (the pre-existing psychopathology factor).

In addition, the senior author notes that a complicating confound that assessors need to gauge carefully is the extent to which pre-existing traumatic reactions and their psychological effects alter the opinion with respect to the presenting picture of the evaluee. Prior traumatic reactions might be deemed extreme enough to render the opinion that the PTSD or related diagnosis that might be ascribed to an index event actually reflects fully or almost fully the prior traumatic state of the person. In psychological evaluations of trauma survivors, it is imperative to differentiate the cumulative effects of early adversities/abuse on the presenting psychological state and to determine if the index event has merely exacerbated prior traumatic effects, adding little to them, or, conversely, whether all past traumatic situations had been handled well by the person and that the new incident at issue is fully responsible for diagnoses such as PTSD. In cases in which the ICD's complex PTSD is used to diagnose, this issue becomes especially important because CPTSD implicates a history of trauma that could stretch back even to the early years of the person, having a cumulative effect on the psychological state leading into the index event at issue.

Only a careful history in the interview, along with consultation of prior documentation, records, and primary care physician clinical notes, can help elucidate the proper response to the question, which will surely be brought up in court in such cases. Responses to evaluee validity scales in terms of establishing possible symptom exaggeration, feigning, or malingering serve little purpose in addressing this issue, because they are not scales that are meant to examine dynamic reactions over time. The evaluator should be wary to assume that cumulative traumas automatically assume cumulative PTSD and related reactions because, at different ages and in different circumstances, the person might have coped better than is presently observed in relation to the new event. That said, the new event might be the one that had pushed the person over the edge, so to speak, activating latent vulnerabilities that not had been evident beforehand despite the sequences experienced in trauma. The evaluator will need to document for court the steps taken to ensure a reliable and valid diagnosis of the person's condition post-index event, including whether little or nothing has been added/exacerbated by the most recent trauma in the history.

In their article, Mailis et al. (2020) point out the confusion that has dominated for years the field of pain concepts, definitions, classifications, assessment, and diagnosis, which has arisen partly due to application of the dualistic Cartesian model of pain rather than the biopsychosocial one. Notably, the 4th (Diagnostic and Statistical Manual of Mental Disorders DSM-IV; American Psychiatric Association, 1994) and the 5th (DSM-5) revisions of DSM in regard to pain conditions continue to confuse clinicians, particularly in the medicolegal and disability context, because, for the first time in decades, the DSMs have failed to include a pain-specific mental disorder. In consequence, some clinicians tend to resort to DSM-IV-TR (Diagnostic and Statistical Manual of Mental Disorders, Text Revision, American Psychiatric Association, 2000) or use elements of both DSM versions.

Another important confound in dealing with pain patients is to disambiguate pre-existing pains and those that are reported after an event at issue. Has the new injury actually caused an increase in pain, an exacerbation of the pain that had been present before the index event, new pains not there before, and so on? Does the new/exacerbated pain reach a threshold of more than just being a minimal/minor addition/aggravation of the prior pain condition? Careful clinical examination, reading of the records and diagnoses on file, and exact history taking can help answer these bedeviling questions that are so important for medicolegal practice and court.

Young's (2020a) roadmap article on MTBI and PPCS underscores a full range of confounds, confusions, and conundrums that complicate the reliable and valid assessment of the psychological effects from the brain damage related to the original event at issue. Young (2020a) argues that the original MTBI will have temporary effects on the person and that pathophysiologically, the injury will be considered to have healed. Even if there are residual effects that last, for the person the duration will not be long enough to induce a chronic state with a biological basis underwriting the expressed symptoms. Rather, following the biopsychosocial model, he maintains that psychosocial factors will be the source of any propagation and maintenance of the sensory/neurological, physical, cognitive, and social/emotional symptomatologies with which the person might present. Also, Young (2020a) notes that, as in the cases of PTSD and chronic pain, pre-existing factors might be present in sufficient degree to explain the complete post-event presentation profile and the alleged PPCS can be dismissed as invalid, without any index-event causal linkage.

Young (2020a) examines the full range of pre-event, event, and post-event complicating factors that would detract from diagnosing any diagnosis in cases of MTBI. These include cognitive dynamics, such as thinking inappropriately of the past in ideals ways and, therefore, inappropriately maximizing the effects of the index event on brain function and behavior. Similarly, there might be social factors, such as the family encouraging sick role rather than engaging in active participation in order to recover optimally from the event.

There are multiple complications in assessment in psychological injury and law, as can be discerned from the article by Fokas and Brovko (2020). This is a rapidly changing area with new tests and scales, including the MMPI-3 (Minnesota Multiphasic Personality Inventory-3; Ben-Porath & Tellegen,

2020) to be released in 2020. Moreover, the area is heavily researched, and the psychometrics are very refined, but the differences between various tests are not well studied. Thus, the assessor is left to read and learn a vast and changing literature, and the assessor is expected to know the research behind opinions, conclusions, and recommendations made to court. At the same time, this paper cautions against using the quick fix of computer-generated interpretations of these test results. It is impossible that the interpretations are based on the up-to-date literature search required; neither are they individualized to the case at hand nor take into account the full range of reliable data gathered for the case from all the sources of data examined.

Kohutis and McCall (2020) point to complications in psychological injury cases that involve alternative diagnoses having in common that they are more than likely to raise concerns about the validity of a case. This is less true of somatic symptom disorder (SSD), which is an overriding category for SSD with predominant pain, for example. It involves both physical and psychiatric symptoms, associated with clear distress and impairment. This disorder falls into the category of medically unexplained symptoms (MUS) and has been referred to as organic and the like, which are pejorative terms. The patient might engage in extensive doctor shopping, for example, believing that there is a physical ailment present despite tests to the contrary. The person is exaggerating in this sense, but not consciously for monetary gain. Young (2008) described the biopsychosocial factors that are involved in the development of this symptom profile, and malingering is not one of them, by definition. In the case of factitious disorders, the motivation to deceive is present, but not for monetary gain. These patients appear to seek the attention that accompanies the patient role. Any diagnosis of this sort jeopardizes the success of any legal action in the case.

Foote et al. (2020) explore in depth the legal and ethical bases for proper psychological assessments for court and the criteria for their admissibility to court. They review the *Daubert* trilogy and FREs (federal rules of evidence) in this regard. They review the ethics code and forensic speciality guidelines of the American Psychological Association. These sources make clear that multiple confounds and conundrums exist in the area of psychological injury and law related to these extra competencies that are required to function effectively in court while meeting professional standards expected in the field. The complexities relate to learning and applying the required knowledge arriving at probative rather than prejudicial testimony/reports for court despite the high bar expected of assessors legally and ethically.

There are other confounds that complicate the assessment process, and the articles in the special issue do not deal with them, but assessors and the court need to be aware of them. In particular, evaluees might express more than one psychological injury due to their experienced event at issue. It is not uncommon for the assessor to have cases with orthopedic injuries, who then have developed chronic pain, self-medication with alcohol, overuse of opioids to mask the pain, and associated major depression, aside from comorbid PTSD and MTBI. The assessment procedure becomes exponentially complicated in such cases. Moreover, one could ask to what extent are the psychometric tests that are administered valid for polytraumatic cases? For example, symptom validity tests (SVTs) might consider answers to questions about pain as embellished in testing for PTSD, but the responses might indicate genuine comorbidities.

Assessment and Testing

In this section of the paper, the authors of the special issue examine assessment and testing procedures. Each paper deals with this area, even the legal ones, finding that instruments that test for negative response bias, negative impression management, and so on are important to use in the circumstances. That said, the whole spectrum of assessment procedures, from interview to consulting collaterals and then to referring to documents, records, prior reports, and their diagnoses, inform the assessment process; and all these reliable sources need to be examined in concert to arrive at judicious, fair decisions on the matter at hand.

Fokas and Brovko (2020) have prepared an incisive paper on the two most commonly used tests in the field. They concern the personality inventories, the MMPI-2-RF and the PAI. Both have extensive respondent validity scales, commonly referred to as the F scales for the MMPI-2-RF and the NIM (negative impression management) and related measures for the PAI, which has recently expanded its repertoire of such tests. The instruments are called SVTs, because when they reach certain thresholds, it indicates the likelihood of symptom overreporting/exaggeration, or respondent validity. Other validity tests that are used in psychological injury case are PVTs, or performance validity tests. These tests include stand-alone tests, such as for memory, that are forced choice/two-choice tests, which are relatively easy to succeed quite well on despite surface appearances, and this result is found even for the seriously brain-injured. Therefore, chance scores on these types of instruments raise notable suspicions of malingering. Further, statistically significant below-chance scores on these types of instruments are considered compelling evidence of malingering, although relying on only one test result in attributing malingering is not an accepted standard of practice (the whole file and reliable data set need to be examined carefully in these regards).

Fokas and Brovko (2020) present an exacting survey of the forensic use of the MMPI-2-RF and the PAI in the disability context for court purposes. They have examined every possible aspect of the question and describe the most recent client validity scales that have been developed for the tests. There is

more research on the ones of the MMPI-2-RF, but for the PAI, the scales in this regard are expanding in recent research. There has been little direct comparison of the two tests for their accuracy and utility, and the authors recommend more extensive research of this type. Like the special issue of psychological injury and law as a whole, the Fokas and Brovko (2020) article will serve as a fundamental reference source for work in the field, in their case pertaining to assessment, and for the court, as well.

Fokas and Brovko (2020) present tables that summarize the F scales of the MMPI-2-RF and the validity scales of the PAI. The former table is presented in modified form in this article (see Table 1). The senior author advises that although norms are provided for the litigant population, they have not been subject to peer-review in articles or even supported in reported research in the test's manual that could be analyzed critically for its quality; therefore, normative research on them is unknown (Young, 2014). The assessor should always use test norms that have sufficient research on their reliability and validity when choosing test cutoffs in order to stand up to court scrutiny. That said, the second set of norms provided in the table for the MMPI-2RF F tests constitutes a good starting point in the required research on this matter, and Fokas and Brovko (2020) recommend their use.

For PTSD, Kerig et al. (2020) highlight the importance of utilizing diagnostic interviews which, although more effortful and time-consuming than self-report measures, have the advantages of higher validity and reliability, less vulnerability to feigning, and clarity regarding whether all diagnostic criteria are met; for example, many self-report measures fail to assess for functional impairment and some neglect to establish that the posttraumatic symptom ratings emerged in the aftermath of a bona fide traumatic event. However, although "gold standard" diagnostic interviews exist for the diagnosis of PTSD according to DSM-5 criteria in adulthood, they are still "under construction" for youth and are in the very early stages of validation for the diagnoses of PTSD and CPTSD according to the ICD-11 criteria. Self-report measures therefore continue to have high value and can be helpful in confirming the presence of clinically significant levels of symptoms across the spectrum of the PTSD and CPTSD disorders.

While assessment and testing, per se, was not the focus of their article, Mailis et al. (2020) cannot underscore enough the importance for clinicians to use a combination of clinical interview (and/or medical examination if they are physicians), and validated psychometrics in order to complete a pain assessment. These assessment tools should include tests with proper scales related to discerning the presence of negative impression management, symptom exaggeration, feigning, or malingering. Assessors also need to review medical records and previous diagnoses. While the DSM-5 outlines a number of criteria that must be met for the diagnosis of somatic symptom disorder (as well as adjustment disorder and psychological factors affecting a medical condition, which also might apply to the pain patient), under the ICD-11 (the combined effort of WHO and IASP), the severity of chronic pain will be determined as a compound measure of pain intensity, pain-related distress, and task interference. Significant psychological and social factors will also be documented with an extension code as needed.

For MTBI, Young (2020a) reviews the recommendations in the literature for adequate neuropsychological assessment of the effects of MTBI. However, he recommended a full-scale article on the topic, which was considered beyond the scope of his paper. In a certain sense, more so than standard neuropsychological test protocols, individuals claiming chronic effects of their original MTBI leading to PPCS should be examined with the same psychometric tests that ascertain the extent of symptom exaggeration and malingering that might be involved in the presentation. That is, tests that

Table 1 MMPI-2-RF F family overreporting scales

Number	Validity indicator/scale	Symbol	Upper T cutoff: feigning very likely	Disability litigant T cutoffs for men (N) and women (W)
1	Infrequent responses	F-r	≥ 120 (profile invalid)	M: 78
				W: 73
2	Infrequent psychopathology responses	Fp-r	≥ 100 (profile invalid)	M: 57
				W: 55
3	Infrequent somatic responses	Fs	≥ 100	M: 70
				W: 69
4	Symptom validity	FBS-r	≥ 100	M: 75
				W: 79
5	Response bias	RBS	≥ 100	M: 74
				W: 73

Table values from Ben-Porath and Tellegen (2011)

Adapted from Fokas and Brovko (2020)

involve SVTs and PVTs should be the primary ones in the neuropsychologist's assessment toolbox. For example, if there is a small but significant intellectual deficit 2-year post-event in an MTBI case, should the neuropsychologist automatically infer residual, permanent brain damage without verifying the extent of lack of effort in cognitive testing?

One area of assessment not examined greatly in these articles in the special issue on psychological injury and law concerns combined assessment procedures for establishing the evaluee's validity of presentation in cases of PTSD, chronic pain, and MTBI. The systems used, respectively, at this level include the works on the malingered neurocognitive dysfunction (MND) and malingered pain-related dysfunction (MPRD) models (which has been applied to PTSD, as well) (respectively, Slick, Sherman, & Iverson, 1999; Bianchini, Greve, & Glynn, 2005; Bianchini, Curtis, & Greve, 2013). Some of the articles in the special issue have sections that deal with these systems, especially the ones of Fokas and Brovko (2020) and Kohutis and McCall (2020).

The MND has been recently revised by Sherman, Slick, and Iverson (2020). Any new forensic instrument/assessment system needs the test of time and research before it can be widely accepted and implemented. Beyond that, as with the forensic imperative to explain why a preferred opinion, conclusion, or recommendation is more valid than other ones possible in a case at hand, the developers of any instruments and assessment systems, forensic or otherwise, should always explain why detractors might be wrong, why their tools are better than others, and so on, and not be selective in the research cited. In this regard, the authors of the new MND have not referred to Young et al. (2014) in which serious criticisms of the MND were raised.

The authors of this paper maintain that these malingering diagnostic systems might have fruitful research results but that they should not be reified and used to assess individual evaluees without the proper precautions. Indeed, these systems could lead assessors to cut and paste conclusions that have not been sufficiently subject to reliability and validity research. For example, Young (2014, 2020a) points out that these systems and others promote in one way or another three SVT/PVT test failures as equivalent to compelling evidence of malingering, even though many such tests might be administered and the percentage of failures on the array of tests given is reduced. Face validity lacks in this manner of proceeding in assessments, despite the use of superficially convincing statistics, as per the next section.

This paper could list all the tests that might be useful to the assessor of psychological injuries for court purposes. However, that task would be redundant, given all the tests mentioned in the articles (e.g., Fokas & Brovko, 2020; Kerig et al., 2020; Young, 2020a). We have listed the major personality inventories. The reader should consult the articles in the special issue for their extended list of tests that can be administered to psychological injury evaluees, including for PTSD, and the some of the best SVTs and PVTs. Even the two law articles (Foote et al. 2020; Kohutis & McCall, 2020) have extensive listing of tests that can be used in psychological injury cases. This attests to their importance and also indicates one critical advantage that psychologists bring to assessments and to court compared to other professionals. We are schooled in science, statistics, tests, measurement, psychometrics, reliability, validity, and other quantitative methods that give substance to our opinions, conclusions, and recommendations in court.

Feigning/Malingering

If there is one issue that stands out in the field of psychological injury and law, it is the one of malingering and its proper assessment. The prevalence of malingering in psychological injury cases has been estimated at 40 ± 10% (Larrabee, Millis, & Meyers, 2009). However, Young has multiple publications examining the validity of the claim, which careful analysis of the cited research refutes it (Young, 2015, 2019). More accurate, Young (2015, 2019) reported that the prevalence of malingering, problematic presentations, or both reach the level of 15 ± 15%, depending on the context, with the percentage higher for cases of MTBI. He settled for a likely average of malingering itself toward 10%, and high-quality research has often found a lower percentage.

The raison d'être of the Fokas and Brovko (2020) article on the MMPI-2-RF and the PAI client validity scales is to offer the conceptual and empirical base for use of these scales on the tests. The scales stand as the penultimate SVTs in the field. Fokas and Brovko (2020) list other instruments used for the same purposes, but none are broadband like the MMPI-2-RF and the PAI nor have the same empirical support.

As Kerig et al. (2020) note, the assessment of PTSD is particularly challenging in the light of the high potential for malingering, given that many of the key features of the diagnosis are known to the general public. However, just as important and challenging is the differentiation of malingering from a genuine "cry for help" (Young, 2019) given that severe posttraumatic symptoms may present as heightened patterns of responding that may be falsely tagged as signs of "exaggeration" on the validity indices of commonly utilized assessment tools, such as the Minnesota Multiphasic Personality Inventory-2 (MMPI-2; Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989) for adults and the Minnesota Multiphasic Personality Inventory-Adolescent (MMPI-A; Butcher et al., 2006) for youth. Therefore, assessment of malingering requires not only examination of validity indices and administration of tests specifically designed to assess for feigned psychopathology but skilled interviewing techniques, careful observation, and meticulous history taking. This is

particularly true in the case of youth, for whom few PTSD-specific malingering measures have been validated.

Mailis et al. (2020) note that it is very important for pain clinicians, as well as forensic examiners, to properly interpret the meaning of a patient's data in their testimony or report, explaining fully how they arrive at their opinions, conclusions, and recommendations. This is very important given the high-stakes consequences for treatment, disability, compensation, and legal or court matters. They caution that exaggerated pain reports may arise from multiple factors in addition to conscious exaggeration or simulation of a disease process, such as anxiety/psychopathology and cry for help/emphasizing pain so the patient/client "can be heard."

Young (2020a) considers malingering and problematic presentations in cases of MTBI, being careful not to conflate the two. The same care should be taken in conflating probable malingering in the MND with definite malingering. The ethics of forensic psychological assessment should lead one to consider alternative interpretations to the data gathered in an assessment before ruling in malingering. Furthermore, all the other possible interpretations should be refuted with reference to the assessment contents and data gathered. That said, when ruling out malingering, the same care should be taken. For example, failing at a significant statistical level on a two-choice, forced-choice memory test could be considered compelling evidence for malingering. Also, there might be irrefutable video evidence, such as a person claiming not to work actually found to be working. In all such cases, though, the assessor should view the video evidence with the evaluee and ascertain her or his explanation for the behavior at issue (which would not be required, though, in cases of someone working when claiming they are not).

Young (2020a) refers to the relatively new Inventory of Problems-29 (IOP-29; Viglione, Giromini, & Landis, 2017) as a newer stand-alone SVT that has the required psychometric properties for use in forensic disability and related assessments. Its research profile is accumulating, a hallmark for use in legal settings. Another widely used stand-alone SVT is the Structured Inventory of Malingered Symptomatology (SIMS; Smith & Burger, 1997). The memory test referred to above is the Test of Memory Malingering (TOMM, Tombaugh, 1996). Generally, stand-alone SVTs are good complements to within-test SVTs.

Compelling inconsistencies might also be found in the interview behavior, in the verbal report of the evaluee to the evaluator, in what is reported and what is written in the documentation, in collateral information in relation to the verbal report offered, and so on (see Young, 2014, for a full list). The evaluee should not be attributed malingering without defensible evidence in court. Also, the evaluee should demonstrate the evidence for the attribution, and not be tainted based on what might be reported in the literature nomothetically. Every individual should be evaluated ideographically in assessments in psychological injury and law cases with the set of data gathered being allowed to speak for itself, but with full knowledge of the science involved as a background for informed decision making.

The legal papers in the special issue on psychological injury and law (Foote et al. 2020; Kohutis & McCall, 2020) place the determination of malingering as central to the psychological injury assessment exercise. They consider the conceptualization/definition of the term, its proper assessment, and its role in court.

One area that is not dealt with in the articles of the special issue relates to the psychometric statistics used to determine test sensitivity and specificity, but it is noted that the base rate used for the condition being targeted by a particular test has huge consequences for these metrics. For example, test psychometrics is optimized in these regards when the base rate approaches 50%. Then, the test can have a hit rate that is effective for court purposes, However, when the base rate is lower, such as toward 15%, 10%, or even 2%, as Young (2014, 2019) has found for overt malingering, then the integrity of the accuracy statistics of a test can be severely affected.

Another major lacuna in the papers relates to the absence of best practices in neuropsychological assessment. Young (2020a) only briefly deals with this type of assessment. One area in psychological injury and law that is underexplored concerns psycho-vocational assessments. What are the reliable and valid tests in this area of practice?

Court

Assessors might feel confident in the assessment procedures and methods, but then worry about the next step in their legal journey in this field, of attending court and the stresses involved. The best way of dealing with the stress of court is to conduct the best possible assessments in the circumstances that are reliable, valid, and helpful (probative) to court, with an absence of bias. The assessor owes duty to the court, not the referral source or the evaluee or other stakeholders. Triers of fact will be attuned to possible bias or will be apprised of this motivation by the attorneys involved, if evident. Assessors who are deemed advocates instead of expert scientists in psychological injury cases will find their careers impaired and disabled.

Kohutis and McCall (2020) review causal analysis that the court uses to determine responsibility for negligent acts. The classic test is the "but for" test, in which one asks would the injured party in an event at claim have suffered the consequences due to the said event absent the event having taken place. When there are multiple factors and events that might contribute to the outcome being assessed, the legal rationale for causality is that any factor at issue must be a

"substantial" contributor to the outcome in order that it is actionable. Events that reach this threshold are also called proximate, and one of its rest is the foreseeability criterion, which asks whether a reasonable person could have predicted the event taking place and mitigated the outcome through action or inaction.

Foote et al. (2020) present research on the equivalence of remote tele-assessment procedures for court purposes, when compared to the standard face-to-face assessment protocol, citing Drogin (2020) among others on the value of these types of assessments in these trying times. For further information on remote tele-assessment for court purposes, consult Young (2020b). There, he argues that the research is burgeoning in the area, and difficulties will arise in this new assessment modality that might challenge its use in court.

For PTSD (Kerig et al., 2020), there are a number of potential implications for the court. The accuracy, reliability, and validity of psychological assessment reports can expect to be challenged not only on the basis of an assessor having used one diagnostic system over the other but in relation to the fact that two such conflicting systems exists, which suggests an inability of even those "expert" in the field to agree on the definition of and criteria for the diagnosis. Similarly, the small body of information available regarding the psychometric properties of the diagnostic instruments used to assess PTSD and CPTSD, especially in the case of youth, also will leave assessors vulnerable to being challenged on the quality of their evidence.

Pain diagnosis in the medicolegal context should include clinical interview, document review, collateral consultations as required, medical and psychological testing, as per the specialty of the assessor, and consideration of all the reliable evidence gathered in the case at hand. In particular, for chronic pain, the court needs to know that the evaluator has used the best definitions, nosology, and models, as Mailis et al. (2020) describe in their paper, while being aware of the outstanding issues, confounds, conundrums, and so on.

As for the MTBI article, Young (2020a) reviews the federal legal decisions and federal rules of evidence that prescribe the scientific requirements for reaching the bars of admissibility to court (e.g., Daubert v. Merrell Dow Pharmaceuticals, Inc, 1993). However, there are jurisdictional variations in these regards, and assessors should know their local requirements legally. The rules concern scientific methods used in the assessment work for the most part, which is consistent with the best practice approaches in psychological injury and law that assessments should be comprehensive, scientific, and unbiased.

One area in psychological injury and law at the legal level that has not been sufficiently addressed by the articles of the special issue on the field concerns case laws that have dealt with relevant assessment procedures used in the field. As well, the articles in the special issue have not examined the types of admissibility challenges that have arisen in the field and their outcomes. The workers in the field should have a compendium available of case decisions along these lines to serve as precedents and also constraints on practice.

Conclusions

The special issue articles on psychological injury and law were quite in agreement that the field is still in flux, without stable conceptualizations and even definitions to guide it. In law, the legal thresholds for court action are complex and at times confusing. Foote et al. (2020) have described the legal procedures in psychological injury and law cases, and Kohutis and McCall (2020) have explained some of the pitfalls in establishing causality in assessments and legally. Also, legally, even when the assessor completes the assessment and is ready to proffer testimony/report, it could be subject to admissibility challenges. Among the likely targets of the challenges will be how the assessor defines terms—e.g., what is PTSD and are the DSM or ICD reliable (Kerig et al., 2020)? Is chronic pain a scientifically supported concept (Mailis et al., 2020)? Are the definitional variations in MTBI so extensive that the concept is meaningless (Young, 2020a)? Then, likely admissibility challenges could focus on the tests used. Do they possess adequate psychometric properties of reliability and validity for court purposes? Do they have sufficient sensitivity and specificity such that their test results are not inappropriately labeling? Finally, are conclusions related to probable or definite feigning and malingering likely to stand up to court expectations for reliable and valid assessment procedures, testing, and interpretative protocols? These types of allegations are serious, but so is avoiding them or feebly or inappropriately dealing with them in the assessment in one way or the other.

The authors have no definitive answers to these questions of concepts, definitions, confusions and confounds in the field, best assessment and testing practices, dealing with feigning/malingering, and being well-prepared for court and its questions of admissibility and the weight given to testimony/proffered reports. However, we maintain that adopting a scientifically informed, comprehensive approach to assessments and court preparation, using comprehensive, multimodal assessment procedures that are scientifically reliable and valid, while dealing fairly and impartially with complex issues such as possible malingering, will likely lead to high-quality assessments and testimony that will be deemed admissible to and gain respect in court and related venues (e.g., worker compensation) (Young, 2014).

Compliance with Ethical Standards

Conflict of Interest The authors declare that they have no conflicts of interest.

References

American Psychiatric Association. (1994). *DSM-IV: Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

American Psychiatric Association. (2000). *DSM-IV-TR: Diagnostic and statistical manual of mental disorders (text revision)* (4th ed.). Washington, DC: Author.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders, fifth edition (DSM-5)*. Washington, DC: Author.

American Psychological Association. (2013). Specialty guidelines for forensic psychology. *American Psychologist, 68*(1), 7–9. https://doi.org/10.1037/a0029889.

American Psychological Association. (2017). Ethical principles of psychologists and code of conduct. Retrieved from https://www.apa.org/ethics/code/ethics-code-2017.pdf.

Ben-Porath, Y. S., & Tellegen, A. (2011). *MMPI-2-RF (Minnesota Multiphasic Personality Inventory-2 Restructured Form): Manual for administration, scoring, and interpretation (rev. ed.)*. Minneapolis, MN: University of Minnesota Press (Original manual published in 2008).

Ben-Porath, Y. S., & Tellegen, A. (2020). *Minnesota Multiphasic Personality Inventory-3 (MMPI-3)*. Minneapolis, MN: University of Minnesota Press.

Bianchini, K. J., Curtis, K. L., & Greve, K. W. (2013). Cognitive performance validity assessment in mild traumatic brain injury, physical pain, and posttraumatic stress. In D. S. Carone & S. S. Bush (Eds.), *Mild traumatic brain injury: System validity assessment and malingering* (pp. 323–346). New York: Springer.

Bianchini, K. J., Greve, K. W., & Glynn, G. (2005). On the diagnosis of malingered pain-related disability: Lessons from cognitive malingering research. *The Spine Journal, 5*(4), 404–417. https://doi.org/10.1016/j.spinee.2004.11.016.

Butcher, J., Williams, C., Graham, J. R., Archer, R. P., Tellegen, A., Ben-Porath, Y. S., & Kaemmer, B. (2006). *Minnesota Multiphasic Personality Inventory-Adolescent (MMPI-A) (revised manual version)*. Minneapolis, MN: University of Minnesota Press.

Butcher, J. N., Dahlstrom, W. G., Graham, J. R., Tellegen, A., & Kaemmer, B. (1989). *MMPI-2 (Minnesota Multiphasic Personality Inventory-2): Manual for administration, scoring, and interpretation*. Minneapolis: University of Minnesota Press.

Daubert v. Merrell Dow Pharmaceuticals, Inc. (1993). 509 U.S. 579.

Drogin, E. Y. (2020). Forensic mental telehealth assessment (FMTA) in the context of COVID-19. *International Journal of Law and Psychiatry 71*. Retrieved from: https://www.sciencedirect.com/science/article/pii/S0160252720300546?via%3Dihub.

Fokas, K. F., & Brovko· J. M. (2020). Assessing symptom validity in psychological injury evaluations using the MMPI-2-RF and the PAI: An updated review. *Psychological Injury and Law, 13*.

Foote, W., E., Goodman-Delahunty, J., & Young, G. (2020). Civil forensic evaluation in psychological injury and law: Legal, professional, and ethical considerations. *Psychological Injury and Law, 13*.

Health Insurance Portability and Accountability Act. (1996). Retrieved from https://www.cdc.gov/phlp/publications/topic/hipaa.html.

Kerig, P. K., Mozley, M. M., & Mendez, L. (2020). Forensic assessment of PTSD via DSM-5 versus ICD-11 criteria: Implications for practice and future research. *Psychological Injury and Law, 13*.

Kohutis, E. A., & McCall, S. (2020). The eggshell and crumbling skull plaintiff: Psychological and legal considerations for assessment. *Psychological Injury and Law, 13*.

Larrabee, G. J., Millis, S. R., & Meyers, J. E. (2009). 40 plus or minus 10, a new magical number: Reply to Russell. *The Clinical Neuropsychologist, 23*, 841–849.

Mailis, A., Tepperman, P. S., & Hapidou, E. G. (2020). Chronic pain: Evolution of clinical definitions and implications for practice. *Psychological Injury and Law, 13*.

Morey, L. C. (2007). *Personality assessment inventory: professional manual* (2nd ed.). Lutz, FL: Psychological Assessment Resources (Original manual published in 1991).

Resick, P. A., Bovin, M. J., Calloway, A. L., Dick, A. M., King, M. W., Mitchell, K. S., Suvak, M. K., Wells, S. Y., Stirman, S. W., & Wolf, E. J. (2012). A critical evaluation of the complex PTSD literature: Implications for DSM-5. *Journal of Traumatic Stress, 25*(3), 241–251. https://doi.org/10.1002/jts.21699.

Sherman, E. M. S., Slick, D. S., & Iverson, G. L. (2020). Multidimensional malingering criteria for neuropsychological assessment: A 20-year update of the malingered neuropsychological dysfunction criteria. *Archives of Clinical Neuropsychology, 35*(6), 735–764. https://doi.org/10.1093/arclin/acaa019.

Silverberg, N. D., Iverson, G. L., & on behalf of the ACRM Mild TBI Definition Expert Consensus Group, ACRM Brain Injury Special Interest Group Mild TBI Task Force. (2020). Expert panel survey to update the American Congress of Rehabilitation Medicine definition of mild traumatic brain injury. *Archives of Physical Medicine and Rehabilitation*. https://doi.org/10.1016/j.apmr.2020.08.022.

Slick, D. J., Sherman, E. M. S., & Iverson, G. L. (1999). Diagnostic criteria for malingered neurocognitive dysfunction: Proposed standards for clinical practice and research. *The Clinical Neuropsychologist, 13*, 545–561. https://doi.org/10.1076/1385-4046(199911)13:04;1-Y;FT545.

Smith, G. P., & Burger, G. K. (1997). Detection of malingering: Validation of the structured inventory of malingered symptomatology. *The Journal of the American Academy of Psychiatry and the Law, 25*, 180–183.

Tombaugh, T. N. (1996). *TOMM: The test of memory malingering manual*. North Tonawanda, NY: Multi-Health Systems.

van der Kolk, B. A., Pynoos, R. S., Cicchetti, D., Cloitre, M., D'Andrea, W., Ford, J. D., Lieberman, A., Putnam, F. W., Saxe, G., Spinazzola, J., Stolbach, B. C., & Teicher, M. (2009). Proposal to include a developmental trauma disorder diagnosis for children and adolescents in DSM-V. National Child Traumatic Stress Network Developmental Trauma Disorder Taskforce. Retrieved from https://www.cttntraumatraining.org/uploads/4/6/2/3/46231093/dsm-v_proposal-dtd_taskforce.pdf.

Viglione, D. J., Giromini, L., & Landis, P. (2017). The development of the inventory of problems–29: A brief self-administered measure for discriminating bona fide from feigned psychiatric and cognitive complaints. *Journal of Personality Assessment, 99*(5), 534–544. https://doi.org/10.1080/00223891.2016.1233882.

World Health Organization. (2020). *International statistical classification of diseases and related health problems (11th ed.; ICD-11)*. Geneva, Switzerland: Author.

Young, G. (2008). Somatization, and medically unexplained symptoms in psychological injury: Diagnoses and dynamics. *Psychological Injury and Law, 1*(4), 224–242. https://doi.org/10.1007/s12207-008-9021-4.

Young, G. (2014). *Malingering, feigning, and response bias in psychiatric/psychological injury - implications for practice and court*. New York: Springer Science + Business Media.

Young, G. (2015). Malingering in forensic disability-related assessments: Prevalence 15±15%. *Psychological Injury and Law, 8*(3), 188–199. https://doi.org/10.1007/s12207-015-9232-4.

Young, G. (2019). The cry for help in psychological injury and law: Concepts and review. *Psychological Injury and Law, 12*(3–4), 225–237. https://doi.org/10.1007/s12207-019-09360-y.

Young, G. (2020a). Thirty complexities and controversies in mild traumatic brain injury and persistent post-concussion syndrome: A roadmap for research and practice. *Psychological Injury and Law, 13*.

Young, G. (2020b). Psychology, law, ethics, telehealth, and the global pandemic. In N. Rezaei, S. Hanaei, & A. Saghazadeh (Eds.), *Integrated science of global epidemics (Vol 9, pp. XX)*. Cham, Switzerland: Springer Nature Switzerland AG.

Young, G., Lareau, C., & Pierre, B. (2014). One quintillion ways to have PTSD comorbidity: Recommendations for the disordered DSM-5. *Psychological Injury and Law, 7*(1), 61–74. https://doi.org/10.1007/s12207-014-9186-y.