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False Expert Reports by Psychologists Contracted by Car Insurance Companies

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Abstract

***Background**: Psychologists contracted and remunerated by car insurance companies to evaluate the insurance claims of injured motorists work under the implied pressure to rule out malingering.*

This study evaluates their use of psychological tests.

***Method**: 43 psychological reports were examined with respect to their use of evidently fallacious measures of malingering such as the Structured Inventory of Malingered Symptomatology (SIMS), Miller Forensic Assessment of Symptoms Test (M-FAST), Modified Somatic Perception Questionnaire (MSPQ), and also Paul Green's Medical Symptom Validity Tests (MSVTs), i.e., of tests never properly validated to assess malingering in injured motorists.*

***Results and Discussion**: About a half (48.9%) of the 43 psychological reports relied on the SIMS, M-FAST, or MSPQ. An additional 4 reports (9.3%) listed the test of malingering only generically as a Symptom Validity Test (SVT), but the descriptive paragraphs about its results strongly suggested that it was the SIMS. Unknown to the insurance psychologists, all 43 patients were carefully pre-screened by another agency via the Gutierrez questionnaire that assesses the presence of the typical polytraumatic psychological symptom pattern after vehicular accidents, i.e., persistent pain, pain-related insomnia, post-concussion syndrome, PTSD, depression, generalized anxiety, driving anxiety, and subjective psychological signs of spinal injury such as tingling, numbness, or reduced feeling in the limbs: all 43 reported symptoms in at least half of these symptom areas. The insurance contracted psychologists typically neglected to properly assess such typical post-accident symptoms, but declared about two-thirds of the patients (67.4%) as free of accident related psychological impairments. This rejection rate of patients' claims seems higher than reasonably assumed rates of malingering.*

***Conclusions**: The SIMS, M-FAST, and MSPQ were used in about a half of 43 psychological reports contracted by car insurance companies: these are fallacious tests in which legitimate psychological symptoms are scored falsely as indicators of malingering.*

Keywords: *malingering, SIMS, M-FAST, MSPQ, car accidents*

Introduction

The financial incentive ($3,000 to $10,000) for preparing a psychological expert report for an insurance company is seductive, especially as it may involve less than 10 hours of work. The implicit goal is detection of malingering or of "exaggeration" of post-accident symptoms. The incentive may trigger a subjective cognitive restructuring that re-interprets the participation by the "expert" psychologist in ways eliminating his or her cognitive disharmony or guilt feelings.

Detection of true malingerers is very difficult. Secretive video recordings of the "patient" performing strenuous chores, or carrying home heavy bags of groceries, are now often considered of little value as a "proof" because the patient may have ingested large

doses of analgesic medication to complete urgently needed housekeeping activities in the wake of the insurance companies refusal to provide legally owed financial support for hired household help.

Over the last decade, a "proof of malingering" via expert psychological assessment has been increasingly accepted by arbitrators and judges in insurance litigations. Especially popular among insurance contracted psychologists are tests that are not time consuming, easily administered, and known to yield high frequencies of "detection of malingerers." Psychologists who provide high rates of detected "malingerers" are likely to be perceived as having "special skills" and are more likely to be rehired because the savings, by the car insurance, on legally owed benefits not paid to injured patients amount to millions.

Especially popular with these insurance psychologists are the following tests:

The Structured Inventory of Malingered Symptomatology (SIMS)[1,2]

Miller Forensic Assessment of Symptoms Test (M-FAST) [3]

Modified Somatic Perception Questionnaire (MSPQ) [4] – note that the author of the MSPQ did not intend it as a test of malingering and may object to such inappropriate use.

Medical Symptom Validity Test (MSVT)[5] and

Nonverbal Medical Symptom Validity Test (NV-MSVT) [6]

From a scientific perspective, the common features of these tests are:

(1) excessive frequencies of false positives (i.e., of legitimate patients classified as "malingerers"),

(2) ease of administration, and/or

(3) unrealistic claims by the authors or by frequent users of these tests in professional publications about validity of these tests of malingering.

Scientific facts about the above tests are sobering. The SIMS, M-FAST, and MSPQ list mainly very legitimate medical symptoms common in survivors of high impact motor vehicle accidents (MVAs) or other medical patients, but score them, in an absurd manner, as indicative of malingering.[7,8,9,10,11, 12] Thus, injured persons with more post-MVA symptoms are far more likely to be classified as malingerers than patients with less symptoms: [13] this is obvious with respect to common post-accident symptoms such as chronic pain, pain related insomnia, post-concussion syndrome, PTSD, depression, anxiety, and neuropsychological signs of spinal injury such as tingling, numbness, or reduced feeling in the limbs.[14] This is also true of Department of Veterans Affairs (DAV) patients who experience similar polytraumatic symptom patterns from their repeated combat exposure to explosive blasts and to emotionally traumatic events. For instance, a recent study by Erika Wolf's team of DAV scientists determined that, in a sample of 171 war exposed US veterans, the SIMS classified as malingerers 82.7% of those clinically assessed as "probable PTSD," compared to only 41.8% of the veterans assessed clinically as probably free of PTSD.[15] The profit and savings by not paying medical benefits to *more injured* persons are considerably higher than those from denying payments to *less injured* (less needy) patients: the former would require more intense, more long term, and far more costly financial support than the latter group of patients.

The M-FAST consists of 25 items. Erika Wolf's team of DAV scientists followed the usual administration of M-FAST to their sample of 176 war exposed US veterans by subsequently re-interviewing them about their responses to all 25 M-FAST items. They encouraged the veterans to elaborate on each initial response. These re-interviews were used to determine if these veterans' responses to each item indeed deserved to be scored in the direction of malingering or if such scoring was only fallacious. The proportions of those correctly classified as malingerers were always lower than those provided by the usual M-FAST scoring system. [15] This trend occurred, without any exception, for all 25 items of the M-FAST, see a tabular summary of Wolf's data in Cernovsky et al.[11] The effect size of this pseudodiagnostic trend of M-FAST was calculated statistically to amount to point biserial correlation coefficient r=.49 (p<.001, 2-tailed) or Cohen's d=1.12. [11] For example, item 2 of the M-FAST ("*feeling depressed most of the time*") was endorsed by 50% of the veterans in the direction scored via M-FAST manual as indicative of malingering, but subsequent clinical interviews indicated that such scoring of Item 2 in the direction of malingering seemed justifiable only in 3.8% of the veterans. The rest were considered depressed.[11]

There is no North-American or European validation study of the SIMS, M-FAST, MSPQ, MSVT, or NV-MSVT that would demonstrate that these tests indeed differentiate legitimate patients from malingerers among persons injured in high impact MVAs or among war exposed veterans. While the assessment of malingering is the intended purpose of the test, the authors of SIMS and of M-FAST resorted to a rather absurd procedure of "analogue validation"[16] that consists in comparing SIMS and M-FAST scores of college students instructed to respond honestly to those instructed to feign medical symptoms. Since the both the SIMS and the M-FAST list mainly legitimate medical symptoms, but fallaciously score these symptoms such as depression or tinnitus as indicators of malingering, the SIMS and M-FAST differentiate only reporters from non-reporters of medical symptoms, but have no capacity to differentiate malingerers from genuine patients. For instance, in a recent meta-analytic study of survivors of high impact MVAs, SIMS scores of motorists injured in high impact collisions were not statistically different from the scores of persons instructed to malinger post-MVA symptoms (with some exceptions), and both groups scored significantly higher on the SIMS than normal controls or patients with only mild injuries from MVAs.[13]

The author of MSPQ, Chris J. Main,[4] did not intend it to be a measure of malingering. When the MSPQ was published in 1983, Main described it as "*a scale for the measurement of heightened somatic and autonomic awareness*" in back pain patients.[4] As discussed elsewhere, the MSPQ has no capacity to distinguish malingerers from legitimate post-MVA patients: "*About two-thirds of MSPQ items (8 of the 13 scored items, i.e., 61.3%) show a definite overlap with medical symptoms legitimately experienced by post-MVA patients. Three of these, the dizziness, blurring of vision, and nausea, are listed in the widely used Rivermead Post-Concussion Symptoms scale where they are scored correctly as indicators of the post-concussion syndrome, not as signs of malingering. Three other items, "Muscles in neck aching," "Legs feeling weak," and "Muscles twitching or jumping", can be considered as associated with whiplash injury to cervical spine or also with sprain or strain of other tissues, and the associated fatigue. Furthermore, symptoms of "Feeling hot all over" and Sweating all over" are familiar to persons who experienced sudden episodes of excruciating back pain.*"[12]

Similarly, more than 50% of items of the SIMS were found to overlap conceptually with symptoms of the post-concussion syndrome or whiplash syndrome (i.e., typical symptoms of survivors of high impact MVAs), but are fallaciously scored by the SIMS as indicative of malingering.[17] Studies of item content of each of the 5 SIMS scales (i.e., including all 75 items of the SIMS) found no items with any reasonable capacity to differentiate malingerers from legitimate patients.[7,8,9,10]

With respect to the M-FAST, a recent review study[11] concluded that "*More than a half of M-FAST items have content that can be legitimately endorsed by psychiatric patients, or those injured in MVAs, or by injured war veterans, but in the M-FAST, these items are erroneously scored as indicators of malingering. This can lead to high rates of false positives, e.g., 33% to 63% in the 2017 study by Weiss and Rosenfeld.*"

The MSVT[5] and NV-MSVT[6] belong into the general category of so called "effort tests." The MSVT and NV-MSVT were developed by Paul Green on the unreliable assumption that "poor effort" or inconsistent effort (e.g., proportionately better than expected performance on difficult tasks than on easy tasks) reliably indicates malingering.[18] Experienced clinical psychologists have observed such inadequate, substandard, or inconsistent effort on score distributions over items of other cognitive tests such as the famous Raven's Matrices[19] with test-taking persons who had no motive to malinger. Patients who experience fatigue or wide fluctuations in attentional focus (e.g., those with chronic pain, insomnia, or post-concussive syndrome, or symptoms of multiple sclerosis) are especially likely to be misclassified by Paul Green's tests as "malingerers." His tests have never been demonstrated to adequately differentiate malingerers from legitimate patients in clinical groups such as survivors of high impact MVAs. It is noteworthy in this context that the American Academy of Clinical Neuropsychology published a consensus statement to indicate that scores on "*effort tests*" can be confounded by factors such as fatigue, see Heilbronner, et al.,[20] page 1100. Fatigue is a frequent symptom in post-MVA patients and in war veterans with post-concussive injuries.

Professional standards of the American Psychological Association (APA) require that tests are to be used only on clinical groups on which they were specifically validated.[21] This is not the case with the SIMS, M-FAST,

MSPQ, MSVT, and NV-MSVT when these tests are used to assess malingering among persons injured in car accidents.

The present study examines the frequency of fallacious use of these tests on survivors of motor vehicle accidents, by psychologists contracted as experts by car insurance companies, within the context of legal litigations about insurance benefits.

Method

A sample of 43 psychological reports was provided in 2020 to the College of Psychologists of Ontario by Ms. Karen Hamilton, a senior official of Intact car insurance in Greater Toronto Area. These 43 psychological reports were contracted by the Intact company or its subsidiaries Jevco and Belair. These 43 reports are not a randomized sample. It is possible that they include only those deemed of satisfactory quality by the insurance clerks. Furthermore, it is not a sample preselected by us in a manner biased against the insurance company: we did not decide which reports would be included or excluded among thousands in the archives of that insurance company. All psychologists who produced these reports were licensed (in Canada, the equivalent legal term is "registered") to independently practice psychology in Ontario, Canada. They were thus legally empowered to provide psychological assessment services as "expert witnesses" in legal litigations in regards to post-accident insurance benefits.

The legal system in insurance litigations regarding post-MVA benefits in Ontario, Canada, is adversarial. Insurance companies contract psychologists to provide expert reports which usually happen to declare the patient as free of "*any accident related psychological impairments*." The injured motorist can hire a personal injury lawyer who then asks some other psychologists to assess the patient for typical psychological post-MVA symptoms: pain, insomnia, PTSD, post-concussive and whiplash symptoms, post-MVA depression, generalized anxiety, and post-accident driving anxiety.[14]

The insurance contracted psychologists were not aware that all 43 patients previously completed the Gutierrez pre-screening questionnaire,[14] and that answers of the patients on that questionnaire indicated numerous post-accident symptoms, and that all patients signed that questionnaire and initialled its pages.

When evaluating the insurance contracted "expert" reports, our analysis focused primarily on the presence of alleged tests of malingering: the SIMS, M-FAST, MSPQ, MSVT, NV-MSVT.

However, most of these 43 reports also included some other tests such as the Minnesota Multiphasic Personality Inventory-II (MMPI2)[22] or Personal Assessment Inventory (PAI)[23] or the 22 item Personality Assessment Screener (PAS)[24] which have not been specifically validated to detect malingering among post-accident patients. As already explained, the APA standards require that tests are not to be used on clinical groups for which they were not specifically validated, in particular for the purpose of diagnosis of malingering.[20]

Most psychologists and psychiatrists have high regard for the MMPI2, however, it is well known by experienced users of MMPI2 that elevated scores on its validity scales, in particular, on the F scale, do not always indicate malingering. Such "boilerplate interpretations"are considered injudicious. Elevated scores on the F scale may involve intense help seeking behavior that is sometimes referred to by MMPI psychologists as "a cry for help," or other reasons that have little to do with malingering. [22]

Using the de-identified numeric data set (no names and no other identifying information with respect to the patients or psychologists) from these 43 reports, we examined the frequencies of the use of the SIMS, M-FAST, MSPQ, MSVT, and NV-MSVT and also frequencies of the reports concluding that the patient was free of any accident related psychological impairment.

Results

Lack of Standardized Assessment of Typical Post-Accident Symptoms

As noted, all 43 patients reported numerous post-MVA symptoms on the Gutierrez pre-screening questionnaire[14] administered to them elsewhere (i.e., not by insurance contracted psychologists): their post-MVA symptoms (persistent post-MVA pain, pain related insomnia, post-concussion signs, PTSD, depression, anxiety, and neuropsychological signs of spinal injury such as tingling, numbness, or reduced feeling in the limbs) sufficiently justified their application for payments for assessments or treatments, submitted on their behalf to their car insurance by another independent agency.

The majority of reports by insurance contracted psychologists (29 of 43, i.e., 67.4%) declared the patient as free of *accident related psychological impairments* or free of DSM diagnosable *psychological conditions*. Two reports (i.e., 4.7%) were inconclusive. Less than a third of the injured persons (12 of 43, i.e., 27.9%) were given a psychological diagnosis, usually only such as "Adjustment Disorder."

The expert reports in this sample almost never mentioned the use of standardized assessments of PTSD, or of insomnia, or of the post-concussion syndrome, or of post-accident fear of driving (amaxophobia), even though these conditions are evidently *psychological impairments* or *conditions* that occur in the majority of survivors of high impact car accidents.

Various psychological questionnaires are available to assess these common post-MVA symptoms, but it is noteworthy that they were almost never used or mentioned in the 43 reports by the insurance contracted psychologists.

Credentials of some of these psychologists indicated that they were trained in neuropsychology, but they all failed to administer any standard questionnaire to properly assess the post-concussion syndrome (e.g., the Rivermead scale[25]) or the other common post-MVA neurological symptoms such as those listed in the Post-MVA Neurological Symptoms (PMNS) scale[26]. The use of such psychological scales could demonstrate that the patient indeed reports numerous typical post-MVA symptoms, unlike brief interviews by insurance contracted psychologists focused primarily on the possibility of malingering rather than on an adequate screening for the full spectrum of post-MVA symptomatology.

Some reports by these insurance contracted psychologists included tests such as the MMPI2, PAI, or PAS, i.e., those developed for assessments of typical psychiatric or psychotherapy patients. Such tests are inadequate for assessments of typical polytraumatic symptom pattern of survivors of high impact MVAs.

Frequency of Use of the SIMS, M-FAST, MSPQ, MSVT, or NV-MSVT

The present study evaluated the frequencies of use, in the 43 reports by insurance contracted psychologists, of the SIMS, M-FAST, MSPQ, and Green's MSVT or NV-MSVT. The frequencies are listed in Table 1.

Table1. *Tests of malingering used in the "expert witness" reports*

	SIMS	M-FAST	MSPQ	MSVT or NV-MSVT	Unspecified "SVT"
Frequency of use	34.9%	4.7%	9.3%	0%	14.0%
N of use (within the 43)	15	2	4	0	6
N of patients classified as malingerers	6	0	1	0	unreported
% classified as feigning by the given test	40%	0%	25.0%	N/A	unreported

About a half (48.9%) of the insurance contracted psychological reports included clearly fallacious measures of malingering: the SIMS, M-FAST, or MSPQ.

Very noteworthy are also the unspecified "*Symptom Validity Tests*" (SVTs), see the last column on the right. It is possible that some insurance contracted psychologists are already aware of recent professional criticisms of tests such as the SIMS, criticisms pointing out rates of false positives in excess of 66% (see Richard Rogers et al.[27]), or of inadequate validation[16] and statistical failure to reliably differentiate genuine patients such as injured motorists from malingerers.[13] Listing the malingering test only generically as a "*Symptom Validity Test (SVT)*" may deceive the insurance clerks and judges or arbitrators in insurance litigations, in case some of these persons are already aware of the scandalous nature of the M-FAST or the SIMS, or of the "off label use" of the MSPQ to "measure malingering." Thus, listing a test generically as an "SVT" rather than by its specific name may help to dodge or at least postpone peer criticisms and also legitimate complaints by patients about this professional malpractice.

Six of the 43 psychological reports included this obfuscation. Perusal of the paragraphs discussing results of these 6 "unspecified SVTs" suggested that in 4 of those 6 reports, the SVT was almost certainly the SIMS. If these 4 "probable SIMS" are added to the total count of fallacious uses of the SIMS, M-FAST, and MSPQ, the cumulative count of uses of these 3 flagrantly fallacious tests of malingering rises to 58.2%.

Two reports (i.e., 4.7% of the 43) included the Rey test of malingering (see a review by Reznek[28]),

however these two reports were inconclusive (neither confirming nor rejecting the patient's insurance claim). Another three reports (i.e., 7.0% of the 43) included the Test of Memory Malingering (TOMM),[29] however, the TOMM scores of these 3 patients did not indicate malingering. The psychometric discussion or evaluations of the Rey and TOMM are beyond the scope of the present article.

Discussion

Use of Pseudopsychological Malingering Tests

The main finding of the present study is that about a half (48.9%) of the 43 insurance contracted psychological reports included fallacious measures of malingering: the SIMS, M-FAST, or MSPQ. The proportion increases to 58.2% if the 4 instances of "probable SIMS" among the unspecified "SVTs" are counted.

Diagnosing Absence of Accident Relevant Psychological Conditions Without Assessing Them

The majority of the 43 psychological reports contracted by car insurance company failed to include, in the assessment of post-accident patients, adequate psychological measures of the polytraumatic symptom pattern (pain, pain related insomnia, post-concussion and whiplash symptoms, PTSD, post-accident driving anxiety, etc.). The 43 reports appeared primarily intent on examining the possibility of malingering.

As already mentioned, all 43 patients were previously screened in another agency by the Gutierrez questionnaire[14] which is a 4 page measure of the typical polytraumatic post-MVA symptom pattern. The responses of all these 43 patients indicated the presence of most symptoms that form the post-MVA polytraumatic pattern. The patients signed the Gutierrez questionnaire after responding to its items, to confirm that they reported those symptoms. The summaries of most salient post-MVA symptoms reported by these 43 patients were available to all of the insurance contracted psychologists (these summaries of post-accident symptoms were included on the last page of their application for assessments or treatments). The insurance contracted psychologists were not informed that these summaries of symptoms were extracted from each patient's responses to the Gutierrez questionnaire. They not only chose to ignore these symptom summaries, but also neglected to conduct proper testing to determine if such symptoms were present. As a result, 67.4% of the 43 psychological reports by insurance contracted psychologists declared the patient as free of MVA related psychological impairments or free of DSM diagnosable psychological conditions. It seems absurd to declare an absence of accident-related psychological conditions without properly assessing their presence or absence. It can be argued that subjective symptoms such as pain, insomnia, post-concussive signs, certain whiplash symptoms, PTSD, post-accident driving anxiety, and so on, can in fact be considered psychological conditions that may be properly evaluated via psychological questionnaires. Briefly, they constitute diagnosable psychological conditions. These psychological conditions have a multitude of adverse ramifications with respect to inability to work, financial consequences (e.g., defaulting on mortgages, and in extreme, homelessness), and family life.

Most experts agree that "malingering" is unlikely to occur at rates as high as 67.4% in groups such as previously healthy persons injured in high impact car accidents, yet the present study demonstrate that this was indeed the rate of rejecting the presumably mostly genuine claims by injured persons and that this was usually done without a proper assessment of the relevant symptoms via appropriate specialized psychological tests, those suited for this clinical group of patients.

Unrepresentative Nature of this Sample of 43 Reports

The rates of identified "malingerers" in Table 1 are perhaps not at all representative of those usually identified so by psychologists contracted by Intact insurance or its subsidiaries. The sample is not a randomized one. It is a selection of reports that were presumably considered as exemplary by car insurance clerks, as suited for "a display" to the College of Psychologists of Ontario, those assumed not to cause criticism by peer professionals.

Deception in Insurance Litigations

Over the last decade, thousands of judges or arbitrators in insurance litigations were deceived by expert testimonies based on the alleged "symptom validity tests." In the adversarial system, the rulings in such litigations were usually in favor of experts using what appeared to be "objective, scientifically based, and impartial measures of malingering." Current

scientific evidence shows that using tests such as the SIMS, M-FAST, MSPQ, MSVT, and NV-MSVT can be considered a travesty of legitimate psychology. These tests present an alarmingly high iatrogenic risk to injured members of the public.[30]

False Expert Witness as a Socio-Psychiatric Phenommenon

The present study is relevant to socio-psychiatric phenomenon of so called hired false expert witnesses. The phenomenon can be observed also in other branches of health care, such as among some specialized physicians. For example, an orthopaedic surgeon has been noted to examine the patients' files for presence of documented fractures and tissue injuries and, in their absence, to repetitively declare that, from a strictly musculoskeletal perceptive, there is *no accident related impairment.* It is noteworthy that such statement would also rule out certain impairments of muscular function associated with cerebral palsy, multiple sclerosis, Parkinson's, or with the whiplash syndrome (e.g., tingling, numbness, and somewhat impaired muscular control over limbs). Within psychology, the phenomenon of false expert testimony includes professionals engaged in a lucrative but highly iatrogenic enterprise that, as suggested by the present study, may be based on routine use of false psychological tests to discredit patients' claims for therapies and other lawfully owed medical benefits.

Multidimensionality Underlying the Concept of Help Seeking and Malingering

The dichotomous view of malingerers versus genuine patients is an undue simplification of multidimensional patterns. In Ontario, most insurance claimants soon realize the full impact of being assessed within a highly adversarial system in which insurance clerks seem under pressure to reduce the expenditures or to be themselves laid off or let go. In such situations, an injured driver of a transport truck who obtains less than 3 hours of sleep per day due to persistent post-MVA pain and post-concussive symptoms may be exhorted, by the insurance clerk, to resume his employment.

The injured patient with post-concussive signs such as slow speed of thinking, impaired attentional focus, and impaired memory, may become increasingly anxious about the possibility of being flatly denied insurance benefits, may feel overwhelmed by repeated requests for documentation over many months or years since the accident, and seemingly interminable delays of medical benefits. The patient may feel lost in the stacks of documents written in office jargon or medical terminology, and may indeed, as a part of help seeking behavior, anxiously over-report some symptoms in the effort to finally obtain some therapy. Immigrants from countries where it is still very maladaptive to trust government institutions or commercial organisations may be especially prone to consider overreporting of symptoms as perhaps the only viable strategy to obtain their (in fact) legitimately owed insurance compensations.

There is a wide spectrum of adaptive or maladaptive reactions to persistent pain including alcohol consumption to cope with insomnia, escalating use of opiate based medications, or suicide attempts. The adjustment reactions usually include anxiety and depression. The overall discouragement may involve extreme social withdrawal ("*nobody would understand how I feel*"). Such maladaptive reactions are usually perceived as "self-inflicted" rather than as "accident related."

Some patients with less severe injuries who experience excessive pain only over the first few months after their accident, may find themselves in a narrow mode of existence, with their inner life restricted by an extensive focus on physical problems magnified by high anxiety. While some experts may diagnose them as "*free of accident related impairments*," these persons would benefit from psychological counselling to overcome the accident related generalized anxiety, especially the catastrophic style of thinking in regards to physical functioning.

The anecdotal examples provided here can only begin to allude to the daunting complexities underlying the clinical relationship between malingering and help seeking. A separate monograph based on empirical data would be needed to adequately address such issues. It seems unlikely that the false measures of malingering as discussed here would be helpful in such endeavor.

Conclusions

About 50% of expert psychological reports prepared in the context of insurance litigations were based on the SIMS, M-FAST, or the MSPQ, i.e., on fallacious tests that allegedly measure malingering. Almost all of the insurance contracted psychologists failed to use specialized psychological tests that would make

a proper assessment of the polytraumatic post-MVA symptom pattern possible. The rate of rejections of presumably legitimate patients' claims seems much higher than reasonable estimates of rates of malingering.

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