

Psychopathology simulation: clinical expertise

Gioacchino Mazzola¹, Andrea Zanghì¹, Salvatore Calamera², Serena Giunta³

Abstract

Each clinical act, whether strictly therapeutic or expert in nature, presupposes an assessment of the credibility of our interlocutor. This necessary and preliminary act becomes all the more important as our doing gets closer to the expert (professional) dimension. But simulating a mental illness or, on the contrary, pretending not to have problems when instead you are afflicted by a psychiatric condition, are all behaviors united by the fact that the subject who carries them out, reports a lie with respect to the real condition, with motivations and purposes that can be completely different. Clinical analysis is the only one that can demonstrate and discriminate the real disorder from those who are not. In light of this, the present work intends to highlight how the simulation of pathology in the expert field is a field that needs further study as it is complex and at the same time rich in phenomena that does not allow an easy solution and which necessarily require the examination of different levels.

Keywords: *Clinical psychology, expertise, simulation.*

¹ Giudice Onorario Minorile, Tribunale di Palermo

² Psicologo dell'età evolutiva e di comunità, Psicoterapeuta IACP

³ Docente LUMSA, Santa Silvia, Palermo

Introduction

The appraisal brings with it specificities such as to construct a real different setting compared to a “more traditional” clinical work. Generally, access is not the result of customer voluntary action to which expert assessment is recommended, if not imposed. The same purpose of clinical action, in case of expert opinion, is different: the aim is not to promote the well-being of the subject, if not as a possible and accessory relapse, but to evaluate a specific psychological condition relative to a specific and contextual action that has legal relevance (Ferracuti, Parisi, Coppotelli; 2007).

Given these conditions, it is evident that the subject naturally tends to propose himself by assuming the position he deems most self-reliant. There may be different benefits that being affected by a mental disorder can bring: in criminal matters, being transferred to a psychiatric ward or accessing a different regime of custody or not having to respond to magistrates or, again, seeing redefined one’s ability to understand and intent on the related question; in the civil sphere, the recognition of a condition of suffering linked in a causal way to a fact can represent for appraising the condition for the recognition of biological damage or of a psychic nature and, therefore, access to any compensation. What has been said certainly does not mean that the clinical setting is removed from the problem relating to simulation, but it is certain that it occurs to a lesser extent.

With regard to the strict clinical setting, it must be emphasized that within the relationship with the patient there may be blind spots deriving from the existence of some “pre-judice”: among these the belief that the possibility of honestly expressing oneself by the patient is a pre-requisite for developing common and shared goals. Having to question the presence of this relational assumption can have an important countertransference reflection on the clinician, so much so as to represent a real resistance in defining a client as a simulator

or as a carrier of a fictitious disorder or the like. The explanation of this condition would lead to presuppose the possibility that, within the relationship, there may be a dimension, linked to deception. Perhaps it is also for this particular emotional resonance that in many clinical manuals this aspect is not treated, limiting it to the criminological literature (Merzagora, Bateson; 1987) or, if it is, done in a non-specific way by inserting it, for example, within a more general analysis of patient compliance (Tatarelli *et al.*, 1998).

Comparative interpretative models

In the purely legal/medical field, Paolo Zaccaria (1628) addresses the theme of simulation, defining it as an attempt for the guilty to escape a just and deserved punishment; the same Tommaso Campanella (1568-1639) Italian philosopher, arrested pretending to be mad, managed to get the death penalty commuted to life imprisonment. Even Isaac Ray, founder of the American psychiatry, in his Treatise (1838/1962), addresses the problem by noting that in the simulation there is often a grotesque character that is not found in the real symptomatological process.

The simulation took on new proportions close to the First World War. What is certain is that, before the development of instrumental medical methods, the simulation possibilities were innumerable.

In a fairly usual way, the analysis of the possible simulation by the subject is, however, one of the first questions that the psychiatrist and the forensic psychologist usually ask themselves.

Both in the DSM IV (Diagnostic and Statistical Manual of mental disorders) and in the DSM V there is no specific diagnostic category related to simulation, but, in both versions of the well-known diagnostic manual, it is included in the “other categories that can be subject to clinical attention” and, specifically, both versions suggest the clinician to suspect a simulation if at least one of the following conditions occur:

- The symptoms occur within a legal/medical context;
- Marked discrepancy between stress or reported disability and objective data;
- Lack of cooperation;
- Presence of an antisocial personality disorder.

The proposed indications would seem to follow a criminological model, in which a combination of bad personalities and simulation is assumed, in fact not contemplating the possibility of other conditions or situations (Yudofsky et al, 1992).

The DSM binds the simulation to a conscious behavior, under volitional control, aimed at an objective linked to an illicit advantage.

Adherence to this model has raised some doubts also in relation to the other proposed criteria: the lack of collaboration, for example characteristic of a CHT (Compulsory Health Treatment), would make it noteworthy in relation to the issue of simulation? Or, again, in relation to the second point it is not always easy or only determinable what can be understood by “marked discrepancy” between stress and complained symptoms, especially in the psychic field. A further criticism derives from the observation that the manuals, in the presence of the simulation, only propose a definition of a voluntary act intended to deceive: the possibility that the simulation may be the result of a defensive configuration implemented is not minimally considered by the client. Furthermore, in the proposed reading the simulation would always seem to be linked to a pathological condition of the character, not considering that the simulators can be desperate.

For the understanding of the simulation, an adaptive model was also proposed, Rogers (1990; 1997). According to this model, the simulation attempt would be nothing but the “best self-protecting choice” that the subject can implement under certain conditions. Specifically when the context is evaluative and is considered hostile or neutral; in the absence of valid alternatives and in the presence of specific expectations; following a cost-benefit assessment, the client may decide

to simulate a disorder. The adaptive model has found several clinical confirmations (Wilcox and Krasnoff, 1967; Braginsky *et al.*, 1969; Walters, 1988).

An important theme connected to the simulation is the evaluation of the reasons that led the subject to act in this way. This aspect is extremely complex, since it can respond to both environmental and internal needs.

At an operational level it is possible to consider useful the definition proposed by Callieri and Semerari (1959), according to which the simulation is, “a psychological process characterized by the conscious decision to reproduce, imitating them, pathological symptoms and to maintain this imitation for a more or lesser time, with the help of a continuous effort until the goal is achieved, that is, until the simulator realizes the uselessness of his attitude”. This definition has the advantage of linking the simulation to a broader psychopathological evaluation, without thereby classifying it univocally.

In the staging of one or more psychiatric symptoms, the subject could act starting from his own convictions about mental illness (Nivoli *et al.*, 2001); by imitation, reproducing symptoms observed on psychiatric subjects or recalling symptoms currently absent, but present in the clinical history of the simulator. A consideration must then be made in relation to the dissimulation or the ostentation of a state of well-being in the face of a condition of suffering (Nivoli *et al.*, 2006).

In any case there are disturbances similar to the simulation and they are fictitious and conversion disorder; to distinguish these from simulation it can be useful to identify two dimensions: one of awareness of motivation and the other of intentionality. In fictitious disorder the motivation is unaware, but the formation of the symptom is intentional; in conversion disorders the motivation is unaware, while the formation of the symptom is unintentional; finally, in the simulation, in the face of a conscious motivation there is also an intentionality of the symptom.

Over time, methods have been developed to identify lies. Ekman (2001; 2003) considers, as a possible identifying element, the dissonance between facial expressions and posture; at the basis of this idea some neurological studies, which had identified the activation of some involuntary muscles of the face only in the presence of genuine emotions; likewise other studies have identified facial microexpressions related to emotions. However scientifically founded these studies are, the risk is to be carried away by a methodological error and to be fascinated by cinematographic finds; specifically, even if it was possible to be certain that a certain emotion is not genuine, this in itself is not a guarantee that the subject is lying. The genuineness or otherwise of the emotions, deduced from facial micro-expressions or from the activation of specific muscle groups, has no relation to the cause: exemplifying, during the investigation it is possible to profess oneself serene, when in reality the body betrays tension, but there is no possibility to discriminate if the mood is caused by one's own will to mystify or by having met an unpleasant colleague in the elevator.

Among the methods used to identify the truthfulness of the claims, also the psychophysiological ones; among these, the most famous is the polygraph, which simultaneously measures skin conductivity, blood pressure, breath and peripheral motor vessel activity. All these parameters identify the degree of arousal; the basic hypothesis, which raises many doubts, is that a variation of the arousal is connected to the simulation. The polygraph has had more cinematographic luck than anything else, in fact only in six countries around the world is it accepted as a possible tool. Another family of tools refers to the analysis of the verbalization produced by the subject; the SVA Statement Validity Analysis (Steller and Boychuk, 1992), and the CBCA Criteria-based Content Analysis (Steller and Koehnken 1989) the basic theoretical assumption are part of this class) is that the verbalization of a true memory is qualitatively different from that related to an

induced or created memory. Both techniques, in any case, show good internal consistency. One of the aspects that characterizes the expert's work is to offer a motivated technical opinion and, to do this, the use of tests is increasingly frequent, which has become almost a real operating practice.

A survey (Malagoli Togliatti, Lubrano Lavadera; 2003) conducted on a sample of 106 expert reports revealed not only the constant use of test instruments, but also a percentage of their use was defined.

TEST	% of use in civil field	% of use in juvenile field
Rorschach	79%	73%
Graphic tests	56%	75%
MMPI	49%	11%
TAT	49%	71%

The extensive use of reagents requires a brief examination of the tests and which can be within each of them the elements that could help us identify a possible simulation.

Below is a description of the tools most used in the expert field; for each of them we will indicate the elements that could suggest a simulation:

- *WAIS-R (Wechsler Adult Intelligence Scale - Revised)* (Wechsler, 1981), is a level test for the assessment of intelligence in adults; it is composed of 11 subtests, 6 of which make up the verbal scale and the remaining 5 the performance scale.

If there are doubts about the simulation, the test, however much this choice is calibrated in relation to the time and resources it requires, can inform us about the consistency between the configuration obtained and the complained pathology. Some research (Binder and Willis, 1991; Trueblood and Schmidt, 1993; Trueblood, 1994) would seem to highlight how simulators would tend to give wrong answers from the first items; this immediacy of the errors can only be explained or if there is a very serious disturbance or if the indications are not clear to the subject: in fact the average IQ (Intellectual Quotient) of the simulators was 79.6 compared to 92.8 for

the controlled group. In general, the group of simulators has lower scores in all sub tests, but the scores that most distinguishes between simulators and non, are: Memory of digits, Vocabulary, Completion of figures and Association of symbols with numbers. The Digit Memory sub test is the one that best distinguish, perhaps because the subjects that tend to simulate consider it as a measure related exclusively to memory; where the clinic shows us that this sub test is the first or one of the first to recover after a brain injury (Mittenberg *et al.*, 1993).

- *The Rorschach test* (Rorschach, 1981), consists of a series of 10 plates that reproduce tendentially symmetrical ink spots, some in black and white, others colored. The subject, reporting what he sees or what those spots evoke, reveals his ways of perceiving, his cognitive-affective tendencies and the basic configuration of his personality. In relation to the attempt to detect a simulation it is not easy and, at the dangerous limit, to identify specific test data in order to be able to affirm, with certainty, the existence of this understanding on the part of the subject. The following indications are purely indicative and must necessarily be included within a wider evaluation context.

In general a simulator shows at Rorschach:

- a general resistance to the test and an extension of the reaction times. This could be the result of an attempt to hyper-control the reality and its possible manipulation, of an elusive and evasive behavior during the test;
- low number of replies. This modality could be an attempt to make the test less effective in finding possible inconsistencies;
- high number of responses with Form(Matter). A high number of Form(Matter) responses, in which the subject says to use the form as the element that determines perception, accompanied by a low number of responses, could indicate the choice of intense functioning to “economize”;

therefore indicating an operation below the actual capabilities of the subject;

- the presence of two or more refusals. Generally, the clinician manages to manage the refusal by trying to “correct” the alliance with the subject or by making sure that he has well understood the purpose of the examination. When these small corrections doesn’t work, we may face great resistance to take note of. Refusal could also be read as a theatrical and exhibitionist form of bad adaptation;
- The absence of movement responses. Every movement response are an expression of ideologies as in the attribution of movement, they are expression of movements to an implicit conceptualized object. The simulation of bad adaptation could take the form of a refusal of the capacity of elaboration.
- hyperproduction aimed at “confusing ideas” to the expert;
- clearly “allusive” verbalizations to pathological contents. The simulators present
- high and significant scores on dramatic contents.

- *MMPI-2 (Minnesota Multiphasic Personality Inventory-2)* (Hathaway, McKinley; 1943), is a broad-spectrum test to evaluate the main structural characteristics of personality and emotional disorders. The questionnaire consists of 567 items with a double alternative answer (“true” or “false”), eight validity scales, ten basic, sixteen additional, fifteen content. The protocol has a series of validity indicators that are used by the clinician to evaluate the acceptability of the protocol; that is, how much the information reported can be used to infer elements inherent in the subject’s personality. Only after having passed the validity criteria can one be sufficiently certain that the subject has responded, net of simulations or

dissimulations, in a manner consistent with his perception of himself.

The ways to simulate or dissemble can express themselves, in relation to the reagent considered, in different ways.

- Omitted items (“I don’t know”) the number of these items does not constitute a real scale: if their count exceeds 30, the profile is probably not valid; the validity is doubtful if it is from 11 to 29.
- Self-described idealization: the L scale (Lie - L). The person describes himself as overly virtuous, scores above 65 show a subject who is proclaiming virtues that are not found in the general population. As well as scores below 49 can indicate a bad adaptation simulation.
- Random answers or answers given in a way that deliberately exaggerates the difficulties. Both attitudes can alter the profile and determine an elevation of the F scale (Frequency). Scores greater than 90 make the protocol unusable; between 71 and 90 the profile is doubtful and could hide a disease simulation. Even extremely low scores could be the consequence of a simulation of a good adaptation.
- The Pathological Frequency scale (Fp) is made up of poorly represented items in a sample of people with severe form of psychopathology. The scale therefore assesses the degree to which a person undergoing the test declares a greater number of symptoms than that reported by psychiatric patients on outpatient treatment. If this condition is not reflected in the anamnesis, it is very likely that there is a simulation of bad adaptation.
- The K scale is the most complex of the validity indicators. The content of the scale concerns a wide variety of characteristics that many prefer to deny to themselves and their family members. Scores greater than 70 may indicate a good fit simulation. This

staircase is affected by a defensive attitude; to stem these tendencies fractions of K are added to some clinical scales.

- The F-K index. This scale was specifically developed to evaluate the degree of simulation, the tendency to exaggerate the symptoms. The idea that a high score on the symptom scale (F), accompanied by a low defensive attitude (K), could indicate the invalidity of the profile due to a tendency to exaggerate the symptoms. In the first version (Gough, 1950) the cut off was 9. Subsequent studies have found this value too low and have raised the score needed to talk about simulation to 12 or 15. If K is greater than F (and the difference is greater than or equal to 12), a dissimulation can be assumed.

- *Graphic Test: The family drawing* (Corman, Cavara Medio; 1978); *the test of the human figure* (Machover, 1948); *the reagent of the tree* (Koch, 1958); *the family drawing test* (Castellazzi, 2014). Drawing is the product of a real language (the graphic one) to be used as an alternative to the verbal one. Their usefulness with children is immediately understood, being for them an excellent means of promoting the expression of psychic contents even more than speech. By exploiting the mechanism of projection, the drawing stimulates the psyche to produce material closer to the apperceptive way in which each of us looks at and interprets reality; different levels and sides of the personality interact in it. From the drawing it is possible to detect, among other things, the well-being and vitality of the subject, aggressiveness, the presence of anxious nuclei, adaptation to the reference environment. The graphic tests foresee different deliveries: from the drawing of the human figure to that of the family, passing through that of the tree.

Generally drawings are evaluated at several levels: graphic, formal, content. At the graphic level there are elements such as the

strength of the stroke, the shading, the blackening or the erasure. On a formal level, the placement of the drawing in the sheet is considered, the dimensions and proportions, any omissions, the presence of movement or stillness and the style of execution. The last level is the one that examines the content and is certainly linked to delivery, but still leaves ample variability to the subject. The execution order, the overall impression of the design and the elements present will be considered. Numerous researches (Jacks, 1969; Vinay, 2007; Hammer, 1986; Pulver 1931) have shown that certain conditions of suffering tend to bring with them a pattern of both graphic and formal and content characteristics.

By way of example, consider a depressed subject; one of his drawings is likely to have the characteristics in table 1.

In relation to the presence of simulation or dissimulation attempts, an indicative element could be the assessment of coherence within the levels and between the levels.

Indications for simulation: clinical example

As already mentioned in the initial part of the contribution for a clinician, it is never obvious or easy to activate a thought related to simulation since this requires complex work that takes into account different levels, first of all the trust relationship that binds us to our client. Other elements such as the economic one and the one linked to the expectations of the patient and the client, increases the complexity: this last aspect proves to be particularly intense in the event that it is called to draw up partisan advice.

As advice, the party must necessarily be a reasoned technical opinion that guarantees the client in the best possible way.

A lawyer asks to evaluate the psychic biological damage reported by one of his clients following an illicit act.

The subject is a 54-year-old man, married and father of a daughter; due to the vicissitudes also related to the event, he sold most of his

business to his daughter. He finished his studies at the high school biennium.

At the time of the appraisal, he lives with his wife and economically participates, in part, in the profits of the company of which he remained a minority shareholder. From a relational point of view, it has a sufficiently solid emotional support network, even if it is composed of few people.

Already during the interview some elements had highlighted an important divergence between the symptoms accused and the observations made and the information acquired about one's own context of life.

This first information, when called to express an opinion, is only a first indication of the evaluation process.

From the testistic point of view, the appraisal includes at least one personality test, one level test and one projective; generally the choice of the test is built along the path, that is, considering the subject and the results of the first meetings, you choose which test to administer; to be clear if the subject shows poor availability and / or health conditions that do not allow him to be engaged for a long time as a level test, it will be difficult to choose a WAIS-R, whose administration takes about an hour, will instead opt for the administration of the short Neuropsychological examination; or in the case of a projective, it may be decided not to administer Rorschach, but the WZT (Wartegg Test) (Wartegg, 1953).

Returning to the clinical case under examination, to settle the element relating to the simulation, we choose to start with the administration of MMPI2, within which validity scales are provided.

In the protocol in question, the F scale (scale that is composed of items with a low frequency, 10%, in the regulatory population) has a high value reaching the score $t = 99$. Scores greater than 90 pose serious doubts about the usability of the protocol to formulate a diagnostic hypothesis. This impossibility extends over the whole protocol since F_b , the final part of the F scale, also has a high value $t = 96$.

The same indications come from the F-K dissimulation index whose value is 26; well above the cut-off marked in 12 even by the most forgiving authors.

The increase in the scale in question is not attributable to the presence of confusion or lack of attention since the VRIN scale, composed of pairs of similar items or of opposite meaning, has a modal value $t = 49$.

As if that were not enough two other scores on the validity scales warns us about the unusability of the protocol: the L scale and the K scale.

The L scale is made up of items that refer to relatively common behaviors, to small infringements, flaws / weaknesses that most people are willing to admit; the K scale measures the defensive attitude of the subject and the tendency to deny a condition of suffering. In the two scales in question, the subject respectively has the values $t = 34$ and $t = 30$ and, as the manual reminds us, very low scores on the L scale can be associated with very low scores on the K scale, reflecting the effort to exaggerate emotional problems and difficulties in adaptation by defining a possible simulation.

In summary, the profile is characterized by F ($t = 101 > 80$), an elevation also of Fb ($t = 96$); clinical scales with significant elevations and peak on scale 6 and scale 8 (respectively the two highest scores $t = 90$ and $t = 83$); F-K index greater than 11, this configuration shows an attempt to simulate a serious psychopathological disorder.

ENB-2 (Short Neuropsychological Exam 2) (Mondini, Mapelli, Vestri, Arcara, Bisiacchi; 2011) is chosen as the level test, the test consists of a battery of neuropsychological screening for adult subjects (between 15 and 96 years of age), to be used for a rapid neuropsychological examination that allows hypotheses on cognitive deficits to be made, to be further analyzed with other more specific tests. Contains the following 15 tests: Digit span; Trail making test - A (TMT-A); Trail making test - B (TMT-B); Drawing copy; Memory with interference; Abstraction test; Token test; Prose memory test; Prose memory test - Delayed re-enactment; Test of

tangled figures; Spontaneous drawing; Phonemic fluency test; Test of cognitive estimates; Praxic tests; Clock test.

The results show a below-average performance, but what is surprising is that the drop occurs in many of the tests in which an explicit activation of the subject's will is required. The appraisal, for example, shows a drop in direct memory tests while it has a liminal score in the memory with interference at 30 "and a better performance in the memory of deferred prose. Furthermore, in the face of a speech that appears fluid during the meetings, and at times sought after, the score obtained in the phonemic fluency sub test is amongst the lowest.

A final instrument is administered to the appraisal, the SIRS-2 (Structured Interview of reported Symptoms) (Rogers, 1992), an instrument consisting of 8 primary scales and 5 additional scales for the evaluation of the simulation of mental disorders and is by far the forensic tool most popular for measuring disease simulation. The tool not only recognizes the presence of simulation, but also the way in which it occurs (exaggeration of symptoms vs invention of symptoms) and the degree of reliability (indeterminate, probable, certain simulation).

The subject has a markedly high score pattern which is highly characteristic of an individual who simulates a mental disorder. This pattern is rarely observed in clients with genuine disorders who try to present themselves faithfully. The protocol presents an elevation in the SR (Rare Symptoms) scale, this elevation is determined by the declaration of very infrequent symptoms in the genuine clinical population. On the scale in question, the score leads to evaluate the simulation as Defined, ie at least 90% certain. Another scale that has the same probative value is the IA scale (Improbable or absurd symptoms). For the two scales just described, the subject has a score of 9 and 7 respectively.

Also on three other scales the simulation appears probable (with a degree of reliability of 75%): CS (Combination of symptoms); SEL (unconditional endorsement of

symptoms) and GRAV (excess of symptoms reported as serious).

The reagent presents a decision tree that guides the clinician in reading the results: in the case under consideration, the presence of two scales with a defined score and a total SR value greater than 4 leads to the conclusion that the subject simulates a bad adaptation.

All the data, both those from the interviews and those from the testological reagents, show a unitary profile of a subject who tends to simulate a bad adaptation, emphasizing his malaise and expressing performances that would seem to betray his own concept of marked mental illness, mainly from mnemonic difficulties and from the deficiency in accessing information held by the subject. It is probable that the simulation attempt was driven by the subject's hope to benefit from a significant reward. Being called to express oneself as a party expert does not mean colluding with the wishes of the subject and the legal client.

In the light of the results, the conclusion that closes, prematurely, the expert path is lapidary and the report delivered to the lawyer ends in this way: and too easily attackable in the hearing.

Conclusion

Paul Ekman, in 1985, stated that “there are two main ways of lying: dissimulating and falsifying. In dissimulation, whoever lies hides certain information without actually saying anything false. Those who falsify go further: not only is true information kept silent, but false information is presented as if it were true”.

The clinical example shown, illustrates how a clarity in the intent and methodology of the clinician, together with customer performance that approximates falsification, allow for rigorous and functional pronouncements to be made in the expert field. But sometimes, quoting the well-known Groucho Marx (1890-1997) “the secret of life is to be honest and to behave well. If you can simulate all this, you did it “and, starting from this premise, simulation can be seen as a

phenomenon that borders on the unaware attempt to tell the story in the most appropriate way. So, faced with the possibility of a simulation, like any human phenomenon, with all its complexity and nuances, it will be the professional's ability to grasp these nuances and his acting in a complex perspective, to act as warranty.

Each tool and each theoretical framework available to the professional brings closer to a plausible recognition of a simulation, precisely by virtue of the awareness of the limits of the theory and of the tool itself. The knowledge and updating of the professional, of the clinical psychologist who acts in the expert field, in this case, are of primary value: the in-depth study of the test tools, the careful analysis of the results and the constant correlation of the results with multiple tests and the results of the interview, although unable to lead to the “truth”, ensure at least an “approach” to the identification of the frames of meaning and, therefore, of the intentions of those in front of us.

Very often, the results that emerge from a battery of tests do not all converge in the direction of that coveted horizon in which parameters and cut-offs are satisfied: the clinical case reported, as mentioned, is the example of a convergence, which dispels doubts and which almost leads to a “truth”. The daily life of this profession, on the other hand, confronts the limit of “divergence”, of the different sensitivities of the tools available; each of them, in its solipsistic administration, offers us a surprisingly clear and tempting picture in its verisimilitude, but which is still an “arch of reality”, that is, that piece of truth that the power of the instrument has made it possible to bring out.

The “criticality” before the simulation, but, more generally, before the definition of a style of behavior, lies precisely in the mending of a series of data, each likely, but which leads in a non-converging direction. So? How does one arrive at the formulation of a judgment on the credibility of our interlocutor? The limit of the instrument, or rather, the limit of the intersection of instruments, whose use, however, is fundamental to speak of

“objective data”, represents the “opportunity” of the professional: the clinician is used to “looking”, the psychologist is “trained” to “distinguish”, to verify during the interviews

the presence of inconsistencies, overlaps and conflicts, which determine the direction to choose in the final interpretation of the data.

Table 1. Expected drawings characteristics of a depressed subject.

Graphic level	Formal Level	Content Level
Discontinuous pressure	Very long latency time	Varies significantly in relation to delivery
Very light pressure barely noticeable	Positioning at the bottom or edge of the sheet	
Uncertain or flickering stretch	Very small size	
Thin and faded lines	Staticity and rigidity	
Blackening and shading	Line on the top of the sheet	

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