Catching the Fakers In Front Of Us:
Malingering Assessment in Forensic Mental Health Evaluations

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What is malingering?

- DSM-IV--“the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives.”

- Malingering is not listed as an official diagnostic code in the DSM-IV. It is classified under V code.

DSM-IV

- Malingering - V65.2 - Product of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives such as avoiding military duty, avoiding work, obtaining financial compensation, evading criminal prosecution, or obtaining drugs. These may represent adaptive behavior (p. 683).
Crucial Elements for DSM-IV Definition

- the patient exaggerated his or her level of symptomatology
- the patient produced such exaggeration consciously
- the patient has some external motivation for exaggerating his or her level of deficit

DSM-IV-TR Considerations

1. Medicolegal settings
2. Discrepancy between claimed disability and objective findings
3. Lack of cooperation or treatment compliance
4. Presence of APD

Malingering vs. Inaccuracy

- Inaccuracy may stem from several factors:
  - intentional deception
  - measurement error
  - fatigue due to excessive testing
  - overestimation of the frequency/severity of deficit (pseudodementia, conversion reaction, hypochondriasis, characterological factors)
Dimensions of Malingering

- Frederick and colleagues have proposed a four-fold classification scheme that combines two dimensions of test taking characteristics:
  - 1. Effort
  - 2. Motivation

(Frederick, 1997; Frederick, Crosby, & Wynkoop, 2000)

Factitious Disorder

- The intentional production of physical or psychological symptoms in order to assume the sick role (APA, 1994).
- Includes both "intentionality and misrepresentation"
- Can also include high effort to perform poorly (but not due to external incentives)
- Must always look for the incentive underlying intentionally poor performance
Three Explanatory Models

1—The Pathogenic Model

2—The Criminological Model

3—The Adaptational Model

Three Models of Malingering

- Rogers (1990a, 1990b) has argued that the DSM definition relies on moralistic judgment and is not based on empirical evidence.
- Suggested that explanatory models of malingering must be differentiated from DSM definition in order to lessen the reliance on moralistic judgment in our understanding of this phenomenon.
Pathogenic Model

- Assumes that examinees malinger in an attempt to gain control over their symptoms.
- Suggests that by intentionally exaggerating existing symptoms, examinees will feel as though the severity of the symptoms is under their direct control.
- Assumes mental disorders are the motivational force underlying exaggerated symptomatology.

Pathogenic Model (Continued)

- Predicts that malingering examinees eventually lose control over their exaggerated symptoms.
- Because this prediction has not been supported by research or clinical findings, the pathogenic model has fallen out of favor (Rogers, 1997a).

Criminological Model

- Some form of inherent "badness" on the part of the examinee motivates malingering.
- Most closely matches the DSM-IV (1994) description of malingering, which indicates that the presence of an antisocial personality disorder should raise suspicion of potential malingering.
- Not empirically supported
Adaptational Model

- Malingering represents a response to adversarial circumstances in which examinees have significant personal investment.
- Examinees engage in a cost-benefit analysis in which they evaluate the potential personal impact of various levels of test performance.

Adaptational Model (Continued)

- Less pejorative than criminological model
- Generally supported by studies comparing the test performance of examinees that have a high personal incentive to malingering with those who have no apparent incentive.
- Whereas Rogers’ model proposes an etiological process, the other two conceptualizations offer concrete methods for operationalizing behavior.

Comparison of Models

- Rogers, Sewell, and Goldstein (1994)
  - Used prototypical analysis
  - Survey of 320 experts
    - Consider a “prototypical” case and rate different factors
    - Subjective approach
      - However, with random or quasirandom selection of experts, the direction of such subjectivity is assumed to be randomly distributed throughout the sample.
Comparison of Models

Rogers et al. (1994)
  - PCA revealed three well-defined factors that accounted for 41.2% of the variance
    - Pathogenic
    - Criminological
    - Adaptational
  - Based on 7-point scale, adaptational model was rated as most prototypical
    - Adaptational $M = 4.63$
    - Criminological $M = 3.95$
    - Pathogenic $M = 2.80$

Comparison of Models

Rogers et al. (1994)
  - Limited to a forensic sample
    - The criminological model may assume greater importance in forensic mental health settings.

Comparison of Models

Rogers et al. (1998)
  - Surveyed 221 forensic experts
    - Average of 17 yrs. of postdoc experience
  - Experts rated both forensic and nonforensic prototypical malingering cases
  - Looked at different types of malingering
    - Psychiatric symptoms
    - Cognitive symptoms
    - Medical symptoms
Comparison of Models

Rogers et al. (1998)
- Pathogenic Items
  - Posit underlying psychopathology, deterioration in clinical status, and ineffectual attempts at its control as the impetus for feigning.
    - Feigned to ward off emotional crisis
    - Gradually lost control over feigning
    - Compelled to feign by unconscious forces
    - Controlled impending psychosis by feigning

Rogers et al. (1998)
- Criminological Items
  - Derived from two sources:
    - DSM indices of malingering
    - Core traits of psychopathy from the PCL-SV
  - Superficial and shallow with others
  - Has generally poor impulse control
  - Malingered as misconduct associated with APD
  - Malingered as a form of deception (chronic liar)

Rogers et al. (1998)
- Adaptational Items
  - Stressed from malingering’s perspective the adversarial nature of the evaluation, the consideration of malingering among other alternatives, and choice of feigning as a method of achieving an important objective.
    - Malingered as a way to cope with a difficult situation
    - Tried to make the best of a bad situation
    - Tried to meet needs in unsympathetic system
Comparison of Models

Rogers et al. (1998)

- PAF analyses were conducted separately for forensic and nonforensic cases
- Four factor solution fit the data best in both analyses
  - Accounted for 42.7% of variance (forensic) and 49.3% of variance (nonforensic) with no cross loadings
    - Criminological
    - Pathogenic
    - Cost-benefit analysis
    - Adversarial context

Comparison of Models

Rogers et al. (1998)

- Prototypical ratings generally confirmed results of 1994 study regarding the relative unimportance of the pathogenic model.
- Criminological model was rated in the midrange of prototypicality (<4.0)

Comparison of Models

Rogers et al. (1998)

- Adaptational Model
  - Cost-benefit analysis (p < .001)
    - Forensic M = 5.06
    - Nonforensic M = 4.09
  - Adversarial Circumstances (ns)
    - Forensic M = 4.31
    - Nonforensic M = 4.35
Why Do People Malinger?

- Seen in both civil and criminal settings:
  - **Civil:**
    - personal injury
    - workers’ compensation
    - SSDI

  In the civil context, it may benefit a plaintiff to appear emotionally and physically injured at the hands of the defendant.

Why Do People Malinger?

- Seen in both civil and criminal settings:
  - **Criminal:**
    - trial competency
    - insanity
    - diminished actuality
    - sentencing mitigation
    - death penalty

  Used when a defendant determines it is in his/her best legal interests to be lacking certain abilities or to be suffering from emotional problems.

Why Do People Malinger?

- We commonly see blatant malingering of psychotic symptoms in competency and insanity cases (many times in the same persons).

- Malingering of cognitive deficits is common in competency cases and various civil cases.
Malingering Trial Incompetence

There are a number of reasons a criminal defendant may malinger trial incompetence:
- To get away from jail and spend time at the (more pleasant) state hospital
- To delay the proceedings for tactical reasons
- To delay the finding of guilt and subsequent sentence to prison
- To lay a foundation for a mental health defense (i.e., insanity or diminished actuality)

The Three Strikes Law

This law is designed to take “career criminals” off the streets
- First two felonies must be “serious” or “violent” felonies
- The “third strike” felony can be ANY felony, including minor offenses treated as felonies (65% of third strikes are nonviolent)
- The sentence is 25 years to life

Three Strikes and Malingering

Many less sophisticated defendants will malinger to delay the trial:
- Slows down the inevitable results of the trial – the more time in the hospital, the less in prison
- Can also be done for tactical reasons
- If the person can remain undetected as malingering for three years, the question of a Murphy Conservatorship arises
Murphy Conservatorships

- These were created in 1974 to comply with Constitutional requirements set forth in Jackson v. Indiana, 406 U.S. 715 (1972), and In Re Davis, 8 Cal. 3d 798 (1973).

- The legislature added another definition of "grave disability" for civil commitment purposes.

The definition is found at WIC §§ 5008(h)(1)(B). A person is "gravely disabled if:

- Already incompetent under PC 1370
- The indictment charges a felony involving serious physical harm
- The indictment has not been dismissed
- The person remains incompetent

The California Supreme Court "read into" the requirements for a Murphy Conservatorship that the defendant must also represent a substantial danger of physical harm to others.

"We therefore hold that every judgment creating or renewing a conservatorship for an incompetent criminal defendant . . . must reflect written findings that, by reason of a mental disease, defect, or disorder, the person represents a substantial danger of physical harm to others." Conservatorship of Hofferber, 28 Cal. 3d 161 (1980).
Murphy Conservatorships

- The Murphy Conservatorship law has provided the possibility of ultimate legal success for malingering defendants:
  - Those who engaged in a non-violent offense cannot be "Murphied" – if they get to three years as incompetent, they must be released
  - For those who engaged in a violent offense, they could still avoid prosecution if they can show they are not dangerous

When a defendant can be "Murphied," continued malingering of incompetence, beyond the three years, drains valuable resources and prevents the case going forward to trial.

Note that for truly incompetent defendants, the Murphy Conservatorship can lead to arguably unconstitutional commitment contrary to the intent of Jackson v. Indiana

Obstruction of Justice?

- One federal court ruled that intentional malingering by a criminal defendant amounted to obstruction of justice, and the court added 25 months to the defendant's sentence.
- On appeal, the Court of Appeals held the trial court did not abuse its discretion. U.S. v. Greer, 158 F.3d 228 (5th Cir. 1998); see also, U.S. v. Patti, 337 F.3d 1317 (11th Cir. 2003), U.S. v. Batista, 483 F.3d 193 (3d Cir. 2007).
The Role of Clinical Judgment

- Eckman and O’Sullivan (1991) study
  - Subjects
    - U.S. Secret Service
    - CIA
    - FBI
    - National Security Agency
    - California Police and Judges
    - Psychiatrists
    - College Students
    - Working Adults

More recent research (Bond, 2008) indicates that some select individuals may be able to detect deception better than others:
- Various law enforcement personnel viewed videotapes of paroled felons who either lied or told the truth
- Out of 112 subjects, 11 obtained accuracy scores ranging from approximately 81% to 94%
- 2 subjects continued to show over 80% accuracy in a second experiment (both were BIA Correctional Officers) and were identified as “experts” in deception detection

Strategies for Detecting Feigned Cognitive Impairment

- 1. Floor Effect
- 2. Performance Curve (Goldstein, 1945)
- 3. Magnitude of Error
- 4. Symptom Validity Testing (Pankratz)
- 5. Atypical Presentation
Floor Effect Principle

- Administer test items that all but the most severely disabled can answer correctly
- Normative data often are available for brain-injured individuals
- Poor performance is suspicious, as most individuals obtain high scores

Performance Curve

- Items of varying difficulty are randomly distributed throughout the test.
- Following test administration, the items are re-ordered according to difficulty.
- When scores are plotted by difficulty level, individuals who are responding honestly should obtain a characteristic "compliant effort" curve.

![Image of Performance Curve for a Compliant Test-Taker]
### Magnitude of Error

- It is suspicious when an examinee presents with symptoms that are significantly outside of what is expected (e.g., $1 + 1 = 329$).
- Ganser’s Syndrome = coming up with an answer that is slightly incorrect on most item.
  - Little empirical investigation into the validity of this sign.

### Symptom Validity Testing

- Also called two-alternative forced-choice testing
  - Items are presented in a two-alternative forced-choice format.
  - Even if the examinee has no ability, he or she should correctly answer approximately 50% of the items.
  - Statistical calculations can be used to determine the probability that a specific score (below 50%) would be obtained by chance.

### Forced-Choice Testing

- Advantages
  - Evaluators can create their own tests
  - Does not require normative sample
  - Items can be tailored to the deficits that are being presented by the examinee
Atypical Presentation

- Endorsement of symptoms that are inconsistent with the purported diagnosis or infrequently endorsed by examinees.
- This strategy is used in some structured interview measures.
- This strategy is used on the MMPI-2.

Standardized Testing

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- Specificity (TN)
- Nonspecificity (FP)
- False Negatives
- Sensitivity (TP)

Standardized Testing

- Base Rates (i.e., prevalence rates)
  - The clinician must consider base rates of possible diagnoses
  - Confidence in a diagnosis is increased with high base rates and reduced with low base rates
  - Base rates often vary by age and other risk factors
Base Rate Examples

– You go to Las Vegas and the casino lets you bet $100 on one of two outcomes:
  1. In one role of a fair six-sided die, you win if they role a “3” (i.e., 1/6 chance or 16.7%)
  2. In one flip of a fair coin, you win if it lands on “heads” (i.e., 1/2 chance or 50%)
– If each option has the same payoff, which option are you going to bet on?

Base Rate Example

– You know based on the research literature that approximately 17% of mental health examinees in your setting are exaggerating. In the absence of any additional information, what is the probability that an individual in your setting is malingering?

Back to Base Rates

- Positive Predictive Power (PPP) = the likelihood that an individual has the disorder given the presence of a positive test score and the known base rate
- Negative Predictive Power (NPP) = the likelihood that an individual does not have the disorder given the presence of a negative test score and the known base rate
Stated Differently

- PPP = the confidence a clinician can place in conclusions based on a positive test score
- NPP = the confidence a clinician can place in conclusions based on a negative test score

Putting it all Together

- Unlike Sensitivity and Specificity, PPP and NPP are strongly affected by base rates
- Most clinicians over-estimate PPP when base rates are low (i.e., they are over-confident in the test findings)
- One recent study found that only 8.6% of neuropsychologists correctly answered a question that required computation of PPP

Reporting Probability Statistics

- Score of 5: Sens = .53, Spec = .92, PPP = .75, NPP = .87
- Incorrect:
  - Based on his score of 5 on the Clown Malingering Test, there is a 75% chance that Mr. Smith is malingering clown characteristics.
- Correct:
  - Only 8% of bona-fide clowns in the CMT normative sample produced scores above that of Mr. Smith. Therefore, Mr. Smith's score suggests a high probability that he is exaggerating clown characteristics.
The Assessment of Malingering

- It is important to specify the type of malingered deficit that one is attempting to measure.
- As with bona-fide cognitive tests, measures of motivation should be selected based on the examinee’s reported deficits.

Malingered Memory Deficits

- Memory difficulty is the most commonly reported symptom following brain injury
  – (Schacter & Corvitz, 1977; Williams, 1998)
- In one study, memory difficulties were the most common complaint among SSDI applicants (43%)
  – Griffin, Normington, May, and Glassmire (1996)

Psychological Testing

- There are many instruments that are based on published sensitivity and specificity rates
- We will only discuss a few instruments today:
  - Measures of Cognitive Malingering
    - Rey Fifteen-Item Test
    - Test of Memory Malingering
    - Validity Indicator Profile
  - Measures of Malingered Psychiatric Symptoms
    - Structured Interview of Reported Symptoms (SIRS)
    - Miller Forensic Assessment of Symptoms Test (MFAST)
    - Objective Personality Assessment Instruments (MMPI-2, PAI, etc.)
Cognitive Malingering

- Cognitive validity measures can be administered at the same time as actual measures of cognitive/neuropsychological functioning.
- Invalid performance on a validity measure indicates that the performance on the actual cognitive tests likely was not valid
  - However, you can state that the obtained level is the "minimum level" at which the person can perform

Rey Fifteen Item Test

- Uses floor effect principle
- Scores are negatively correlated with memory, age, and IQ in some studies
- It is useful to consider qualitative errors
- Boone et al. (2002) created a recognition measure that increases the sensitivity of the instrument

TOMM

- Uses a two-alternative forced-choice format (i.e., symptom validity testing)
- Also uses the floor effect principle with normative data
- Bonafide patients with psychotic diagnoses, depressive disorders, pain disorders, and memory deficits perform well on the TOMM
- Most patients with brain injury perform well on the TOMM
- Use caution with individuals with documented severe dementia (potential false positive errors)
- Little research on MR populations, but one promising study indicates low false positive error rate with mild MR population
Validity Indicator Profile

- Measures malingered IQ/Cognitive deficits
- Two subtests
  - Verbal
    - Vocabulary items
  - Nonverbal
    - Matrix reasoning items from TONI-3

Validity Indicator Profile

- Performance Curve Analysis
  - Based on Frederick et al.’s two dimensions underlying malingering (effort; motivation)
    - Compliant/Valid
    - Inconsistent/Invalid
    - Irrelevant/Invalid
    - Suppressed/Invalid
- Floor Effect Principle (Point Of Entry)
- Two-Alternative Forced-Choice Testing
Caution

- There is not a lot of research to support the use of cognitive malingering tests with individuals who have bona fide mental retardation.
  - There are likely higher false positive rates in this population.
  - However, one recent study indicated that individuals with Mild MR may perform well on the TOMM.

Structured Interview of Reported Symptoms (SIRS)

- Contains a number of scales that measure:
  - Severity of reported symptoms
  - Inappropriate or absurd symptoms
  - Rare symptom combinations
  - Subtle symptoms
  - Severity ascribed to symptoms
  - Observed vs. reported symptoms
  - Obvious symptoms

SIRS

- Often misses subtle malingerers or sophisticated individuals
- High scores on 3 or more scales indicate a high probability of malingering
- Takes about 40 – 45 minutes
Miller Forensic Assessment of Symptoms Test (MFAST)

- Much shorter than the SIRS (10-15 min)
- Provides probability statements based on research samples
- Can be followed up by the SIRS
- More sensitive to subtle malingering

Self-Report Instruments

- Multi-scale self-report instruments (e.g., MMPI-2, PAI, MCMI-III, etc.) can provide valuable information regarding psychiatric functioning
- The evaluation of deception on self-report instruments often involves several steps

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**MMPI-2 Administration**
- Omissions: Cannot say (O)
  - Acceptable
  - Unacceptable
- Consistency of item endorsement
  - Acceptable
  - Unacceptable
- Accuracy of item endorsement
  - Acceptable
  - Unacceptable
- Overreporting of psychopathology
  - Unacceptable
- Underreporting of psychopathology
  - Unacceptable

Greene (2000)
Accuracy of Item Endorsement

Greene (1997, 2000)

Scales to Consider:
- F, Fb, Fp
  - The F scale can be elevated for three reasons
    1. Overreporting/malingering
    2. Inconsistency of Item Endorsement
    3. Bona Fide Psychiatric Pathology
  - VRIN assesses for consistency (lower scores = more consistent)
  - Fp assesses for malingering in settings characterized by psychotic-spectrum illnesses
  - FBS assesses for exaggeration of symptoms in personal injury/disability settings (less focused on psychotic sx)