

**Assessment of Malingering:  
Theory and Forensic Practice**

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**Cautions**

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- Scope of the material
- Professional training
  - Poll the audience
  - Forensic practice vs. reliance on consultants?
  - Criminal forensic, civil forensic, and/or neuropsychological?

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**Morning Objectives**

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- A theoretical understanding
- Current myths and misconceptions
- Detection strategies
- Review of the MMPI-2, MMPI-2-RF, and PAI

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### Afternoon Objectives

- SIRS-2
- Detection strategies for feigned cognitive impairment
- Critique a malingering report
- Malingering: Reports and Testimony
- Wrap-up

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### First, The Definitions

- Malingering:
  - Fabrication or *gross* exaggeration of symptoms
    - Example: SADS
  - External goal (evaluated not assumed)
    - Example: Satan fighter
- Feigning vs. malingering tests

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### More definitions

- Factitious disorders: feigning to assume the "patient" role
  - Intentional fabrication or gross exaggeration
  - Internalized need : sick role
  - Example: Mr. Fork

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**Definitions: simulated adjustment**

- Defensiveness:
  - Opposite of malingering;
  - Deliberate denial or gross minimization
  - Psychopathology
- Examples:
  - MMPI-2 K and
  - Edward's social desirability (Esd)

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**More simulated adjustment**

- Social desirability
  - Not necessarily defensiveness
  - Creating a positive (not necessarily idealized) image
- Example:
  - MMPI-2 Wiggins social desirability (Wsd)

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**More simulated adjustment**

- Impression management
  - Create a desired image
  - Not necessarily prosocial
  - Used extensively in work settings
    - Example: aggressive business persons
- Denial and disacknowledgement
  - Substance abuse populations

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**Disengagement**

- Random response style
  - Example: 15 minute MMPI-2
- Irrelevant response style
  - Inconsistent or
  - Role-playing (e.g., MMPI-2 by an artist)
- Occasionally observed on the SIRS
  - Simulation research

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**DSM-IV and Malingering**

Malingering "strongly suspected" with  $\geq 2$  indices:

- Medicolegal context
- Marked discrepancy with objective findings
- Lack of cooperation in assessment and treatment
- Antisocial Personality Disorder

(no changes for DSM-5)

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**DSM-IV Commentary**

- Medicolegal context
  - Too broad
- Marked discrepancy with objective findings
  - May apply to medical
  - What objective findings of mental disorders?

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**DSM-IV Commentary**

- Lack of cooperation in assessment and treatment
  - Hopelessly confounded
- Antisocial Personality Disorder
  - Methodological artifact

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**Rogers (1990): DSM Indices\* of Malingering**

- Sample:
  - 24 malingerers and 113 inpatients
- Results: "two or more indices"
  - true positive rate of 20.1%
  - false alarm rate of 79.9%.

\*same as DSM-IV

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**Dangers of DSM-IV**

- Poor screen sometimes used for classification
- Disastrous results in criminal forensic evaluations
  - All "medicolegal" or Forensic
  - Majority are APD
  - Many are uncooperative

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### MND criteria (Slick et al., 1999)

#### Malingered Neurocognitive Dysfunction (MND)

1. Presence of a substantial external incentive
2. Definite negative response bias
  - SVT below .05 ( $\geq 1$  failed of \_\_ measures)
3. Behaviors meeting necessary criteria from group B are not fully accounted for by Psychiatric, Neurological, or Developmental Factors.

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### MND references

- Slick, D., Sherman, E., & Iverson, G. (1999). Diagnostic criteria for malingered neurocognitive dysfunction: Proposed standards for clinical practice and research. *Clinical Neuropsychologist*, 13(4), 545-561.
- Boone, K. (2007). A reconsideration of the Slick et al. (1999) criteria for malingered neurocognitive dysfunction. In K. Boone (Ed.), *Assessment of feigned cognitive impairment: A neuropsychological perspective* (pp. 29-49). New York, NY US: Guilford.

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### Boone (2007) Critique

- "Fully account" impossible to apply
- SVT was originally developed to examine conversion disorders (Pankratz, 1979)
- Quotes Pankratz and Erickson (1990):
  - "establish the likelihood of motivated wrong answering but not conscious intent"
- Genuine patients occasionally score below chance
  - Non-forensic dementia case: 0 of 50 on TOMM

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### Probable MND: Consider the complexity

Criterion A: Hypothesized external incentive

Criterion B: Discrepancy with testing ( $\geq 2$  types of "evidence" from B2-B6)

- B2. Performance on tests "consistent with feigning"
- B3. Discrepancy with test data and brain functioning
- B4. Discrepancy with test data and observations
- B5. Discrepancy with test data and collaterals
- B6. Discrepancy with test data and history

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### Probable MND #2

3. One type of B "evidence" and one or more C "evidence" from self report:

- C1. Inconsistent self and documented history
- C2. Inconsistent symptoms and brain functioning
- C3. Inconsistent symptoms and observations
- C4. Inconsistent symptoms and informant information
- C5. Evidence of feigned **psychological** impairment
  - a. Observations or test data (e.g., MMPI-2)

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### Probable MND #3: Criterion D

□ "Not fully accounted" by "psychiatric, neurological, or developmental factors"

- Why *fully* accounted versus *better* accounted? (DSM-IV standard)
- *Better accounted* 51% with two alternatives versus, *fully accounted* = 100%
- a. What is ever *fully accounted* in forensic practice?
- b. Uses insanity standard language (appreciate wrongfulness and unable to conform conduct)

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**MND criteria → Adequacy of *MND*  
feigning studies?**

Limitations

- Probable (most) and definite MND (few) are collapsed
- Criterion A is assumed but not evaluated
- Criteria B (B2—B6)
  - Average study includes 1.8 of 5 criteria per study (i.e., 64.0% missing)

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**MND criteria → Adequacy of *MND*  
feigning studies? #2**

- Criteria C (C1—C5)
  - Average study includes 1.1 of 5 criteria (i.e., 78.0% missing)
  - C5 assumes faking on the MMPI-2 equals faking cognitive impairment.
- Criteria D
  - Generally ignored
  - Beyond the expertise of most psychologists

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**Forensic example of *MND* research**

- Reference:
  - Ardolf, B., Denney, R., & Houston, C. (2007). Base Rates of Negative Response Bias and malingered neurocognitive dysfunction among criminal defendants referred for neuropsychological evaluation. *The Clinical Neuropsychologist*, 21(6), 899-916.
  - Consecutive sample of 105 criminal defendants referred for neuropsychological assessments

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### Ardolf et al. (2007)

- Prevalence of Negative Response Bias (NRB)\*
  - 89.5% for  $\geq 1$  indicator
  - 70.5% for  $\geq 2$  indicators
  - 54.3% for  $\geq 3$  indicators
- MND criteria
  - 32.4% for Probable MND
  - 21.9% were Definite MND

\*B2 "evidence"

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### Ardolf: MND criteria

- A. External criteria
  1. "All evaluations occurred in relation to ongoing criminal forensic proceedings. As such all criminal defendants had significant motivation to exaggerate or feign neurocognitive dysfunction in order to either cause their charges to be dismissed or their punishment lessened." (p. 903)
  2. *Your thoughts?*

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### Ardolf: MND Classification

- Probable MND is defined as positive findings on one or more well-validated psychometric tests or indices designed to measure exaggeration or fabrication of cognitive deficits such that it is consistent with feigning along with inconsistencies from other sources.
- *Your thoughts?*
  - The devil is in the details.

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### NRB Indicators used $\geq$ 50% cases

Scale	Cut	% identified
Rey 15-item	<9	25.3%
Reliable Digit Span	<7	36.5%
Booklet Category Test	>1	54.8%
Vocabulary-Digit Span	>1	48.2%
MMPI-2 FBS	>24	38.5%
WAIS Digits forward	>0	34.2%
Finger oscillation test	<63	27.5%

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### NRB Indicators: Detection strategies

- Floor effect
  - Rey-15
  - Reliable digit span
  - WAIS Digits forward
  - Finger oscillation
- Performance “curve”
  - Vocabulary-digit span
- Rare “psychological” symptoms
  - MMPI-2 FBS

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### MND feigning studies: Bottom line

1. Misrepresentation:
  - a. Do not use Criteria A and D
  - b. Use less than 1/2 of Criteria B and C
2. Criteria have questionable value
  1. Many are subjective
  2. Several are conceptually questionable or beyond most psychologists' expertise

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### Conceptual framework

- Myths of Malingering
- Myths of secondary gain
- Explanatory models
- M Test and malingering
- Detection Strategies

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### Six Common Myths about Malingering

1. Prevalence: Rare or everywhere?
  - Survey data of forensic psychologists
    - Criteria: DSM determination of malingering
    - 15.7% (N = 320 forensic psychologists)
      - Rogers et al., 1994
    - 17.4% (N = 221 forensic psychologists)
      - Rogers et al., 1998

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### Myth #1 prevalence: Surveys of neuropsychologists

- Mittenberg et al., 2002 (N = 131)
  - Broad criteria: malingering, probable malingering or symptom exaggeration
    - Civil cases: 26.5% to 31.0%
    - Criminal cases: 11.3% to 21.1%

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### Myth #1: Sharland (2007) survey

- Reference
    - Sharland, M., & Gfeller, J. (2007). A survey of neuropsychologists' beliefs and practices with respect to the assessment of effort. *Archives of Clinical Neuropsychology*, 22(2), 213-223.
  - Survey of 188 NAN members
  - Results
- |                              | mdn % | min % | max % |
|------------------------------|-------|-------|-------|
| Probable insufficient effort | 10    | 0     | 90    |
| Definite insufficient effort | 5     | 0     | 80    |
| Probable malingering         | 3     | 0     | 50    |
| Definite malingering         | 1     | 0     | 30    |
| Litigation/compensation      | 20    | 0     | 90    |

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### Myth #2: Stable and predictable rate

#### Survey Data

- Rogers et al. (1998)
  - $SD = 14.4\%$
- Sullivan et al. (2005)
  - Modelled after Mittenberg ( $N = 14$ )
  - Civil,  $SD$  from 10 to 14%
  - Criminal,  $SD = 24\%$

#### Referral issue/clinical status

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### Myth #3: Malingering = trait

- Malingering is a static response style
  - "Once a malingerer, always a malingerer"
- Walters (1988) classic study
- NGRI example
  - Pre-acquittal
  - Post-acquittal

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### Myth #4: Global Style

- Global Style: General
  - “I know it when I see it.”
    - Borrowed from Justice Potter Stuart’s description of hard pornography
  - Avoid screens and standardized assessments
- Global malingering: Across domains
  - Rogers et al. (in press): FMD vs. FCI
    - **9.5% overlap** (4 of 42 with FCI also had FMD)

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### Myth #5: Mutually exclusive

- Mutually exclusive with mental disorders
  - Malingering ≠ absence of genuine disorders
  - “Immunity theory”

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### Myth #6: Confusion

Common vs. distinguishing characteristic

- Common but useless:
  - Criminal cases: antisocial backgrounds
  - Civil cases: compensation seeking
- Distinguishing (*uncommon* by definition)
  - Accurately differentiate feigned from genuine disorders
  - Irrespective of being antisocial or wanting money

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### Myths about Secondary Gain

- The implicit assumption: Greed
  - “With enough incentives (money), everyone will deceive.”
  - Example: Houston attorney
- Unwarranted clinical inference:
  - *Potential* ≠ *determination* of secondary gain.
  - Apply to forensic experts?

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### 3 Divergent Models of Secondary Gain

- **Psychodynamic**
  - Primary gain is the patient's protection from psychic trauma.
  - Secondary gain is motivated by
    - maintenance of this protection and
    - satisfaction of psychic needs derived from incapacitation.
  - Is the motivation intentional?

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### More Secondary Gain

- **Behavioral**
  - Illness behavior responds, as all behavior, to salient contingencies within the environment.
  - Secondary gain is conceptualized as a consequence of a genuine disorder, no primary gain is formulated.
  - Is the motivation intentional?

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### More Secondary Gain

□ **Forensic**

- Posits an explicit legal incentive
  - Example: unwarranted compensation
- Emphasizes the intentional selection of secondary-gain behaviors

□ Forensic Studies of Secondary Gain?

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### Backward Reasoning about Secondary Gain

“Established” fact:

The patient receives \$4,000 per month in disability insurance and is freed from a high pressured position.

Clinical observation:

The patient continues to be preoccupied with his/her impairment.

Unwarranted inference:

The patient is motivated by secondary gain to maintain his/her "sick role."

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### Diagnostic myth of *laser accuracy*

- Single point cut scores = laser accuracy myth of cut scores
- Example with the PAI and feigning
  - $\pm 5T$  about the cut score = 60% error
  - Just common sense with overlapping distributions

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### Why Do People Malingering?

1. Pathogenic Model (sick)
2. Criminological Model (bad)
3. Adaptational Model (between a rock and a hard place)

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### Pathogenic Model

- Underlying mental disorder
- Patient losing control
- Deliberately produces symptoms to exert a semblance of control
- As the disorder worsens, *voluntary* symptoms become *involuntary*

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### Pathogenic (continued)

- Predicted outcomes: not found
  - “sudden cures”
- Not compelling explanation
- Possible exception: borderlines
  - Case example

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### Criminological model (DSM-IV)

- Core issues include
  - Bad person (APD)
  - Bad circumstances (medicolegal context), and
  - Bad effort (uncooperative)
- Motivation: a variation of criminal intent

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### Adaptational Model

- Avoids monistic notions of mad (pathogenic) or bad (criminological).
- Assumes cost-benefit analysis of options.
- Assumes highly adversarial circumstances.

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### 3 Simple Assumptions about Malingers

- Sees the evaluation as adversarial
- Something to gain by malingering
- Best available way to obtain objective

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**Data on the Adaptational Model**

- Braginsky study of inpatients
- Walters (1988) MMPI forensic study

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**Quasi-constructs of Dissimulation**

- *Secondary Gain*
- *Symptom Magnification*
  - ill-defined term
  - circumvents the classification of malingering
  - level of exaggeration?

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**Other Quasi-constructs**

*Suboptimal effort*

- ignores situational and psychopathological effects

*Overreporting (Greene)*

- “range from being very conscious and intentional to being out of awareness and unconscious.”

(How do you study unconscious faking?)

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### Questioning Suboptimal Effort

- You stated that the defendant was likely feigning because he put forth “suboptimal effort, correct?”
- Please define for the court what is *optimal* effort.
- During your hours of evaluating the defendant, did you always put forth *optimal* effort? Every minute?
- As you have acknowledged moments of suboptimal effort, would it be fair to say that you were “faking” at those moments?
- If the judge is not her best, would you accuse **her** of faking?

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### Interpersonal #1: Self disclosures

#### Clinical practice

- Agency: the clinician works for the patient
- Confidentiality: assured
- Social control/ personal consequences: typically inconsequential

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### Interpersonal #2

#### Forensic evaluations

- Agency: the clinician does *not* work for the patient
- Confidentiality: nonexistent
- Personal consequences: very high

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### Interpersonal #3

#### Countertransference issues

- Anger and frustration at being fooled.
- Ad hominem fallacy
  - Negatively, manipulative patients?
  - Positively, children?

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### Theory to practice

- Briefly covered the conceptual issues
- Next, issues of assessment and practice
- First, the challenges of malingering

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### Can you “get-away” with Malingering?

- Can you successfully fake a mental disorder?
  - How good are you at feigning?
  - Your goal: an “inpatient”
  - The challenge is to appear (a) severely impaired but (b) genuine

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Workshop material: not copied

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Approaches to Malingering

- Intuitional: *My* judgment
- Technician-based: The printout *says*
- Detection strategies: Conceptual and empirical

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Different Forms of Malingering

- Cognitive-only
- Psychopathology-only
- Medical (not covered today)
- Combined (“kitchen sink”)

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### Malingering Tasks

- Cognitive: simply “goof” on intellectual tasks while appearing to “try”
  - Effortful failure
- Psychopathology: create
  - Believable set of related symptoms
  - Onset/course of the disorder
  - Insight into symptoms

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### Cheating?

- Use the MMPI-2 for feigned brain injury?
  - Remember Rogers et al. (2010): only 9.5% overlap!
- Logically, it shouldn't work
- Why? Different detection strategies

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### Why Detection Strategies?

- Strategies have a conceptual basis that can be tested.
- Strategies can be systematically tested by designs (analogue and known-groups)
- Strategies can be tested across measures.

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### Typology of detection strategies

- Unlikely (implausible) strategies
  - *Presence* is indicative of feigning
  - Example: Symptom Combinations
- Amplified strategies
  - *Magnitude* is indicative of feigning
  - Example: Indiscriminant symptom endorsement

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### Unlikely: Rare Symptoms

- Definition: very infrequent symptoms
  - Typically 5-10% (some scales use 20%)
  - Must consider heterogeneous populations
    - TSI ATR scale
  - Examples: Fp, RS, and NIM scales
- Examples of psychotic symptoms:
  - Neologisms
  - Auditory hallucinations in another language

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### Quasi-rare symptoms (*Not unlikely*)

- Key difference:
  - Developed infrequent items in normative or community samples
  - Why a problem? Difficulty separating genuine and feigned protocols
- Examples: MMPI-2 F and Fb
  - Meehl's (1946, p. 517) F is a measure of "carelessness and misunderstanding."

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### Unlikely: Improbable Symptoms

- Definition: fantastic or preposterous symptoms that are unbelievable.
- Examples: SIRS IA, MCMI-III VI
- Sample items:
  - Smell cremated bodies whenever you take a shower?
  - Do hair dryers emit heat-activated death rays?

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### Unlikely: Symptom Combinations

Definition: Common Sxs rarely paired together.

Examples:

- Before you hear voices, do you notice your palms begin to itch?
- When others are following you, do often become dizzy?

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### More Examples

- Can people can listen in on your private thoughts at the same time your appetite for food increases?
- After the trauma, do you experience facial numbness accompanied strange smells?

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### Symptom Combinations #2

- Spurious correlations
- What symptom pairs are
  - Highly correlated in feigning samples
  - Uncorrelated in genuine samples
- Determinations of feigning with inconsistent profiles

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### Spurious Patterns of Psychopathology

- Certain scale configurations are—
  - Characteristic of malingering
  - But uncommon in clinical populations
- Strength: complexity foils coaching
- Example
  - PAR-P (persecution) 15+ higher than
  - PAR-H (hypervigilance)

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### Amplified: Indiscriminant endorsement

- Definition: “More is better.”
  - Observed in the sheer number of endorsed symptoms
- Requirement: a wide array of psychopathology
  - *Not* the BDI!
- Example: SIRS SEL scale

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### Amplified: Symptom severity

- Definition: many symptoms “extreme” or “too painful to stand.”
- Requirement: a wide range of symptoms
- Examples:
  - SIRS SEV scale
  - MMPI-2 Lachar-Wrobel (LW)

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### Amplified: Obvious vs. Subtle Symptoms

- Obvious: clearly evidence of a severe disorder
- Subtle: appear like common problems
  - Early morning awakening
- Examples:
  - MMPI-2 O-S and Ob
  - SIRS BL and SU scales

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### Amplified: Erroneous Stereotypes

- Description: Common misconceptions about mental disorders
- Examples:
  - MMPI-2 Ds (Dissimulation) Scale
  - Psychological Screening Inventory (PSI) EPS (Erroneous Psychiatric Stereotype) scale

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**Potential strategies**

- Close Approximations to Genuine Symptoms
  - Example: Malingering Probability Scale MAL (Malingering) scale
- Overly Specified Symptoms
  - SIRS OS (Overly Specified) scale

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**Ineffective strategy: inconsistency**

- Inconsistency of symptoms
  - Okay in “normal” samples
  - Poor discrimination in patients
- Many confounds
  - Too impaired
  - Literacy and confusion

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**Overview of the MMPI-2**

- Most extensive research on malingering
- Used by many health care disciplines
- 567 T-F items, dozens of clinical, content, and special scales

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**Just a word on defensiveness**

- Most used: Scales L and K
  - Best effect sizes
  - Works with coaching
- Single best: Wsd
- Second best: Other Deception (Odecp) scale

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**MMPI-2 Common Mistakes**

- Inconsistent profiles (not malingering)
- Incompatible profiles (misunderstood)
- No clinical elevations (WNL)
- Configurations (less accurate)

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**MMPI-2 Strategies**

□ <b>Unlikely Strategy</b>	<b>Scale</b>
■ Rare Symptoms	Fp
□ <b>Amplified Strategies</b>	<b>Scales</b>
■ Quasi-Rare Sxs	F & Fb
■ Erroneous Stereotypes	Ds & Dsr
■ Symptom Severity	LW & Ob
■ Obvious vs. Subtle	O-S

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**MMPI-2 Meta-analysis**

- Rogers et al. (2003)
- 65 MMPI-2 feigning studies
- 11 MMPI-2 diagnostic studies

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**Strengths of the “Meta”**

- Compared effect sizes and cut scores
- Took into account diagnoses ( $n \geq 100$ )
  - Schizophrenia
  - Depression
  - PTSD
  - Cognitive problems

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**More “Meta” Strengths**

- Examined referrals
  - Forensic
  - Child custody
- Added normative analysis
  - Current genuine patients
  - Caldwell

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**General Effect Sizes**

- *Rare or Quasi-Rare Symptoms*
  - F 2.52
  - Fb 2.13
  - Fp 2.02
- *Erroneous Stereotypes*
  - Ds 2.08
- *Symptom Severity*
  - O-S 1.75

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**The tried and true F scale?**

- Highest effect sizes
- But an alarming range of cut scores
  - Raw: 8 to 30 raw
  - T: 61 to 128
- Why? Because of its development.

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**Variability in MMPI-2 indicators**

<u>Indicator</u>	<u>Clinical Samples*</u>	<u>Prob. Feigning</u>
□ F	3 to 21	>30
□ Fb	NA	>28
□ F-K	-15 to 12	>32
□ O-S	-15 to 211	>221
□ L-W	17 to 65	>90
□ Ds	7 to 30	>35

\*15<sup>th</sup> to 85<sup>th</sup> percentile

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Cut Scores for MMPI-2 F Scale	
30	87%
29	93%
28	73%
22	95%
20	median
19	78%
18	85%
17	86%
8	88%
7	89%
6	94%

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F Scale and Diagnoses	
<input type="checkbox"/> Schizophrenia	<ul style="list-style-type: none"><li>■ Mean is very high, <math>T = 80</math> (<math>SD = 23</math>)</li></ul>
<input type="checkbox"/> PTSD	<ul style="list-style-type: none"><li>■ Mean is even higher, <math>T = 87</math> (<math>SD = 23</math>)</li></ul>

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F Scale Cut Scores	
<input type="checkbox"/> Clinical literature	<ul style="list-style-type: none"><li>■ <math>&gt;29</math> very high PPP</li></ul>
<input type="checkbox"/> Current meta-analysis	<ul style="list-style-type: none"><li>■ <math>&gt; 21</math> (<math>&gt; 100T</math>) has .98 PPP</li></ul>
<input type="checkbox"/> Caldwell's data set	<ul style="list-style-type: none"><li>■ <math>&gt; 24</math> (<math>&gt; 110T</math>) has .98 PPP</li></ul>

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**Bother with Fb?**

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- Same strategy
- More variable results
- More confounded by psychopathology

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**The Fp Alternative**

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- True rare strategy
- Smaller range of cut scores
  - >5 to >8
  - 77T to 99T

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**Fp Effectiveness**

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- Use of cut score >9
  - high PPP (.98) both meta and Caldwell
  - high PPP with schizophrenia
  - high PPP with PTSD

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### Ds: Erroneous Stereotypes

- Consistent cut score (Ds > 35)
- Normative data: few (i.e., < 2%) false-alarms
- Good with problematic diagnoses
  - PTSD
  - Schizophrenia

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### MMPI-2 Conclusions

- Examine multiple scales (strategies)
- Some elevations are common to patients
- Extreme elevations may signify feigning
- Fp is much more accurate than F

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### Forensic comparisons

- General forensic: similar to genuine patients
- Child custody: never malingering
- Litigation: low to moderate effects
  - Differential prevalence design?

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### Why not just stay with the MMPI-2?

- MMPI-2 uncertainties
  - Range of “optimum” cut scores (e.g., raw cut scores for F from 7 to 30)
  - Accuracy of individual scores
    - SEM and 95% confidence levels
- Daubert issue with error rates?

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### Uncertainty about MMPI-2 scores

Scale	mean	SEM	95%	$M \pm 95\%$
F T	57.5	11.3	$\pm 22.1$	35.4 to 79.6
Fb T	59.3	11.6	$\pm 22.8$	36.5 to 82.1

- Based on Caldwell’s clinical data
- Estimates are higher for Rogers et al. (2004) for schizophrenia and major depression.

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### Errors with too-close-to-call ( $\pm 5T$ )

Cut	Too-close	false-positives	false-negatives
$F \geq 80$	75-85T	31%	100%
$F \geq 100$	95T-105T	50%	57%
$F \geq 105$	100-110T	63%	75%
$F \geq 120$	115-125T	25%	75%

Eg.  $\geq 80$  (80-85T genuine = false positive)  
 (75-79T fake = false negative)  
 (Rogers et al., in press; reference under MMPI-2-RF)

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**F, Fb, and Fp cut scores and laser myths**

- Should we consider  $\pm 5T$  as “too close to call?”
- Classification errors for F, Fb, and Fp
  - False positives:  $M$  for 10 cut scores = 37%
  - False negatives:  $M$  for 10 cut scores = 62%
  - Classification errors = coin-flip (49.5%)

\*Does not include measurement errors (37.8%)

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**MMPI-2 and feigned pain**

- Bianchini et al. (2008)
  - 32 known-group feigned-pain: below chance performance on a cognitive measure (TOMM, WMT, CARB etc.)
    - What are your thoughts about that?
  - 26 college simulators
  - 23 pain patients
  - 34 “incentive only” pain patients (litigation)
    - What are your thoughts about that?

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**What to you make of these data?**

	Pain	Litig	Know	Sim	$d$
F	53.2	53.8	82.1	79.6	1.8
Fb	47.0	56.1	88.1	76.4	2.1
Fp	50.9	50.2	66.3	67.0	1.1
FBS	16.5	21.1	29.7	28.9	2.4
DS-r	46.3	54.4	72.7	72.0	1.6

$d$  = Known vs. Genuine (Pain and Litigation)

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### MMPI-2-RF and feigning

- Source: MMPI- RF Administration Manual (Ben-Porath & Tellegen, 2008)
- “Overreporting is defined as occurring when the test taker’s self presentation portrays a degree of dysfunction that is ‘non-credible’ (i.e., more extreme than would be indicated by a hypothetical objective assessment of the individual).” (p. 24)

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### Overreporting explained

- No inference of intentionality (in contrast to faking-bad)
- Does not distinguish faking-bad from
  - Unintentional overreporting (e.g., somatoform disorders)
  - Misperceptions of reality (e.g., thought disorders)
  - Internal motivation (e.g., factitious disorders)

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### Overreporting scales

- F-r: 32 items (60 items on MMPI-2)
- Fp-r: 21 items (27 items on MMPI-2)
  - 3 new items were added
- FBS-r: 30 items (43 items on MMPI-2)
- FS-r: 16 items—overreporting somatic content “rarely” endorsed by medical patients
  
- Note: Most items overlap with clinical scales.

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### Correlations? MMPI-2-RF Table 3-10

- Inpatient simulators of mental disorders
  - $M r = .94$  for all combinations of F, Fr, Fb, Fb-r, Fp and Fp-r
- Simulators of medical disorders
  - $M r = .92$  for all combinations of F, Fb, Fp and F-r, Fb-r, Fp-r, and Fs (all pairs)
- Genuine patients for these groups
  - Not reported

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### Scale interpretations: F-r scale

- 120T Invalid
  - Inconsistent or overreporting
- 100-119T May be invalid
  - Inconsistent, severe psychopathology, severe emotional stress, overreporting
- 90-99T May be overreporting
  - Inconsistent, severe psychopathology, severe emotional stress, overreporting

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### Elevations in genuine populations?

Tellegen & Ben-Porath (2008) Technical manual  
(Table D-1, male clients: *Ms* and 95% confidence levels)

Scales	Outpatients	Inpatients	VA
F-r ( $\pm 19.6$ )	72	76	84
Fp-r ( $\pm 19.6$ )	58	60	62
Fs ( $\pm 23.5$ )	62	63	70

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### MMPI-2 RF Malingering

- One study of “susceptibility”
  - Sellbom, M., Ben-Porath, Y., Graham, J., Arbisi, P., & Bagby, R. (2005). Susceptibility of the MMPI-2 clinical, Restructured Clinical (RC), and content scales to overreporting and underreporting. *Assessment, 12(1)*, 79-85.
- Clinical scales—reanalysis
  - 3.58 (Graham et al., 1991)
  - 1.54 (Arbisi & Ben-Porath, 1998)

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### Wygant and feigning

- Reference:
  - Wygant, D. B., Ben-Porath, Y. S., Arbisi, P. A., Berry, D. T. R., Freeman, D. B., & Heilbronner, R. L. (in press). Examination of the MMPI-2 Restructured Form (MMPI-2-RF) validity scales in civil forensic settings: Findings from simulation and known group samples. *Archives of Clinical Neuropsychology*.

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### Wygant results #1

- MMPI-2 for feigned head injury?
- Sample
  - 23 head injured
  - 23 head injury simulators
- Validity scales
  - 54T to 66T in head injured
  - 65T to 91T in head injury simulators
- What does it mean?
  - Assumes malingering is a global response

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### Wygant results #2

Scale	Medical controls (n = 44)	Medical simulators (n = 32)	Effect size
F-r	58.2	115.7	2.03
Fp-r	49.0	105.7	1.73
Fs	57.3	109.0	1.97
FBS-r	53.4	84.6	2.31

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- ### Wygant results #3
- Simulation instruction:
    - "Service Connected disability based on a physical injury incurred while on active duty" (Wygant et al., 2007, p. 5)
  - Generalizability of simulators?
    - VA patients with average age of 61
    - Given mandatory retirement is generally 55, retrospective feigning for 5+, likely 10+ years
    - Focuses only on *physical injury* not illness
      - Applicability?

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- ### Wygant results #4
- "Known groups" in disability cases
    - Cut scores (not specified) on PI/disability
    - TOMM, CARB, WMT, and VSVT
    - 33.6% failed  $\geq 1$  test
    - 17.8% failed 2 or 3 tests
  - Results
    - Passed all: 50 to 67 T
    - Failed 2 or 3: 63 to 93 T
    - Effect sizes: 1.2 to 1.6

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### Sellbom et al. (2010) #1

- Reference:
  - Sellbom, M., Toomey, J., Wygant, D., Kucharski, L., & Duncan, S. (2010). Utility of the MMPI-2-RF (Restructured Form) validity scales in detecting malingering in a criminal forensic setting: A known-groups design. *Psychological Assessment, 22*(1), 22-31. doi:10.1037/a0018222.

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### Sellbom et al. (2010), Design #2

- Known-groups study using the SIRS as the criterion measure
- Referrals: competency to stand trial
- Groups:
  - probable malingering ( $n = 27$ )
  - probable genuine ( $n = 90$ )

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### Sellbom et al., Results #3

- Very large effect sizes
  - F-r ( $d = 2.37$ )
  - Fp-r ( $d = 2.34$ )
  - FBS-r ( $d = 1.74$ )
- Cut score Fp-r > 110T
  - Very low false-positive rate ( $1 - .97_{\text{specificity}} = .03$ )
  - False alarm rate (BR = 15%) = 22%
  - Moderate sensitivity of .67

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### Rogers et al. (in press) #1

- Reference:
  - Rogers, R., Gillard, N. D., Berry, D. T. R., & Granacher, R. P., Jr. (in press). Effectiveness of the MMPI-2-RF validity scales for feigned mental disorders and cognitive impairment: A known-groups study. *Journal of Psychopathology and Behavioral Assessment*.

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### Rogers et al. (in press) #2

- Lexington Forensic Institute
  - Disability claims: civil forensic referrals
  - 32 probable feigners of mental disorders (FMD)
  - 42 probable feigners of cognitive impairment (FCI)
  - 345 probable genuine patients (GEN)

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### Rogers et al. (in press) #3

- Known-groups design
  - SIRS-2 for FMD
  - For FCI, below chance performance on either
    - Test of Memory Malingering (TOMM)
    - Victoria Symptom Validity Test (VSVT)

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MMPI-2-RF FMD effect sizes			
Scale	General	MDD	PTSD
F-r	2.06	2.04	2.09
Fp-r	2.00	1.82	1.29
Fs	1.77	1.70	1.76
FBS-r	1.14	.99	1.11
Ds-rf	1.52	1.57	1.40

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MMPI-2-RF FCI effect sizes			
Feigning vs. General Honest etc.			
Scale	General	<85 IQ	Cog Dx.
F-r	1.05	.96	1.10
Fp-r	.89	.65	.64
Fs	.99	1.10	1.08
FBS-r	.97	1.67	1.86
Ds-rf	.64	.87	.61

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FMD Cut scores (20% BR)						
□ Scales	Sen	Spec	PPP	NPP	OCC	
□ F-r > 70T	.94	.63	.39	.98	.65	
□ F-r > 130T	.56	.98	.88	.90	.94	
□ Fp-r > 90T	.22	.99	.85	.83	.93	
□ Ds-rf > 25	.16	.997	.93	.82	.93	

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**F and Fp-r cut scores and laser myths**

- Should we consider  $\pm 5T$  as “too close to call?”
- % of errors for F-r and Fp-r
  - False positives:  $M$  for 10 cut scores = 46%
  - False negatives:  $M$  for 10 cut scores = 58%
  - Likelihood of being wrong = chance (52%)

Does not include measurement error (36.5%)

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**Rogers et al. (in press) conclusions**

- FCI
  - Doesn't work: False alarm rates even for optimized cut scores typically exceed 60%
  - Rule-out: most probable feigners exceed  $F-r \geq 70T$
- Fp-r and false alarms
  - Across specific diagnoses,  $M_s \approx 55T$
  - Very small percentages above 80T

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**Rogers et al. (in press) conclusions**

- FMD
  - Normative-based cut scores don't work well for FMD.
  - Rule-out: Most feigners score  $F \geq 79T$ .
  - Optimized cut scores do not agree with Sellbom et al.; they use much higher scores.
  - Ds-rf shows great potential but need to be cross-validated.

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### Rogers et al. (in press) question

- Classify everyone including too-close-to-call cases?
- Treat  $\pm 5T$  as unclassified?
  - Avoid 50% classification errors
  - (Laser accuracy myth of cut scores)

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### Personality Assessment Inventory (PAI)

- Shorter than the MMPI-2
- Grade 4 reading level
- Excellent internal reliability
- Good discriminant validity
- Uniform cut scores for feigning

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### PAI Response Consistency

- INF (infrequency) neutral to psychopathology with very high or low endorsement rates
- INC (inconsistency) highly correlated items (5 pairs same and 5 opposite direction)
  
- Should not interpret inconsistent profiles
  - Random, NIM  $M = 95T$  (Morey, 2007, p. 146)

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### PAI and Malingering (Morey, 2007)

- NIM scale  $\geq$  84T
  - Genuine patients: false alarms about 10%
  - Minority inpatients: not reported
- NIM scale  $\geq$  92T
  - Genuine patients: false alarms about 6-9%
  - Minority inpatients: false alarms about 21%

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### More NIM

- NIM scale  $\geq$  84T
  - 86 to 88% feigners of severe mental disorders
- NIM scale  $\geq$  92T
  - 82 to 86% feigners of severe mental disorders
  - Lower for specific disorders (22 to 60%)

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### Rogers et al. (1996) PAI simulation

- 166 naive simulators/controls
- 80 sophisticated simulators/controls
- 45 patients with schizophrenia
- 136 patients with major depression
- 40 patients with generalized anxiety disorder

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### Design

- ❑ Fake specific disorders
- ❑ Two stage discriminant analysis

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### Good and Bad News

- ❑ Good: >80% classification for cross-validation
- ❑ Bad: 60% in a subsequent known-groups design

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### PAI Simulation studies\*

	<b>NIM</b>	<b>MAL</b>	<b>RDF</b>
Bagby (2002)	0.53	0.48	1.55
(coached)	0.44	0.05	1.87
Baity (2007)	1.61	1.30	1.20
Blanchard (2003)	2.48	2.48	2.61
Liljequist (1998)	1.08	-	-
Morey (1998)	1.63	1.75	1.96

\*Sellbom & Bagby (2008; 3<sup>rd</sup> ed.)

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**PAI Known-Groups\***

Known-groups	NIM	MAL	RDF
□ Boccaccini (2006)	1.54	1.10	ns
□ Kucharski (2007)	1.82	1.21	-0.09
□ Wang (1997)	1.05	0.68	ns

\*Sellbom & Bagby (2008; 3<sup>rd</sup> ed.)

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**Hawes & Boccaccini (2009) meta**

Indicator	Simulation		Known-groups
	Gen	Coach	
NIM	1.68	1.59	1.06
MAL	.94	1.00	1.27
RDF	1.69	1.65	.31

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**Hawes & Boccaccini (2009) meta**

Indicator	Simulation Studies	
	Mood/Anxiety	Psychotic/incapacity
NIM	1.25	2.32
MAL	.90	1.89
RDF	1.23	2.03

Incapacity: inpatient admission, incompetent, NGRI

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### PAI NIM Cut scores

- Rule-out feigning: NIM score < 73T (4.5% of feigners misclassified; Morey, 2007, p. 156)
- Screen for feigning: Elevations on NIM: 77T to 109T; about 20% genuine misclassified; Hawes & Boccaccini, 2009, p. 120)
- Likely feigning: Extreme elevations on NIM:  $\geq 110T$  (about 2% genuine misclassified; Hawes & Boccaccini, 2009, p. 120)

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### PAI MAL Cut scores

- Screen for feigning: MAL scores > 2 or > 3; Hawes & Boccaccini, 2009, p. 120)\*
- Likely feigning: MAL scores > 4 (about 1% genuine misclassified; Hawes & Boccaccini, 2009, p. 120)

\*Feigners misclassified of 33% (>2) and 14% (>3)

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### Laser myth accuracy?

- Reference:
  - Rogers, R., Gillard, N. D., Wooley, C. N., Ross, C. A. (2011). *The detection of feigned disabilities: The effectiveness of the PAI in a traumatized inpatient sample*. Manuscript submitted for publication.
- Design and setting
  - Within-subjects simulation design on inpatient Trauma Unit

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% of Errors for unclassified ( $\pm 5T$ )				
		FP	FN	% Errors
□ NIM ( $\pm 5T$ )	$\geq 84T$	38	100	64
	$\geq 110T$	80	50	68
□ RDF ( $\pm 5T$ )	$\geq 59T$	62	50	56
	$\geq 70T$	50	54	54

False positives: 0 – 5 points above but genuine  
False negatives: 1 – 5 points below but feigning

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MCMII-III Footnote	
□ Debasement Index: confounded	
□ Clinical and Severe Syndromes (normative)	
■ A = .77 (anxiety)	
■ H = .79 (somatoform)	
■ D = .85 (dysthymia)	
■ R = .77 (PTSD)	
■ SS = .82 (Thought disorder)	
■ CC = .85 (major depression)	

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MCMII-III	
□ Few studies with mixed results	
□ Schoenberg et al. (2003)	
■ Moderate effect size (.59)	
■ Concluded “minimal clinical utility”	

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### MCMI-III: Schoenberg et al. (2006)

- Reanalysis of Schoenberg et al. (2003) with 181 inpatients and 114 simulators
- Results
  - Cohen's  $d = .59$
  - "Optimal" cut score  $Z_{BR} > 82$ 
    - Sensitivity of .61 and specificity of .62
    - PPP of .47 and NPP of .75

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### More Schoenberg et al. (2006)

- Discriminant Function A
  - Sensitivity of .45 and specificity of .90
  - PPP of .72 and NPP of .75
- Discriminant Function B
  - Sensitivity of .71 and specificity of .83
  - PPP of .69 and NPP of .84

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### Afternoon Objectives

- SIRS-2 Update
- Detection strategies for feigned cognitive impairment
- Optional: Unstructured interview
- Forensic reports of malingering
- Wrap-up: questions

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**Structured vs. unstructured interviews**

- Structured interviews
  - Standardize the inquiries
  - Standardize the sequencing of inquiries
  - Standardize the ratings
  - Standardize the decision model
- Example: major depression
  - Medical: missed diagnoses and misdiagnoses

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**Structured Interview of Reported Symptoms (SIRS)**

- Rogers and his colleagues
- Standardized interview format
  - Avoid reading comprehension
  - Minimize confusion
- 172 ratings
- Fully structured format

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**SIRS Continued**

- Premise: minimize false-positives
  - Great harm being misclassified as a malingerer
  - Created an indeterminate group to reduce errors\*
  - Set cut scores above “optimum” to minimize false-positives

\*Avoid the myth of the laser cut score

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### SIRS Primary Scales

- RS: Rare Symptoms
- SC: Symptom Combinations
- IA: Improbable and Absurd Symptoms
- BL: Blatant Symptoms
- SU: Subtle Symptoms
- SEL: Selectivity of Symptoms
- SEV: Severity of Symptoms
- RO: Reported versus Observed Symptoms

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### Validation of the SIRS

- Extensively validated by developers and other researchers
- Uses both simulation design and known-groups comparisons
- Clinical, forensic, and correctional populations

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### Interrater reliability

Study	Alpha	<i>M</i>	range
SIRS manual	.86	.98	.93 to 1.00
Goodness (1999) (RT)	.89	1.00	1.00 to 1.00
(CT)	.87	1.00	1.00 to 1.00
Norris & May (1998)	.80		
Ustad (1997)	.79		
Vitacco et al. (2007)	.86	.99	.95 to 1.00
Unweighted averages	.85	.99	.97 to 1.00

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### Rogers et al. (2009)

- Rogers, R., Payne, J. W., Berry, D. T. R., & Granacher, R. P., Jr. (2009). Use of the SIRS in compensation cases: An examination of its validity and generalizability. *Law and Human Behavior*, 33, 213-224.

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### Description

- Lexington Forensic Institute
  - 497 cases with consecutive sampling
- Referral questions:
  - 65.2% worker's compensation
  - 20.1% personal injury
  - 14.5% disability determinations

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### Lexington bootstrapping design

- Used MMPI-2 to identify suspected malingerers
- Criteria:
  - $Fp > 7$
  - $Ds > 35$

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### SIRS and diagnosis

- Diagnostic heterogeneous groups
  - Rationale: National Comorbidity Studies
  - Typical: 2+ Axis I diagnoses + substance abuse + Axis II diagnoses
- Rogers, Payne and Berry
  - Cannot look at single disorders
  - Looked at non-overlapping disorders

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### Diagnostic differences (*M*s)

SIRS	Dep	PTSD	Cog	< 80 IQ
RS	.81	.62	.58	.68
SC	.87	.62	.58	.79
IA	.46	.24	.35	.43
BL	2.88	2.00	1.42	2.14
SU	9.46	7.57	7.29	8.23
SEL	8.95	7.10	6.65	7.82
SEV	3.39	2.48	2.06	2.55
RO	2.14	1.86	1.77	2.02

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### SIRS and Dissociative Identity

- Brand, McNary, Loewenstein, Kolos, and Barr (2006)
  - 43 simulators to 20 DID patients.
  - One-third DID patients exceeded  $\geq 3$  scales in the probable feigning range

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### SIRS-2 Professional Manual

- Descriptive data under standard instructions
  - 193 Clinical-General protocols
  - 1,232 Clinical-Forensic protocols
  - 589 Correctional protocols
- Feigning data on 167 protocols

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### Severe Clinical Inpatient Sample

- Goal: test the SIRS scales and classification with a very impaired population.
- Trauma Unit:
  - 93.8% acute inpatients
  - 6.2% day-patients following acute admission
- Impairment:
  - 36.12 *M* GAF

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### Severity of Axis I symptomatology

- Depressive symptoms: 22.3% moderate, 64.9% severe
- Suicidal ideation: 80.0% (current episode)
- Psychotic symptoms: 22.9% moderate, 12.0% severe
- Dissociative symptoms: 18.7% moderate, 32.0% severe
- *Mean* PTSD: 13.2 SCID symptoms

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### Overview

- SIRS-2 psychometric properties
- SIRS-2 classification
- Spanish SIRS-2

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### Reliability, SEM, and 95% confidence

Scale	Rel.	SD	SEM	95% confidence
RS	0.98	3.10	0.44	± .86
SC	0.98	3.29	0.46	± .90
IA	0.98	2.67	0.38	± .74
BL	0.98	5.27	0.74	± 1.45
SU	0.99	6.83	0.68	± 1.33
SEL	0.99	6.59	0.66	± 1.29
SEV	1.00	6.33	0.00	± .00
RO	0.95	2.63	0.59	± 1.16
Wt. <i>M</i>	0.98	4.62	0.51	± 1.00

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### Test-retest reliability

- Inpatients: 1 to 2 week interval
- Primary scale scores
  - Consistent scores  $|2| = 74.4%$
  - Correlation = .71
- Scale classification (feigning vs. not-feigning)
  - Concordance = 95.9%
  - Kappa = .78 or Yule's Q = .98
- Overall classification = 100%

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**SIRS-2 Modifications**

- RS Total Scale
  - Scope = uses only non-primary items
  - Goal = reduce atypical genuine protocols (i.e., decrease false positives)
- MT (Modified Total) Index
  - Sum = RS, SC, IA, and BL
  - Goal = classify marginal profiles as feigning or genuine

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**SIRS-2 Modifications**

- Disengagement response style
  - Avoid feigning detection by remaining disengaged
- SS (Supplementary Scale) Index
  - Sum = DS, DA, OS, and IF
  - Very low scores: “too-good-to-be-true” SIRS profiles
  - Very different from other feigners ( $d = 3.99$ ) and genuine responders ( $d = 3.11$ )

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**SIRS-2 Modifications**

- Indeterminate classification
  - Indeterminate-evaluate: greater than 50% likelihood of feigning
  - Indeterminate-general: no heightened concern; its base rate (34%) is similar to the SIRS-2 validation.
- Base rates:
  - Different from prevalence rates!
  - Variable depending on the screens that are used

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### SIRS-2 Classification #1

- Meet basic rule for feigning: 3+ probable or 1+ definite?
  - Apply the RS-Total classification scale
- Why?
  - Reduces further false-positives
- How?
  - Uses non-primary items almost never reported ( $M = 92.1\%$ ) by genuine patients—potential false-positives

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### SIRS-2 Classification #2

- Have 1 or 2 probable feigning range?
  - Apply the MT Index (sum of RS, SC, IA, and BL)
- Why?
  - Eliminates scoring problems with the Total Score
  - Increases true-positives
  - Decreases false-positives

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### SIRS-2 Classification #2 (cont.)

- How?
  - Very elevated scores = high probability of feigning
  - Middle-range scores = indeterminate-evaluate and indeterminate-general
  - Low scores = high probability of genuine responding (after review of SS Index)

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### SIRS-2 Classification #3

- No scores in definite or probable range
  - Apply Supplementary Scale Index (SS Index) = sum of DA, DS, OS, and IF
- Why?
  - Disengagement response style
  - Extreme outliers from both feigners ( $d = 3.99$ ) and genuine responders ( $d = 3.11$ )

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### SIRS-2 Classification #3 (cont.)

- How?
  - Very low scores: indeterminate-evaluate group
  - Others: Genuine responders

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### SIRS-2 Utility estimates

Prevalence of feigning	31.8%
False-positives	2.5%
Sensitivity	.80
Specificity	.975
Positive Predictive Power (PPP)	.91
Negative Predictive Power (NPP)	.91
Overall Correct Classification (OCC)	.91

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### SIRS-2 Criticisms: Rubenzer (2010)

- Should we classify everyone?
  - If not, are all the unclassified errors?
- Our perspective
  - Classify 77% of protocols with 91% accuracy
  - 10-15% indeterminate-evaluate (more likely than not to be feigning)
  - 10-15% indeterminate-general (likely to be genuine)

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### Alternative: 100% classification

- Classify all:
  - Fake = feigning and indeterminate-evaluate
  - Non-fake = genuine and indeterminate-general
  - OCC = 88%
  - False-positive rate of about 10%
- Laser accuracy myth

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### SIRS-2 Criticism: Green et al.

- Reference
  - Green, D., Rosenfeld, B., Belfi, B., & Rohlehr, L. (2011, March). *New and improved: A comparison of the SIRS and the SIRS-2*. Paper presentation at the Annual Meeting of the American Psychology-Law Society, Miami, FL.
- Issue
  - SIRS is better than the SIRS-2 at classification

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### Green's methodology

- Claims "known-groups comparison"
  - Used routine psychiatric interviews as the "gold standard"
  - Logic: Use an unstandardized approach with unknown reliability (i.e., interview) as the gold standard to evaluate a highly reliable and well validated measure (i.e., SIRS-2)
- Example of the partial-criterion comparison

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### SIRS-2 Flip-flop on the M-FAST

- Green et al. used the SIRS-2 and psychiatrists as standards to evaluate the M-FAST
- M-FAST did better with the SIRS-2 than psychiatrists
  - Sensitivity: 92% SIRS-2 vs. 48% psychiatrists
  - Specificity 84% vs. 81%
  - OCC for the SIRS-2 = 88%
  - OCC for psychiatrists = 65%

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### SIRS-2 Flip-flop

- Reference:
  - Belfi, B., Green, D., Klaver, J., & Rohlehr, L. (2011, March). *Use of the M-FAST to evaluate feigned symptoms in a sample of incompetent defendants*. Paper presentation at the Annual Meeting of the American Psychology-Law Society, Miami, FL.

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### SiRS-2 Generalizability

- Ethnicity
  - Similar data on convergent validity
  - Comparable PPP and NPP (slightly higher in Hispanic Americans)
- Gender
  - Similar data on convergent validity
  - Comparable PPP and NPP

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### Spanish SIRS-2

Linguistic equivalence: 3 steps

1. Three bilingual Hispanic psychologists independently translated the SIRS-2 from English to Spanish. They then developed a consensus translation.
2. A fourth bilingual psychologist independently back-translated the consensus Spanish translation back to English.
3. A fifth bilingual psychologist independently examined both the English and Spanish versions and addressed any discrepancies.

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### Spanish SIRS-2: Clinical Equivalence

Miami sample of 23 bilingual outpatients

SIRS-2	<i>M</i> diff.	% [2]	<i>d</i>
RS	.00	100.0	0.00
SC	.22	100.0	0.25
IA	.00	100.0	0.00
BL	.04	95.7	-0.02
SU	1.17	78.0	-0.23
SEL	.65	78.3	-0.13
SEV	.56	91.3	-0.25
RO	1.39	82.6	-0.56

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Spanish SIRS-2 Reliability		
Scale	Alpha	Inter. <i>r</i>
RS	.81	1.00
SC	.89	1.00
IA	.84	1.00
BL	.96	1.00
SU	.95	.99
SEL	NA	1.00
SEV	NA	.99
RO	.76	.98

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Spanish SIRS-2: Discriminant validity	
40 monolingual Hispanic outpatients:	
Scales	Cohen's <i>d</i> s
RS	1.92
SC	2.07
IA	1.84
BL	2.47
SU	1.87
SEL	2.25
SEV	2.18
RO	1.38

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Spanish SIRS-2 Utility estimates	
False-positives	2.5%
Sensitivity	.88
Specificity	.92
Positive Predictive Power (PPP)	.93
Negative Predictive Power (NPP)	.88
Overall Correct Classification (OCC)	.90

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**TEA Ediciones**

- License agreement with PAR
- Slightly revised translations and validations
- Spain and Spanish-Speaking South America

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**Multi-method approach to feigned mental disorders**

- Structured interview: SIRS-2
- Multiscale inventory:
  - MMPI-2
  - PAI
- Interview methods
  - Unstructured: provide salient examples
  - Structured: SADS

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**Multi-method continued**

- Cognitive feigning measures
  - Claimed impairment
    - Example: business entrepreneur who could make change
- Specialized measures
  - Competency: ECST-R Atypical scales

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### Multi-method conclusions

- Always use multi-method approaches
- Consider domains of feigning
- Consider the accuracy of measurement
- Consider validation
  - Simulation
  - Known-groups

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### Feigned Cognitive Impairment

- Our focus will be on detection strategies
- Review of specific measures
  - Boone (2007): excellent overall
  - Larrabee (2007): excellent overall
  - Bender (2008, 3<sup>rd</sup> ed.): TBI
  - Sweet et al. (2008, 3<sup>rd</sup> ed.): memory
  - Berry (2008, 3<sup>rd</sup> ed.): other cognitive processes

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### Feigning Cognitive Impairment

- Remember the differences?
  - Frown and be frustrated
  - “Try”
  - Get it wrong
- Need different detection strategies

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### Empirical Strategies: Feigned Deficits

- **Unlikely strategies**
  - Magnitude of error
  - Performance curve
  - Violation of learning principle
- **Excessive-impairment strategies**
  - Floor effect
  - Symptom validity testing (SVT)
  - Forced-choice testing (FCT)

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### Magnitude of error

- Unlikely Strategy
  - genuine patients often make predictable errors.
  - malingerers do not focus on *which* incorrect answers
- Features:
  - less transparent and vulnerable to coaching
  - easily adapted to the forced-choice formats (Matrix Reasoning of the WAIS-III)
- Example: “d errors” on the “b Test”

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### Performance Curve

- Unlikely Strategy:
  - Genuine patients produce predictable pattern of more errors with increased item difficulty (i.e., the “curve”)
  - Malingers produce much less discrimination between easy and difficult items.
- Features:
  - Sophisticated strategy, likely resistant to coaching
- Example:
  - Validity Indicator Profile (VIP)

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### Violation of Learning Principles

- Unlikely Strategy:
  - Malingers are unaware of learning principles in failing comparative tasks
- Examples:
  - recognition vs. recall,
  - cued recall vs. un-cued recall
  - immediate vs. delayed recall,
  - simple recall vs. cognitive transformation

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### Violation #2

- Example:
  - California Verbal Learning Test (CVLT)
- Untapped examples:
  - Word Memory Test
    - E.g., Immediate vs. Delayed Recognition
  - TOMM
    - Case example: Retention

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### Floor effect

- Excessive-Impairment Strategy:
  - Some malingers do not recognize that simple cognitive tasks can be completed by most impaired persons.
- Features:
  - Easiest to adapt and most popular
  - Very transparent and easily coached
- Examples:
  - Rey-15
  - Test of Memory Malingering (TOMM)

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**Symptom Validity Testing**

- Excessive-Impairment Strategy:
  - Significantly below chance rarely occurs in genuine populations
- Features:
  - Great specificity but modest sensitivity
  - Equiprobable items
- Examples:
  - Portland (PDRT)
  - Victoria Symptom Validity Test (VSVT)

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**SVT #2**

- Individualized use
  - Amnestic defendants
  - Creation of equiprobable items
- Example: “global amnesia”

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**Forced Choice Testing**

- Strategy:
  - (not really) “feigners do worse”
- Limitations: Typically not tested on-
  - Heterogeneous groups
  - Diagnostic comorbidity
  - Severely impaired
- Example:
  - Portland revised scoring

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**Inconsistent Presentation**

- Prone to errors
- Variable performance due to
  - Fluctuating cognitive state
  - Comorbidity

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**Specific Cognitive Measures**

- Portland Digit Recognition Test (PDRT)
- Word Memory Test (WMT)
- Test of Malingered Memory (TOMM)
- Validity Indicator Profile (VIP)
- “b” Test

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**Portland Digit Recognition**

- Standard PDRT
  - 72 trials with 5 digit numbers
  - Must choose 1 of 2 alternatives
  - Uses a distracter
  - Increased latency: 5, 15, and 30 sec.
- Abbreviated PDRT
  - Use 36 “easy” items with additional rules

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**PDRT Detection strategies**

- Symptom validity testing
  - Binder (1992) test manual
    - < 29 feigning ( $p < .04$ )
    - 30% of mild injuries; 12% of moderate/severe, using  $p < .10$
  - Greve et al. (2008): descriptive data
    - Mild TBI: 6.6%; moderate-severe TBI: 3.4%
    - [TOMM goes in the opposite direction 3.7 to 5.3%]
    - Your thoughts?

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**PDRT Detection strategies #2**

- Forced choice testing
  - Greve & Bianchini (2006)
    - Using MND criteria, 4 definite and 52 probable MND were combined
    - Criterion A appears to be assumed
    - Reported <5% false-positives using FCT
  - Your thoughts?
    - Assuming Criterion A
    - Combining definite (7.1%) with probable (92.9%)

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**Criteria for “known groups”**

- Probable
  - Exaggeration or fabrication on  $\geq 2$  measures, or
  - 1 measure and  $\geq 1$  self-report discrepancy
- Feigning Measures
  - TOMM
  - Reliable digits
  - CVLT
  - WCST
  - MMPI-2 F, Fb, Fp ( $>100T$ )
  - MMPI-2 FBS ( $>30$  raw)

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### Word Memory Test (WMT)

Description: memory for 20 word pairs (pseudo-examples, boy/girl; cow/steak)

#### Measures of Effort

- ❑ IR = immediate recognition: word-pairs are presented twice with original words and foil words (boy/girl)
- ❑ DR = delayed recognition: 30 minute delay; 40 original words 40 new foil words (e.g., boy/bird)

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### WMT Memory Measures

- ❑ Multiple choice (MC): first word of the pair and asked to select the second from eight options
- ❑ Pair Associates (PA): Tester says the first word and person is to supply the second word
- ❑ Delayed free recall (DFR) Recall all the words from the list in any order.
- ❑ Long delayed free recall (LDFR): The DFR after a 20 minute delay

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### WMT Detection Strategies

- ❑ Floor effect: recognition tests are very easily
- ❑ Consistency: similar errors 30 minutes later
- ❑ Potential performance curves
  - recognition tests = easy
  - MC and PA = more difficult
  - DFR and LDFR = much more difficult

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**WMT Findings**

- Studies are difficult to follow (CARB)
- Use cut scores set at 1.5 SD below genuine
- Floor effect with IR (immediate) and DR (delayed) recognition: moderately effective
- Learning principle: IR compared to DR

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**False alarms and dementia**

- Reference:
  - Green, P., Flaro, L., & Courtney, J. (2009). Examining false positives on the Word Memory Test in adults with mild traumatic brain injury. *Brain Injury*, 23(9), 741-750.
- Study
  - 164 moderate-severe TBI (>24 hours post trauma amnesia)
  - Failure rate of 22.7%

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**WMT and TOMM: Clinically Obvious**

- Reference
  - Merten, T., Bossink, L., & Schmand, B. (2007). On the limits of effort testing: Symptom validity tests and severity of neurocognitive symptoms in nonlitigant patients. *Journal of Clinical and Experimental Neuropsychology*, 29(3), 308-318
- Criterion group of "Clinically obvious symptoms"
  - Obvious during informal contact without formal cognitive tests
  - Examples are easily observable in patients
    - telling repeatedly the same idea
    - not knowing recent personal facts,
    - not being able to refer to an earlier subject of conversation.

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**Merten study: false-positives**

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**Clinically Obvious**

□ WMT	False-positives
■ Immediate Recognition	50%
■ Delayed Recognition	42%
■ Consistency	50%

**Not Clinically Obvious**

□ WMT	False-positives
■ Immediate Recognition	0%
■ Delayed Recognition	0%
■ Consistency	8%

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**Merten study: TOMM**

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**Clinically Obvious**

□ TOMM	False-positives
■ 2 <sup>nd</sup> Trial	17%
■ Retention	17%

**Not Clinically Obvious**

□ TOMM	False-positives
■ 2 <sup>nd</sup> Trial	8%
■ Retention	10%

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**WMT and Coaching**

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□ Reference

- Dunn et al. (2003) *Archives of Clinical Neuropsychology*, 18, 121-134

□ Results

- Coaching about strategies has a strong effect
- Information about symptoms *worsened* performance
- Coaching and information less effective than coaching alone
- Effects on cut scores?

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### Test of Memory Malingering (TOMM)

Description:

- 50 pictures of common objects with two choice alternatives
- Two trials plus retention trial after 20 min.
- Primary strategy: floor effect

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### TOMM's Effectiveness

- 90% correct on 2<sup>nd</sup> trial and retention
  - 2.2% of TBI
  - 27.0% of dementias
- Validation
  - More prompting of cognitively impaired persons (e.g., look at both alternatives)
- Comorbidity

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### Forensic Applications: TOMM

- Weinhorn et al. (2003)
- Sample
  - Pretrial (competency & sanity)
  - NGRI and Civil Commitment
- Diagnoses
  - Psychotic: 36% vs. 69%
  - Mental retardation: 20% vs. 17%

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**TOMM: Forensic Continued**

- Results: Pretrial vs. Committed (*Ms*)
  - Trial 1            38        41
  - Trial 2            43        48
  - Retention        44        48
- False positives
  - Trial 2            40%      17%
  - Retention        41%      12%

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**TOMM: nonforensic false-positives**

- Teichner & Wagner 2004
  - Teichner, G., & Wagner, M. (2004). The Test of Memory Malingering (TOMM): Normative data from cognitively intact, cognitively impaired, and elderly patients with dementia. *Archives of Clinical Neuropsychology*, 19(3), 455-464.
- Cognitively impaired, false-positives
  - 8.3% T-2 and Retention
- Dementia, false-positives
  - 76% T-2 and 71% Retention
  - Cut score of 40 = 52% T-2 and 48% Retention

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**TOMM and Axis I Disorders**

- Boone (2007) False-positives
  - Table 13.5 (p. 297)
- Depression (3 studies)
  - 3 of 77 or 3.9% (the 3 had severe depression)
- Psychotic disorder (1 study)
  - Impaired concentration: 3 of 29 (10.3%)
  - Not impaired concentration: 0 of 21 (0.0%)

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### Validity Indicator Profile (VIP)

Description:

1. 78 item verbal test
2. 100 item non verbal test
3. 2-choices; randomly ordered for difficulty

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### VIP Response Styles #1

1. **Compliant:** (valid) high effort

2. **Inconsistent:**

- Defined: "effort is incomplete, intermittent, or minimal" (Test manual, p. 3)
  - *Note the range is from minimal to less than optimal.*
- Causes:
  - Disenchantment with test-taking
  - Stress
  - Organic conditions
  - Distractions in testing environment

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### VIP Response Styles #2

3. **Irrelevant:**

- Defined: "test taking responses bear no relationship to item content" (Test manual, p. 3)
  - Random or patterned responses (ABAB)
- Causes:
  - Deliberate: "attempt to perform poorly but with poor effort" (p. 3)
  - Non-deliberate: reading or language problems
  - Non-deliberate: lack of familiarity with multiple-choice tests
  - Non-deliberate: severe cognitive impairment

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### VIP Response Styles #3

4. **Suppressed**

- Defined: “concerted effort on the part of the test-taker to answer incorrectly” . . . “has the ability to answer correctly but *suppresses* correct responses” (Test manual, p. 3)
- Criteria: uses SVT for below-chance performance

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### Performance curves

- **Compliant:**
  - Perfect (or Near perfect) on easy items to chance levels on very difficult items
- **Suppressed**
  - Below chance on easy items (able to suppress) to chance levels on very difficult items (unable to suppress)

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### Accuracy of the VIP: Nonverbal

Groups	Compliant	Inconsist.	Irrelev.	Suppress
Brain injured	80%	16%	3%	0%
Simulators	37%	27%	29%	8%
Poss. Maling.	65%	18%	8%	8%
Random (50)	0%	2%	96%	2%
Random (10K)	0%	5%	89%	6%
M.R. ( $\leq 64$ IQ)	5%	50%	45%	0%

(Percentages are rounded.)

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Accuracy of the VIP: Verbal				
Groups	Compliant	Inconsist.	Irrelev.	Suppress
Brain injured	85%	10%	3%	2%
Simulators	35%	40%	15%	10%
Poss. Maling.	90%	6%	4%	0%
Random (50)	0%	2%	94%	4%
Random (10K)	0%	5%	89%	6%
M.R. ( $\leq 64$ IQ)	0%	20%	75%	5%

(Percentages are rounded.)

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- ### Accuracy: criterion group issues
- **Simulators**
    - 39% feigned on all tests
    - 27% feigned on most tests
    - 35% feigned on some tests
  - **At-risk for malingering (poss. maling.)**
    - Includes adults claiming cognitive impairment, seeking compensation, unlikely symptoms in medical history
    - Excludes: abnormal scans, LOC  $\geq 5$  min. etc.

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- ### “b” Test
- **Description:**
    - Simple letter recognition
    - discrimination task using overlearned material (often preserved with brain damage)
  - **Strategies:** floor effect, magnitude of error, and response time

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### Usefulness of the “b” Test

- Strengths
  - Cut scores for different groups
  - Examples: schizophrenia (180), stroke (170), and brain injury (90)
- Weaknesses
  - Different base rate assumptions
  - Small clinical groups (about 30)
  - Use of response time

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### “b” test: type of errors

- “d” errors are very uncommon
  - Magnitude of error
- Almost never made by any group:
- Cut score >3:
  - False-positives for functional disorders less than 5%
  - False-positives for cognitive disorders is 0.0%

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### Cognitive methods: Conclusions

- Dozens of measures
- Most use very similar strategies
  - Floor effect
- Questions to ask
  - Use simulation *and* known\* groups?
  - Test comorbidity?
  - Cross-validated cut scores?

\*Not partial MND criteria

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### Critique of a malingering report

- Test data and report excerpts
  - Please return
- 10 minute quick review and critique

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### MCMI-II analysis

- MCMI-II test manual (Millon, 1987, p. 118).
  - Efforts to “separate levels of disclosure from ‘good and bad impression-making’ was only partially successful, in the self-disclosers gain higher debasement than desirability scores on a regular basis. . .”
- Debasement scale is defined (p. 119):
  - “the tendency of some patients to demean or denigrate themselves, to accentuate their psychological anguish, and to play up their emotional vulnerabilities”
  - This tendency to “put the worst foot forward” (p. 120) does not necessarily involve feigned mental disorders.

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### SIMS commentary

- SIMS is a screen for which false-positives are more tolerable
  - Indicates that the “*suspicion* of malingering” (Widows & Smith, 2005, p. 15, emphasis added) not the *evidence* of malingering.
- With the SIRS as the external criterion in a study of court-ordered competency and sanity evaluations, the test manual (Widows & Smith, 2005, p. 27) reported a PPP of .54.

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### Final Section

- Forensic reports
  - Clarity vs. obfuscation?
  - One-sided vs. balanced?
  - Basis of testimony?

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### Forensic report: My examples

- Suspected malingerer:
  - The SIRS is widely recognized as the best-validated measure for evaluating feigned or malingered mental disorders. It was administered to the examinee on two occasions in 2004: Dr. Beta (March 2004) and Dr. Alpha (December 2004). Because Dr. Alpha had administered the SIRS very recently, its re-administration was unnecessary and would have questionable validity.

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### Suspected #2

- In reviewing Dr. Beta's protocol, the SIRS primary scales were in the honest range. Although Dr. Alpha declined to share his test data, his interpretation parallels the test manual for persons who have all primary scales in the honest range. Therefore, these results are highly consistent; individually, they indicate that at least a 95% probability that the examinee is genuine in reporting his symptoms.

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### Suspected #3

- Dr. Alpha raised the question of whether the examinee might be feigning incompetency. The ATP scales of the ECST-R are the only standardized measures to address this issue specifically. His ATP scales are not elevated (T scores from 47 to 50) but do include sufficiently atypical items as to require a fuller evaluation. With respect to Dr. Alpha's question, the examinee's scores are definitely lower than the minimum levels for this profile to be considered ancillary data for feigned incompetency. In addition, his recent SIRS results indicate a very high likelihood that the examinee is not feigning.

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### Rule-out malingering: The Peters case

#### *Evidence of Malingering*

- There is no evidence, whatsoever, that Mr. Peters is malingering. In review of multiscale inventories, the MMPI-2 (administered June 24, 2009) feigning scales are unelevated (F = 55T, FB = 55T, Fp = 63T) and unremarkable. These scores are far below the cut scores for feigned mental disorders and fall in the expected range for persons with genuine disorders. A similar pattern is observed on the PAI. The Negative Impression scale (NIM = 51T) and the Malingering Index (MAL = 0) provide no evidence of feigning and fall clearly in the range found with genuine patients.

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### Peters: Rule-out #2

- To evaluate for feigned cognitive impairment, two measures were administered at the Detention Center by Ms. Freud. On the TOMM, Mr. Peters has perfect scores on Trial 1, Trial 2, and Retention. Likewise, the "b" Test provides no evidence of feigning with 0 "d" errors, 0 commission errors, and 5 omission errors.

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### Peters: Rule-out #3

- For interview-based approaches, the ECST-R includes several screens for possible feigning. For the ATP-P and ATP-I, Mr. Peters's scores were 0. On the ATP-N, he had an equivocal score of 1—first responding “yes” and then spontaneously modifying it to “rarely.” If considered a “1,” then further assessment is warranted. As the most accurate measure of feigned mental disorders, the SIRS was administered. Mr. Peters's primary scales were consistently at the low end of the genuine range. This profile indicates a very high probability of genuine responding and provides strong evidence that Mr. Peters is not malingering.

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### Peters: Rule-out #4

- Throughout the assessment, Mr. Peters presents himself as well-adjusted and emotionally capable of handling his circumstances. In combining standardized measures with clinical data, I found no evidence that Mr. Peters is feigning any mental disorder or cognitive impairment.

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### Peters: Other response styles

#### *Other Response Styles*

- Mr. Peters responded consistently on the MMPI-2, PAI, and SIRS. He appeared to be attending to the questions and responding relevantly to the material.
- MMPI-2 data indicate that Mr. Peters likely lacks insight into his own behavior and psychological issues. His extreme elevation of the L scale (92T) falls in the 99th percentile for both normal individuals and patients with mental disorders.

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### Peters: Defensiveness

- His K (21 raw or 62T) and Wsd (19 raw or 67T) scales are also moderately elevated; these elevations are commonly found among persons who are not acknowledging mental health problems. The PAI PIM scale (18 or 57T) is categorized as a moderate elevation providing some support for the MMPI-2 interpretations.

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### Smith: Malingering #1

- The objective data are compelling that Mr. Smith is malingering mental disorders. These data include results from measures administered by Dr. Beta (MMPI-2 and SIRS) and Dr. Alpha (MMPI-2). Importantly, all three measures include scales to measure response consistency; this was not a problem for Mr. Smith. Instead, his results clearly indicate feigning.

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### Smith: Malingering #2

- Malingering was also indicated on two tests that I administered: the PAI and the PDRT. These results are not explained by confusion or a lack of concentration. In addition, the SADS offers corroborative data on the likelihood of feigning.

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### Smith: Malingering #3

- Combining all the objective data, several observations about the malingering are warranted.
  - Over-Reporting rare Symptoms. Evidence of fabrication is found on F scale of the MMPI and MMPI-2; RS and IA scales of the SIRS, and the NIM scale of the PAI.
  - Endorsement of Unusual Pairs of Symptoms. Evidence is found on the SC scale of the SIRS and symptom combinations on the SADS.
  - Indiscriminant Endorsement of Symptoms. Evidence is found on the SEL of the SIRS, total symptoms of the SIRS and the SADS, and DS scale of the MMPI.

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### Smith: Malingering #4

- Mr. Smith reported marked problems with concentration and memory as a result of mental disorders. To examine the authenticity of these problems, I administered the PDRT. His performance was substantially below that which is expected in either depressed or brain injured groups. His performance was consistent with persons feigning problems with concentration and memory.

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### Smith: Malingering #5

- In addition to objective data, gross inconsistencies were observed between current presentation and what was reported by past clinicians.
- Extremely atypical hallucinatory experiences. Some examples include:
  - He reported undulating walls that rolled like the sea; an alive and moving ceiling, chairs rocking back and forth on their accord. These experiences continue to occur on a regular basis, a couple times a week. He reported they first occurred in Dr. Beta's waiting room over a 20 minute period.

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### Smith: Malingering #6: Atypical hallucinations

- He reported that his plants become animated and begin to move. In particular, his ferns move their leaves in synchrony, sometimes to the Dance of Sheba.
- His mail also begins breathing with a rising and falling action.
- He reports that persons and his dog melt away. They become fluid-like and limbs retract; the head becomes a lump.
- Cartoon characters, including Daffy Duck and Yosemite Sam, play out episodes when his TV is off and he is completely awake.

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### Presenting evidence of malingering

- Experts speak in a foreign language
  - Use funny words
  - Use abbreviations
  - Use numbers (math phobias)
- Conclusion: "I can't hear you"

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### Expert evidence

- Demonstrative displays
  - Can see patterns
  - Can understand differences
  - Written material can appear to be real
- MMPI-2 example of non-feigning
  - Average scores for malingerers
  - Average scores for genuine patients
  - Mr. X's score at the low end of genuine patients

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### Cross-examination on malingering?

Cross: Misunderstanding of DSM-IV

- *Doctor, did you rely on the DSM-IV indices in reaching your conclusions that the defendant was malingering?*
- *[if not covered on direct] What are those four indices?*
- *Doctor, are the DSM-IV indices valid for the identification of malingers? . . . How were they validated? [Any explanation is inaccurate]*

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### Malingering and DSM-IV #2

- *What source describes the validation of the DSM-IV indices of malingering? . . . [if answers "DSM-IV"] Here is a copy of the DSM-IV-TR, please turn to page 739. Is that the section on malingering? . . . Take your time, where does it describe the validation of the DSM-IV indices of malingering?*
- *Isn't it true, doctor, you really don't know whether the DSM-IV indices were validated?*

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### Cross: SIRS and feigning

Sloppy administration

- *Doctor, are you aware of any gross deviations in its administration and interpretation in the SIRS-2 given to Ms. Jaspers on May 12, 2010?*
- *Doctor, would you identify those deviations for the court?*
- *Please turn to page 4, what is her answer to question 28? Isn't it true that either the question was skipped which is wrong and her answer wasn't recorded which is wrong?*

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### Cross: SIRS-2 and feigning #2

#### Sloppy administration

- And question 31, no answer to the either? What is it: not recorded or not asked?
- Okay, please turn to page 6. What went wrong to Question 48? Or Question 49? Or Question 55? Now on page 7, what about Question 60? Or Question 65 on the next page?
- Now we have another 32 questions that were messed up. Now, doctor, wouldn't that be enough flaws in the SIRS-2 administration to throw out its results?

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### Cross: MMPI-2 F scale

- [might as well admit this upfront] His F scale is pretty high, isn't it? . . . Really off the charts?
- Based on your evaluation of Mr. Jones can you absolutely rule out a schizophrenic or schizoaffective disorder? . . . Would you be surprised that persons with schizophrenia typically have extreme elevations of Scale F? . . . That T-score elevations over 100 are not uncommon?

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### Cross: MMPI-2 F scale

- [option: MMPI-2 meta-analyses] Do you recognize this article? Please turn to page 170.
- What is the average score for genuine schizophrenics? [80] What is the standard deviation? [23] Isn't it true that about 2% of genuine patients with schizophrenia exceed two standard deviations?
- Can you help me with the math—What is  $23 \times 2$ ? [46] And  $46 + 80$ ? [126] . . . Would that be accurate, that about 2% of genuine patients with schizophrenia will clearly outscore Mr. Jones?

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