Trust everyone
But always cut the cards

Malingering And Other Distortions
in Psychological Assessments

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Test of Memory Malingering (TOMM) scores are not affected by chronic pain or depression in patients with fibromyalgia.

Clin Neuropsychol. 2007 May;21(3):532-46.
Malingering

Assumes intent.
The intentional production of falsely 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.

Susan

Chronic pain subsequent to automobile collision four years ago

declared inability to work because of pain

complains of poor concentration, traumatic memories, afraid to drive
Is Susan malingering (a) physical, (b) psychological symptoms?

Is Susan’s reporting confused or otherwise unreliable?

Is Susan exaggerating?

Is Susan minimizing?
Symptom feigning:
• Malingering
• Exaggerating
• Factitious Disorder

Disavowal:
• Defensiveness / minimizing
• False presentation of positive traits

Unreliable reporting:
• Irrelevant or random responding
Factitious Disorder
(aka Munchausen syndrome)

• a diagnostic category (a type of symptom feigning)

• similar to malingering

• but the intention is presumed to be for the purpose of assuming the sick-role (not for external incentives)
The psychologist’s toolbox

1. Tests of response style

2. Tests with embedded measures of response style

3. Behavioural observations

4. Examination of multiple sources of evidence
1. Tests of response style

• Specific to purpose and context

e.g., *Test of Memory Malingering (TOMM)*

• Assesses feigning of memory impairment
1. Tests of response style

• Specific to purpose and context

*Structured Interview of Reported Symptoms (SIRS)*

• Assesses probability that the individual is faking psychopathology
SIRS assesses

- Rare symptoms
- Symptom combinations
- Improbable symptoms
- Selectivity of symptoms
- Severity of symptoms
- other aspects of the symptom-picture
Principles for use

1. Appropriateness of test to the domain (e.g., cognitive, psychopathological, pain)

2. Appropriateness of test to the response style (e.g., exaggerating, minimizing, reliability)
The psychologist’s toolbox

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2. Tests with embedded measures of response style

- Minnesota Multiphasic Personality Inventory (MMPI)
  - MMPI-2 (Revised edition published, 2001)
  - MMPI-2-RF (Restructured Format; 2008)
MMPI-2

Consistency:

– VRIN (Variable Response Inconsistency)

  • pairs of items that should be consistent
    e.g., “I often feel blue”
    “I am seldom sad”
MMPI-2

Consistency:

– TRIN (True Response Inconsistency)

  • pairs of items to which the same response is semantically inconsistent

  • identifies extreme “Yea-saying” and “Nay-saying”
MMPI-2

False presentation of positive traits:

– L (Lie) scale

• claims of unrealistic virtue
  – individuals with high scores are unwilling to admit even minor flaws
  – or are naïve about themselves
  – or have personality adjustment problems
  – or…
Defensiveness:

- K (Defensiveness)
  
  • claim of no personal weakness or psychological frailty
  
  • self-presentation as very well adjusted (may be true)
MMPI-2

Defensiveness:

– S Scale (Superlative self-presentation)

  • belief in human goodness
  • serenity
  • contentment with life
  • patience / denial of irritability/anger
  • denial of moral flaws
MMPI-2

Malingering / Exaggerating:

- F Scale (Infrequency)
  
  • contains items infrequently endorsed by the general population
Additional validity scales:

– F(B) (same as F, but in latter portion of test)

– F(p) Symptom Exaggeration (indicates exaggeration compared to psychiatric norms)

– FBS-r Symptom Validity (somatic & cognitive complaints associated with over-reporting)
Interpreting MMPI validity scales is complex
Interpretation of the F scale...
Summary of Interpretative Rules for the MMPI–2 F in Forensic Evaluations

The MMPI infrequency scales indicate unusual response to the item pool through claiming excessive, unlikely symptoms.

*T* scores below 50 may be associated with a response pattern that minimizes problems.

*T* scores from 55–79, inclusive, reflect a problem-oriented approach to the items.

*T* scores from 80–89, inclusive, indicate an exaggerated response set, which probably reflects an attempt to claim excessive problems. *VRIN* *T* scores ≤ 79 can be used to rule out inconsistent responding.

*T* scores from 100–109, inclusive, are possibly indicators of an invalid protocol. Some high *F* profiles are obtained in inpatient settings and reflect extreme psychopathology. *VRIN* *T* scores ≥ 79 can be used to rule out inconsistent profiles.

*T* scores ≥ 110 indicate an uninterpretable profile because of extreme item endorsements.

Interpretive hypothesis for elevated *F* scores:

- Confusion, reading problems
- Random responding (refer to *VRIN*)
- Severe psychopathology
- Possible symptom exaggeration
- Faking psychological problems
- Malingering
“Righteous Responder”
Malingering vague neurological symptoms

Figure R-44. MMPI-2 profile of an individual malingering vague neurological symptoms. The profile is plotted on the MMPI-2 norms (see the same profile plotted on the original MMPI norms in previous figure).
FIGURE R-19. MMPI-2 basic profile of airline pilot applicants ($N = 437$), illustrating how well-adjusted individuals who present themselves in a positive light score on the MMPI-2 norms. (Source: Butcher, 1992c. Reprinted with permission.)
2. Tests with embedded measures of response style

- Numerous other tests include less extensive indices of validity.

- Data from some tests can be analyzed for validity (e.g., WAIS).

- The typical basis for interpretation is excessive or atypical response-patterns.
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4. Examination of multiple sources of evidence
3. Behavioural observations

What do we think we know about behavioural cues of invalidity?

Ruback & Hopper (1986):
• parole officers based post-interview decisions on
  – amount of information volunteered
  – politeness
  – level of fidgeting
3. Behavioural observations

Ruback & Hopper (1986):

- parole officers based post-interview decisions on
  - amount of information volunteered
  - politeness
  - level of fidgeting

- Their decisions were worse after interviews (assessed by later recidivism).
3. Behavioural observations


Customs officials, police officers, judges, FBI agents, forensic psychiatrists & others 

rely largely on myths: e.g., “shifty eyes”, avoiding direct gaze, difficult to anger
3. Behavioural observations


- Customs officials, police officers, judges, FBI agents, forensic psychiatrists & others
- largely rely on myths: e.g., “shifty eyes”, avoiding direct gaze, difficult to anger

--> no better than chance at judging honesty of videotaped speakers.
3. Behavioural observations

Porter, Woodworth & Birt (2000):

Deception:

- fewer “illustrators”
- differences in detail and narrative
- exaggerate
- *micro-expressions*
- other behavioural cues
3. Behavioural observations during psychological assessment

- multiple interview opportunities
- over lengthy time-period
- with interruptions (creates opportunity to assess consistency)
- close observation of verbal and non-verbal cues (as identified by Porter et al.)
The psychologist’s toolbox

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• Use of multiple sources of information:
  – records over time
  – collateral interview
  – comparing current with past information
  – looking for convergence, or explanation of divergence
Red Flags

• inconsistency in self-report
  – BUT unless specific and replicable, it is of little use in demonstrating deception

(most people have misrepresented themselves)
Red Flags

• inconsistency in self-report
• inconsistency between records and self-report
  – BUT there may be good reasons for this, which do not invalidate assessment results

(e.g., the physician’s record of Mr. S., who was reluctant to complain, had considerable evidence of problems documented by lab tests, but little mention of anxiety problems.)
Red Flags

• inconsistency in self-report
• inconsistency between records and self-report
• symptoms all over the place

  – BUT some clients are both confused and have legitimate psychopathology;
  – some exaggerate out of an attempt to be taken seriously and also have significant problems.
Red Flags

• inconsistency in self-report
• inconsistency between records and self-report
• symptoms all over the place
• **symptom-picture is too tidy**

  – BUT some people are very organized in their self-presentation;
  – some people have done considerable research on their problems **and** have serious problems
Red Flags

- inconsistency in self-report
- inconsistency between records and self-report
- symptoms all over the place
- symptom-picture is too tidy

- **history of faking**
  - BUT this leads to too many false positives
  - and over-reliance on historical data may prohibit a conclusion of valid complaints
Red Flags

- inconsistency in self-report
- inconsistency between records and self-report
- symptoms all over the place
- symptom-picture is too tidy
- history of faking

- **excessively rapid improvement**
  - BUT not all of the incentives or internal factors may be known to the observer
Caveats

• Someone can exaggerate and also have significant problems.

• Encouraging plaintiffs to be forthright helps them be taken more seriously.
Managing difficult clients

• Ask yourself, why are they being difficult?
Managing difficult clients

• Ask yourself, why are they being difficult?
  – anxiety?
    • about being taken seriously
    • about practical matters
    • about possible outcomes
  – Listen; summarize; communicate clearly and ask for summaries.
  – Call them regularly (not necessarily frequently) with updates.
Managing difficult clients

– Difficult person? (e.g., judged as difficult by others)

• treat seriously
• establish boundaries clearly and keep them (e.g., no weekend phone calls)
What are the differences among...

psychologist
psychiatrist
neurologist
neuropsychologist
• **psychologist**
  – 6-10 years univ. in human behaviour;
  – expert in assessment and psychological treatment;
  – assessments tend to be comprehensive, not wholly reliant on self-report, data-based

• **psychiatrist**
• **neurologist**
• **neuropsychologist**
• psychologist

• **psychiatrist**
  – med school, then specialty in psychiatry (~4 years)
  – medical/physiological approach
  – interview-based, often narrative assessments

• neurologist
• neuropsychologist
- psychologist
- psychiatrist

- **neurologist**
  - med school, then specialty in neurology
  - physical exam and medical-test-based assessments
  - “diseases of the nervous system”

- neuropsychologist
• psychologist
• psychiatrist
• neurologist

• neuropsychologist
  – 6-10 years univ in human behaviour & neuro-physiology
  – expert in cognition and memory
  – assessments based on history, self-report, and systematic, research-based testing
What doesn’t work in assessing malingered symptoms?

most tests

e.g., Trauma Symptom Inventory (TSI):

73% of undergraduates deliberately malingering PTSD were classified as “valid” with recommended cutoff of “Atypical Response” validity scale.
If in doubt consult
Recommendations

• Psychological assessments should always address issues of response-style.

• Failure to do so can be taken as rendering assessment conclusions invalid because the appropriate level of confidence in them is unknown.
What about coaching?

- Evidence is mixed, but mostly favourable for MMPI-2 detection.

- i.e., coaching about symptoms does not affect detection of malingering.
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References


