

The background features several puzzle pieces. A large, light beige puzzle piece is in the top left corner. Another light beige piece is in the top right. On the right side, there are two dark blue puzzle pieces, one above the other, each containing a stylized brain icon. The text is centered on the page.

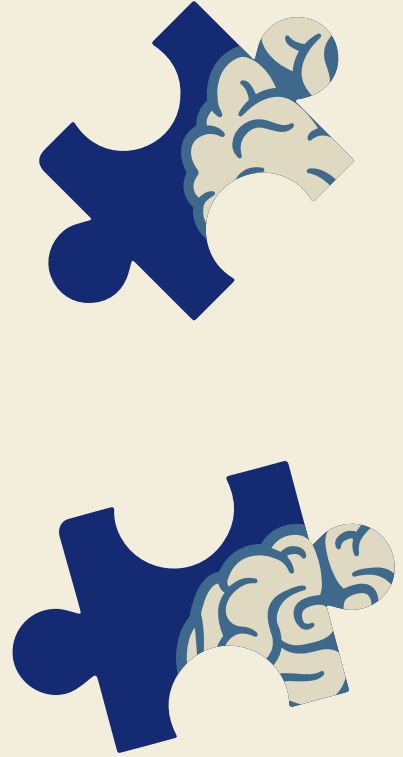
Introduction to Malingering: **Performance & Symptom Validity Testing**

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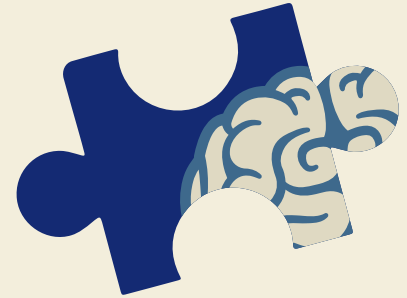
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Objectives

Attendees of this presentation will be able to:

1. Describe at least three possible presentations of malingering in psychological evaluations.
2. Differentiate between effort/performance and symptom validity.
3. Identify at least three methods of detecting deception in psychological evaluations.
4. Describe the difference between purposeful malingering and unintentional or suboptimal performance.



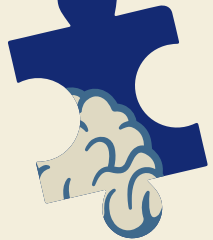


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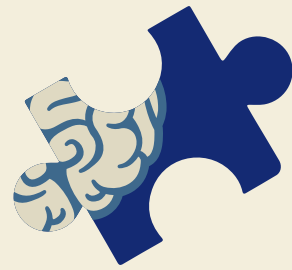
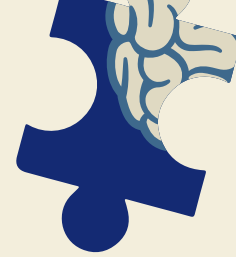
04 | Detection of Malingering

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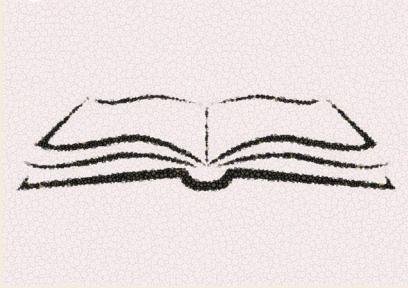
01

Terminology & History

What is malingering?



History



Bible

[Samuel 21:13]

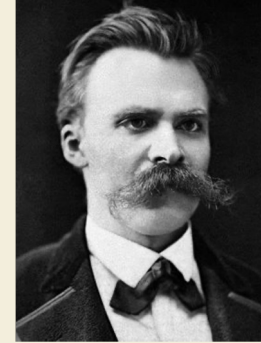
David, fearful of a king's wrath, "changed his behavior {...} and feigned madness; he scratched on the doors of the gate and let his saliva run down his beard."



Paolo Zacchia

Father of Forensic Medicine

"There is no disease more easily feigned or more difficult to detect."



Friedrich Nietzsche

Philosopher

"There is only one world and that world is false..."

History

Reliance on clinical judgement & observation to identify the faking of symptoms/injuries

**Ancient – 19th
Century**

Rey 15-item test
1940's

Computerized
Administration Techniques
Present

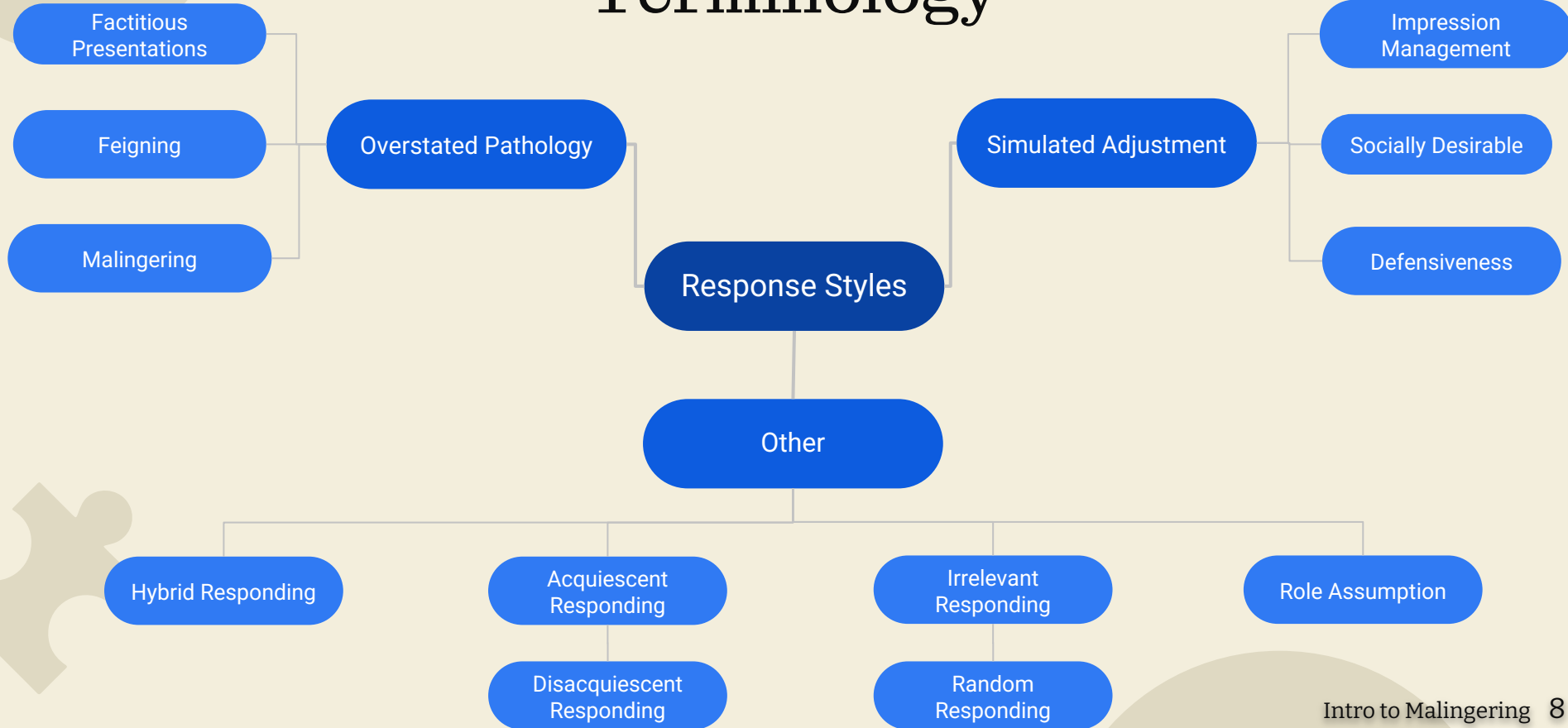
WWI-WWII

PTSD & injuries from soldiers & veterans –
Introduction of personality tests

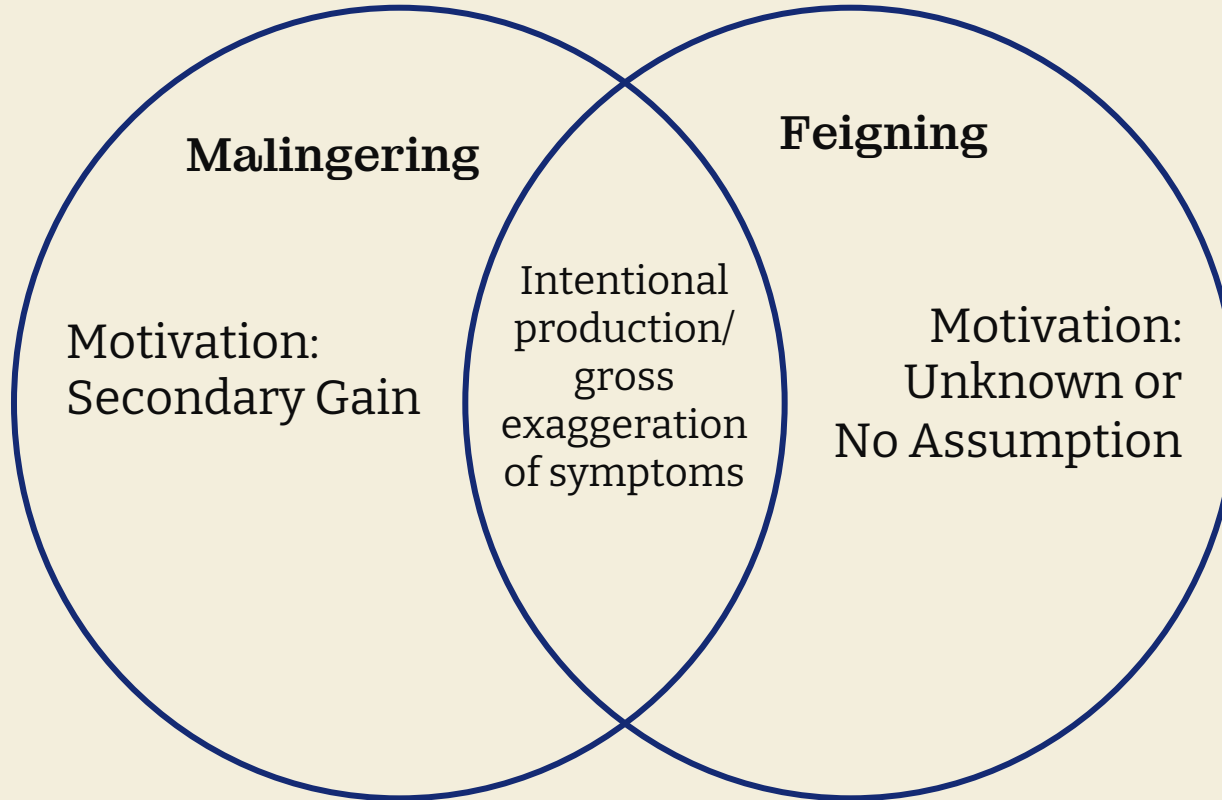
40's-2000's

Forced choice to complex drawings –
Reduce transparency & increase sensitivity

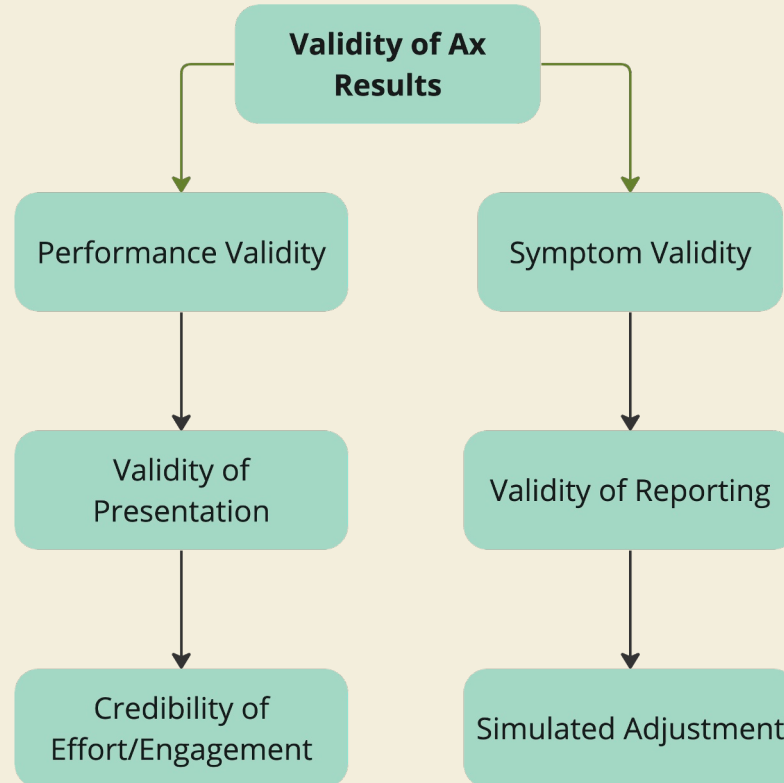
Terminology



Feigning vs. **Malingering**



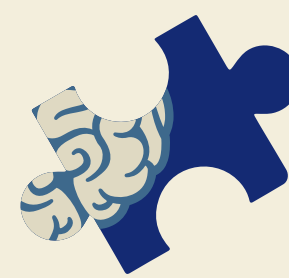
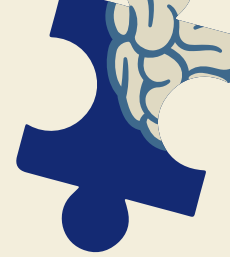
More Terminology...

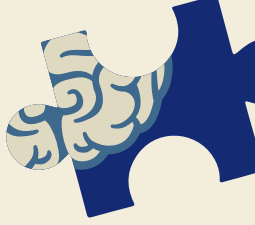


02

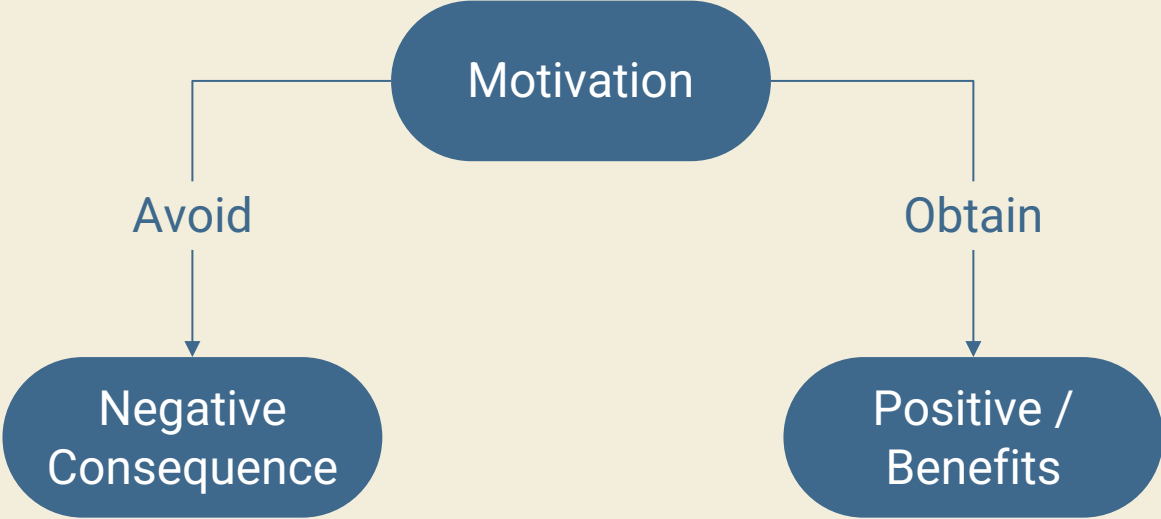
Rationale & Presentations

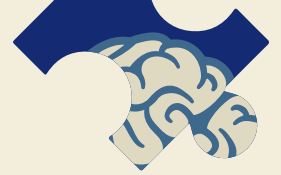
Why and how individuals may malingering





Reasons for **Malingering**





Reasons for **Malingering**

- Avoidance of criminal responsibility, trial, and punishment
- Avoidance of military service
- Avoidance of work, social responsibility, and social consequences
- Financial gain
- Facilitation of transfer from prison to hospital
- Admission to a hospital
- Drug-seeking





Secondary Gain in **Institutionalized Settings**

- Medications (i.e., sedation, intoxication, or barter)
- Housing changes (i.e., single cell)
- More time out of cell - MH groups, extra yard time, etc.
- In prison: appeals, early release, etc.
- In jail: delaying court processes, easier release on bail, increase chance of a plea deal, contribute to legal strategy

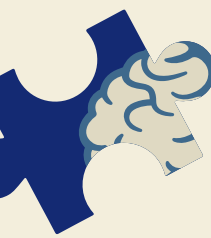


Evaluations with large impetus for **Secondary Gain**

Criminal Justice System

- CST
- NGRI
- Mitigation

Civil

- Medical-Legal
 - Disability/SSI
 - Personal Injury
- 

Accommodations

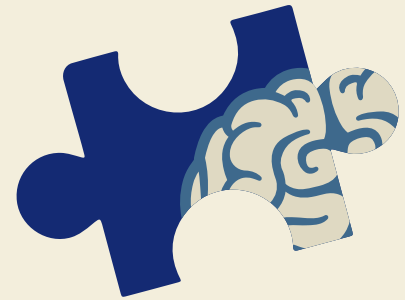
- ADHD/LD
- Standardized testing (LSAT, GRE, SAT, etc.)

Employment

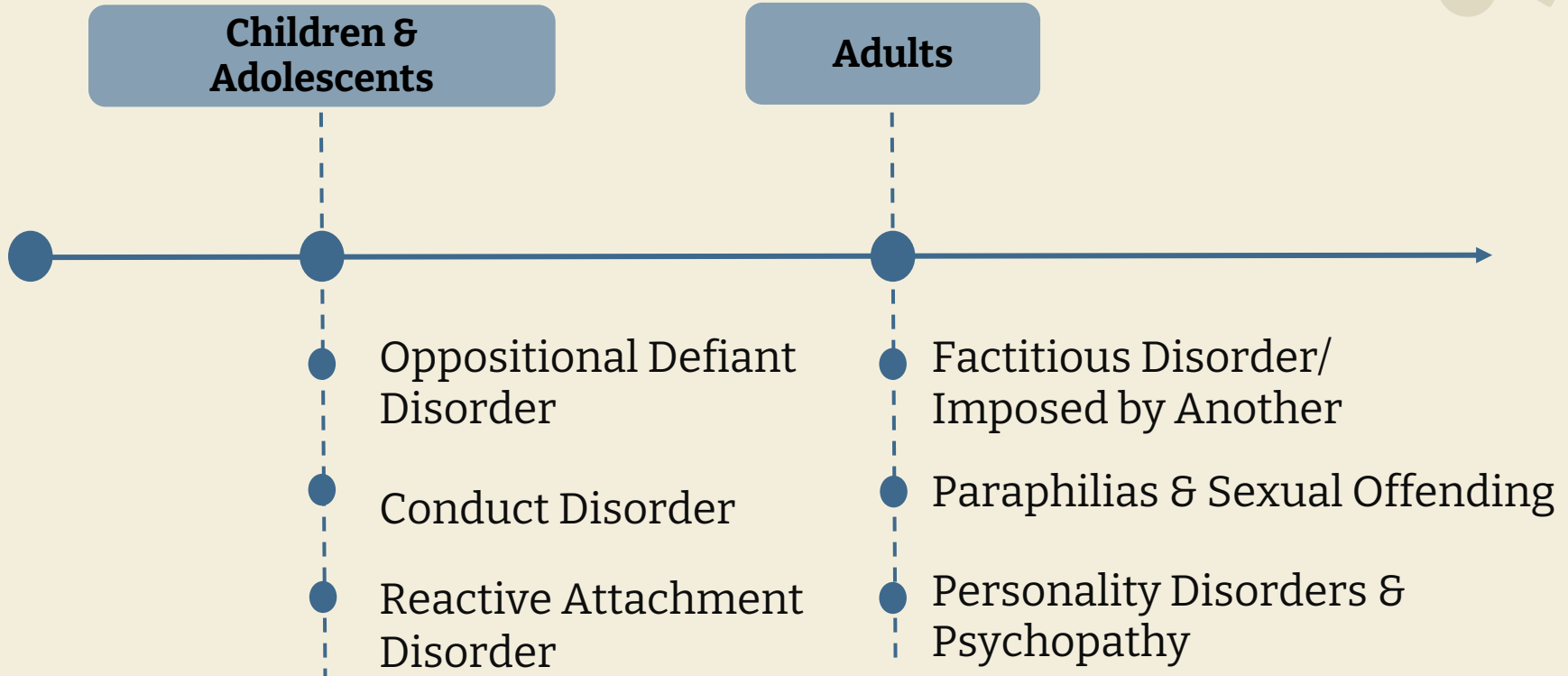
- Worker's Comp (QME/AME)
- PTSD
- Sexual Harassment

Legal Considerations

- People v Ford, 2009; Conclusion: CST
 - 7 psychologists: 5 = CST + 4 = Malingering
 - Psychologist #'s 1 & 3: Rey-15
 - Psychologist #'s 2, 5, & 6: No PVTs/SVTs
 - Psychologist #7: Used 3 “malingering assessments” (TOMM Trial 1: 2/50; Trial 2: 1/50; #3?)
- People v Steele, 2022; Conclusion: CST
 - Psychologist #'s 1, 2, & 3: N/A (clinical interview)
 - Competency Restoration Progress Reports: TOMM (malingering)
 - Psychologist #3 (2019): TOMM (malingering) + MFAST (not malingering)



Disorders Associated with **Deception**



Theoretical Models of **Malingering**

Adaptational Model



Malingering is an attempt to succeed when faced with adverse circumstances (cost/benefit)

Pathogenic Model



Malingering is a result of a psychotic disorder (not supported)



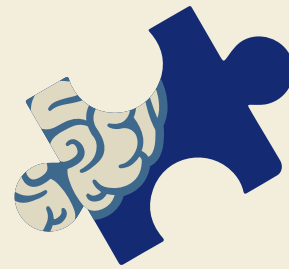
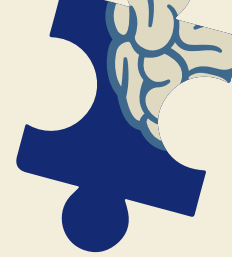
Criminological Model

Malingering is a specific manifestation of antisocial behavior and attitudes (i.e., person is “bad”)

03

Additional **Considerations**

It might not be malingering



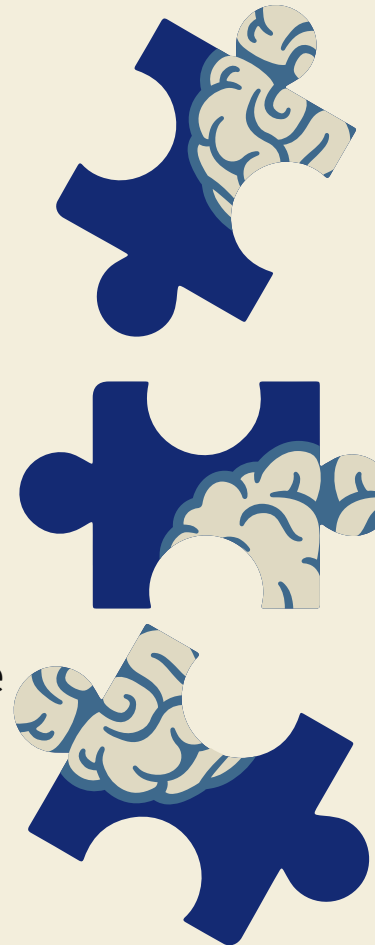
Suboptimal **Performance**

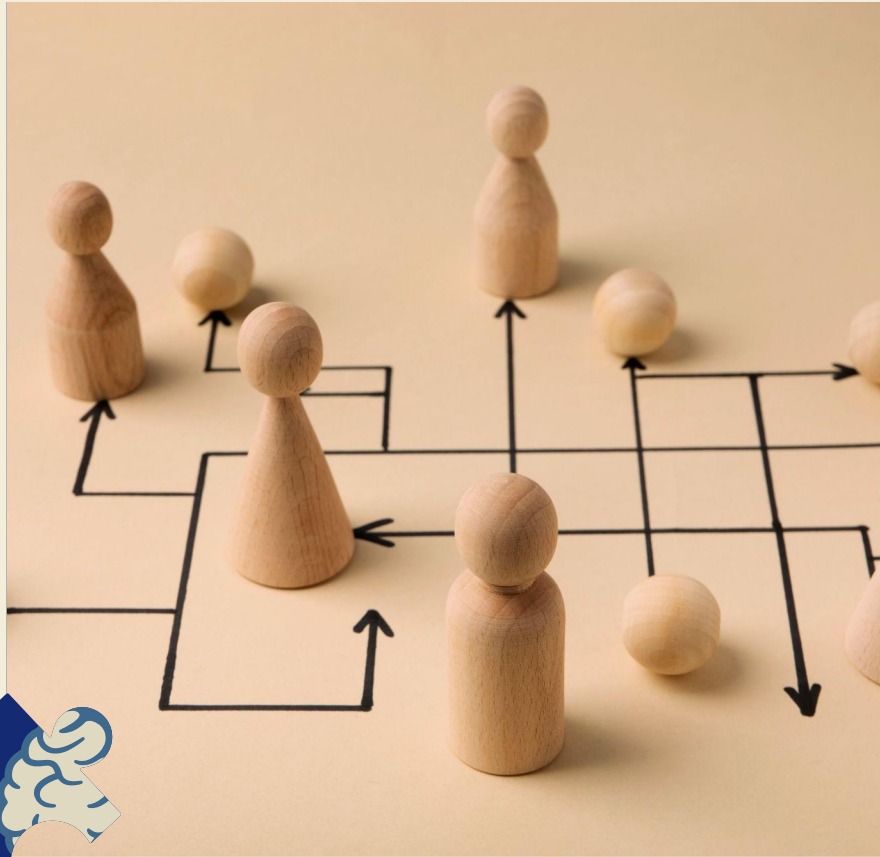
- NOT a synonym for malingering
- Encompasses any instance of less than maximal effort on testing



Reasons for **Suboptimal Performance**

- Decreased interest & effort - as a result of:
 - Genuine cognitive impairment
 - Comorbid conditions (e.g., depression secondary to head injury)
- Expectations of failure based on recent performance
- Stress & preoccupation with potential consequences of the evaluation (e.g., loss of disability income)
- Reaction to examiner (e.g., encouragement seen as examiner rejection of real impairment)





Also **Consider...**

- Misunderstanding instructions
- Fatigue
- Motivation
- Medication effects
- Intoxication

Contextual and Individual **Circumstances**



- Situational stressors
- Previous and compounding traumas
- Personality traits
- Internalization of other symptoms
- Memory distortions due to passage of time



Rule **Out**

Real Illness

Anxiety, psychosis, depression

Ganser Syndrome

Dissociative disorder - nonsensical or wrong answers

Factitious Disorder

Psychological *need* to be seen as sick

Functional Neurological Disorder (Conversion Disorder)

Physical & sensory problems (e.g., paralysis, numbness, blind, deaf, seizures, etc.)

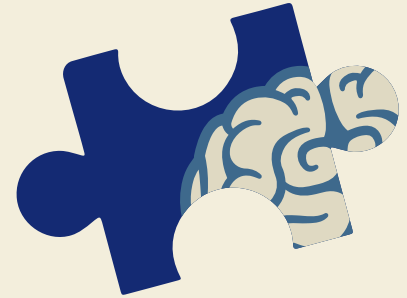
Somatic Symptom Disorder

Extreme focus on physical symptoms (e.g., pain or fatigue)



Cultural Considerations

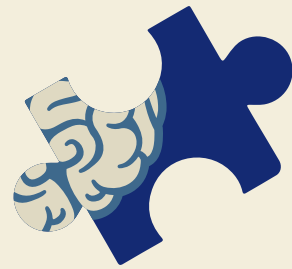
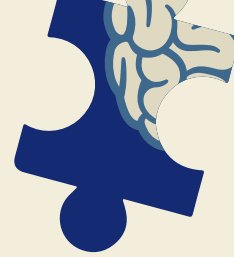
- Language barriers / not understanding instructions
- Response styles & societal norms
- Education level
- Acculturation
- Examinee-Examiner characteristics
- Normative data
 - May permit adjustment for normative characteristics



04

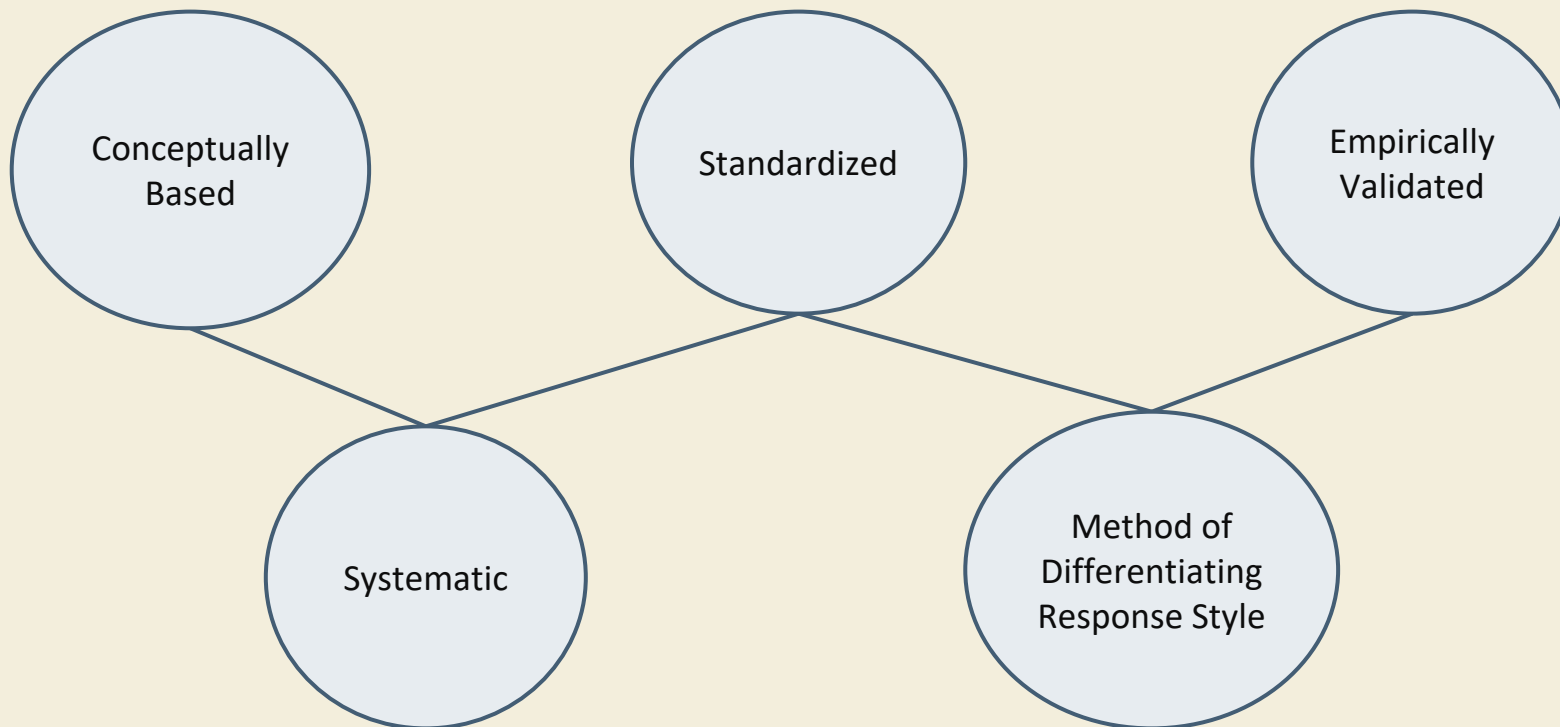
Detection of **Malingering**

Identifying malingering through empirical methods



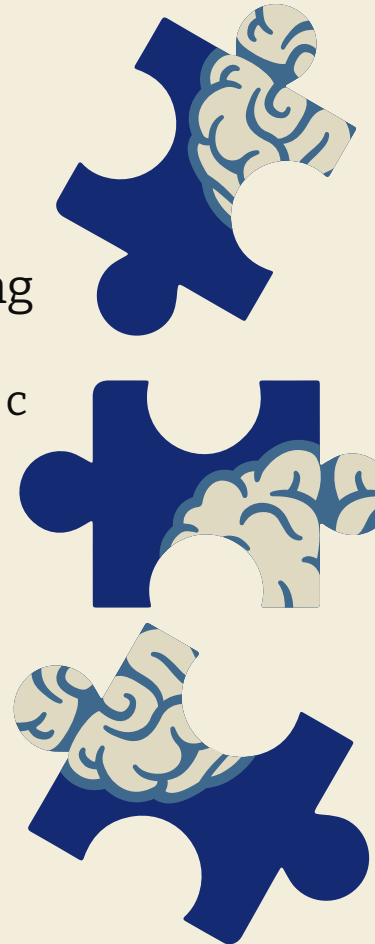


Detection Strategies **Should Be...**



Update to **Slick Criteria** (2020)

- A. Presence of External Incentive
- B. Invalid Presentation on Examination Indicative of Feigning or Exaggeration
 - 1. Invalid Neurocognitive Presentation (One or more of a, b, or c must be present)
 - a. One or more compelling inconsistencies pertaining to cognitive deficits or symptoms are observed or documented during the evaluation
 - b. Invalid scores on PVT's
 - c. Psychometric evidence of exaggerated cognitive symptoms on SVT's



Update to **Slick Criteria (cont.)**

B. (cont.) Invalid Presentation on Examination Indicative of Feigning or Exaggeration

2. Invalid Somatic Symptom Presentation (One or both of a or b must be present)

- a. One or more compelling inconsistencies pertaining to somatic symptoms are observed or documented during the evaluation
- b. Psychometric evidence of exaggerated somatic symptoms on SVT's



Update to **Slick Criteria (cont.)**

B. (cont.) Invalid Presentation on Examination Indicative of Feigning or Exaggeration

3. Invalid Psychiatric Presentation (One or both of a or b must be present)

- a. One or more compelling inconsistencies pertaining to psychiatric symptoms are observed or documented during the evaluation
- b. Psychometric evidence of exaggerated somatic symptoms on SVT's

4. Invalid Mixed Symptom Presentation



Update to **Slick Criteria (cont.)**

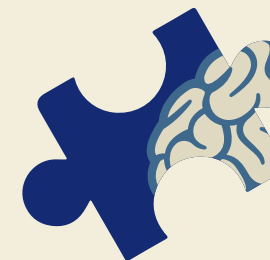
- C. Marked Discrepancies (One or more discrepancy obtained from the following)
 1. Natural history and pathogenesis of the condition in question
 2. Records and other media
 3. Reliable collateral informant report

- c. Behaviors Meeting Criterion B are Not Fully Accounted for by Another Developmental, Medical, or Psychiatric Condition



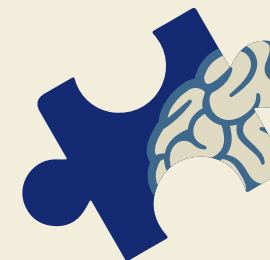
Systematic **Approach**

- 01** | **Clinical Suspicion**
- 02** | **Determine Presence of Malingering**
- 03** | **Evaluate & Compare**
- 04** | **Determine Genuine Abilities**
- 05** | **Communicating Findings**



Systematic **Approach**

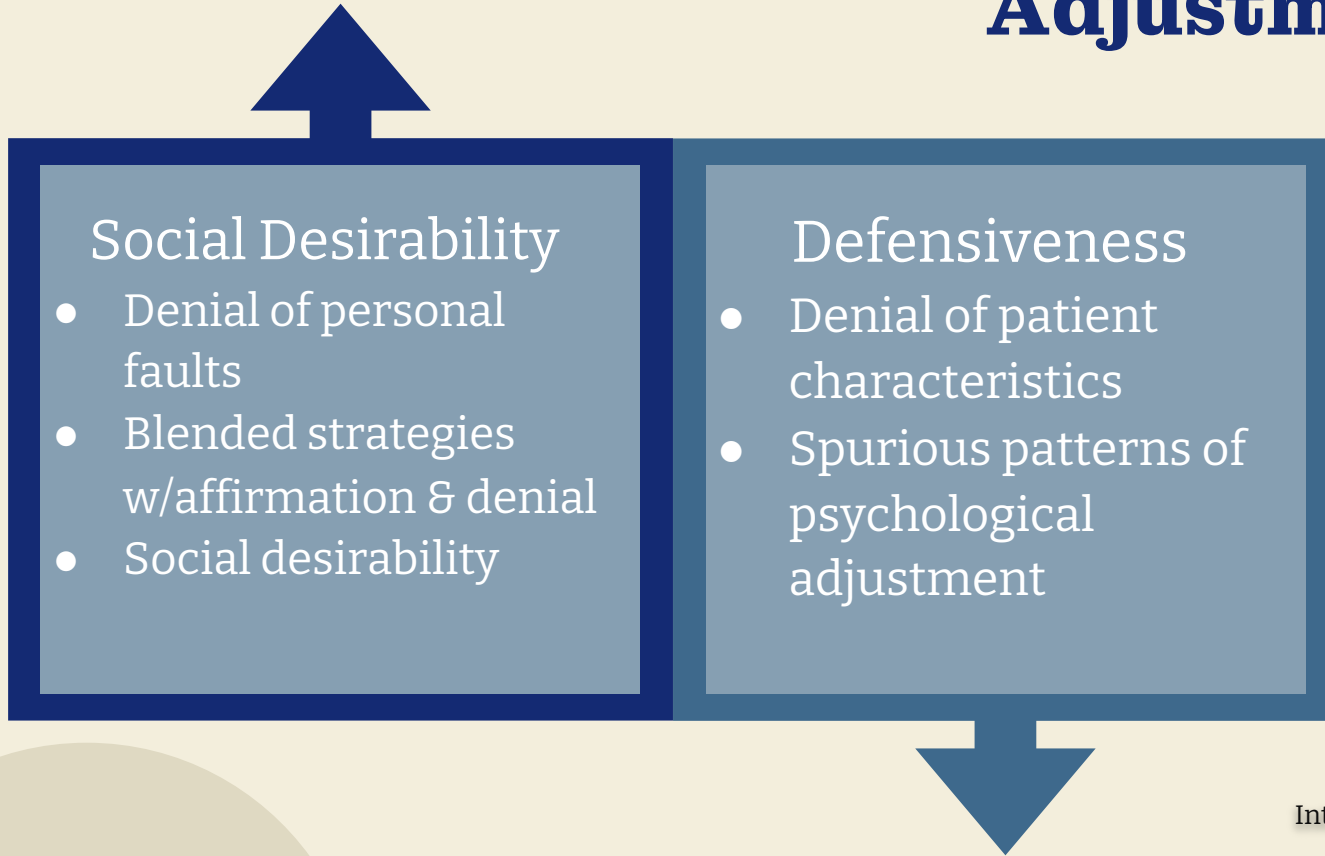
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Presentations found in **Feigning**

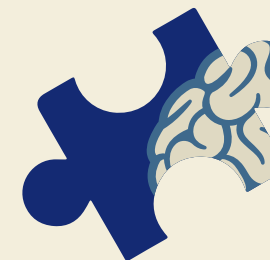
Domain	Mental Disorder	Cognitive Impairment
Unlikely Presentations	<ul style="list-style-type: none">● Rare symptoms● Quasi-rare symptoms● Improbable symptoms● Spurious patterns of psychopathology	<ul style="list-style-type: none">● Magnitude of error● Performance curve● Violation of learning principles
Amplified Presentations	<ul style="list-style-type: none">● Indiscriminate symptom endorsement● Symptom severity● Reported vs. observed symptoms● Erroneous stereotypes	<ul style="list-style-type: none">● Floor effect● Significantly below chance performance

Detection Strategies for **Simulated Adjustment**



Systematic **Approach**

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Determine Presence of Malingering:

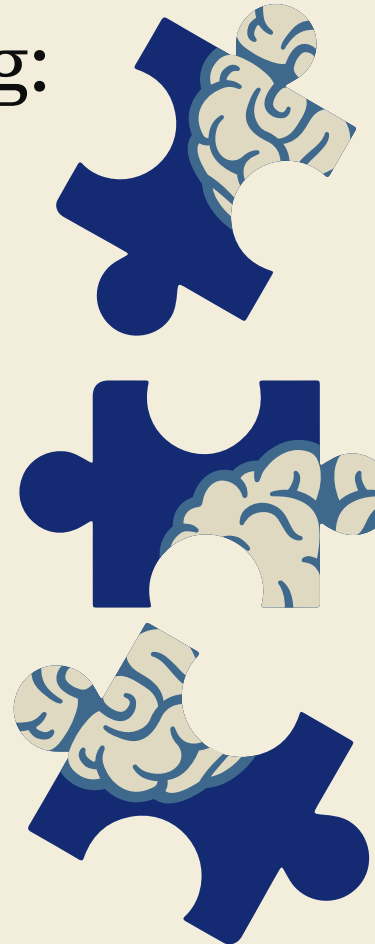
Clinical Interview

Compare and Contrast:

- Records
- Collateral Information
- Clinical Interview
- Behavioral Observations
- Previous Test Results

Consider

- Context of Evaluation
- Issues of Diversity
- Rapport
- Reason for Referral
- Lower Cognitive Functioning

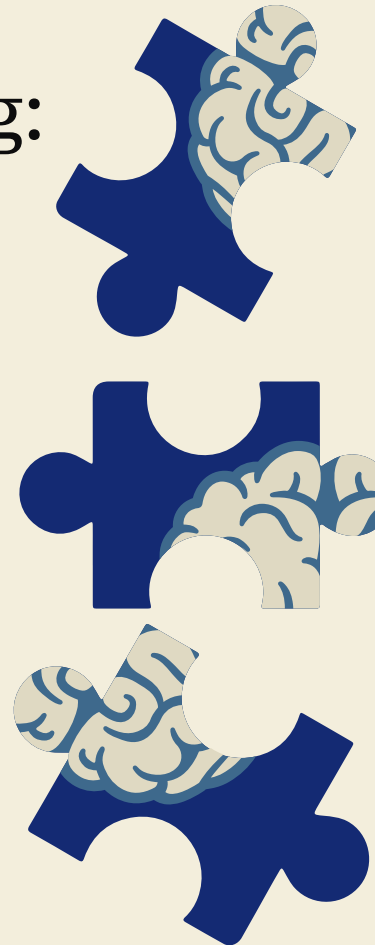


Determine Presence of Malingering: **Test Instruments**

- Use of test instruments helps alleviate examiner bias
- Compares scores to normative samples
- Adds objective and standardized measures

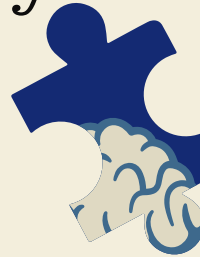
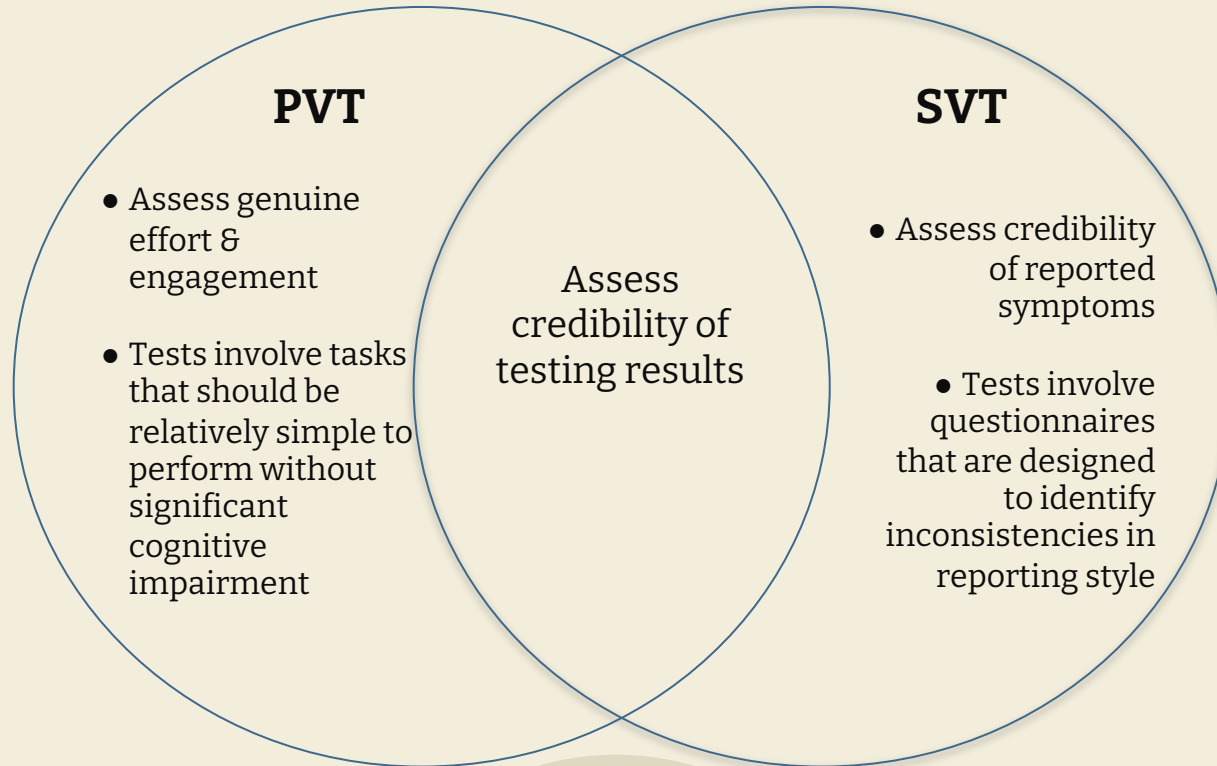
Caveats:

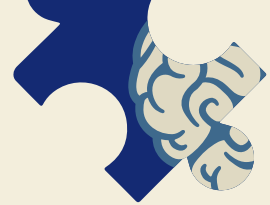
- Normative Samples
- Sensitivity/Specificity
- Criterion Validity



Performance Validity

vs. Symptom Validity

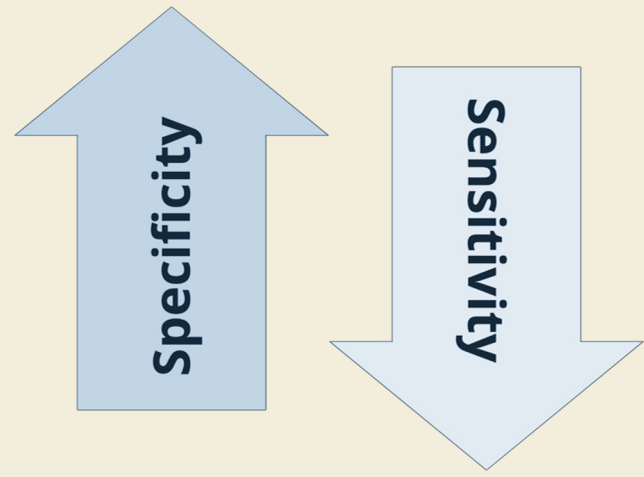




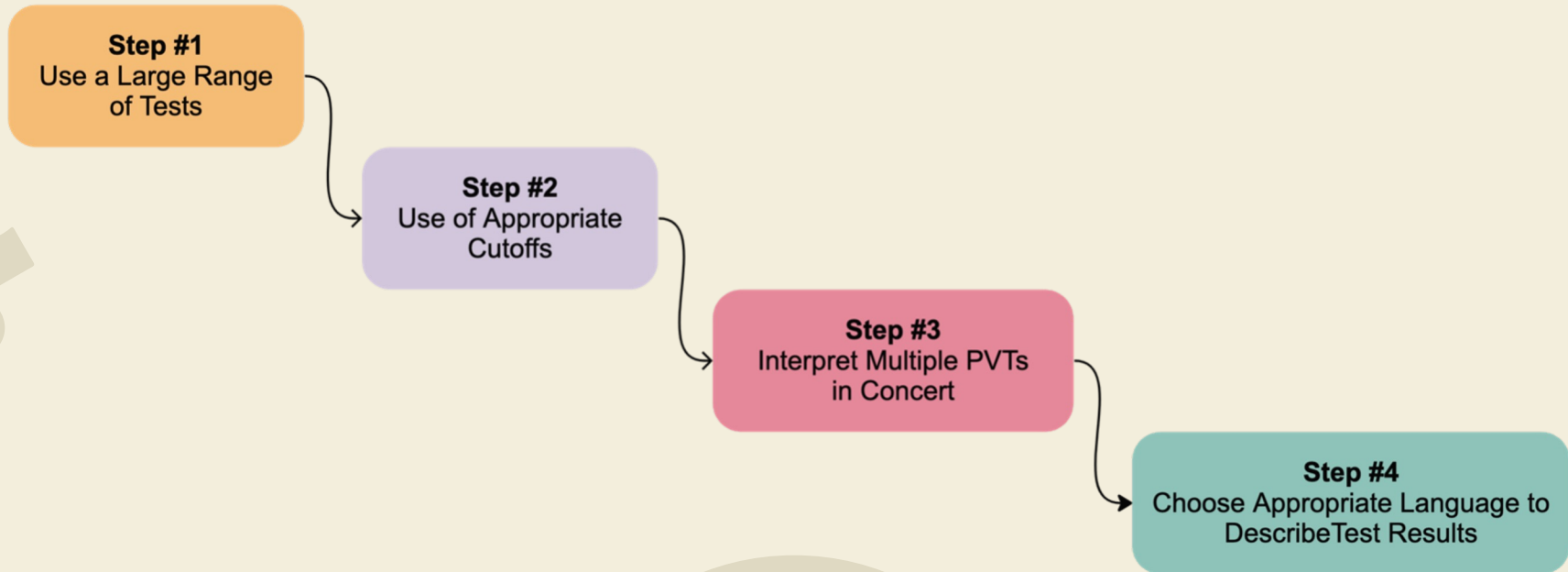
Choosing Tests:

Statistical Terminology

- Sensitivity
 - Percentage of non-credible individuals detected as non-credible (True Positives)
- Specificity
 - Percentage of individuals who are correctly classified as credible (True Negatives)
- Sensitivity < Specificity (90%+)

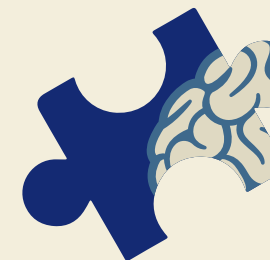


Appropriate PVT Administration & Interpretation: **Step-by-Step Guide**



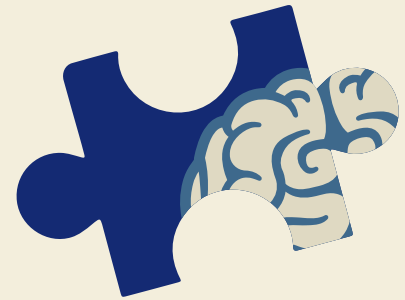
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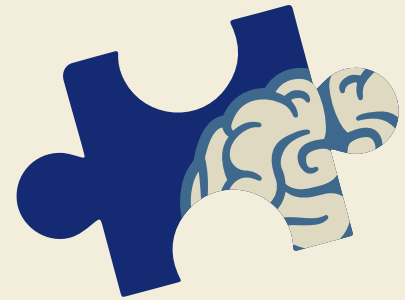
Evaluate & Compare

- Evaluate performance across SVT & PVT measures
 - Cut-offs, elevations, level of effort
 - Rare or improbable symptoms
- Compare performance across measures
 - Are there any discrepancies?
 - If so, do they make sense?
- Remember: Don't Generalize
 - E.g., invalid responses on personality measures does not mean that cognitive testing is invalid



Determine Genuine **Abilities/Symptoms**

- Behavioral observations
 - “Casual” conversations during breaks
 - Observations of behavior with admin/staff
- Collateral interviews
 - E.g., Admin/staff, teachers, family, etc.
- Compare performance and behavioral observations
 - E.g., Rare symptoms vs. functioning
- Compare performance and gathered information
 - Use self-reported history/symptoms, collateral information



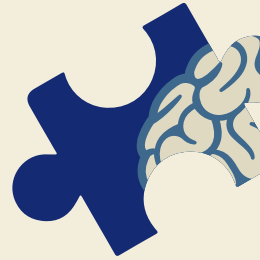
Caveat



- There is no “test for malingering”
- There are instruments that compare scores to populations and explore feigned or exaggerated symptoms, levels of effort, and response styles
- Clinicians need to use use a **multi-test** and **multi-method** approach

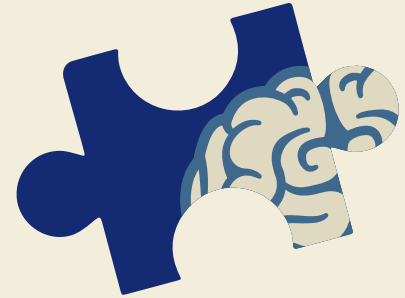
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Communicating **Findings**

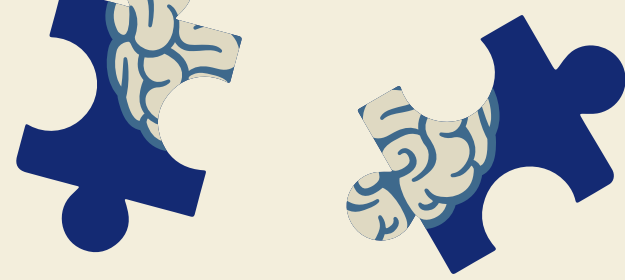
- Audience/Reader
 - Do they have an accurate understanding of malingering?
 - Use of other verbiage
- Time Since the Evaluation
 - Malingering is not permanent
 - Possible changes since the evaluation
- Context of the Referral Question
 - Is malingering an integral aspect of your response/opinion?



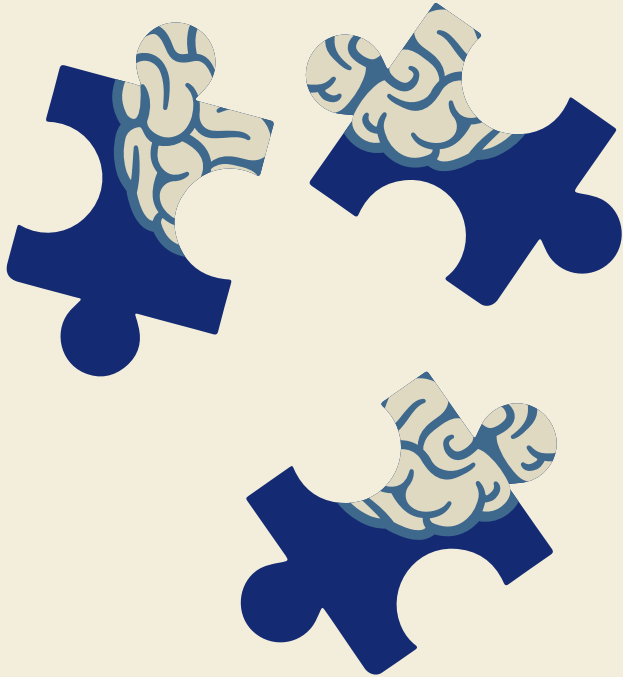
05

Common **Tests**

Practical Application



Options



Response Style/Validity Scales

(e.g., MMPI-3, PAI, MCMI)

Embedded Measures

(e.g., WAIS-IV, RCFT, ECST-R)

Performance Validity

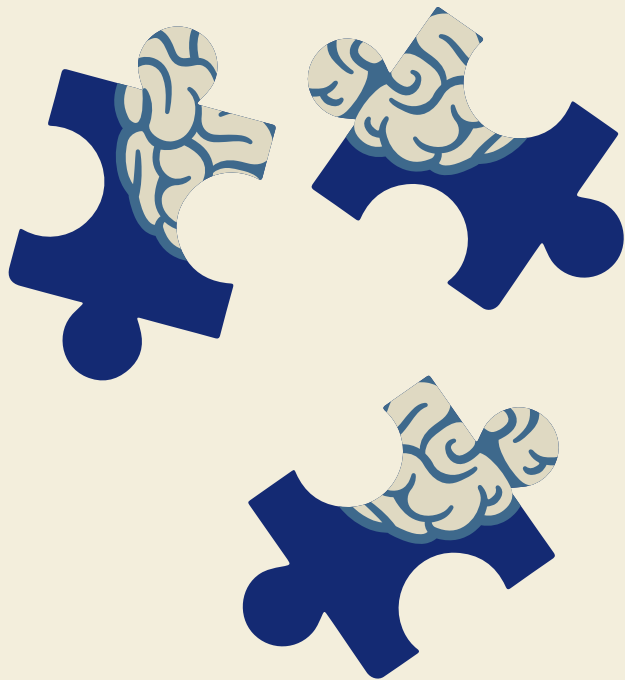
Tests

(i.e. effort)

(e.g., Rey-15, DCT, TOMM)

Symptom Validity Tests

(e.g., MENT, SIRS-II, SIMS)



Response Style/Validity Scales

(e.g., MMPI-3, PAI, MCMI)

Embedded Measures Performance Validity

(e.g., WAIS-RCPT, ECST-R)

Tests

(e.g., Rey-15, DCT, TOMM)

Symptom Validity Tests

(e.g., MENT, SIRS, SIMS)

Minnesota Multiphasic Personality Inventory (**MMPI-3**)

- Psychometric test for personality traits and psychopathology
- Ages 18 + | 35-50 minutes
- Validity Scales
 - Response Patterns
 - VRIN: random responding
 - TRIN: item pairs (“yea-saying” or “nay-saying”)
 - Overreporting
 - F: overall psychopathology
 - Fb: 2nd half psychopathology
 - Fp: infrequent psychopathology
 - Ds: “faking bad”
 - Underreporting
 - L: “lie scale;” uncommon virtues
 - K: self-deception
 - S: superlative self-presentation



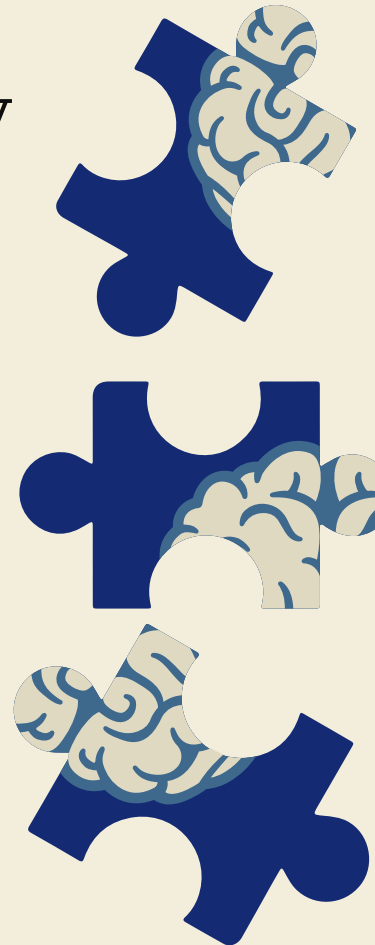
Personality Assessment Inventory (PAI)

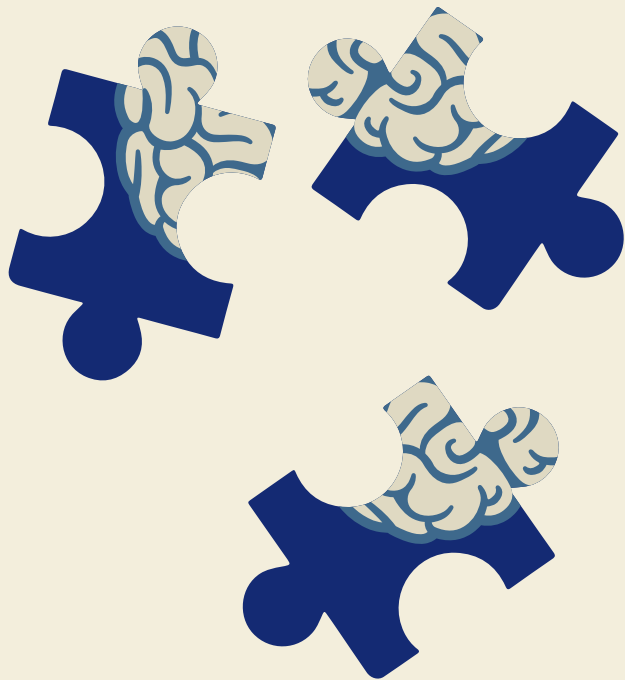
- Psychometric test for personality traits and psychopathology
- Ages 18 + | 50-60 minutes
- Validity Scales
 - ICN: Inconsistency
 - INF: Infrequency
 - NIM: Negative impression management
 - PIM: Positive impression management
 - Supplemental Indices



Millon Clinical Multiaxial Inventory (MCMI-IV)

- Measure of personality and symptom dynamics
- Ages 18 + | 25-30 minutes
- Validity Scales
 - X: Disclosure
 - Y: Desirability
 - Z: Debasement
 - V: Invalidity
 - W: Inconsistency





Response Style/Validity Scales

(e.g., MMPI-3, PAI, MCMI)

Embedded Measures

Performance Validity

(e.g., WAIS-IV, ECST, ECST-2)

Tests

(e.g., Rey-15, DCT, TOMM)

Symptom Validity Tests

(e.g., MENT, SIRS, SIMS)

Wechsler Adult Intelligence Scale **(WAIS-IV)**

- Measure of intelligence and cognitive ability
- Ages 16-90 years, 11 months | 60-90 minutes
- Embedded measures
 - Reliable Digit Span
 - Also consider:
 - Floor effect
 - Significantly below-chance performance
 - Performance curves
 - Magnitude of error



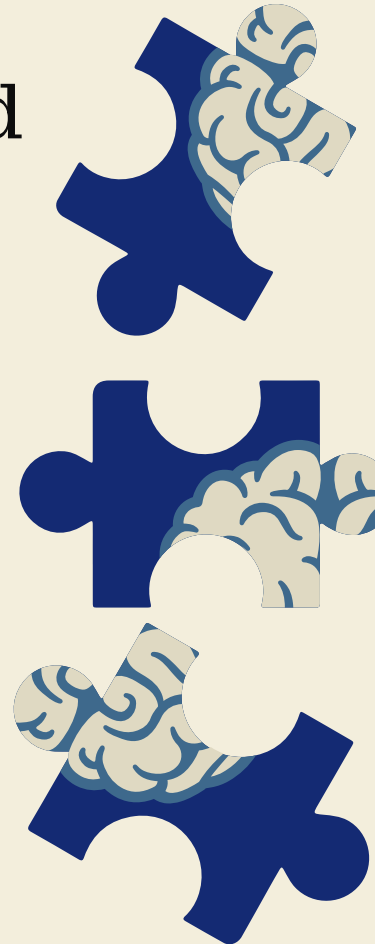
Rey Complex Figure Test (RCFT)

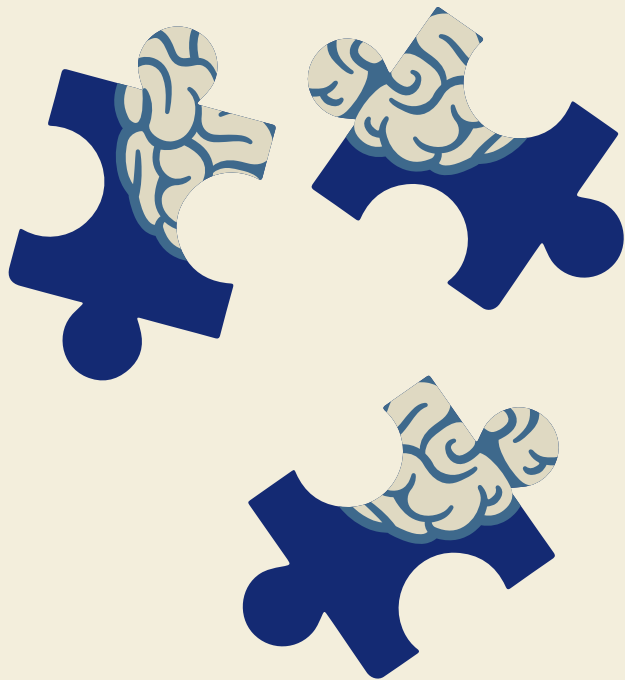
- Neuropsychological assessment tool
- Ages 6-89 years | 45 minutes (including delays)
- Embedded measures
 - Forced Choice Recognition Trial (FCR)



Evaluation of Competency to Stand Trial (**ECST-R**)

- Semi-structured interview
- Ages 18-87 years | 25-45 minutes
- Embedded scales of atypical responding
 - Realistic
 - Psychotic
 - Nonpsychotic
 - Impairment
 - Both (Psychotic and Nonpsychotic)





Response Style/Validity Scales

(e.g., MMPI-3, PAI, MCMI)

Embedded Measures Performance Validity

(e.g., WAIS, RCP, ECST-R)

Tests

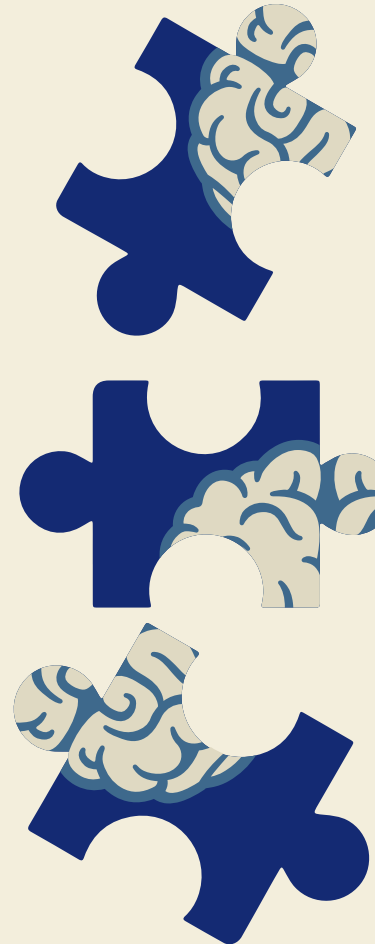
(e.g., Rey-15 DCT, TOMM)

Symptom Validity Tests

(e.g., MENT, SIRS, SIMS)

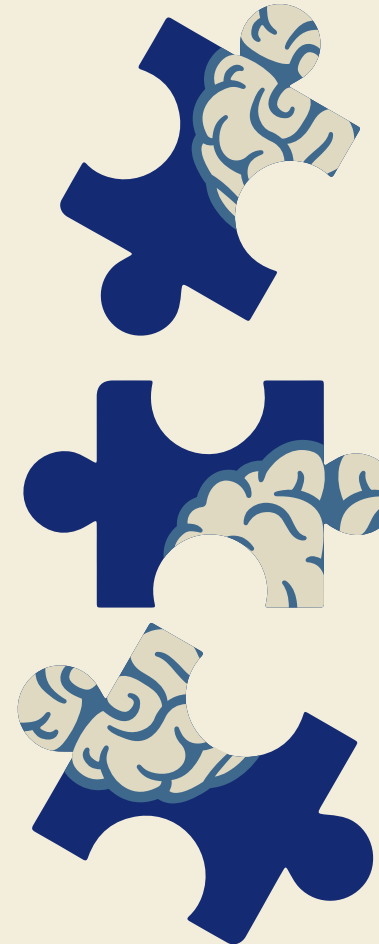
Rey 15-Item Test (FIT)

- Neuropsychological assessment tool often used to assess feigned memory impairment
- Ages 11+ | 5 minutes
- Validity
 - Suggested Cutoffs
 - 9/15 = Suspect Effort (Lezak et al., 2004)
 - 7/15 (Lee et al., 1992); 8/15 (Bernard & Fowler, 1990; Schretlen et al., 1999)



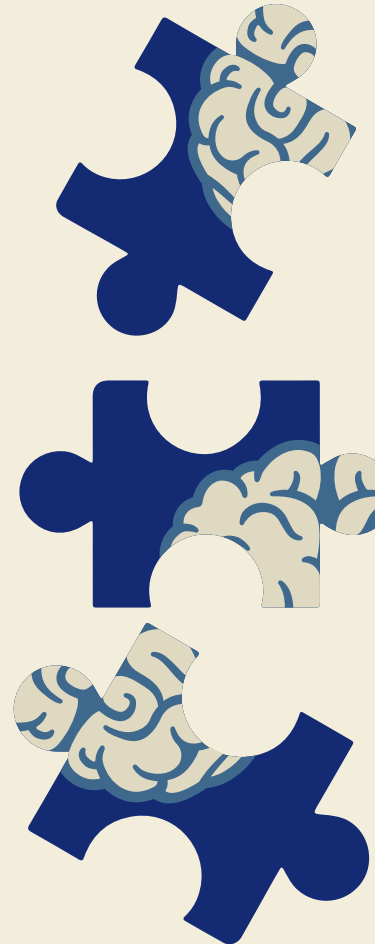
Dot Counting Test (DCT)

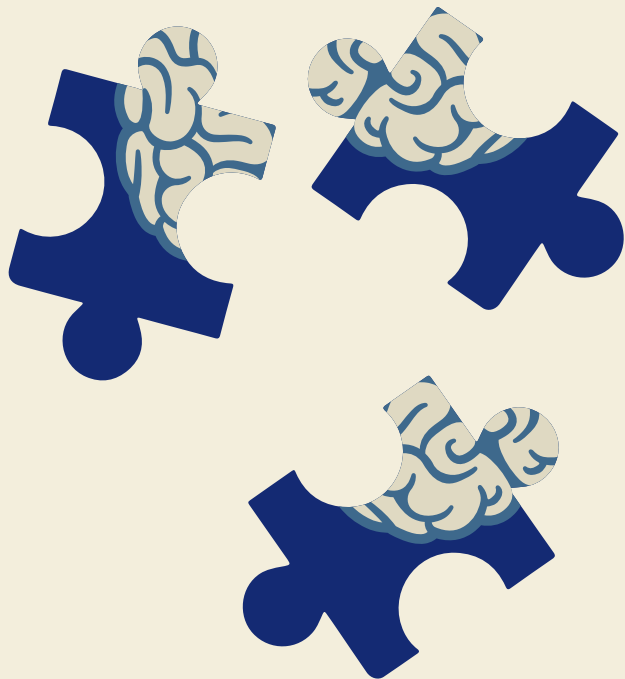
- Designed to assess test-taking effort
- Ages 17 + | 5-15 minutes
- Validity
 - “E-Score” Cutoff Comparison Groups
 - Depression
 - Schizophrenia
 - Head Injury, Stroke
 - Learning Disability
 - Nonclinical Comparison Groups



Test of Memory Malingering (TOMM)

- Visual recognition test designed to differentiate between malingered and real memory impairment
- Ages 16-84 years | 10-20 minutes
- Validity
 - Cutoff score of ≤ 45 for either Trial 2 or Retention





Response Style/Validity Scales

(e.g., MMPI-3, PAI, MCMI)

Embedded Measures Performance Validity

(e.g., WAIS, RCP, ECST-R)

Tests

(e.g., Rey-15, DCT, TOMM)

Symptom Validity Tests

(e.g., MENT, SIRS, SIMS)

Morel Emotional Numbing Test (MENT)

- Designed to aid in differentiating simulated symptoms of PTSD from genuine symptoms
- Ages 18-87 | 5-15 minutes
- Available in 13 languages
- Validity
 - Cutoff score



Structured Interview of Reported Symptoms (**SIRS-2**)

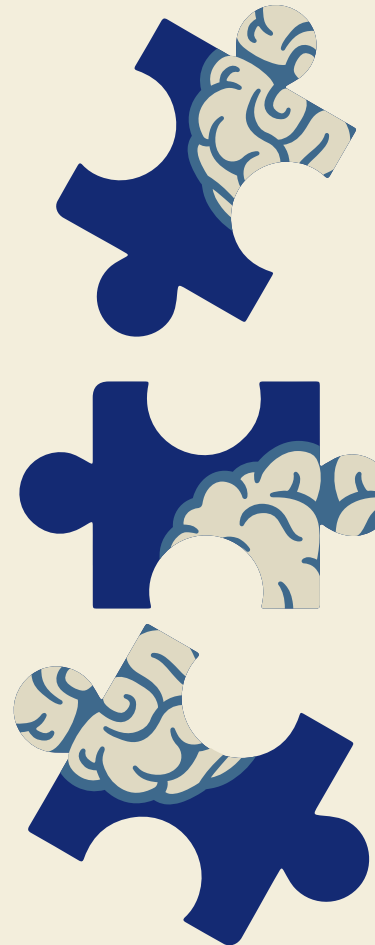
- Designed to assess feigning of psychopathology (FULLY structured - Don't go off script!)
- Ages 18-100 years | 30-40 minutes
- Primary Scales (each different cutoffs- decision tree)
 - Rare symptoms (RS)
 - Symptom Combination (SC)
 - Improbable/Absurd Symptoms (IA)
 - Blatant Symptoms (BL)
 - Subtle Symptoms (SU)
 - Severity of Symptoms (SEV)
 - Selectivity of Symptoms (SEL)
 - Reported vs. Observed Symptoms (RO)



Structured Inventory of Malingered Symptomatology

(SIMS)

- Designed to assess both malingered psychopathology and neuropsychological symptoms
- Ages 18 + | 10-15 minutes
- Scales
 - Psychosis
 - Neurological Impairment
 - Amnestic Disorders
 - Low Intelligence
 - Affective Disorders





**HONORABLE
MENTION**

Embedded

- Wechsler Memory Scales (WMS)
- Advanced Clinical Solutions (ACS)
- Wisconsin Card Sorting Test (WCST)
- Trail Making Test (TMT)
- Conners Continuous Performance Test (CPT)
- Repeatable Battery for the Assessment of Neuropsychological Status (RBANS)
- California Verbal Learning Test (CVLT)

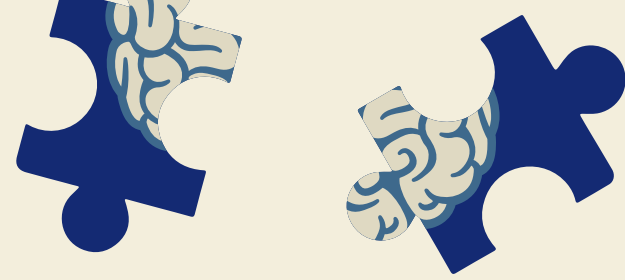
SVT/PVT Stand alone tests

- The B Test
- Validity Indicator Profile (VIP)
- Memory Validity Profile (MVP)
- Victoria Symptom Validity Test (VSVT)
- Dr. Green Tests
- Miller Forensic Assessment of Symptoms (M-FAST)
- Malingering Probability Scale (MPS)
- Inventory of Legal Knowledge (ILK)

06

Challenges & Recommendations

& Future Directions...





Challenges & What to Do About Them

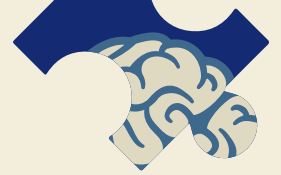
- False positives & negatives
- Test sensitivity
- Cultural & linguistic factors
- Comprehension challenges
- Response style variability
- Coaching
- Motivation & cooperation
- Time & Resources
- Ethical considerations
- Overemphasis on SVTs
- Stigma

A Avoid accusations of lying

B Beware of countertransference

C Clarification, not “confrontation”

S Security measures



General **Recommendations**

Incorporate:

- Record review
- Clinical interview
- Observations
- Collateral
- Testing
- Assessments

Using assessments:

- Stay up to date on literature / research
- Consider feigning of cognitive psychiatric and/or behavioral symptoms
- Use a multi-method (not just multi-test) approach
- “Consistently look for consistency”
- Honesty and good effort
- Psychometric properties (specificity vs. sensitivity)

Future **Directions**

Cross-Culture

How does malingering manifest across culture?

Cognitive Processes

What cognitive processes are involved in malingering?

Transparency

Movement away from non-transparent measures

Clinical Applications

Develop & validate interventions for those identified as malingers.

Improving Ax

Enhancing sensitivity & specificity in detecting malingering

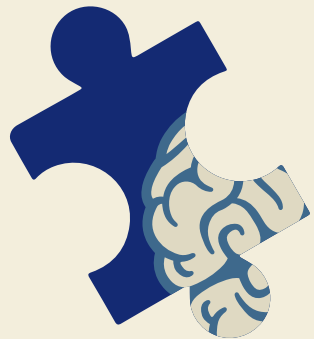
Dimensionality

Malingering may be more dimensional than taxonomic which may change the way we use SVTs



Questions?





Thank
You!

Do you have any questions?
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www.psychassessment.us

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