



PII S0887-6177(98)00049-3

Comment: Warning Malingerers Produces More Sophisticated Malingering

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Warning persons that attempts to malingering on neuropsychological testing will be detected is not an effective way of reducing malingering behavior. Rather, the literature on coaching consistently shows that malingerers who are warned of the presence of symptom validity assessment techniques are able to feign deficits in a less exaggerated and more believable fashion and therefore elude detection. Warning persons about the presence of these techniques reduces the validity and scientific quality of forensic evaluations. Rather than warning persons that they will be caught if they try to malingering, we recommend that persons be told to do their best and that forensic examiners encourage maximum effort, consistent with accepted testing practices and test manual instructions. © 1999 National Academy of Neuropsychology. Published by Elsevier Science Ltd

Johnson and Lesniak-Karpiak (1997) recently investigated the effect of warning malingerers that their efforts at simulation of traumatic brain injury may be detected. They demonstrated that those analog malingerers who were cautioned about the presence of techniques to detect faking and exaggeration improved their performances on some neuropsychological tests over those who were not warned. This led to 45% of the warned malingerers being misclassified as controls. The authors suggested that providing a warning prior to testing may be an effective way of reducing malingering behavior. They went on to recommend that forensic examinees be informed of the use of techniques to detect faking or exaggeration in order to reduce malingering behavior and increase validity of test data.

We are concerned that the authors may not have interpreted their data correctly and that they may be making a recommendation that will reduce the scientific quality of forensic evaluations. Careful inspection of Johnson and Lesniak-Karpiak's (1997) results reveals that on none of the tests did the warned malingerers perform as well as the controls. Instead, their averaged performances consistently suggested mild impairment relative to the control group. Indeed, the warned malingerers performed significantly more poorly than the controls on three out of five WMS-R indices. Their Manipulation Check section demonstrates that both of the malingering groups complied with the experimental instructions, that is, to exaggerate in a believable fashion and not to fake too obviously. Consequently, the more likely interpretation of Johnson and Lesniak-Karpiak's data is that the warned malingering group was able to feign deficits in a less exaggerated and more believable fashion than those who were not warned about measures of malingering.

Beginning the evaluation by telling the patient that malingering will be detected may be ill-advised. The concern is with how some examinees will interpret these warnings, however politely presented. Many patients may be insulted by this sort of warning. Additionally, it is a misrepresentation to claim that we will be able to detect malingering when the truth is that the state of the art is quite imperfect, sometimes working quite well to detect malingering and at other times resulting in false negatives. To some extent, the claim that deception will be detected is a bluff. Despite substantial progress in recent years, at the current level of scientific knowledge we do not know the underlying base rate of malingering, we do not know how many times we are deceived, and some of our tests which indicate deception may entail an unclear number of false positives.

Following Johnson and Lesniak-Karpiak's (1997) recommendation to warn forensic examinees about symptom validity techniques may produce more sophisticated malingering instead of reducing malingering. Thus, rather than increasing the validity of forensic neuropsychological evaluations, warnings about validity assessment procedures may inadvertently produce precisely the opposite result.

Studies where malingerers have been informed of the presence of techniques to detect exaggeration and/or faking have consistently shown that coached malingerers successfully modify their response patterns to appear more like patients with actual disorders, plus they improve their chances of avoiding detection of their simulation efforts. Rose, Hall, Szalda-Petree, and Bach (1998) examined genuine traumatic brain injury subjects (TBI) and compared them to two groups of analog malingerers, one simply told to fake deficits and the other given information on the effects of head injury (HI), told not to fake too obviously, and told that major exaggerations are easy to detect. They found that coached subjects were better able than their uncoached counterparts to avoid detection on all measures.

Martin, Bolter, Todd, Gouvier, and Niccolls (1993) administered a forced-choice symptom validity test to genuine TBI subjects and two groups of analog malingerers, one told simply to fake deficits and the other told to fail more difficult items than easy ones and to perform at better than chance levels. The uncoached malingerers performed well below chance on the test and the coached group performed much better, although not so well as the genuine TBI group.

A number of investigators have examined the effects of informing analog malingerers of the presence and nature of validity scales on the MMPI-2. Lamb, Berry, Wetter, and Baer (1994) told their uncoached analog malingering group simply to fake believable deficits likely to be present after a HI. They had three groups of coached malingerers. One group was given specific information on the symptoms of HI. One was given specific information regarding the MMPI-2 validity scales. A third coached group was given

information on both MMPI-2 validity scales and HI. They found that providing MMPI-2 validity scale information consistently lowered validity scale elevations, making those groups more likely to successfully elude detection. Only providing information on HI, on the other hand, resulted in increased MMPI-2 validity scale elevations. These results led to a debate in the literature, with one side taking the position that this kind of research could be misused and that informing subjects of the presence of validity scales potentially violated American Psychological Association Ethical Principles on maintaining test security (Ben-Porath, 1994). The other side indicated that this type of coaching was already taking place in clinical settings, so we had better learn more about the effects of it (Berry, Lamb, Wetter, Baer, & Widiger, 1994).

Rogers, Bagby, and Chakraborty (1993) conducted a similar study on the effects of coaching persons feigning schizophrenia on the MMPI-2. In addition to a group of genuine schizophrenics, four analog malingering groups were examined. Their malingering groups included subjects coached on the symptoms of schizophrenia, subjects informed of strategies for the detection of fakers, subjects given both types of information, and subjects told to feign schizophrenia in the absence of information. They found that knowledge of detection strategies alone allowed many simulators to elude detection. By contrast, knowledge of the disorder appeared less useful to simulators in avoiding detection. Coaching on both symptoms and detection strategies also was not as effective as knowledge of detection strategies alone.

Baer, Wetter, and Berry (1995) examined this issue from another angle. They looked at the effects of coaching on the MMPI-2 scales sensitive to the underreporting of psychopathology, or faking good. Specifically, they examined three analog faking good groups, one given no information, a low-detail group that was only told that these scales were present, and a high-detail group that was informed regarding the nature and function of the underreporting scales. They found that both of the coached faking good groups were able to decrease the elevations of both the validity scales for underreporting and the clinical scales relative to the uncoached group and, therefore, more successfully elude detection. The differences between the low-detail and the high-detail groups were not significant. The authors interpreted their results as suggesting that "minimal knowledge about the existence and purpose of the validity scales may be sufficient to allow some subjects to fake convincingly" (Baer et al., 1995, p. 197).

We view the Johnson and Lesniak-Karpiak (1997) study as a replication of these other investigations. The information that they provided to their warned malingering group was quite similar and in some cases essentially identical to the information provided in many of the analog coached malingering studies described above. The effect of the information provided was also similar, with the warned malingerers performing better than those who were not warned, but still worse than the controls, that is, more like patients with genuine TBI. The high misclassification rate that they reported for their warned malingering group demonstrates that providing this information is likely to enable malingerers to successfully elude detection.

The practice of attorneys coaching their clients prior to examination undermines the validity of psychometric evidence, and is increasingly being recognized as a problem in the forensic arena (e.g., Lees-Haley, 1997a; Pope, Butcher, & Selen, 1993; Rosen, 1995; Taylor, Harp, & Elliot, 1992; Wetter & Corrigan, 1995; Youngjohn, 1995; Ziskin & Faust, 1988). In addition, patients sometimes are coached by persons examined in similar litigation, for example, co-plaintiffs in mass torts. For example, support groups in disasters and litigation-related meetings in mass tort settings sometimes include coaching, suggestion, and influences on the language used to characterize events, as well as influencing causal attributions and expectations for the future (e.g., see Lees-Haley, 1997b;

Rosen, 1995, 1996). The validity of forensic neuropsychological evaluations will be further jeopardized if psychologists also begin engaging in this practice. As Ben-Porath (1994) notes, providing this information to clinical or research subjects may also be in violation of American Psychological Association Ethical Principles (American Psychological Association, 1992).

To the extent that we are striving for accurate diagnosis and external validity—generalizing from our findings—our evaluation should be a sample of the examinee's behavior in general. Thus, efforts to alter the examinee's typical behavior serve to render our sample atypical. If the examinee is malingering with other doctors, at work, in depositions, and so on, we still want to make valid measurements but we do not want to create misleading impressions that such an individual is reliable when that is clearly not the case.

CONCLUSION

Johnson and Lesniak-Karpiak's (1997) goal of reducing malingering is commendable. However, we are skeptical that advising a deceitful individual to be honest is a reliable procedure for producing full effort, particularly when handled in the manner suggested by Johnson and Lesniak-Karpiak. To the contrary, we feel that following their recommendation to alert the examinee of the presence of symptom validity measures is not the way to achieve full cooperation.

We suggest two alternative methods of eliciting good motivation in evaluations that may have forensic implications. (Almost any exam following a motor vehicle accident or work-related injury eventually will have forensic implications.) We recommend that examinees be asked if there is anything limiting their ability to answer all questions accurately to the best of their knowledge, or anything besides their injury limiting their ability to put forth their best effort on performance tests. Thereafter, the issue of symptom validity should not be emphasized or reemphasized during the course of the evaluation. Alternatively, they can be asked to agree to try their best and to inform the examiner if anything occurs which prevents them from doing so. We further recommend that examinees be encouraged to put forth their best effort and helped to maintain their motivation on tests just as we do in clinical and educational settings. Note that these recommendations are consistent with generally accepted testing practices in neuropsychology and with instructions for test administration as set forth in the manuals for widely used tests (e.g., Reitan & Wolfson, 1985; Wechsler, 1997a, 1997b). These methods encourage good effort without violating the security or reducing the sensitivity of symptom validity measures.

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