You Can’t Fool a Neuropsychologist!
The Importance of Performance Validity Testing (PVT) in Evaluations

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Psychology of Lying

• False statements and any form of behavior with the **intention** to make others form false beliefs about health and cognition
  – Omissions
  – Withholding information

• Purpose
  – Deviant behavior
  – Socially useful behavior

(Seron, 2014)
Psychology of Lying (cont’d)

• De Paulo and colleagues (1996)
  – College students
  – Community residents
    • Daily record for a week
      – Intentionally trying to mislead someone
  – College students → 2 lies/day or 1/3 interactions
  – Community residents → 1 lie/day or 1/5 interactions
Purpose of Lying

• Most frequently
  – Feelings
  – Preferences
  – Attitudes
  – Opinions
  – Achievements
  – Failures

• Less frequently
  – Actions
  – Plans
  – Whereabouts

(Seron, 2014)
Development

• Pre-school and early primary school years (Talwar et al., 2007)

• Associated with
  – Conceptual moral understanding of lies
  – Executive functioning
  – Theory-of-mind understanding

(Seron, 2014)
Lie Production

- **Fantasy-prone individuals** (Merckelbach, 2004)
  - Emotional
  - Plausible
  - Richer

- **High Emotional IQ (EI)** (Porter et al., 2008)
  - Perceive, process, manage, and regulate emotion
  - Deceptive facial expressions

- **Personality traits** (Grieve, 2011)
  - Efficient emotional manipulation
Lie Detection

• Ekman and O’Sullivan (1991)
  – Secret service agents
  – Psychiatrists
  – Judges
  – Police officers
  – Polygraph examiners
  – College students
Lie Detection (cont’d)

• Good liars
  – Positive but small correlation

• 54% correct judgments with bias towards truthful (Vrig, 2008)

• High EI
  – Impairment in evaluating sincerity (Baker et al., 2013)
Lie Detection (cont’d)

• **Stereotypical cues** *(Vrig, 2008)*
  – Nervous
  – Hesitant speech output
  – Increased speech rate
  – Averted gaze
  – More body movements

• **Liars** *(Vrig, 2000)*
  – Less time to respond to questions
  – Speak about themselves less
Neuropsychological Assessment

• Assess cognition to answer referral questions
  – Decline from previous level of functioning
  – Worker’s compensation
  – Competency to stand trial

• Interpretations and conclusions contingent on validity of the data
Why poor effort/exaggeration?

• Legal motives
  – Personal injury
  – Worker’s compensation
  – Criminal cases

• Other motivational factors
  – Uninterested in testing
  – Obtain medication
Why poor effort/exaggeration? (cont’d)

• Depression → pervasive negativism and cognitive distortions → exaggerated self-reported symptoms

• Chronic pain → environmental factors and social reinforcement → exaggerated verbal and nonverbal behaviors
Why poor effort/exaggeration? (cont’d)

• Fear symptoms dismissed/minimized

• Gain sympathy/help from medical professionals

• Influence dynamics of the doctor-patient relationship
Malingering

• **Intentional** production of false or exaggerated symptoms motivated by external incentives

• Diagnostic criteria for Malingering Neurocognitive Dysfunction (MND) (Slick et al., 1999)
Definite MND (Slick et al., 1999)

• Substantial external incentive (Criterion A)

• **Definitive negative response bias** (Criterion B1)

• Not accounted for
  – Psychiatric
  – Neurological
  – Developmental factors (Criterion D)
Probable MND (Slick et al., 1999)

• Substantial external incentive (Criterion A)

• 2+ from testing EXCLUDING definite negative response bias (Criteria B2-B6)

  OR

  1 from testing and 1 from self-report (Criteria C1-C5)

• Not accounted for
  – Psychiatric
  – Neurological
  – Developmental factors (Criterion D)
Possible MND (Slick et al., 1999)

• Substantial external incentive (Criterion A)

• Evidence from self-report (Criteria C1-C5)

• Not fully accounted by
  – Psychiatric
  – Neurological
  – Developmental factors (Criterion D)

OR

• Criteria for Definite or Probable MND met EXCEPT primary psychiatric, neurological, or developmental etiologies cannot be ruled out
Criteria A – Substantial External Incentive

- Personal injury settlement
- Disability pension
- Evasion of criminal prosecution
- Release from military service

(Slick et al., 1999)
Criteria B – Evidence from Testing

1. Definite response bias
2. Probable response bias
3. Test data and known patterns of brain functioning
4. Test data and observed behavior
5. Test data and reliable collateral reports
6. Test data and documented background history

(Slick et al., 1999)
Criteria C – Evidence from Self-Report

1. Discrepant with documented history
2. Discrepant with known patterns of brain functioning
3. Discrepant with behavioral observations
4. Discrepant with information obtained from collateral informants
5. Evidence of exaggerated or fabricated psychological dysfunction

(Slick et al., 1999)
Criteria D - Behaviors

• Behaviors meeting necessary criteria from groups B or C are NOT fully accounted for by
  – Psychiatric
  – Neurological
  – Developmental factors

(Slick et al., 1999)
(Slick et al., 1999)
Key Considerations

• Failure to meet proposed criteria **DOES NOT** constitute conclusive evidence that NOT malingering

• **CANNOT** automatically conclude that **NOT** malingering if “pass” effort measures
American Academy of Clinical Neuropsychology (AACN) Consensus 2009

• Intent may be inferred as combined improbability of events rather than a single indication of intent
  – Real-world observations and either test performance or self-report
  – Type or severity of injury and test performances
  – Individual’s behavior when aware being evaluated vs. when not aware being evaluated
  – Inconsistency across serial testing that cannot be explained by neurological process or psychiatric condition
Consequences of Inadequate Effort

- Unjust monetary awards
- Avoidance of criminal prosecution
- Attainment of worker’s compensation
- Access to limited resources
- Failure to receive accurate diagnosis
Consequences of Inadequate Effort (cont’d)

• Horner and colleagues (2014)
  – 355 Veterans
    • 80% adequate effort
    • 20% inadequate effort

  – Healthcare utilization
    • Emergency Department visits
    • Inpatient hospitalizations
    • Inpatient days
    – Inadequate effort group = overuse of resources
Consequences of Inadequate Effort (cont’d)

• Additional resources for diagnostic clarification

• Treatment for inaccurate diagnosis

• “Marker” for general lack of full cooperation

(Horner et al., 2014)
Psychometric Assessment of Effort

- Performance Validity Tests (PVTs)
  - Assess actual abilities

- Symptom Validity Tests (SVTs)
  - Assess actual symptom experience

50+ measures in Neuropsychological Assessment (Lezak et al., 2012)
PVTs

• Stand-alone measures
  – Forced-choice
    • Significantly below chance performance evidence of deliberate under-performance
  – Non-forced choice
    • Random responding
    • Unrealistically slow or erroneous responding
    • Inconsistent response pattern relative to known patterns for disorder
PVTs (cont’d)

• Embedded Measures
  – Indicators specifically developed for such measurement
  – Scores found in post-release research to be sensitive to insufficient effort
SVTs

• Validity of self-report via response bias
• Disorder-specific inventories
• Embedded within personality inventories
• Inventories/checklists that do not have effective means of determine response bias/invalidity → DO NOT use in isolation
Survey of Beliefs and Practices

- Mittenberg and colleagues (2002)
  - 144 members of American Board of Clinical Neuropsychology (ABCN)
  - Symptom exaggeration or probable malingering
    - 30% civil cases
    - 20% criminal cases
    - 10% medical cases
  - 7 out of 9 indicators
Survey of Beliefs and Practices
(cont’d)

• Lally (2003)
  – 53 diplomates in forensic psychology
  – Acceptable measures
    • MMPI-2
    • Structured Interview of Reported Symptoms (SIRS)
    • WAIS-III
    • Validity Indicator Profile (VIP)
    • Test of Memory Malingering (TOMM)
    • Rey 15-Item Test
    • Halstead-Reitan Battery
Survey of Beliefs and Practices
(cont’d)

• Slick and colleagues (2004)
  – 24 experts
    • TOMM
    • Rey 15-item Test (FIT) and Warrington Recognition Memory Test (RMT)
    • Green’s Word Memory Test (WMT)
    • Validity Indicator Profile (VIP)
    • Computerized Assessment of Response Bias (CARB)
    • Portland Digit Recognition Test (PDRT)
    • Victoria Symptom Validity Test (VSVT)
    • Digit Memory Test
Survey of Beliefs and Practices (cont’d)

• Prevalence
  – Definite malingering 5-30% cases
  – Possible malingering 5-30% cases

• Warning
  – 54.2% NEVER
  – 37.5% ALWAYS

(Slick et al., 2004)
Survey of Beliefs and Practices (cont’d)

- Communication
  - 91% invalid
  - 83% suggested or indicated exaggeration
  - 96% inconsistent with severity of injury
  - 46% often or always stated suggest or indicate malingering when indications present

(Slick et al., 2004)
Survey of Beliefs and Practices (cont’d)

• Sharland and Gfeller (2007)
  – 188 NAN members

<table>
<thead>
<tr>
<th>Estimated base rates of insufficient effort and malingering</th>
<th>Median (%)</th>
<th>Minimum (%)</th>
<th>Maximum (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on the examinees you have seen for evaluation in the previous year, what percentage do you believe</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Probably gave insufficient effort</td>
<td>10</td>
<td>0</td>
<td>90</td>
</tr>
<tr>
<td>Definitely gave insufficient effort</td>
<td>5</td>
<td>0</td>
<td>80</td>
</tr>
<tr>
<td>Probably were malingering</td>
<td>3</td>
<td>0</td>
<td>50</td>
</tr>
<tr>
<td>Definitely were malingering</td>
<td>1</td>
<td>0</td>
<td>30</td>
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<tr>
<td>Please estimate the percentage of examinees in general, who deliberately exaggerate their deficits or feign cognitive impairment in cases involving civil litigation or compensation</td>
<td>20</td>
<td>0</td>
<td>90</td>
</tr>
<tr>
<td>Please estimate the percentage of examinees in general, who deliberately exaggerate deficits or feign cognitive impairment where there is no litigation or possibility of compensation</td>
<td>5</td>
<td>0</td>
<td>90</td>
</tr>
</tbody>
</table>
Survey of Beliefs and Practices (cont’d)

• Warning
  – 22% often or always provide warning
  – 52% never or rarely provide warning
  – 89% often or always encourage examinees to give best effort

(Sharland and Gfeller, 2007)
### Table 7
Frequency of use of measures to detect malingering

<table>
<thead>
<tr>
<th>Measure</th>
<th>Percentage of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Never</td>
</tr>
<tr>
<td>Test of Memory Malingering</td>
<td>24.7</td>
</tr>
<tr>
<td>MMPI-2 F–K ratio</td>
<td>23.5</td>
</tr>
<tr>
<td>MMPI-2 FBS scale</td>
<td>24.9</td>
</tr>
<tr>
<td>Rey 15-item test</td>
<td>25.5</td>
</tr>
<tr>
<td>California Verbal Learning Test</td>
<td>36.8</td>
</tr>
<tr>
<td>WAIS-R/WAIS-III Reliable Digit Span</td>
<td>37.5</td>
</tr>
<tr>
<td>Rey Complex Figure Test</td>
<td>35.3</td>
</tr>
<tr>
<td>Wisconsin Card Sorting Test</td>
<td>38.9</td>
</tr>
<tr>
<td>Trail Making Test: TMT-A/TMT-B ratio</td>
<td>46.2</td>
</tr>
<tr>
<td>Booklet Category Test: Subtest I and II errors</td>
<td>52.7</td>
</tr>
<tr>
<td>Rey Auditory Verbal Learning Test</td>
<td>56.0</td>
</tr>
<tr>
<td>WMS-III Aud. Recog. Raw Score</td>
<td>52.2</td>
</tr>
<tr>
<td>Word Memory Test</td>
<td>59.3</td>
</tr>
<tr>
<td>Validity Indicator Profile</td>
<td>59.2</td>
</tr>
<tr>
<td>WAIS-R/WAIS-III Vocab-Digit Span Difference</td>
<td>57.9</td>
</tr>
<tr>
<td>WMS-R General Memory/Attention Concentration Difference</td>
<td>58.5</td>
</tr>
<tr>
<td>WMS-III Faces Raw Score</td>
<td>57.8</td>
</tr>
<tr>
<td>Dot Counting Test</td>
<td>61.4</td>
</tr>
<tr>
<td>Seashore Rhythm Test</td>
<td>66.3</td>
</tr>
<tr>
<td>Memory Assessment Scales</td>
<td>70.7</td>
</tr>
<tr>
<td>Portland Digit Recognition Test</td>
<td>67.8</td>
</tr>
<tr>
<td>Booklet Category Test: Bolton Items</td>
<td>69.2</td>
</tr>
<tr>
<td>Computerized Assessment of Response Bias</td>
<td>74.3</td>
</tr>
<tr>
<td>Hiscock Digit Memory Test</td>
<td>74.5</td>
</tr>
<tr>
<td>Victoria Symptom Validity Test</td>
<td>82.0</td>
</tr>
<tr>
<td>Warrington Recognition Memory Test</td>
<td>76.5</td>
</tr>
<tr>
<td>HRB discriminant function</td>
<td>82.6</td>
</tr>
<tr>
<td>WAIS-R/WAIS-III discriminant function</td>
<td>81.5</td>
</tr>
<tr>
<td>WMS-R/WMS-III discriminant function</td>
<td>84.2</td>
</tr>
</tbody>
</table>

(Sharland and Gfeller, 2007)
### Survey of Beliefs and Practices

(Sharland and Gfeller, 2007)

<table>
<thead>
<tr>
<th>Method</th>
<th>Percentage of respondents</th>
</tr>
</thead>
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<tr>
<td></td>
<td>Never</td>
</tr>
<tr>
<td>Severity of cognitive impairment inconsistent with the condition</td>
<td>0</td>
</tr>
<tr>
<td>Discrepancies among records, self-report, and observed behavior</td>
<td>0.5</td>
</tr>
<tr>
<td>Pattern of cognitive impairment inconsistent with the condition</td>
<td>0</td>
</tr>
<tr>
<td>Implausible self-reported symptoms in interview</td>
<td>1.1</td>
</tr>
<tr>
<td>Implausible changes in test scores across repeated examinations</td>
<td>1.1</td>
</tr>
<tr>
<td>Scores below empirical cut-offs on measures specific to the assessment of effort/malingering</td>
<td>8.6</td>
</tr>
<tr>
<td>Scores below empirical cut-offs on forced choice tests</td>
<td>3.8</td>
</tr>
<tr>
<td>Validity scales on objective personality tests</td>
<td>5.9</td>
</tr>
<tr>
<td>Scores below empirical cut-offs on embedded measures of effort</td>
<td>12.4</td>
</tr>
<tr>
<td>Scores on empirically derived discriminant function analyses indicative of poor effort</td>
<td>37.2</td>
</tr>
</tbody>
</table>
Survey of Beliefs and Practices (cont’d)

- Communication
  - 85% inconsistent with severity of injury
  - 81% suggest or indicate exaggeration
  - 66% no firm conclusions
  - 59% invalid
  - 29% suggest or indicate malingering
    - 24% NEVER state this in report or professional communication

(Sharland and Gfeller, 2007)
AACN Consensus (2009)

• Decision **NOT** to use effort test and embedded validity indicators only **rarely** justified
  – Severe time restraints
  – Administrative prohibition
  – Severe and well-documented mental retardation

• **MUST** document rationale and note limitations in interpretation
Note: Archives = Archives of Clinical Neuropsychology; TCN = The Clinical Neuropsychologist; Articles relating to addresses, conference information, introductions, book reviews, test reviews, single case studies, editorial boards, grand rounds, commentary, and position papers were excluded from this analysis.

(Odland et al., 2015)
Warning!!!!

Research Methods
and
Statistics Ahead
Research Designs

• Differential Prevalence
  – 2 groups expected to have very different rates of malingering

• Simulation Groups
  – Instructed to feign impairment vs. non-litigating, non-compensation-seeking usually with moderate-to-severe TBI

• Criterion Group/Known Group
  – Suspected clinical malingering sample vs. non-malingering clinical sample
Sensitivity and Specificity

- **Sensitivity (True Positive)**
  - Those with disorder who are accurately identified with the disorder

- **Specificity (True Negative)**
  - Those without the disorder who are accurately identified as NOT having the disorder

- **Goal**
  - ↓ false positive errors
  - Cutoff score 90% specificity = 10% false positive rate
  - Lower sensitivity to detection of invalid performance
Predictive Power

- **Positive predictive power (PPP)**
  - Proportion of those with disorder who are accurately identified with the disorder

- **Negative predictive power (NPP)**
  - Proportion of those without the disorder who are accurately identified as NOT having the disorder

<table>
<thead>
<tr>
<th>Positive Test Result</th>
<th>Condition Present</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Yes</td>
<td>True Positive</td>
</tr>
<tr>
<td>No</td>
<td>False Negative</td>
</tr>
</tbody>
</table>
Predictive Power (cont’d)

• PPP = \( \frac{\text{True Positives}}{\text{True Positives} + \text{False Positives}} \)

• NPP = \( \frac{\text{True Negatives}}{\text{True Negatives} + \text{False Negatives}} \)
Likelihood Ratios

\[
\frac{\text{Sensitivity}}{1 - \text{Specificity}}
\]

- Indicates how many times more (or less) likely it is that those with the disorder obtain a positive result compared to those without the disorder who obtain a positive result.
Area under the curve (AUC)

- Receiver operating curve (ROC)
  - Plot test’s sensitivity (y-axis) vs. its false positive rate (x-axis)
  - Each point on graph represents different cut score
  - **Magnitude** (Hosmer and Lemeshow, 2000)
    - 0.50 = no discrimination
    - 0.70 – 0.80 = acceptable
    - 0.80 – 0.90 = excellent
    - ≥ 0.90 = outstanding
AACN Consensus 2009

• Literature
  – Classification accuracy of validity indicators
  – How well sample of given study generalizes to individual in question

• STAndards for the Reporting of Diagnostic accuracy studies (STARD)
  – Improve quality of reporting of diagnostic studies
  – www.stard-statement.org
Continuous Sampling (Boone, 2009)

• Case 1
  – 51
  – High school
  – Caucasian female
  – Disability 3 months prior
    • Fibromyalgia
    • Anxiety
    • Depression
  – Cognitively
    • Decreased memory
    • Distractibility
    • Word-retrieval difficulties
  – Physically
    • Pain from “toes to my neck”
    • Headaches that “come in spurts”
    • Episodes of dizziness
Continuous Sampling
(Boone, 2009) (cont’d)

• Effort measures passed
  – Rey WRT
  – Dot Counting Test
  – Warrington RMT-Words
  – Digit Span Variables
  – RO effort equation
  – RO/RAVLT discriminant function
  – Dominant-hand finger tapping

• Effort measures failed
  – b Test total time
  – RAVLT effort equation

• Failures occurred halfway through exam

• MMPI-2 and MSPQ
  – non-plausible
  – over-report of physical symptoms
Continuous Sampling
(Boone, 2009) (cont’d)

• Cognitive results
  – Processing speed (borderline to high average)
  – Visual memory (borderline to superior)
  – Verbal memory (borderline to superior)
  – Timed executive task (low average)

• Conclusion
  – Cannot be accepted at face value given evidence of suboptimal effort
Continuous Sampling (Boone, 2009) (cont’d)

• Case 2
  – 56
  – 14 years education
  – Caucasian female
  – Worker’s compensation
    • Struck head on wooden post
    • No loss of consciousness
    • Immediately returned to work
    • Treatment later that day for headache and nausea
    • Brain imaging normal
Continuous Sampling
(Boone, 2009) (cont’d)

• Cognitively
  – Left-right discrimination
  – Errors writing letters
  – Shifting between tasks
  – Visual tracking
  – Word-retrieval
  – Focus
  – Comprehension
  – “Overall slower”

• Physical
  – Headaches
  – Involuntary movements
  – Poor balance
  – Dizziness
  – Knees buckling
  – Pain in neck

• Psychiatric
  – Irritability
  – Occasional anxiety
Continuous Sampling
(Boone, 2009) (cont’d)

• Effort measures passed
  – RFIT plus recognition
  – Warrington RMT-Words
  – b Test
  – Digit Span Variables
  – RAVLT variables

• Effort measures failed
  – Dot Counting Test
  – Finger tapping
  – Finger agnosia
  – RO effort equation

• MMPI-2 and Somatic Complaints Scale
  – significant over-report of physical symptoms
Continuous Sampling
(Boone, 2009) (cont’d)

• Cognitive results – all in normal range except
  – Processing speed (impaired to borderline)
  – Motor function (impaired to borderline)
  – Visuospatial skills (impaired to borderline)
  – Visual memory (impaired to borderline)

• Conclusion
  – Normal range accepted as representing minimum but not maximum level of cognitive functioning
Key Points (Boone, 2009)

- Variability in negative response bias occurs throughout the evaluation.
- Effort indices for differing cognitive abilities necessary for feigning of selective deficits.
- Presence of response bias **MUST** be considered even when standard cognitive scores are within normal range.
Utility of Multiple Measures

• Larabee (2007)
  – Failure on 3 or more → definite malingering
  – Failure on 2 → probable malingering

• Berthelson and colleagues (2013)
  – Adding tests leads to increased rates of significant scores
  – False positive rates increase as number of effort tests administered increases
  – Extent to which PVTs/SVTs correlated
Utility of Multiple Measures (cont’d)

• Berthelson and colleagues (2013)
  – Meta-analysis
    • 22 independent samples
    • 407 correlations among 31 effort measures
    • Aggregate sample of 3564 participants

  – Result
    • Average correlation $\rightarrow r = 0.31$
Utility of Multiple Measures (cont’d)

– Monte Carlo methodology
  • Estimates false positive rates when measures correlated

– Conclusion
  • Combined false positive rate of multiple PVTs
    – Degree of interscale correlation
    – Individual PVT sensitivity/specificity rates
    – Total number of tests administered

(Berthelson et al., 2013)
Utility of Multiple Measures (cont’d)

• Odland and colleagues (2015)
  – Validated Monte Carlo simulation
    • 24 embedded and stand-alone validity indicators
    • 7 noncompensation-seeking clinical samples
  – Guidelines
    • Real time $\rightarrow$ decision tree
    • Retrospectively $\rightarrow$ additive effect of individual PVT/SVT sensitivity/specificity
Notes. False-positive rates are positioned at the top of each cell and true-positive rates are positioned at the bottom of each cell.
PVT = Performance validity test
Individual PVTs at 90% Specificity and 69% Sensitivity.

(Odland et al., 2015)
Odland and colleagues (2015)

- Aggregate false-positive base rates assuming various
  - Specificities
  - Numbers of administered PVTs
  - Interscale correlations

Table 6  Aggregate false-positive rates for \( n \) correlated (\( r=0.1 \)) PVTs/SVTs with 85, 90, and 95 % specificities

<table>
<thead>
<tr>
<th>Number of PVTs/SVTs administered</th>
<th>( \geq 1 )</th>
<th>( \geq 2 )</th>
<th>( \geq 3 )</th>
<th>( \geq 4 )</th>
<th>( \geq 5 )</th>
<th>( \geq 6 )</th>
<th>( \geq 7 )</th>
<th>( \geq 8 )</th>
<th>( \geq 9 )</th>
<th>( \geq 10 )</th>
</tr>
</thead>
<tbody>
<tr>
<td>85</td>
<td>15</td>
<td>10</td>
<td>5</td>
<td>27</td>
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<td>40</td>
<td>30</td>
<td>75</td>
<td>65</td>
<td>55</td>
<td>100</td>
</tr>
</tbody>
</table>

Note. PVT = Performance validity test; SVT = Symptom validity test; Light Gray = FP rate ≤ 15%; Medium Gray = FP rate ≤ 10%; Dark Gray = FP rate ≤ 5%
Communicating Results

• Ethical obligation to explain results
  – Ethical standard 9.10, Explaining Assessment Results (APA, 2002)

• Do not
  – Fail to administer effort tests
  – Omit feedback on topic
  – Comforting, but inaccurate, explanations

• Discomfort does not outweigh potential harm to patient and society by withholding diagnosis of malingering (Seward and Connor, 2009)
Phase 1 – Building Rapport

• Informal
  – Casual conversational comments
  – Appropriate humor throughout interview
  – Eye contact

• Interview
  – Encourage to share
  – Heard and understood
  – Inquisitive manner

(Carone et al., 2010)
Phase 1 – Informed Consent

• Ethical standard 9.03, Informed Consent in Assessments (APA, 2002)

• Set expectations
  – Risks
    • No guarantee of agreement with their beliefs
  – Effort assessed
    • Try best and avoid exaggeration
    • Inconclusive findings
    • Negative impact

(Carone et al., 2010)
Phase 2 – Evaluation and Preliminary Discussions

• Initial measures → unequivocal evidence
  – Obtain additional evidence
  – Consistency of performance
  – Minimum ability level

• Upon completion
  – Willing to acknowledge poor effort?
  – Cognitive restructuring technique
  – Avoid pejorative terms

(Carone et al., 2010)
Phase 3 – Feedback Session

• Conversational comment
  – Seek input and value perspective

• Findings
  – Strengths and weaknesses
  – Good news vs. bad news
  – Objective data
  – Severely impaired clinical group

(Carone et al., 2010)
Phase 3 – Feedback Session (cont’d)

(Carone et al., 2010)
Phase 3 – Feedback Session (cont’d)

• Substantial improvement
  – Psychotherapy
  – Case management

• Debrief
  – Opportunity to correct misperceptions

(Carone et al., 2010)
Terminology

• Exaggeration
  – Explicitly explain meaning to avoid misinterpretation
    • Many factors underlie and does not equate to willful deceit

• Malingering
  – Probabilistic language (Slick et al., 1999)
  – Attempt to determine motivation

(Carone et al., 2010)
Ultimately……

• Conclusion
  – Patient’s history
  – Objective psychometric data
  – Behavioral observations
  – Scientific knowledge
References


References (cont’d)


References (cont’d)


References (cont’d)


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