

Best Practices in Assessment of Symptom and Performance Validity

Joseph L. Etherton

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Dedication

To my dear wife Karen, and our wonderful sons Jack and Bobby.

And with gratitude to Kevin Bianchini and Kevin Greve, whose mentorship in research and clinical applications of validity assessment has been invaluable.

Contents

Dedication	v
Chapter 1: Introduction	1
Assessing Validity Related to Disability Exaggeration	3
Chapter 2: Theoretical Underpinnings	13
Frameworks for Detecting and Diagnosing Malingering: MND and MPRD	14
Validity Detection: Principles and Strategies	16
Classification Accuracy	21
Chapter 3: Review of Commonly Used Validity Measures	25
A Note on Psychometric Properties of Validity Scales	25
Performance Validity Tests (PVTs)	26
Self-Report and Interview-Based Symptom Validity Tests (SVTs)	37
Chapter 4: Professional Issues in Validity Assessment	41
Disability Evaluations	41
Planning for a Disability-Related Neuropsychological or Psychological Assessment	48
Conducting the Assessment	57
Interpretation of Validity Measure Findings	59
Summary of Steps for Interpreting Validity Measure Results	72
Integrating Assessment Data	74
Differentiating Malingering From Nonmalingering Factors	74
Drawing Conclusions	78
Book Summary	81
References	83
Appendix	93

Chapter 1

Introduction

In the movie “E.T. The Extraterrestrial” (Spielberg, 1982) there is a scene in which Elliott, the young protagonist, urgently needs to stay home from school to take care of E.T., the alien creature he has just met. Because he does not yet want to tell his mother about E.T., he needs a compelling reason for missing school, and the classic reason for missing school is being sick. Although Elliott cannot simply make himself ill on demand, he can create the appearance of being sick, in part by lying in bed groaning and speaking in a weak voice and “acting” sick (which he does). But because his mother may not accept these signs as legitimate proof of illness, Elliott takes a thermometer, holds it under a lamp to raise the temperature on the thermometer, and then allows his mother to read the elevated temperature as proof that he has a fever. Elliott has taken a reliable instrument for measuring temperature and detecting fever (the thermometer) and distorted its output (the temperature reading) to mislead others about his actual status.

In psychological assessment, we use a variety of measures to gather information from people about their mood, their preferences, their personality traits, and their typical patterns of behavior. For example, a self-report measure of depression may include items asking how frequently or how intensely one experiences sleep disturbance, feelings of worthlessness, inability to enjoy activities, and other symptoms of depression. The examinee may attempt to be completely accurate and forthright in responding to the questions, in which case we would have a fairly accurate estimate of the person’s depression severity. However, someone who wanted to feign depression so they can receive compensated time for work for a psychological disability, or so they can be discharged from unwanted military service, may untruthfully endorse items that create the appearance of severe depression, such that the resulting test scores would present a picture of the examinee that would be far from accurate.

The forensic psychologist Richard Rogers wrote that “nearly all psychological measures are based on three unballasted [i.e., lacking weight or support] assumptions: that each patient (1) is psychologically engaged in the assessment process, (2) shares the same goals as the clinician, and (3) cooperates with the clinician’s methods of achieving these goals” (Rogers, 2001, p. 405). We cannot assume that the examinee is engaged in the assessment process

because some examinees are unmotivated, indifferent, or even hostile to the assessment process. Examinees may not share the same goals as the clinician when the examinee very much wants a certain outcome (e.g., a particular diagnosis) while the clinician's goal may be to accurately characterize the examinee, whether the outcome is favorable to the examinee or not. And we cannot assume that the examinee will cooperate with the process of reaching an accurate characterization of the examinee, because the examinee may very much wish to appear more psychologically healthy than is the case, in seeking child custody; or may wish to appear more impaired than is the case, as when pursuing a disability claim.

Given that some examinees may be motivated to avoid helping the clinician develop an accurate understanding of their psychological status, it is important for clinicians to consider whether the examinee has misrepresented themselves, and to examine objective indicators of the validity of the examinee's self-reported statements and item responses.

Psychological assessment involves using a variety of different methods to gather information about a person. The types of information to be gathered depend on the purpose of the evaluation, but may include information about their personality traits, whether they have symptoms of a psychological disorder, their preferences, concerns, strengths, weaknesses, and so on.

Information from psychological assessments may be used to determine whether someone meets criteria for a psychological disorder, whether they are suitable for hire as a police officer, whether they have the capacity to make their own important decisions, among others. Importantly, information from psychological assessments depends in large part on whether the person is providing accurate information. To the extent that a person attempts to present themselves in a manner that is different from how they actually are, the results of psychological assessment will be inaccurate. For example, someone who wants others to conclude that they have a psychological disorder may report having symptoms or problems that they do not actually have or may exaggerate symptoms that they do have. In addition, test results may lead to an inaccurate perception of an examinee when the examinee responds somewhat randomly because of factors such as indifference to testing, inability to understand test items, or inattention to the items.

Validity assessment broadly speaking refers to a variety of different methods and measures used to evaluate whether the data obtained from an evaluation accurately characterizes the examinee in terms of psychological symptoms, cognitive abilities, or other relevant domains. Validity assessment tools may indicate whether an examinee appears to be feigning psychological problems or cognitive deficits, and whether they appear to have tried their best on cognitive tasks or given forthright responses to questions. Including

Chapter 3

Review of Commonly Used Validity Measures

This chapter will provide a review of some of the most commonly used and studied validity measures in neuropsychological and psychological assessments involving claims of impairment or disability. Far more validity measures have been developed than could be reviewed in the current chapter; however, the measures that surveys indicate are most frequently used in practice are included. The validity measures will generally be grouped together as performance validity tests (PVTs), which detect underperformance on tasks; and symptom validity tests (SVTs), which detect invalid self-reports such as symptom overreporting or endorsement of implausible symptoms or problems. Although most SVTs are based on self-report items, some standardized clinical interviews such as the SIRS and M-FAST have been developed to detect symptom invalidity.

A Note on Psychometric Properties of Validity Scales

It is standard practice in describing psychological measures to provide information about their psychometric properties, including different forms of reliability and validity. For most measures this is important because these properties describe the precision with which the measure assesses the construct of interest (reliability), and the extent to which the measure is appropriate for making inferences about the construct of interest for certain groups of examinees in particular situations.

The relevant psychometric properties of validity scales differ somewhat because the constructs that validity scales measure are not stable features of the examinee, but rather are indicators of whether the examinee responded consistently and in an accurate, forthright manner during testing. Although psychometric properties such as test-retest reliability are useful indicators of measures of stable constructs such as personality traits, we would not

Age: The WMT has been validated for administration in children as young as 7 (Green & Flaro, 2003) and adults at least 80 years of age.

Administration Time: Total administration time for the WMT is approximately 20 minutes, not including the 30-minute delay from immediate recognition to delayed recognition, or the 20-minute delay for the optional long-delay free recall trial.

Languages: The publisher's website (Green, n.d.) for the WMT (<https://word-memorytest.com/languages/>) lists 17 languages for which the WMT may be administered: Arabic, Danish, Dutch, English, Farsi, French, German, Greek, Hebrew, Italian, Japanese, Mandarin, Portuguese, Punjabi, Russian, Spanish, and Turkish.

Medical Symptom Validity Test (MSVT)

The MSVT (Green, 2004) is essentially a shorter version of the WMT, with half the number of word pairs as the WMT, with 4 subtests rather than 6, and with a shorter delay of 10 minutes between immediate and delayed subtests. These features allow the MSVT to be administered more quickly than the WMT, reducing overall administration time.

Like the WMT, some subtests of the MSVT are sensitive to feigning while insensitive to cognitive impairment, while other subtests are actually sensitive to significant memory impairment. This allows the MSVT to differentiate more accurately between poor performance that is attributable to feigning from poor performance attributable to significant memory dysfunction, as in dementia. The MSVT manual includes an algorithm based on patterns of memory performance to differentiate likely feigned performance from a genuine memory impairment. When using the algorithm, the specificity of the MSVT in early dementia (92%) and advanced dementia (89%) remained high (Green, 2004).

Ages: Adults, and children with at least a 3rd grade reading level.

Administration Time: The MSVT is administered by computer and takes approximately 5 minutes for the examinee to complete initial trials, with a 10-minute delay before completing delayed recognition, paired associate, and free recall trials, which take an additional 5 minutes.

Languages: The MSVT is available in English, Spanish, German, Dutch, Norwegian, Portuguese, and Danish.

True or False responses without regard to item content). In such cases, CRIN may become significantly elevated even when VRIN and TRIN may not become sufficiently elevated to signal the invalid responding. CRIN T-score values from 70 to 79 indicate evidence of response inconsistency, which may be attributable to an uncooperative approach to completing the test, difficulties with reading or comprehending items, or carelessness. Although scores in this range do not necessarily invalidate the entire protocol, the different responses to similar items imply that at least some of the responses do not reflect the examinee's actual intent. Accordingly, substantive scales should be interpreted with caution for CRIN T-scores of 70–79. CRIN T-scores ≥ 80 render the protocol invalid because of excessive inconsistency.

Clinical Pearl

Before examining self-report validity scales, ensure that the examinee did not leave too many items blank and did not respond with excessive inconsistency.

Effects of Noncontent Responding on MMPI-3 Overreporting and Underreporting Validity Scales

The MMPI-3 interpretive manual describes confounds that may artifactually increase or decrease validity scale scores. Whereas nonresponding, detected by CNS (Cannot Say), tends to lower all validity scale scores, random responding, detected by VRIN (and by CRIN, for the MMPI-3), tends to increase both overreporting scales (F, Fp, Fs, FBS, and RBS) as well as underreporting scales (L and K). Fixed responding in the True direction (TRIN-T) results in artifactually elevated scores on all overreporting scales, but artifactual lowering of underreporting scales L and K. Fixed responding in the False direction (TRIN-F) results in artifactual elevation of all overreporting and underreporting scales.

Clinical Pearl

If inconsistent responding on self-report measures has been ruled, then any overreporting validity scale elevations may be presumed to have been purposeful.

Interpreting Overreporting Validity Scales

As described in Chapter 2, the MMPI, MCMI, and PAI contain both overreporting and underreporting measures. Because disability and personal injury

Appendix

Proposed Definition and Criteria for Possible, Probable, and Definite Malingering of Neurocognitive Dysfunction (MND)

Definition

Malingering of Neurocognitive Dysfunction (MND) is the volitional exaggeration or fabrication of cognitive dysfunction for the purpose of obtaining substantial material gain, or avoiding or escaping formal duty or responsibility. Substantial material gain includes money, goods, or services of nontrivial value (e.g., financial compensation for personal injury).

Formal duties are actions that people are legally obligated to perform (e.g., prison, military, or public service, or child support payments or other financial obligations). Formal responsibilities are those that involve accountability or liability in legal proceedings (e.g., competency to stand trial).

Diagnostic Categories for Malingering Neurocognitive Dysfunction (MND)

Definite MND

This is indicated by the presence of clear and compelling evidence of volitional exaggeration or fabrication of cognitive dysfunction and the absence of plausible alternative explanations. The specific diagnostic criteria necessary for Definite MND are listed below:

1. Presence of a substantial external incentive [Criterion A]
2. Definite negative response bias [Criterion B1]
3. Behaviors meeting necessary criteria from group B are not fully accounted for by Psychiatric, Neurological, or Developmental Factors [Criterion D]

Peer Commentaries

This handbook provides a comprehensive yet concise overview of validity assessment within psychological and neuropsychological evaluations. By detailing the critical role of symptom and performance validity testing, the text offers accessible guidance on integrating these measures into routine clinical practice. It serves as an excellent resource for experienced practitioners as well as clinicians new to neuropsychological evaluations seeking to strengthen the rigor of their validity assessment protocols.

Bradley N. Axelrod, PhD, ABN, John D. Dingell Department of Veterans Affairs Medical Center, Detroit, MI

This well written book exploring the use of performance and symptom validity measures commonly used in the field of neuropsychology could easily become an indispensable desk reference for practitioners. It provides clinicians with a resource for understanding and applying methods to evaluate the validity of assessment data – an essential component of accurate interpretation. I can recommend this to any reader seeking a concise, well-articulated guide to validity assessment.

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