

Detection of Malingering in Competency to Stand Trial Evaluations*

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A simulation design with multiple contrast groups was used to test the effectiveness of two instruments, the Structured Interview of Reported Symptoms (SIRS) and the Georgia Court Competency Test—Mississippi State Hospital (GCCT-MSH) in detecting malingering of competency to stand trial. Thirty simulators were compared with 23 incompetent defendants, 25 competent defendants, 30 offender controls, and 7 suspected malingerers on both instruments. Results revealed that the simulators and suspected malingerers scored significantly higher on all of the SIRS primary scales and significantly lower on the GCCT-MSH than the three comparison groups. The SIRS had an overall hit rate of 97.8% using three or more primary scales as the criterion for malingering. Information concerning the simulator's strategies of deception is presented.

The detection of malingering is a crucial component of forensic evaluations. In no other circumstance are the repercussions of being determined mentally ill so far reaching and potentially advantageous. One specific forensic evaluation likely to be influenced by malingering is the assessment of competency to stand trial (CST; Davis, 1986; Grisso, 1988). CST evaluations have been associated with malingering partly because CST referrals are sometimes suspected to be legal maneuvers (Hartman, 1984; Morris & Meloy, 1993) and partly because a finding of incompetency can be beneficial to certain defendants (Hartman, 1984; Roesch & Gol-

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ding, 1980). The assessed relationship between CST evaluations and malingering is also implicit in the studies categorizing defendants undergoing CST evaluations as suspected or potential malingerers (Cornell & Hawk, 1989; Grossman & Wasyliv, 1988; Wasyliv, Grossman, Haywood, & Cavanaugh, 1988).

Despite the abundance of literature suggesting the possibility of malingering in CST evaluations (Davis, 1986; Grisso, 1988; Hartman, 1984) and the advent of an instrument designed specifically for the assessment of malingering (i.e., the Structured Interview of Reported Symptoms, SIRS; Rogers, Bagby, & Dickens, 1992), faking of CST has never been directly assessed using malingering instruments or CST instruments. Even within published studies of feigning that use CST defendants as a comparison group, the simulators never specifically have been instructed to fake incompetency.

The focus of this study, in part, was to address feigned incompetency by comparing incompetent, competent, fake incompetent, and control respondents on a quantifiable competency instrument, The Georgia Court Competency Test—Mississippi State Hospital (GCCT-MSH; Johnson & Mullett, 1987; Nicholson, Robertson, Johnson, & Jensen, 1988), and the SIRS (Rogers et al., 1992). We anticipated that the results would provide empirical support for using these instruments to detect malingering in CST evaluations.

The study was designed to correct some of the weaknesses of previous simulation research. To increase the external validity of the study (Rogers, 1988; Schretlen, Wilkins, Van Gorp, & Bobholz, 1992), all participants were drawn from an adult forensic population, rather than from a student body or other community sample. In addition, the simulators and control respondents were provided a monetary incentive for their participation. Finally, the instructions to simulate were written so as to increase the generalizability of the findings to competency cases. Participants specifically were instructed to fake incompetency, rather than given more vague directions, such as to “fake bad” or “fake crazy.” The external validity of the study was further enhanced with the addition of suspected malingerers to the sample studied.

The primary goal of the study was to test the effectiveness of the SIRS in discriminating the simulators and suspected malingerers from the competent, incompetent, and control respondents, using various classification criteria recommended in the SIRS manual (Rogers et al., 1992a). To control for Type 1 error, initial analyses tested whether the simulators and suspected malingerers scored significantly higher on a total score of the SIRS eight primary scales. Follow-up analyses of the individual and multiple scale elevations as classification criteria were undertaken only after a significant finding on the total score of the 8 primary scales. A second goal of the study was to examine the effectiveness of the GCCT-MSH in discriminating the simulators and suspected malingerers from the incompetent respondents. It was anticipated that the simulators and suspected malingerers would score significantly lower (i.e., appearing less competent) than the incompetent respondents. The final objective of the study was to obtain follow-up information regarding the simulators’ strategies of deception and their conceptual understanding of competency to stand trial.

METHODS

Participants

The total sample was 115 male participants categorized into five groups: incompetent defendants ($n = 23$), competent defendants ($n = 25$), simulators ($n = 30$), controls ($n = 30$), and suspected malingerers ($n = 7$).

The first two groups were obtained from the San Diego County evaluation unit, where they were referred for an evaluation of their competency to stand trial. They were assigned to either an incompetent or competent group by an experienced forensic examiner on the basis of a lengthy clinical interview.

These participants were screened for evidence of malingering before being included in the study. This assessment was based on their performance on the M Test (Beaber, Marston, Michelli, & Mills, 1985), a brief malingering screening instrument, and a 5-point Likert rating on the probability of malingering provided by their evaluating clinician. Only subjects who were classified as nonmalingerers on both the M Test and Likert scale were retained in the competent and incompetent groups. Although neither screening measure is without classification error, conservative cutoff scores were used, which increased the likelihood of detecting malingerers.

The Likert rating was only scored by the forensic examiner after having completed their formal evaluation. For the M Test, the Rule-In Scale (to identify possible malingerers) and the Rule-Out Scale (to eliminate bona fide patients), developed by Rogers, Bagby, and Gillis (1992), were used to screen potential malingerers. Both scales comprise the 10 items with the highest predictive power for their respective scale. The cutoff scores recommended by Rogers et al. (1992b) are a Rule-Out Score of <4 , followed by a Rule-In cutoff score of 0. In the Rogers et al. (1992b) study, this scoring criterion eliminated 70.6% of the patients from further consideration, but retained 95.2% of the suspected malingerers.

Two other groups were incarcerated inmates randomly selected from a larger sample of volunteers at a local detention center. They were randomly assigned to either a simulation (fake incompetency without detection) or control (honest response) group. The simulators and control respondents were given a financial incentive of \$5.00 to participate in the study. Because those inmates chosen to work could only earn a maximum of \$.50 a day, we considered \$5.00 for less than two hours of participation to be a valuable incentive. Furthermore, more than 100 inmates expressed interest in participating in the study the first day of its announcement, reflecting widespread motivation to take part in the study.

An additional seven defendants referred for a CST evaluation scored as malingering on both the M Test and the Likert rating. These defendants were assigned to a "suspected malingering" group. Although this group was not a formal component of the study, their data are included in the results for descriptive purposes.

Nine potential participants in the CST groups were excluded because they were designated as malingering either on the M Test or the Likert rating. Three

potential participants were excluded from the simulation and control groups because they had a history of psychiatric treatment, while an additional participant was excluded because he did not comprehend the instructions. Altogether, a total of 13 potential participants were excluded from the study.

Instruments

The SIRS is a structured interview comprising 13 scales which the authors designed to correspond with malingering strategies derived from their extensive reviews of the literature (Rogers et al., 1992a). Eight of these scales are termed primary scales, as they have consistently been demonstrated to be the most accurate in sorting fakers from honest respondents (Rogers et al., 1992a). The remaining five are referred to as supplementary scales and are used primarily for descriptive purposes. The primary scales include Rare Symptoms (RS), Symptom Combination (SC), Blatant Symptoms (BL), Subtle Symptoms (SU), Selectivity of Symptoms (SEL), Severity of Symptoms (SEV), Reported Versus Observed Symptoms (RO), and Improbable or Absurd Symptoms (IA). The supplementary scales include Overly Specified Symptoms (OS), Symptom Onset and Resolution (SO), Inconsistency of Symptoms (INC), Direct Appraisal of Honesty (DA), and Defensive Symptoms (DS) (Rogers et al., 1992a).

The GCCT-MSH is a brief, quantifiable assessment instrument to aid in conducting competency to stand trial evaluations (Nicholson et al., 1988). The test is administered in a structured interview format and has clearly delineated scoring criteria. It consists of 21 questions reflecting defendants' knowledge in four areas of courtroom competency: (a) understanding of courtroom procedure, (b) knowledge of the charge, (c) knowledge of possible penalties, and (d) ability to communicate rationally with an attorney (Nicholson et al., 1988). Respondents receive a score reflecting their knowledge of the major components of courtroom competency. A total score of 70 or above indicates that the defendant has a sufficient understanding of those components of courtroom competency measured by the GCCT-MSH (Nicholson et al., 1988). It must be emphasized that this cutoff score does not establish legal competency; rather, it reflects an adequate understanding of those legal constructs measured by the instrument.

PROCEDURE

The participants referred for an evaluation of their competency were approached for participation in the study while waiting for their evaluation. Once a consent form was signed, they were administered the SIRS, the GCCT-MSH, and the M Test. After their clinical evaluation, independent of the research measures, a Likert rating was completed by their forensic examiner.

The simulation and control group respondents followed a similar procedure, but neither completed the M Test nor received a rating by a clinician. After signing a consent form, they were randomly assigned to one of the two groups and given specific directions as to how they were to respond to the interview (i.e., honest or fake incompetency without detection). The directions were given by a person who

did not conduct the interview and the interviewers were blind to the subjects' condition. Instruction for the simulation group were as follows:

Thank you for volunteering to participate in this study about competency to stand trial. Competency to stand trial is a legal term used to describe a person's ability to participate in a trial. If a person is competent to stand trial, this means they can go to court, understand what is going on, and cooperate with their attorney. If a person is incompetent to stand trial, this means that for some reason they have been judged by a psychologist or psychiatrist to *not* have the ability to understand what is going on or to cooperate with their attorney. In a few moments an interviewer will be asking you some questions as if you are being evaluated for your competency to stand trial. Some of the questions are about legal processes and some are about your thoughts, feelings, and emotions. Your goal is to trick the interviewer into thinking you are NOT competent to stand trial, even though you really are.

To make this easier, I want you to imagine that you are a defendant charged with a serious crime. You have not yet gone to trial. Your attorney has recommended that a psychologist evaluate you before you go to trial to see if you are able to do this. This evaluation is called competency to stand trial. You have heard that if a psychologist thinks you are INCOMPETENT to stand trial, this may help your legal case. Therefore, your task is to fake that you are incompetent to stand trial, WITHOUT THE PSYCHOLOGIST KNOWING THAT YOU ARE FAKING.

The control respondents were asked to answer all questions truthfully. Following the interview, both groups of participants were given a questionnaire to ascertain whether they understood and complied with the instructions and to obtain follow-up information regarding their faking strategies, which questions they chose to fake, and their understanding of competency to stand trial.

Strategies of deception were tallied according to the narrative responses provided by the simulators. In order to be coded as a particular strategy, the response provided had to precisely match the particular strategy, thereby eliminating questions of reliability. If a response was not verbatim of a particular category, it was tallied as "other."

RESULTS

The majority of the participants had never been married (71.3%); few were either married (14.8%) or divorced (13.9%). Most of the subjects were White (54.8%), Black (27.8%), or Hispanic (11.3%), and their current charges were a mixture of violent (25.0%), property (44.0%), drugs (9.6%), and other offenses (19.6%). Chi-squares were computed to assess whether the four groups differed in ethnicity, marital status, and charge. Because some of the simulators and controls were awaiting trial (69.7%) and others were already convicted (30.3%), chi-squares were computed within these groups to test the relationship of sentencing status and the dependent variables. None was significant. Analyses of variance were conducted to assess whether the four groups differed in age, education, number of prior arrests, number of months of current incarceration, and number of months of incarceration prior to the current one. The results indicated that only age was significantly different across groups, $F(3, 104) = 10.07, p < .0005$. The

simulators were significantly younger ($M = 26.2$, $SD = 5.8$) than both the incompetent subjects ($M = 36.0$, $SD = 11.1$) and competent respondents ($M = 38.0$, $SD = 11.0$). In addition, post-hoc comparisons indicated that the control respondents were significantly younger ($M = 30.6$, $SD = 7.0$) than the incompetent group.

To evaluate the relationship of age with the dependent variables, Spearman rank order correlations between age and the dependent variables for the combined groups as well as between age and the dependent variables for each individual group were computed. Rank order correlations were chosen because of the skewed distribution of the SIRS data. The correlation between age and the total SIRS scores for the combined groups was significant, $r = -.35$, $p < .0001$, reflecting the younger age of the simulators and their elevated mean scores on the SIRS. The only significant correlation within the groups was between age and the total SIRS score, $r = -.49$, $p < .02$, within the CST incompetent group. Although the possibility exists that age may affect the psychological sophistication of a faker, no prior research has demonstrated this relationship.

At the time of the study, the participants had been incarcerated an average of four months. They had previously served an average of 17.7 months and had been charged with a mean of four prior offenses. Their mean education level was 11.9 grades.

Group descriptive statistics for the GCCT-MSH, the SIRS total score, and the SIRS individual scales are presented in Table 1. Nonparametric statistics were utilized in the analyses because the data were highly skewed and because the dependent variables did not meet the homogeneity of variance criterion. Separate Mann-Whitney tests were conducted between the simulators and the comparison groups to test whether the simulators scored significantly differently on the total score of the SIRS eight primary scales. Results revealed that the simulators scored a mean rank significantly higher on a total score of the SIRS eight primary scales than did the incompetent, competent, and control respondents. A follow-up Mann-Whitney test between the simulators and suspected malingerers was not significant, although the mean rank of the simulators was higher than that of the suspected malingerers. Because of the small sample size of the suspected malingerers and consequent limited power, the question of whether or not the simulators reliably scored higher than the suspected malingerers remains unanswered.

To determine whether the total SIRS score could discriminate the simulators from the other groups, a cutoff score for malingering was determined. The score was derived from a visual examination of histograms for each group on this measure. After a cutoff score was established, a contingency table was produced. Results indicated that using a cutoff score of 83, 83.3% ($n = 25$) of the simulators would have been appropriately classified, whereas 16.7% ($n = 5$) would have been inappropriately categorized as honest respondents. This cutoff score would have accurately classified 100% of the participants in the remaining three groups. It would also have classified 71.4% (i.e., 5 of 7 participants) of the suspected malingerers correctly. Examination of the distribution of scores for each group revealed that there was one outlier on this variable in the competent group with a score of 83. When this participant's data were removed from the analysis, a cutoff

Table 1. Group Descriptive Statistics for GCCT-MSH, SIRS Total Score, and SIRS Individual Scales

	Incompetents (<i>n</i> = 30)	Competents (<i>n</i> = 25)	Controls (<i>n</i> = 30)	Simulators (<i>n</i> = 30)	Malingers (<i>n</i> = 7)
GCCT-MSH					
<i>M</i>	60.52	82.32	86.67	37.07	34.86
<i>SD</i>	15.38	7.50	7.19	21.42	23.63
Range	16–92	68–98	70–98	0–74	10–66
SIRS total score					
<i>M</i>	39.78	25.20	15.47	114.10	90.86
<i>SD</i>	16.97	24.70	10.83	35.52	11.11
Range	0–61	0–83	0–32	62–216	72–103
SIRS rare symptoms					
<i>M</i>	3.39	1.64	0.73	11.77	9.71
<i>SD</i>	2.87	1.96	1.20	4.95	3.64
Range	0–11	0–6	0–4	2–24	5–16
SIRS symptom combination					
<i>M</i>	2.91	1.44	1.13	9.33	8.57
<i>SD</i>	1.88	1.90	1.63	4.94	3.36
Range	0–7	0–6	0–6	3–24	4–14
SIRS blatant symptoms					
<i>M</i>	5.61	3.32	1.63	17.83	15.00
<i>SD</i>	3.91	4.64	1.87	5.59	4.83
Range	0–12	0–19	0–6	9–30	8–20
SIRS subtle symptoms					
<i>M</i>	7.87	5.96	4.20	17.43	15.71
<i>SD</i>	4.40	5.83	3.30	6.91	4.61
Range	0–17	0–20	0–10	7–30	9–22
SIRS selectivity of symptoms					
<i>M</i>	10.57	6.88	4.57	20.30	19.14
<i>SD</i>	5.47	6.48	3.25	4.87	3.39
Range	0–19	0–21	0–10	12–31	13–23
SIRS severity of symptoms					
<i>M</i>	3.65	2.64	1.40	15.03	11.57
<i>SD</i>	2.82	3.82	1.81	6.28	6.53
Range	0–9	0–15	0–6	6–29	1–18
SIRS reported vs. observed symptoms					
<i>M</i>	2.13	1.40	0.87	7.53	5.57
<i>SD</i>	1.71	1.56	1.07	2.57	3.21
Range	0–7	0–6	0–4	3–12	1–10
SIRS improbable/absurd symptoms					
<i>M</i>	3.09	1.44	0.97	14.53	8.71
<i>SD</i>	2.43	1.78	1.30	8.69	4.96
Range	0–8	0–6	0–5	1–38	4–17
SIRS direct appraisal					
<i>M</i>	3.13	2.12	3.33	5.67	3.86
<i>SD</i>	1.63	1.88	2.31	3.67	2.34
Range	0–6	0–7	0–10	0–14	2–8
SIRS symptom onset					
<i>M</i>	2.87	2.08	2.30	4.47	4.43
<i>SD</i>	2.12	1.44	1.64	2.11	1.90
Range	0–8	0–4	0–5	0–8	3–8
SIRS overly specified symptoms					

Table 1. Continued

	Incompetents (<i>n</i> = 30)	Competents (<i>n</i> = 25)	Controls (<i>n</i> = 30)	Simulators (<i>n</i> = 30)	Malingers (<i>n</i> = 7)
<i>M</i>	0.65	0.24	0.73	4.30	3.57
<i>SD</i>	0.98	0.44	1.11	3.71	3.78
Range	0-3	0-1	0-3	0-16	0-11
SIRS inconsistency of responses					
<i>M</i>	4.09	2.48	2.93	7.57	6.14
<i>SD</i>	3.06	2.42	2.46	4.17	4.10
Range	0-10	0-9	0-9	0-16	1-12
SIRS defensiveness					
<i>M</i>	23.48	22.32	25.90	31.90	33.14
<i>SD</i>	7.05	13.44	7.53	10.37	4.38
Range	5-38	0-45	12-43	0-44	24-37

Note: GCCT-MSH = Georgia Court Competency Test-Mississippi State Hospital; SIRS = Structured Interview of Reported Symptoms; Higher scores on GCCT-MSH indicate better knowledge of CST issues; Higher scores on the SIRS total and Individual Scales indicate greater probability of malingering.

score of 67 accurately classified 96.7% (*n* = 29) of the simulators, yielding one false negative, and 100% of the participants in the remaining four groups. Therefore, a total SIRS cutoff score of 67 accurately discriminated 99.4% of the total sample upon removal of the outlier. These analyses revealed that either lowering or raising the cutoff score would have increased the number of false positives or false negatives, respectively.

Accuracy rates (see Table 2) were computed to determine how effective each of the eight primary scales was in discriminating the fakers from the honest respondents. The cutoff scores were selected according to those recommended in the SIRS manual to reflect malingering (Rogers et al., 1992a). Although the scales varied in their accuracy rates for the simulators and suspected malingers, all of the scales classified the competent respondents and controls with 100% accuracy. Six of the primary scales classified the incompetent respondents without error, whereas the remaining two (i.e., RS scale and IA scale) produced one false positive. However, these two scales also produced the highest hit rates for the suspected malingers and simulators at the expense of the false positive.

An alternative method for determining malingering on the SIRS is to use multiple scale elevations, implementing more conservative cutoffs. Using three or more scale elevations as the criterion for malingering, 96.7% of the simulators were classified as malingers, whereas 100% were classified as malingering using two or more scale elevations as the criterion. The false positive rates for the three comparison groups are presented in Table 3.

Statistical analyses also assessed whether the simulators scored differently than the incompetents on the GCCT-MSH. We found that the simulators scored significantly lower (i.e., appearing less competent) than did the incompetents, with mean ranks being 19.8 and 36.4, respectively. Mann-Whitney U test difference was statistically significant, $Z = 3.88$; $p < .0001$. An exploratory Mann-

Table 2. Accuracy Rates for SIRS Primary Scales

	Incompetents (n = 23)	Competents (n = 25)	Controls (n = 30)	Simulators (n = 30)	Malingers (n = 7)
Rare symptoms >9					
Correct	96%	100%	100%	73%	57%
Incorrect	4%	—	—	27%	43%
Symptom combination >12					
Correct	100%	100%	100%	30%	29%
Incorrect	—	—	—	70%	71%
Blatant symptoms >24					
Correct	100%	100%	100%	20%	—
Incorrect	—	—	—	80%	100%
Subtle symptoms >26					
Correct	100%	100%	100%	17%	—
Incorrect	—	—	—	83%	100%
Selectivity of symptoms >32					
Correct	100%	100%	100%	—	—
Incorrect	—	—	—	100%	100%
Severity of symptoms >17					
Correct	100%	100%	100%	30%	14%
Incorrect	—	—	—	70%	86%
Reported vs. observed symptoms >12					
Correct	100%	100%	100%	7%	—
Incorrect	—	—	—	93%	100%
Improbable/absurd symptoms					
Correct	96%	100%	100%	83%	43%
Incorrect	4%	—	—	17%	57%

Whitney test between the simulators and suspected malingerers was not significant, although the mean rank of the simulators, 19.3, was slightly higher (i.e., appearing more competent) than the suspected malingerers' mean rank of 17.9. Table 1 provides descriptive data on this variable.

Follow-up data were obtained from the simulators regarding their strategies of malingering. Table 4 provides a breakdown of the different faking strategies employed as well as the types of questions the simulators reported to fake. Although provided with a description of what constitutes competency and incompetency, participants had many different definitions regarding their idea of someone who is incompetent to proceed to trial. The majority (70%) of the sample

Table 3. Hit Rate for Multiple Scale Elevations on SIRS Primary Scales

	Cutoff exceeded on two or more scales		Cutoff exceeded on three or more scales	
	Correct	Incorrect	Correct	Incorrect
Incompetents	74%	26%	96%	4%
Competents	92%	8%	96%	4%
Controls	100%	0	100%	0
Simulators	100%	0	97%	3%
Suspected malingerers	100%	0	100%	0

Table 4. Simulators Postparticipation Questionnaire Data

	Percentage attempted
Faking strategy	
Act confused	13%
Imitate a disorder	13%
Imitate a person	10%
Act crazy	10%
Respond positively to unusual questions	10%
Respond to questions opposite of truth	7%
Use common sense	3%
Lie without a plan	20%
Other	17%
Type of questions faked	
All questions	39%
Auditory hallucinations	21%
Unusual personality questions	8%
Questions pertaining to symptomatology	7%
Other	25%
Ideas of incompetency	
Correct concept	27%
Unstable	20%
Crazy	20%
Out of touch with reality	17%
Unable to make decisions	3%
Need someone to explain everything	3%
Cannot deal with daily things	3%
Other	7%

Note: $n = 30$.

reported having heard of the term competency to stand trial prior to the study and 10% reported having attempted to fake a mental illness in the past.

DISCUSSION

The validity of the SIRS as an index of malingering in CST evaluations was supported in our study. Using a total score on the eight primary scales as the classification criterion yielded an overall hit rate of 90.8% for this sample. It is likely, however, that the cutoff score would need to be adjusted as a function of the particular population evaluated. The individual primary scales varied in their effectiveness in classifying the simulators and suspected malingerers but were all extremely accurate in classifying the honest respondents. Using a combination of scale elevations rather than individual scale elevations, however, proved to be a more discriminating classification criterion. As with prior research (Rogers et al., 1992a), the best overall indicator of malingering was three or more mean elevations on the primary scales, producing an overall hit rate of 97.8%.

For all of the criteria evaluated, the most difficult discrimination was between

the fakers (i.e., simulators and suspected malingerers) and the incompetent respondents. This difficulty may be due to the incompetent respondents having more psychopathology and therefore endorsing more test items in the keyed direction. In addition, research has demonstrated that it is more difficult to discriminate actual patients from simulators and suspected malingerers than it is to discriminate community samples or controls from simulators and suspected malingerers (Anthony, 1971; Schretlen, 1988; Walters, White, & Green, 1982). Alterations in the cutoff scores to accommodate the incompetent group would simultaneously lower the hit rate for the simulation group.

The most conservative and precise way to verify malingering is to use multiple malingering indicators. Corroborating data provide additional credibility to the examiner as well as support for the accuracy of a determination that is very difficult to verify. If the SIRS suggests malingering and other instruments (e.g., MMPI or MMPI-2) corroborate this information, the probability of malingering of the data in question is high. If other data do not corroborate the existence of malingering, caution in interpretation is warranted.

GCCT-MSH

Analyses also revealed that the GCCT-MSH proved to be very useful in sorting the simulators and suspected malingerers from the incompetent respondents, even though it does not include a formal faking component. Consistent with faking patterns on other tests, the simulators and suspected malingerers tended to overexaggerate their deficiencies. In other words, they pretended to have much less knowledge than was necessary to be found incompetent, claiming to lack the answers to rudimentary questions often understood by genuinely impaired defendants. From an evaluator's standpoint, very low scores may raise the index of suspicion for faking. Despite the fact that both the simulators and suspected malingerers scored significantly lower on the GCCT-MSH than the incompetent respondents, the test should be subject to cross validation on an additional sample before being used as an indicator of malingering. However, further assessment of malingering is warranted if a defendant scores extremely low on the test.

Strategies of Deception

A final component of the study examined the simulators' strategies of faking. As with prior research (Rogers, Gillis, Dickens, & Bagby, 1991), the simulators seemed to adopt a "more is better" approach to faking, tending to respond to every item on the SIRS in what then interpreted as a psychopathological manner. This extreme response style extended to their performance on the GCCT-MSH. For example, simulators provided many absurd responses (e.g., "What is the function of the judge?" "to laugh"), many perseverations (e.g., all courtroom participants were said to have the same function), and many "I don't know" responses. It seemed that the less specific and more open-ended the question, the more difficult to fake, and therefore, the more absurd the response. In contrast, the genuine incompetents often had partially correct answers which were not

accurate enough to indicate competency. They did not, however, provide absurd responses.

Although the simulators were informed that a finding of incompetency is directly related to courtroom knowledge, virtually all of the participants extended this meaning to incorporate symptoms of psychopathology. This finding was corroborated with information from a postparticipation questionnaire on which participants described their ideas of incompetency to include mental illness. Although slightly more than one-fourth of the respondents provided a correct conceptualization of incompetency, the remaining participants provided answers such as being "crazy," "unstable," "out of touch with reality," and "unable to make decisions" (Table 4). This finding has important implications for clinicians conducting competency evaluations in that it provides empirical support for using a general malingering instrument, the SIRS, for the specific evaluation of competency.

The strategies of deception used by the simulators who evaded detection on the SIRS included imitating a person, imitating a disorder, and endorsing questions related to emotional problems. These strategies suggest the possibility that these inmates had prior contact with mentally ill people, providing them with a reasonable notion of its manifestation (Meloy, 1988). The strategies employed by those simulators who were detected on the SIRS were more global. For example, participants who endorsed items that were unusual or who responded deceptively to all of the questions were more easily detected. On the whole, however, information from the postparticipation questionnaire demonstrated that the simulators were quite unsophisticated in their faking strategies, tending to fake incompetency through the use of lay persons' conceptions of mental illness.

The results of this study have several implications for clinicians conducting competency evaluations as well as any evaluation where malingering may be of concern.

The validity of the SIRS as an index of malingering in competency evaluations has been demonstrated. Clinicians can confidently use this instrument to assist with malingering determinations. However, cutoff scores may need to be adjusted as a function of the population of defendants evaluated. Although the GCCT-MSH should be subject to cross validation before being used as an index of malingering, extremely low scores warrant further evaluation of faking. It is best to use both instruments in combination with other malingering criteria, such as the MMPI or MMPI-2, and test for corroboration of findings. Although neither test was specifically designed to measure malingering of CST, participants instructed to fake incompetency and suspected malingerers perform significantly differently than competent defendants, incompetent defendants, and controls on both instruments.

We recommend that more research incorporating "suspected malingerers" be conducted. If simulation samples are to be used, continued enhancement of the external validity is recommended. It is also important to extend this research to other referral groups for whom malingering is a possibility. For example, evaluations of insanity and drug rehabilitation appropriateness warrant research of this nature. Because our subject pool did not include a sufficient number of minorities

to create subgroups for analysis, future research may want to examine how ethnicity effects SIRS and GCCT-MSH performance.

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