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Debasement and faking bad on the Millon Clinical Multi-axial Inventory III: An examination of characteristics, circumstances and motives of forensic patients

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Purpose. This article constitutes the first effort to consider debasement employing the Millon Clinical Multi-axial Inventory III (MCMI-III) in a forensic clinical population and incorporating the recommendations of Van Denburg and Choca (1997). It considers the proposition (Rogers, 1990a) that the pathogenic and criminological models of malingering can be rejected in favour of the adaptional model.

Methods. A total of 142 MCMI-III profiles were collected over a 17-month period by a forensic psychology service. Of these, 47 had Debasement scale scores greater than 74. From the remaining 75, a group of 47 were randomly selected for comparative purposes. Of the total sample there were 75 males and 19 females, 68 were out-patients and 26 were in-patients, the latter having been detained under the Mental Health Act 1983, applicable to England and Wales. The two groups were compared on personality variables, offending history, presenting problems and referral circumstances.

Results. There is tentative support for Rogers (1990a) in that situational variables appear to have a significant impact on debasement as would be predicted by the adaptional model of malingering. However, this was insufficient evidence to reject the pathogenic and criminological models of malingering.

Conclusions. It is suggested that a longitudinal study examining the impact of different stages of the mental health or criminal justice system on debasement, and other validity scales, would illuminate the adaptional model further. Factors that influence the inclination to exaggerate psychopathology and which could be manipulated experimentally are also noted. Some speculation about the possible combined use of Debasement and Histrionic, Narcissistic and Compulsive scales in distinguishing between malingerers is offered.

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The use of the Minnesota Multiphasic Personality Inventory (MMPI) to detect 'faking bad' has a long history. Schretlen (1988) reviewed 14 studies examining this subject, dating back to 1946. Schretlen concluded that normal participants can fake mental abnormality on the MMPI but 'malingered profiles can be accurately distinguished from non-pathological ones' (p. 473). However, it was more difficult to distinguish faked profiles from those offered by the genuinely mentally disordered. Heilbrun, Bennett, White, and Kelly (1990) built on this body of MMPI research to develop the MMPI-based Empirical Response Style (MERS) procedure to detect false profiles. A review of assessments of malingering and defensiveness using the MMPI and other objective personality inventories is available in Greene (1988). In Greene's chapter, the use of the first Millon Clinical Multi-axial Inventory (MCMI) in the detection of malingering, which until then had not featured in the literature, is referred to. The validity scales of the MCMI, and the assessment itself, have since developed to the extent that their role in the detection of malingering has been subject to significant research, some of which is reviewed below. One of the validity scales, used to modify the scores of the MCMI-III, is known as debasement (known as the Z scale). It is this scale and its place in detecting faking bad that is the particular interest of this article.

In the manual of his most recent of clinical inventories, Millon (1994) defines high scores on Debasement as 'an inclination to deprecate or devalue oneself by presenting more troublesome emotional and personal difficulties than are likely to be unconvered upon objective review' (p. 198). This scale has become most closely associated with the phenomenon of 'faking bad' or 'crying for help'. Faking bad on the original form of the MCMI (McNiel & Meyer, 1990; Van Gorp & Meyer, 1986) and MCMI-II (Bagby, Gillis, & Dickens, 1990; Retzlaff, Sheehan, & Fiel, 1991) has received some attention in the literature, typically by contriving circumstances experimentally. For example, Retzlaff *et al.* asked 250 student participants to answer the questionnaire with one of five instructions such as 'as if you were in a great deal of distress and wanted to get admitted to hospital' (p. 468). Other instructions asked participants to fake good. In addition three computer control groups of 50 profiles each were generated. As the MCMI is a true/false questionnaire and requires predominantly positive endorsement to score on scales, the proportion of positively endorsed items was varied in the random computer profiles.

Faking bad profiles were easily distinguished from randomly generated, 95% true profiles, as the former had lower response bias and greater variability. However random 50% true profiles could only be distinguished from fake bad profiles with the help of Desirability and Debasement validity scales. The important finding here is that fake bad profiles can be distinguished from random or response biased profiles.

Two other findings from this study are also interesting. It was observed that elevated Histrionic (H), Compulsive (C) and Narcissistic (N) characteristics are most notable on 'fake good' profiles, suggesting that there may be correlates from the personality pattern scales that operate inversely to Debasement. Secondly, 92% of profiles from clinical samples that had been told to fake bad had high Debasement scores. There remains a question of whether Histrionic, Compulsive

and Narcissistic characteristics among this group were abnormally low. In response to these contrived experimental studies Van Denburg and Choca (1997) have called for an empirical evaluation of the correlation between Debasement scale scores and idiosyncratic patient presentations.

One of the problems with identifying those who fake bad is the prevalence of high Z scores among some populations. In clinical populations it has been estimated that as many as 17% of those administered the MCMI-II had Debasement scores greater than BR84 (Wetzler & Marlow, 1990), suggesting that either the prevalence of 'faking bad' is high, or it is a generic index of psychological disturbance.

Among forensic populations Lees-Haley (1992) has noted a significant proportion of high Debasement scorers and that elevated scores on this scale readily distinguish between forensic and non-forensic populations. One possible interpretation is that as forensic populations, who may be more willing to falsify their responses, have high Z scores, it may be used to identify malingerers in other populations.

Others have questioned this, arguing that the inclination to score highly on the debasement scale is a characterological issue, perhaps one that is commonly found among forensic patients, rather than evidence of malingering (Price & Lees-Haley, 1994). Evidence in support of this comes from an earlier study (Bagby, Gillis, Toner, & Goldberg, 1991) where debasement and disclosure correlated with measures of dysthymia and major depression with coefficients as high as .98, although this can be interpreted in several ways. It seems likely that there will be some individuals subject to compulsory detention or forensic scrutiny who would wish to represent themselves in a very positive light. Differences between response styles may emerge in the comparison of those who are being required to undergo psychological evaluation and those who seek evaluation, perhaps as a means to increase their liberty.

A further problem is that defining malingering is not as straightforward as it might seem. DSM-IV (American Psychiatric Association, 1994, p. 683) offers the following definition, which gives weight to criminal intent:

> . . . intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives such as avoiding military duty, avoiding work, obtaining financial compensation, evading criminal prosecution or, obtaining drugs. Under some circumstances, Malingering may represent adaptive behaviour—for example, feigning illness while a captive of the enemy during war time.

This differs from the description of debasement offered by Millon, in that it emphasizes the participant's motive. In doing this, it implies that the circumstances of an assessment will have a bearing on the participant's response style or the propensity to dissimulate. For those who work in forensic psychology, this is a statement of the obvious.

Millon (1997, p. 166) would appear to concur, although he infers personological and pathological influences in those who exaggerate their disturbance:

> Perhaps there is no greater challenge in the forensic area than in detecting the true malingerer. This is always a possibility in a forensic case. There are multiple factors which can be operating other than the patient's intent to deceive.

Pollock (1996) makes this point when reporting that those with acquiescent response styles who are liable to interrogative suggestibility are readily classified as malingering when examined in a closed interview situation using verbally presented questions, such as that developed by Rogers, Bagby, and Dickens (1992).

Rogers (1990a, 1990b) offers three models of malingering to assist one's thinking about those who fake bad. The pathogenic model implies internal processes designed to cope with psychic tensions, and is closely associated with what has become known as factitious disorders. Rogers, Bagby, and Rector (1989) and Rogers (1990a) have offered critiques of the pathogenic model which, they argue, is based on tenuous logic and is without empirical support. The criminological model of malingering reflects the underpinning of DSM-III, -III-R and -IV implied explanatory processes of greed, dishonesty and deception for personal gain. It seems likely that no one would dispute that the criminal motivation does exist; however, Rogers argues that it is insufficient to explain all types of malingering. Rogers (1990a) reports findings that indicate that logical corollaries of this model, such as the expected prevalence of antisocial personality disorder among malingering groups, do not stand scrutiny. As a consequence of these limitations, Rogers offers the adaptional model, which draws on decision theory to postulate 'that malingerers perceive their circumstances as both adversarial and risky. In response to this, would-be malingerers seek the most advantageous choice to maximize their chances of success . . . Malingering is one of many options. The process is seen as adaptive . . . although the end result may not always be so' (p. 327).

This article arises from the work of a forensic psychology service within a regional secure unit. The authors observed a surprising number of elevated debasement (Z) scores among in-patients and out-patients and sought to explore this phenomenon. From a service point of view, they were interested to know the impact on Z of the purpose of their involvement. From a theoretical point of view it was thought important to explore debasement among clinical populations without experimental instructions. The article constitutes the first effort to consider debasement in this way, employing the MCMI-III and incorporating the recommendations of Van Denburg and Choca (1997).

It was anticipated that there could be evidence of the adaptational model arising from the data, in that circumstances of the participants' contact with the department would be significant in predicting Z.

Method

Sample

This study examined the MCMI-III profiles of 94 mentally disordered offenders referred to and assessed by a clinical psychology department in a regional secure unit between May 1996 and September 1997. The sample comprised 47 profiles with MCMI-III Debasement scores of over 74. These were identified among a total of 142 available MCMI-III profiles. In addition, a comparison group was created by randomly selecting a further 47 profiles from the remaining 95, where all scores on the Debasement scale fell below 75. It was important to determine a clinically meaningful discrimination between the groups. The difficult judgments to make are rarely those that involve

Table 1. Summary of primary psychiatric diagnosis for each group

Primary psychiatric diagnosis	High Z group (>74)	Not abnormal Z group (<75)
Schizophrenia / psychosis	7	15
Personality disorder	19	9
Depressive illness	3	6
Other[a]	8	3
None	10	14

[a]Other category included diagnoses of PTSD, OCD, anxiety, other neurotic mental disorders, epilepsy, and other organic mental illness.

participants who fall in the upper or lower quartile of any distribution. The question was how are those who score BR75 and greater different from those who score less than BR75, in terms of their characteristics and circumstances?

The total sample comprised 75 males and 19 females. Mean age was 32.58 years (SD = 9.27, min. = 17.97, max. = 57.19). Of the 94 participants, 68 were out-patients at the time of their assessment and 26 were in-patients at the regional secure unit, having been detained under the Mental Health Act 1983.

A formal diagnosis was not always stated within out-patient case records because of the administrative procedures falling into disuse. Clinicians failing to record the absence of a diagnosis partly explain these omissions in case notes. To remedy this problem, two raters allocated participants to one of the broad diagnostic categories indicated in Table 1. Having reviewed these case records 24 out-patient participants did not have a diagnosis and were allocated the status of None. A further 24 omissions in the remainder of the sample were identified. Omissions of all types were equally distributed in the two groups. The inter-rater reliability of this process was assessed by random selection of 20% of these participants who were categorized by two raters, which resulted in a mean percentage agreement of 90% (κ = .80), indicating good inter-rater reliability.

Measure

The MCMI-III is a 175 item true–false self-report inventory. Each item contributes to one or more of 27 scales. The MCMI-III comprises 11 basic personality scales (Schizoid; Avoidant; Depressive; Dependent; Histrionic; Narcissistic; Antisocial; Aggressive; Compulsive; Passive–Aggressive; Self-defeating); three severe personality scales (Schizotypal; Borderline; Paranoid); seven clinical syndrome scales (Anxiety; Somatoform; Bipolar; Manic; Dysthymia; Alcohol Dependence; Drug Dependence; Post-traumatic Stress Disorder); and three severe syndrome scales (Thought Disorder; Major Depression; Delusional Disorder). In addition, the MCMI-III incorporates three modifying indices (Disclosure, Desirability and Debasement scales) which serve to adjust scores on the aforementioned scales according to the patient's response style. The MCMI-III is scored by converting raw scores to base rate (BR) scores, which take into account the prevalence of personality and clinical syndromes within clinical populations. Based on these data, a BR score of over 74 indicates the presence of personality or symptom features, whereas a BR score of over 84 suggests that the syndrome is prominent (Millon, 1994).

Procedure

Having obtained prior permission from the clinicians concerned, the corresponding case notes for each of the 94 MCMI-III profiles were examined. For each individual, additional information pertaining to diagnosis, referral reason, presenting difficulties, index offence(s), previous conviction(s), and previous therapeutic input was collated.

Results

The MCMI-III modifying indices and personality scales of the two groups of high and not abnormal Debasement participants were compared using MANOVA followed by a series of univariate F tests. Comparing the modifying indices of the two groups using MANOVA (d.f. = 1,2) yielded a significant main effect supported by Wilk's Lambda .38 ($p < .0000$). Comparison of the groups in respect of combined clinical and severe personality scales indicate a similar finding of significant main effect supported by Wilk's Lambda .36 ($p < .0000$).

The results of the univariate analysis for both comparisons are shown in Table 2, which shows how the two groups compare in terms of the modifying indices (Disclosure, Desirability and Debasement), and in terms of the clinical and severe personality characteristics. From Table 2 it is evident that the high Debasement group had significantly higher scores on Disclosure and Debasement and significantly lower scores on the Desirability scale.

In terms of the clinical and severe personality scales (Table 2), the high Debasement group had significantly higher scores on all scales except for Histrionic, Narcissistic and Compulsive, on which the not abnormal Debasement group had significantly higher scores. This latter finding concurs with those of Retzlaff *et al.* (1991), as described in the introductory text above.

Table 2. Differences (univariate F test) between high and not abnormal Debasement groups on the modifying indices, clinical and severe personality characteristics

	High Z group (>74)		Not abnormal Z group (<75)			p level
	Mean	SD	Mean	SD	F	d.f. = 1,92
Disclosure	85.55	9.33	58.27	16.07	2816.27	.0000
Desirability	33.36	18.07	64.46	18.49	672.84	.0000
Debasement (z)	85.10	6.86	53.06	17.40	2565.36	.0000
Schizoid	76.25	17.58	48.19	27.67	677.21	.0000
Avoidant	79.11	11.14	46.40	29.22	757.38	.0000
Depressive	87.89	10.77	53.17	30.00	920.66	.0000
Dependent	73.76	15.54	55.94	26.81	823.25	.0000
Histrionic	21.64	17.44	50.72	20.32	343.28	.0000
Narcissistic	36.15	17.70	57.38	19.20	602.90	.0000
Antisocial	68.25	15.42	61.85	23.35	1015.84	.0000
Aggressive	66.64	14.75	53.96	19.74	1125.66	.0000
Compulsive	26.51	17.61	49.55	19.46	394.85	.0000
Passive–aggressive	82.98	10.48	56.47	26.87	1098.34	.0000
Self defeating	78.06	9.78	51.51	26.74	973.46	.0000
Schizotypal	78.34	12.60	44.45	28.48	730.81	.0000
Borderline	84.32	9.68	54.87	22.91	1471.61	.0000
Paranoid	77.66	14.67	50.15	27.51	789.99	.0000

Table 3. Groups compared in terms of age and number of offences

	High Z group (>74)		Not abnormal Z group (<75)				
	Mean	SD	Mean	SD	t	d.f.	p^*
Age	32.79	8.82	32.35	9.85	0.22	87	.8259
No. index offences	0.83	1.13	1.23	1.72	−1.35	92	.1817
No. prev. offences	2.34	3.21	2.45	4.15	−.14	92	.8898
Total no. offences	3.17	3.67	3.68	4.74	−.58	92	.5609

*Bonferroni adjustment indicated p value of .002 as acceptable.

Table 4. Summary of offence types for each group

Type of offence	High Z group (>74) N	Not abnormal Z group (<75) N
Acquisitive	25	18
Homicide	1	5
Against the person	17	19
Sexual	4	8
Destructive	14	13
Public order	8	10
Miscellaneous	8	11

Note. N is the number in each group with at least one offence of the given offence type. The offence categories are not mutually exclusive: an individual can have committed offences of more than one type.

The high Debasement group consisted of 37 males and 10 females, and the not abnormal debasement group of 38 males and 9 females ($\chi^2(1)$ = .00, p > .05, n.s.) (Pearson χ^2 with Yates' correction is used as the statistical measure of significance). The continuous variables of age and number of offences for the two groups were compared using independent samples t tests. The results of these tests are presented in Table 3. There were no significant differences between the groups either in terms of the number of index offences or number of previous offences, although the mean for both measures was higher in the not abnormal Debasement group. Similarly, Table 4 shows the distribution of offence types in both groups, between whom no significant differences were found.

The groups were found to differ in only one diagnostic category (Table 1). Individuals in the high Debasement group are more likely to have a primary psychiatric diagnosis of Personality Disorder ($\chi^2(1)$ = 4.12, p < .05).

From Table 5, it is evident that individuals who are referred for routine in-patient clinical assessment tend to fall into the not abnormal Debasement group

Table 5. Groups compared in terms of reason for referral

Reason for referral	High Z group (>74) N	Not abnormal Z group (<75) N
Routine admission/assessment	5	16
Initial assessment for treatment or risk management	14	7
Anger management assessment	16	3
Assessment for admission to regional secure unit	1	0
Child protection issues	4	10
Court assessment	5	10
Suggestibility	1	1

Table 6. Summary of reason for referral

Reason for referral	High Z group (>74) N	Not abnormal Z group (<75) N
Required assessment (imposed)	15	36
Desired assessment (patient-driven)	31	11

($\chi^2(1) = 5.88$, $p < .05$). In contrast, individuals who are referred for anger management assessments tend to have high Debasement scores ($\chi^2(1) = 9.85$, $p < .01$).

A further analysis of presenting difficulties was attempted, but the large number of categories meant that cell size was too small for meaningful comparisons. Some potential differences are indicated though. All individuals referred for child protection issues, sexually deviant behaviour, substance abuse and disturbed behaviour (total 14) fall into the not abnormal Debasement group. This is also true of all except one of the individuals presenting as acutely psychotic (total 7). It might be argued that these participants represent those who have no desire to be seen as disturbed, in order to secure release or access to their family. Conversely, all but one individual presenting with self-harming behaviour, and all of those presenting with depressed mood, disturbing ideation or confusion (total 14) fall into the high Debasement group.

Table 6 summarizes the data in Table 5 and shows the number of individuals in each group referred for imposed and patient-driven assessments. It emerged during the analysis that individuals referred for routine admission assessments, child protection issues and court assessments could be regarded here as having these

assessments imposed upon them, whilst the remainder of the sample might be classified as participating in patient-driven assessments.

This distinction is not ideal because it infers the nature of motivation on the basis of circumstances without taking into account the participants' individual psychological motivation. Nevertheless it may be the case that those on whom such assessments are made have a vested interest in participating in order to achieve their goals, that typically involve access to their family, or discharge from secure provision. Hence these two broad categories of required and desired assessment groups would seem to be a potentially useful distinction to make. Table 6 supports this conclusion by indicating a predominance of desired assessments in the high debasement group and required assessments in the not abnormal Debasement group ($\chi^2(1) = 16.43$, $p < .01$). Closer examination of this distinction in a subsequent study where the motivations of individuals have been more specifically ascertained may be useful.

Discussion

This statistical reflection on this clinical sample would appear to be congruent with Rogers' (1990a) support of the adaptional model of malingering. Situational variables (i.e. the circumstances of the assessment) appear to have an impact on Z as would be predicted by the adaptional model of malingering.

It would seem pertinent to consider a more systematic appraisal of the perceived functional utility/secondary gain of being assessed in respect of avoiding prison, discharge from security, access to children/family and so on, in each case. Closely associated with this is the phenomenology of need. That is, to what extent does a particular individual value the potential outcomes of being assessed? It is only in understanding the participant's attributions about the assessment process and the meaning of the potential outcomes that one can begin to understand their motivation to dissimulate. Varying these characteristics would seem to offer one means of exploring the parameters of malingering and one's capacity to predict, identify and manage it. It could also be hypothesized that a longitudinal study examining the changing Z and other validity scales at differing stages of the mental health or criminal justice system would illuminate the adaptional model further.

Criminal motives have not been specifically examined in this sample, although there is no evidence of differences between the groups in respect of offending behaviour or numbers of offences committed. There remains a question about the role of pathology in those who 'fake bad'. Tables 1 and 2 clearly indicate differences between high debasement participants and those with no significant elevation of Debasement in respect of their diagnosis and personality. It is therefore obvious that pathology is evident in the differences between the groups. Several issues are raised by this observation.

One question is to consider whether these diagnostic and personality differences explain the variation of Z, or whether such variations predict diagnosis and personality. It was observed that those with a diagnosis of schizophrenia/psychosis are more than twice as likely to be in the not abnormal Debasement group (15/7).

The overwhelming number of these schizophrenic patients are also inpatients (14/15). It may be reasonable to infer that those diagnosed as suffering from schizophrenia/psychosis, being cared for in hospital and who are well enough to complete psychometric assessments are generally concerned not to be seen as worse than they are, and hence do not exaggerate their psychopathology. It may be that some participants of this subgroup are keen to portray themselves in a negative way as a means of sustaining their dependence on supportive care. This proposition is supported by a supplementary *t* test comparing dependent scores of the five schizophrenia/psychotic in-patients in the high Debasement group (M = 89.2) with the 14 similar participants in the not abnormal group (M = 64.3). This reveals significantly higher scores among the five high Debasement group in-patient participants (t = 2.32, p = .033). In general terms, for the majority it can be argued that it is not their diagnosis that predicts Z but their circumstances. However there appears to be a minority who are likely to display a strength of motivation to meet psychological needs through representing themselves negatively, offering some support for the pathogenic model of malingering rejected by Rogers (1990b).

A second and related issue is to distinguish between those who fake bad as a result of an adaptive motive to do so, and those who characteristically express themselves and describe their experience in an exaggerated form. One possible way of distinguishing those who are actively seeking to 'fake bad' from those who perceive themselves to be suffering greatly, regardless of objective review, may be the combination of Z and Histrionic, Narcissistic and Compulsive scales. The not abnormal Debasement group had significantly higher scores on these three scales, a finding which concurs with research into faking good profiles on the MCMI-II (Retzlaff *et al.*, 1991).

The combination of high Z and low H, N and C might prove to be a useful apparent and subtle means of identifying those who make deliberate efforts at faking bad (high Z and very low H, N and C) and those who experience great need (high Z but moderate H, N and C). If this is so, then there may be a means of distinguishing between those with adaptional sources of malingering and those with other motivations, and managing them accordingly.

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