How to detect the malingering of insanity to avoid criminal responsibility

Authors: Francisca Fariña, Ramón Arce and Mercedes Novo

Abstract

In a task of simulated criminal insanity, a sample of experts and laypeople in psychopathology were asked to simulate a mental disorder in order to avoid criminal responsibility. The results reveal a high level of malingering (78.8% of the subjects could simulate insanity), and no differences were observed between laypeople and experts. The control scales of the MMPI, and the configuration of the scales of validity, confirm that they are effective though they have a margin of error, given that they fail to classify 7.5% of subjects who simulated criminal insanity. Moreover, the scales are not a robust index because alternative hypotheses are possible. Thus, a complementary instrument was employed i.e., a clinical interview with a free discourse format". This procedure was much more difficult to simulate since 58.8% were incapable of simulating insanity, this figure rising to 71.25% taking into account the absence of internal consistency in the interview. Nevertheless, the margin of error was significantly large, 28.75%. Consequently, a multimethod approach (MMPI and interview) was contrasted and observed to classify correctly all subjects. Thus, we estimated the efficiency and subsequently the need for "convergent invalidity" based on, at least, two methods of assessing inconsistency in order to label a protocol as malingering. Practical guidelines are established for the detection of simulated and false positives in the legal context.

Keywords: criminal responsibility, forensic psychology, insanity, malingering, mental disorder, simulation.

Introduction

Under Spanish law, three legal criteria must be considered for judgement-making: an offence, offender, and criminal responsibility. An offence is an act that contravenes the statute of the Spanish Penal Code; an offender is the actor/s who has/have committed the offence; and criminal responsibility refers to the accountability of the offender. Accountability entails the ability to distinguish between right and wrong and free will (Cabrera and Fuertes, 1997). Consequently, Spanish Supreme Court has ruled that, if at the time of committing a crime (actus rea), cognition and/or volition were impaired the offender should be acquitted (e.g., the Supreme Court ruling of 22 April 1982, RA 2104). Two factors may limit criminal responsibility: mitigating circumstances involving partial exemption of criminal responsibility and consequently a partial reduction in the sentence (Spanish Penal Code, 1995, art. 61), and criminal insanity where the offender is entirely exempt of criminal responsibility.

Spanish jurisprudence has established several sources of criminal insanity leading to complete acquittal: schizophrenia (e.g., Spanish Supreme Court ruling of 22 December of 1984, RA 6633), paranoia (delirium) (Spanish Supreme Court ruling of 15 October 1984, RA 4839), mental handicap or retardation IQ below 25 (Spanish Supreme Court ruling of 13 December 1994, RJ 10147), senile dementia (Spanish Supreme Court ruling of 24 June 1994, RA 5028), epilepsy (Spanish Supreme Court ruling of 28 September 1996, RA 6934) and transitory mental disorders (TMD) if associated to paranoia or schizophrenia. Other mental disorders such as depression, personality disorders, drug addiction (except when there are other pathological symptoms like psychosis), compulsive gambling, are not sufficient grounds for acquittal though they are considered to be mitigating circumstances (for further examples see a review of the literature by Torre 1999). Thus, as Carbonell, Gómez and Mengual´s (1987) review has shown that in most judgements unaccountability was based on insanity, that is, paranoia, schizophrenia, and TMD.

Given that diminished criminal responsibility due to mental illness leads to lighter sentencing, defendants often attempt to malinger mental illness in order to obtain a lighter sentence or to elude legal responsibility. The DSM-IV defines malingering as "the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives (American Psychiatric Association, 1994, p. 683) such as avoiding a prison sentence. Malingering implies the wilful and conscious attempt to fake, the malingering of pathological disorders or symptoms aimed at obtaining benefits i.e., lighter sentencing or acquittal (Gisbert, 1991).

Psychologist and psychiatrists are often required to assist the court to determine insanity or mental illness, and thus criminal responsibility, through biological examination to diagnose the mental disorder e.g., schizophrenia, retardation, followed by psychological examination to asses the degree of cognitive capacity or volition. Nevertheless, traditional clinical evaluation techniques do not appear to be effective in determining malingering due to the fact that they are not intended or designed to do so (Rogers, 1997a). This underlines the need to develop procedures designed to evaluate mental illness and malingering. Thus, this work seeks to evaluate the effectiveness of two methods, a psychometric measurement instrument i.e., MMPI, and an interview designed to detect the malingering of two mental disorders frequently malingered in legal contexts: schizophrenia and paranoia (Carbonell, Gómez and Mengual, 1987). A further objective is to establish a protocol for the Spanish judicial context.

Method

Sample

The sample was composed of a total of 80 subjects, 40 of which were psychology students with knowledge in Psychopathology from the University of Santiago de Compostela, and the other 40 subjects were laypeople with no knowledge of psychology. According to gender, there were 29 men (36.25%) and 51 women 63.75%, with an age range of 19 to 45, mean age 25.09 (Sx=5.32). 64 subjects were university graduates (80%), 4 (17.5%) were from high school, and 2 (2.5%) had elementary schooling.

Design

Psychopathological evaluation was undertaken using two measurement instruments i.e., the MMPI and the clinical interview with a free discourse format. Subjects were first required to complete to the MMPI questionnaire as part of standard clinical observation (control condition). This procedure was undertaken as a safeguard to identify any mentally ill subjects in order to exclude them from the study.

Thereafter, the subjects were asked to imagine they had committed a serious offence, and that their defence council had requested a psychopathological examination to plead insanity. To give them the chance to malinger realistically, the subjects were given time (approximately 7 days) to

think about how they should behave in order to malinger the mental illness. Then they were administered the MMPI again (malingering condition).

Two weeks after the MMPI and without warning, the subjects were evaluated using a free-narrative account interview. The interviews were recorded on video to be analysed and encoded in order to identify the malingered mental illness in relation to the diagnostic criteria outlined in the DSM-IV.

The experimental design consisted of two groups i.e., a group of laypeople who had no knowledge of psychopathology, and the group of experts who had studied psychopathology as part of their degree in psychology. The aim of this design was to assess the ability to malinger mental illness, and evaluate the inter-measurement consistency between the MMPI and the free narrative account interview, and the consistency through time.

Measurement instruments

According to the prescriptions reported in the literature (Shuman, 1994), the MMPI of Hathaway and McKinley (1988) edited and adapted for the Spanish context by Tea was employed as a psychometric instrument to measure psychopathology. Furthermore, in order to contrast the convergent validity of the measurements, the subjects were also evaluated using a "free-narrative clinical interview", where subjects were required to talk about their mental state, i.e., symptoms, feelings, behaviour, at the time of committing the offence in order to recreate the context (that is, EEAG referred to clinical evidence in V axis of DSM-IV). If subjects did not respond spontaneously, they were prompted by open questions, according to the V axis of DSM-IV, about their relationships i.e., family and social ties (EEGAR) and social relations i.e., interpersonal relations, work or school relations (EEASL) e.g., How did you get on with your family? The plausibility of this instrument lies in that, a priori, all the subjects were able to describe their symptoms, behaviours, and thoughts by narrating the events. Thus, all subjects followed malingering strategies that involved co-operation, that is, no subject avoided answering. This instrument may be generalised to the real context since even elderly subjects or those suffering from neurological disorders have a considerable capacity to store and recall information if it is set in a visual context (Freed and cols., 1989; Tombaugh, 1997); or even the most difficult or rare symptoms and experiences can be reported by patients, though to a lesser degree (Lewis and Saarni, 1993). This procedure has proven to be reliable, valid, and productive for the detection of simulated post-traumatic stress disorder linked to false claims of sexual aggression or intimidation (Freire, 2000; Arce, Fariña and Freire, in press).

Fariña, F., Arce, R. & Novo, M. (2004). How to detect the malingering of insanity to avoid criminal responsibility. In R. Abrunhosa (Ed.), *Victims and offender: Chapters on psychology and law* (pp. 229-241). Brussels: Uitgeverij Politeia NV. **ISBN: D-2004-8132-142.**

Hypothesis

H1.- Subjects, both lay and experts, were expected to be able to malinger mental illness related to criminal insanity on the MMPI (Rogers, 1997b).

H2.- Subjects will not attempt to simulate all the mental illnesses included on the MMPI. That is subjects will employ symptom discrimination strategies.

H3.- Mediated by "metasimulation" (Porot, 1977; Aldea, 1994), the experts will be better at simulating mental illness than the lay subjects.

H4.- Presumably, the control scale of the MMPI will detect most of the simulation.

H5.- The free narrative account clinical interview will detect robust simulation.

Analysis of the protocols

The free-narrative interviews were recorded on video for systematic content analysis. The objective was to detect diagnostic criteria of mental illness. The analysis categories were taken from the criteria of the DSM-IV. Thus a mutually exclusive categorical system was created, which was reliable and valid, in terms of what Weick (1985) called a methodic categorical system.

The category detection responded to two complementary methods: the subject's direct response or the encoder's inferences of the protocols. For example, the memory loss may be overtly manifested by the subject or might be inferred by the encoder during the codification of the interview.

The clinical content analysis of the protocol followed four steps: (a) the encoders evaluated the incidence of the symptoms; (b) whether the symptoms constituted a mental illness; (c) the internal consistency (consistent v. inconsistent) of the subject's free narrative interview was evaluated using six traditional simulation strategies described in the literature: rare symptoms, symptom combination, obvious symptoms, consistency of symptoms, improbable symptoms and severity of symptoms; and (d) the extent to which the mental illness detected was sufficient grounds for acquittal according to the criteria established by the research team.

The internal consistency of the interview was evaluated using content analysis designed to identify the six forms of malingering described in the literature: a) rare symptoms, that is, infrequent symptoms in psychiatric populations; b) symptom combination which never appear simultaneously c) obvious symptoms; d) inconsistency of symptoms; e) improbable symptoms with a high probability that they are never true; and f) extreme severity of symptoms i.e., more than 60% of

symptoms reported were extreme (for a definition of each category and examples see Rogers & Mitchell, 1991).

Reliability

The protocols of the free narrative interview were submitted to content analysis by four expert encoders (Freire, 2000; Jólluskin, 2000), who were trained specially for this study with examples taken from each category. The encoders were divided into two groups of two encoders each who jointly evaluated the protocols. Each group encoded 50% of the interviews of each of the experimental conditions.

To assess within-judge reliability, the encoders of each group repeated the encoding of 10 of their own interviews one week later. Likewise, to assess between-judges reliability the encoders of each group encoded 10 of protocols that had initially been encoded by the other group.

In the all of the variables measured i.e., the criteria of the DSM-IV, the within- and between-encoder consistency computed using the Agreement Index [AI= agreements/ (agreements + disagreements)] was greater than the cut-off .80[1] (Tversky, 1977). Moreover, the encoders classified the protocols as internally consistent or internally inconsistent, when they detected the presence of rare symptoms, indiscriminate grouping of symptoms, inconsistency of symptoms, severity of symptoms (>60% of the extreme symptoms), obvious symptoms and/or improbable symptoms. The results showed total within- and between-encoders consistency between the symptoms observed and the mental illness described in the criteria of the DSM-IV as well as in the classification of the mental illness described criminal responsibility or criminal insanity.

Thus, having contrasted the results i.e., the within and between encoder consistency, we can conclude that our results are reliable (Wicker, 1975).

Results

Evaluation of simulations in the MMPI clinical scales

---

[1] Raw data is too extensive to be included in this work, for further details of raw data contact the authors.

Fariña, F., Arce, R. & Novo, M. (2004). How to detect the malingering of insanity to avoid criminal responsibility. In R. Abrunhosa (Ed.), *Victims and offender: Chapters on psychology and law* (pp. 229-241). Brussels: Uitgeverij Politeia NV. **ISBN: D-2004-8132-142.**

Table 1. *Means and standard deviations in the MMPI clinical scales. Malingering responses.*

Variable	m*	Sx*	m**	Sx**	m***	Sx***
Hypochondriasis	65.03	17.09	62.43	19.91	18.62	67.63
Depression	64.80	15.07	62.35	15.49	67.25	14.41
Hysteria	59.33	13.48	58.33	13.69	60.33	13.37
Psychopathic deviation	75.61	12.62	77.35	11.79	73.88	13.32
Masculinity-femininity	57.13	12.50	58.68	13.38	55.58	11.53
Paranoia	81.22	14.38	82.45	14.68	80.00	14.16
Psychasthenia	63.24	11.63	62.10	12.17	64.38	11.09
Schizophrenia	80.78	12.49	82.00	12.14	79.55	12.87
Hypomania	64.91	13.45	67.60	12.31	62.23	14.14
Social introversion	66.71	12.69	63.98	14.29	69.45	10.33

*Total sample; **experts; ***laypeople.

The results show that, with a cut off point of 70 in T scores, that is, the point of reference beyond which a subject is considered to be pathological (e.g., Roig-Fusté, 1999), subjects were capable of effectively malingering the following disorders: psychopathic deviation (Pd), paranoia (Pa), and schizophrenia (Sc) (see Tables 1 and 2). In terms of subsamples, lay subjects were able to malinger paranoia (Pa) and schizophrenia (Sc), but for psychopathic deviations marginally significant differences were found. The experts exhibited significantly higher pathological disorders in psychopathic deviation (Pd), paranoia (Pa) and schizophrenia (Sc). In short, the subjects as a whole were capable of malingering a mental illness to avoid criminal responsibility, i.e., paranoia and schizophrenia, which supports the first hypothesis. Nevertheless, they failed to simulate psychopathic deviation associated to criminal responsibility. In other words, they do not differentiate psychopathic deviations. Moreover, in relation to the second hypothesis, the results show there is no "attempt to malinger all the symptoms included in the MMPI".

Table 2. *T for a sample with a test value of 70. Malingering responses.*

Variable	t(79)*	p	t(39)**	p	t(39)***	p
Hypochondriasis	-2.390	.019	-2.407	.021	-.879	.385
Depression	-3.087	.003	-3.124	.003	-1.207	.235
Hysteria	-7.082	.000	-5.392	.000	-4.578	.000
Psychopathic deviation	3.978	.000	3.944	.000	1.840	.073
Masculinity-femininity	-9.210	.000	-5.355	.000	-7.915	.000
Paranoia	6.981	.000	5.365	.000	4.466	.000

Psychasthenia	-5.203	.000	-4.106	.000	-3.208	.003
Schizophrenia	7.717	.000	6.254	.000	4.694	.000
Hypomania	-3.384	.001	-1.234	.225	-3.477	.001
Social introversion	-2.317	.023	-2.667	.011	-.337	.738

*Total sample; **experts; ***laypeople.

Evaluation of the variables knowledge and malingering

The subsample factor (experts vs. lay) did not mediate differences in the malingering of psychopathological disorders, $F_{multivariate}(10,69)=1.345$; ns; T.E.=.163. Likewise, the univariate effects (see Table 3) did not exhibit significant differences in any of the pathological variables measured by the MMPI, that is, there are no differences between experts and laypeople in their ability to malinger mental illness. This does not support the "metasimulation" hypothesis (Porot, 1977; Aldea, 1994),that predicts the greater ability of experts in malingering mental illness. Moreover, the cases study of malingering capability revealed that, of the 62 subjects who were able to malinger schizophrenia, 29 were lay and 33 experts. Thus, experts and lay subjects showed similar malingering abilities, $X^2(1)=.258$; ns. In relation to paranoia, of the 67 subjects who scored higher than 70, 32 were lay and 35 experts. Once again, the findings do not confirm that experts are better at malingering than laypeople, $X^2(1)=.134$; ns.

Two possible explanations are that either experts are not better at malingering mental illness than lay subjects, or that the material itself may be suggestive i.e., the closed-ended items (true vs. false) are inductive to responses of mental illness.

Table 3. *Test of the inter-subject effects.*

Variable	MC	F	p	eta^2	m$_{lay}$	m$_{expert}$
Hypochondriasis	540.800	1.572	.214	.020	67.625	62.425
Depression	480.200	2.146	.147	.027	67.250	62.350
Hysteria	80.000	.437	.511	.006	60.325	58.325
Psychopathic deviation	241.513	1.526	.220	.019	73.825	77.350
Masculinity-femininity	192.200	1.233	.270	.016	55.575	68.675
Paranoia	120.050	.577	.450	.007	80.000	82.450
Psychasthenia	103.513	.764	.385	.010	64.375	62.100

Schizophrenia	120.050	.768	.384	.010	79.550	82.000
Hypomania	577.813	3.288	.074	.040	62.225	67.600
Social introversion	599.513	3.857	.053	.047	69.450	63.975

D.F.(1,78).

Analysis of the MMPI validity scales

The ? scale (i.e., the non-response scale) classifies protocols as valid only if less than 30 items are unanswered. Our data show that all the protocols are valid since the maximum number of unanswered items in any particular protocol was never above 8 and 82.5% of the subjects answered all items. This finding is not in line with the assumption of the criminological model (American Psychiatric Association, 1980) that malingerers will resort to the strategy of avoiding answering. Thus, the use of "non-answer" as a criterion for detecting malingering is counterintuitive (Rogers, 1997b). It is plausible to suggest that malingerers do not resort to the answer avoiding strategy because they are in the belief that the burden of proof of insanity falls on them, and thus they must directly mislead the evaluator. The lie scale mean (m=53.913) was within the value range of the valid protocols. As for the case study, all of the protocols were valid. Thus, as expected, the protocols do not portray images of socially desirable subjects. The frequency scale mean, designed to detect attempts to give a bad impression (90.18; S_x=11.62), was not within the value range (i.e., T>70) of the valid protocols, and classified correctly 88.7% of the protocols as malingerers, indicating it is an effective discriminator $X^2(1)$=48.05; p<.001. The defensiveness scale mean (K factor) (m=38.66; S_x=9.06), designed to measure the exaggeration of symptoms, showed that, in general, the protocols were not valid (the cut-off being T<50) because they were malingering. The case study revealed 87.5% of the protocols were correctly classified as malingerers, indicating that it is a robust simulation indicator, $X^2(1)$=45; p<.001.

Two combinations of validity scales have been described in the literature for the evaluation of malingering (Duckworth and Anderson, 1995): the F-K index, known as the Gough index, and the "inverted V" profile. F-K index was found to be a robust indicator in the detection of attempts to malinger a bad image (Nicholson et al., 1997). A subject is considered to be malingering a bad image if the difference in T scores is equal to or greater than 30 (Zabalegui, 1990). Our results show the mean (m=51.825; S_x=16.5359) was higher than this cut-off. As for the case study, this index correctly classified 90% of bad image malingerers, which confirms the reliability of this instrument in the detection of malingering, $X^2(1)$=51.2; p<.001. According to the predictions of the "inverted V" profile, subjects with L and K below 50 and F above 80, are probably exaggerating symptoms. A

total of 48 subjects (60%) were detected as exaggerating symptoms, which means this profile is not more reliable than chance, $X^2(1)=3.2$; ns. On the whole, the results confirm the predictions of hypothesis number 4 given that the validity scales were effective. Nevertheless, we should also bear in mind that really mentally ill subjects would also be detected by these scales leading to "false positives" (e.g., Roig Fusté, 1993; Hathaway & McKinley, 1999).

Analysis of malingering at the interview

A total of 35 subjects (43.8%) were incapable of malingering mental disorders, 45 (56.2%) were able to malinger at least one mental illness (see results of specific disorders in Table 4) but 12 were unable to malinger criminal insanity. Of the 33 subjects who were able to malinger insanity, the internal consistency analysis of the interview revealed that 10 interviews were internally inconsistent, that is, rare symptoms, symptom combinations, obvious symptoms, inconsistency of symptoms, improbable symptoms, and/or extreme severity of symptoms were reported. Consequently, a total of 57 subjects (71.25%) were detected as malingerers, indicating that this type of interview is robust for the detection of malingering as predicted by the fifth hypothesis, $X^2(1)=14.45$; p<.001. As for the subsamples, 22 experts subjects (55%) were effective malingerers at the interview in comparison to 11 lay subjects (27.5%), which indicates that experts better malingerers, $X^2(1)=5.16$; p<.05; phi=.279. In all likelihood, these results are due to the experts' knowledge of psychopathology that the lay subjects tried to compensate for this deficiency by reporting obvious or rare symptoms (Greene, 1980). That is, the metasimulation hypothesis would explain the better performance of the experts at the interview (Porot, 1977; Aldea, 1994).

Table 4. *Contingency of the disorders malingered at the interview.*

Disorder	Frequency(%)
No disorder	35(43.8%)
Delusions of grandeur disorder *	3(3.8)
Delusions of zelotypic disorder*	1(1.3)
Delusions of persecution disorder *	4(5.0)
Paranoid schizophrenic disorder *	13(16.3)
Undifferentiated schizophrenia*	4(5.0)
Depression with psychotic symptoms *	1(1.3)
Unspecified psychotic *	4(5.0)

Antisocial personality disorder	2(2.5)
Schizoid personality disorder	4(5.0)
Paranoid personality disorder	1(1.3)
Schizotypal personality disorder	1(1.3)
Narcissist personality disorder	1(1.3)
Avoidant personality disorder	1(1.3)
Dysthymic disorder	1(1.3)
Dyscontrol disorder	1(1.3)
Paranoid schizophrenia + antisocial personality disorder*	1(1.3)
Dysthymia with psychotic symptoms *	1(1.3)
Paranoid schizophrenia + schizoid personality disorder *	1(1.3)

* Effective malingering of criminal insanity.

Analysis of the between-measurement consistency: MMPI and interview

One of the key strategies for detecting malingering is to evaluate the consistency of symptoms in terms of time and between-measurements (Rogers & Mitchell, 1991). The results for the between-measurements agreement (see Table 5) reveal a high degree of consistency (about 30%) among subjects with paranoia, and/or schizophrenia. Nevertheless, the lack of consistency is a robust indicator of malingering since it detects 70.1%, $X^2(1)=10.881$; p<.001, of the false paranoids, and 64.3%, $X^2(1)=5.714$; p<.05 of the false schizophrenics. Moreover, if all the variables (e.g., depression, hysteria, etc), and not just those relating to criminal insanity, are considered, the inconsistency rises to 97.5% (only two subjects revealed total between-measurements consistency).

In short, between-measurement consistency is a reliable indicator for the detection of malingerers, it also highlights the limitations: a) a measurement error (mainly in the content analysis of the protocols, and in particular the analysis of specific cases); b) limitations in the subject's responses (thus subjects may have difficulties in exhibiting symptoms in the free-narrative account interview); or c) that the inconsistency is the product of a mental illness itself. These considerations underline the drawbacks of this method if used in isolation.

Table 5. *Contingency of between-measurement agreement*.

Variable	Consistency	Inconsistency
Hypochondriasis	------	35(100%)
Depression	2(6.3%)	30(93.8%)
Hysteria	------	20(100%)
Psychopathic deviation	3(4.9%)	58(95.2%)
Masculinity-femininity	------	12(100%)
Paranoia	20(29.9%)	47(70.1%)
Psychasthenia	------	27 (100%)
Schizophrenia	25(35.7%)	45(64.3%)
Hypomania	------	37(100%)
Social introversion	32(54.2%)	27(45.8%)

Combination of indexes

Three control indexes were used in this study to detect malingering: a) malingered illness with no criminal responsibility; b) detection by the validity scales and combinations of validity scales of the MMPI, and the internal consistency of the interview; and c) the between-measurements consistency. First, for a subject to be considered as criminally insane s/he must have malingered one or more of the criminally insane disorders. In other words, the subject who cannot malinger this type of illness will not pass the first cut-off for being declared criminally insane. Second, the measurements must be internally consistent in the interview and pass the validity scales of the MMPI. It is important to note that if both do not occur it would clearly indicate the lack of reliability of the data. Third, the evaluation must be between-measurement consistent over span of time. The analysis of the case studies showed that the malingerers were correctly detected by at least two different indexes. Thus, in order to classify a protocol as a malingerer at least two invalidation indexes need be considered i.e., a "convergent invalidity" is required.

Discussion

The results highlight the following practical implications:

A) Malingering criminal insanity is possible in psychometric instruments i.e., MMPI.

B) The validity control scales of the MMPI are robust indicators of malingering.

C) Metasimulation (Porot, 1977; Aldea, 1994) is not a valid construct to explain the ability to malinger on the MMPI given that laypeople and experts malinger to the same degree. Consequently, no specific training is required to malinger effectively on the MMPI.

D) Contrary to the assumption of the criminological model (Lewis and Saarni, 1993), malingerers do not employ an evaluation avoidance strategy.

E) The free-narrative interview together with the analysis of internal consistency (rare symptoms, symptom combination, obvious symptoms, consistency of symptoms, improbable symptoms and severity of symptoms) is a robust detector of malingering. In this evaluation method, experts seem to be better malingerers than laypeople lending support to the metasimulation hypothesis (Porot, 1977; Aldea, 1994).

F) All of the malingering indexes are only partially reliable.

G) A combination of indexes is required in order to detect malingerers.

H) Convergent invalidity with at least two malingering indexes is advisable given that, in isolation, each index is subject to a considerable degree of error. Furthermore, convergent invalidity would minimise the margin of error and increase detection of malingerers since it correctly classified all subjects under study.

Nevertheless, convergent invalidity entails a certain degree of error given that false positives, that is, real mental illness would be detected as malingered. For this reason, this detection method should be complimented with the verification of all the criteria described in the Clinical Decision Model for establishing malingering (see Cunnien, 1997).

References

Aldea, M. J. (1994). Revisión del estado actual de los conocimientos sobre la neurosis de renta. Informaciones Psiquiátricas, 138, 411-436.

American Psychiatric Association. (1980). Diagnostic and statistical manual of mental dif¡sorders (3rd ed.). Washington, DC: Author.

American Psychiatric Association. (1994). Diagnostic and statistical manual of mental desorders (4th ed.). Washington, DC: Author.

Arce, R., Fariña, F., & Freire, M. J. (in press). Contrastando la generalización de los métodos empíricos de detección del engaño. Psicologia: Teoria, Investigação e Prática,

Cabrera, J., & Fuertes, J. C. (1997). Psiquiatría y derecho: Dos ciencias obligadas a entenderse. Madrid: Cauce Editorial.

Fariña, F., Arce, R. & Novo, M. (2004). How to detect the malingering of insanity to avoid criminal responsibility. In R. Abrunhosa (Ed.), *Victims and offender: Chapters on psychology and law* (pp. 229-241). Brussels: Uitgeverij Politeia NV. **ISBN: D-2004-8132-142.**

Carbonell, J. C., Gómez, J. L., & Mengual, J. B. (1987). Enfermedad mental y delito. Aspectos psiquiátricos, penales y procesales. Madrid: Cívitas.

Código Penal. (1995). Madrid: Cívitas.

Cunnien, A. J. (1997). Psychiatric and medical syndromes associated with deception. In R. Rogers (Ed.), Clinical assessment of malingering and deception (pp. 23-46). New York: Guilford Press.

Duckworth, J. C., & Anderson, W. P. (1995). MMPI and MMPI-2: Interpretation manual for counselors and clinicians. Bristol: Accelerated Development.

Freed, D. M., Corkin, S., Growdon, J. H., & Nissen, M. J. (1989). Selective attention in Alzheimer's disease: Characterizing cognitive subgroups of patients. Neuropsychologica, 27(3), 325-339.

Freire, M. J. (2000). Evaluación de la credibilidad de testigos identificadores y simulación de victimización. Doctoral Thesis, Universidad de Santiago de Compostela.

Gisbert, J. A. (1991). Medicina legal y toxicología. Barcelona: Ediciones Científicas y Técnicas.

Graham, J. R. (1992). Interpretation of MMPI-2. Validity and clinical scales. Brujas, workshop.

Greene, R. L. (1980). The MMPI: An interpretive manual. New York: Grune & Stratton.

Hathaway, S. R., & McKinley, J. C. (1988). Cuestionario de personalidad MMPI. Manual. Madrid: TEA.

Hathaway, S. R., & McKinley, J. C. (1999). Inventario Multifásico de Personalidad de Minnesota-2. Manual. Madrid: TEA.

Jólluskin, G. S. (2000). Influencia social mayoritaria, minoritaria y decisiones de jurados. Doctoral Thesis, Universidad de Santiago de Compostela.

Lewis, M. & Saarni, C. (1993). Lying and deception in everyday life. New York: Guilford Press.

Nicholson, R. A., Mouton, G. J., Bagby, R. M., Buis, T., Peterson, S. A., & Buigas, R. A. (1997). Utility of MMPI-2 indicators of response distortion: Receiver operating characteristic analysis. Psychological Assessment, 9(4), 471-479.

Porot, A. (1977). Diccionario de psiquiatría clínica y terapéutica. Barcelona: Labor.

Rogers, R. (1997a). Structured interviews and dissimulation. In R. Rogers (Ed.), Clinical assessment of malingering and deception (p. 301-327). New York: Guilford Press.

Rogers, R. (1997b). Introduction. In R. Rogers (Ed.), Clinical assessment of malingering and deception (p. 1-19). New York: Guilford Press.

Rogers, R., & Mitchell, C. N. (1991). Mental health experts and the criminal courts: A handbook for lawyers and clinicians. Scarborough, ON: Thomson Professional Publishing.

Roig-Fusté, J. M. (1993). MMPI y MMPI-2 en la exploración de la personalidad. Barcelona: Agil Offset.

Fariña, F., Arce, R. & Novo, M. (2004). How to detect the malingering of insanity to avoid criminal responsibility. In R. Abrunhosa (Ed.), *Victims and offender: Chapters on psychology and law* (pp. 229-241). Brussels: Uitgeverij Politeia NV. **ISBN: D-2004-8132-142.**

Shuman, D. W. (1994). Psychiatric and psychological evidence. Deerfield, IL.:Clark Boordman Callaghan.

Tombaugh, T. N. (1997). The Test of Memory Malingering (TOMM): Normative data from cognitively impaired individuals. Psychological Assessment, 9(3), 260-268.

Torre, J. de la (1999). La resposabilidad penal en las psicopatologías: Valoraciones judiciales y jurisprudenciales. Estudios de Psicología, 63-64, 163-173.

Tversky, A. (1977). Features of similarity. Psychological Review, 84, 327-352.

Weick, K.E. (1985). Systematic observational methods. In G. Lindzey, & E. Aronson (Eds.), The handbook of social psychology (vol. 1) (pp.567-634). Hillsdale, N. J.: LEA.

Wicker, A. W. (1975). An application of a multipletrait-multimethod logic to the reability of observational records. Personality and Social Psychology Bulletin, 4, 575-579.

Zabalegui, L. (1990). La medida de la personalidad por cuestionarios. Madrid: Servicio de Publicaciones de la Universidad Pontificia, Comillas.