SUSCEPTIBILITY OF COMMON SELF-REPORT MEASURES OF DISSOCIATION TO MALINGERING

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ABSTRACT

This paper reports the results of a study undertaken to determine the extent to which common self-report measures of dissociation may be consciously distorted. It also examines the relationships between the Perceptual Alterations Scale, the Dissociative Experiences Scale, and the Questionnaire of Experiences of Dissociation. Three hundred and twenty nursing students were randomly assigned to one of four groups and instructed to respond to the aforementioned questionnaires honestly, "faking good," "faking bad," or "trying to appear as if you had multiple personality disorder." Results indicate that scores on these instruments correlated very highly within all groups. Also indicated is a high level of susceptibility on each instrument for subjects to consciously exaggerate the degree of dissociative symptomotology being measured. The implications of findings for clinical use of these measures is discussed.

INTRODUCTION

Over the last fifteen years there has been a tremendous surge of interest among mental health professionals in the diagnosis, treatment, and study of dissociative disorders (Kluft, 1987). During the past decade alone there have been nine international conferences on multiple personality/dissociative states, and five major journals have devoted special issues to these disorders. Additionally, numerous regional and "national" conferences have been organized, and a recently published bibliography of readings on multiple personality, dissociative states, and traumatic stress disorders identified over 1,000 citations on dissociation and related topics (Torem, 1992).

The increased interest in dissociative disorders and subsequent marked increase in their being diagnosed has led to efforts aimed at objectifying the assessment process. Steinberg (Steinberg, Rounsaville, & Cicchetti, 1990) has developed the Structured Clinical Interview for *DSM-III-R* Dissociative Disorders, and Ross (Ross, Heber, Norton, & Anderson, 1989; Ross, et. al., 1990) has reported on use of structured clinical interviews to aid in diagnosis.

Three self-report inventories aimed at measuring dissociation have been developed and reported in the literature. Sanders (1986) developed the Perceptual Alteration Scale (PAS) to measure dissociative behaviors such as "alterations in regulatory control, changes in self-monitoring, concealment, and alterations in consciousness" (p.1). The PAS is a 60-item inventory using Likert scaling of items. The Dissociative Experiences Scale (DES) was developed by Bernstein and Putnam (1986). The DES is a short, self-administering questionnaire that asks the respondent to indicate by marking on a 100 millimeter line visual analog scale, the frequency with which they experience specific dissociative or depersonalization experiences. Riley (1988) reported an instrument which he developed the Questionnaire of Experiences of Dissociation (QED). The DES is a 26-item, true/false questionnaire which queries subjects regarding common dissociative symptoms.

Previous research has examined the validity and reliability of the PAS, DES, and QED. These studies have focused primarily on clinical populations and have generally related favorable psychometric properties for each measure. Gilbertson and Torem (unpublished data) have conducted several studies which yielded high correlations between scores on all three of these measures in both clinical and normal populations. One of the purposes of this present study was to extend our understanding of the relationships between

these three measures.

The PAS, DES, and QED are all relatively simple measures which appear quite "transparent." While this establishes the generally desirable characteristic of good face and content validity, it may also render these instruments susceptible to conscious distortion, either exaggeration or minimization of symptoms. The principle goal of this study was to examine the extent to which each of these instruments is affected by different instructional and response sets aimed at either exaggerating or concealing dissociative symptoms.

The F scale, or dissimulation scale, of the Minnesota Multiphasic Personality Inventory (Graham, 1977) is a set of items purporting to measure "faking bad" with regards to psychopathology. It is comprised of 64 true/false items from the MMPI which are overtly indicative of severe disturbance but do not cohere in any usual psychological/psychiatric syndrome. Elevations on the scale are generally interpreted to reflect exaggeration of symptoms. The scale was incorporated in the present study to assess subjects' compliance with instructions to either exaggerate or minimize the appearance of psychopathology.

TABLE 1
Means and Standard Deviations for the Comparison Groups on the PAS, DES, QED, and F Scale

Normal Group			
Variable	**N**	**Mean**	**Std Dev**
PAS	75	103.02	19.23
DES	81	16.00	14.77
QED	77	9.55	2.71
F Scale	81	7.86	8.02
"Fake Bad" Group			
Variable	**N**	**Mean**	**Std Dev**
PAS	73	159.21	42.30
DES	78	56.22	26.43
QED	78	13.55	3.95
F Scale	81	34.70	19.18
"Fake Good" Group			
Variable	**N**	**Mean**	**Std Dev**
PAS	81	97.83	20.09
DES	82	15.03	12.48
QED	81	9.48	3.05
F Scale	82	5.89	6.60
"Fake MPD" Group			
Variable	**N**	**Mean**	**Std Dev**
PAS	74	156.05	28.83
DES	77	54.66	20.59
QED	78	14.43	3.5
F Scale	79	35.32	15.46

METHOD

Subjects

The subjects in this study were 320 freshman and sophomore nursing students from a large Midwest university. There were 253 male and 67 female subjects whose ages ranged from 18 to 57 years.

Procedure

The subjects were randomly assigned to one of four groups and administered the PAS, DES, QED, and Dissimulation (F) Scale of the MMPI. Individuals assigned to the "Normal" group (N=81) were instructed to respond to the inventory questions in an honest fashion. Individuals in the "Faking Good" group (N=82) were instructed to respond to the items on the questionnaires in a manner that would present them as being as free from emotional illness as possible. Individuals in the "Fake Bad" group (N=81) were instructed to respond to the test items in a manner which would make them appear as emotionally unstable/sick as possible. Individuals in the "MPD Group" (N=79) were read a description of multiple personality disorder from the *DSM-III-R*. Subjects in this group were then instructed to respond to the inventories in a manner which would make them appear to have this disorder.

Subjects were administered the inventories in a closely monitored group setting. Their participation was entire-

TABLE 2
Correlation Matrix for the 4 Groups on the PAS, DES, QED, and F Scale

Normal Group

	PAS	DES	QED	F Scale
PAS	1.00 0.0	0.62 0.0001	0.47 0.0001	0.58 0.0001
DES	0.62 0.0001	1.00 0.0	0.51 0.0001	0.51 0.0001
QED	0.47 0.0001	0.51 0.0001	1.00 0.0081	0.29 0.0
F Scale	0.58 0.0001	0.51 0.0001	0.29 0.0081	1.00 0.0

"Fake Bad" Group

	PAS	DES	QED	F Scale
PAS	1.00 0.0	0.86 0.0001	0.65 0.0001	0.76 0.0001
DES	0.86 0.0001	1.00 0.0	0.48 0.0001	0.73 0.0001
QED	0.65 0.0001	0.48 0.0001	1.00 0.0	0.66 0.0001
F Scale	0.76 0.0001	0.73 0.0001	0.66 0.0001	1.00 0.0

"Fake Good" Group

	PAS	DES	QED	F Scale
PAS	1.00 0.0	0.67 0.0001	0.56 0.0001	0.63 0.0001
DES	0.67 0.0001	1.00 0.0	0.52 0.0001	0.57 0.0001
QED	0.56 0.0001	0.52 0.0001	1.00 0.0	0.54 0.0001
F Scale	0.63 0.0001	0.57 0.0001	0.54 0.0001	1.00 0.0

"Fake MPD" Group

	PAS	DES	QED	F Scale
PAS	1.00 0.0	0.65 0.0001	0.43 0.0001	0.67 0.0001
DES	0.65 0.0001	1.00 0.0	0.33 0.0001	0.43 0.0001
QED	0.43 0.0001	0.33 0.0001	1.00 0.0	0.46 0.0001
F Scale	0.67 0.0001	0.43 0.0001	0.46 0.0001	1.00 0.0

ly voluntary and they were assured anonymity of their test scores. All tests of significance conducted on the data were based on a non-directional hypothesis.

RESULTS

Table 1 presents the means and standard deviations for the comparison groups on the PAS, DES, QED, and F Scale. The F Scale was utilized to examine subjects' adherence to the instructional sets they were provided. The data indicate that subjects followed their instructions and truly attempted to "fake good," or "fake bad," etc. As would be expected, subjects faking good and presumably normal subjects both scored very low on the F scale. Subjects faking globally bad or attempting to present the spectrum of dissociative symptomatology seen with MPD both scored very high on the F Scale. The differences on this scale between both the normal and "fake good" groups and the "fake bad" and "fake MPD" groups were both highly significant ($p>.001$). The differences between the normal and "fake good" group and those between the "fake bad" and "fake MPD" group were not significant.

It is noteworthy that the mean scores obtained by the normal and "fake MPD" groups on the DES correspond very closely to the mean scores reported by Putnam (198, p.11) on this instrument by other normal groups and patients diagnosed with MPD respectively. Similarly the F scale scores for the normal, "fake good," and "fake bad" groups all fall within ranges reported in previous studies for subjects approaching the MMPI with these response sets (Graham, 1977:21-23). The mean F scale score obtained by the "fake MPD" group corresponds closely with those scores obtained by patients diagnosed with this condition also (Gilbertson, Torem, and Kemp, 1987).

The same pattern of significant differences on all three of the dissociation measures was observed between the comparison groups as with the F Scale. These findings also indicate that our subjects were highly successful at

intentionally producing scores that suggest a high level of dissociative symptomatology. The groups feigning general mental illness as opposed to specific MPD symptomatology did not appear markedly different. Similarly, no significant differences were noted between the groups of subjects who were presumably normal and those "faking good."

Table 2 presents the correlation matrices for the four groups on the PAS, DES, QED, and scales. Examination of Table 2 reveals consistently high and statistically significant relations between the PAS, DES, and QED (as well as the F Scale) within each of the four groups.

Table 3 presents the correlation matrix for all subjects on all measures. These findings indicate that the very strong correlation among these three measures of dissociation and the F Scale are observed across a broad range of scores.

TABLE 3
Correlation Matrix for the total Sample on the PAS, DES, QED, and F Scale

Normal Group	PAS	DES	QED	F Scale
PAS	1.00 0.0	0.88 0.0001	0.70 0.0001	0.85 0.0001
DES	0.88 0.0001	1.00 0.0	0.65 0.0001	0.80 0.0001
QED	0.70 0.0001	0.65 0.0001	1.00 0.0081	0.69 0.0
F Scale	0.85 0.0001	0.80 0.0001	0.69 0.0081	1.00 0.0
MPD Group	0.39 0.0	0.40 0.0001	0.38 0.0001	0.42 0.0001
FGood Group	-0.45 0.0001	-0.42 0.0	-0.33 0.0001	-0.44 0.0001
FBad Group	0.43 0.0001	0.43 0.0001	0.25 0.0001	-0.41 0.001
Normal Group	-0.35 0.0001	-0.40 0.0001	-0.30 0.0001	-0.38 0.0001

**Correlations between the dichotomous variable of groups with the dependent variables of PAS, DES, QED, and F are point biserial correlations and can be interpreted as T tests.*

DISCUSSION

The only other reported study on the simulation of dissociative disorders on a self-report inventory was conducted by Antens et al. (1991). Their study utilized only the DES in an unbalanced design with relatively small numbers. Still, their findings were similar to those reported herein in indicating that both sophisticated and unsophisticated simulators obtained very high scores on this instrument. Antens et al. reported that the simulators could be distinguished from "real MPD patients" and "real DDNOS patients" by virtue of having obtained even higher scores. The actual MPD patient scores reported by that study (M=55.0, SD=19.2) are remarkably similar to the simulators reported in our findings.

The data presented in this study are consistent with previous findings by these authors in indicating that the PAS, DES, and QED correlate very highly with each other. The present data demonstrate that this correlation exists among normal individuals and suggest this relationship may also extend throughout the range of severity of dissociative symptomatology. None of these instruments seemed less susceptible to attempts at distorting the report of a subject's actual symptomatology or malingering. It appears that these measures are equally effective in detecting dissociative symptomatology and have similar validity strengths and limitations. Obviously it would be desirable to validate these hypotheses further in a clinical population.

Because there are few differences in the he length or complexity (i.e., comprehension and reading level requirements) between the PAS, DES, and QED, one could argue that they could be used interchangeably. The DES has been subjected to more rigorous evaluation and utilized more extensively in published research than the PAS and QED. In light of these factors, and considering greater availability of referent norms for the DES, it emerges as the instrument of choice with the present authors.

Evidence from this study that all three of these inventories appear highly susceptible to the malingering of dissociative symptoms raise serious concerns and limitations pertaining to their clinical use. It may be stating the obvious, but these inventories appear to measure just what they appear to measure: What subjects want to tell you regarding their experiences of dissociative symptoms. It is clear that at least normal subjects can markedly exaggerate their

symptomatology on each of these tests. Thus, if subjects are motivated to malinger high levels of dissociation, they can readily do so. The validity of results on any of these tests needs to be seriously questioned when subjects completing them may derive some secondary gain for appearing "sick."

The aforementioned findings do not detract from the utility that each of these inventories may hold for research, screening for dissociative symptomatology, or quantifying the severity of dissociative symptoms in subjects with no motivation to misrepresent themselves. We could discuss at length the complexities of determining whether subjects possess any motivation to misrepresent themselves, but that issue is obviously beyond the scope of the present paper.

It would seem desirable that some validity measures be included on any inventory aiming to measure psychopathology. The difficulties involved in doing this with measures of dissociative symptomatology are exemplified by the high correlations between each of the inventories used in the present study and the MMPI F Scale. The apparent inconsistencies and diversity of symptoms manifest in persons with pathological levels of dissociation are likely to suggest exaggeration by any usual standard.

It is important to recognize that the present study focused on presumably normal subjects. Important questions which are left unanswered are whether individuals who are truly experiencing dissociative symptomatology could mask this and "fake good," and the extent to which our findings regarding "faking bad" can be generalized to clinical populations. We are currently undertaking some investigation of these important issues. ■

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