

The MMPI-2 in Sexual Harassment and Discrimination Litigants

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Abstract

In order to understand patterns of respondents on validity and clinical scales, this study analyzed archival MMPI-2s produced by 192 women and 14 men who brought legal claims of ongoing emotional harm related to workplace sexual harassment and discrimination. The MMPI-2s were administered as a part of a comprehensive psychiatric forensic evaluation of the claimants' current psychological condition. All validity and clinical scale scores were manually entered into the computer, and codetype and cluster analyses were obtained. Among the women, 28% produced a "normal limits" profile, providing no MMPI-2 support for their claims of ongoing emotional distress. Cluster analysis of the validity scales of the remaining profiles produced four distinctive clusters of profiles representing different approaches to the test items.

The MMPI-2 in Sexual Harassment and Discrimination Litigants

Since the Civil Rights Act of 1964, the number of Title VII claims of employment-related discrimination has increased dramatically. Within this broad category, claims have been brought based upon allegations of discrimination of all types, including biological sex, race or ethnic group, country of origin, sexual preference, and disability, to name a few. Commonly, such lawsuits describe alleged workplace discrimination and include claims that the circumstances of the workplace, the conduct of employees or management, or the lack of response by management, inflicted “psychic injury” (synonymous with “emotional, mental, or psychological harm”) for which the employer should be held liable. Awards made for such “psychological injury” have sometimes been in the seven figures, and, since the Civil Rights Act of 1991, as amended, plaintiffs may obtain both compensatory and punitive damages for sexual harassment². An example is *Weeks v. Baker & McKenzie* (1998), in which the jury awarded Ms. Weeks punitive damages in the amount of \$6.9 million, almost twice what Ms. Weeks had requested.

The Challenge of Forensic Assessment of Emotional Harm Claims

Increasingly, psychiatrists, psychologists, and other mental health and medical professionals have been asked to evaluate claims of emotional harm arising, allegedly, from workplace discrimination (Long, 1994). Such professionals face significant obstacles in conducting fair and independent

evaluations of emotional harm. Although an extended discussion of the evaluation of such claims is beyond the scope of this paper, a limited discussion of some of the key obstacles faced by the examiner is useful as a means of understanding more fully the value of including the MMPI-2 in such assessments.

Obstacles to Objective Forensic Assessment

There are several important problems that surround the process of assessing emotional harm claims. First, the term, “emotional harm,” which is synonymous with “psychological harm” or “injury” is a legal, rather than psychological term and thus has no universally accepted psychological or behavioral definition. Consequently, most forensic psychological examiners take a pragmatic approach to assessment, focusing on issues of diagnosis, causality, and function. They attempt to determine whether, on examination, the claimant suffers from any diagnosable psychiatric disorder, which can reasonably be causally linked to the alleged workplace events, and which has created impairment in functioning. Litigants whose emotional distress satisfies these three elements may be characterized as having suffered emotional harm.

A second obstacle involves reliance upon the subjective self-report of litigants, who claim that they have been “psychologically injured”. Although treaters rely upon a patient’s self-report in order to plan treatment, forensic examiners recognize that a person’s self-report of symptoms in litigation may be distorted by secondary gain, defined by the Psychiatric Glossary of the American

Psychiatric Association (1984, p. 122) as “the external gain derived from any illness, such as personal attention and service, monetary gains, disability benefits, and release from unpleasant responsibility”.

In order to correct for possible bias inherent in a claimant’s self-report, many forensic examiners attempt to cross-verify a claimant’s self-reported symptoms using other sources of information, including a comprehensive interview, a review of records, and psychological testing. Absent such cross-verification, there is no practical way to separate valid claims from false ones, and conceivably, any litigant claiming to feel emotional distress might be eligible for substantial monetary compensation by the courts, even if the emotional distress was caused by circumstances outside of the workplace.

Third, because of differences in background, training, credentials, and experience among forensic examiners, there is currently no standardized approach to the evaluation of emotional harm claims. In some cases, forensic expert opinions are based exclusively upon a brief interview in which a claimant’s self-report of psychological symptoms and their causality is accepted without question. In other cases, examiners have access to a stronger data base upon which to formulate their expert opinions. Past medical, mental health, school, legal, and employment records provide longitudinal information on the claimant’s development and adjustment in broad areas of life. Past records can sometimes reveal pre-existing psychological or other adjustment problems that may have

impacted the individual's perception of or reaction to stressful workplace events. Since, ultimately, forensic data involving sexual harassment and discrimination does not appear in a vacuum, but are obtained during the course of litigation, availability of data often depends upon whether the litigants and their attorneys limit such data.

A fourth obstacle involves assessing the contribution of multiple causal factors to the psychiatric diagnosis. Examples include the role of genetics in the onset of a manic or depressive episode, or the significance of contemporaneous financial, social, or medical stressors. Examination of the litigant's functioning historically in a variety of contexts, including those contemporaneous with, but outside of the workplace conflict, can help the examiner to assign causality.

A final obstacle involves the timing of the forensic examination, which occurs after the disputed events occurred, and the resulting inability of the examiner to compare the claimant's "pre-morbid" or "baseline" psychological state with his or her emotional state following the disputed events. Although this obstacle represents a challenge, it is a structural problem that is common to treatment as well as forensic contexts. This problem is also well known to clinicians who evaluate claimants seeking disability or other compensation for medical injuries that are difficult to establish through medical tests, such as chronic pain patients and claimants with closed head or low back injury.

The Role of Psychological Testing in Forensic Assessment

The challenges facing the forensic examiner have resulted in increasing use of psychological tests in an effort to improve the validity, reliability, and objectivity of assessments. Psychological testing can provide a useful cross-sectional view of a claimant, another piece of data to be cross verified with information from the records and clinical interview. The clinician obtains psychological tests in order to gain more objective information about diagnostic possibilities. The forensic examiner may also include psychological test data in order to gain more objective information about diagnostic possibilities.

Separating Valid and False Claims

One important goal of the forensic examination is to distinguish between valid and false claims. Psychological testing can assist in this determination. Although there is no unique test that can prove that a claim is valid or false, tests that compare a subject to a standard reference population can strengthen the objectivity of the examiner's opinions on the validity of the claims. The test results can either support or fail to support findings from the other components of the examination and, hence, the subject's legal claim of emotional harm.

For example, normal limits, as well as exaggerated MMPI-2s, can reflect invalid claims, depending upon the results of the clinical interview and review of records. If the MMPI-2 results are within normal limits, and findings from the interview and records are unremarkable, the litigant's claim of ongoing psychological injury is weakened because of lack of objective support from the

evaluation. If the MMPI-2 results are highly exaggerated and inconsistent with known psychiatric disorders, and the records and clinical exam reveal a high-functioning individual, lack of objective support exists for the litigant's claim of ongoing psychological injury. In these individuals, personality style, cultural factors, and motivation may be important factors that call into question the validity of the emotional harm claim, and in certain cases, malingering is a possibility.

Use of the Reference Population

Although the forensic examiner, like the clinician, cannot compare the claimant's pre- and post-event mental status, he or she can use psychological testing to compare the claimant's psychological condition with a standard reference population. In making such a comparison, the examiner assumes, hypothetically, that prior to the disputed events, the claimant's psychological status resided within the parameters of the "normal" population, although, realistically, the claimant may, indeed, have been an "outlier." In making such an assumption, the examiner conservatively gives the claimant the benefit of the doubt in demonstrating that a significant and objectively measured change in psychological condition has occurred and is ongoing.

Objective Psychological Tests and the Courts

The forensic evaluator must choose among hundreds of tests and defend to the court and opposing attorneys the choice of any particular test administered.

Tests that are subjective, biased, or lack norms are subject to attack under *Daubert v. Merrill Dow Pharmaceuticals Inc.* (1993), a landmark decision having important implications for the use of psychological tests in forensic assessments (Long, 1994). In issuing its opinion in this case, the Supreme Court argued that in order to be admissible, scientific evidence, which would include the results of psychological testing, must be scientifically valid. Scientific validity in this sense means that the testing process must be based upon the scientific method rather than subjective belief or conjecture (*Daubert v. Merrill Dow Pharmaceuticals*, 1993; Lees-Haley & McDonald, 1997; McDonald & Lees-Haley, 1995).

The Use of the MMPI-2 in Court

The MMPI-2 and its predecessor, the MMPI, have been used in clinical practice for many years and have been extensively researched. The MMPI-2 has proven to be the most objective method of evaluating a litigant's current mental health status (Lubin, Larson & Matarazzo, 1984; Watkins, Campbell, Niebirdling & Hallmark, 1995). It is a paper and pencil test consisting of 567 true-false questions that can be answered by any adult with an sixth grade education. It is simple to administer and take and is the most widely used instrument in forensic evaluation (Borum & Grisso, 1995; Keilen & Bloom, 1986; Lees-Haley, Smith, Williams & Dunn, 1995) including those involving personal injury, emotional harm, workers compensation, pain, and disability (Boccaccini & Brodsky, 1999; Butcher, 1985; Bradley, Prokop, Margolis & Gentry, 1978; Fordyce, 1979; Keller

& Butcher, 1991; Shaffer, 1981; Shaffer, Nussbaum & Little, 1972; Alfano, Neilson, Paniak & Finlayson, 1992). One survey of 100 examiners conducting personal injury examinations on adults found that the MMPI was the second most frequently used psychological test, ranking behind the Wechsler Adult Intelligent Scale (Lees-Haley, et al.1996).

The MMPI-2 contains 10 clinical scales: 1 (*Hs*--Somatization), 2 (*D*--Depression), 3 (*Hy*--Hysteria), 4 (*Pd*--Psychopathic Deviate), 5 (*MF*—Masculinity or Femininity), 6 (*Pa*--Paranoia), 7 (*Pt*---- Psychasthenia), 8 (*Sc*--Schizophrenia), 9 (*Ma*--Mania), 10 (*Si*--Social Introversion). T-scores greater than or equal to 65 reflect responses that are equal to or greater than two standard deviations above the mean or the “normal” comparative population. These scales have been objectively derived, scored, and interpreted, and have been associated with well-established behavioral measures. When combined with an analysis of the validity and other scales, the T-scores obtained on these clinical scales can provide the examiner a wealth of information about an individual’s personality, as well as offer hypotheses about psychiatric diagnosis, personality type, chronicity of psychological disturbance, and prognosis.

The MMPI and the Problem of Assessing Malingering

According to the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV; American Psychiatric Association, 1994, p. 683), malingering is the “intentional production of false or greatly exaggerated physical

or psychological symptoms motivated by external incentives”. Malingering must be considered whenever the psychological examination occurs within the context of litigation. As Resnick (1995) has pointed out in his study of malingered Post-traumatic Stress Disorder, malingering is difficult to establish, absent independent observation that catches the malingerer in the act or a frank admission by the evaluatee.

The MMPI-2 Validity Scales and the Detection of Malingering

Research has shown that the MMPI-2 can assist in determining malingering, when the test is used in conjunction with other sources of information (Rogers, 1988). The MMPI-2’s validity scales are of value in this regard. Three of the validity scales, the *L* (“Lie”), *F* (“Faking Bad”), and *K* (“Denial”), were developed in the original MMPI and have an extensive research base supporting their use and reflect the test taker’s approach to the test. Elevations of each of the three scales measure different types of test-taking attitudes, which can result in distortions of the clinical scales and other scores. Significant elevations on the validity scales and other indices that measure the respondent’s approach to the test can preclude inferences about clinical and other scales and render the test results invalid (Butcher, 1997a; 1997b).

According to Pope, Butcher, & Seelen (1988), in addition to the three validity scales that appear on the original and revised MMPI, the MMPI-2 has added three additional scales: the *F(b)*, *VRIN*, and *TRIN* scales. Whereas, the *F*

scale is based upon responses to the first 370 items of the original MMPI, the *F(b)* scale is based upon responses to 40 items in the second half of the MMPI-2. As for the *F* scale, significant elevations in *F (b)* (i.e., T- scores at or above 65) suggests possible exaggeration. The True Response Inconsistency (*TRIN*) scale measures inconsistency in responding to items, and the Variable Response Inconsistency (*VRIN*) scale measures random responding (Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989). The *S* “Superlative” scale was developed in order to understand the overly positive responses made by subjects who attempt to claim extreme virtue by presenting themselves in a superlative fashion (Butcher & Han, 1995).

The Use of the MMPI-2 in Personal Injury Cases

To our knowledge, there have been no previously published studies describing empirical research on MMPI or MMPI-2 profiles produced by sexual harassment and discrimination litigants. However, a number of researchers have studied MMPI-2 scale patterns among other groups of personal injury litigants, including those with chronic pain, low back and closed head injuries, and those claiming PTSD from physical injuries (Arbisi & Butcher, in press; Butcher, 1995; Butcher & Miller, 1998; Keller & Butcher, 1991; Long, Nelsen & Butcher, 1995; Love & Peck, 1987; Riley & Robinson, 1998; Strassberg, Tilley, Bristone & Oei, 1992; Vendrig, de Mey, Derksen & van Akkerveek, 1998).

Many litigants have common characteristics, including significant psychiatric overlay to physical symptoms and involvement in processes, such as workers compensation, disability, and litigation, which involve possible compensation and other forms of secondary gain. Such issues make objective assessment of their complaints difficult, leading examiners increasingly to turn to the MMPI-2 for objective assistance in overall evaluation of claims and the exclusion of frank malingering or other forms of distortion, such as exaggerating (“*Faking Bad*”) and denying or claiming unrealistic virtue (“*Faking Good*”) (Berry & Butcher, 1998; Butcher, Arbisi, Atlis & McNulty, 2001; Lim & Butcher, 1996).

The purpose of this study was to examine archival MMPI-2 data on a large sample of workplace sexual harassment and discrimination litigants. Because of the absence of previously published research in this area, the goals of the study included the following:

1. To identify common validity and clinical response patterns
2. To compare our results to other groups of personal injury litigants in which the MMPI-2 has been studied.
3. To discuss the clinical behavioral correlates of the different response patterns.

4. To describe the role of the MMPI-2 in assessing the validity of a woman's claim of emotional harm allegedly caused by sexual harassment and discrimination in the workplace.
5. To discuss the limitations of the MMPI-2 used in this context, particularly with regard to determining causality of symptoms endorsed and ascertaining malingering.
6. To describe avenues for further research.

In this study, the authors use of the use the term "sexual harassment and discrimination," as opposed to "gender harassment and discrimination" is consistent with the use of the term, "sexual harassment," by the Equal Employment Opportunity Commission in its legal definition (E.E.O.C., 1980).

Method

Participants

This study examined archival data for 206 individuals, (192 women and 14 men) who had received forensic psychiatric evaluations at the request of defense counsel during the course of active litigation against a current or former employer between 1993 and 2001. All subjects claimed that they had been psychologically "harmed," "injured," or "damaged" as a result of workplace sexual harassment and/or discrimination. Referrals for the evaluation came from attorneys representing defendants. The evaluation sought to establish whether or not the litigant suffered from any current or past diagnosable mental disorder, and,

if present, the cause or causes of that disorder, as well as a determination of the claimant's functional capacity. The components of the overall evaluation included review of past and present medical, mental health, work, school, and legal records and administration of psychological testing, including the MMPI-2. The study included all MMPI-2s that contained sufficient responses for analysis.

Results

Mean Scale Profiles

Means for the validity scales and clinical scales were calculated separately for men and women. For purposes of comparison, the mean profiles of the women and men are presented in Figures 1 and 2. However, because the number of men was too small to allow for reliable statistical analyses, no additional analyses were performed on this subset. All remaining analyses were performed using only the 192 women claimants.

Codetype Analysis

Two-point codetypes were determined for the sample of women; a tallying of the common codetypes is provided in Table 1. Clearly, the most common codetype was WNL (Within Normal Limits), as 28% of the participants obtained clinical scale scores that were all below a T-score of 65. Of those who met the criteria for a well-defined two-point codetype (two scores elevated above a T-Score of 65, and both at least 5 points higher than the third highest score) or a one-point code-type (only one score elevated above a T-score of 65, and it is more

than 5 points greater than the second highest score), the most common clinical configuration was the 1-3/3-1 codetype (accounting for 10% of the participants).

Valid Scale Analysis

The majority of the participants produced profiles for which elevated validity scale scores would suggest cautious interpretation. One hundred thirty-eight participants (72%) obtained at least one elevated validity scale score. Table 2 provides the number of participants who obtained elevated scores for each individual validity scale.

Cluster Analysis

A cluster analysis was performed to determine common patterns of Validity Scale scores among sexual harassment litigants. Participants were clustered on the basis of their scores on scales *L*, *F*, *K*, *F(b)*, *TRIN*, *VRIN*, and *S* using SPSS Version 11.0.1. Ward's method was selected for the clustering, and squared Euclidean distances represented distances between cases. An examination of the agglomeration coefficients³ suggested that an appropriate point at which to discontinue agglomeration was at the point of 4 clusters.

The largest cluster, accounting for 101 profiles (53% of the sample) was characterized by slightly elevated means for scales *L*, *K*, and *S*. This suggests that a common tendency for claimants is to approach the inventory with unrealistically positive self-descriptions and a moderate level of defensiveness. This group also received a slightly elevated mean score on scales 1, 2, and 3. This suggests that

the majority of the respondents in this setting approached the inventory in a mildly defensive manner, endorsing items consistent with significant depression, and pessimism accompanied by physical complaints.

A second cluster, accounting for 36 profiles (19%), was characterized by mean validity scale scores comparable to the general population. This group appears to have approached the test with openness and frankness, acknowledging both realistic positive and negative characteristics. The mean clinical scale scores were almost indistinguishable from those of the first cluster, with slight elevations on scales 1, 2, 3 which might indicate a valid description of depressive and somatic symptoms.

A third cluster, accounting for another 36 profiles (19%), was characterized by moderately elevated ($T = 65$, two standard deviations above the mean) mean scores on scales F and $F(b)$, suggesting a tendency to “fake bad” or to make unrealistic claims of psychological distress. As would be expected, this group obtained mean scores on the clinical scales representing an unrealistic pattern of generalized pathology, with elevations on scales 1, 2, 3, 4, 6, 7, and 8. This suggests that a sizable proportion of claimants in this setting approach the test attempting to describe themselves as highly distressed, but make an implausibly high number of claims of distress.

A fourth cluster, accounting for only 19 profiles (10%), produced mean scores similar to those of cluster 3, but more exaggerated, with a mean score on F

of 86.68 and a standard deviation of 15.33. The mean score on $F(b)$ for that group was 92.11 and a standard deviation of 9.63. These extremely elevated scores on scales F and $F(b)$ suggest that these profiles should not be viewed as self-descriptions but as attempts to present extremely unrealistic descriptions of distress. As with the third cluster, the extreme elevations on scales 1, 2, 3, 4, 6, 7 and 8, along with an elevation of scale 0 that was not seen in the third cluster, is a self-description that is unrealistic in its claims of generalized pathology.

Discussion

This study found that litigants typically fell into one of five groups based upon response patterns determined by the validity scale scores.

1. The Normal Limits profile with no elevations on validity or clinical scales.
2. The Valid Non-Defensive profile with no elevation of validity scales and elevations of clinical scales 1,2, and 3, the Neurotic Triad.
3. The Fake Good profile with elevation of the L , K , and S validity scales and elevations of the Neurotic Triad.
4. The Psychologically Distressed profiles with moderately elevated F and $F(b)$ scales and elevation of seven clinical scales indicating a Generalized Pathology Presentation.

5. The Exaggerated or Malingered profile with markedly elevated *F* and *F (b)* scales and marked elevation of eight clinical scales, an extreme form of the Generalized Pathology Presentation.

These results are consistent with research findings among chronic pain, closed head injury, low back injury subjects, and workers compensation subjects (Keller & Butcher, 1991; Strassburg et al., 1992; Vendring et al., 1998; Riley & Robinson, 1998; Love & Peck, 1987; Berry & Butcher, 1998; Lim & Butcher, 1996; Butcher et al., in press; Gandolfo, 1995; Snibe, Peterson & Sosner, 1980) revealing the same four types of profiles:

1. The Normal Limits profile
2. The Valid Non-Defensive profile with elevation of either the Neurotic Triad or Conversion V (clinical scales 1 and 3)
3. The Fake Good with elevation of the Neurotic Triad or Conversion V
4. The Fake Bad profile with elevations of the *F* validity scales and a Generalized Pathology presentation demonstrating elevations on a number of clinical scales.

Shaffer et al. (1972), who examined MMPI Profiles of 7097 male and 7209 female non-psychiatric disability claimants, found that between 34.6 and 43.7 percent of the sample of this large sample of claimants of both sexes produced MMPIs with low *L*, *F*, and *K* scores and elevations on the Neurotic Triad, the same pattern as our Valid Non-Defensive profile with elevation of the

Neurotic Triad clinical scales. According to Shaffer, behavioral correlates of this population included excessive somatic and mood complaints, along with histrionic tendencies, a pattern characteristic of individuals with “psychoneuroses or personality disorders.”

Behavioral Correlates for Sexual Harassment/ Discrimination Litigants

Producing Neurotic Triad on MMPI-2

In this study, clinical elevations most commonly involved Scales 1, 2, and 3 with elevation on scale 2 being a reliable indicator of the degree of success the individual has in implementing a variety of defenses, especially repression, denial, and somatization. When scales 1 and 3 are clearly elevated above scale 2 (five or more T-score points is typically viewed as a substantial difference), the resulting 3-point profile is referred to as the Conversion V. However, when scale 2 is elevated along with scales 1 and 3, the defense mechanisms have become ineffective in curtailing an emergence of depressive symptoms. These women are likely to appear to be resigned to their symptoms, demonstrating signs of depression and pessimism accompanied by somatic complaints. The individual, however, appears resigned to their symptoms.

Characteristically seen in women, individuals with the Neurotic Triad pattern usually complain of chronic symptoms of depression and a variety of physical symptoms: sleep disturbance, low sex drive, fatigue, dizziness, and numbness. Problems involving eating are common among this group of

respondents, including nausea following eating, bulimia, and anorexia. They tend to resist psychological inquiry and to insist that their problems are physical rather than “mental.”

In this study, an interesting phenomenon appeared among the Neurotic Triad group of women discrimination and harassment litigants. They alleged in their legal complaint psychological harm as a result of unwanted and inappropriate behavior from others in the workplace. Their legal complaints described a wide variety of comments and physical touches, which they stated represented sexual harassment, a form of discrimination based upon sex. Some alleged that such conduct had created emotional distress by contributing to a “hostile work environment,” while others stated that demands were made for sexual favors in return for favorable work treatment. Others asserted that unfavorable treatment was threatened if sexual favors or sexual harassment was not tolerated. In all cases, litigants asserted that they sustained psychological injury or harm as a result of the inappropriate conduct.

Upon psychiatric examination and psychological testing, however, this group demonstrated a chronic pattern of minimizing the degree of psychological impairment and focusing instead on physical, that is, medical, causes for their emotional discomfort, which they experienced in the form of depression.

Elevation of Scales F, F(b), and Clinical Scales 1,2,3, 4, 7 and 8—A Measure of Generalized Pathology or Possibly Malingering

Significant elevations of scale *F* are typically associated with elevations on some or all of the clinical scales, in part because the person has responded to the items in an extreme manner, endorsing many rarely endorsed items. In a clinical setting, *F* scores between 65 and 89 may reflect valid marked psychological distress and disturbance or may indicate that such respondents over-endorse pathology, viewing themselves as more disturbed than is actually the case. An important aspect of the forensic exam is discerning which of these possibilities applies to a particular individual. According to Butcher and Williams (2000), the possibility of malingering should be considered with a highly elevated *F* score, i.e. 90 or higher, particularly given the possibility of secondary gain associated with litigation.

In our study, one group of respondents produced *F* scores close to 65 and a pattern of global elevation of all the clinical scales except scale 9, *Ma*. This pattern suggests a “cry for help,” i.e., generalized psychological distress. Although the MMPI-2 cannot determine the cause of the claimant’s distress, the examiner has an opportunity to cross-verify the subject’s report in the interview with this objective MMPI-2 result and examine external sources for further verification and clues to proximate cause, including the alleged sexual harassment and discrimination.

The final group of our respondents produced a mean *F* score of 86.68 (standard deviation of 15.33), mean *F(b)* score of 92.11 (standard deviation of

9.63), and marked elevations of all of the clinical scales. Thus, a considerable proportion of this sample produced F and $F(b)$ scores at or above 90, suggesting the possibility of exaggeration or malingering. For respondents producing this type of profile, the examiner can look to the results of the clinical interview and records for inconsistencies in presentation in order to assess these possibilities. Examples of important inconsistencies include variation between the subject's current claims of distress and his or her presentation to treaters, discrepancies between reported inability to function and independent evidence of functioning, and complaints of inability to work because of symptoms, while functioning in social or other non-vocational areas is preserved. External records, especially those that are contemporaneous to the time that the alleged workplace harassment occurred, may reveal indications of exaggeration or malingering, including personal or financial stress.

The MMPI-2 pattern of elevated generalized pathology is seen among groups other than sexual harassment litigants. Gandolfo's (1995) population of workers compensation subjects claiming harassment featured elevations of scales 1, 2, 3, 7 and 8. This pattern suggested exaggerating or malingering.

Other research has found that this overall pattern of elevation on Scales 1, 2, 3, 4, 7, and 8 reflects the presentation of generalized psychological pathology among chronic pain, psychiatric, low back, head injury, and workers compensation claimants (Arbisi & Butcher, in press; Snibe, Peterson, Sosner,

1980). All of these groups have disorders that are partially or entirely based upon psychological factors, which are difficult to establish by objective medical tests. According to the MMPI-2 pattern produced in these groups, no particular psychiatric disorder is revealed. Depending upon the degree of exaggeration as exhibited by the F scale elevations, there is endorsement of generalized pathology reflecting global distress or possibly an attempt to malingering psychiatric illness for secondary gain.

Conclusions

In assessing a claim of emotional harm, the forensic examiner is concerned with issues of diagnosis, causality, and function. How can the MMPI-2 assist in assessing the validity of such claims?

1. The MMPI-2 can provide an objective way to compare a claimant's current psychological condition with a standard population. This provides one independent and objective piece of data that can be used to assess diagnostic possibilities. The claimant's response to the MMPI-2 may have implications for her approach to the forensic context.
2. A valid "normal limits" MMPI-2 profile is inconsistent with a claim of disability or ongoing emotional harm as defined as the presence of a significant diagnosable psychiatric disorder.
3. For claimants who endorse symptoms of depression and somatization on the MMPI-2, i.e., the Neurotic Triad, there is little psychometric support for other

- psychiatric diagnoses, such as PTSD. Review of external sources of information is necessary in order to establish whether the somatization pattern is a longstanding coping pattern, independent of the alleged workplace events, and whether the workplace conflict had any effect on the use of this defense mechanism. If the use of somatization appears to have been intensified during the disputed time interval, external sources of information may reveal whether or not alternate causes of stress might have been operative. In addition, the relationship between this personality type and the possible genesis of the workplace interpersonal conflict needs further clarification, so that cause and effect, as reflected in the MMPI-2 result, can be more clearly understood.
4. For claimants who endorse global clinical symptoms on the MMPI-2, the degree of elevation of the *F* and *F(b)* validity scales can help distinguish between individuals who are acutely in a state of generalized distress and those who may be malingering a claim of general mental illness. The examiner must use external sources of collateral information in exploring all possible causes of the generalized distress, including the work environment, in formulating opinions about exaggeration or malingering a claim of emotional harm.
 5. The MMPI-2 can generate diagnostic hypotheses, which can support or discount an individual's claim that she has suffered a particular psychiatric condition in response to alleged sexual harassment or discrimination.

However, the examiner can only confirm or reject these diagnostic possibilities, as well as address issues of causality of the disorders, by cross-verifying the MMPI-2 result with other external sources of information, if available.

6. The possibility that these results represent “standard” ways of responding among women sexual harassment and discrimination litigants, and the effect of the litigation process on the claimant’s MMPI-2 and clinical presentation needs further research.

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Table 1
Codetypes of total sample of sexual harassment discrimination litigants

<u>Codetype</u>	<u>Frequency</u>
WNL	54
1-2/2-1	3
1-3/3-1	19
1-6/6-1	1
2-3/3-2	7
2-4/4-2	1
2-6/6-2	6
2-7/7-2	3
3-6/6-3	4
3-8/8-3	1
6-9/9-6	1
Spike 1	2
Spike 2	2
Spike 3	4
Spike 4	3
Spike 6	2
Spike 7	1
Spike 9	3
<u>(not defined)</u>	<u>75</u>
Total	192

Table 2
Frequency of elevated scores on each validity scale

<u>Scale</u>	<u>Frequency</u>
L	40 (21%)
F	55 (29%)
K	36 (19%)
F(b)	47 (25%)
TRIN	24 (13%)
VRIN	8 (14%)
S	42 (22%)

Figure 1
Mean MMPI-2 Validity Scale scores for males and females

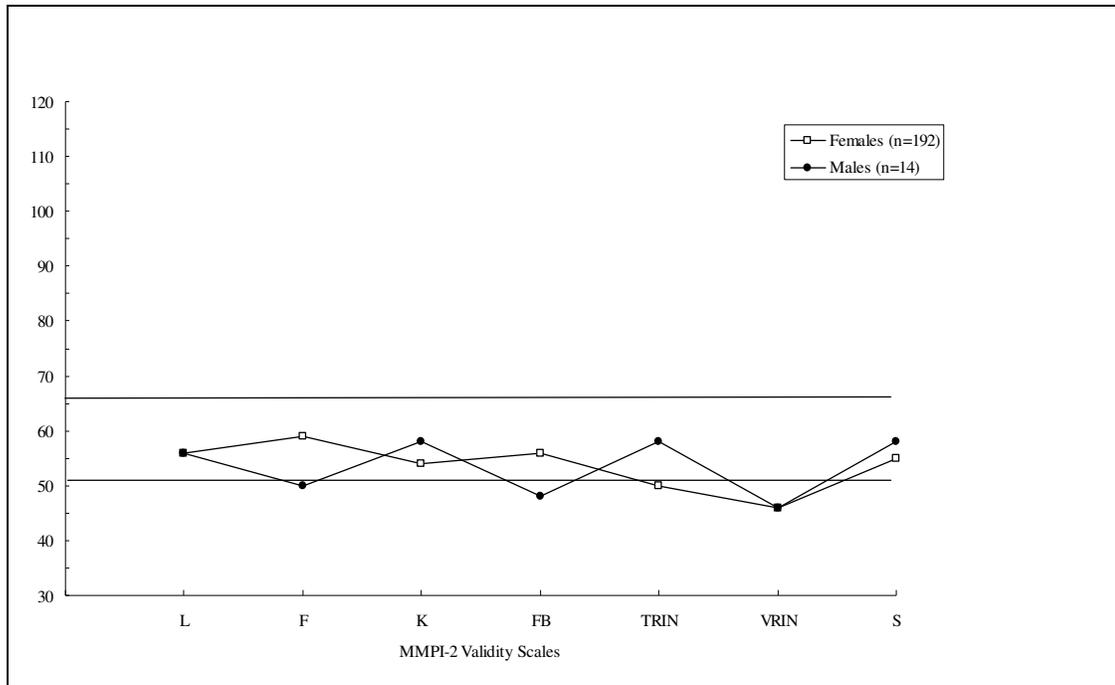


Figure 2
Mean MMPI-2 Clinical Scale scores for males and females

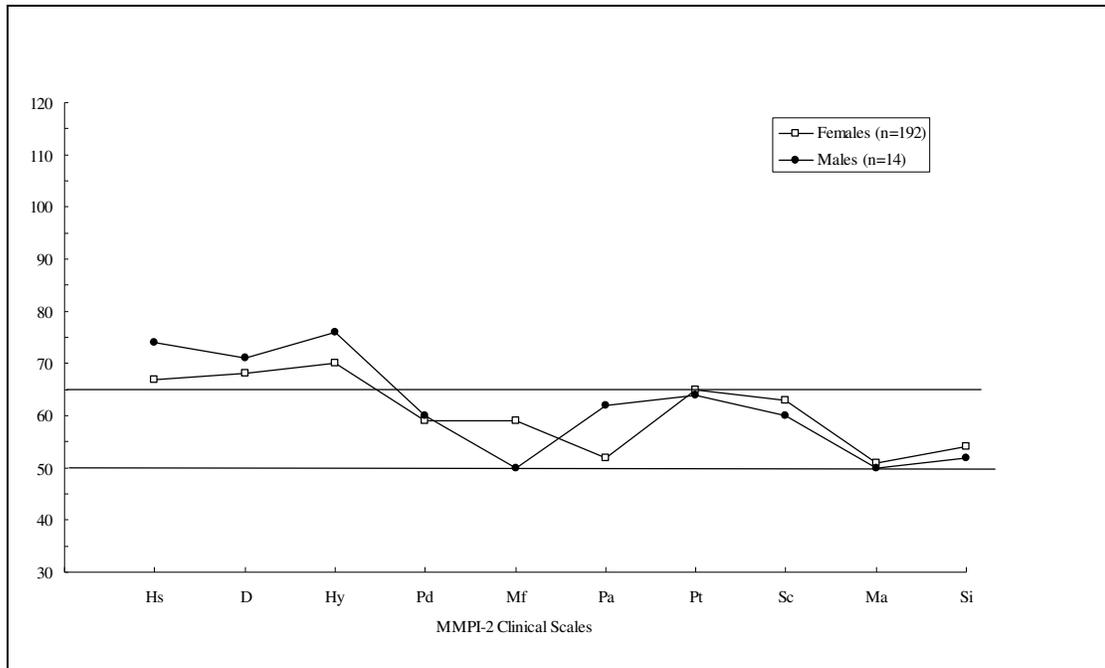


Figure 3
 Mean MMPI-2 Validity Scale scores for four validity clusters

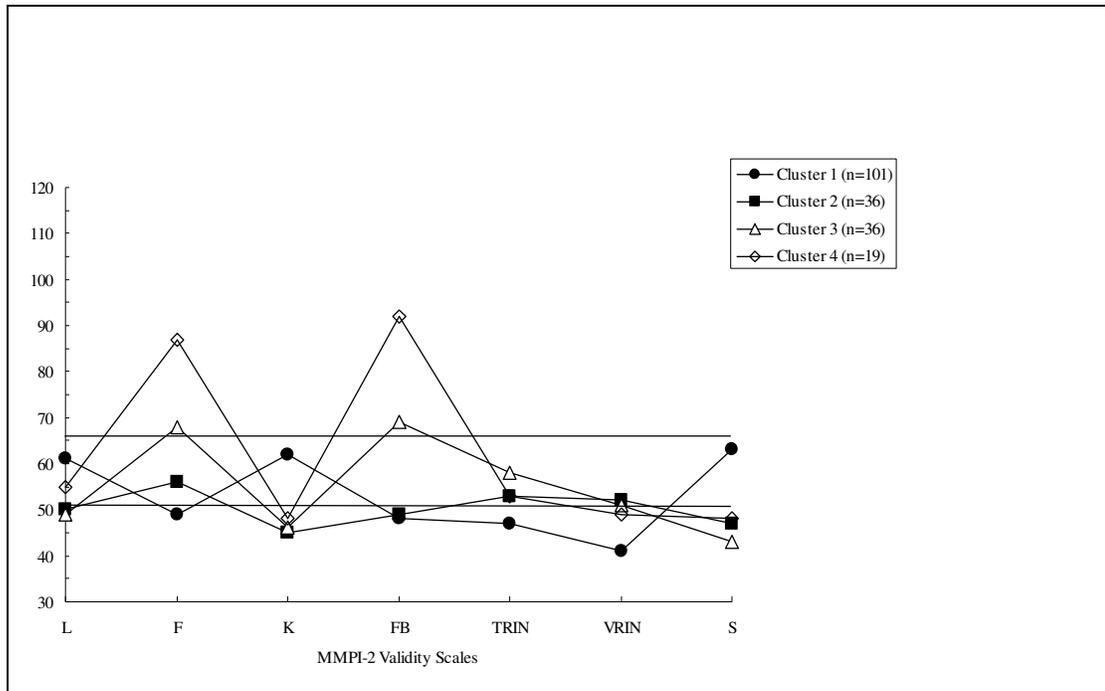
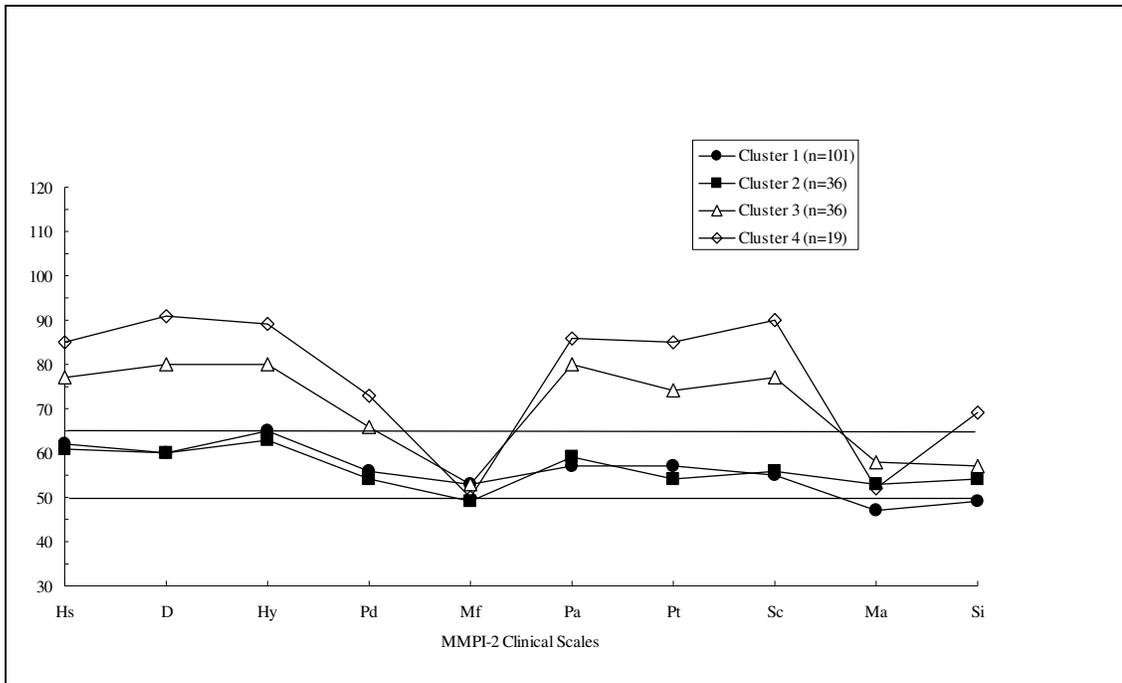


Figure 4
Mean MMPI-2 Clinical Scale scores for four validity clusters



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2. See 42 U.S.C.A. § 1981 a (b)(1) (stating that the complainant is entitled to punitive damages if he or she can demonstrate that the respondent engaged in a discriminatory practice or discriminatory practices with malice or with reckless indifference to the federally protected rights of an aggrieved individual); 42 U.S.C.A. § 1981 a (b)(3).

3. In an effort to be space-efficient, the agglomeration schedule and agglomeration coefficients are not reproduced here. However, the first author will gladly send a copy of this table to any interested reader upon request.