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Reducing MMPI-Defensiveness in Professionals Presenting for Evaluation

Steven Walfish, PhD

ABSTRACT. Due to the possibility of negatively impacting their license to practice, professionals presenting for an intensive fitness for duty multidisciplinary evaluation might have a motivation to minimize emotional difficulties in a psychological evaluation. This study examines the incidence of “fake-good” Minnesota Multiphasic Personality Inventory-2 (MMPI-2) profiles in those being evaluated and changes in psychometric test scores when extremely defensive patients are asked to repeat the testing with specialized instructions. As part of the evaluation process, patients completed an MMPI-2, as well as other psychometric instruments. The validity of each MMPI-2 profile was evaluated. Patients who produced an invalid test profile due to hyperdefensiveness were provided feedback on their defensiveness and asked to be more open and honest in a repeat testing. More than half (59%) of the patients produced invalid test profiles. Being given feedback and a request for openness and honesty resulted in 90% of valid profiles in the repeat testing. On the second testing, there were significant differences on 6 of the 13 MMPI-2 scales, as well as on each of the separate measures of depression, anxiety, and anger. It appears to be important to include a psychometric measure that includes a validity scale in the evaluation process of professionals because the majority produced invalid MMPI-2 profiles. It is recommended that patients who are defensive in their testing be asked to repeat the test battery to gain a more accurate clinical picture of the individual professional.

KEYWORDS. MMPI, impaired professionals, assessment

INTRODUCTION

Gold, Gres, and Frost-Pineda note that impairment due to substance abuse or mental health problems prevent physicians from being able to fulfill their professional responsibilities. These authors suggest that at least 15% of physicians will be impaired at some time during their career. Physicians are not the only group of professionals serving the public who can develop problems in these areas to the point where it impairs their ability to safely and competently practice. Authors have identified problems with attorneys, nurses, dentists, and pharmacists. In a study focusing on the substance patterns of pharmacists, Kenna and Wood found more than one half of these professionals reported using a nonprescribed drug at least once in their lifetime. When compared to other professional groups (e.g., physicians, nurses, and dentists), a greater proportion of pharmacists reported lifetime use of minor opiates, anxiolytics, and stimulants.

Most states have developed monitoring and advocacy programs for professionals who have had mental health and substance abuse problems and would like to continue to practice their occupation. High success rates are reported for professionals participating in these programs. Those professionals who have a positive
outcome report high levels of satisfaction with these monitoring programs.9

Some professionals self-refer to these monitoring programs because they have come to the realization that their mental health or substance abuse problems have significantly interfered with their lives or their ability to practice safely and competently. More likely, they are referred by a third party such as a State Regulatory Board, a hospital, or the professional practice where they are employed or are a partner. When there is a question regarding impairment due to mental health or substance abuse issues, these professionals are often referred to specialized treatment centers or practices to complete an intensive multidisciplinary evaluation. These are often referred to as “96-hour evaluations” (because they take 4 days to complete), “Extended Professional Evaluations,” or “Fitness to Practice Evaluations.” Stacy, Graham, and Athey10 outlined four general goals of such an evaluation: (1) to identify the presence and extent of any disorder that impedes the ability to practice, (2) to identify circumstances related to the impairment, (3) to explain why the problem arose, and (4) to make appropriate treatment recommendations. Stacy et al.10 point to the importance of including psychological testing as a component of the evaluation process. One function of such testing is to rule out deception on the part of the individual undergoing evaluation.

Walfish11 suggested that patients undergoing mental health evaluations, especially at the request of a third party, may be motivated to present in an overly positive and virtuous manner. Bathurst, Gottfried, and Gottfried12 found this to be the case in a sample of parents involved in child custody litigation. Butcher, Morfit, Rouse, and Holden13 made a similar observation in a sample of individuals applying for positions as pilots for a commercial airline. In the Butcher et al. study, 27% of the applicants produced invalid testing profiles as a result of hyperdefensiveness. Butcher et al.13 then experimented with a procedure in which they provided the feedback to the applicant that they were being defensive and then had them repeat the testing. Of those repeating the testing, 79% then produced valid profiles on the second attempt. Walfish11 followed-up with this methodology in a sample of bariatric surgery applicants. He hypothesized that due to the possibility of being denied or delayed in having surgery bariatric patients might have a motivation to minimize emotional difficulties they might be experiencing in life. When patients produced an invalid MMPI-2 due to defensiveness, they were asked to repeat the testing with a mindset of “rigorous openness and honesty.” On the second testing, 94% of the patients produced valid profiles.

When completing these assessments, it is imperative that the evaluation team feel confident that the information they receive from the professional is open and honest. Stacy et al.10 suggested that such professionals may not be able to acknowledge their distress. In addition, as with couples in litigation, airline pilots applying for employment, and patients applying to undergo bariatric surgery, there may be a motivation (conscious or unconscious) to distort in a defensive manner the test results for fear a negative evaluation would impact their ability to practice their profession. The purpose of the current investigation is to two-fold. The first purpose is to examine the incidence of defensive MMPI-2 profiles in a sample of professionals presenting for an Extended Professional Evaluation. The second purpose is to determine whether those individuals who do produce invalid test profiles would be able to produce valid test profiles on a second testing following the methodology of Butcher et al.13 and Walfish.11

**METHOD**

**Participants**

This is an archival study of the author’s patient records. Patients completed a comprehensive multidisciplinary 4-day evaluation. Patients were referred from several sources, including State Regulatory Boards (e.g., Board of Medicine or Board of Nursing), hospitals, and professional practices. The 4 days included evaluation by a psychiatrist, addictionologist, clinical social worker, and psychologist. The purposes of the evaluation were to rule out substance abuse or mental health problems and to
make appropriate treatment recommendations if problems were present.

The patients were predominantly male (81%) and Caucasian (91%), with an average age of 47.25 years (standard deviation = 7.64 years). Most were physicians (64%), and the others were dentists (11%), attorneys (9%), nurses (6%), pharmacists (4%), chiropractors (2%), optometrists (2%), and physician’s assistants (2%).

**Procedures**

As part of the psychological evaluation, all patients completed the MMPI-2, the Beck Depression Inventory-II (BDI-II), Trait Anxiety Scale (STAI), and the State-Trait Anger Expression Inventory (STAXI), which includes a measure of Trait Anger (TANG).

Each MMPI-2 profile was examined to determine whether it was valid or invalid. Profiles could be invalid either due to a “faking bad” (or exaggerated) profile or “faking good” (hyperdefensive) response set while completing the tests. A “fake good” response set was defined by an L-Scale score of more than 65 or a K-Scale score of more than 70. This is the same criteria used by Butcher et al. in their study of airline pilot applicants. A total of 53 patients were referred for evaluation and 31 patients (59%) met the criteria for “faking good.” Following the procedures of Butcher et al. and Walfish, after completing the invalid test profile the psychologist met with each patient and explained these results. The standard feedback was as follows:

We can tell a person’s test taking attitude from the tests. This attitude can either be on a conscious basis, which means someone means to do it on purpose. It could also be on an unconscious basis, which means they don’t mean to do it on purpose but it comes out that way anyway because people aren’t always aware of the reasons they do something or that they are even doing something. For example, some people this may be considered a ‘cry for help.’ On the other hand some people do just the opposite. They want whoever is evaluating the tests to know that they are fine, have no problems or cares in the world. However, this is done to such an extreme that this is called minimizing your difficulties, being hyperdefensive, presenting in an overly virtuous manner and “too good to be true” or “faking good.” And this is how your test results came back, as being overly defensive to the point of being invalid.

It was stressed to the patient that this was most likely done on an unconscious basis and that the psychologist did not think they were trying to consciously lie or be deceptive in any manner. However, the patients were told that they would need to repeat the tests with “a mindset of rigorous openness and honesty on a conscious basis.” All patients agreed to retake the tests as part of the evaluation process and did so within the next day.

**RESULTS**

Using paired t tests, the data included for analysis were the validity and K-corrected clinical scales of the MMPI-2 and scores on the BDI-II, the trait portion of the STAI, and the TANG portion of the STAXI. In all but three instances (10%), each patient produced a valid profile on the second testing. This was defined as having both an L Scale score less than 65 and a K-Scale score less than 70.

Scaled scores from the first testing were compared with scores from the second testing. The mean scores for the three validity scales from the MMPI-2, the 10 clinical scales from the MMPI-2, the BDI-II, STAI, and TANG are presented in the Table 1. As can be seen from these data using a p value of 0.05, there were significant changes on 12 of the 16 comparisons. To control for the possibility of experimenter-wise error rates due to multiple comparisons, a Bonferroni correction was calculated to bring the alpha level to 0.003. Using this adjusted alpha level, there were still significant changes on 9 of the 16 comparisons.
TABLE 1. Mean t Scores and Standard Deviations on MMPI Scales (K-corrected) and Mean BDI, STAI, and TANG Scores on Repeated Testing

<table>
<thead>
<tr>
<th>Scale</th>
<th>First Testing</th>
<th>Second Testing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>X</td>
<td>SD</td>
</tr>
<tr>
<td>L</td>
<td>62.26</td>
<td>9.15</td>
</tr>
<tr>
<td>F</td>
<td>43.61</td>
<td>3.83</td>
</tr>
<tr>
<td>K</td>
<td>67.48</td>
<td>6.88</td>
</tr>
<tr>
<td>Hs</td>
<td>53.22</td>
<td>6.96</td>
</tr>
<tr>
<td>D</td>
<td>50.64</td>
<td>7.01</td>
</tr>
<tr>
<td>Hy</td>
<td>55.48</td>
<td>7.66</td>
</tr>
<tr>
<td>Pd</td>
<td>56.52</td>
<td>8.46</td>
</tr>
<tr>
<td>Mf</td>
<td>49.77</td>
<td>8.42</td>
</tr>
<tr>
<td>Pa</td>
<td>55.29</td>
<td>9.22</td>
</tr>
<tr>
<td>Pt</td>
<td>51.64</td>
<td>7.62</td>
</tr>
<tr>
<td>Sc</td>
<td>50.23</td>
<td>6.11</td>
</tr>
<tr>
<td>Ma</td>
<td>44.71</td>
<td>6.35</td>
</tr>
<tr>
<td>Si</td>
<td>46.84</td>
<td>7.01</td>
</tr>
<tr>
<td>BDI-II</td>
<td>4.87</td>
<td>5.77</td>
</tr>
<tr>
<td>STAI</td>
<td>29.29</td>
<td>7.82</td>
</tr>
<tr>
<td>TANG</td>
<td>13.19</td>
<td>2.73</td>
</tr>
</tbody>
</table>

BDI-II = Beck Depression Inventory-II; STAI = Trait Anxiety Scale; TANG = Trait Anger.

Using the conservative alpha level of .003, there were significant changes on all three of the MMPI validity scales (L, F, and K). This suggests a reduction in defensiveness and a willingness to endorse more symptomatic items on the second completion of the MMPI.

Using the conservative alpha level of .003 on the MMPI-2 clinical variables, there were significant changes on 3 of the 10 scales. There was a significant increase on the D, Pd, and Si scales.

Using the conservative alpha level of .003, there were significant increases in all three of the other psychometric tests included in the test battery. This included an increase in depression scores measured on the BDI-II, anxiety scores measured by the STAI, and anger scores as measured by the TANG portion of the STAXI.

**DISCUSSION**

Professionals presenting for evaluation at the request of a third party for possible impairment may be motivated, either consciously or unconsciously, to minimize the extent of their problems. They may fear that an evaluation outcome that indicates they are impaired will impact their ability to practice their profession and consequently to earn a living. The results of the current investigation suggest that slightly more than half (59%) of professionals presenting for intensive evaluation will produce invalid MMPI profiles due to hyperdefensiveness. Interestingly, when given feedback about these test results and provided an opportunity to be more forthcoming, 90% of these professionals subsequently produced valid test results. Taub, Morin, Goldrich, Ray, and Benjamin suggested that when professionals’ health or wellness may compromise their ability to practice they should engage in honest self-assessment. This second opportunity may aid in this process.

Stacy et al. suggested that when completing fitness for duty evaluations with professionals their inappropriate behaviors or level of distress may be either denied or outside of their awareness. For this reason, they advocate using the Rorschach Test, an ambiguous projective test where it is more difficult to identify socially desirable answers to the tests, as a component of the evaluation process. However, the Rorschach Test is clearly controversial in the field of psychological assessment. With the current results, there are now three studies indicating that providing feedback on a response style of hyperdefensiveness and allowing individuals to repeat the
testing will result in valid test results in the majority of cases (79% with airline pilot applicants, 94% with bariatric surgery patients, and 90% in professionals appearing for evaluation). As such, rather than using the controversial Rorschach Test, valid information may be obtained from the professional presenting for evaluation simply by asking them to repeat the tests with a mindset of rigorous openness and honesty.

Long, Cassidy, Sucher, and Stoehr examined successful completers of a health professional’s monitoring program with those participants who had relapsed to active addiction. They found that contributors to the relapse included both dishonesty to the self and denial of the problem. In the current investigation, the second testing found reductions in L and K scale scores and an increase in F scale scores. This suggests that those presenting for evaluation were willing to be less defensive and more willing to report unconventional thoughts or behaviors. On the second MMPI, there were increases in scale scores on the D, Pd, and Si scales. The average score on the Pd scale ($T = 64.35$) closely approached the cutoff for clinical significance. This suggests a willingness to report more rebellious and nonconforming behavior and difficulties with authority. It is possible to hypothesize that the increase of scores on the Si scale (in the introverted direction) may reflect a belief that being extroverted would be viewed by evaluators as a positive attribute. On the second testing, professionals were willing to report more symptoms of depression (MMPI-2 D scale and the Beck Depression Inventory), as well as symptoms of anxiety and anger. It is possible to speculate that communicating defensiveness helped to break through the hypodefensive denial on the part of the professional. In turn, this may help later on in the recovery process, as Long et al. found dishonesty to self and denial to be associated with a negative outcome.

Dabro suggested that serious consequences may ensue when professionals lack acceptance of their impairment. In the current investigation, a small percentage (10%) of those presenting for evaluation produced a second invalid testing profile. The reason for this can only be speculative. It may be that these individuals were so rigid in their presentation and felt the need to “stick to their story” of not having many or any problems that they did not allow themselves to reduce their defensive response set in answering test items. Many individuals undergoing evaluation view the process as adversarial in nature and may feel they have a lot to lose (e.g., their ability to practice their occupation). Therefore, they may not want to be fully cooperative with the evaluation process. However, as noted above this is speculative at this time and is an area deserving of further study.

Taub et al. urged professionals whose health or wellness may be compromised to seek appropriate help and to engage in honest self-assessment. The results of the current investigation suggest that professionals may be reluctant to initially follow this sage advice. However, with feedback in the context of an intensive multidisciplinary evaluation, they may be willing to be less defensive and admit problems they may be experiencing.

REFERENCES


