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Detection of Overreporting on the MMPI-2: Differentiation between Faking Bad and Cry for Help

Jeeyoung Lim †

Seoul National University

The purpose of this study was (a) to evaluate the effectiveness of the validity indices of the MMPI-2 in detecting overreporting of psychiatric disorder by mildly to moderately disturbed outpatients; (b) to differentiate between two response sets of symptom overreporting (Faking Bad and Cry for Help); (c) to cross validate cutting scores suggested by Rogers, Sewell, and Ustad (1995) for detection of exaggeration of psychiatric symptoms by chronic outpatients instructed to overreport problems in order to be hospitalized. Participants were 80 mild to moderately disturbed outpatients who were administered the MMPI-2 twice, once under standard instructions and again under Faking Bad or Cry for Help instructions. Similar to the results reported in the previous studies, Faking Bad and Cry for Help instructions produced significantly elevated scores on the *F*, *Fb*, and *Fp* scales, and *F-K* index as well as significantly lower scores on the *K* scale. Scores on all clinical scales were also significantly elevated in the Faking Bad and Cry for Help conditions. Overall, cutting scores suggested by Rogers et al. (1995) Worked fairly well although slightly higher scores on the *Fb* and *Fp* scales were needed. The attempt to differentiate between the two response sets for symptom overreporting, Faking Bad and Cry for Help, was not successful. However these results should not be taken to indicate that the particular response sets assessed in this study cannot be differentiated. Methodological issues reviewed suggest that further research may be able to yield more meaningful understanding of the nature of symptom overreporting in clinical settings.

"Malingering", also known as Faking Bad, is defined by the fourth edition of the Diagnostic and

† Corresponding Author : Jeeyoung Lim Ph.D / Department of Psychology, Seoul National University / San 56-1, Shillim-dong, Kwanak-gu, Seoul, Korea, 151-742 / FAX : 880-6428 / E-mail : mmpi2@unitel.co.kr

Statistical Manual of Mental Disorders (*DSM-IV*) as "the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives" (American Psychological Association, 1994). It is distinguished from factitious disorders by the conscious production of symptoms. Individuals sometimes take advantage of feigning psychological maladjustment in the current medicolegal system. For example, veterans with Posttraumatic Stress Disorder may obtain pensions through the Veteran's Administration system, defendants found to have mental problems may avoid responsibility for legal infractions, young men of draft age found psychologically disturbed may be exempted from military service, and workers with psychological problems secondary to work-related injuries may be compensated by Workers' Compensation.

In other cases, some psychiatric patients may attempt to overreport problems on psychological tests such as the Minnesota Multiphasic Personality Inventory (MMPI; Hathway & McKinley, 1943) and MMPI-2 (Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989) even when they have no obvious gain such as is the case in Faking Bad. These patients are often considered to be engaged in Cry for Help or a Plea for Help (Dahlstrom, Welsh, & Dahlstrom, 1972). Psychologists working in various clinical settings frequently face this interpretation, and it is covered in most MMPI and MMPI-2 interpretive manuals (Butcher, 1990; Graham, 1993). Patients especially may be engaged in Cry for Help in an evaluation program in which they feel that unless they exaggerate or fabricate their symptoms they would not be able to get appropriate treatment (Dahlstrom et al., 1972). Although individuals Crying for Help may have different goals from those engaged in Faking Bad (e.g., getting treatment for some kind of help vs. socially undesirable goals such as obtaining pensions or avoiding legal responsibility) (Dahlstrom et al., 1972), little research has been published to differentiate between these two approaches.

Research on the MMPI and MMPI-2 scales and Faking Bad has shown that several validity scales from the MMPI and the MMPI-2 were useful to detect individuals' tendency to overreport psychological symptoms. In every study, the faking-bad protocols had higher *F* scale and clinical scale scores and lower *K* scale scores than for valid profiles obtained by psychiatric patients and normal persons (Anthony, 1971; Gendreau, Irvin, & Knight, 1973; Grow, McVaugh, & Eno, 1980; Schretlen, 1986). For the *F* scale, cut off scores have ranged from 15 to 20. The *F-K* Index, proposed by Gough (1950), involves comparing the tendency to exaggerate to the tendency of minimizing psychological disturbance. The *F* scale is intended to identify deliberate exaggeration or fabrication of symptoms, whereas the *K* scale is seen as index of subtle defensiveness. Higher levels of exaggeration relative to defensiveness result in higher *F* scores compared to *K* scores, and hence a positive *F-K* score suggesting "Faking Bad." The classification rates of invalid protocols ranged from 82% to 98% and the optimal cut off has varied across studies, ranging from 9 to 16. The *Fb* (back *F*) scale, one of the new validity scales in the MMPI-2, is very similar to the standard *F* scale but includes items from the latter part of the test booklet. Recent studies have consistently shown that the *F* and the *Fb* (back *F*) scales, and to some extent the *F-K* Index, are valuable indicators of the tendency of some individuals to fake bad on the MMPI and the MMPI-2 (Berry, Baer, & Harris, 1991; Graham et al., 1991). However, suggested cut off scores have varied across settings and most studies asked college

students to feign psychiatric symptoms, failing to include an appropriate clinical comparison group. These problems limit the generalizability of findings and leave clinicians uncertain as to the effectiveness of cutting scores on validity indices in clinical populations.

Compared to plentiful studies on Faking Bad response set, empirical research on the Cry for Help approach to the MMPI and MMPI-2 is rarely present. Post and Gasparikova-Krasnec (1979) classified the MMPI results of psychiatric inpatients into three groups on the basis of their *F-K* scores. Those with highly positive scores (*F-K* 〉 11) were classified as the Cry for Help profiles, those with highly negative scores (*F-K* 〈 -13) as the Hyper-defensive profiles, and remaining protocols as the Average profiles. Patients with the Cry for Help profiles were evaluated by ward staff as engendering more "feelings of frustration" and "acting out" more frequently on the unit (e.g., alcohol and drug abuse, sexual acting out, aggression, self-injurious behavior) than patients in the other two groups. More than 80% of the patients in the seclusions were those with the Cry for Help protocols. They concluded that Cry for Help patients showed inappropriate, destructive behavior because of difficulties in impulse control and thus produced more management problems.

Recently Rogers et al. (1995) asked 42 chronic psychiatric outpatients to complete the MMPI-2 twice, once with standard instructions and again with instructions to simulate severe psychiatric problems in order to be hospitalized immediately. They evaluated the utility of several MMPI-2 validity indices, such as the *F, Fb, Fp* scales and *F-K* index, to detect overreporting of psychological problems by psychiatric outpatients. The *Fp* (*F* psychopathology) scale is a new validity scale developed by Arbisi and Ben-Porath (1993), and consists of items endorsed infrequently (less than 20% in the keyed direction) by the MMPI-2 normative sample as well as psychiatric inpatients. Consequently, elevated scores on the *Fp* scale are unlikely to reflect psychopathology, suggesting aberrant responses, and thus imply that the client responded to the MMPI-2 in a manner to overreport or exaggerate his or her psychological problems. Rogers et al. (1995) reported that all these overreporting indices discriminated well between the profiles produced under standard instructions and simulating instructions. Especially the *F* and *Fp* scales showed promising results for detection of overreporting, producing hit rates ranging from 80% to 93%.

The purpose of this study was (a) to evaluate the effectiveness of the validity indices of the MMPI-2 in detecting overreporting of psychiatric disorder by mild to moderately disturbed outpatients; (b) to differentiate between two response sets of symptom overreporting (Faking Bad and Cry for Help); (c) to cross validate cutting scores suggested by Rogers et al. (1995) to detect overreporting of psychiatric symptoms by chronic outpatients who were instructed to overreport psychological problems in order to be hospitalized.

METHOD

Participants

The participants used in this study were 80 outpatient clients (42 women and 38 men) at local mental health center in Indiana. Through the cooperation of the therapists, patients whose MMPI-2 intake results are available and are willing to take the MMPI-2 twice agreed to participate in the study. The mean ages of the male and female participants were

32.4 years and 36.2 years, respectively. The participants were typically well educated; 69% reported some level of education beyond high school, 25% reported 12 years of education, and 6% reported less than 12 years. The majority of the clients were White (92%), with Black constituting only 8%. Regarding marital status, 42% described themselves as married, 3% as widowed, 22% as divorced, 8% as separated, and 25% as never married. Most patients were mildly to moderately disturbed, and had the following *Diagnostic and Statistical Manual of Mental Disorders (DSM IV; American Psychological Association, 1994) diagnoses*: 33% were diagnosed with major depressive disorder, 18% with substance abuse, 17% with schizophrenia, 15% with adjustment disorder, 9% with paranoid personality, and 8% with posttraumatic stress disorder.

Procedure

As noted earlier, all participants completed the MMPI-2 as part of comprehensive intake procedures. For the experimental observation, participants were randomly assigned to either Faking Bad or Cry for Help condition, with 40 in each condition. Results of *t* tests and chi-square tests revealed no significant differences between the two groups on any of the demographic parameters such as sex, race, age, and levels of education as well as on any validity or clinical scale.

Participants completed the MMPI-2 twice, once with standard instructions to answer the items "as they apply to oneself," and again with Faking Bad or Cry for Help instructions. The order of the standard and overreporting instructions were counterbalanced. In each condition, participants were given a scenario illustrating a realistic situation in which overreporting might occur. Faking Bad instructions were as follows:

> We want you to imagine yourself in a psychological assessment program. You are informed that if you are diagnosed from a psychological test called the MMPI-2 as having severe emotional problems you may qualify for disability benefits. We would like for you to respond to the MMPI-2 statements as though you were having severe psychological problems and want to qualify for disability benefits. Also keep in mind that you need to be convincing in your response to the items in order that the psychologists evaluating your MMPI-2 answers would consider your performance consistent and reliable.

Cry for Help instructions were as follows:

> We want you to imagine yourself in a psychological assessment program because you have been experiencing emotional disturbance for a few months and decide to get professional help in your local mental health center. Since there are many clients, you will be placed on a waiting list after taking a psychological test called the MMPI-2 for evaluation of the severity of your problems. You are informed, however, that if you are diagnosed as having severe emotional problems it may be recommended that you see a psychologist now. We would like for you to respond to the MMPI-2 statements as if you were having severe psychological problems in order to see a psychologist immediately. Also keep in mind that you need to be convincing in your response to the MMPI-2 items in order that the psychologists evaluating your MMPI-2 answers would consider your performance consistent and reliable.

When most participants completed about half of the test items, they were given the instructions again in order to emphasize the importance of responding

convincingly in accordance with overreporting instructions. At the completion of the MMPI-2, participants were asked to complete the following debriefing form to assess their understanding and adherence to the instructions:

1. How consistently did you respond to the MMPI-2 items in accordance with the instructions? (a) not consistent with the instructions, (b) only occasionally consistent, (c) about half the time consistent, (d) mostly consistent, (e) completely consistent
2. In this study you were asked to respond to the MMPI-2 in order to:

Following completion of a debriefing form, participants received a meal ticket of 10$ value which they can use in a hospital cafeteria.

Exclusion Criteria

Participants were eliminated from the study if they showed any of the following characteristics: failure to complete the MMPI-2 twice, endorsement of a or b on the first question of the debriefing form, and a *T* score of 70 or greater on *VRIN*. Participants who answered the first question of the debriefing form as "a" or "b" were considered to be random responders. No participants were eliminated from the study on the basis of the first two criteria. However, four participants (3 participants in the Faking Bad and 1 participant in the Cry for Help condition) were excluded based on the *VRIN* score. Thus, a total of 76 participants was included in the final analyses, with 37 in the Faking Bad and 39 in the Cry for Help condition, respectively.

Analyses

Since the purpose of validity scales are different from that of clinical scales (evaluation of response attitude vs. evaluation of psychopathology), analyses for the MMPI-2 results were conducted into separate sets, one for validity scales and the other for clinical scales. A multivariate analysis of variance (MANOVA) was conducted on each set of variables to test the overall significance of the hypothesis that there are no differences between mean profiles for the Faking Bad and Cry for Help conditions. When the multivariate results were significant, further univariate analyses of variance (ANOVAs) were performed to determine which scales contribute to the overall differences between the two conditions. Finally, percentage of participants correctly classified was compared with correct calssification rates found by Rogers et al. (1995) using their cutting scores.

RESULTS

Results on the validity scale scores are presented in Table 1. MANOVA showed the overall differences between patient profiles under Faking Bad and standard instructions and differences between profiles produced in Cry for Help and standard conditions. Therefore, univariate *t* tests were used to examine further which scales revealed the differences between overreporting and standard conditions. In the Faking Bad condition, scores on the *F*, *Fb*, and *Fp* scales, and *F-K* index were more significantly elevated than the same patients under standard instructions. In contrast, the *K* scale scores were significantly lower in the Faking Bad condition than in the standard condition. Similar to the results obtained in the Faking Bad condition, Cry for Help instruction produced much higher scores on the *F*, *Fb*, and *Fp* scales, and *F-K* index, and much lower scores on the *K* scale.

Clinical scale results are presented in Table 2.

TABLE 1. Validity Scale Scores for Standard, Cry for Help, and Faking Bad Groups

	Standard 1		Faking Bad[a]		Standard 2		Cry for Help[b]	
Scale	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
L	56.0	9.9	53.3	7.9	46.4	11.3	47.0	9.1
F	70.1	19.0	118.7	1.8*	69.9	14.2	115.2	3.3*
K	45.4	10.5	35.7	5.6*	51.6	9.2	33.0	7.5*
Fb	79.9	23.4	119.7	1.5*	70.1	21.0	116.4	5.1*
F-K	-2.2	9.2	19.9	13.2*	1.4	7.2	22.1	14.8*
Fp	50.1	10.7	109.7	2.8*	48.9	9.1	105.1	4.4*

Note. *L, F, K, Fb,* and *Fp* are linear *T* scores except *F-K,* which is in raw score units.
Standard 1 is for the standard condition after which patients were given Faking Bad instruction. Standard 2 is for the standard condition after which patients were given Cry for Help instruction.
[a]n = 37. [b]n = 39.
* $p < .001$ based on univariate t tests between standard and overreporting (Faking Bad or Cry for Help) conditions.

TABLE 2. Clinical Scale *T* Scores for Standard, Cry for Help, and Faking Bad Groups

	Standard 1		*Faking Bad*[a]		*Standard 2*		Cry for Help[b]	
Scale	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
Hs	55.7	15.8	81.3	20.6*	51.0	10.3	81.4	9.1*
D	61.1	12.4	82.5	11.4*	58.3	12.9	89.8	12.0*
Hy	56.9	15.3	77.8	17.8*	59.3	12.5	78.9	11.0*
Pd	68.1	11.0	95.7	7.0*	63.0	10.4	91.7	7.8*
Pa	70.3	18.5	107.5	15.6*	66.1	15.7	99.8	17.2*
Pt	62.6	15.8	93.4	13.5*	63.5	11.4	94.5	9.7*
Sc	72.7	17.9	116.4	10.2*	62.5	9.9	107.0	13.5*
Ma	61.1	12.7	84.2	10.5*	54.0	9.3	71.2	12.6*
Si	58.8	11.2	77.9	11.2*	55.7	10.2	78.5	9.2*

Note. *Hs, D, Hy, Pd, Pa, Pt, Sc,* and *Ma* are uniform *T* scores except *Si* scale, which is in linear *T* score units.
Standard 1 is for the standard condition after which patients were given Faking Bad instruction. Standard 2 is for the standard condition after which patients were given Cry for Help instruction.
[a]n = 37. [b]n = 39.
* $p < .001$ based on univariate t tests between standard and overreporting (Faking Bad or Cry for Help) conditions.

Since the results of MANOVA were significant, univariate *t* tests were used to compare differences between profiles under Faking-Bad and standard instructions and differences between profiles produced in Cry for Help and standard conditions. Both Faking Bad and Cry for Help instructions produced higher scores on all clinical scales than standard instructions. Consistent with the previous studies on

symptom overreporting (Berry et al., 1991; Graham et al,, 1991; Rogers et al., 1995), scales 6 (*Pa*) and 8 (*Sc*) showed the most elevated scores in both Faking Bad and Cry for Help conditions.

Table 3 Shows the correct classification rates with those found in Rogers et al. (1995). correct classification rates of standard profiles were higher on all overreporting indices for this study, but the percentage of overreporting profiles correctly classified were slightly lower. The *F* scale and *F-K* index produced higher hit rates in this study, whereas the *Fb* and *Fp* scales produced slightly lower hit rates. Employing slightly higher cut off scores on the *Fb* and *Fp* scales led to somewhat higher hit rates in this study. On the *Fb scale,* a cut off score of 27 or greater produced higher hit rates (83.2% in Cry for Help condition and 83.7% in Faking Bad condition). An *Fp* raw score of 10 or greater appeared appropriate, producing hit rates of 92.1% in Cry for Help condition and 91.4% in Faking Bad condition, respectively.

To explore the possible differences between the two response sets for symptom overreporting, Faking Bad and Cry for Help, MANOVA was performed on the validity and clinical scale sets. MANOVA on each set of scales did not achieve significance, $F(6,69)=4.89$, $p>.05$ for the validity scales, and $F(9,66)=3.36$, $p>.05$ for the clinical scales, respectively. Therefore, there were no significant differences between the MMPI-2 protocols for the two conditions. Because the multivariate results are not significant, there is no reason to examine the univariate results.

DISCUSSION

The MMPI-2 results of Faking Bad and Cry for Help patients found in this study closely resembled the previous report on detecting Faking Bad and Cry for Help MMPI-2 profiles. Faking Bad and Cry for Help profiles produced significantly higher scores on the *F, Fb,* and *Fp* scales, and *F-K* index, significantly lower scores on the *K* scale, and significantly higher scores on all clinical scales. Using cutting scores suggested by Rogers et al. (1995), correct classification rates of standard profiles were higher for this study, but the percentage of overreporting profiles correctly classified were somewhat lower. The *F* scale

TABLE 3. Percentage of Patients Cerrectly Classified under Standard and Overreporting (Cry for Help and Faking Bad) Instructions

Scale & Cutting Scores	*Rogers et al. (1995)*			*This Study*					
				Cry for Help[a]			*Faking Bad*[b]		
	Standard	*Overreporting*	*Hit Rates*	*Standard*	*Overreporting*	*Hit Rates*	*Standard*	*Overreporting*	*Hit Rates*
F > 29	92.1%	93.9%	92.9%	100%	92.3%	96.5%	100%	93.1%	96.2%
F-K > 18	84.2%	87.9%	85.9%	100%	80.4%	90.3%	100%	86.5%	91.1%
Fb > 25	94.7%	68.4%	82.5%	100%	61.9%	80.6%	100%	66.8%	83.1%
Fp > 9	94.7%	87.9%	91.5%	100%	78.2%	88.8%	100%	81.6%	90.3%

Note. Cutting Scores developed by Roger et al. (1995).

Hit Rates are the percentage of patients in the combined groups correctly classified using the given cutting score on the indicated scale.

[a]*n* = 37. [b]*n* = 39.

and *F-K* index produced higher hit rates in this study, whereas the *Fb* and *Fp* scales produced slightly lower hit rates. Employing slightly higher cut offs on the *Fb* and *Fp* scales improved hit rates in this study. Consistent with the previous report, the *F* and *Fp* scales, and *F-K* index detected a very high percentage of Faking Bad and Cry for Help profiles, and the *Fb* scale was somewhat less successful than other symptom overreporting indices. Further research using hierarchical regression analyses on these indices would be helpful to determine the relative contribution of each scale in detecting overreporting protocols. Overall, cutting scores suggested by Rogers et al. (1995) fared well in discriminating between overreporting and standard profiles.

The attempt to differentiate between the two response sets for symptom overreporting, Faking Bad and Cry for Help, was not successful, as demonstrated by MANOVA results. Although individuals involved in Faking Bad have different goals from those Crying for Help (e.g., a socially undesirable goal such as getting disability benefits vs. receiving psychiatric care) (Dahlstrom et al, 1972), the MMPI-2 results appear quite similar between the two approaches. However, the results of this study should not imply that the two response sets for symptom overreporting, Faking Bad and Cry for Help, can not be differentiated. Rather, these findings could result from some limitations of this study including the same amount of monetary award given to all participants regardless of the level of their participation and manipulations of overreporting. Subsequent studies need to direct attention toward exploring overreporting strategies with a larger sample in various clinical settings and different amount of payment depending on successful simulation. In addition, recent research (Lanyon, 1993) to investigate particular strategies for faking bad showed that symptom overendorsement and erroneous psychiatric stereotype could be differentiated on the Psychological Screening Inventory. Considering the methodological issues raised in this study and suggestions from the recent study, further research may yield more meaningful understanding of the nature of symptom overreporting in clinical settings.

In conclusion, this study has demonstrated that elevated *F, Fb,* and *Fp* scales, and *F-K* index, lower K scales, and elevated clinical scales, especially scales 6 and 8 to be the most elevated, may be the most characteristic features of the Faking Bad and Cry for Help response sets. However, further research is still needed to address the issues presented in this study and to examine further the generalizability of the findings to other clinical settings.

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MMPI-2 프로화일에 나타난 Symptom Overreporting의 탐지: Faking-Bad와 Cry For Help의 변별

임 지 영

서울대학교 심리학과

본 연구는 (1) 정신과 외래환자들(만성적, 중증 환자 제외)에 의한 증상의 과장보고(Overreporting)를 탐지해내는 데 있어서 MMPI-2의 타당도 척도들의 효과를 평가하고, (2) Symptom Overreporting의 두 가지 전략, Faking Bad와 Cry For Help의 변별을 시도하고, (3) 만성적인 정신과 외래환자들을 대상으로 Symptom Overreporting의 탐지를 시도했던 Rogers, Swell, 그리고 Ustad의 연구(1995)에서 제안된 cutting score의 유용성을 평가하였다. 80명의 정신과 외래환자들을 대상으로 표준지시하에서, 그리고 Overreporting 지시(Faking Bad나 Cry For Help)하에서 MMPI-2를 실시한 결과, 이전의 연구에서 보고된 바와 마찬가지로 Overreporting 프로화일에서 *F, Fb, Fp, F-K,* 그리고 임상척도 점수가 상승되었고, *K* 점수는 낮게 나타났다. Rogers 등의 연구(1995)에서 제안된 cutting score는 비교적 긍정적인 탐지율을 보였다. Faking Bad와 Cry For Help를 변별하고자 했던 시도는 성공하지 못했으나, 임상장면에서의 Symptom Overreporting에 대한 더 많은 연구가 필요한 것으로 판단된다.