

## FBS MMPI-2 Critique

I would encourage you to look at Meyers, Millis and Volkert (2002) paper in the Archives of Clinical Neuropsychology (17) A validity index for the MMPI-2. They have a weighted formulary method for classifying malingering in chronic pain patients and it may be of interest to look at the information this may provide.

Jill R. McConnell, Ph.D.  
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drstevekalat@comcast.net 2/28/2006 12:01 PM >>> Can an FBS scale on the MMPI-2 be considered to be a valid indicator of response bias or symptom exaggeration in a case of a patient with "mild" multiple sclerosis in a personal injury lawsuit (not MVA, not TBI, but rather emotional stress and injury).

The MMPI 3/1 profile is extreme (105T and 100T, respectively). These elevations are two to three standard deviations above the average MS patient (Nelson et al., 2003). After an MS neuro-correction factor is extracted, the 3/1 profile remains rather high (Scale 3, 88T; Scale 1, 80T).

FBS was originally 37! After the neuro-correction factor is applied it remains at 31, remaining items claiming excessive virtue and stomach complaints. Have there been any studies of FBS data among MS patients? Is it reasonable to apply the FBS in this case?

Stephen Kalat, Ph.D. Denver, CO

The list's administrator is David Loring (david.loring@neurology.ufl.edu)

I think it's important to look at the Butcher et al paper in the Archives of Clinical Neuropsychology, Vol 18, 473-485, 2002. They examined FBS scores in six patient samples totaling over 20,000 profiles, and found that the FBS correlated more highly with clinical scales than with validity measures, and was especially prone to misclassifying women as malingering. The concluded that the FBS is, in their words, "likely to classify an unacceptably large number of individuals who are experiencing genuine psychological distress as malingerers. It is recommended that the FBS not be used in clinical settings nor should it be used during disability evaluations to determine malingering."

The list's administrator is David Loring (david.loring@neurology.ufl.edu)

I am curious. What do you use to separate the 'genuine neurological problems' from the somatoform overlay?

Dave

David Ranks, Ph.D., ABPN

-----Original Message-----

From: Stephen S. Kalat, Ph.D. [mailto:drstevekalat@comcast.net]

Sent: Tuesday, February 28, 2006 11:54 AM

To: Neuropsychology

Subject: Re:[npsych] MMPI- FBS scale and MS patient

Thank you.

I think the Butcher paper has problems, (see Larrabee, Forensic Neuropsychology). MMPI validity scales are psychopathology oriented not related to personal injury exaggeration. There is a high base rate of exaggeration in personal injury lawsuits (see Mittenberg et al.), unaccounted for in Butcher's conclusions.

However, I am concerned about the distortion of the FBS in a genuine neurology patient with personal injury complaints and probable overlay of somatoform processes.

Stephen S. Kalat, Ph.D.

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In a message dated 2/28/2006 1:13:25 PM Eastern Standard Time, drstevekalat@comcast.net writes:

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Stephen: The T scores you report on Scales 1 and 3 are extremely high, even for an MS patient. If you check my paper in Archives of Clinical Neuropsychology, v. 18, 2003, pp. 673-686, Table 1 lists MMPI-2 T-Scores for a pooled MS sample of 66 Ss. The mean (sd) for Scale 1 are 72.0 (9.8) and for Scale 3 are 71.4 (11.6). Hence, your patient's scores of 100 and 105 are nearly 3 sds above these MS means. You do have an external incentive (PI litigation). FBS scores in the 30s are usually not associated with any false positives, particularly a score of 37!! Greiffenstein, Fox and Lees-Haley have a chapter "in press" in a book Kyle Boone is editing on non-credible test performance that has just over 1000 clinical cases (medical, neurologic, psychiatric), and they have a 90% specificity at scores of 23 or higher, with essentially a 100% specificity over 30. Do you have additional evidence of any performance invalidity? Failure on SVTs (e.g. WMT, TOMM)? Failure on embedded SVTs (forced choice CVLT, Reliable Digit Span)? I would be hesitant to rely on the FBS alone, even though it is in the 30s. You are correct about the flaws in the Butcher et al study. I addressed some of the more critical errors in the same ACN paper cited above. Last, can you provide me a reference for the MMPI-2 MS correction factor you mentioned above? Glenn Larrabee

< [The list's administrator is David Loring david.loring@neurology.ufl.edu](mailto:david.loring@neurology.ufl.edu)

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