-----Original Message-----
From: Dr. Kanter [mailto:medpsych@comcast.net]
Sent: Wednesday, March 10, 2004 6:42 PM
To: Neuropsychology
Subject: RE: [npsych] Millon vs. Minnesota: FBS!

Here is an excerpt of what I put in my reports whenever someone is well past the threshold of failing the FBS (thanks and consideration given to Glen Larrabee et al):

"There are grave concerns from a variety of tests and areas which suggest that there is a great degree of symptom exaggeration/enhancement possibly for possibly different reasons (e.g., attempting to get help/payments from Worker's Compensation or desire for increased narcotic treatment, or other more unconscious reasons). In particular, ___ obtained a score on the Lees-Haley Fake/Bad Scale of (e.g., 30), which is severely elevated, beyond the criteria level typically utilized to identify symptom invalidity and symptom exaggeration.

There is a large body of research, which document the FBS as a valid measure of symptom exaggeration. Larrabee (2003) found the FBS to be superior to any other MMPI-2 Validity or standard clinical scale in terms of sensitivity to malingering of neuropsychological symptoms. Dr. Larrabee noted that other studies such as Meyers, Millus, and Volkert (2002), found that no non-litigating chronic pain patients scored higher than 29 on the FBS. Larrabee (2003b) found that the FBS was more sensitive to symptom exaggeration than the MMPI-F, Fb and F(b) scales; he also found that definite and probable malingerers produce elevated scores on the MMPI-2 scales 1, 3, and 7 that were much higher than those of non-litigating severe closed head injury patients such as multiple sclerosis, spinal cord injury, chronic pain, and depression patients.

Larrabee noted that Meyers, et al. (2003) found that only 16 of 100 non-litigating chronic pain patients had an FBS of 25 to 29, and that none had an FBS of 30 or higher. By contrast 27 of 100 litigating chronic-pain patients had an FBS of 25 to 29, and 15 had an FBS of 30 or more. Larrabee (1997) suggested that "somatic malingering should be considered whenever elevations on scales 1 (Hs) and 2 (Dep) exceeds T-80, accompanied by significant elevation on the FBS" (p. 203). This is, in fact, exactly the case with _. The MMPI-2 Scales 1 (Hs), 2 (Dep) and 3 (Hy) are so high (e.g., 90+) as to represent an extremely low probability of occurring in the normal population, well beyond what is typical for psychiatric patients, and far beyond what is typical for even severely injured chronic pain patients.

Larrabee's 2003 TCN paper, "Detection of symptom exaggeration with the MMPI-2 in litigants with malingered neurocognitive dysfunction", v. 17, 54-68, found that only one moderate/severe TBI patient had an FBS of 30. It is pretty safe to say that based on Meyers et al (the ACN cite given by others), my above paper, and Ross et al (in press, given by Gamboa), scores of 30 or higher are basically associated with no false

positives, and essentially represent 100% positive predictive value."

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-----Original Message-----
From: Terry Levitt [mailto:tlevitt@sasktel.net]
Sent: Wednesday, March 10, 2004 6:49 PM
To: Neuropsychology
Subject: Re: [npsych] Millon vs. Minnesota

Thanks David - well I have you in the FBS dept - this woman's was 31 (!). Effort appeared good per WMT, reliable digits and finger tapping among others.

The RC scales were useful as Som stood far above the rest. Content scales also just emphasized HEA and nothing else.

HY1 61
HY2 59
HY3 83
HY4 69
HY5 39

PA3 60

The last Hy surprises me although the family says she expresses anger more freely vs. pre-injury.

One question I have is how much should physical background qualify interpretation. This person has longstanding hearing impairment in one ear, bilateral inner ear damage from the injury (ENT said don't ever fly), an eye condition, which causes lost vision in one eye and she had 8 hospitalizations a few years ago for a liver abscess.

Does she get some "free Hs/Hy" points for all this?

The MMPI and MCMI have never been co-normed, but I would suspect that your patient is trying to deny existing problems and weaknesses and present in socially desirable ways that are quite different than how others see them, especially others who know them well. Alex Caldwell has said he does not think the MMPI-2 will reach the clinical accuracy of > the MMPI (current issue of JPA). If your person has a college

education. Th patient I described has an - I would say the L scale is showing problems with naivete and denial. How are the Hy subscales? Pa3? I very much like Greene's way of looking at L as impression management vs. K and S as self-deception.