From: "Dr. Kanter" <medpsych@comcast.net>
To: "Neuropsychology" <npsych@npsych.com>
Subject: RE: [npsych] Millon vs. Minnesota: FBS!
Date: Wednesday, March 10, 2004 18:32

Terry, you make a good advocate,

I apologize for what may have been a bit of hyperbole in terms of pointing to "malingering" automatically if someone has a high FBS. I certainly always look at SVT's and clinical pattern; however, my take that is the data on the FBS is pretty good when scores get to 30 and above. Somatization disorder is always a differential consideration with high FBS scores. I look at the pattern that Dr. Larrabee outlined with very high 1,2,3 scores. If you are not considering enhancement or exaggeration then you have to come up with reasonable hypotheses as to why someone with limited or no medical/neuro findings (is this the case for you?) would score so much higher than patients with bona fide medical conditions which cause severe physical, emotional, and social dysfunction such as with MS, non-litigating chronic pain patients, etc. The fact that other (cognitively-oriented) SVT's may be normal does not rule out conscious or unconscious exaggeration as Dr. Gervais (in his post about a month ago) said that he found the correlation between the WMT and FBS is not great at lower FBS levels (WMT-DR=-.294; in FBS >= 30 cases, WMT-CONS = -.400). If I am allowed to quote an excerpt from Dr. Gervais, "WMT effort measures and FBS are clearly tapping different aspects of symptom exaggeration, cognitive and physical." I don't think depression in and of itself can explain such a high FBS. But, a better answer/explanation may come from Dr. Larrabee if I could ask him to chime in on this?

Geoffrey

-----Original Message-----
From: Terry Levitt [mailto:tlevitt@sasktel.net]
Sent: Wednesday, March 10, 2004 8:38 PM
To: Neuropsychology
Subject: Re: [npsych] Millon vs. Minnesota: FBS!

Dr. Kanter:

Thanks for this information - I think it is useful. But, to play devil's advocate, does anyone have information on FBS scores in individuals with somatization tendencies? Depression? I do not doubt that there is a major psychosocial influence in her presentation but the extent that it should be characterized as "malingering" I'm not too comfortable with...although always interested in other's perspectives. Also, just to reiterate that there was no evidence of feigned cognitive difficulties per validity testing which forms some of the criterion

evidence referred to.

Terry Levitt

----- Original Message -----
From: "Dr. Kanter" <medpsych@comcast.net>
To: "Neuropsychology" <npsych@npsych.com>
Sent: Wednesday, March 10, 2004 6:42 PM
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):

From: "Dr. Kanter" <medpsych@comcast.net>
To: "Neuropsychology" <npsych@npsych.com>
Subject: RE: [npsych] Millon vs. Minnesota: FBS!
Date: Wednesday, March 10, 2004 16:43

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 Comp 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 documents 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 Myers, 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 Myers, 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 "somatic malingering should be considered whenever elevations on scales 1 and 2 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, 2 and 3 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."

Geoffrey Kanter, Ph.D.
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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 Somatization 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 causing lost vision in one eye and she had 8 hospitalizations a few years ago for 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 - the patient I described has an MA - I would say the L scale is showing problems with naiveté 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.