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Exaggerated MMPI-2 symptom report in personal injury litigants with malingered neurocognitive deficit[☆]

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Abstract

Traditional MMPI-2 validity scales, the Lees-Haley Fake Bad Scale (FBS), and the Arbisi and Ben Porath Infrequency Psychopathology Scale (F(p)) were evaluated in 33 personal injury litigants who had failed forced-choice symptom validity testing and other measures of effort in patterns consistent with the [Slick, Sherman, and Iverson \(1999\)](#) criteria for definite and probable malingered neurocognitive deficit (MND). The FBS was more sensitive to symptom exaggeration than F, Fb, and F(p). The definite and probable MND litigants also produced mean elevations on MMPI-2 scales 1, 3 and 7 that were significantly higher than those produced by various clinical groups including non-litigating severe closed head injury, multiple sclerosis, spinal cord injury, chronic pain, and depression. These data suggest that MMPI-2 profiles characteristic of malingered injury differ from those associated with malingered psychopathology.

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Malingering is the intentional distortion or exaggeration of symptomatic complaints for external incentives, such as financial reward in personal injury litigation or avoidance of prosecution in the criminal courts ([Iverson & Binder, 2000](#)). In neuropsychological practice, malingering can occur in three patterns: (1) exaggeration of symptomatic complaint, (2) intentionally poor performance on neuropsychological testing, and (3) both exaggeration of complaint and intentionally poor performance ([Iverson & Binder, 2000](#); [Larrabee, 2000](#)).

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Malingering of neuropsychological test performance can be assessed by specialized tests of effort that utilize forced-choice methodology, such as the Portland Digit Recognition Test (PDRT; Binder & Willis, 1991), and by determination of neurologically atypical patterns of performance, such as poor attention co-occurring with normal memory (Mittenberg, Azrin, Millsaps, & Heilbronner, 1993). Forced-choice tests of effort, such as the PDRT, can be scored in two manners: (1) for the presence of significantly worse-than-chance performance, and (2) for the presence of atypically low performance relative to a group of non-litigating patients with medically-documented brain damage (Iverson & Binder, 2000; Larrabee, 2000). The second method of scoring usually sets a performance cut-off that minimizes false positive diagnosis in the legitimate patient group. Obviously, cut-offs that eliminate false positives or “zero percentile” levels (worse than 100% of non-litigating brain injured subjects), identify fewer malingerers than more liberal cut-offs. Binder and Kelly (1996) identified 30% of litigating minor closed-head-injured (CHI) as motivationally impaired using a zero percentile cut-off on the PDRT total score versus 43% using a second percentile cut-off (i.e., performance worse than 98% of non-litigating brain injured subjects). Fewer litigants are identified by a criterion of significantly worse-than-chance performance.

The presence of symptom exaggeration traditionally has been evaluated with the MMPI-2 F scale and Fb (Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989), as well as with the newer Arbisi and Ben Porath Infrequency Psychopathology Scale (F(p)) (Arbisi & Ben-Porath, 1995). Berry et al. (1995) demonstrated the validity of F, Fb and F(p) for detection of exaggerated responding on the MMPI-2 for both non-injured persons dissimulating head trauma, and for compensation-seeking CHI patients. The highest clinical scale elevations for the compensation-seeking CHI patients occurred on MMPI-2 scales 1, 2, 3, 7, and 8.

Despite the results reported by Berry et al. (1995), and the long history supporting the use of the F scale and its derivatives in evaluating malingering (Graham, 2000), the F scale may not be the most sensitive MMPI-2 scale in personal injury settings. The F scale is particularly suited to detection of exaggerated psychopathology or “acting crazy,” which may be a less frequent occurrence in personal injury settings wherein illness behavior is exaggerated and the litigant “acts hurt.” The F scale, and F(p) are particularly suited for detection of exaggerated psychopathology, due to the significant correlations of these measures with items on scales 6 and 8 (Arbisi & Ben-Porath, 1995). By contrast F and F(p) show much lower correlations with scales 1 and 3 (Arbisi & Ben-Porath, 1995), the MMPI-2 scales most susceptible to exaggeration of physical and medical illness (note: Table 5 of Arbisi & Ben-Porath shows that F and F(p) correlate, at .84 and .56, respectively with scale 8, but correlate at only .22 and .03 with scale 3). In this regard, there is only one F scale item on either scale 1 or 3 (Larrabee, 1998).

Lees-Haley and colleagues have developed an MMPI-2 validity scale for use in personal injury settings, the Lees-Haley Fake Bad Scale (FBS; Lees-Haley, 1992; Lees-Haley, English, & Glenn, 1991). There is mounting evidence that the FBS may be more sensitive to exaggerated symptom report in personal injury settings than F, Fb or F(p). Slick, Hopp, Strauss, and Spellacy (1996) found a greater number of significant correlations between FBS and performance on the Victoria Symptom Validity Test, than were demonstrated with the traditional F scale. Millis, Putnam, and Adams (1995), found that the FBS was a more efficient scale

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