Conference Materials: ACPN 2014, Seal Beach

Printouts and Handouts will be minimal. The following are recommended references:

Paul Green, PhD


http://wordmemorytest.com/DISCUSSIONS/WMT_%26_hippocampal_damage_neuropsychology_09%29.pdf

Also see the reference list at Green’s Publishing Website at: www.wordmemorytest.com

Jeffrey Webster, PhD

MMPI-2-RF References by Topic

August 2014

BASIC SOURCES


BOOKS AND BOOK CHAPTERS


**PEER-REVIEWED PUBLICATIONS**

**General Issues:**


**Validity Scales:**


Correctional Settings:


**Forensic Settings:**


**Medical Settings:**


**Mental Health Settings:**


Reid, R. C., & Carpenter, B. N. (2009). Demoralization, hypomanic activation, and disconstraint scores on MMPI-2 as significant predictors of hypersexual behavior. *Sexual Addiction and Compulsivity, 16*, 173-189. doi: [10.1080/10720160903202448](http://dx.doi.org/10.1080/10720160903202448)


**Substance Abuse Treatment Settings:**


**Police and Public Safety Settings:**


**Other Non-Clinical Settings:**


BASIC SOURCES


BOOKS AND BOOK CHAPTERS


**PEER-REVIEWS PUBLICATIONS**

**General Issues:**


dimensions in the classification of personality pathology: Evidence that dimensions, but
not prototypes, are robust. *Psychological Medicine, 41*, 1151-1163. doi:
10.1017/S0033291710001650

Finn, S. E., & Kamphuis, J. H. (2006). The MMPI-2 RC Scales and restraints to innovation, or
“What have they done to my song?” *Journal of Personality Assessment, 87*, 202-210. doi:
10.1207/s15327752jpa8702_10

and illustration with the MMPI-2 Computerized Adaptive Version (MMPI-2- CA).

MMPI-2 Restructured Clinical (RC) Scales and redundancy: Reply to Tellegen, Ben-
Porath, and Sellbom. *Journal of Personality Assessment, 91*, 222-226. doi:
10.1080/00223890902800825

Psychopathology Five (PSY–5): Recent constructive replication and assessment literature

MMPI-2-RF Personality Psychopathology Five (PSY-5) Scales: Development and validity
research. *Journal of Personality Assessment, 96*, 140-150. doi:
10.1080/00223891.2013.823439

psychology and psychiatry: Adaptive systems, Personality Psychopathology-Five (PSY-5),
and DSM-5. *Journal of Personality Assessment, 96*, 121-139. doi:
10.1080/00223891.2013.823438

(RC) Scales. *Journal of Personality Assessment, 90*, 443-455. doi:
10.1080/00223890802248711

Lanyon, R. I., & Thomas, M. I. (2013). Assessment of global psychiatric categories: The
PSI/PSI-2 and the MMPI-2-RF. *Psychological Assessment, 25*, 227-232. doi:
10.1037/a0030313


McNulty, J. L., & Overstreet, S. R. (2014). Viewing the MMPI-2-RF structure through the
Personality Psychopathology Five (PSY-5) lens. *Journal of Personality Assessment. 96*,

Nichols, D. S. (2006a). The trials of separating bath water from baby: A review and critique of
doi: 10.1207/s15327752jpa8702_02


Validity Scales:


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**Forensic Settings:**


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**Mental Health Settings:**


**Substance Abuse Treatment Settings:**


**Police and Public Safety Settings:**


**Other Non-Clinical Settings:**


Treatment Implications of Performance Validity Measures

Jeffrey Webster, Ph.D.
Chief Psychologist, V A Medical Center, Long Beach

What is Effort?

- Merriam-Webster: A serious Attempt to do something

Insufficient Effort Criteria

- Slick criteria
- Cogniform Disorder Criteria

Inadequate Effort

- More than Malingering
  - Somatophorm Disorder
  - Cogniphobia
  - Pernicious Perfectionism
  - Panic
  - Investment in the Process

Somatophorm disorder

- 69% of Boone and Lu’s patients showed results suggestive of malingering

- We found that 44% of our “conversion V” patients also failed “malingering tests”
  - Also conversion V comprised 38% of all patients failing malingering tests

Somatoform Patients Fail Performance Validity Tests

Other Reasons for Less than Full Effort

- Quitting participation
  - Protective/defensive maneuvers
  - Limited frustration tolerance.
- How does quitting early impact testing results
  - Lowers testing scores artificially
  - Lowers pathognomonic errors as patients elect not to challenge themselves.

Cogniphobia

- Fear that concentrating hard will exacerbate cognitive deficits and make illness worse.
- Patients asked if thinking hard will cause:
  - No real residuals
  - Increase in psychological distress
  - Increase in both pain and psychological distress
- Asked what they will do to manage:
  - Accept pain
  - Quit if start to feel stressed
  - Never try hard for fear of feeling bad

Pernicious Perfectionism: Long Beach Simultaneous Digits Test

- Test designed to investigate when patient will disengage from assessment and/or panic during tasks.
- Perception time task: Five digits numbers presented progressively more quickly until subject begins failing test.
  - When item failed, digit presentation slows until subject begins doing well again.

Patient 2

- Correct
- don't know

Dr. Webster 09/13/2014
Dr. Webster 09/13/2014

Part 2

- Once Part 1 is finished all errors (don’t knows + wrongs) are totaled and 6 trials done correctly are added to the second part.
- Patient told that incomplete answers are not allowed and a full 5 or 6 digit answer is required.
- Also collected are
  - Ratings of confidence
  - Impulsive errors (responding before signal)

Patient 2: Part 2

Analyzing DK Response Type

- 324 patients separated by Don’t Know and wrong ratios (don’t know-wrong)
  - -15 or less = mostly wrong response, rare don’t knows
  - -14 to -9 = mostly wrong but a few don’t knows
  - -9 to -2 = mixture of wrong and don’t know resp with greater wrong
  - -2 to 8 = mixture of wrong and don’t know resp with slightly greater dk
  - >8 = mostly don’t knows, much lower wrong

<table>
<thead>
<tr>
<th>Group</th>
<th>Frequency</th>
<th>Percent</th>
<th>DK/WRG</th>
<th>Percent</th>
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<td>65</td>
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<td>324</td>
<td>100.0</td>
<td>100</td>
<td>100</td>
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</tbody>
</table>

Testing Results and DK–WRG Groups

Group 5 (>8; Pernicious Perfectionists)

- Some younger patients have no strong value in academic performance.
  - Where C to D students in school, now find themselves C to D students in college and worry
  - Get referred to us and are just following orders
    - Tendency to vary effort and not try if
      - Task too hard
      - Task too easy
With the Onset of Polytrauma Program in 2008
- Larger community interested in my reports
- Rarely used the term “Malingering” but often used “Exaggeration” in my reports
- Polytrauma team had an intervention and protested my use of “Exaggeration”.
  - We agreed on “Amplification” and “Embellishment” instead
  - I was also shamed for saying such derogatory things about our Veterans.
  - This would later change!

Blind Men and the Elephant
New Combat Veteran Enters VA

- Enters Transition Office
- PTSD Program
- Psychiatry
- Empirically Based Programs
  - PE
  - CPT
  - Other programs
- Poly Trauma Program
  - Physiatrist
  - Speech Pathology
  - Memory Training
  - Problem solving
- College Connection
  - Occupational Therapy
  - Sleep Hygiene
  - Practical problem solving
- Physical Therapy
  - Kinesthetic Therapy

Transition Office

One month before influx
- Lost one neuropsychologist
- Lost Technician

Started doing 7 evaluation weekly
- 4 hour evaluations

Frequency of Neuropsychology Consults per Year

Neuropsychological Assessment Influx
- One month before influx
  - Lost one neuropsychologist
  - Lost Technician
- Started doing 7 evaluation weekly
  - 4 hour evaluations

Neuropsychological evaluation
- Attention Concentration
  - Digit Span
  - LBSDT
- Working Memory
  - Mental Control WMS
  - Trail Making Test
- Memory
  - HVLT with modifications
  - Logical Memory WMS III
  - BVMTr
  - Rey Figure Immediate Recall
- Construction
  - Rey Figure
  - BVMTR Copy
- Executive Functions
  - Category Test, Verbal Fluency and Iowa Gambling Test

Tests of Effort
- Long Beach Symbol Memory Test
- Long Beach Simultaneous Digit Test
- HVLTFC: Like CVLT forced Choice
- Category Test, Imbedded Validity Test

LBSDT
- This is not a great test for insufficient Effort
  - Like any test, exceedingly bad scores suggest amplification
  - Comparisons of those who fail LBSMT reveal the following
    - Exaggerators = .805 ms
    - Normal responders = .289 ms
  - I use a cut-off score of >.900 milliseconds to suggest that something is wrong with effort.
15 minutes following delayed recall Patients are asked to discriminate which of two words was on the presentation list (e.g.,)
- Lion or Banner
- Pie or Emerald
Comparisons of those who fail LBSMT reveal the following
Exaggerators = 1.26 errors
Normal responders = .211 errors
I use a cut-off score of >1 error to suggest that something is wrong with effort.

Category Validity Scores
- Use of Bolter Index : Simple items statistically rarely failed such as IIII not generating a “4” response.
  - Exaggerators = .778
  - Normal responder = .377
- The test is also sensitive to frustration intolerance and Pt’s can selectively give up on this test without impacting others.


Long Beach Symbol Memory Test
- Developed in Mid 1990’s
- Structured similarly to typical SVT at the time
- Probably more sophisticated tests out there
  - Keep it because of the lack of publicity
  - My ego
  - Correlates with PTSD measures which is a large proportion of my sample (66% with DX)
    - With PCL .35
    - Typically scores are above exaggeration cut off and most likely reflect hypervigilance.

PTSD and Other Groups Performance on the LBSMT

Long Beach Symbol Memory Test (LBSMT)
- Symbol presented for 2.5 second

A 5 second delay first 12 trial
A 10 second delay next 12
A 15 second delay last 12
"WAIT"
Patient asked to indicate the object

- Which of the following did you see?

1 = 

2 = 

3 = 

4 =

Results of Validity Study (LBSMT)

- 20 normal controls all scored above 90%
- 18 of 20 brain damaged patients all scored above 85%
- 19 of 20 malingerers (simulators asked to feign brain injury) scored below 80%
- True positive: 95% (false positive 10%)
- True negative: 95% (false negative 5%)

Created Test with Part 2

- If patient made more than 2 errors at 5 seconds or 6 errors by 10 seconds Part 1 stopped and went to Part 2
- Part 2, patients could strike space bar during waiting period and bring back the stimulus
  - A. looked for accuracy and how cue was used
  - B. cue used at end of waiting interval viewed as good use and considered more likely to be indicative of poor motivation.

Looked at next 200 patients who took task this way

- Result in 61 (30%) of patients going to Part 2 of task
  - Of these patients 28 had normal neuroimaging and 32 had positive scans
  - While we cannot be sure, the 28 were considered likely exaggerators while the 32 were considered likely confused or failing the test legitimately. (92 patients with positive scans actually past the LBSMT).

Time of Cue by Patients with Positive and Negative Scans

- The positive scanned pts. used the cue less well than those with normal scans. F (1,59)=4.556, p<.000

Use of Cue by Patients with Positive and Negative Scans

- The positive scanned pts. used the cue less than those with normal scans, especially during the 15 second wait. F (1,59)=4.556, p<.000
Now it is 2011

- Polytrauma comes to me to ask how do they discharge Veterans who are not progressing in Program
- Of those identified and we assessed, all failed the LBSMT in ways suggesting exaggeration
- We put together a study to get a sense of the cost of these Veterans to the VA and our associated programs.

The Study

- Five Veterans were identified by Polytrauma and another 6 Veterans were added who had been:
  - Evaluated by me and shown to fail the LBSMT
  - Entered into the Polytrauma program and perhaps the PTSD program
- Eleven Veterans who had normal LBSMTs and had entered the Polytrauma program were compared on a variety of measures.

Comparison Pts

- Neurobehavioral Inventory screening results
  - High LBSMT = 41.8
  - Normal LBSMT = 34.55  F(1/20) = 1.76  NS
- Positive neuroimaging did not differ across groups
- Exaggerators: 1 positive scan
- Normal Performers: 3 positive scans
- Number of prescribed drugs differed across groups
- Exaggerators: 8.2 drugs
- Normal Performers: 4.0 drugs  (F[1,20]=5.52; p=.03)

Differences in Appointments

<table>
<thead>
<tr>
<th>Analysis</th>
<th>Group on LBSMT</th>
<th>Mean</th>
<th>Std Dev</th>
<th>F (1,20)</th>
<th>Significance</th>
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<tbody>
<tr>
<td>Days in Treatment</td>
<td>Exaggerate Normal</td>
<td>866 days</td>
<td>477 days</td>
<td>394.6</td>
<td>188.2 7.931 p=.011</td>
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<td>Exaggerate Normal</td>
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<td>27.2</td>
<td>6.7</td>
<td>24.6</td>
<td>5.1    6.73 p=.018</td>
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<td>Exaggerate Normal</td>
<td>10.6</td>
<td>5.2</td>
<td>7.6</td>
<td>3.2    4.31 p=.053</td>
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<td>Speech</td>
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<td>47.5</td>
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<td>Exaggerate Normal</td>
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</tr>
</tbody>
</table>
Those who exaggerated often saw providers in multiple settings including CBOCs and other VAs. There seemed to be a Flood of Treatment.

Those who exaggerated on the LBSMT missed or cancelled many of these appointments.

The Patients who would not leave
- 1. Family and Economic Pressures: Poor job market and pressure from immediate family
- 2. Fear of Abandonment: If they improved in therapy they would lose their therapist
- 3. Entitlement: Especially true for those who frequently missed appointments

Conclusions:
- They listen to us now
- Performance Validity Measures have implications for subsequent treatment