Discriminating Malingered From Genuine Civilian Posttraumatic Stress Disorder

A Validation of Three MMPI-2 Infrequency Scales (F, Fp, and Fptsd)

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The Infrequency-Posttraumatic Stress Disorder scale (Fptsd), recently created for the Minnesota Multiphasic Personality Inventory–2 (MMPI-2), has demonstrated incremental validity over other MMPI-2 scales in malingered posttraumatic stress disorder (PTSD) detection. Fptsd was developed with combat-exposed PTSD patients, potentially limiting its use with PTSD patients in general. The current study evaluated the MMPI-2's F, Infrequency-Psychopathology scale (Fp), and Fptsd scales in discriminating genuine civilian PTSD among 41 adult victims of child sexual abuse from a group of 39 students instructed to simulate PTSD. Analyses demonstrated Fptsd's incremental validity over F but not over Fp. Based on the two studies examining Fptsd, Fptsd may be more appropriate for combat trauma victims, and Fp may be more appropriate for civilian trauma victims.

Keywords: Infrequency-Posttraumatic Stress Disorder scale (Fptsd); malingering; symptom overreporting; Minnesota Multiphasic Personality Inventory–2 (MMPI-2); child sexual abuse

Research indicates that Minnesota Multiphasic Personality Inventory–2 (MMPI-2) (Butcher et al., 2001) F scale elevations may be misleading among victims of traumatic events. Rather than suggesting malingering, high F scores among trauma victims have been empirically associated with trauma exposure and its effects, specifically severe

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Assessment, Volume 11, No. 2, June 2004 139-144
DOI: 10.1177/1073191104264965

trauma exposure history (Glenn et al., 2002; Smith, Frueh, Sawchuck, & Johnson, 1999); depression, dissociation, and posttraumatic stress disorder (PTSD) (Klotz Flitter, Elhai, & Gold, 2003); and increased somatic complaints (Glenn et al., 2002). Chaotic family-of-origin environments, often found in trauma victims, are also correlated with high F scores (Klotz Flitter et al., 2003).

Given the F scale's confound with psychopathology and distress among psychiatric patients, the Infrequency-Psychopathology scale (Fp) was developed using items infrequently endorsed by psychiatric inpatients to provide a more accurate index of symptom overreporting (Arbisi & Ben-Porath, 1995). Although an accumulation of research has supported Fp's efficacy in distinguishing malingered from genuine psychopathology (Rogers, Sewell, Martin, & Vitacco, 2003), few studies have examined Fp's utility in detecting malingered PTSD. For example, Fp demonstrated superiority to F in detecting malingered from genuine PTSD in civilians (Elhai, Gold, Sellers, & Dorfman, 2001) but not in combat veterans (Elhai, Gold, Frueh, & Gold, 2000). Given the compensatory issues often involved in accurate PTSD detection, the need for a valid indicator of malingered PTSD is evident.

The Infrequency-Posttraumatic Stress Disorder scale (Fptsd) (Elhai et al., 2002) was created to further facilitate malingered PTSD detection. Fptsd was constructed from MMPI-2 items infrequently endorsed (< 20%) within a large sample ($N = 940$) of male combat veterans diagnosed with PTSD by structured interviews at two Veterans Affairs Medical Center's PTSD clinics. Fptsd shared 20 items with Fp, with its remaining 12 items reflecting family/social problems, self-injurious and antisocial behavior, and morally righteous attitudes. Fptsd was validated on another treatment-seeking combat PTSD sample (N = 323). In validation, Fptsd demonstrated reduced sensitivity to PTSD-related psychopathology relative to existing F-related scales, evidenced by slightly lower correlations for Fptsd with MMPI-2 clinical and content scales. Fptsd provided some incremental validity over F and Fp in discriminating between PTSD patients and trained simulators, through hierarchical regression and receiver operating characteristics analyses (Elhai et al., 2002).

The current study is an attempt to compare F, Fp, and Fptsd in discriminating PTSD simulators from a civilian PTSD sample of adult child-sexual-abuse (CSA) victims. As previously mentioned, both F and Fp have been evaluated in detecting malingered from genuine civilian PTSD. However, Fptsd has not been previously examined in this regard. Fptsd may work differently to identify malingering in CSA versus combat PTSD populations because of differences in the nature of their respective traumatic events, including (a) CSA involves interpersonal trauma typically with the threat to one's physical integrity (most often by someone known to the victim), whereas combat involves life threat by an unknown enemy; and (b) CSA victims react to trauma inflicted on them, whereas combatants can be both victims and trained agents of inflicting trauma. Thus, differences in the nature of trauma exposure between these populations may affect symptom expression and reporting style, potentially making malingering identification different across groups.

METHOD

Participants

CSA PTSD patients. Archival data (not previously published) were used from 41 adult (3 male, 38 female) CSA victim outpatients diagnosed with PTSD at a CSA treatment program, marketed at community agencies and housed within a university-based mental health center serving the local community of a large metropolitan area in the southeastern United States. All individuals seeking services at the mental health center were initially screened by a clinician via telephone, using a brief, standardized screening protocol. Only individuals answering affirmatively to the following screening questions were considered eligible for treatment in the CSA program: (a) Were you sexually abused as a child? (b) Do you see a relationship between your current difficulties and those sexual abuse experiences? and (c) Would you eventually be willing to address those experiences in therapy? Admission criteria included a minimum age of 17 (although the present study only included patients aged 18 years or older), self-report of CSA before age 18, and presentation with traumatic aftereffects of CSA. Although these patients were not screened for compensation- or disability-seeking status, no external incentive appeared available for fabricating or exaggerating problems at the mental health center to which they presented.

The PTSD sample was diagnosed according to *DSM-IV* (American Psychiatric Association, 1994) by advanced clinical psychology doctoral students, supervised by a licensed clinical psychologist (SNG) with numerous years of trauma-related clinical experience. Diagnoses were established via nonstandardized psychological interviews at intake (and by a structured clinical abuse interview, discussed below, to confirm *DSM-IV* PTSD's trauma-exposure Criterion A). PTSD diagnoses were further validated by the Impact of Event Scale (IES), which has demonstrated good validity in PTSD detection (Horowitz, Wilner, & Alvarez, 1979; Zilberg, Weiss, & Horowitz, 1982). More than 92% of participants exceeded an IES score of 25, suggesting significant posttraumatic stress (Fischer & Corcoran, 1994). Additional Axis I diag-

noses given included mood (73.2%; predominantly major depression), anxiety (24.4%), dissociative (19.5%), substance-related (12.2%), and psychotic (2.4%) disorders, reflecting the large degree of psychiatric comorbidity in PTSD patients (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995).

The CSA PTSD sample's average age was 33.7 years (*SD* = 10.3). The group was 85.7% Caucasian, 5.8% Hispanic, and 2.9% African American, averaging 12.5 years of education (*SD* = 2.4). Sixty percent of participants reported being single, 20.0% married, and 20.0% separated/divorced. Thirty-seven percent were employed full-time, 14.3% part-time, 45.7% unemployed, and 2.9% retired. Annual household income of less than $10,000 was reported by 41.9% of participants, and 35.5% earned between $10,000 and $29,999. More than 19% of participants reported an annual income of between $30,000 and $49,999.

The mean age at onset of CSA was 5.8 years (*SD* = 3.3) and number of perpetrators averaged 4.8 (*SD* = 6.8). For 46.3%, the CSA involved vaginal or anal intercourse with at least one perpetrator, and force (threatened or used) was experienced by 56.1%.

College student PTSD simulators. The PTSD simulation data were part of a larger study (Wetter & Deitsch, 1996) examining serial testings of faking either PTSD or closed head injury on the MMPI-2. The sample included 39 undergraduate students (19 male, 20 female) from introductory psychology courses participating in research credit. Age averaged 19.5 years (*SD* = 3.1). Eighty-six percent were Caucasian, 5.1% African American, and 2.8% other racial backgrounds. Almost 95% were in their first, second, or third year of college.

Instruments and Procedure

Participants in the CSA PTSD sample completed paper-and-pencil MMPI-2s for their treatment evaluation, but diagnoses were made independent of test results. Psychological assessment included a structured interview querying about abuse and trauma history (to confirm *DSM-IV* PTSD's trauma-exposure Criterion A) with established psychometric properties (Gold, Hughes, & Swingle, 1996), MMPI-2, and several self-report measures (part of a larger research protocol). Assessment was conducted by Session 1 for 82.9% of participants and by Session 4 for 94.3%.

For PTSD simulators, a detailed procedural description is discussed elsewhere (Wetter & Deitsch, 1996). Briefly, student participants (in groups of approximately 30) completed a consent form and demographics survey. They were given training materials on PTSD to study, including symptom descriptions and a case scenario detailing involvement in a motor vehicle accident, and were quizzed on the information. They were subsequently instructed to imagine being involved in litigation for PTSD and asked to complete the pencil-and-paper MMPI-2 in a believable manner as if they suffered from PTSD. Monetary prizes were offered as an incentive to malinger convincingly. The original study reported that no one failed the PTSD quiz (judged by performance of < 70%) and that on average, participants reported excellent clarity of the PTSD training materials and very good subjective understanding of PTSD. Furthermore, little perceived psychological disturbance was reported by simulators (based on a single Likert-type scale rating query of general psychological disturbance), reflecting a decreased chance of contamination by participants with actual psychopathology (Wetter & Deitsch, 1996). However, simulators were not queried about CSA.

Statistical Analyses

MMPI-2 data were excluded for any of the following conditions: (a) True Response Inconsistency scale *T*-scores ≥ 100[1]; (b) Variable Response Inconsistency scale *T*-scores ≥ 80, or (c) Cannot Say raw scores ≥ 15. Three CSA PTSD participants and one PTSD simulator were excluded, leaving 38 CSA PTSD patients and 38 PTSD simulators.

RESULTS

One-way analyses of variance (ANOVAs) revealed group differences between PTSD patients and simulators on (a) the F scale, $F(1, 74) = 5.3$, $p = .02$, with PTSD simulators ($M = 103.9$; $SD = 24.4$) scoring higher than PTSD patients ($M = 91.6$; $SD = 22.4$); (b) Fp, $F(1, 74) = 27.8$, $p < .001$, with simulators ($M = 98.5$; $SD = 24.1$) scoring higher than patients ($M = 72.7$; $SD = 18.0$); and (c) Fptsd, $F(1, 74) = 12.7$, $p = .001$, with simulators ($M = 89.2$; $SD = 25.0$) scoring higher than patients ($M = 72.2$; $SD = 15.4$). Effect sizes were medium for F (Cohen's $D = .51$; $R^2 = .26$), and large for Fp (Cohen's $D = 1.04$; $R^2 = .52$) and Fptsd (Cohen's $D = .76$; $R^2 = .38$). Power was adequate for these analyses, with only the F scale yielding observed power of less than .8 (demonstrating power of .71); Fp and Fptsd each yielded power of 1.0.

Hierarchical logistic regression was conducted (dummy coding CSA PTSD patients "0" and simulators "1") to evaluate incremental validity in detecting malingered PTSD. Findings revealed that Fptsd added incremental validity over F. However, Fptsd did not demonstrate incremental validity over Fp (Table 1). To further compare Fp and Fptsd, we assessed Fp's incremental validity over Fptsd, finding that Fp did incrementally

TABLE 1
Summary of Hierarchical Logistic Regression Analyses for F, Fp, and Fptsd in Predicting PTSD Patients From PTSD Simulators (*N* = 76)

Variable	B	SEB	*Odds Ratio*	*Wald Statistic*	R^2
Step 1					.09*
F	.02	.01	1.02	4.80*	
Step 2					.20**
F		–.01	.02	.99	.50
Fptsd	.05	.02	1.05	6.29*	
Step 1					.35***
Fp		.05	.01	1.05	16.88***
Step 2					.38
Fp		.09	.03	1.09	9.77**
Fptsd	–.04	.03	.96	2.36	

NOTE: F = Infrequency scale; Fp = Infrequency-Psychopathology scale; Fptsd = Infrequency-Posttraumatic Stress Disorder scale. R^2 = Nagelkerke's adjusted R^2.
*$p < .05$. **$p < .01$. ***$p < .001$.

TABLE 2
Summary of Hierarchical Logistic Regression Analysis Exploring the Contribution of Fp Over Fptsd in Predicting PTSD Patients From PTSD Simulators (*N* = 76)

Variable	B	SEB	*Odds Ratio*	*Wald Statistic*	R^2
Step 1					.19**
Fptsd	.04	.01	1.04	9.81**	
Step 2					.38***
Fptsd	–.04	.03	.96	2.36	
Fp		.09	.03	1.09	9.77**

NOTE Fp = Infrequency-Psychopathology scale; Fptsd = Infrequency-Posttraumatic Stress Disorder scale. R^2 = Nagelkerke's adjusted R^2.
*$p < .05$. **$p < .01$. ***$p < .001$.

contribute variance to simulated PTSD predictions over Fptsd (Table 2).

DISCUSSION

We found in regression analyses that Fptsd outperformed F in discriminating PTSD simulators from genuine civilian CSA PTSD patients, but Fp outperformed Fptsd. Two studies now demonstrate Fptsd's incremental validity to F in statistically predicting simulated versus genuine PTSD, including the present study with civilian CSA-related PTSD and another with combat PTSD (Elhai et al., 2002). In fact, although F generally produces the largest effect sizes among other MMPI-2 scales in detecting malingered psychopathology, F does not seem to be as robust of a measure in malingered PTSD studies (Rogers et al., 2003). For example, although significantly predictive, F did not serve as one of the best MMPI-2 malingered PTSD predictors in studies using civilian CSA victims (Elhai et al., 2001) or combat veterans (Elhai, Gold, et al., 2000) and did not produce the largest odds ratios in a study using industrial accident victims (Bury & Bagby, 2002). Thus, PTSD research accounting for extreme F scores and research investigating F's utility as a PTSD malingering indicator both find some fault with F when used with trauma victims and PTSD patients.

In contrast, whereas the initial Fptsd study found more support for Fptsd than Fp in predicting malingered PTSD using combat PTSD patients (Elhai et al., 2002), the present study seems to argue that Fp is better when using civilian CSA PTSD patients as the comparison sample. Interestingly, Fp was found to be one of the best malingered PTSD indicators in studies using civilian PTSD patients (Bury & Bagby, 2002; Elhai et al., 2001) but not in a study using combat PTSD patients (Elhai, Gold, et al., 2000), further supporting its use with civilian trauma victims when assessing symptom overreporting. Interestingly, Fp's large (Cohen's *D*) effect size of 1.0 was similar, but slightly smaller, than that found in a recent MMPI-2

meta-analysis of malingering, whereby Fp's effect size across studies comparing PTSD patients and simulators was 1.22 (Rogers et al., 2003).

In conclusion, although one report (Elhai et al., 2002) demonstrated that Fptsd may be a better malingering predictor with male combat veterans (the population on which it was constructed), the present study's findings argue that Fp may be better with civilian CSA victims evaluated for PTSD. This difference across trauma type should be considered in the context of recent research demonstrating that the MMPI-2's clinical scale scores of civilian and combat PTSD patients are quite similar but yield some differences (Elhai, Frueh, Gold, Gold, & Hamner, 2000; Kirz, Drescher, Klein, Gusman, & Schwartz, 2001). Furthermore, these few symptom differences found between combat and CSA populations appear to differentially affect malingering detection rates by Fp and Fptsd, possibly because of differences in the nature of combat and CSA trauma experiences. In fact, on examining Fptsd's item content, some items endorsed in the keyed direction are more relevant to older male veterans than younger female civilians (with those items reflecting gender- and age-related experiences).

Several limitations apply to the current study. First, the civilian PTSD sample solely comprised CSA victims and thus may not be generalizable to PTSD-diagnosed civilians reporting other types of traumatic events (e.g., disaster, physical assault, etc.). Second, the PTSD sample primarily included women and very few men, and the disproportionate sampling of genders could have biased results. Moreover, because Fptsd was created solely with men, differences in malingering detection ability between this study and the original Fptsd study could potentially be explained by gender differences (rather than traumatic event differences). Third, PTSD patients were not diagnosed with structured PTSD interviews, decreasing the validity of diagnoses. Fourth, neither this study nor the original Fptsd study accounted for disability compensation-seeking, a factor demonstrating profound MMPI-2 effects in PTSD evaluations (Franklin, Repasky, Thompson, Shelton, & Uddo, 2002, 2003; Frueh et al., 2003). Future studies should further assess Fptsd's utility and confirm whether it is advised for use with civilian PTSD patients. Specifically, studies with large datasets should explore optimal Fptsd scores for correctly classifying PTSD simulators and patients.

NOTE

1. Consistent with Arbisi and Ben-Porath (1995), we used a more conservative cutoff score for the True Response Inconsistency Scale (TRIN) than the Variable Response Inconsistency Scale (VRIN) to exclude for invalid protocols. At this time, there is still a dearth of studies examining optimal cutoff scores for TRIN. In our data sample, no PTSD patients and only one PTSD simulator scored higher than 80 on TRIN (scoring 88), suggesting minimal effect on findings.

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ERRATA

In the June 2004 issue, in the article "Discriminating Malingered From Genuine Civilian Posttraumatic Stress Disorder: A Validation of Three MMPI-2 Infrequency Scales (F, Fp, and Fptsd)," Tables 1 and 2 were misaligned. The corrected tables are listed below.

TABLE 1
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Step 1					.35***
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Fp	.09	.03	1.09	9.77**	
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NOTE: PTSD = posttraumatic stress disorder; F = Infrequency scale; Fp = Infrequency-Psychopathology scale; Fptsd = Infrequency–Posttraumatic Stress Disorder scale. R^2 = Nagelkerke's adjusted R^2.
*$p < .05$. **$p < .01$. ***$p < .001$.

TABLE 2
Summary of Hierarchical Logistic Regression Analysis Exploring the Contribution of Fp Over Fptsd in Predicting PTSD Patients From PTSD Simulators (*N* = 76)

Variable	B	SEB	*Odds Ratio*	*Wald Statistic*	R^2
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NOTE: PTSD = posttraumatic stress disorder; Fp = Infrequency-Psychopathology scale; Fptsd = Infrequency–Posttraumatic Stress Disorder scale. R^2 = Nagelkerke's adjusted R^2.
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DOI: 10.1177/1073191104267371