

## MMPI-2 *F* Scale Elevations in Adult Victims of Child Sexual Abuse

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The present study assessed whether the Minnesota Multiphasic Personality Inventory—2 (MMPI-2) *F* scale elevations may reflect genuine trauma-related distress and/or psychopathology, rather than malingering, in a clinical sample of adult child sexual abuse (CSA) victims. Eighty-eight women seeking outpatient treatment for CSA after-effects participated. Self-report measures of dissociation, posttraumatic stress, depression, and family environment individually correlated significantly with *F*, and collectively accounted for 40% of its variance. Dissociation was the strongest predictor. Findings suggest that high *F* elevations may reflect genuine problem areas often found among CSA victims, rather than symptom overreporting.

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**KEY WORDS:** sexual abuse; child sexual abuse; MMPI-2; malingering; dissociation.

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The Minnesota Multiphasic Personality Inventory (MMPI; Hathaway & McKinley, 1943) and MMPI-2 (Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989) have been used in numerous studies to assess adult victims of child sexual abuse (CSA). Most studies reveal a modal 48/84 codetype for CSA victims (Elhai, Klotz Flitter, Gold, & Sellers, 2001), often associated with social withdrawal and mistrust, hostility, inappropriate mood, suicide attempts, poor judgment, and schizoid features (Greene, 2000). Multiple MMPI-2 clinical scale elevations are also quite common in CSA victims (Carlin & Ward, 1992; Follette, Naugle, & Follette, 1997).

CSA studies also reveal highly elevated *F* scores among victims (Elhai, Klotz Flitter, et al., 2001). The *F* scale, a validity scale from the original MMPI, consists of items endorsed by fewer than 10% of the MMPI's

normative sample, thus measuring infrequent and atypical responding. It includes content areas such as bizarre sensations, thoughts and experiences, as well as feelings of alienation, and unlikely beliefs and expectations (Dahlstrom, Welsh, & Dahlstrom, 1972).

In MMPI/MMPI-2 literature, *F* is considered to be the best predictor of malingering across studies (Rogers, Sewell, & Salekin, 1994). However, in addition to reflecting malingered responding, *F* elevations can also result from two other types of responding. First, *F* elevations can result from a mostly-true or random response set. Fortunately, when extreme *F* elevations are observed, the MMPI-2's True Response Inconsistency (TRIN) and Variable Response Inconsistency (VRIN) scales can rule out mostly-true and random response sets, respectively.

Second, *F* elevations can result from extreme genuine distress and/or psychopathology (Greene, 2000). In fact, a number of genuine clinical features of distress and psychopathology commonly found in CSA victims may contribute variance to *F*. For example, Briere and colleagues (Briere, 1997; Briere & Elliott, 1997) have suggested that among CSA victims, *F* elevations may reflect the tendency for symptoms of dissociation, post-traumatic stress disorder (PTSD), and depression to

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produce atypical, unusual, and disorganized experiences. In addition, it is possible that other factors known to influence distress and psychopathology in CSA victims may also serve to elevate *F* scores. For example, poor family-of-origin environments and specific abuse characteristics have been shown to account for psychopathology and distress in CSA victims (Alexander, 1993; Nash, Hulsey, Sexton, Harralson, & Lambert, 1993), and thus the presence of these factors may elevate *F* scores.

The purpose of the present study was to assess whether *F* elevations in clinical samples of adult CSA victims may reflect genuine trauma-related distress and/or psychopathology, rather than the exaggeration or fabrication of symptoms. This issue is important for several reasons. First, it directly bears on the validity of elevated MMPI-2 profiles generated by many CSA victim clinical samples. Anecdotal reports suggest that a number of clinicians who work with victims of traumatic events may disregard MMPI-2 profiles with elevated *F* scores based on the assumption that they are invalid, and that clinical and forensic professionals avoid using the MMPI-2 with their trauma patients, for fear that elevated *F* scores will create the impression that their patients are malingering. Whether these profiles are often valid rather than feigned is therefore of crucial relevance. Second, other treatment-seeking traumatized groups have evidenced extremely elevated *F* scores (Frueh, Hamner, Cahill, Gold, & Hamlin, 2000), suggesting that the problem of extreme *F* elevations may extend to a variety of traumatized groups, and the often accompanying multiple elevated clinical scales may accurately represent the diverse symptomatology found in individuals with complex trauma histories (Follette et al., 1997).

## Method

### Participants

The sample included 98 women, consecutively seeking outpatient treatment at an adult CSA victim specialty program, at a university-based community mental health center. The program is marketed with brochures available at local community agencies. All women were self-referred, identified upon phone screening as appropriate for treatment. Criteria for admission included a minimum age of 17, self-report of CSA occurring before age 18, and presentation with traumatic after-effects of CSA. Initial phone screening questions asked included: (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?

The sample was 81% Caucasian, 8% Hispanic, 5% African American, and 6% of other backgrounds. Mean years of education was 12.52 ( $SD = 2.44$ ), ranging from 8 to 20. Age ranged from 18 to 57 years ( $M = 32.64$ ,  $SD = 8.56$ ). Annual household income of less than \$10,000 was reported by 44% of women, between \$10,000 and \$19,999 by 30%, between \$20,000 and \$29,999 by 17%, and \$30,000 or higher by 12%. Twenty-four percent reported being employed part-time, 31% full-time, and 45% unemployed. The mean age at onset of abuse was 7.10 years ( $SD = 3.46$ ), with a mean of 3.09 perpetrators ( $SD = 2.61$ ). Forty-six percent reported having experienced anal or vaginal intercourse, and 56% experiencing force as part of their CSA.

The clinical sample was diagnosed with *DSM-III-R* or *DSM-IV* (American Psychiatric Association, 1994) criteria by a clinical team of advanced clinical psychology doctoral students, supervised by a licensed clinical psychologist (third author) with several years of applied clinical experience. Diagnoses were taken during initial intake examination, obtained from nonstandardized clinical interviews. Diagnostic information (nonmutually exclusive) was available from a subsample ( $n = 59$ ), with the most commonly noted Axis I diagnoses including PTSD (63%), mood disorders (75%), and dissociative disorders (20%). Diagnoses were made independent of MMPI-2 results.

## Instruments

### Structured Clinical Interview

Data were collected using a structured clinical interview, addressing CSA (pertaining to each perpetrator, up to a total of three) and demographic characteristics. Interrater reliability has been demonstrated using audiotaped interviews (Gold, Hughes, & Swingle, 1996). More than 90% of kappa coefficients (for categorical-scaled variables) were substantial to perfect, ranging from .42 to 1.00 (median = .80). The present study analyzed CSA-related variables found to have particularly harmful effects (Beitchman et al., 1992; Browne & Finkelhor, 1986), including (a) force/threat of force during CSA, (b) penetration (vaginal intercourse or oral-genital sex), and (c) the presence of a father figure CSA perpetrator (all dichotomous variables, scored 1 = *Yes* and 2 = *No*).

### Minnesota Multiphasic Personality Inventory-2 (MMPI-2)

The MMPI-2 is a widely used 567-item true-false self-report instrument used to generate behavioral and

clinical data. The MMPI-2 manual reports test-retest reliability estimates range from .58 to .92 for the basic scales (Butcher et al., 1989). Dahlstrom, Welsh, and Dahlstrom (1975) cited 6,000 studies investigating MMPI profile patterns, providing extensive evidence for the MMPI's construct validity. The number of studies using the MMPI (and now, the MMPI-2) is continuing to increase each year. The present study used raw *F* scores.

#### *Impact of Event Scale (IES)*

The IES is a frequently used 15-item measure of intrusion and avoidance symptoms. The IES has demonstrated very good internal consistency (.78–.82) and discriminant validity in detecting PTSD (61%–91% hit-rates; Zilberg, Weiss, & Horowitz, 1982). Mean total IES scores of 24–44 have been reported for patients suffering a significantly stressful life event (Horowitz, Wilner, & Alvarez, 1979). The total IES score was used for analyses.

#### *Beck Depression Inventory (BDI)*

The BDI is a 21-item instrument measuring depression, with established reliability (coefficient alpha ranging from .81 to .86; Beck, Steer, & Garbin, 1988) and construct validity (.60–.72 for nonpsychiatric and psychiatric patients, respectively; Beck et al., 1988). Within clinical populations, mean scores on the BDI have been reported for patients with minimal or no depression ( $M = 10.9$ ), mild to moderate depression ( $M = 18.7$ ), moderate to severe depression ( $M = 25.4$ ), and severe depression ( $M = 30.0$ ; Beck, 1967). The total BDI score was used for analyses.

#### *Dissociative Experiences Scale (DES)*

The DES is a 28-item dissociation self-report measure. The DES has demonstrated good internal consistency (.83–.93), and construct validity, with a cutoff score higher than 30 suggesting the possibility of a dissociative disorder (74%–89% hit-rates; Carlson & Armstrong, 1994). The total DES score was used.

#### *Family Environment Scale (FES)*

The FES is a 90-item true/false questionnaire assessing 10 areas related to perceptions of family environment, with subscales demonstrating moderate to good internal consistency (alphas ranging from .61 to .78), acceptable test-retest reliability (.66–.91), and good construct and dis-

criminant validity (Moos & Moos, 1994). A composite score was obtained by summing the 10 subscale *T* scores (reverse scoring two subscales, to represent pathology with low scores) and arriving at a total average *T* score, analogous to the composite score of family environment derived by Nash et al. (1993).

#### *Procedure*

After the initial phone screening, advanced clinical psychology doctoral students who staff the program conducted assessments during intake evaluation, receiving training and ongoing supervision in instrument administration. Informed consent was obtained. Data were collected after the initial intake session when participants did not feel ready to respond to interview questions, with 60% tested in session one, and 90% tested by session five. Participants tested at session one or two were not significantly different from those tested later on any demographic variables ( $p < .05$ ); of the primary variables examined, these groups were only significantly different on the FES.

Participants' MMPI-2 data were excluded if at least one of the following conditions was present: (a) True Response Inconsistency scale (TRIN) *T* scores  $\geq 100$  (indicating mostly-true responding); (b) Variable Response Inconsistency scale (VRIN) *T* scores  $\geq 80$  (suggesting random responding); or (c) Cannot Say (CS) raw scores  $\geq 15$  (indicating too few responses). These criteria resulted in the exclusion of 10 participants, resulting in an overall sample of 88 women.

#### *Results*

First, demographic variables were assessed for their relationship to *F*. Using univariate analyses of variance (ANOVAs; for categorical-scaled) and Pearson correlations (for continuous-scaled demographic variables), none yielded a significant relationship with *F* at the .01 level (only one variable, Education, yielded  $p < .05$ ). Other forms of maltreatment were also examined (i.e., witnessing parent-to-parent physical violence, physical neglect before age 18, and physical assault/abuse by a former or current partner), and none were significantly related to *F* at the .01 level.

Means, standard deviations, and Pearson correlations are listed for continuous-scaled variables in Table 1, demonstrating that these variables (IES, BDI, DES, and FES) were significantly related to *F* ( $p < .01$ ; varying sample sizes reflect missing values). Univariate ANOVAs assessed the relationship between *F* and the dichotomous

**Table 1.** Descriptive Statistics and Intercorrelations Between Variables for CSA Victims

Scale	<i>M</i>	<i>SD</i>	Scale				
			<i>F</i>	IES	DES	BDI	FES
<i>F</i>	13.41	7.17	—				
IES	42.86	15.89	.36** (88)	—			
DES	22.32	17.32	.51** (85)	.27* (85)	—		
BDI	24.96	12.55	.46** (87)	.52** (84)	.50** (87)	—	
FES	33.94	9.99	-.33** (83)	-.16 (81)	-.19 (83)	-.19 (83)	—
			(74)	(72)	(74)	(72)	(74)

Note. Numbers in parentheses indicate sample sizes for each analysis. IES = Impact of Event Scale; DES = Dissociative Experiences Scale; BDI = Beck Depression Inventory; FES = Family Environment Scale.

\* $p < .05$ . \*\* $p < .01$ .

variables. Force/threat of force, penetration, and presence of a father figure CSA perpetrator were unrelated to *F* scores, all  $F(1, 86) < 1$ .

A multiple regression analysis assessed the linear combination of significant variables (IES, BDI, DES, and FES) in predicting variance in *F*. This combination significantly accounted for variance in the *F* scale ( $R^2 = .40$ ),  $F(4, 65) = 11.01$ ,  $p < .001$ . Unstandardized (*B*) and standardized ( $\beta$ ) regression coefficients are presented in Table 2, finding that only the DES was a significant predictor in the model.

In order to ensure that these predictors were actually explaining variance in *F* elevations (rather than normal variation within *F*), we also conducted a logistic regression analysis. In this analysis, a dummy-coded *F* elevation variable was created, with an *F* score  $< 100$  coded "0," and  $F \geq 100$  coded "1." The IES, BDI, DES, and FES were examined for their role in predicting variance in the dummy-coded *F* elevation variable. Results indicated that as a set, the predictors significantly discriminated between  $F < 100$  and  $F \geq 100$ ,  $\chi^2(4, N = 70) = 17.70$ ,  $p < .001$ . The variance in *F* accounted for by the model was moderate (Nagelkerke's  $R^2 = .35$ ). Prediction success was strong for the  $F < 100$  group (96%), but not

**Table 2.** Regression Analysis Summary for Variables Predicting Continuous *F* Scores in CSA Victims ( $N = 70$ )

Variable	<i>B</i>	<i>SE B</i>	$\beta$
IES	0.09	0.05	.22
DES	0.18	0.04	.45**
BDI	0.03	0.07	.06
FES	-0.11	0.07	-.16

Note. IES = Impact of Event Scale; DES = Dissociative Experiences Scale; BDI = Beck Depression Inventory; FES = Family Environment Scale.

\*\* $p < .01$ .

**Table 3.** Logistic Regression Analysis Summary for Variables Predicting *F* Elevations ( $F < 100$  and  $F \geq 100$ ) in CSA Victims ( $N = 70$ )

Variable	<i>B</i>	<i>SE B</i>	Odds ratio
IES	0.002	0.03	1.00
DES	0.06**	0.02	1.06
BDI	0.02	0.04	1.02
FES	-0.08	0.05	0.92

Note. IES = Impact of Event Scale; DES = Dissociative Experiences Scale; BDI = Beck Depression Inventory; FES = Family Environment Scale.

\*\* $p < .01$ .

for the  $F \geq 100$  group (43%), with an overall success rate of 86%. Based on Wald's criterion, only the DES was a reliable predictor of *F* elevations,  $z = 6.47$ ,  $p = .01$ . However, the odds ratio of 1.06 demonstrated little change in *F* elevations given a one unit change in the DES (Table 3).

## Discussion

Overall, a significant relationship was revealed between *F* and measures of posttraumatic stress, dissociation, depression, and family environment. Literature supports the role of depression in *F* elevations among CSA victims (Briere & Elliott, 1997; Lundberg-Love, Marmion, Ford, Geffner, & Peacock, 1992), which may be partly explained by the social isolation and alienation content that is tapped by *F*. Additionally, poor family environment has been shown to contribute to PTSD and depression beyond the impact of abuse (Boney-McCoy & Finkelhor, 1996).

Specifically, dissociation appeared to be the best predictor of *F*. When examining *F* as a continuous variable and as a dichotomous variable (predicting extreme vs. nonextreme elevations), the DES appeared to capture a moderately large amount of variance in *F*. In fact, Briere

and Elliott (1997) noted that dissociative (and posttraumatic) intrusive symptoms in abuse victims involve the unusual and chaotic experiences that *F* specifically taps, suggesting that these experiences (rather than malingering) account for elevated *F* scores. Furthermore, while victims may (consciously or unconsciously) magnify their symptoms in a “cry for help” manner (Briere & Elliott, 1997), seemingly invalid MMPI-2s may be most reflective of dissociation in victims (Carlson & Armstrong, 1994). Given the lack of normative MMPI-2 data with dissociative patients, Carlson and Armstrong (1994) question the accuracy of MMPI-2 scale interpretation in dissociative individuals.

Results demonstrated no significant relationship between specific abuse characteristics with the most harmful effects and *F* scores, in contrast to empirical support for such a relationship between these harmful abuse characteristics and long-term experienced distress (Beitchman et al., 1992; Browne & Finkelhor, 1986). Given that some discrepancy exists in the literature regarding which abuse characteristics are most linked to distress, it is possible that other abuse characteristics would demonstrate a significant relationship with *F* scores. Alternatively, perhaps *F* scores are more strongly related to the disturbed family of origin environment of many victims of prolonged CSA, rather than the nature of the abuse itself.

An alternative interpretation of our findings is that participants in the present sample may have overreported their symptoms, elevating *F* scores because of the fabrication of psychopathology, or the magnification of genuine psychopathology. In fact, in the current study 20% of participants exceeded a *T* score of 100, and a total of 13% exceeded 120 on *F* (with highest clinical elevations on scales 8, 6, and 7 in both groups). Recent evidence using the Infrequency-Psychopathology scale (*Fp*) suggests it may be less sensitive than *F* to psychopathology in psychiatric patients and trauma victims (Arbisi & Ben-Porath, 1998; Elhai, Gold, Sellers, & Dorfman, 2001). Using the empirically-derived optimal *Fp* raw cutoff score of 7 (*T* score of 97 in women) to detect overreporters (Arbisi & Ben-Porath, 1998), only one participant scored higher than this cutoff in the current sample. Thus, malingering is probably not a complicating issue in these analyses.

There are a number of limitations in the current study. First, evaluations were primarily based on self-report, because we did not possess medical or legal records to confirm participants' abuse histories. Second, results may only generalize to women CSA victims seeking treatment. In fact, our sample was unique, given its low socioeconomic status, and high level of comorbidity. Third, although we used the IES as a measure of posttraumatic stress, it does not exactly measure posttraumatic stress per

se, because it does not query about the hyperarousal experiences of PTSD. Future studies could examine variables that account for elevations on additional fake bad scales from the MMPI-2 and other measures, additionally implementing data on disability seeking in trauma victims.

In conclusion, MMPI-2 *F* elevations may reflect a genuine diversity of clinical difficulties (i.e., depression, PTSD, dissociation, and poor family-of-origin environment) in clinical samples of CSA victims, rather than an overreporting response set. This finding has vital implications for professionals in both clinical and forensic settings. It suggests that elevated *F* scores among some trauma victims, rather than being an indicator of an invalid profile, may reflect the actual presence of extreme distress. Research with other trauma populations needs to be conducted to further test this hypothesis, and to investigate whether elevated *F* scores associated with genuinely severe and varied symptomatology are more common in patients with complex PTSD (disorders of extreme stress, not otherwise specified; DESNOS) than in “simple” PTSD.

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