Issues involving the new MMPI2Rf WATCH OUT!! IT CAN HURT YOUR CLIENT

Note: This is the MMPI2 minus several hundred items. The MMPI2 contains 567 true/false items vs. only 338 items in the shorter version. There are concerns that the shorter version fails to identify psychopathology and recent articles this to be true. Therefore, a plaintiff or claimant may test out as less impaired using this shortened version. Many experts for the defense do not understand that the RF is nothing more than a shorter MMPI2 and believe, in fact, there are newer and better questions. They are also unaware or ignoring the controversy. The MMPI2 is more well validated and has been around longer and takes longer to administer. Make sure you point this out.

What is this "new" test? Not much, in my opinion. The "new" MMPI-RF is actually simply the MMPI2 less a couple of hundred questions. The original MMPI2 consists of 567 items to which the person responds with "true" or "false" and the MMPIRF only has 338[1] items and takes less time to administer so it may be more competitive than a shorter personality inventory like the Personality Inventory Assessment. With the health care dollar shrinking, psychologists may feel they cannot spend the time (2 hours +) with a patient administering the MMPI2 when a shorter test is available. The problem is that *shorter* doesn't mean *better*. Consider this. Many of the statements to which your client would answer "true" which indicate anxiety or depression have been removed. What does this mean? This means that the "new" and "less" MMPI2 results in those time honored and respected symptoms of depression and anxiety are now missing such that a person who does not have the opportunity to endorse those symptoms may be found to be not suffering from depression or anxiety. This is a problem. The core scales of the "new" MMPI RF are called the "RC" scales. That is why the references to articles having to do with RC scales below. Those scales, according to research below, are not as well validated as the original content scales on the MMPI2 which existed since the 80's. Watch out for this test and consider filing Frye/Daubert Motions asking doctors to prove how this test with fewer questions, less validation is actually reliable.

This requires a 5-7th grade reading level and should not be read to the patient

Questions:

Was this test normed on persons with physical injury/pain?

Ask the psychologist the following:

What is the average profile of the MMPI-2-RF scales for brain injured individuals?

What is the average profile for personal injury litigants?

What research studies show these results?

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[1] 9/9/09 http://www.upress.umn.edu/tests/mmpi2-rf.html

Can you draw me a typical profile of people who have severe brain damage on the MMPI-2-RF ?

Are you aware it's never been studied in brain injury populations?

The MMPI-2-RF is a new test with low research and lack of demonstrated use in assessing clients with disability

Can you explain why you decided to use the MMPI-2-RF rather than the well established MMPI-2 test?

Did you administer the MMPI-2-RF because you believed it to be a shortened and more efficient MMPI-2?

Is it not correct to state that the MMPI-2-RF is a different test than MMPI-2?

Does a new psychological test need to be validated before it is used in forensic evaluations?

What studies have you read that validate MMPI-2-RF in clients with disability like the plaintiff

Can you provide any research that supports the validity of this new test?

Isn't the use of the MMPI-2 RF for a forensic evaluation a misuse of a psychological test given that there are no relevant validity studies?

Are you aware of the low utility of the new F-r scale for assessing malingering?

Have you participated in any validation studies of the MMPI-2-RF?

What did the study Richard Rogers did show about the shortened MMPI-2 F scale?

Did the MMPI-2-RF version on which you based your opinion about ____ perform less well than the MMPI-2 F scale?

Even though you uncovered the failure of the F-r scale on the MMPI-2-RF you nevertheless based your evaluation of Ms ____ on this measure?

Your study showed that the scale you used to question Ms ____ cooperation in the evaluation was significantly below the MMPI-2 standard F scale?

Possible bias against women in the MMPI-2-RF

Has there been research showing that women and men differ in their response to personality items? (of course, that's why there are gendered norms)

Are you familiar with the original MMPI developers (Hathaway and McKinley) studies showing that there are significant gender differences on several MMPI measures?

Isn't this why they developed separate comparison norms for men and for women?

Does the MMPI-2-RF follow this tradition of separate gender specific norms?

The MMPI-2-RF scores men and women on the same norms, right?

Does this not bias the evaluation against women when the same cut-off scores are used?

Use of measures that are unreliable

Your report shows that you relied upon the LP and BRF scales on the MMPI-2-RF. Is that correct?
Have the authors of the MMPI-2-RF acknowledged in their test manual that these RF measures have low reliability? Have you researched this?

You included an interpretation of the Helplessness or HLP scale (5 items) in your report. Is this a scale one can trust? Wasn't the reliability quite low?
Do you know the reliability?
If you do not know the published reliability then how can you testify it is scientific?
What is the false positive
False negative?
Error rate?

You also included an interpretation of the Behavior-Restricting Fears or BRF scale (9 items) in your report. Is this a scale one can trust?
Wasn't the reliability of this scale also quite low?

Suggestion: Have your expert administer the full MMPI2 with a Minnesota report (a computerized interpretive report) then have the same answer sheet run scoring the MMPI2RF (ignoring several hundred answers in the traditional MMPI2) The results may very well show your client has significant psychopathology using the traditional longer test which is essentially missed by the newer shorter test. This should not be expensive as it requires the doctor to simply have the answer sheets computer scored by the publisher which is not costly at all. I am aware of a case wherein a patient completed the full MMPI2 and was found to be suicidal with the interpretation. When the shorter MMPI2 RF was used, he did not test out as suicidal. This is potentially a very very dangerous problem.

Simms, Casillas, Clark, Watson, Doebbeling, 2005, p. 357) concluded that the RC Scales could not replace the Clinical Scales. They pointed out

"Also, despite the temptation to do so, it also is apparent that the RC scales cannot be interpreted on the basis of previous empirical studies of the original scales; the RC scales represent new measures whose meanings now must be determined empirically."[2]

Rogers and Sewell (2006, p. 177) also pointed out that the RC scales could not replace the clinical scales:

> "This recommendation is lacking in both conceptual and empirical foundation. Conceptually, the RC scales are fundamentally different from the clinical scales in their focus and coverage. With such core differences, RC scales cannot be used to clarify clinical scales. Empirically, RC scales would need to demonstrate incremental validity before their use in augmenting traditional interpretations."[3]

Rogers, Sewell, Harrison & Jordan, 2006

"We caution against the use of the MMPI-2 RC scales in professional settings until these and other issues of test validation are satisfactorily addressed." p.146[4].

Gordon (2006, p. 870) criticized the Restructured Clinical Scales (RC) scale development approach as making "false assumptions" about psychopathology because consistent items are needed to assess all psychopathologies like Hysteria, Post Traumatic Stress Disorder, and Borderline Personality Disorder:

"The RC3 Cynicism scale is not an improvement of the MMPI-2 Hysteria Scale as the new scale serves as an example of a failure of behaviorism to account for complex psychopathology." (p. 870).[5]

Butcher, Hamilton, Rouse & Cumella, 2006

"In sum, the RC3 scale bears so little resemblance to the Hy scale that it carries over none of the "core" constructs of the parent scale that the RC scale developers had intended. It is, in effect, a very different scale and needs to be studied through a wide range of settings and applications before it can take its place as a "standard." P. 190[6]

Nichols (2006, p. 136) pointed out that the RC scales show "construct drift" from the

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[2] Simms, L J., Casillas, A., Clark, L. A., Watson, D., & Doebbeling, B. N. (2005). Psychometric evaluation of the Restructured Clinical Scales of MMPI-2. *Psychological Assessment, 17,* 345-358.
[3] Rogers, R., & Sewell, K.W. (2006). MMPI-2 at the crossroads: Aging technology or radical retrofitting? *Journal of Personality Assessment, 87*, 175-178.
[4] Rogers R, Sewell KW, Harrison KS, Jordan MJ. 2006. The MMPI-2 Restructured Clinical Scales: A Paradigmatic Shift in Scale Development. *J. of Pers. Assess. 87*: 139-147
[5] Gordon, R. M. (2006). False assumptions about psychopathology, hysteria and the MMPI-2 restructured clinical scales. *Psychological Reports, 98*, 870-872.
[6] Butcher, J. N., Hamilton, C. K., Rouse, S. V. & Cumella, E. J. (2006). The Deconstruction of the Hy scale of MMPI-2: Failure of RC3 in measuring somatic symptom expression. *Journal of Personality Assessment,87(1)*, 186-192.

clinical scales and are simply redundant measures of several content scales.

"The RC Scales selectively emphasize a single content theme embodied within each Clinical Scale. As such, they stand at considerable remove from the Clinical Scales because of the loss of the syndromal complexity that characterizes their parent scales and closer to content-based scales, scales that are all but invisible in the *Manual*. In virtually all cases, the selected RC core dimensions are already adequately, if not abundantly, represented in one or more of the numerous content-based scales of the MMPI–2 as indicated by the extremely high correlations of the RC Scales with their respective content-based scales (p 336)."[7]

Ranson, Nichols, Rouse & Harrington (2009, p. 136) summarized the problem with the development of the Restructured Clinical Scales and ways in which these measures did not meet current test revision standards:

"We conclude that neither the deficiency goal nor the growth goal driving the scale revision process was accomplished in a way that establishes the RC Scales as unique or deserving of wide-ranging acceptance. We view this outcome to be, at least in part, a reflection of the authors' inadequate attention to the kinds of test revision considerations outlined here." (p. 136)[8]

Gacano & Reid, (2009, p. 174-175) describe the inadequacy of the RC scales to address psychopathy as well as the MMPI-2 Pd scale.

"The RC scales in criminal populations appear to be problematic as measures of both psychopathology in general and antisocial behavior in particular." (p. 175)[9]

Gass, (2009), p. 442 critiques the failure of the RC scales to appropriately assess patients in a neurological evaluation.

"The radical alteration of scale 3 (RC3), which is aptly described a deconstruction by Butcher et al. (2006), is particularly disconcerting from a neuro-psychological standpoint, given the original scale's sensitivity to conversion symptomatology. One example of this is psychogenic seizures, which account for almost one-third of seizure presentations (Ansley et al., 1995)." (p.442).

"Anecdotal evidence that the RC Scales under-estimate level of psychopathology received support in a recent study of substance abusers (Forbey & BenPorath, 2007). RC scores were consistently lower than their Clinical Scale counterparts." (p. 442)."

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[7] Nichols, D. S. (2006). The trials of separating bath water from baby: A review and critique of the MMPI-2 Restructured Clinical scales. *Journal of Personality Assessment, 87,* 121-138.

[8] Ranson, M., Nichols, D. S., Rouse, S. V. & Harrington, J. (2009). Changing or Replacing an Established Personality Assessment Standard: Issues, Goals, and Problems, with Special Reference to Recent Developments in the MMPI-2. In J. N. Butcher (2009). *Handbook of personality assessment.* (112-139). New York: Oxford University Press

[9] Gacano, C. B. & Meloy, J. R.. (2009). Assessing anti social and psychopathic personalities. J. N. Butcher (Ed). *Oxford Handbook of Personality Assessment.* (pp.567-581). *New* York: Oxford University Press.

“The elimination of over 200 MMPI-2 items that are “working items” has additional implications for information loss and its potentially adverse impact on clinical use of the MMPI-2. “It is clear, however, that if clinicians abandon the original Clinical Scales and body of code-type information, they will sacrifice the most impressive body of empirically based interpretive material ever amassed in the history of personality assessment.” (p. 442)[10]

Binford & Liljequist (2008, p. 613) reported that some RC scales do not predict behavior as well as MMPI-2 clinical and content scales.

“In contrast, RC Scale 2 appears to predict fewer behaviors conceptually related to depression than its Clinical sale counterpart or Content Scale DEP reflecting the more narrow focus of RC2. Removal of the general stress component changes the strength of the empirical correlates of two Clinical scales measured in this study and may do so for the other scales not assessed in this study, possibly to the benefit of some and the detriment of others.” (p. 613).[11]

Wallace & Liljequist (2005, p. 290) pointed out that the RC scales have low sensitivity in detecting mental health problems in clinical settings:

“Mean T scores of the restructured scales were significantly lower than their original scale counterparts for every clinical scale except Scale I (hypochondriasis). Individual profiles exhibited fewer scale elevations using the restructured clinical scales (M=2.15, Mdn = 2.0) than the original clinical scales (M=3.29. Mdn= 3.0). The majority of client profiles (56%) had fewer scale elevations when plotted using the restructured scales versus the original clinical scales.” (p. 290).[12]

Concerning the use of the MMPI-2-RF in forensic settings, Rogers and Granacher (2011) pointed out the following: “As a final note, the MMPI-2-Revised Format (MMPI-2-RF; Ben- Porath & Tellegen, 2008) was recently published with substantially modified validity scales. With minimal data on their effectiveness for assessing feigned mental disorders (Tellegen & Ben-Porath, 2008), it is likely to be years before the body of research justifies their use with suspected malingering in forensic cases. Initial forensic studies (Sellbom, Toomey, Wygant, Kurcharski, & Duncan, 2010; Rogers, Gillard, Berry, & Granacher, 2010) produced promising yet disparate results.”

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[10] Gass, C. S. (2009). Use of the MMPI-2 in Neuropsychological Evaluations. J. N. Butcher (Ed). *Oxford Handbook of Personality Assessment.* (pp.432-456). *New* York: Oxford University Press.

[11] Binford, A. & Liljequist, L (2008). Behavioral Correlates of Selected MMPI-2 Clinical, Content, and Restructured Clinical Scales *Journal of Personality Assessment,* 90, 608 - 614

[12] Wallace, A., & Liljequist, L. (2005). A comparison of the correlational structures and elevation patterns of the MMPI-2 Restructured Clinical (RC) and Clinical Scales. *Assessment, 12,* 290-294.

Rogers, R. and Granacher, R. P. Jr (2011), Conceptualization and Assessment of Malingering In.   Drogin, E. Y., Dattilio, R. M. Sadoff, R. L. & Gutheil, T. G. Handbook of Forensic Assessment: Psychological and Psychiatric Perspectives,