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An Autopsy on the Fake Bad Scale: The Political and Scientific Ramifications of the Methodology and Application of the Fake Bad Scale Against Persons with Brain Impairment

By:

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The Minnesota Multiphasic Personality Inventory-2, is the most commonly administered psychological test in the world.[1] In 2006, the publishers of the MMPI-2 adopted "Fake Bad Scale." The scale consists of 43 statements to which the patient responds "True" or "False." Unfortunately, many of those same statements are statements one would *expect* a person with brain damage to endorse. Traumatic brain damage can cause attention and concentration difficulties, confusion, anxiety and depression.[2] Persons with cognitive dysfunction and related emotional issues such as anxiety, depression and/or physical problems due to a brain injury may endorse items on the scale such as anxiety symptoms, depressive symptoms, head pain and/or confusion. The patient incurs points on the Fake Bad Scale by admitting to the very symptoms of brain injury.[3] In fact, if one removes the items in the scale which are symptoms of brain impairment, the patient may very well *pass*, thus making elevations on the Fake Bad Scale potentially an indication of true brain impairment versus symptom amplification or ,in worst case scenarios, malingering.

The distributor sells an in-depth computer analysis of the results called The Minnesota Report in which there is *no* discussion of the Fake Bad Scale, unlike the other traditional validity scales. The absence of FBS discussion is due to the fact that Dr. James Butcher, the creator of the report, did not include the FBS in his interpretive report since he believes it is not reliable.[4] Additionally, there are no alternative explanations for internally consistent, very high elevations on the FBS as exist in other traditional validity scales contained within the MMPI-2 manual. For example, an extreme elevation in the F scale ($t > 110$) is not limited to "exaggeration," but can also include, confusion, random responding and severe psychopathology.[5] The Fake Bad Scale pulls physical and psychiatric symptoms that legitimate patients with brain injury could endorse. This test was first called the Fake Bad Scale, then referred to as the FBS, and is now referred to as the SVS according to the publisher.[6] Since the scale is so widely recognized by

its original moniker, it will continue to be referred to as such in this article. The original scale, Fake Bad Scale, suggests that elevated scores indicate that the patient is *lying*. This tremendous potential for harm cannot be undone once the mere name of the test is uttered. Even the acronym FBS, then SVS, presents little solution, as an inquisitive juror could Google the initials and clearly be swayed by the underlying name.

Use of FBS in Cognitive Malingering

The use of the Fake Bad Scale to support *cognitive* malingering may violate the National Academy of Neuropsychology published methods for assessing symptom validity which states "Invalid performance on a measure of personality" (such as the MMPI in this case) "cannot be used, *a priori*, to determine malingering of cognitive tests."[7] The FBS is not an effort test and should not be used as one.

The Adoption of the Scale

On 1/23/06, the publisher chose eight psychologists to send a request by e-mail asking for their reviews on the FBS and only gave the reviewers several weeks to respond.[8] The researchers were sent only two articles, both *in favor* of the scale. In so doing, the publisher failed to send the article with the largest sample size that was critical of the scale.[9] The actual recommendations by the eight reviewers failed to reveal consensus as to *how* to score the FBS . Should the FBS be used to diagnose malingered PTSD? Cognitive feigning? Faking physical symptoms? All of the above? Some of the above?[10] The distributor's website cautions doctors to consider the FBS which may be elevated due to legitimate physical conditions, but does not say *how* to do this. Remove points? Don't give the test? Give it little or no weight? The actual scoring method is also a problem. There are so many suggested scores above which one might conclude exaggeration, (20, 22, 23, 24, 26, 28, 29, and 30)[11] so as to make use of the FBS, relative to its validity, questionable.

Furthermore, any scale created to be used only in forensic settings makes it inherently suspect. Imagine an MRI of the brain which is reliable only if the patient is in litigation.

The publisher's interpretation manual for the MMPI-2 was published in 200l and makes no reference to the Fake Bad Scale. Recently, a newer manual has been published discussing the MMPI-2 RF (a shorter version of the MMPI-2 with its own set of issues) and this manual gives instructions on how to use the Fake Bad Scale. Unfortunately, it's not the *same* Fake Bad Scale.[12] The scale discussed in the manual contains only *30* items, while the original Fake Bad Scale contains *43* items. What happened to the other l3 items? Why were they excluded and on what basis? Which Fake Bad Scale is more reliable, specific and/or sensitive to exaggeration… the longer version or the shorter version?

The RF manual reports, on page 23 of the MMPI-RF Technical Manual, that the internal consistency (reliability) of the Fake Bad Scale is only .50 for men and .56 for women.[13] The sample was based upon 1,138 men and 1,138 women. Internal consistency refers to whether the

items on the scale hang together, thus measuring a similar construct. If they do not, then the scale measures multiple constructs, some of which may be unknown. The lower the internal consistency of a scale, the lower its validity is. For example, if an intelligence test also measures anxiety, does the score represent intelligence, anxiety, or both? Unfortunately, the FBS scale was not a "new" scale with "new" items, but borrowed items from other scales that measure *real* disturbances such as cognitive dysfunction.[14]

In a recent newspaper article discussing issues surrounding the manner with which tests/scales were adopted, University of Minnesota officials stated they were willing to let the marketplace decide".[15] As one might expect, the FBS scale tends to be used more by defense-oriented practitioners in personal injury lawsuits, since the scale depicts a large percentage of clients as "malingering."[16] Should the marketplace decide if a scale is scientific? If a scale frequently concludes malingering and is embraced by the defense industry, does that fact make it scientific or simply profitable?

Bias Against Persons with Brain Injuries

On 5/3l/07 in a letter by Arnie Abels, Ph.D., Chair of American Psychological Association's Committee on Disability Issues in Psychology, Dr. Abels expressed concerns that the scale had the potential to harm those with disabilities and recommended a review by Buros Mental Measurements, an independent organization.[17] If the scale is valid then why is there reluctance to have an independent evaluation? The authors are unaware of such an independent review ever taking place.

The Courts

Back in January, 2002, Doctors Butcher and Arbisi and others found "the FBS is *not likely to meet legal criteria* in forensic cases because of the lack of empirical validity …"[18] (emphasis supplied). Their prediction rang true. If a patient or examinee admits to legitimate symptoms secondary to brain injury on the FBS, points are accumulated which can result in a score that supports the contention of malingering. Five different judges had hearings on the FBS and ultimately rejected the scale.[19] Last year a judge found, "the FBS has significant potential to negatively impact persons with true disabilities."[20]

Critique of Butcher et al. by Ben-Porath, Greve, Bianchini and Kaufmann

In an article responding to Dr. Butcher's concerns about the FBS, the above-referenced authors support the use of the FBS. The critique finds, "When the FBS is elevated at levels described in this paper, our best science indicates that the examinee was likely over endorsing symptoms, a fact that plaintiff attorneys *misconstrue* as the expert calling the plaintiff a fake, a fraud, or a liar"[21](emphasis supplied). According to the American Psychiatric Association, malingering "is suspected if any combination of the following are observed

1. Medicolegal context of presentation
2. Marked discrepancy between the person's claimed stress of disability and the objective findings

3. Lack of cooperation during the diagnostic evaluation and in complying with prescribed treatment regimen
4. The presence of Antisocial Personality Disorder "[22]

The author of the scale itself discusses the FBS in the context of malingering which also includes "intentional production of false or exaggerated symptoms."[23] Intentional misrepresentation is *dishonest* and *does* suggest *lying.* This can result in a plaintiff with a legitimate brain injury being prosecuted for perjury and/or insurance fraud. Claims of "malingering" are not to be taken lightly and claiming a scale, originally called the "Fake Bad Scale", has nothing to do with dishonesty or faking is inconsistent with logic.

The first article authored by Dr. Lees-Haley discusses the scale's use in differentiating *malingerers.*[24] The publisher's website discusses *credibility* of symptoms and lists references discussing "malingering".[25] In an outline presented to ABA members, co-author of this critique, Dr. Kaufmann, states "So when the plaintiff's attorney asks, 'Are you calling my client a fake, fraud, and a liar?', one effective response is, 'No, FBS is just one indicator of symptom invalidity associated with the *exaggerated* reporting of symptoms'. Upon hearing such testimony, a reasonably prudent juror would likely conclude the plaintiff was *faking*"[26](emphasis supplied). Accusing the plaintiff's attorney of misconstruing the scale by perceiving its use as an attack on the plaintiff's credibility is confusing at best. The original name of the scale was the FAKE BAD SCALE. Does that not imply *dishonesty* or *faking*? How does one determine the boundaries between exaggeration and faking? To claim that a scale does not mean "faking", but then assume a reasonably prudent juror, after hearing reference to the scale, would conclude *the plaintiff was faking,* is an exercise in cognitive dissonance.
The article is also critical of Dr. Butcher for discussing the harmful effects of a cut score of 20 "that has long ago been identified by the developer of the scale as too low."[27] However, the critique also referenced a book authored by Dr. Larrabee which recommended "an FBS cutting score above 20 or 2l provided optimal classification of the malingering and head injury groups…"[28]

The critique also states that "numerous board certified clinical neuropsychologist experts report admissions of FBS testimony into evidence, with some testifying that they have never had FBS excluded" and then cites *Upchurch v. Broward Co School Board 2008* and *Solomon v. TK Power*. [29]

A letter from Upchurch's attorney revealed that the case was *not* a l5th circuit case as represented, nor was the testimony admitted and considered by the court".[30] After discovery depositions on the FBS, the defense agreed to provide the benefits sought, pay costs and attorney fees, and further agreed not to send the claimant to the doctor who claimed malingering based on the FBS.[31] The critique then cites *Solomon v. TK Power* and indicates that objections were withdrawn after evidence and oral arguments were presented.[32] The plaintiff's attorney did, in fact, withdraw her Frye motion because she believed that the jury would be *outraged* should the defense continue to rely upon the FBS.[33] After the defense expert testified, the defendants offered *additional sums* to settle the case… and it was.[34] These cases are hardly an endorsement of the FBS.

In the response criticizing Butcher, et al for discussing the contents of the actual reviews of the FBS conducted at the request of publisher, the authors say they do not wish to reinforce conduct, i.e. discuss review process of the FBS and these issues are not addressed in the response. Why? The University of Minnesota is a publicly funded institution and the review process should be open to the public.

Perhaps the best argument reflecting the weaknesses of this scale can be found in the Critique in which it is stated, "As research has progressed, the FBS score range considered to be consistent with malingering has risen."[35] Does that mean the people in the "malingered" range 5 years ago were incorrectly identified? If so, what is being done to correct the incorrect accusation? Considering that the cut scores have continued to go *up* over time, the problem for scientific reliability only increases with time. The newly increased scores are similar to DNA testing in criminal cases, which essentially exonerate the defendant. The only difference being there appears to be no attempt to contact those individuals to whom the *wrong* cut score was applied, which resulted in a loss of benefits, in order to make them whole. Now that the cut score is higher, what efforts have been made to reimburse those persons wrongfully denied benefits by use of lower cut scale?

Conclusion

This scale is too controversial and has too many psychometric problems to be valid. The scale has the potential to consistently measure a construct, (real problems, unknown issues) which is not consistent with its original name, "faking bad." It consistently measures something other than its original name implied. The scale is biased against those with legitimate brain impairment; thus, those least able to defend themselves against such charges of dishonesty are the ones most likely to be victimized by it. The scale gives points for malingering for endorsing legitimate symptoms of TBI and as such, it should not be considered valid.

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