



Effortless Effort: Current Views on Assessing Malingering litigants in Neuropsychological Assessments

Corresponding Author:

Dr. Simon B Thompson,
Associate Professor, Psychology Research Centre, Bournemouth University, BH12 5BB - United Kingdom

Submitting Author:

Dr. Simon B Thompson,
Associate Professor, Psychology Research Centre , Bournemouth University, BH12 5BB - United Kingdom

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Author(s): Thompson S B

Abstract

Neuropsychological assessment is often revealing and valuable not only to assist litigants in their rehabilitation but also to build a case towards claiming compensation in the legal system. However, sometimes malingering litigants with unscrupulous views attempt to deceive assessors through performances that actually do not reflect their true effort. It may be suspected by assessors but it can often be difficult to establish categorically. Therefore, there is a need to decide which performances are true and which are spurious. A comprehensive profile that also takes account of the litigant's lifestyle and background may be more revealing than only accepting face-value performances on a few neuropsychological tests.

Introduction

In litigation suits, effort and malingering in neuropsychological testing is often difficult to assess not only because of functional benefits to clients such as possible compensation awards but also because it may be problematical to distinguish between actual effort (albeit minimal) and an attempt at deception.

Knowing the client well has the benefit of knowing how much effort s/he has given to the exercise but presents with a problem for the Court in terms of potential or possible coercion or collaboration between client and Expert Witness.

Reference is often made to the Diagnostic and Statistical Manual of Mental Disorders (APA, 1995) where malingering is defined as "the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives..." (p.683). A number of clinicians and researchers have attempted to make sense of the difficult problem that malingering and minimal effort presents to assessors, particularly of neuropsychological disorders and sequelae (eg British Psychological Society (2009), Larabee (2007), Thompson (2003), Thompson (2011), Venderploeg and Curtiss (2001). However, there is no single test that achieves the detection of effort in patients, leaving

the assessor to make a judgement on the profile of test results obtained from the client/patient.

Discussion & Recommendations

Powell and colleagues (2011) present findings on suboptimal effort from work with non-litigious acquired brain injury patients seeking outpatient rehabilitation. Using the Trail Making Test (TMT) (Corrigan & Hinkeldy, 1987; Gaudino, Geisler & Squires, 1995; Reitan & Wolfson, 1992), patients who exhibited optimal effort elsewhere, completed the TMT Parts A and B faster than suboptimal effort patients. Although TMT Part A time to completion demonstrated adequate sensitivity to suboptimal effort, the authors advise that positive predictive value was fair to poor unless the base rate of suboptimal effort was inflated to 40%. TMT Part B time to completion yielded poor sensitivity and predictive value.

Visual spatial measures have also been used in order to discern performance deception in clients seeking compensation (Thompson, 2006; Thompson, Ennis, Coffin, & Farman, 2007). Whiteside, Wald and Busse (2011) investigated the use of the Judgment of Line Orientation Test, the Benton Facial Recognition Test, the Hooper Visual Organization Test, and the Rey Complex Figure Copy and Recognition trials (Osterrieth, 1944; Rey, 1941). Using a receiver operating characteristic (ROC) analysis, all of the measures were found to have acceptable accuracy.

Suggested cut-off scores for the measures had sensitivity levels of approximately 32-46%, when specificity was at least 87%. When combined, the authors found that measures suggested cut-off scores had sensitivity increase to 57% while maintaining the same level of specificity at 87%. Whiteside, Wald and Busse (2011) conclude that multiple measures of effort are needed rather than a single measure and that sensitivity and specificity are important components to consider when attempting to assess minimal effort on psychological tests. However, a sensitivity value of 57% does appear to be unacceptably low.

Some researchers have considered the possibility of embedded indicators of effort within standard

assessments. Donders and Strong (2011) investigated the logistic regression method developed by Wolfe and colleagues (2010) for the detection of invalid effort on the California Verbal Learning Test Second Edition (CVLT-II). However, the authors conclude that whilst the CVLT-II logistic regression formula demonstrated a statistically significant level of agreement with results from the Word Memory Test, it was also associated with an unacceptably high proportion of false positives. It would seem, therefore, that this formula should be used with extreme caution and only in the context of other neuropsychological assessment techniques.

The situation context of the assessment has been deemed important by some researchers and would appear to be a valid point especially when considering the positive gains of claimants and litigants. Blavier (2011) considered the family circle as a strong influence on the management of patients receiving rehabilitation for a traumatic incident. The context also seems to be influential on the type of malingering that may be chosen; that is, conscious or unconscious, and depends if the patient is a child (for example, the well documented Munchausen by proxy syndrome – Meadow, 1993; Rand, 1993). Blavier (2011) concludes that although psychological tests might be used to attempt to discover malingering, a meticulous assessment, empathy, and neutral and benevolent attention are indispensable elements to assure authentic complaints and to prevent malingering.

This standpoint has led to the conclusion by many that intentional faking can in fact lead to a less conscious form of symptom reporting. Merckelbach, Jelicic and Pieters (2011) propose that blindness for the intentional aspect of symptom endorsement may explain the intrinsic overlap between feigning and somatoform complaints. Twenty-eight students were asked to complete a symptom list of psychiatric complaints and then were asked to explain why they had endorsed two target symptoms that they did not really endorse. Fifty-seven per cent did not detect this mismatch between actual and manipulated symptom endorsement and even tended to adopt the manipulated symptoms when provided with an opportunity to do so. This leaves us with the problem of deciding whether or not clients properly understand the assessment task, whether they are trying to please the assessor, or whether they are presenting with suboptimal effort, not due to an underlying disorder.

The message from all of these studies is that caution must be made when referring to single test results and that a comprehensive profile of the patient in terms of clinical background as well as neuropsychological testing will help to form an impression by the assessor of whether or not the client before them is attempting

deception. This debate will continue.

Indeed, it is possible that some deceivers actually internalise their beliefs to such an extent that they become apparently impaired. This situation poses the question of whether or not the psychological and psychiatric consequences of attempting to fake effort should also be taken into consideration when assessing patients. The whole picture of assessing patients for compensation becomes more complex for the assessor and the burden of judgement rests with the expert assessor as a matter of expertise, experience and clinical intuition – all difficult to accurately quantify and are perhaps unsurprisingly rather subjective

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