Assessing Effort During Clinical Neuropsychological Testing of Patients: Relevance to Law Suits, Patients with Neurological Disorders and Financially Motivated Claimants

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Assessing Effort During Clinical Neuropsychological Testing of Patients: Relevance to Law Suits, Patients with Neurological Disorders and Financially Motivated Claimants

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Abstract

For some time, clinicians and researchers have attempted to find measures of effort and malingering. The problem has arisen from increasing litigation suits and the various motives of patients seeking compensation. Insurers are also under increasing pressure to determine whether or not claimants are genuine and for law courts to be assured that claimants are being honest. There are no single tests that determine effort and there is continuing debate over the usefulness of tests that purport to measure effort and malingering versus the clinical interview.

Introduction

The assessment of effort during neuropsychological examination has been debated by clinicians and researchers interested in obtaining a true picture of their patient’s abilities. Difficulties have arisen because of the motives behind certain assessments, for example, often patients seeking compensation may have a tendency to exaggerate their residual abilities following trauma. Fatigue and altered concentration can also affect a patient’s ability to perform on a given test. Also, there is considerable debate over which tests actually measure a patient’s effort in particular circumstances whether measured directly or embedded within another test of performance. Therefore, it has been important to consider the specificity and sensitivity of neuropsychological tests, as well as how some patients may demonstrate “malingering” during testing.

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (APA, 1995) defines “malingering” as “the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives...” (p.683). However, it is commonly agreed that there is a difference between those who intentionally fake their responses and those who may not try quite as hard as their optimal potential for various reasons. The point here is that some patients do not make an effort during assessment because they do not feel it is in their best interest. It may be subtle to distinguish between outright fakers and those who could try harder. Pankratz and Binder (1997) have proposed that any of the following factors suggest the possibility of malingering:
1. Late onset of cognitive complaints following an accident;
2. Lying to health providers;
3. Marked inconsistency between reported and observed symptoms;
4. Marked inconsistency between present diagnosis and neuropsychological findings;
5. Failure on any specific measure of neuropsychological faking;
6. Resistance, avoidance, or bizarre responses on standard tests;
7. Functional findings on orthopaedic or neurological examinations.

In order to discern which tests are useful to detect malingering, Thompson (2003) has provided a comprehensive review of tests of malingering. The reader is referred to the original text for an evaluation of these tests:
1. Rey Auditory Verbal Learning Test
2. Binder-Gestalt
3. Wechsler Adult Intelligence Scale (Revised)
4. Wechsler Memory Scale (Revised)
5. Finger Tapping
6. Recognition Memory Test
7. Portland Digit Recognition Test
8. Orientation Questions
9. Rey Complex Figure Test
10. Wisconsin Card Sorting Test
11. Trails Making Test

Discussion

Thompson (2003) concluded that it is sometimes the simplest tests that are the easiest to detect malingering, such as the Coin-in-the-Hand test or Finger Tapping. Many malingerers will simply
disbelieve the simplicity of the test and will exaggerate their responses as they believe the test may have underlying or subtle assessment capabilities. However, some tests do require further evaluation (see Vanderploeg & Curtiss, 2001), whereas others should be used as part of a battery of tests. In any case, sound neuropsychological practice should encourage the use of several tests that enable the clinician to build a profile of the patient’s capabilities and neuro-functional disabilities. The British Psychological Society (BPS, 2009) has provided guidance on the assessment of effort in clinical testing. It suggests, amongst others, that the Reliable Digit Span sub-test of the Wechsler Adult Intelligence Scale (Third Edition) may be helpful in determining effort when computing the longest string of digits forwards and backwards in which both trials are passed and comparing it to the cut-off score of less than 7. Larabee (2007) suggests that this provides generally good specificity but variable sensitivity. The Warrington Recognition Memory Test has also been reported as being useful in this respect. Iverson and Franzen (1998) found that a score of less than 32 on the Words sub-test was successful in detecting 90 per cent of malingerers with 100 per cent specificity. A score of less than 30 on the Faces sub-test showed 80 per cent sensitivity to malingering with 100 per cent specificity. Millis (2002) has provided similar data on a Traumatic Brain Injury group of patients. The use of multivariate formulae rather than the use of a single index seem to be the case when using the Wisconsin Card Sorting Test to determine effort (Greve, et al., 2002).

Conclusions

There are no single tests that achieve the detection of effort in patients. Even those identified have difficulties with certain populations of patients, for example, people with intellectual delays, traumatic brain injury, dementia, exposure to toxic gases and substances. This is because of the lack of baseline data on these groupings. It is also because there remains uncertainty as to exactly how these tests might measure effort.

The BPS (2009) concludes that tests of cognitive function which simply include embedded assessments of effort need further development. There is also a need for further evidence on the base rates of cognitive impairment and failure on effort tests in a range of clinical presentations. The BPS warns against the affects of cultural issues and that a better understanding of the sensitivity and specificity of tests of effort is needed.

Some older tests, such as the Wechsler Adult Intelligence Scale (Revised), as compared with newer versions, are useful in providing data on particular cognitive deficits of patients as they include sub-tests no longer included (or modified or added to with further sub-tests) in the newer versions. A profile of the patient can be built up using such sub-tests as part of a battery of tests.

However, of paramount importance to any clinical assessment is questioning the patient about his/her abilities and symptoms. Thompson (2011) outlines the importance of the clinical interview in this respect and the use of open and closed questions as well as a background information gathering about cultural issues, and socio-economic data. So much can be gained by simply persisting with a thorough clinical line of questioning. As well as the motives of the patient, an understanding of the attitudes and the way the patient tackles tests in general, can be discerned through careful questioning.

Perhaps then it is more about how we conduct our assessments, paying particular attention and sensitivity to the way we conduct ourselves, ask our questions and present our instructions, rather than looking for a deceitful patient or a patient that is not trying and hard as they could be in a particular tests that we hope detects deceit.

References


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