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Assessing Neuro-Cognitive Complaints After Brain Injury: Distinguishing Fact from Fiction in Civil and Criminal Litigation

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Plaintiffs and other petitioners often sue for damages due to reported cognitive or emotional impairment. These impairments are often said to be the result of traumatic brain injury suffered in accidents or toxic exposures or due to medical procedures. Such impairments can often be subtle, not easily understood by nonprofessionals, but still claimed to have changed a person's life.

In such cases how can a claim be assessed for its reliability or "truth." In other words is Mr. Smith really a victim who deserves compensation or is he a "malingerer" who is pulling a fast one?

Clinical and neurophysiologists provide attorneys and third party administrators with admissible evidence on the reliability of clients reported neuro-cognitive and emotional deficits. This article presents a brief overview of malingering assessment and symptom validity testing so that attorneys and third party administrators are better informed on how assessments can help them in their work.

Malingering, or the exaggeration and/or fabrication of deficits in the pursuit of external gain, is a typical response by persons with compensable claims following injury or malpractice. It also occurs by defendants in criminal cases during pretrial assessment. Clinical studies conducted into the past fifteen years estimate that the prevalence (or base rate) of malingering is close to 50% for both civil and criminal cases. The figure does not mean that half of every defense firm's case load includes malingering plaintiffs. It does mean that attorneys should perform "due diligence" and recognize the reality of malingering in civil and criminal cases.

Malingering is defined in the DSM of the APA as the intentional production of false or grossly exaggerated physical or psychological symptoms motivated by external gain. Making the determination that a person intentionally produces symptoms is often difficult to prove. The most common provable case is when a person denies a history of alcohol abuse, claims memory impairment, performs poorly on tests of cognitive functioning, and also has a documented medical or criminal history of alcohol abuse. Unfortunately, few cases are that simple for psychologists to review.

Clinical psychologist strongly suspects malingering when any of the following behaviors are documented or evident on examination:

- Symptom exaggeration – pre-existing mild symptoms are inflated in their severity during examination;

- Fabrication – Creation of false deficits where none exist, or the creation deficits that are not associated with know pathology of brain dysfunction.

Psychologists measure these examination behaviors with a procedure that is now called "Symptom Validity Testing." Since 1985, over 300 articles have published in the psychology and neuropsychology literature to document so-called "feigned" cognitive and emotional symptoms and how to perform symptom validity testing.

Psychologists also aid attorneys in deliberation or negotiations by distinguishing between malingering and factitious disorder. In the latter case, the person reports symptoms to assume a "sick role" and obtain treatments. Such patterns are not motivated by external gain.

Psychologists can also make the distinction between Malingering and person with a Somatoform Disorder, who produce physical symptoms for a psychological need that is unconscious, and outside of there awareness.

There is no "typical" malingered presentation. That is, plaintiffs can exaggerate problems on assessment, by area of deficit (motor, cognitive, emotions) or by misreporting.

In assessment, psychologists find evidence of the behavior that we call, "response bias." That is, a less than below chance (< .50%) performance on forced choice measures of cognitive dysfunction. In other words, if a person just guessed at an answer (yes or no) they should get at least 50 percent correct any score far less than that suggests poor effort.

Clinicians also assess bias when a person's performance is at odds with known pathology of brain dysfunction. For example, a person may exaggerate motor deficits such as stamina or speed in relation to orthopedic injuries.

Finally, suspected malingerers also engage in misrepresenting psychological/emotional dysfunction in the area of mood (depression) and thinking (hallucinations). To assess those reported symptoms, psychologists use the MMPI where clinical and validity scores can suggest when a person is exaggerating a mood disorder versus exaggerating psychosis.

While this information educates non clinicians on malingering assessment, there remains the question of how reliable is the doctor's evidence?

That is, what is the ability of any assessment to differentiate a person with and without a specific disorder, such as Malingering? That is, what is the probability or likelihood that a person has a disorder (malingering)?

In malingering assessment, psychologist employ test instruments that have high rates on the statistical properties known as "sensitivity" and "specificity." Sensitivity refers to the

percentage of "true" malingerers predicted by a test. That is, the likelihood of a positive test score in a person with the condition. If a person with mild traumatic brain injury can immediately recall only three digits from the Digit Span subtest, how likely does that suggest malingering?

Over the past fifteen years, psychologists have accumulated considerable scientific evidence to indicate that persons with a variety of conditions (clinical depression, mild Traumatic Brain Injury, bona fide malingers, and "normal" controls) perform differently on symptom validity tests. Hence, a plaintiff's performance can be compared to these groups and the doctor can begin to asses for the presence of malingering or inadequate effort.

In contrast, Specificity refers to the percentage of false malingers who perform on a test. Or, how likely will a person who is not a malingerer still perform poorly on a test? A person can perform poorly on a verbal list learning test but it does not mean they are faking. Such a person may have a learning disability, ADD, or just be fatigued at the time of assessment. With this data in hand, psychologists may or may not be able to make a diagnosis of Malingering. But we routinely do indicate that the Diagnosis is "deferred." That is, there is not sufficient or reliable evidence to substantiate the claim of psychological disability. Such evidence makes for a compelling argument in court.

In closing, attorneys and administrators should expect an assessment of symptom validity and/or malingering in all forensic reports they receive from psychologists and neuropsychologists. And such assessments should not be based on administration of just one test. In 2005, the National Academy of Neuropsychology issued a position paper that recommends the use of multiple measures of symptom validity tests throughout an assessment. In this manner, deliberations and negotiations will be on a more firm scientific foundation when malingering is suspected in civil or criminal cases.