Determining causation of traumatic versus pre-existing psychological conditions

David Fisher, Ph.D., ABPP, LP
Chairman of the Board
PsyBar, LLC
952-285-9000
Part 1: First steps to determine causation
Information to gather prior to psychological/psychiatric evaluation

- All prior psychological/psychiatric evaluations
- Collateral contact information (doctors, supervisors, etc.)
- “Raw test data” and “raw test protocols” mailed directly from the past psychologist to the IME psychologist/psychiatrist
  
- (They relate to assessing validity and duration of the problems)
Information to gather prior to psychological/psychiatric evaluation

• Relevant medical information such as neuroimaging studies, physicals…

• Past psychiatric/psychological treatment records for as far back in time as possible
Part 2:
Neuropsychological IMES:
Neuropsychology:

• Includes the assessment of cognitive abilities with a combination of objective procedures as well as largely subjective observations.
Neuropsychological assessment used when:

- There is a trauma, injury or disease causing:
  - Cognitive difficulties
  - Physical functioning problems (e.g. fatigue, perceptual problems)
  - Emotional problems
Neuropsychological assessment used even if:

- Neurological or other evaluations do not show problems (MRI, CT etc. show structure, not function).
Neuropsychological assessment used even if:

- There is no impairment in cognitive functioning that would be obvious to a physician.
A good evaluation to determine functioning and causation will include:

• Extensive interview with the patient (2 - 3 1/2 hours) with an additional 4 to 10 hours of testing.

• Collateral interviews with spouse, employer, and / or others (often used in tx settings)
A good evaluation to determine functioning and causation will contain a range of tests measuring:

- Intellectual abilities
- Memory
- Motor speed and coordination
- Naming skills & verbal fluency
A good evaluation to determine functioning and causation will include:

• Attention
• Executive
• Processing speed
• Personality traits & mood
• Truthfulness, motivation and effort/malingering
In a normal individual with no brain damage:

• The measurement of different cognitive abilities should result in test scores that are roughly equivalent to each other.
Neuropsychological Test Scores of Average Individual, with No Neuropsychological Problems

(average = 100)

Memory   IQ

Category
IQ usually remains stable after injury, while other tests might not.

• “Full Scale” IQ scores tend to be largely unaffected by most brain injuries.

• Scores on other psychological test scores frequently decline.
Injuries to the front part of the brain can cause problems with:

- The ability to understand abstract concepts
- Concentration
- The ability to form memories
- Personality changes
Phineas Gage
(1848 injury)
Typical Neuropsychological Test Scores for Patient with Frontal Brain Injury

(average = 100)

<table>
<thead>
<tr>
<th></th>
<th>IQ</th>
<th>Memory</th>
<th>Concentration</th>
<th>Abstract thought</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Frontal Brain Injury</td>
<td>98</td>
<td>95</td>
<td>80</td>
<td>60</td>
</tr>
</tbody>
</table>

©PsyBar LLC 2015. All rights reserved.
The previous graph implies acquired, rather than normality or a pre-existing condition because the scores:

- Are consistent with a frontal injury, rather than with a normal medical history

- Severely depressed people often have worrisome problems with more “effortful” memory tasks. (If this were due to longer term depression, rather than a recent frontal injury, with some the score would be low)
Often pre-existing psychological vs. acquired brain injury:

• Inconsistency from one evaluation to the next and problems worsen during times of emotional stress

• Inconsistency from one conceptually similar test to the next
Determining deception by comparisons to prior scores:

- Person with brain injury:
- Scores show rapid recovery in first 4 months after injury.
- Recovery very slow after 1.5 years.
- (If we don’t see these patterns it could be pre-existing or something else)
Mild Traumatic Brain injury:
Lots of misinformation:

Anatomy of a Concussion

A concussion is a brain injury caused by a hit to the head or body.

Your brain is suspended in fluid, which has the consistency of Jell-O. It sits inside the skull, which is kind of like nature's helmet.

If your head whips around too fast, your brain moves through the fluid and bounces off the inside of your skull.

That prompts what is referred to as a “metabolic cascade,” during which the brain's nerve cells stop functioning as they should and blood flow is slowed.

Concussed athletes need cognitive rest, meaning no reading, writing—or texting.

While they heal, cells are vulnerable to a second injury, which is why concussed athletes must sit out.

©PsyBar LLC 2015. All rights reserved.
Clinical presentation

• Recent head trauma, often with no loss of consciousness
• Memory, concentration, irritability, decline in work performance, depression and anxiety
• Collateral sources confirm behavior change
• Nobody can find anything physically wrong
• Seem clinically identical to people with more severe TBI
Defining MTBI without LOC

- Alteration in mental status
- Confusion or amnesia
- Delayed verbal/motor responding
- Difficulty focusing attention
- Disorientation
- Slurred/incoherent speech
- Gross motor incoordination

- American Academy of Neurology Guidelines for Management of Sport Concussion
Participants

- NCAA Concussion Study (4,251 college athletes)
- Concussion Prevention Initiative-CPI (9,094 high school/college athletes)
- Project Sideline (3,279 high school athletes)
- Pre-post measures
- Less concern about litigation bias
Higher score indicates more severe symptoms; error bars represent 95% CI

McCrea et al., JAMA 2003

©PsyBar LLC 2015. All rights reserved.
Physical Symptoms: Summary

• Most severe immediately following injury, measurable improvement within hours
• Gradual improvement occurs up to ~7 days
• Headache tends to remain the longest, may be primary in clinical management
Cognitive Symptoms

• Most severe immediately following injury, measurable improvement within hours
• Gradual improvement occurs up to ~7 days for most individuals
• Memory most susceptible to change but shows complete recovery within days
• Frank cognitive abnormalities are not common
Misattribution: PCS Sx are present in numerous groups resulting in attribution problems, sometimes to pre-existing issues

<table>
<thead>
<tr>
<th></th>
<th>Headache</th>
<th>Dizziness</th>
<th>Irritability</th>
<th>Memory Problems</th>
<th>Concentration Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>College Students</td>
<td>36%</td>
<td>18%</td>
<td>36%</td>
<td>17%</td>
<td>42%</td>
</tr>
<tr>
<td>Chronic Pain Pts.</td>
<td>80%</td>
<td>67%</td>
<td>49%</td>
<td>33%</td>
<td>63%</td>
</tr>
<tr>
<td>Depressed Pts.</td>
<td>37%</td>
<td>20%</td>
<td>52%</td>
<td>25%</td>
<td>54%</td>
</tr>
<tr>
<td>Personal Injury Claimants (non TBI)</td>
<td>77%</td>
<td>41%</td>
<td>63%</td>
<td>46%</td>
<td>71%</td>
</tr>
<tr>
<td>MTBI</td>
<td>42%</td>
<td>26%</td>
<td>28%</td>
<td>36%</td>
<td>25%</td>
</tr>
</tbody>
</table>
$64,000 questions:

• Have symptoms worsened with time?
• Are symptoms more persistent than expected with this diagnosis?
• Inconsistency from one evaluation to the next and problems worsen during times of emotional stress
If yes, then . . .

- Assess for complicating factors, including pre-existing conditions.
- Depression (Adjustment Reaction, Major Depressive Episode)
- Posttraumatic Stress Disorder (PTSD)
- Somatic Disorders
- Malingering
Part 3: Validity
Definition of malingering:

• For an external goal, an individual deliberately fabricates a symptom.
Attribution of problems

- Attributing an illness or symptom to the wrong cause is also a type of malingering. Sometimes seen in workers’ compensation claims.
Rates of malingering/ exaggeration of cognitive impairment:

- Personal Injury: 29%
- Disability: 30%
- Fibromyalgia/CFS: 35%
- Chronic fatigue: 35%
- Chronic pain: 31%
- Mild head injury: 39%


©PsyBar LLC 2015. All rights reserved.
Can have both cognitive impairment and deception

- Most claimants probably accurately report their psychiatric symptoms.

- “Gilding the lily” for insurance reimbursement.

- Tough forIME examiners to see genuinely impaired people who exaggerate.
Can have both cognitive impairment and defensiveness

- Embarrassment about brain injury or other problems.

- Claimants might conceal the true cause of their problems, such as a brain injury, out of embarrassment.
False appearance of defensiveness

• Brain injury (many don’t realize the extent of their injuries).

• Importance of collateral interviews, objective psychological testing, careful records review, and observation. (Often critical in determining new versus pre-existing)
Clinical Judgment/ “intuitional” perspective

• “I’ve evaluated thousands of patients over 30 years and I know a faker when I see one. Why do I need psychological tests?”
Clinical judgment/ “intuitional” perspective

- Myth: With an interview, a psychologist or psychiatrist, using many years of clinical knowledge, can consistently identify those individuals who are deceptive.
Clinical judgment/ “intuitional” perspective

• Fact: There is little, if any, credible evidence that experienced mental health professionals are able, across a variety of situations, to reliably identify deception using clinical judgment alone.
Treating doctors:

• Assumption of truthfulness from their patients.

• Don’t necessarily develop the skills to assess this according to forensic standards.
Objective testing:

- Over a hundred years of research on objective psychological testing has demonstrated that it can often measure skills and behavior more accurately than can the most skilled clinicians.
Objective psychological testing is often critical in resolving these claims.
Objective testing:

• Usually desirable for the psychologist or psychiatrist to rely in part on objective psychological test results to assess deception and determine the onset of the problems.
Test of Memory Malingering

• 15 minutes long and requires claimant to remember simple drawings
• Claimants who are not putting forth full effort receives scores lower than those obtained by patients with genuine neuropsychological problems
• Correct classification rate is approximately 80%
Validity Indicator Profile

• Sophisticated computer-scored test
• Cannot be used with individuals who are severely cognitive impaired
• Both verbal and visual portions
• Approximately 77% correct classification rate
How to ask questions about causation and validity:

• Avoid leading questions.

• Unintentionally, Independent Examiners might be influenced by leading questions.

• Even when Independent Examiners impartially answer leading questions, those responses are vulnerable to challenges during litigation.
Referral question

• Rather than directly asking about “malingering:”

• Please explain how your sources of evidence above are consistent or inconsistent with each other. For example, is the examinee self-report consistent with your observations and with test data? (Questions © PsyBar 2006 -2016)
Tests designed to help assess for deception of psychological symptoms, such as depression and anxiety:
MMPI-2 and MMPI-2-RF

- Revised throughout the 1980s
- Examines validity of reports of psychological disturbance (not specifically designed to evaluate truthfulness regarding neuropsychological dysfunction)
- Evaluates areas such as depression, anxiety, attitude towards work and psychotherapy, tendency to report physical problems when under emotional stress, and self-confidence.
MMPI-2 and MMPI-2-RF

• Also useful in detecting defensiveness, or “downplaying” the severity of symptoms.
MMPI-2 and MMPI-2-RF
MMPI-II

- Not specifically designed for medical populations
- Contains some of the best (sub) tests to assess malingering of psychiatric problems.
- Can over-estimate psychological problems in medical patients
• To compensate for the MMPI’s shortcoming, objectively compare claimant’s psychiatric distress and other complaints to those of others who are undergoing physical rehabilitation using the BHI-2:
Battery for Health Improvement 2

• Compares claimant to many people with substantiated physical problems and to healthy individuals.

• Does not overpathologize what is normal for medical patients.

• Has measures of validity. (Measures symptom minimization and magnification).

• 217 items
Battery for Health Improvement 2 measures affective factors:

- Depression
- Anxiety
- Hostility
Battery for Health Improvement 2 measures character factors:

- Borderline (a range of personality disorders) (Often pre-existing)
- Symptom Dependency (use of symptoms for secondary gain) (Sometimes pre-existing)
- Chronic Maladjustment (Often pre-existing)
- Perseverance
- Substance Abuse (claimant report only)
Battery for Health Improvement 2 measures psychosocial factors:

- Family Dysfunction (identifies potentially enabling tendencies that might undermine functionality)
- Job Dissatisfaction (avoidance might be source of secondary gain)
- Doctor Dissatisfaction
Battery for Health Improvement 2 measures general Physical symptoms:

- Somatic Complaints (Somatic preoccupation often pre-existing)
- Pain Complaints (Claimants’ perception of pain in 10 body areas often pre-existing)
- Functional Complaints (Claimants’ perception of own limitations)
- Muscular Bracing (Claimant perception of muscular tightness)
Structured Interview of Reported symptoms (1992)

• Designed to assess feigning (The deliberate production of psychological symptoms. The purpose, or goal, is not known).
Personality Assessment Inventory (PAI)

- Well researched and designed test
- Not used as frequently as the MMPI-2
- Has standardized cut-off scales for feigning.
• Tests designed to help assess for deception of cognitive symptoms, such as problems with memory and concentration
TOMM

• 15 minutes long and requires claimant to remember simple drawings
• Claimants who are not putting forth full effort receives scores lower than those obtained by patients with genuine neuropsychological problems
• Easily hand scored
• Classification rate approximately 80%
Validity Indicator Profile (1997)

- Sophisticated computer-scored test
- Assesses suboptimal effort.
- Cannot be used with individuals who are severely cognitive impaired
- Both verbal and visual portions.
- Approximately 77% correct classification rate.
When does it make sense to use more than one test to evaluate deception?

• Usually, as multiple validity tests recommended throughout long assessments.
How to request Specific Psychological Tests

• Very diplomatically
• Don’t tell the psychologist what to do
• Focus more on defining the problem to be answered and working with the psychologist about the best tests to use
• Very complex process, taking into consideration test validity/reliability, examinee age, sex, capabilities, etc.
"Whatever it is, I didn't do it."
Projective tests that, when used alone, might confuse issue of traumatic vs. pre-existing:

• Rorschach ("Inkblots")
• TAT (Telling stories about pictures)
• House-tree Person ("Draw a house, a tree, and a person")
• Incomplete Sentences (e.g. "When I was young, my mother used to....")
Where are your employees located?