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EFFORT TESTING IN FORENSIC VOCATIONAL ASSESSMENT

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As contributors to [Assessment of Feigned Cognitive Impairment](#), Stone and Boone (2007) offer a provocative and noteworthy outline regarding the feigning of physical, psychiatric, and cognitive symptoms found in history, literature, film/television, and even the animal kingdom, to argue that deception is not necessarily deviant but indeed fundamental to survival. Stone and Boone present a range of anecdotes and cultural reflections of symptom fabrication ranging from the well-known example of the opossum lying on its side with its mouth open in the presence of a predator, “playing possum,” to ancient Egyptian poetry of faking illness:

I think I'll go home and lie very still
feigning terminal illness.
Then the neighbors will all troop over to stare,
my love, perhaps, among them.
How she'll smile while the specialists
snarl in their teeth!
She perfectly well knows what ails me.
(Stone, 2007, p.5)

One is left to conclude that feigning is not a rare, aberrant phenomenon, but indeed a natural human behavior of perseverance under perceived psychosocial threat. Silver (2012) writes, “Although most individuals who suffer a mild traumatic brain injury have complete recovery, a number experience persistent symptoms that appear inconsistent with the severity of the injury. Symptoms may be ascribed to malingering, exaggeration or poor effort on cognitive testing.”

Silver goes on to propose that post-concussion symptoms can be the result of social and economic factors, “...previously unconsidered multiple factors may result in symptom magnification (either increased symptom reporting or misattribution of symptoms) or poor effort, and the incorrect interpretation that these are conscious efforts and malingering. Poor effort and exaggeration are not categorical values, but are complex and multi-determined and have a differential diagnosis of their own. Some factors are intrinsic to the circumstances of the injury or the evaluation process. Others are well-described phenomena that are ubiquitous, and found in common human relationships and reactions.”

Forensic or court-related vocational disability evaluation secondary to a person's diagnosis of mild traumatic brain injury (mTBI) can be a challenge because the condition itself is amorphous. Well-accepted classifications (Iverson & Lange, 2012) document that mTBI may involve a brief period of unconsciousness (less than 30 minutes or none at all), a Glasgow Coma Scale score of 13 to 15 (with 15 being normal), and post-traumatic amnesia of less than 24 hours.

By definition, uncomplicated mTBI, which is injury absent macroscopic, structural, trauma-related abnormalities visible on computed tomography or magnetic resonance imaging, is of short duration. Williams, Levin, and Eisenberg (1990) noted that patients with complicated mTBIs are more likely to have worse cognitive functioning acutely, compared to uncomplicated mTBI, and need six months for functional recovery. Whether complicated or uncomplicated, symptoms of mTBI are of brief duration in the various classifications of brain injury and generally do not result in permanent deficits or disabling sequela.

Regardless of mTBI classifications at the onset, it is also thought that a percentage of individuals can experience, or at least claim, continuing biopsychosocial deficits following minor head trauma or concussion, and these post-concussion deficits or limitations may interfere with their employability. However, evaluations of employability and associated earning power are nonmedical concepts explained in part by the important distinction between medical impairment and vocational disability.

Impairment is defined by the American Medical Association (Cocchiarella & Andersson, 1971/2004) as the loss, loss of use, or derangement of any body part, system, or function. According to [Walker and Krauss \(2016\)](#), disability evaluation integrates medical, psychological, social, cultural, educational, vocational, and psychometric data into an assessment process that explains the effects of medical impairment on an individual's occupational capabilities.

Regardless of the etiology, individuals with mTBIs do enter litigation with continuing complaints and possibly medical support for the argument that they are permanently impaired. Forensic vocational disability evaluation, often in conjunction with other forms of assessment including neuropsychological evaluation, is the primary means of determining the occupational consequences of mTBI.

Forensic vocational disability assessments, those conducted for court-related matters, ideally include a battery of standardized tests, and optimally, the test battery includes measures of subject effort or test-taking validity, especially when the acquired test data do not coincide with expectations given the examinee's documented health, educational background, school performance, work history, and demonstrated skills. [Walker and Heffner \(2011\)](#) outline the importance of standardized testing during forensic vocational disability evaluation, which can be limited by the number of contacts the evaluator has with the subject of the assessment. More often than not, when retained by the defendant in a lawsuit, the forensic vocational disability examiner has only one opportunity to interview and test the examinee. As a result, the assessment needs to be as thorough as possible, including measures of the test-taker's effort, if necessary.

Standardized test batteries that include measures of test-taking validity can provide a perspective on the examinee's effort during an assessment and whether the standardized test data are truly representative of the person's potentials. In this article, we explore value and appropriate use of effort testing in forensic vocational disability assessments.

Forensic vocational disability evaluations are generally designed to answer questions regarding occupational disability, residual employability, and earning power. Culling relevant material from available records, including medical documentation, employment files, and deposition testimony, is important. Further gathering of information through observation and interview is often critical. However, the examination findings are generally enhanced with the qualitative and quantitative data generated by standardized test administration.

Walker and Heffner (2011) and Walker and Krauss (2016) among others have discussed the value of standardized vocational testing in forensic assessment. Meyer and colleagues (2001) point out the many benefits of standardized testing as a method of assessment and demonstrate statistically that many published measures are as reliable as medical tests, including x-rays and CT scans. However, tests of ability, aptitude, and personality can be distorted by limited effort or purposeful exaggeration. After all, even a medical imaging study can be considered suboptimal by patient movement during the study. Patient movement during an anatomical imaging study indeed may serve as a metaphor for suboptimal test-taking effort and response manipulation.

McLaughlin and Walker (2008) assert that because of the wide variations in job descriptions and demands, a person's work history alone does not ensure that the individual being evaluated has acquired specific skills. Moreover, it has been the experience of well-trained vocational evaluators that individuals with particular work histories can possess dramatically different skill sets and worker characteristics, attributes that may be reflected in standardized test performance. One could simply perform a "transferability of skills" analysis on the basis of a person's work history. However, not all longshoremen are *simply* longshoremen. Some longshoremen, by virtue of their work experience, do not need to read or write, but to assume from their work experience alone that they cannot process information requiring reading and writing could potentially be a major assessment error.

The assumption that a longshoreman is only interested in and able to work with objects and things because he has manually and mechanically unloaded ships and done nothing else in his employment, could be fraught with miscalculation of alternative occupational potential. In the 1960s through the 1980s, a longshoreman, Harvey Jackins, wrote or collaborated on approximately ten books and made a seminal contribution to a new form of counseling and psychotherapy called Re-Evaluation Counseling. Surely, Jackins did not fit the stereotype. Standardized testing can yield greater, and often times, more predictive data regarding an individual's residual employability than so-called Transferability of Skills Assessment (TSA), especially when the examinee has been medically restricted to lower levels of physical demand, such as sedentary or light work (Dunn & Cain, 2001).

In mTBI cases, neuropsychological evaluation is generally designed to assess brain behavior, functional deficits, and post-injury cognitive capabilities. Vocational disability evaluation intends to describe work behaviors and occupational potential following the onset of disease or injury, including mTBI. Although mTBI can produce impairment, the functional deficits are self-limited and by definition, of relatively short duration. Generally, individuals with mTBI recover over a three-month period and can return to work despite the possibility of persistent minor symptoms (Kushner, 1998).

However, it is well-documented that the context of the evaluation is critically important. Litigations associated with workers' compensation and personal injury claims are potential incentives for poor test-taking effort or exaggerating symptoms and problems during a disability evaluation. Researchers have found that approximately one third of patients seeking disability benefits fail effort testing (Gervais, Green, Allen, & Iverson, 2001). In one study, over 30,000 cases were reviewed, and it was found that 29 percent of personal injury cases and 30 percent of disability cases had probable

malingering and symptom exaggeration (Mittenberg, Patton, Canyock, & Condit, 2002). Effort and symptom validity testing are not necessarily used to “diagnose” malingering or feigning. Actually, those determinations, the feigning of symptoms and/or malingering occupational disability, should be left to psychological and/or psychiatric investigations.

During vocational assessment, effort test findings should be used to clarify the validity of other psychometric results administered during the examination. If an individual is inconsistent or deceptive in response to measures of effort, the evaluator may need to conclude that the examinee set forth less than complete effort or inconsistent responses to other measures within the test battery. The vocational assessment may have been invalidated or sabotaged. As a result, the examinee may need to be referred for more extensive evaluation of feigning or symptom fabrication. We must not lose sight of the importance of effort testing during forensic vocational assessment in matters of mTBI, or any case in which deception or submaximal effort may be a possibility.

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To Assist, Not to Control: Looking at Assistive Technologies

How many psychotherapists does it take to change a light bulb? One, but the light bulb has to want to change. Not unlike that light bulb, the recipients of assistive technologies must desire to work effectively in their fields if the technologies are to be effective. At least that is what members of the National Academies of Sciences, Engineering, and Medicine found in their report titled "[The Promise of Assistive Technology to Enhance Activity and Work Participation.](#)" If certain factors were not met, members of the academies concluded, assistive technologies did not have as great an impact on the individual's ability to return to work. Those factors included: making assistive technologies readily available; properly prescribing, fitting, and training for the use of the devices; undertaking appropriate follow-up to ensure positive progress; and diminishing social as well as environmental lifestyle barriers.

The [Job Accommodation Network](#) (JAN) is a helpful resource that individuals can use to research assistive technologies that can best help them or their employees. For example, when it comes to managing the symptoms of mTBI in the workplace, JAN recommends accommodations including electronic organizers, memory software, noise canceling headsets, and alternative lighting. There are other community resources available, such as the assistive technology fair that students at Penn State DuBois held in the fall of 2018 to introduce individuals with disabilities to available technologies and train them on their uses. All in all, the assistive technologies do not perform 100 percent of the work. The individual has to want to change.

Psychological Help on Climate Change

It is now understood that there is a link between climate change and psychology in both finding solutions to this problem as well as coping with the effects of a warming world. Robert Gifford, Ph.D., a psychologist from the University of Victoria, British Columbia, says, "[Climate change is a human problem. It's the result of 7.6 billion people making decisions every single day. That right there makes it a psychological problem.](#)"

Psychologists are beginning to address the impact of everyday decisions humans make on the climate. They have worked towards behavioral changes, environmental decision making, and how to effectively communicate pro-environmental messages as solutions to the issue.

The link between psychology and climate change is recognized by the Intergovernmental Panel on Climate Change (IPCC) of the United Nations. The IPCC plans to include psychological opinions on their next report due in 2021. Psychologists are also involved to bridge divides between the various branches of science that are attempting to reduce the effects of climate change. As it is a divisive and complex issue, scientists often find themselves in need of a mediator to work toward a solution. Psychologists have become a crucial part in humanity's defense against changing climates.

A Battle Worth Fighting: Reducing Gun Violence in the United States

Since 1968, there have been more gun-related deaths in the United States than on any battlefield the country has fought. This is a problem that the American College of Physicians (ACP) is seeking to solve through a combination of education and advice.

A [new study](#) from the ACP has found that many Americans maintain misconceptions in regard to deaths related to gun violence. Between 2014 and 2015, the number of suicides was greater than homicides in every state, with suicide by firearm being the most prevalent cause of violent death in 29 states. Most people, including medical professionals, are misinformed of the true nature of gun violence in America. For example, of 3,811 respondents to a survey conducted and published in the *Annals of Internal Medicine*, 13.5% of Americans correctly identified the most frequent cause of violent death in their state.

In the [Annals of Internal Medicine](#), the ACP has published recommendations to reduce gun violence, encompassing a “multifaceted and comprehensive approach to reducing firearm violence that is consistent with the Second Amendment.” ACP's suggestions to reduce gun violence include: advocating child access prevention laws to ensure the safe storage of firearms; supporting enactment of extreme risk protection order laws that allow families and law enforcement to petition courts in order to temporarily remove firearms from individuals that are identified as risks (i.e., laws already in effect in Connecticut, Indiana, California, Washington, and Oregon); and encouraging legislation that bans the manufacture, sale, transfer, and ownership of semi and fully automatic weapons as well as large capacity magazines. Furthermore, the ACP advocates access to mental health services, and professionals are urged to regularly ask patients if they have guns in their home and to counsel them on gun safety. An end to gun violence is a battle worth fighting and can be won through expansive conversation and education.

In related news, a physician, working at the West Palm Beach Veterans Affairs Medical Center in Riviera Beach, Florida, is being called a hero after jumping in front of an armed gunman who opened fire in the emergency department on the evening of February 27, 2019. Read more of the story in [The New York Post](#).