Mind Games

How the Neuropsychologist Expert Supports the Defense in TBI Claims

By David Pingitore

Neuropsychologists can now demonstrate that the vast majority of individuals quickly recover from the effects of mild traumatic brain injury.

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Brandon Woodard and Gregory Kendall's fall 2015 article, "Parameters for In-House Counsel and Claims Professionals," outline the unique challenges for defendants in successfully litigating traumatic brain injury claims.

This article follows up on the astute observations and practical strategies for defense attorneys and claims professionals made by the authors. It is offered by a board-certified clinical

psychologist and practicing neuropsychologist with two decades' experience conducting neuropsychological and psychological examinations for defense attorneys and claims administrators.

Mild Traumatic Brain Injury: The Medical Evidence

Plaintiff attorneys routinely assert that their client warrants a diagnosis of traumatic brain injury without adequate foundation of either the diagnostic criteria or the natural history of the injury.

A person may have suffered a concussion with any number of symptoms, such as dizziness, nausea or of being "stunned." This event is different from a mild traumatic brain injury, as defined by the U.S. Department of Defense, which requires the person to have a period of post traumatic amnesia, loss of consciousness, a Glasgow Coma Scale score, and evidence of having undergone some neuro-imagery study. A diagnosis of mild "TBI," or traumatic brain injury, is made at the time of injury and not at some time in the distant future; the latter is a claim offered by plaintiff attorneys who may conveniently avoid documenting any post-injury history that may have a bearing on a case.

There is now at your disposal a large body of medical and neuropsychological evidence that demonstrates the recovery rates for persons who have suffered mild traumatic brain injury. In addition, this evidence documents the minimal neuropsychological deficits that may remain

from mild traumatic brain injury. Neuropsychologists have at our disposal three definitive sources to rely on when assessing the presence of mild TBI: (1) studies from NCAA collegiate football players; (2) studies involving long-term neuropsychological effects from veterans who served and were injured in the Vietnam War; and (3) studies from veterans who were exposed to mild and moderate traumatic brain injury during this country's recent military engagements in the Middle East.

This evidence convincingly demonstrates that the only lasting neuropsychological effects of mild traumatic brain injuries are in the area of auditory attention, working memory, neurological deficits such as gait disturbance, and some executive function problems. Additional research conducted among recent combatants highlighted that subjects' other claimed deficits are likely not due to traumatic brain injury. These neurocognitive deficits have been found to be due to posttraumatic stress disorder, anxiety, or preexisting personality disorders. Competent neuropsychologists use these research conclusions not to "blame the person," but to demonstrate that presumed neuropsychological impairments from a single incident TBI is more complicated and multidimensional than what is presented by a plaintiff.

Defense expert neuropsychologists are now in the position to demonstrate that the vast majority of individuals recover quickly from the unique physiological effects of mild traumatic brain injury. This point is illustrated by studies of collegiate football players who have suffered a single concussion. Their recovery time is typically from three to seven days. Of course, the

particulars of a case require a defense neuropsychologist to examine all aspects of the particular plaintiff's current level of functioning and not force the characteristics of the case into the box of research studies.

It is incumbent upon defense attorneys and claims administrators to have their expert conduct a thorough records review to determine the presence of preexisting psychopathology. As noted above, neuropsychologists retained by defense counsel should conduct a thorough records review, clinical examination and undertake a personality assessment to document whether a plaintiff, who may be a veteran or was exposed to traumatic-like events, has suffered other conditions that mimic traumatic brain injuries.

Refute the "Miserable Minority" Theory

Plaintiff attorneys need to provide evidence that surmounts the research-derived bar that a client's impairments suggest permanent brain damage as opposed to temporary dysfunctions. Plaintiff attorneys often argue that a client is a member of the "miserable minority." That is, the client is among the tiny percentage of individuals who may have lingering neuropsychological deficits after a traumatic brain injury.

Yet, that research needs to be carefully examined and understood by a defense neuropsychologist. The defense expert should be in a position to argue that the "miserable minority" is really a "*questionable minority*." That is, the patient samples that served as the basis

for these studies included persons who were involved in litigation or were suspected of exaggerating symptoms. Such persons cannot in any manner be reliably used to make a claim on the prevalence of chronic neuropsychological deficits in a person with suspected mild TBI.

There is evidence to suggest that mild traumatic brain injury can result in an increased likelihood of eventual neurodegenerative conditions such as Parkinson's disease. The recent study conducted by Rachel Gardner and colleagues and published in the *Annals of Neurology* has documented the increased likelihood of a person suffering from Parkinson's disease who presented to an emergency room for evaluation after a single traumatic brain injury. While this may be the case for hospital-evaluated patients, the defense nonetheless has a tool at its disposal in such a case. For example, defense neuropsychologists can review records, take a history of a plaintiff, and examine them to determine whether the plaintiff exhibited Parkinson's disease *before* the presumed accident. If this is the case, the traumatic brain injury was a result of the underlying neurodegenerative condition and not due to the events that are the basis for the claim.

Case Example: The examination of a plaintiff from my practice illustrates key injury and examination—specific issues that neuropsychologists should address for defense counsel. This case involves a mid-50s-year-old laboratory scientist employed at a university who was the victim of a motor vehicle-on-bicycle accident. In my first examination, he displayed typical symptoms of short-term memory loss and executive functioning problems. He passed symptom validity testing and remained employed for the next year and a half. In my second examination

the plaintiff did not pass symptom validity testing. Equally important, his scores on tests of visual memory were lower than what he scored in the first examination. Persons with mild TIBI do not exhibit a decline over time in memory functioning that can be attributed to the initial injury. Furthermore, his performance on visual memory testing was at odds with how well he performed his activities of daily living, such as riding his bike on lengthy trips. I found him not to warrant any award due to multiple reasons. Persons with mild TBI do not experience a decline in cognitive functions over time, all things being equal, and his performance on assessment was in contradiction to his activities of daily living.

Test More than Memory

A full and competent neuropsychological evaluation involves more than memory testing. The neuropsychological report produced by either a plaintiff or a defense neuropsychologist should include an assessment of all the major neuropsychological functions. I conceptualize neuropsychological assessment to the parties in the following manner:

> If you consider the human brain and mind as a house with many rooms in it, the purpose of a neuropsychological assessment is to evaluate the strengths and limitations of each of those rooms. The purpose of such assessment is to determine how those rooms operate by themselves and also how they operate in conjunction with the other rooms of the house.

A full and competent neuropsychological assessment should include an examination of speech and language, attention, memory in its verbal and visual realm, sensory and motor functions, and executive functions and assess for the presence of psychopathology. With respect to such assessments, it is important to ensure that a plaintiff's neuropsychologist has not committed a Type I error: that is, assigning causation where none exists. If a plaintiff's neuropsychologist uses a large and redundant battery of tests and makes a traumatic brain injury conclusion on one or two test scores, this is an example of attributing causation when none may exist. Most persons exhibit average or below average functions as measured on some neuropsychological test. However, the key issues for defense counsel and claims administrators are these: (1) are the limitations generally known to relate to traumatic brain injury; and (2) are the limitations significantly different from the claimant's peers or their own prior functioning?

Evaluate Plaintiff Effort and Symptom Validity

The neuropsychological literature includes an impressive array of studies on symptom validity and effort as they relate to forensic assessment. Symptom validity and effort involve the measure of response bias in a claimant, meaning the conscious or nonconscious production of over reporting or underreporting of symptoms.

Symptom validity testing is vital in any forensic assessment but particularly in neuropsychological assessment of presumed neurocognitive impairment. Simply put, the purpose

of any forensic neuropsychological assessment is to measure the cognitive and personality functions of a claimant. If response bias is present—to any degree—that objective cannot be attained. In other words, what does the objective data obtained from a plaintiff say about the presence of any response bias?

Effort on testing offered by a plaintiff is different from the measurement of symptom validity. Effort on testing is simply that: the ability to engage accurately and efficiently in simple, easy tests that all people can perform. Symptom validity, on the other hand, is measuring with external criteria the truthfulness of reported symptoms or complaints on a variety of neuropsychological functions. The current standard among neuropsychologists is to administer a minimum of four tests of effort and symptom validity throughout an exam. These tests can include freestanding tests, which are independently constructed and published, or "embedded tests." which are measures of symptom validity that are contained within a particular neuropsychological test. In addition, neuropsychologists need to be conversant with the evidence on the role of medications and diagnosis on performance in symptom-validity tests. This issue is often complicated by plaintiffs who have orthopedic issues that may have resulted from an injury. Such persons may need to take medications on the date of the examination. However, the research suggests that anxiety or antidepressant medications and the conditions that these medications treat do not interfere with performance on symptom-validity tests. Hence, any

presumed failure on testing that a plaintiff's attorney attributes to these medications or conditions is questionable and such performance should be considered as poor effort or invalidity.

Case Example **:** The standard practice of administering symptom-validity testing is borne out by the results of this case, for which a second examiner failed to administer any such tests. The case involved a farm laborer who was struck in the face by a malfunctioning conveyor belt that caused a large and heavy metal chain to strike the person in the face. He suffered extensive dental trauma and a back injury from the force of the accident and a fall. However he returned to work one year after the accident but then complained of head trauma and cognitive impairment.

The examining neurologist did not conduct any symptom-validity testing. More alarmingly, in the course of offering a 60-page report, the examiner concluded that because the person seemingly could not add 1+1+1, that was evidence that the plaintiff was depressed as a result of his reported cognitive impairment. In such a case a defense expert can easily dismantle that opinion by citing the published evidence that documents that both persons with moderate to severe brain trauma and persons with mild dementia demonstrate adequate mental arithmetic skills. In my examination for the defense, I concluded that the person did not offer valid evidence of neuropsychological impairment.

Personality Testing in Mild Traumatic Brain Injury

The aim of personality testing is to provide evidence of both current psychopathology and of longstanding personality characteristics that may have a decisive bearing on a case. Structured tests such as the MMPI-2 and the Millon Inventories, along with unstructured tests similar to the Rorschach inkblot test, offer an expert evidence of response bias on the issues of compensable psychiatric conditions after a traumatic brain injury. It is incumbent upon defense counsel and claims administrators to obtain test raw scores from a plaintiff's examiner. Not having such scores will limit your ability and that of your expert to make a careful assessment of a plaintiff's truthfulness and presumed adverse psychological responses to the incident injury.

Account for the Changing Face of America

All of us are aware of the changing ethnic and racial dynamics of American society. This dynamic has an important, if not decisive, effect on the litigation of mild TBI claims. With increasing frequency, individuals whose dominant language is not English and who have been educated in other countries are filing claims for personal injury involving TBI. It is incumbent upon defense counsel and claims administrators to have a neuropsychologist competent to conduct cross-cultural neuropsychological examinations. Given the increasing percentage of persons in our country of Hispanic background, I recommend that in high-stake claims with a potential, large award to a Spanish-speaking plaintiff that defense counsel and claims

administrators retain a Spanish-speaking neuropsychologist. Professional organizations such as the Hispanic Neuropsychology Society, of which I am a member, can be a potential referral source for such an expert. If retention of a Spanish-speaking expert is not possible or the case is not one that may potentially generate a substantial award, at minimum you should retain a neuropsychologist who is familiar with examining Spanish-speaking persons and who has at his or her disposal tests and measures consistent with this population.

Case Example: I recently conducted a neuropsychological examination of a 52-year-old, Mexican-born laborer who reported suffering a traumatic brain injury secondary to a fall from a tree. The consulting neuropsychologist who evaluated the claimant diagnosed the person with mild traumatic brain injury. Furthermore, he dramatically stated to the claimant that “you will never be able to work again.” In my examination, I found that the plaintiff had virtually no formal education. Obtaining evidence of the plaintiff’s level of education is decisive in neuropsychological evaluation because the research convincingly demonstrates that education is a significant predictor of performance levels on most measures of neuropsychological functioning. When I examined the plaintiff and compared his performance to his peers, that is, his age group and persons with his total years of education, I found that on all neuropsychological measures his performance was within normal limits. There was no evidence that he has suffered any loss of functions as a result of the incident. Furthermore, I concluded

that the consulting neuropsychologist's statement that the plaintiff would never work again sent the claimant into an emotional tailspin and increased his depression.

Defense neuropsychologists should have at their disposal culturally specific measures to assess these clients. There are now published norms on a wide range of neuropsychological measures that defense experts can use to compare the performance of a plaintiff with his or her normal functioning peers.

A Convenient Solution

It is my experience that litigants in traumatic brain injury and other types of claims use the presumed head injury as a "convenient solution" to their presumed and oftentimes evident personal problems. That is, plaintiffs frequently avoid or otherwise deny preexisting family conflicts and personal problems and seek to attribute all of their present emotional and neuropsychological distress to an incident event. In these cases, the plaintiff is not so much deliberately exaggerating his or her symptoms for financial gain. He or she is unconsciously avoiding the emotional challenge of confronting his or her personal life and how the life conflicts or losses are the source of his or her distress.

Case Example: A middle-aged woman claimed traumatic brain injury after being injured in the head and upper extremity while visiting a casino. This plaintiff reported that their complaints of headache, shoulder pain, short-term memory, and concentration problems were

due solely to the incident event. In my records review and examination, it was found that the plaintiff had a significant history of anxiety disorder with routine visits to the Emergency Room. Furthermore, there was a recent history of marital indiscretion that resulted in the near divorce of the plaintiff from the spouse and subsequent entry into marital therapy. I successfully argued that the incident head injury served as a "convenient solution" for the plaintiff. That is, the TBI claim provided a means for the plaintiff to avoid examining the more difficult family conflicts that had nothing to do with the presumed claim.

This case illustrates that a defense expert's approach should be to offer an opinion on both how a *plaintiff is and also how the plaintiff was*. In that regard, a plaintiff's medical history is crucial and should be examined in detail by the defense neuropsychologist. Medical records are of particular relevance and should be thoroughly reviewed for any evidence that the claimant had preexisting psychological problems. The expert's examination approach to this history is crucial. In that regard, reports from both the defense and the plaintiff neuropsychologist should not be limited to a few sentences regarding prior psychosocial history, but it should involve a detailed and careful examination with a focus on the plaintiff's psychological and cognitive functioning across the lifespan. The defense expert's questions on examination should be nonchalant and nonthreatening to make the plaintiff "open up and discuss at length" the plaintiff's life. The expert's questions to the claimant should be both open and closed ended to

give the expert as much opportunity as possible to obtain useful information regarding the claimant's preexisting functioning.

Differential Diagnosis

It is difficult in forensic examinations to definitively diagnose malingering. In some instances, the plaintiffs themselves make it easy for an expert to offer that diagnosis. For example, a definitive diagnosis would be easy for person who claims that he or she has never suffered from an alcohol problem and is requesting an award for a traumatic brain injury claim, when in fact the records indicate that he or she has a long history of inpatient substance abuse treatment.

A more substantial and difficult diagnostic question is whether a person is exaggerating symptoms from a presumed TBI or does the person demonstrate symptoms that suggest a different diagnosis, such as a somatoform disorder. The latter condition involves either vague or specific physical complaints (headache pain, GI discomfort, problems with the sexual response cycle, among others) that are not attributable to exact organic damage. It is useful for defense counsel and claims administrators to understand that persons with somatoform disorders are often deceiving themselves, whereas individuals who are exaggerating claims for financial gain are trying to deceive others. The neuropsychologist Kyle Boone (2016) has provided an excellent outline of the differential diagnosis of malingering versus somatoform disorders in the medical-

legal arena. She has suggested that there is a particular pattern of neuropsychological test scores and history found among malingerers versus a different pattern of scores and history for somaticizing patients that should be considered by defense neuropsychologists. For example, somaticizing patients present with the "invalid role," while malingerers present with the "victim" role, attributing many or all of their complaints on the defendants, doctors, and others.

Conclusion

Defendants should not throw in the towel and offer a quick settlement to plaintiffs in cases of presumed mild TBI. Your perseverance in addressing these complaints is best served by selecting experts who are familiar with mild TBI litigants and who have at their disposal a wide armamentarium of examination strategies and evidence to rebut these claims successfully.