



Detecting Symptom- and Test-Coached Simulators with the Test of Memory Malinger[☆]

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Abstract

The ability of the Test of Memory Malinger (TOMM; Tombaugh, 1996) to detect feigned-memory impairment was explored. The TOMM was administered to three groups: (a) a control group instructed to perform optimally, (b) a symptom-coached group instructed to feign memory problems after being educated about traumatic brain injury symptomatology, and (c) a test-coached group instructed to feign memory problems after being educated about test-taking strategies to avoid detection. The recommended cutoff scores (Tombaugh, 1996) on Trial 2 and the Retention Trial produced overall classification accuracy rates of 96%, with high levels of sensitivity and specificity. Although the symptom-coached group performed more poorly on the TOMM relative to the test-coached group, the test was equally sensitive in detecting suboptimal effort across the different coaching paradigms.

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1. Introduction

There has been an emergent body of research over the past decade focusing on the assessment and detection of poor effort within neuropsychological evaluations (Reynolds, 1998). Mild head injured patients involved in litigation have historically served as the primary target for empirical evaluation of poor effort (Binder & Rohling, 1996; Binder & Willis, 1991; Green, Iverson, & Allen, 1999; Langeluddecke & Lucas, 2003). More recent evidence indicates that a variety of other medical, litigious or psychiatric patient populations (e.g., disability claimants or chronic pain syndromes) may also exhibit compromised effort during neuropsychological evaluation (Gervais, Green, Allen, & Iverson, 2001; Gervais et al., 2001; Mittenberg, Patton, Canyock, & Condit, 2002; Rohling, Green, Allen, & Iverson, 2002). Although base rates of symptom exaggeration for any group will vary widely due to methodological and sample characteristics (Reynolds, 1998), a recent survey of American Board of Clinical Neuropsychology members provides benchmark prevalence estimates of suboptimal effort for a variety of patient populations (Mittenberg et al., 2002).

Given the existence of compromised effort and symptom magnification during neuropsychological evaluation, energy has been devoted to the development and validation of symptom-validity tests (SVT). SVTs are measures designed to be insensitive to bonefide neurocognitive deficits and contribute valuable information to the diagnostic process by objectively assessing patient effort. SVTs often use a forced-choice paradigm and function on the premise that symptom exaggerators (a) perceive the task as more difficult than is actually the case, (b) perform worse than severely impaired clinical groups (e.g., severe traumatic brain injured traumatic brain injury patients), or (c) perform at a level worse than chance (Bianchini, Mathias, & Greve, 2001; Williams, 1998). Bianchini et al. (2001) provide a more comprehensive discussion of symptom-validity testing.

The TOMM (Tombaugh, 1996) is a 50-item, two-alternative forced-choice SVT of visual recognition memory investigated in the current study. In a validation study, Tombaugh (1997) administered three trials of the TOMM to community volunteers and various clinical groups (e.g., cognitively impaired, aphasic, traumatic brain injury, and demented patients). Results support the TOMMs insensitivity to neurological dysfunction; 95% of all nondemented patients (91% of all patients), and 100% of normal controls, performed above 45/50 correct (the suggested cutoff) on Trial 2 of the TOMM. The TOMM was also highly successful at differentiating between nonpatient and patient simulators and controls, and was sensitive to poor effort in litigious samples (Rees, Tombaugh, Gansler, & Moczynski, 1998; Tombaugh, 1997). The TOMM has also been shown to be insensitive to clinically significant depression (Rees, Tombaugh, & Boulay, 2001).

As the efficacy of SVTs is dependent on persons being naïve regarding their purpose, the utility of effort measures could be compromised by education or coaching being provided to clients by third parties prior to the evaluation process (Lees-Haley, 1997; Youngjohn, 1995). Such counseling may encourage symptom exaggeration, resistance and defensiveness during the assessment, or increase the sophistication of feigning symptoms. Given the possibility of clients altering their symptom presentation and exhibiting sophisticated test-taking behaviors on instruments following coaching, investigators have attempted to explore how coaching may influence performance on effort measures.

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