February 8, 2013

Hon. Tom A. Coburn, MD
Russell Senate Office Bldg., Room 172
Washington, DC 20510

Re: Use of Symptom Validity Indicators in SSA Psychological and Neuropsychological Evaluations.

Dear Senator Coburn:

The Inter Organizational Practice Committee (IOPC) is a committee of representatives of the American Academy of Clinical Neuropsychology (AACN), Division 40 of the American Psychological Association (APA), the National Academy of Neuropsychology (NAN), and the American Board of Professional Neuropsychology (ABN), tasked with coordinating advocacy efforts between several of the major neuropsychology professional organizations, representing thousands of neuropsychologists in the United States.

We appreciate your efforts to bring science to bear on the Social Security Administration's (SSA's) ill-advised position against formal assessment of symptom validity in consultative examinations (CEs). By way of definition, symptom validity refers to whether an examinee has put forth adequate motivation and effort during the assessment and/or whether they may be feigning or exaggerating symptoms. The tests and measures commonly used in this effort are known as Symptom Validity Tests (SVTs). Results of SVTs alone do not automatically indicate that someone is attempting to obtain benefits fraudulently, but they speak directly to the validity of psychological and neuropsychological assessment results. We offer our support to your efforts.

Members who conduct assessments for the SSA have informed us that over the past few years the SSA has restricted the Disability Determination Service (DDS) and Administrative Law Judges (ALJs) from ordering tests that would help establish the validity of psychological and neuropsychological examinations. We are told that even the use of symptom validity measures embedded within existing reliable and valid personality and neurocognitive tests have now become off limits with SSA. One result of this, for example, is that results from the Minnesota Multiphasic Personality Inventory (MMPI), a long used, highly reliable and valid, and well researched assessment tool, are being dismissed because of its embedded validity indicators. There is absolutely no means of validly administering and interpreting the MMPI without its embedded validity scales. In fact to do so would entail ignoring an existing large body of peer-reviewed research on these validity measures and constitute unethical and irresponsible practice on the part of the psychologist.

Clinical judgment, observations during testing, and other subjective methods to determine an individual's level of effort and motivation during testing have been known for years, and even empirically demonstrated, to be wholly inadequate. Even well-seasoned clinicians are just not good at deciding who is putting forth adequate effort on testing (in all but the most obvious of cases). Research, however, has filled the gap for us. There are literally hundreds of peer-reviewed publications establishing the reliability, validity, and classification accuracy of symptom validity tests and measures. Yet, SSA insists upon these subjective methods instead of proven objective methods of performance validity.

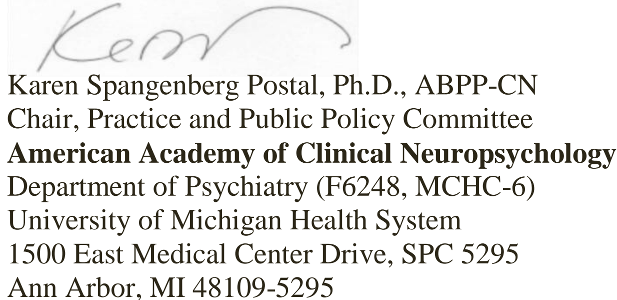
Because of the inadequacy of clinical judgments about performance validity, two of our major professional organizations (AACN, NAN) have issued strongly worded practice guidelines stating that the *failure* to use validity testing in a medicolegal context is considered substandard practice.

Our organizations fully support Dr. Chafetz in advocating against SSA's institutional prohibition against symptom validity testing. We collectively agree that a failure to incorporate symptom validity measures leads to less accurate interpretations of assessment results and has a strong potential to bias our evaluations toward false-positive decisions, allowing a high rate of non-disabled individuals to be paid disability benefits in both the SSDI and SSI programs. These

are costly and unnecessary errors, as you have rightly indicated in your letter to Commissioner Astrue. The private sector recognizes this (i.e., disability insurance carriers), and typically *require* that symptom validity measures (both free standing tests and embedded measures) are administered as part of independent psychological and neuropsychological examinations. In a time of such economic crisis and need for responsible decision making , it does not make sense that measures meant to improve assessment accuracy and, thus, avoid false positive detection of syndromes in need of disability would be summarily dismissed by the SSA.

Thanks again for your time in this matter.

Respectfully,



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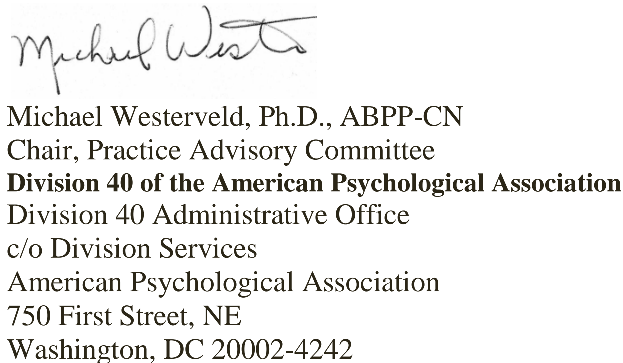

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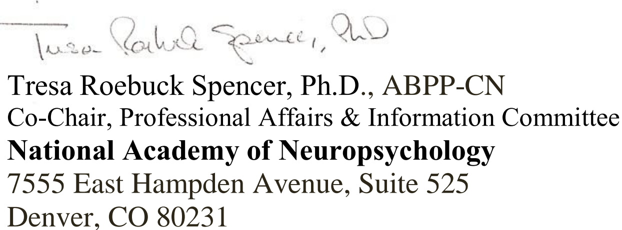

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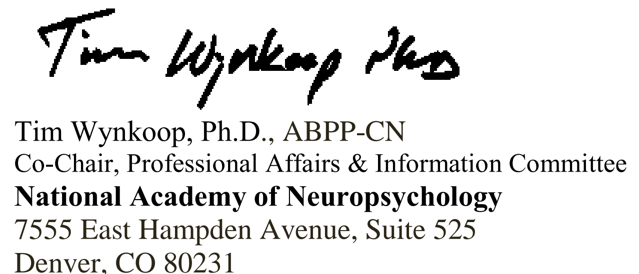

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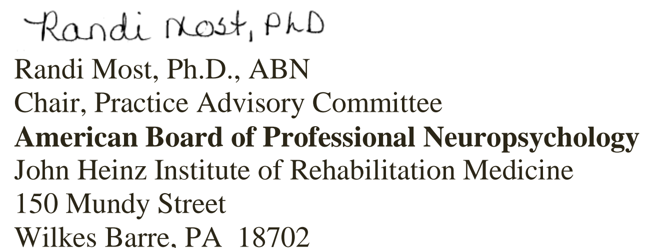

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Cc: Michael Chafetz, Ph.D., ABPP, Clinical Neuropsychologist

References:

Board of Directors (2007): American Academy of Clinical Neuropsychology (AACN) Practice Guidelines for Neuropsychological Assessment and Consultation. *The Clinical Neuropsychologist, 21*:2, 209-231.

Bush, S., Ruff, R., Tröster, A., Barth, J., Koffler, S., Pliskin, N., et al. (2005). Symptom validity assessment: Practice issues and medical necessity NAN Policy & Planning Committee. *Archives of Clinical Neuropsychology, 20*, 419-426.