

Profiles

PUTTING ASSESSMENTS TO WORK

VIP® TEST

VIP® Test Sets New Standard in Forensic Neuropsychology

“Rick Frederick’s work and approach to assessing symptom validity has totally transformed our work in forensics.”

The VIP (Validity Profile Indicator) test by Richard I. Frederick, PhD, was published by NCS Assessments (now Pearson) in late 1997, after more than 7 years in development, and revised in 2003. As a self-administered validity indicator for cognitive assessment, the VIP test is a multi-modal method to help detect malingering and other problematic response styles. In the past six years, the VIP test’s uniqueness, effectiveness and applicability have come to the attention of more and more psychologists who need empirical support for their neuropsychological and forensic examinations and expert testimony.

Stephen D. Sarfaty, PsyD, directs Comprehensive Neuropsychological Services, PC, (CNS) in Chesire, Connecticut. Sarfaty and his colleagues at CNS have been involved with the VIP test for approximately nine years. In the following article, Sarfaty shares his group’s experiences with the test and explains why he believes it is “setting a new standard in forensic neuropsychology.”

The VIP Test Transforms Practice’s Forensic Work

The six doctoral-level neuropsychologists at CNS are a fully-integrated independent group practice that offers comprehensive neuropsychological services across the lifespan. Their services include diagnosis and treatment of central nervous system and general clinical disorders. The practice is 18 years old and they have been a group for a decade. As a result, according to Sarfaty, they have found “an effective balance between the group approach and the individual approach and are in general agreement on clinical and forensic practice.”

CNS associates strongly agree on the value of a symptom validity assessment protocol, especially as they were increasingly called to testify in forensic cases. “The VIP test is universally accepted in our practice,” says Sarfaty, “and about half of the current practice members were involved in the formative stages of the test.”

Their involvement began after Sarfaty read a 1991 research article by Frederick. He called Frederick the next day and expressed enthusiasm. At that point Frederick was looking for additional validation data on neuroimpaired and forensic populations—the types of patients available through CNS.

“Our mutual interest was natural because we wanted to broaden and strengthen our symptom validity assessment capabilities and he needed the data we could provide,” Sarfaty said.

Protocols were established through Frederick's research and ethics committee and CNS began collecting the data for Frederick. When NCS Assessments became involved, CNS was able to extend their data collection to additional populations with NCS Assessments' research and technical support. "Rick Frederick's work and approach to assessing symptom validity has totally transformed our work in forensics."

"We have continually benefited from the scope of Rick's innovation, creativity, and knowledge with respect to procedures that evaluate the validity of cognitive assessments," stated Sarfaty.

"In short, he's done his homework."

Empirical Foundation Helps Redefine Biased Responding

Frederick's "homework," as Sarfaty calls it, involves a statistical and mathematical foundation that "brings the validation of the detection of feigned cognitive impairment to a new level." Frederick's work, he believes, helps demonstrate that "biased responding is not a simple dichotomous distinction between valid responding and malingering."

The VIP test uniquely includes a hierarchy of difficulty in forced-choice questions. The hierarchy of item difficulty helps quantify a respondent's level of effort and motivation and differentiate the "realm of factors that don't qualify as a suppressed response style, but nonetheless characterize patterns of inconsistent or irrelevant responding which are also invalid."

The test's performance curve analysis graphs a respondent's performance on test items by ascending order of item difficulty. One line on the graph depicts the respondent's expected performance assuming a compliant test-taking behavior. The second line illustrates the actual performance. For respondents with compliant response styles, the expected and actual performance lines will be similar. The two lines deviate noticeably when the response style is irrelevant, inconsistent or suppressed.

Based on his group's experience with the VIP test, Sarfaty observes that "In fact, the irrelevant and inconsistent categories represent a larger portion of the respondents than frank malingerers."

The VIP Test at the Center of Symptom Validity Protocol

"Insurance companies, case management, defense council and others are eager to have objective evidence of compromises in validity so that they don't end up paying for untrue or missed diagnoses."

Symptom validity assessment is the standard of practice at CNS whenever there is potential for personal gain if cognitive impairment can be documented. Workers compensation, disability evaluations, medical insurance examinations, competency-to-stand-trial evaluations and child custody disputes are case examples.

Because a person may not malingering on every test in a battery or every aspect of a functional assessment, the group's protocol is multi-modal, incorporating both test-based and non-test-based data.

According to their protocol, the VIP test is administered along with three screening measures, two other forced-choice malingering measures (the TOMM and the PDRT), and the MMPI-2™ or the PAI® tests. Other assessments, such as measurements of chronic pain, may also be administered. CNS neuropsychologists use the VIP results to help analyze the individual's possible effort on the examination. They also document observations in several

categories including: extra-test behaviors; possible presence of potential secondary gain reinforcers; inconsistency in reporting; severity, type and course of symptoms; and mechanism of injury.

“A wide variety of referral sources absolutely go crazy over the test-based data,” Sarfaty said. “To be able to document in an objective and measurable fashion that an injured person’s claim is free of bias is very powerful and desirable to them. Insurance companies, case management, defense council and others are eager to have objective evidence of compromises in validity so that they don’t end up paying for untrue or missed diagnoses. The days of ‘...and the patient appeared to give a good effort...’ are truly over.”

Improved Communication, Increased Confidence

“The use of the VIP test has helped us become more effective at providing diagnostic data for forensic cases—data that have raised the bar on objectively-based differential diagnosis.”

Sarfaty observes that the opportunity to be reimbursed outside of managed care and third-party payor systems helps CNS counter the prevailing pressures in the marketplace. Though the CNS protocol and subsequent analysis require “a significant chunk of time,” according to Sarfaty, “referral sources are willing to reimburse for this time because both sides in an adversarial matter can benefit significantly by objectively strengthening their findings in forensic assessments.”

Furthermore, the VIP test has strengthened their confidence in court. “The VIP test can’t replace your ability to communicate,” he continued, “but your ability to communicate is enhanced because you have something worthwhile to say.”

“The use of the VIP test has helped us become more effective at providing diagnostic data for forensic cases—data that have raised the bar on objectively-based differential diagnosis.” These data have also helped raise the bar and increase effective consideration of the various factors that can compromise the validity of performance, the associated data, and the subsequent interpretation.”

Learning How to Use the VIP Test

Understanding the depth and richness of the VIP test takes some time and effort, Sarfaty observes. Malingering assessments with simple cut scores or baseline comparisons “will not prepare you to appreciate VIP results,” he says. Sarfaty suggests that clinicians study the VIP interpretive report and share questions and observations with a colleague. “This is not a major academic endeavor,” he explains, “it will only take a few such discussions, but it’s worth the effort to have access to a new diagnostic technology and dramatically improve what you have to offer.”

There are certain cases, Sarfaty notes, where VIP results are particularly applicable. Using the VIP test in these cases will clearly demonstrate the test’s uniqueness, he believes, helping clinicians more quickly understand its utility.

One type of case involves some brain compromise or psychopathology with superimposed validity compromise. “Just because you have a brain injury doesn’t mean you can’t feign impairment,” he explains. “The VIP test is particularly helpful in teasing that out.”

The VIP test can also be especially helpful in “surprisingly common cases where a person’s compromised effort and motivation is, in part, compliance with a previous misdiagnosis of brain injury.” These misdiagnosed individuals may believe their ability is compromised, so they tend to act that way. It’s not cheating or flat-out malingering, Sarfaty suggests, but “a response to feedback from perceived authorities.”

Overall, Sarfaty acknowledges that taking the time to incorporate a major new test into established protocols is not always easy. But he also recognizes that the profession is “hurting and frustrated. We are focused on getting the maximum possible advantage out of every minute and every dollar. But taking the time to understand how the VIP test works and using it your practice can more than balance out the losses to managed care.”

About the author

Stephen D. Sarfaty, PsyD, is a Diplomate of the American Board of Professional Neuropsychology, the American Board of Clinical Neuropsychology and the American Board of Professional Disability Consultants. He received his Bachelor’s degree in psychology from Livingston-Rutgers and his Doctor of Psychology from the Illinois School of Professional Psychology. In addition to being the director of Comprehensive Neuropsychological Services, PC, he has taught at Quinnipiac College and was Assistant Clinical Professor at the University of Hartford.

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