

The Role of the Clinical Neuropsychologist in
Disability Determinations: The Legal Perspective

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Disability Determinations: The Legal Perspective

The aim of this presentation is to foster greater understanding of the role of the clinical neuropsychologist in Social Security Disability Determination by providing a legal (and not psychological) perspective. The importance of the role of the neuropsychologist is outlined with special emphasis on their ability to provide norm-referenced information and data on cases which fall through the traditional "safety net" provided by Social Security. The current methods for disability evaluations (including tests required and procedures used) are presented. Weaknesses of the current evaluation system are presented with specific suggestions (e.g., increased use of psychometric data) for revamping the system are discussed. The two disorders in which the clinical neuropsychologist can play a significant role in assisting the legal counsel include, but are not restricted to, chronic brain syndrome and mental retardation. Specific suggestions which enhance the legal/psychological interface this area are addressed including; initial contact with attorneys, clients, and agencies, turnover time, cost of evaluation(s), style and content of report, and courtroom behavior. Forms and supplemental questionnaires used by the Department of Disability Services are also presented.

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The McCarron-Dial System (MDS) is a neuropsychologically based vocational evaluation battery that has been found to be useful in the field of vocational rehabilitation for assessing work potential and identifying differential rehabilitation programming strategies for the neuropsychologically disabled. Considering its theoretical orientation, the MDS might also be potentially useful as a clinical neuropsychological assessment battery. The purpose of this preliminary study was to investigate the effect of brain damage on verbal-spatial-cognitive (VSC) and sensorimotor (SM) measures included in the MDS. The participants include 141 brain damaged adults and 42 psychiatric controls. Analyses of variance revealed significant differences between the brain damaged and control groups on 44 of 53 VSC and SM measures; 97% of the brain damaged group and 71% of the controls were accurately classified by the MDS measures using discriminant analysis. Significant differences between the left and right brain damaged group were also observed on 27 of 44 MDS measures. The results appear to support the validity of the MDS for neurobehavioral diagnosis, but supplemental information is needed to increase prediction accuracy. A key approach to interpretation may have advantages over statistical models. Further validation research is needed to extend the system's utility for neuropsychological diagnosis. *NOTE: Direct correspondence to Jack G. Dial, Ph.D. or Fong Chan, Ph.D., Department of Rehabilitation Science, University of Texas Health Science Center at Dallas, 5323 Harry Hines Blvd., Dallas, TX 75235, (214) 688-2870.*

Luria-Nebraska Neuropsychological Battery Performance By A Closed Head Injury Population: Initial Findings. Robert W. Gillen, William D. MacInnes, Charles E. Ginn, Jr. and Joyzelle H. McCreary. There have been numerous studies which have examined the effects of closed head injuries with a variety of neuropsychological instruments (Levin, Benton, & Grossman, 1982). However, to date, no study has been published which has examined the performance of a head injured sample on the Luria-Nebraska Neuropsychological Battery (LNNB). The initial data analysis was based on 33 closed head injury patients.

Each subject was given the LNNB. Preliminary analyses employing analysis of variance using days of coma as an independent variable and 14 T-scores of the LNNB Clinical Scales as dependent variables found significant differences on the Motor, Tactile and Right Hemisphere Scales. No differences were seen in the time since injury levels. Pearson correlation coefficients were also calculated between days of coma and the T-scores on the LNNB Clinical Scales. Five of these scales, Motor, Tactile, Pathognomonic, Left Hemisphere and Right Hemisphere exhibited significant correlations ($p < .05$). These correlations were .42, .42, between time since injury and any of the LNNB Clinical Scales.

In summary, we found a relationship between LNNB performance and days of coma, but not time since injury. It appears the reason there was little relationship between LNNB performance and time since injury was related to a sampling bias that is examined in the paper. *NOTE: Direct correspondence to Robert W. Gillen, Ph.D., Department of Psychology, Sunnyview Hospital, 1270 Belmont, Schenectady, NY 12308, (510) 382-4589.*

The Role of the Clinical Neuropsychologist in Disability Determinations: The Legal Perspective. Antonio E. Puente and Michael Glancy. The aim of this presentation is to foster greater understanding of the role of the clinical neuropsychologist in Social Security Disability Determination by providing a legal (and not psychological) perspective. The importance of the role of the neuropsychologist is outlined with special emphasis on their ability to provide norm-referenced information and data on cases which fall through the traditional "safety net" provided by Social Security. The current methods for disability evaluations (including tests required and procedures used) are presented. Weaknesses of the current evaluation system are presented with specific suggestions (e.g., increased use of psychometric data) for revamping the system. The two disorders in which the clinical neuropsychologist can play a significant role in assisting the legal counsel include, but are not restricted to, chronic brain syndrome and mental retardation. Specific suggestions which enhance the legal/psychological interface in this area are addressed including: initial contact with attorneys, clients, and agencies, turnover time, cost of evaluation(s), style and content of report, and courtroom behavior. Forms and supplemental questionnaires used by the Department of Disability Services are also presented. *NOTE: Direct correspondence to Antonio E. Puente, Department of Psychology, University of North Carolina at Wilmington, Wilmington, NC 28403, (919) 395-3812 or Michael Glancy, Legal Service of the Lower Cape Fear, Wilmington, NC 28401, (919) 763-6207.*

Communication Skills for Head Injured. Joy Coderre and Norma Shaffer. Six closed head injured patients in a residential treatment facility were selected for a group therapy session designed to retrain communication skills. These patients were characterized by deficits in 1) Memory and attention, 2) Comprehension (abstraction ability, self-assessment), 3) Awareness and Orientation (social awareness and visual/spatial/temporal functions), 4) Emotional control (impulsivity, low frustration tolerance and low motivation). Specific behaviors were identified as interfering with communication and were targeted for remediation. These behaviors included incomplete or excessive utterances, off-topic utterances, memory/attention/word-retrieval difficulties, long pause length, inappropriate interruption, negative mood, unintelligible utterances.

Interfering behaviors were coded before and after treatment from a standard interview which involved information on orientation, short answer and sentence completion topics, and personal discussion questions. A group of six control patients who were not involved in treatment were also interviewed.

Treatment consisted of thirteen forty-minute sessions which involved a four step instructional sequence: 1) Therapist identifies a problem situation from the groups' living environment, 2) Situation is structured for videotaped role play; interactants are instructed to avoid or use specific behaviors, 3) Videotape is played back for identification and discussion of behaviors, 4) Role play is reenacted. Reinstruction and cueing are used throughout the sequence to insure successful interaction.

Results are discussed in terms of the reduction of interfering behaviors. *NOTE: Direct correspondence to Joy*