



Assessing older adults in civil litigation cases

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ABSTRACT

With the population aging, the legal and mental health systems need to be prepared for cases that involve older adults beyond the customary matters of guardianship and competency. Assessing older adults with the current tests raises concerns because these measures may not be adequately normed for this age group. Malingering, factitious disorders, and somatoform disorders are discussed due to health-related issues of normal aging. These topics complicate the assessment procedure and need consideration because they may affect the claimant's performance or symptom presentation. Although claims of posttraumatic stress disorder (PTSD) are common in civil litigation cases, it can be additionally complex in older adults. The evaluator needs to weigh not only factors related to the normal biological process of aging but also those that are attendant with the litigation.

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The population of adults over age 65 is increasing worldwide. According to a report by the United States government, in 2013 over 14% of the population was over 65 (United States Census Bureau, "65+ in the United States"), and it is estimated that over 20% of the world's population will be over 65 by 2035 (United States Census Bureau, "USA QuickFacts"). Advances in medicine have eradicated many diseases, and rising standards of living have improved the quality of life in many parts of the world. People have access to better health care. And they are living longer (National Institute on Aging, "Living Longer").

Older adults therefore are figuring more largely than they once did in our households, on our roads, in our institutions as well as in our courts, where older adults are engaged in both civil and criminal processes. The causes include such general matters as personal injury claims, incidents of domestic violence, automobile accidents, and criminal charges for white-collar crime or for murder. They include also age-related matters of employment discrimination, elder abuse, and injuries at a rehabilitation center or nursing home. In all cases, age may be, or may become, an issue in the case, and it is important that our legal and mental health systems learn to anticipate this reality and handle it effectively.

Forensic evaluation of older adults presents challenges that are not typically present when younger adults are being assessed. (For the purposes of this paper, I am defining older adults as people over the age of 65. This is generally accepted in the United States, Canada (Government of Canada, "Lived or Living Outside Canada—Pension and Benefits"), and many European countries (Organisation for Economic Co-Operation and Development, *Statistics on average effective age and*

official age of retirement in OECD countries) as the age at which most people become eligible for retirement.) In this paper I will address some of these challenges. First, I will provide background on what we know about some of the shortcomings evaluators face assessing the older population in relation to assessment measures. Then, I will discuss malingering, factitious disorders, and somatoform disorders and the ways that they affect older adults. Next, I discuss some factors an evaluator needs to look at in the claimant's symptom and performance presentation in the context of a forensic evaluation and then how posttraumatic stress disorder, a common complaint in civil litigation, is complicated by age. I conclude with some factors that forensic evaluators need to consider when evaluating older adults.

1. Assessing older adults

Various measures have been developed to help assessors ascertain whether or not an older adult is beginning to manifest signs of dementia or is becoming unable to manage the demands of independent living. These measures are frequently used in guardianship evaluations, in capacity assessments, and in other civil matters. However, the personality changes that accompany advancing age have been overlooked by researchers.

Edelstein and Segal (2011) point out that depression manifests differently in older adults than in younger ones. For example, depressed older adults tend to report feelings of hopelessness and helplessness, somatic symptoms and psychomotor retardation, and weight loss; but younger adults who are depressed report feeling guilty and suicidal. Anxiety disorders too are more common in older adults than in younger adults (Edelstein & Segal, 2011). There is evidence that the differences in the way that older adults experience anxiety may be due to physiological changes (Averill & Beck, 2000; Edelstein & Segal, 2011).

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Edelstein and Segal (2011) have asserted that personality changes over the life span, and that some of the traits of the personality disorders listed in the *Diagnostic and Statistical Manual of Mental Disorders IV—Text Revised's* (DSM IV-TR American Psychiatric Association, 2000) are irrelevant for older adults. They and other researchers (Segal, Hersen, Van Hasselt, Silberman, & Roth, 1996; Zweig, 2008; Zweig & Agromin, 2006) have also questioned the suitability of the criteria for assessing mood disorders, anxiety disorders, and personality disorders in older adults. In 2013 the DMS-5 was published. It kept the same major criteria for mood disorders, anxiety disorders (except for PTSD), and personality disorders that had been in the previous edition (American Psychiatric Association, 2013, p. 816). For some people, the symptoms associated with a personality disorder may reemerge in later life in response to the stresses of old age and the diminution of effective coping skills. For other older adults, a personality disorder, obscured for many years, may be revealed by late-life events (Balsis, Zweig, & Molinari, 2015; Edelstein & Segal, 2011, p. 331). For instance, an older woman who had appeared to be reserved and meek as younger woman may become assertive and direct after the death of her spouse or an older man who had been outgoing and fun-loving may become quiet and reclusive later in life. Traits may remain stable but their behavioral manifestations may change with age (Edelstein & Segal, 2011). Methodological artifacts of the use of cross-sectional studies rather than utilizing research designs that assess personality change over the life span have made this difficult to distinguish (Balsis et al., 2015; Edelstein & Segal, 2011).

Zweig (2008) citing Balsis, Carpenter, and Storandt (2005) has said that personality change also occurs with certain neurological diseases or medical conditions (such as dementia) that are more prevalent in older than in younger adults. Personality changes may be noticeable before cognitive changes are perceptible, and behavioral changes may be indicators of the early stages of dementia (p. 303). For example, people with pseudodementia, a disorder that manifests as dementia but is actually depression, have symptoms consonant with dementia and cognitive impairment, but because pseudodementia responds well to antidepressant medication, it is considered to be reversible (Peritogiannis, Zafiris, Pappas, & Mavreas, 2008).

Edelstein and Segal (2011) point out that while many instruments have been developed to measure depression and anxiety in younger adults, little attention has been paid to the question of whether these instruments have content validity (a test measuring what it is supposed to measure), or whether any of their other psychometric properties are acceptable for use with older adults. "There is no 'gold standard' of diagnosis for PD [personality disorder] in older adults," they assert. "This fact, in conjunction with the problems of content validity of some PD diagnostic criteria, is cause for significant caution regarding the use of these instruments [emphasis in original] of PDs in later life" (p. 332).

Some of the diagnostic criteria of a personality disorder may not apply to an older adult, because age-related factors, such as those associated with social or work factors, are not germane (Balsis et al., 2015, p. 80). For example, a feature of Antisocial Personality Disorder is not maintaining consistent work behaviors. If a person is retired, this feature is not relevant.

Administering a measure to a person in the absence of norms for that particular age-group, or without consulting them when they are available, can produce spurious results, and inaccurate and misleading findings. Ziskin (2012) has shown that the likelihood of obtaining false positive error on neuropsychological tests increases when age-corrected norms for older adults are not employed.

Using age cohorts (that is, a group of people born within a certain time span) allows investigators to look at the impact of age, and potentially other factors, such as historical events, as well. Because some studies (Ruffman, Murray, Halberstadt, & Vater, 2012) include older adults encompassing age spans of almost 30 years, it is unclear if reported differences on the various measures are due to age, historical factors, or some other factor.

Furthermore, cohort differences may confound the test results by demonstrating changes within the cohort rather than changes within an individual. For instance, the item "I have enjoyed using marijuana" on the MMPI-2 (Minnesota Multiphasic Personality Inventory-2; Butcher et al., 2001) illustrates such a difference among cohorts (Butcher et al., 1991, p. 369). Older adults are less likely to endorse such an item on a test for a variety of reasons; younger adults are more likely to acknowledge such an item (Butcher et al., 1991).

In an attempt to assess age-cohort difference and to ascertain whether there were age-related norms for the MMPI-2 among men between the ages of 18 and 84, Butcher et al. (1991) found that older men scored higher on its Depression Scale. This elevation may be due to the increased number of somatic symptoms that the older men endorsed and such a finding is not unusual in the elderly (Butcher et al., 1991). Other researchers found that when compared to younger adults, older people tend to minimize or deny psychological symptoms (Aaranson, Dent, Webb, & Kline, 1996).

Many instruments used in forensic assessments report age norms, but provide little information about their standardization samples or the details about psychometric properties (those statistics related to the strengths and weaknesses of a particular test) that an evaluator needs to make an informed decision. Test norms describe the way that a group of people performed on a specific test. If older people are under-represented on a test, an older person's test score cannot be interpreted because there are no norms for that person. Even though the tests are administered to older adults, the prudent evaluator needs to look at the psychometric properties of a test before deciding whether the test is appropriate for the individual.

Table 1 illustrates some of the shortcomings of many of the current instruments in use in this field and shows wide variability in the age cut-offs. For example, although some measures give upper age limits into the 80s and 90s, this does not necessarily mean that older adults were adequately represented in the sample or that age norms are available. Consequently, an evaluator wishing to administer that test to an older adult in a forensic setting should need to contact the publisher of the test and to consult with an independent test review resource to acquire the necessary information and psychometric properties.

The Personality Assessment Inventory (PAI) and Millon Clinical Multiaxial Inventory-III (MCMI-III) are relatively popular measures used in administration in personal injury evaluations. However, a closer examination of their applicability for older adults warrants some caution. The PAI had a census-matched standardization sample of community residents for its sample of adults over the age of 18, but only 1.9% of the adults in the sample were between the ages of 65 and 89 (Personality Assessment Inventory (PAI); Morey, 2007, p. 81). The MCMI-III had 41 adults between the ages of 56 and 88 in the development sample and 27 adults in that same age group in the cross-validation sample (Millon Clinical Multiaxial Inventory-III; Millon, 2006). For the MCMI-IV, 21.7% of the 1547 adults who were involved in the restandardization were between the ages of 50 and 85 MCMI-IV (Millon Clinical Multiaxial Inventory-IV; Millon, Grossman, & Millon, 2015). Edelstein and Segal (2011) state that there are few studies focusing on the validity of the MCMI-III with older adults. The Minnesota Multiphasic Personality Inventory-2 Restructured Form (MMPI-2 RF) consisted of 2276 adults between the ages of 18 and 85 in the normative sample and was compared with the 1990 census (MMPI-2-RF; Ben-Porath & Tellegen, 2008/2011). Of this sample, 336 adults were between the ages of 60 and 85 which is about 15% of sample (Ben-Porath & Tellegen, 2008/2011). The results of 52 healthy, nonpatient older adults between the ages of 60 and 80 on the Rorschach Inkblot Test indicated that their responses were similar to the adult norms (Pertchik, Shaffer, Erdberg, & Margolin, 2007). When the Rorschach Inkblot Test is scored using the Comprehensive System (CS) or the R-PAS (Rorschach Performance Assessment System; Meyer, Viglione, Mihura, Erard, & Erdberg, 2011), and using the International Norms (which consists of 4704 adult protocols from 17 countries) not the CS norms, the Rorschach is

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