

Detection of malingering in clinical practice

(Or, I can tell if you're lying, but I can't tell why)

Derek Tracy, Psychiatrist & Clinical Director, Oxleas, London

Senior Lecturer, King's & University College London

Advisory Council on the Misuse of Drugs

@derektracy1 ; derek.tracy@nhs.net

Royal College of Psychiatrist's Occupational Psychiatry Special Interest Group
September 5th 2019

1

Overview

- Definition & epidemiology
- Clinical assessment: general principles and specific conditions
- Psychometric testing
- Presenting findings: general challenges & court presentations

2

Advances in psychiatric treatment (2014), vol. 20, 495-410. doi: 10.1192/apt.bpj.114.012006

Evaluating malingering in cognitive and memory tests for clinicians

Derek K. Tracy

Cognitive and memory tests are used in clinical practice, but are sometimes raised to detect malingering. However, clinicians with limited experience in malingering in such cognitive tests may raise concerns. Nevertheless, psychiatric assessment has greater potential for legal and professional consequences than other professional assessments. There is a need for clinicians to be aware of the ways in which malingering can be evaluated through the use of cognitive and memory tests.

ARTICLE

BJPsych Advances (2017), vol. 23, 27-35. doi: 10.1192/apt.bpj.116.01999

Malingering in clinical assessment

Derek K. Tracy & Keith J. Rix

Malingering is the dishonest production of symptoms. It can be difficult to detect in clinical practice, and it may expose clinicians to medicolegal situations. In this feature article, we explore typical presentations of malingering and their occurrence in clinical practice. We discuss the difficulties of assessment when malingering is suspected, including collateral information, and recommend an approach to the use of collateral information. The use of psychometric tests are discussed, and the use of 'general' and 'malingering-specific' validity scales.

LEARNING OBJECTIVES

ARTICLE

BJPsych Advances (2017), vol. 23, 115-122. doi: 10.1192/apt.bpj.116.01998

Malingering in mental disorders: a medicolegal perspective

Keith J. B. Rix & Derek K. Tracy

In this second part of a two-part feature article, we consider the challenges of clinical and psychometric diagnosis in the presence of malingering. We discuss the clinical and demographic factors associated with malingering and the risks to an individual case of expert psychiatric witness's evidence. We discuss the use of psychometric data to challenge a diagnosis, expert recognition and report the limitations of psychiatric diagnosis. We do not try to look for or to identify incentives with clinical findings suggest that they should, other than avoid using the term 'malingering' in the court, not the expert witness individual's credibility and motivation.

ARTICLE

BJPsych Advances (2018), page 1 of 3. doi: 10.1192/bja.2018.16

Confessions of a liar-detector: I can tell if you're malingering, but I can't tell why

Derek K. Tracy

Malingering is the intentional feigning of illness for external gain. The author has written several papers on the epidemiology, assessment, testing and reporting of this. However, practice in this area is often poor. I came by this side trade circuitously. I was interested primarily in neurocognitive assessments, but doing them over time I came to suspect that some people were, well, swinging the lead. I looked for

CLINICAL REFLECTION

Derek K. Tracy is a consultant psychiatrist and clinical director at Oxford NHS Foundation Trust, London. He is a senior lecturer at the Institute of Psychiatry, Psychology & Neuroscience, King's College London.

3

Definition & epidemiology

Detection of malingering in clinical practice

4

DSM-5

The intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives such as avoiding military duty, avoiding work, obtaining financial compensation, evading criminal prosecution, or obtaining drugs

- The intentional, dishonest production or exaggeration of symptoms for external gain
- Not a mental illness, so one never 'diagnoses' it, but it is included in ICD-10 & DSM5
- Cf factitious disorders – e.g. Munchausen syndrome –intentional deception for psychological gain
- Are the boundaries that clear? Has been argued¹ this can be done on sociodemographic grounds
- What about someone feigning mental illness for *revenge* upon another

¹Kanaan, 2010

5

How often do you lie? Honestly?

- Inherently difficult to get accurate data on behaviour that crosses from unethical to criminal. Influential study¹ of over 30,000 medical reports determined *probable* malingering in:
 - 30% of personal injury and disability cases
 - 20% of criminal cases
 - 40% of cases of mild traumatic brain injury (TBI)
 - 8% of general medical cases
- Reflections:
 - Rates are typically lower in moderate/severe TBI than mild TBI, & in criminal than in civil cases: why?
 - Which mental illnesses do you think are currently most commonly feigned? Why?

¹Mittenberg, 2002

6

Key point: lying isn't necessarily a binary thing...

- Lipman defined¹ four types of malingering
 - - **Invention** of symptoms
 - - **Perseveration**: describing symptoms that once existed, but no longer do so
 - - **Exaggeration** of genuine symptoms
 - - **Transference**: attributing genuine symptoms to a false cause
- A continuum of deceptive intent and gain
- Our problem: we lack biomarkers & rely on symptom descriptions, our training & expertise
- *Reflections: consider your own clinical practice. Can you think of a presentation that a determined individual could not feign? Which are easier or harder?*

¹Lipman, 1962

7

Clinical assessment

Detection of malingering in clinical practice

8

PTSD

- The most frequently malingered condition? Trauma may lead to requests for compensation - tempting to feign.
- Five significant unique challenges:
 - Many suffer *genuine traumas*, though *amplifying their impact*: most common form ¹; some have undergone a trauma that would precipitate PTSD in another, yet not develop it themselves
 - *External gain* may be obvious & significant
 - Clinician *biases*, positive or negative, which may be subconscious
 - The *validity* of applying a Western model/diagnostic criteria
 - Some have problematic histories with *authority figures*, including doctors
- *Reflections: what different feelings do each of these images of refugees evoke in you? How susceptible are we to media influences and other biases?*

¹Kleinmann, 2004

9



10

| | | 'True' PTSD | 'Malingered' |
|---|---------------------------------|-------------------------------|-----------------------------------|
| <p>Real from feigned PTSD</p> <ul style="list-style-type: none"> • Problematically, 'real' PTSD varies considerably, & "easily malingered"¹ • Symptoms considered more & less consistent with 'true' PTSD¹ • <i>Reflections: consider the challenges in using the information in this table in a report</i> <p>¹Hall & Hall, 2006</p> | Ease discussing symptoms | More reserved | Calls early attention to symptoms |
| | Flashback modality | Multimodal, feel contemporary | 1° visual, like movie |
| | Dissociative states | √ | Dissociate amnesia |
| | Nightmares | Frequent but vary | Frequent, no change |
| | Sleep | Collat: light sleep | Collat: no change |
| | Blame | Some self-blame | Overtly blames others |
| | Description of severity | Minimises | Exaggerates |
| | Relaxation | Difficulties | Enjoys & justifies |
| | Role in trauma | Minimises | Exaggerates to 'hero' |
| | Premorbid problems | Part explain | Denies any |
| | Treatment seeking | On advice of others | In context of litigation |
| | Psychotic symptoms | May be present | Denies |
| | Illness course | Fluctuates with time | Chronic, no change |
| | Survivor guilt | √ | X |
| | Premorbid life | Stable | Litigious, unstable life |

11

Case example: possible exaggeration in true PTSD?

- MT, 33yo Jamaican detained under immigration powers
- Impoverished background: left school at 11, limited literacy, never worked
- Smoked cannabis through his life; short prison spells Jamaica & UK for theft
- Limited social milieu in the UK, no prior involvement of MH services
- Alleged gang-related kidnapping & severely assaulted in Jamaica, leading him to flee
- Described secondary psychological sequelae & that life in danger if returned
- UKBA challenge the veracity of his account & his psychiatric history

12

- Psychiatric assessment: history consistent with PTSD, as was score on PTSD scale
- Two malingering tests were applied:
 - Structured Inventory of Malingered Symptomatology (SIMS): **scored 56**. Scores >14 shown to have 95.6% sensitivity & 87.9% specificity for malingering
 - Test of Memory Malingering (TOMM) (as alleged memory problems post-assault): **scored 35/50**. Individuals with dementia shown to score >45
- Note: due to his limited literacy, against protocol I had to complete the SIMS on his behalf after reading the questions & options, challenging the validity of the result
- Reflections
 - *Genuine PTSD with cultural/educational factors impacting, a desire to impress the degree of deficit?*
 - *The malingering test performance constituted part of broader misrepresentation?*
- Not possible to determine: passed to the court which - perhaps inevitably - found his testimony to be unreliable, and his asylum claim was dismissed by the Home Office

13

ADHD

- Almost all work has been on university populations – why?
 - *Extra tuition* and school/college support
 - *Additional time* during examinations
 - *Differential instructions* to grading examiners
 - Provision of *stimulant medication*: this can enhance cognition in those without ADHD
- A systematic review¹ found current scales *insensitive* to malingerers: in other words, they are easy intentionally to intentionally manipulate without detection
- ADHD malingerers admitted using **multiple strategies**: general inattention, ignoring some questions but not others, making sure some are accurate. Makes it difficult for single scales to detect obvious 'patterns of cheating'.



¹Musso & Gouvier, 2014

14

Psychosis

- Most commonly feigned mental illness in criminal trials, likely due to association with ‘madness’
- For malingered *delusions*, the IDEA acronym has been proposed¹:
 - - **I**nconsistent behaviour relative to delusion
 - - **D**ramatic content without disorganised thought
 - - **E**agerness to talk in detail about the delusion
 - - **A**brupt onset and termination

‘If sanity and insanity exist, how shall we know them?’ – D.L. Rosenhan, On being sane in insane places, Science, 1973

¹Mason et al, 2014

15

Psychosis

- *Hallucinations* are most common¹
- Symptoms considered more & less ‘typical’¹
- *Reflections: consider the challenges in using the information in this table in a clinical assessment or medicolegal report*

| | ‘Typical’ AVH | ‘Atypical’ AVH (<5%) |
|-------------------------|---|--|
| Acoustics | Clear. Mumbling can occur, seldom alone | Mumbling/vague; shouting/yelling |
| Voice quality | Someone else | Changes gender mid-sentence; only female or children |
| Commands | May occur, some resistance | Cannot be resisted, always obeyed |
| Tone | Critical/abusive | Never positive, unbearably distressing |
| Repetition | Often repetitive | Different speech, voice |
| Duration | Variation, min to hours | Continuous |
| Control over AVH | Some control over | No control |

¹McCarthy-Jones & Resnick, 2014

16

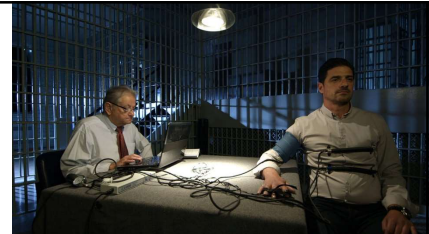
Psychometric testing

Detection of malingering in clinical practice

17

Lies & the lying liars who tell them

- Reflections: how might one design a test to detect lies?



- Four categories:

- **Biomarkers**: physiological markers such as heart-rate, blood pressure etc., the basis of the polygraph
- **General psychometric tests**: a psychometric battery (e.g. the MMPI) that has a wide range of uses, and is not specifically for malingering, but where one might anticipate an atypical or *implausible patterns*
- **Malingering specific tests**: These are specifically designed to detect feigning of symptoms, asking:
 - *Rare* symptoms
 - Symptoms that *seldom occur together*
 - *Fantastical* or preposterous symptoms
 - Symptoms individuals might *mistakenly* think do/do not occur in mental illness
- **Symptom Validity Tests (SVTs)**: primarily, but not exclusively, used to test *cognition*

18

Sample of malingering-specific tests

- Most are copyright; many require evidence of specialist training before purchase
- Rationale is simple: wide availability would undermine utility; evidence some lawyers prep
- Even disclosure in reporting needs to be done with care (discussed later)
- With those caveats, here is a sample of ones I have invented (note all forced choice T/F)

There are eight days in a week T / F

If you had £1.20, and spent 20p, you'd have 50p left T / F

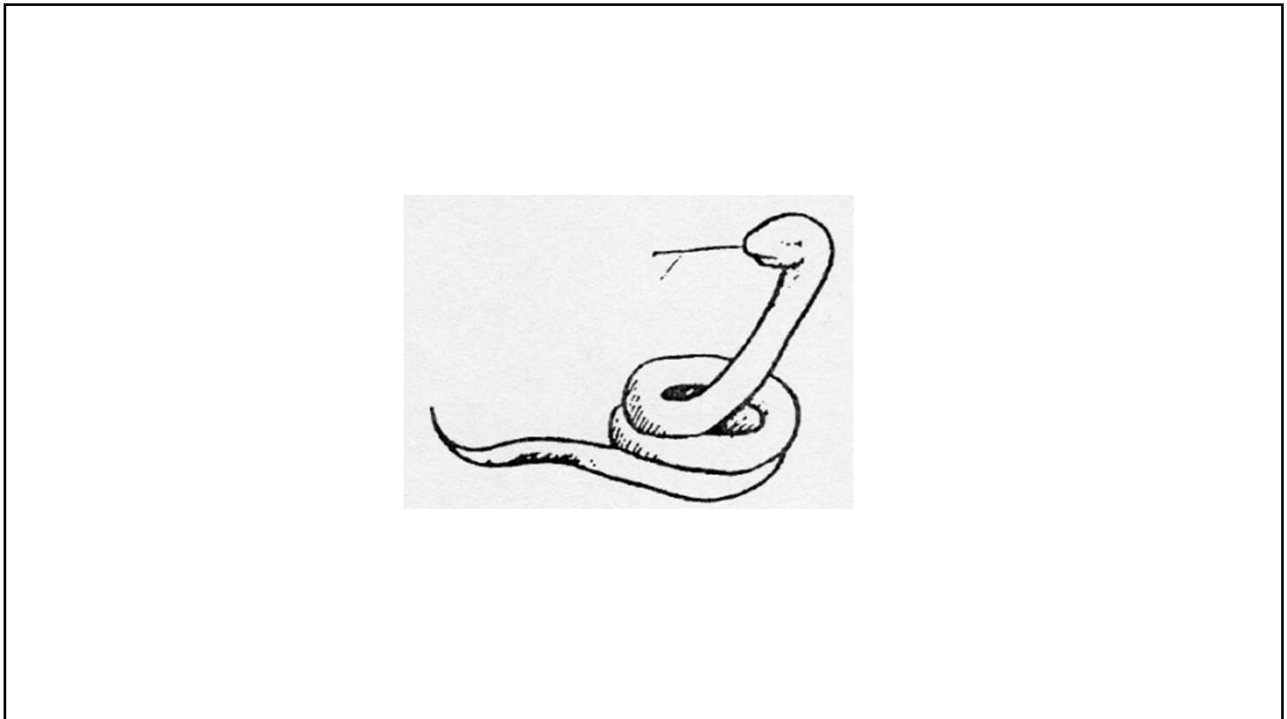
I sometimes cannot remember if my parents are alive T / F

My mood can get so bad that I cannot move my limbs T / F

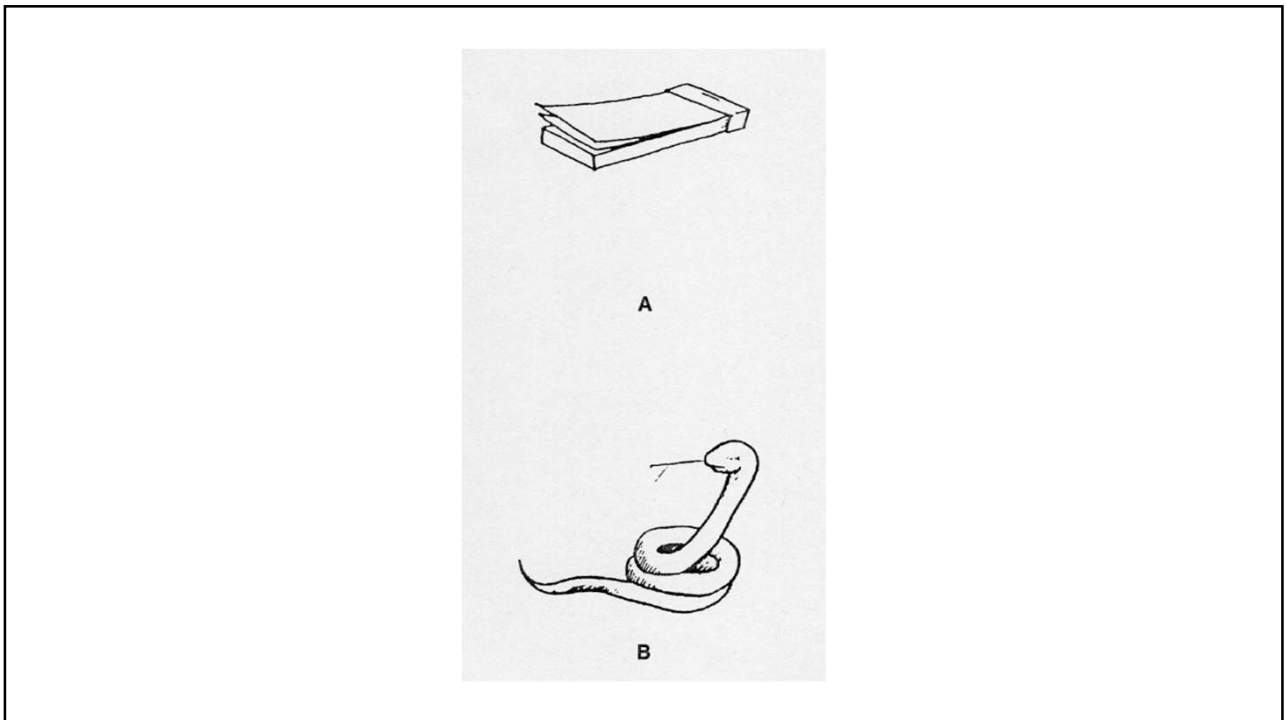
19



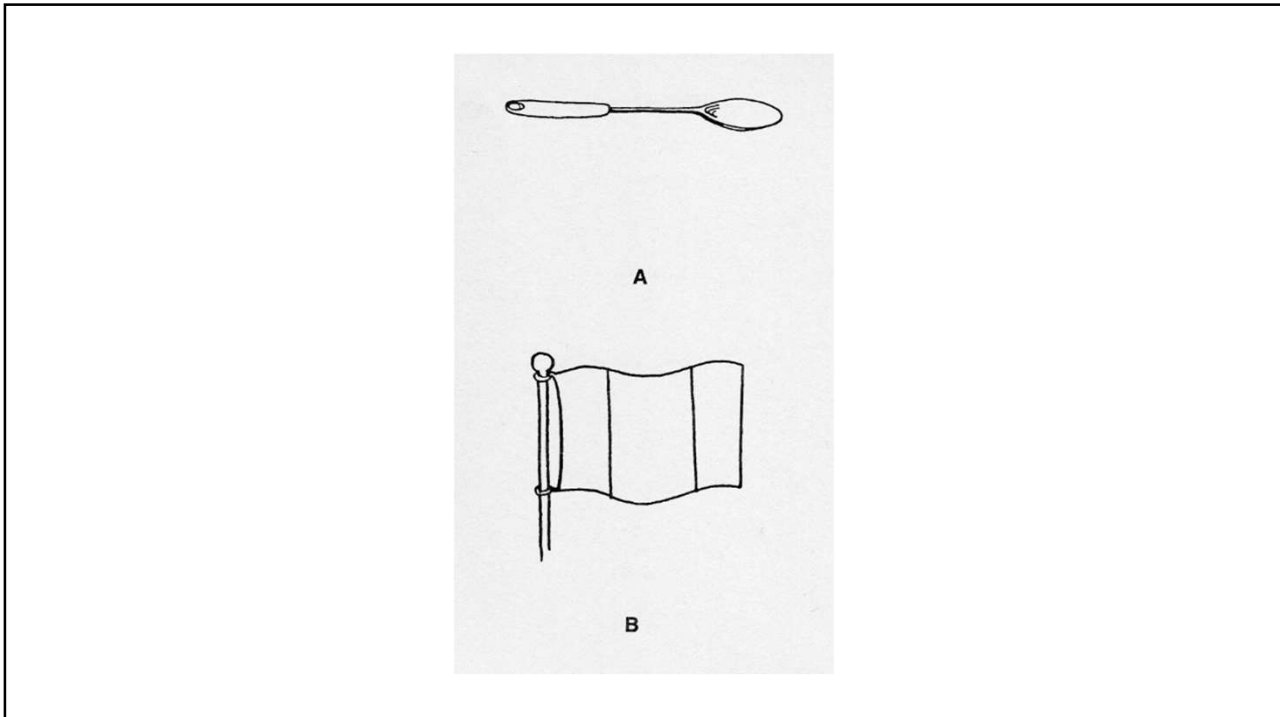
20



21



22



23

Challenges for psychometric tests

- They can *support* an opinion on the strength of a diagnosis, but ***never 'prove'*** in either case
- Some work shown the majority of veterans with *genuine* PTSD score as 'clearly exaggerating' on malingering scales. "*The embellishment of a warrior biography has a long history*"¹ & may be a *normal* part of a soldier's story.
- In legal settings "*the modal plaintiff appears to be an unhappy somatizer involved in a social context that encourages rationalization, projection of blame, and complaining*"²

¹Jones & Milroy, 2016

²Lees-Haley, 1997

24

Presenting findings

Detection of malingering in clinical practice

25

The first rule of malingering club....

- Recognising your limitations
- Three factors¹ especially limit detection:
 - False clinical optimism of ability once a rapport is established
 - Confirmatory bias leading to over-detection
 - Over-reliance on psychometric testing without appreciating its limitations
- Even experienced clinicians found it difficult to identify actors simulating illness
- Conversely, clinicians may be fearful of applying the 'M' word: relationships & litigation



Never try to 'prove' or 'disprove' malingering: describe how well, or otherwise, one's findings fit with the proposed illness

¹Mills & Putnam, 1996

26

Patient incentives and clinician biases

- Malingerers: ↑ rates of PD, substance use, unemployment, past litigation, £ problems
- So do lots of the population, they do not *necessarily* add weight to a malingering label
- We all have secondary goals, agendas (why are you here?): they're easy to find
- The recurring problem of confirmatory bias
- Plus, even a very clear, confirmed, strong incentive does not *prove* malingering: an individual might have a goal of avoiding prison AND have psychosis

Attempts to link atypicalities of mental state/psychometric performance to external incentives are liable to draw censure about your impartiality

'Malingering assessments can be extremely challenging as malingering itself involves two opposite ends of the forensic spectrum: it is so easy to suspect, yet so difficult to prove' – Scott & McDermott (2011: p. 251)

27

Reporting psychometric findings

- All have limitations of validity, reliability, range of scope, test populations
- Expert witnesses might face cross-examination on the '**Daubert questions**':
 - Has the technique been tested in field conditions and subjected to peer review and publication?
 - What is the known or potential rate of error?
 - Do standards exist for the control of the technique's operation?
 - Has the technique been generally accepted within the relevant scientific community?
- Reflections: do you use scales or tests in your practice? How do you feel about facing cross-examination on their use?

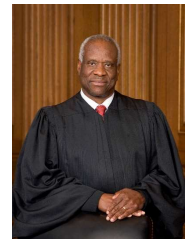
28

The role of the expert, the role of the court

- A good clinical report should capture all relevant information, including pertinent psychosocial history, psychometric data and collateral information
- However, it should be left to a court or tribunal to use this, and other information, to *draw any inferences it wishes on an individual's character or credibility*
- 'Malingering' is not a psychological or psychiatric condition, but a state of dishonesty, and *one without any legal definition*. To opine that an individual is malingering is thus the role of a court or tribunal, not a clinician.

"A fundamental premise of our criminal trial system is that "the jury is the lie detector" [...]. Determining the weight and credibility of witness testimony, therefore, has long been held to be the 'part of every case [that] belongs to the jury, who are presumed to be fitted for it by their natural intelligence and their practical knowledge of men and the ways of men'"

– US Supreme Court Justice Clarence Thomas.



29

A Diagnostic evidence from the history and mental state examination

- Symptoms supporting a true diagnosis, and whether ICD-10, DSM-5 or other recognised criteria are met
- Discrepancies in the history that conflict with the diagnosis, including variation in presentation in different settings
- Discrepancies in mental state observations between, for example, how the subject was observed to present in the waiting room or when leaving the consultation and how they presented in the consultation or between, for example, reported impairment of concentration and ability to concentrate during a lengthy consultation
- The subject's response to the exploration of their previous medical history, particularly a relevant documented history which is not mentioned or about which concealment is attempted
- Relevant psychosocial issues, without assigning undue weight or causal links, e.g.:
 - personality factors or disorder, including any antisocial traits
 - substance misuse
 - employment history and financial responsibilities
 - past litigation
- Temporal nature of presentation, including any changes with time, and response(s) to any intervention(s)
- Any noted differences between the subject's awareness or interest in secondary losses as compared with secondary gains
- Discrepancies between the history and reported symptoms, and the objectively observed mental state
- The subject's interest in investigations and treatments as opposed to any compensation

30

B Diagnostic evidence from psychometric testing

- Clinical scales utilised to support a diagnosis, noting:
 - their general usage, validity, sensitivity and specificity in the scientific literature
 - their usage in populations similar to the assessed individual, considering both mental health difficulties and social factors such as cultural background
 - the findings of the scale(s), including how much or little they support a diagnosis
 - an active reporting of limitations, confounders and cautions regarding results
- Scales utilised to assess malingering, noting:
 - whether a 'general', 'malingering' or neurobiological test
 - the evidence for the use of this scale(s) in this mental health condition, noting validity, sensitivity and specificity in the scientific literature
 - the evidence for the use of this scale(s) in this specific population type, noting individual demographic and cultural factors
 - the findings of the scale(s), including how much or little it supports a diagnosis
 - an active reporting of limitations, confounders and cautions regarding results, including a statement on the general use and limitations of psychometry

31

C Diagnostic evidence from collateral and secondary information sources (where available)

- Discrepancies between reported symptoms, such as loss of appetite and loss of weight, and observations, such as nursing observation of mealtimes and recorded weight
- Discrepancies between described or reported functioning and that of independent witnesses/reports/covert surveillance
- Documentation of whether the subject was present during the interview

D An expert summation from A, B and C

- A balanced, objective summary account of those factors that are in favour and those against the illness or diagnosis, and their relative strengths
- An active consideration of the likely effect of possible diagnostic confounders and biases:
 - that there might be exaggeration, perseveration or transference of real symptoms
 - that there is a gain to the diagnosis and/or difficulty, recognising that this of itself is not evidence of malingering
 - a recognition, where applicable, of the dual considerations that it might be considered reasonable and appropriate to present sympathetically to professional services in light of an individual's circumstances; further, there might be countering public narratives against the type of presentation seen. A statement to the effect that the clinician has considered both of these potential biases with regard to their own practice in this case, and an affirmation that they are presenting their best account
 - a consideration and appropriate referencing of the scientific literature, of the validity of the application of any clinical diagnosis to the specific individual seen, actively identifying any factors that might challenge this
 - a consideration of individual factors that might have affected the assessment, including, but not limited to: culture, religion and gender; the relationship between the clinician and the individual; linguistic challenges, such as variation in the use of English, poor levels of English comprehension and the use of an interpreter
- An expert opinion on the plausibility of the individual's difficulties being fully accounted for by psychiatric, neurological or developmental factors

The above are put to the court in a straightforward, logical sequence to assist the court in its role of determining an individual's credibility. The likelihood of a link with any external incentive and, if it be necessary, whether there is any intended fraud and what motivates any dishonest behaviour, remain ultimately questions for the court to decide.

32



Thanks to Keith Rix

33

| | | Patient state | |
|--------------------|----------|--|--|
| | | Malingerer! | Non-malingerer |
| Assessment outcome | Liar! | TRUE POSITIVE A malingerer caught! | FALSE POSITIVE A liar, but "non-malingerer"? |
| | Non-liar | FALSE NEGATIVE The legendary Moriarty of the malingering underworld! | TRUE NEGATIVE The individual most helped by such work? |

34