Dear Doctor, is this exaggeration/malingering conscious or unconscious …?

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Aims of talk

- Define somatoform disorders, malingering [and factitious disorders-FD]
- Describe prevalence in different settings
- Clinical characteristics
- Can the conscious/unconscious question be answered?
- Recent cases

Opening Comments

- Malingering and illness deception regarded -as pejorative terms best avoided in clinical practice.
- Risk law suits (e.g. for defamation of character), complaints to GMC and even personal danger.
- For much of the 20th century, formal studies of malingering were conspicuous by their absence and the subject has until recently been neglected
- Neglected because it is assumed that prevalence levels are small and /or relatively inconsequential.
- In the absence of convincing evidence about prevalence, there is no reason to believe that malingering-considered as one type of deception (extending from exaggeration to protracted feigning of illness behaviours) is any less common than other forms of deceptive behaviour (e.g. lying or fraud) found in non-medical situations.

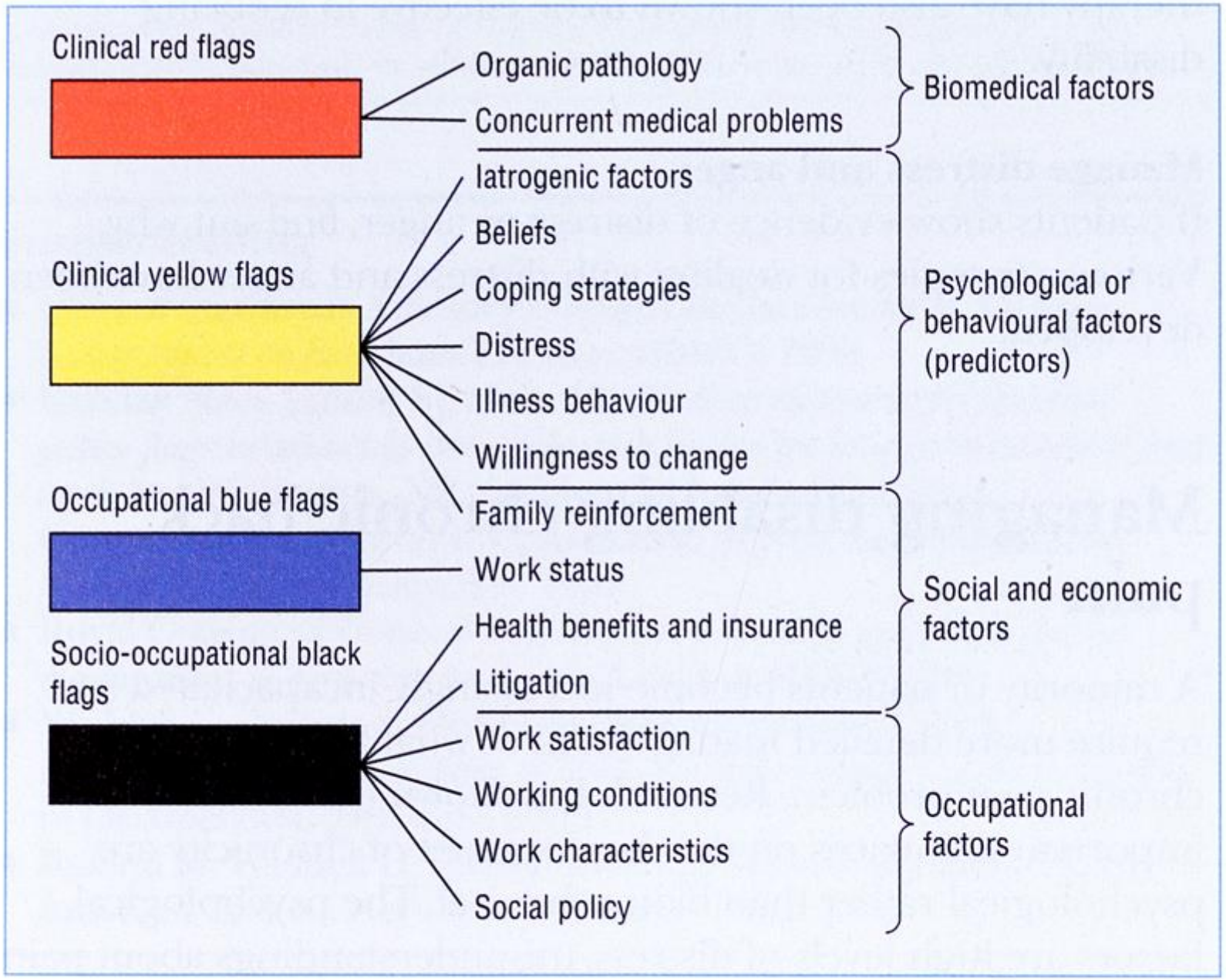
Definition of Somatic symptom disorder 300.82 [DSM-5,2013] ICD-10 [F45.1]

- A. One or more distressing somatic sx
- B. Excessive thoughts, feelings or behaviours related to the somatic sx with:
  - Disproportionate and persistent thoughts about the seriousness of the sx
  - Persistently high level of anxiety about the sx
  - Excessive time and energy devoted to these sx
- C. Symptom(s) last for more than 6 months
- Specify if: predominant pain; mild, moderate,severe

Somatoform disorders: Third most common cause of workplace absence

BOX 3 Chronic physical illness coexisting with somatoform disorder

A 45-year-old man with mild rheumatoid arthritis but with normal inflammatory markers reported a variety of diverse somatic complaints unrelated to his joints, including abdominal pain, headaches and fatigue. He was extremely introspective and worried excessively about his health and had consulted his general practitioner over 20 times in the previous year. His score on the PHQ-15 was grossly elevated at 25/30 and he was functionally impaired, becoming unable to work as a library assistant. He had been retired on medical grounds because of fibromyalgia. He satisfied diagnostic criteria for a persistent somatoform disorder (which had not been treated) coexisting with an (albeit mild) chronic medical disorder, rheumatoid arthritis.



The clinical flags approach to obstacles to recovery from back pain and aspects of assessment

Malingering definition-ICD 10

"…the intentional production or feigning of either physical or psychological symptoms or disabilities, motivated by external stressors or incentives…"
…coded as Z76.5 (not a medical or mental disorder)

The commonest external motives for malingering include:

- evading criminal prosecution
- obtaining illicit drugs
- avoiding military conscription
- attempts to obtain financial benefit or improvements in living conditions such as housing

Factitious disorder imposed on self or FDIOS [DSM-5:300.19,2013] [ICD-10:F68.10]

Factitious disorder imposed on self:

- A Falsification of physical or psychological signs or sx, or induction of injury or disease, associated with identified deception
- B The individual presents himself or herself to others as ill, impaired or injured
- C The deceptive behaviour is evident even in the absence of obvious external rewards
- D The behaviour is not better explained by another mental disorder, such as delusional disorder or another psychotic disorder.

- NOTE: Factitious disorders are more commonly diagnosed in general hospitals [1%] whereas malingering is generally seen in medicolegal/disability assessment settings

Critique of glossary definitions

- Deception is a pervasive, normal and ubiquitous human behaviour
- Patients and doctors frequently engage in deceptive behaviours
- Why is intentional fabrication of illness/sx seen as an illness in its own right?
- Doctors cannot differentiate between malingering and FDs
- FD introduced [in 1980] as a bridging diagnosis between [*unconsciously mediated*] psychiatric disorder –hysteria, and [*consciously mediated*] malingering
- Doctors underestimate role of non-medical deception ie *volitional choice*

Bass C Halligan P. Lancet 2014;383:1422-32.

Free will and patient choice

- Patients have free will or “agency”
- Patients make choices, and engage in certain behaviours
- Some patients embrace the sick role
- Motives are often unclear
- Recovery can depend on the person’s own active effort and will
- Actions and omissions are directly subject to choice and will

Henderson S. Br J Psychiatry 2005;186:273

Bass C and Halligan P. J Roy Soc Med 2007;100:81

Pearce S and Pickard H. J Med Ethics 2010;36:831

Why is exaggeration/distortion not considered? Shortcomings of medical model

- "I was taught that history is 95% of the diagnosis. As Osler said..... *"listen to your patient, he is telling you the diagnosis."*

Stephenson T. Leading by example. *Br Med J* 2014;348:g3465.

But.....

"In these cases....detailed medical history is rendered invalid"

Hall D et al. *Pediatrics* 2000;105:1305-12.

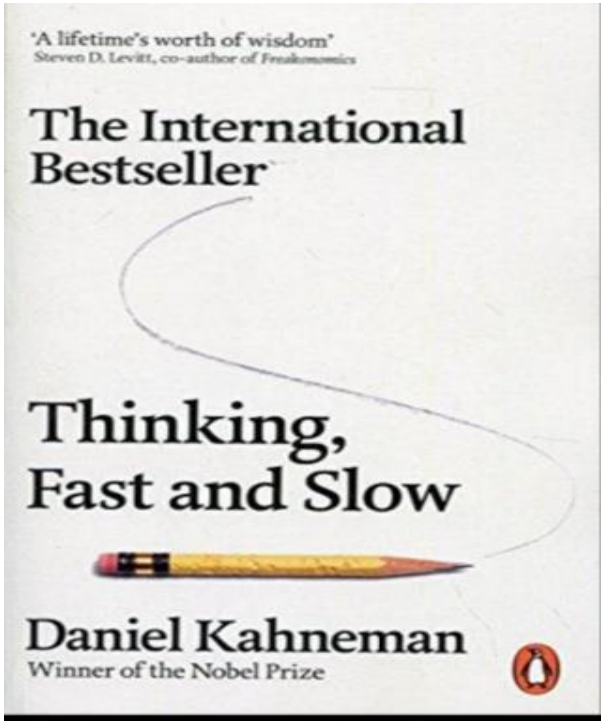
- Child protection cases

History is based on assumptions of parents' truthfulness and reliability- *mother knows best*- described as "System 1 thinking" [Kahneman]*

Davis P et al. *Arch Dis Child* 2018;April 4

*Lovatt v Ruffell, HHJ Hughes, 2018....
"accepting the history at face value..."

"System 2 thinking" =choice, agency, concentration"



Malingering: a dangerous diagnosis

A patient diagnosed as malingering by four orthopaedic surgeons shot three (killing two) before taking his own life.

One of them wrote….

"I can only say that if he has a real disability it is buried under such a mass of functional disorder that I cannot discern it"

Parker N. ***Med J Australia 1979:1:568***

Ways of viewing the world…..

- Health Staff believe everything their patients tell them……
- Police question everything people tell them
- Social workers sit on the fence and consider everyone's view

Secondary gain

- As a means of obtaining one's entitlement for years of struggling
- As a means of converting a socially unacceptable disability (psychological disorder) to a socially acceptable disability(injury or disease beyond one's control)
- As a means of displacing the blame for one's failures from oneself to an apparently disabling illness beyond one's control
- As an attempt to elicit care-giving, sympathy, and concern from family and friends
- As a means of avoiding work
- As a means of obtaining drugs
- Financial rewards associated with disability [video]

Malingering as a continuum disorder

- Exaggeration [sx magnification/embellishment" "I have had meningitis 6 times"]
- Dissimulation [concealment eg. present with gastric bleeding on NSAIDs and withholding info from doctor
- Symptom feignings [eg subjective states-abdominal pain]
- Misattribution/false imputation of cause [eg attributing real sx to a false cause]
- Invention [creating sx and signs when none exist]

- After Lipman 1962

Base rates of malingering and symptom exaggeration: clinical disorders

Mild head injury	**39%**
Fibromyalgia/ chronic fatigue	**35%**
Chronic pain	**31%**
Neurotoxic injury	**27%**
Electrical injury	**22%**

Mittenberg W et al. J Clin Exp Neuropsychology 2002;24:1094
(National survey of neuropsychological practices;
Patients referred by defence attorneys/insurers had higher rates)

Types of clinical presentation

1. post traumatic stress disorder* [1]
2. Brain injury [post concussional syndrome]
3. Psychosis/dementia
4. Chronic pain/whiplash/fibromyalgia/CRPS

*PTSD is the only condition for which DSM-5 specifically warns clinicians to watch for malingering

Bass C, Halligan P. *Lancet* 2014; 383:1422-32.

Ali S et al. *Innov Clin Neurosci* 2015;12:12-20

[1] *Pinkus v Direct Line 2018*

Prevalence of Malingering in chronic pain

- In pts with pain and financial incentives prevalence is between 20-50%, depending on methods and assessment context [1]
- Prevalence in social security disability claimants in USA is 46-60% [2]

[1] Greve K et al. *Arch Phys Med Rehab* 2009;90:1117-26

[2] Chafetz M Underhill J. *Arch Clin Neuropsychol* 2013;28:633-9

Personal injuries compensation

- Whiplash neck injury accounts for 85% of all motor accident personal injury claims in UK [5% in France]
- But 3 prospective studies have shown that, in those countries where compensation is not available after RTA, chronic whiplash does not occur
- The accident is therefore no longer a cause, it is an *"opportunity and a solution" (Ferrari R)*

Ferrari R and Russell A. J Rheumatol 2007;34:450
Ferrari R and Klar L. Matters of causation in personal injury. Eur J Rheum 2014;4:150

Common clinical scenario

- 34 year old woman has a “rear end shunt” from another vehicle: the damage to her vehicle is so trivial that no details are exchanged (because there is no visible damage to either bumper).
- Despite this she develops a “whiplash neck injury” with pain and stiffness that does not respond to physiotherapy.
- Ten months later she is diagnosed with fibromyalgia and is in a wheelchair
- She does not return to her job as an HR manager and 4 years later continues to pursue her claim. She is on benefits. Her claim is over £1,500,000
- In her background, she has a long history of medically unexplained symptoms, and in 2002 had a previous whiplash that led to 6 months in bed and delayed the taking of her degree by one year.
- In one orthopaedic report she has been described as malingering.
- How does the psychiatrist approach this problem?

What to look for: 4 kinds of inconsistencies

- A non organic findings [orthopaedic NAD]
- B inconsistency between behaviour during an exam and behaviour when not being observed [surveillance, social media]
- C inconsistency between subjective report and documented history [medical records, witness statements, social media]
- D submaximal effort [on neuropsychological testing]

- Do symptoms flow from the accident/injury?
- Exaggerating to convince/deceive?

Slick P *Clin Neuropsychol* 1999;13:545-61
Tracy D . *Adv Psych Treatment* 2014;20:405-12.

Measurement: effort testing [ET]

- Word Memory Tests most useful (a test of memory that looks difficult but is in fact easy-WMT) (1)
- As many as 45-50% of patients show insufficient effort on these tests (2)
- “ET and sx exaggeration testing is essential in assessing patients with FM for disabilty” (3,4)

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(1) Green P . *Phys Med Rehabil Clin N America* 2007;18(1):43-68
(2) Stevens A et al. *Psychiatry Research* 2008;157:191-200
(3) Ferrari R and Russell A. *J Rheumatology* 2016;43:11
(4) Kalfon T et al. *J Psychosom Res* 2016;87:30-6.

Forensic examination of data in different domains

- Medical notes [contemporaneous GP record]
- Psychological treatment notes
- DWP records
- Witness statements
- DVD surveillance
- Social media

A forensic analysis of all available records by time tranche combined with clinical detail and familiarity with up to date medical research will maximise the chance of that expert's evidence being preferred [NG,2015].

The key issues

1. Problems with pre-accident circumstances and post accident symptom reporting and functioning
2. Unreliability of memory for clinical events [1,2,3]
3. "Effort after meaning" [4]
4. Dishonesty/lies -Fundamental dishonesty [2]

[1] *Barsky A. Arch Intern Med 2002;162:981-4.*

[2] *Pinkus v Direct Line [2018] EWHC 1671 (QB)*

[3] *Hibbert-Little v Carlton [2018] QBD 06/07/2018 [paras 48-50]*

SPECIAL ARTICLE

Forgetting, Fabricating, and Telescoping

The Instability of the Medical History

Arthur J. Barsky, MD

[4] Bartlett E. Remembering. A study of experimental and social psychology. Cambridge,1932.

[patients may, in recalling the past, exaggerate the significance of events as a way of coming to terms with the illness [eg. impact of whiplash]

Recent examples- CRPS Type 1

- 50 patients
- Limb pains
- 84% somatic symptom disorder
- 65% opiates
- 22 DVD surveillance [5 gross exaggeration, 1 FD]

- *Legal cases: Surface Systems Ltd v Danny Wykes [2014] EWHC 422 QC*

Bass C Yates G. *Med Sci Law* 2018;58:147-53.
Lovatt v Ruffell HHJ Hughes,2018

Mechanisms? Cognitive dissonance model

- Fabrication induces dissonance, which in turn escalates into self-deception [1]
- ...some people become so deeply involved in their own fabrications-which may pertain to autobiographical fiction or false symptoms-that they lose sight of the conscious origins of their fabrications [2]
- ...ie. conscious other-deception [malingering] may develop into unconscious self-deception [3]

[1] Merckelbach H, Merten T. *Clin Neuropsychol* 2012;26:1217-29*
[2] von Hippel W, Trivers R. *Behav Brain Sci* 2011;34:341-56.
[3] Delis D Wetter S. *Arch Clin Neuropsychol* 2007;22:589-604.

Malingering: the legal perspective

1.Burdens of proof
"he who asserts must prove"

2.Standards of proof
"the balance of probabilities"
(allegation of fraud in civil proceedings requires proof of the defendant's intention to deceive)

3.Findings of fact
(a) Weight of the evidence
(b) Objectivity of the evidence eg surveillance; social media
(c) Inherent probability of the truth of the evidence
(d) Manner in which the evidence is presented eg. observing the witness in the witness box.

Jones M. In: Halligan P, Bass C, Oakley D. OUP (2003)

Key questions in medical interpretation of exaggeration

Is it deliberate?

- If so, what is the intent?
- Is it with the intent to deceive?
  - If so, properly a judicial and not a clinical matter;
- Is it with the intent to convince?
  - More likely with iatrogenic distress/confusion

Is it "unconscious" (non-deliberate)? ***and how would we know?***

- If so, what is the evidence?
  - Is it mediated by distress
  - Is it based on misunderstandings about pain etc
  - Is it part of a learned behaviour pattern?

Main C. In: Halligan P, Bass C, Oakley D. (2003)

If Psychiatrists cannot differentiate between conscious/unconscious motivation, what can they do?

[1] Adopt developmental perspective which allows psych to make predictions about future mood and somatoform disorders

[2] provide evidence-based scientific papers to substantiate clinical findings

[3] provide advice about treatments eg FNDs and personality disorders

Conclusions

1. Malingering is not a medical (or psychiatric) disorder (although doctors must be aware of it since patients can engage in deception)

2. Use of the term malingering (denoting wilful fraud) is a judgement for the court and not the expert medical witness *(unless they are also trained in forensic detection)*

3. Instead, focus on the identification and interpretation of
   - symptom exaggeration/amplification
   - Inconsistencies in numerous domains

4. A view on exaggeration can be supported by systematic clinical and psychological appraisal (but to convince or deceive?)

5. Rather than ask about conscious or unconscious motivation, ask what a psychiatric opinion can add to a formulation of the case [in particular vulnerability factors, sound scientific evidence and advice re treatment].