

Malingering, Factitious or Functional Disorder?

Clinical Neuropsychology and the perennial issue of Symptom Validity.



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Many practitioners appear to privately offer medico-legal services involving the assessment of cognitive and emotional functioning after a road traffic accident. What can be challenging is to distinguish between clinicians who have completed all the relevant training, those who are qualified as a Clinical Psychologist and those who instead even lack the basic compulsory registration to practise. It is relatively common to come across practitioners who believe assessing someone's cognitive functioning just consists of "administering some tests". However, even graduate psychologists (employed in the NHS as Assistant Psychologists) can administer tests under supervision. The challenge and the aspect requiring clinical skill, is how to interpret data generated from testing.

Medico-legal assessments involve interpreting potentially complex clinical situations, but also additional litigation factors. Practitioners must be mindful that human behaviour can be influenced by a range of internal as well as external factors. Historical records show that human beings have long engaged in deceptive behaviour to avoid duties or bring them advantages. For instance, the Hebrew Bible reports that David feigned insanity to escape from a king who viewed him as an enemy (Sam 21: 10-15, cited in Stone & Boone, 2007). As early as Roman times, Galen reported two cases involving feigned illness to avoid performance of duties (Lund, 1941).

Currently the term malingering is used to describe the intentional fabrication (or feigning) of physical and psychological symptoms for external incentives. Such incentives may include, avoiding military duty, avoiding criminal prosecution, obtaining financial compensation or obtaining drugs (American

Psychological Association, APA; 2000). Malingering is thought to be more likely when people are interested in pursuing material or financial gains.

Malingering may seem to be a clearly defined behaviour; however, what makes its recognition challenging is that it is often not possible to be sure whether the fabrication of symptoms is intentional and whether external incentives are present. The potential for malingering is nevertheless one possible threat to the validity of information gathered during clinical assessments. Given the potential secondary gains associated with the outcome of a medico-legal evaluation, malingering must be considered a possibility in this context.

A related concept is that of factitious disorder. This term was thought to have been first used by Gavin in 1838 (cited in Kozłowska, 2007) in his book on military malingering, to indicate a type of malingering in which clinical evidence is tampered with or artificially produced. Factitious disorder first appeared as a diagnosis, distinct from malingering, in the Diagnostic and Statistical Manual of Mental Disorders-III-R (DSM-III-R; American Psychiatric Association, APA, 1987). This disorder is thought to be associated with psychopathology and may be a means by which vulnerable individuals maintain attention of healthcare professionals (Shorter, 1992). However, the diagnosis of factitious disorder continues to elicit debate. Richard and Wessely (2010) suggest that this term was coined by doctors who did not want to affect the relationship with malingering patients without providing them with the blameless label of functional disorder. They argue that this term no longer has a role in current medicine and it should not be used.

Both malingering and factitious disorder require the individual has a conscious intention to produce or report symptoms. When considering a behaviour that is outside conscious intention, this can be diagnosed as functional disorder (DSM-IV; APA 2000). Functional disorders (or somatisation disorders), specifically conversion disorders when the symptoms involve the nervous system, were called 'hysteria' and have been reported as early as in pharanoic Egypt, Roman and medieval medicine (Veith, 1993). They are often used interchangeably and their conceptualisation has evolved over time, from being due to wandering womb (King, 1993), to spiritual possession (Veith, 1993) until suggested by Breuer and Freud (1895; cited in Lamberty, 2008) as originating from an unconscious conflict. According to Stone et al. (2005), functional disorder refers to a variety of physical symptoms that have a psychological origin and conversion disorder refers to a psychoanalytic concept that describes neurological and sensory symptoms thought to be not malingered, but related to psychological factors. A similar concept is symptom misattribution; this involves an individual developing an idea that explains their symptoms that is not consistent with established medical evidence. An example may be that benign common cognitive failures are seen as proof of having sustained a brain injury following a minor blow to their head.

Making the distinction between malingering, factitious disorder and functional disorder is difficult as this involves understanding an individual's internal motivation, of which even the individual themselves may not be fully aware. It is also difficult to differentiate between malingering and factitious disorder as the first is thought to be associated with external incentives and the second with internal incentives. For instance, it can be argued that if someone's illness delayed a divorce (which the sufferer does not accept), this may be an external incentive, as well as an internal one. Not only it is difficult establishing intention but also distinguishing between what constitutes an external and an internal incentive.

It is fair to conclude that there could be several reasons as to why a clinical presentation may not be consistent with what is expected based on clinical history, investigations, behavioural observations and/or established medical knowledge of the condition in question. Intentional deception for the purpose of external gains should always be considered, but cannot always be assumed. For instance other psychological processes may underlie symptom over-reporting and poor effort on cognitive tests following head injury. Furthermore it is also possible that symptom over-reporting and poor effort on cognitive measure coexist with organic injury.

Case examples

It may be argued that the Clinical Neuropsychologist's role is identifying inconsistency in a clinical presentation rather than attributing this to malingering, factitious or functional disorder and that it is then the Court that makes the determination on whether malingering has occurred. Consider the case of an individual who reported during the consultation of being unable to drive and to carry out most simple activities of daily living (e.g. buy and cook food) as a result of their brain injury. However, they arrived on time and well kempt on their own to the consultation and reported to live on their own with no obvious problem would certainly raise a strong suspicion of malingering. This clinical picture appears to include many inconsistencies, however, reviewing of the medical notes, clinical interview with the individual (and any third party informant) and the results on specific tests might or might not provide support for a diagnosis of malingering. Whether it is part of the Expert's role or whether it is the prerogative of the Court to make this determination can be debated. Often the legal case may involve additional evidence, such as surveillance recording, that may not be usually available to the medical experts and this may help the Court establishing whether symptoms that appear unusual or unlikely may be consistent with malingering or perhaps just with symptom misattribution or a functional disorder.

Symptom validity testing may also be helpful in cases where individuals develop a perception of being disabled and can also develop mood disorders, which in themselves are often associated with self-reported cognitive difficulties. An example of this could be a young man¹ who following a mild traumatic brain injury during a car accident does not receive any formal cognitive assessment or any guidance on recovery by NHS services. The NHS treatment focuses on his other injuries, but he experiences cognitive problems. He goes online and reads about brain injury symptoms. During his rehabilitation funded by the claim, cognitive symptoms are attributed to emotional disturbances and he does not receive any expert formal assessment of his cognitive functioning. He is referred to a charity for people with head injuries where he shares his difficulties with other attendees. He starts feeling his life is ruined and feels resentful with the driver of the car in which he travelled. Eventually he receives an expert clinical neuropsychological assessment as part of his compensation claim. Twelve months post-accident he has not yet returned to work due to his self-perceived cognitive problems. He still suffers from anxiety and depression and his activities of everyday living are very limited. Symptom validity testing can help rule out any

cognitive underperforming and verify whether the cognitive assessment results are a true representation of his abilities. It can also monitor for the presence of any symptom over-reporting.

At formal assessment his cognitive test results indicate intact cognitive skills and treatment recommendations are made. He then goes on to receive Cognitive-Behavioural Therapy (CBT) by a treating Clinical Neuropsychologist, including guidance on recovery following a mild brain injury and symptom misattribution. The aim is for the young man to feel again satisfied with his abilities, to feel able to cope, for him to gradually return to work, for his mood to improve and for his activities to return to normal levels.

These examples highlight the importance of considering the whole clinical picture, both also relying on validated and standardised tools, both for the purpose of establishing diagnosis, causation and prognosis.

The assessment process

Clinical neuropsychology plays a role in identifying and flagging up inconsistent or dubious symptoms. Assessment usually includes review of the medical records, a semi-structured clinical interview with the individual and ideally a third party informant, such as a family member or a close friend. Additionally psychometric tests of emotional, personality and cognitive functioning can be administered to cover all the cognitive domains (i.e. intellectual functioning, attention, memory, visuo-spatial skills and executive functioning). If the individual to be assessed is a reliable historian and if there is no intentional (or not intentional) symptom exaggeration or cognitive underperformance both the interview and the test administration can yield accurate information. Symptom validity testing contributes to identifying inconsistent presentations (i.e. identify a presentation that is not thought to be consistent with what is known or expected of a certain condition). It is then down to detailed clinical assessment to determine whether a pattern on test results is due to malingering, somatisation or the controversial factitious disorder, or whether perhaps simply the results obtained are not a true representation of someone's cognitive skills. Symptom validity testing is considered increasingly important in clinical or medico-legal assessments as presentations may at times be inconsistent with clinical records, history, behavioural presentation and/or third party accounts. Internationally it has been agreed that assessing for symptom validity, including effort, is nearly always necessary (e.g. British Psychological Society, BPS, 2010.)

It appears important that Experts do not pick and choose when to administer tests of symptom validity but that these are always included in the test battery. This way there can be no doubts over their impartiality. The BPS guidelines indicate that these should always be included unless there are very significant clinical reasons as to why they would not be necessary; an example reported by the guidelines is when assessing people who live in a 24-hour care facility.

Disregarding the complexities of psychosocial variables may otherwise lead practitioners to erroneously conclude someone intentionally feigns their symptoms when this is not the case. Some assessments do not include symptom validity and one may wonder whether these reflect limited knowledge in the field. This is why it is important that only qualified Clinical Neuropsychologists are involved in carrying out medico-legal evaluations of cognitive functioning. For those outside the field: being a Chartered Psychologist with the BPS does not necessarily indicate that the Psychologist is registered with the Health and Care Profession Council (HCPC), which would be statutorily required to be employed in the NHS. Recent BPS professional guidelines (2013) stated that although the title of Clinical Neuropsychologist is at present not legally protected titles, "Clinical Neuropsychologists should meet the competency standards examined by

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Medico-legal assessments for suspected or known brain injury and/or brain dysfunction:

- Traumatic brain Injury,
- Post-Concussion Syndrome,
- Stroke,
- Dementia,
- Neuropsychiatric conditions,
- Including mental capacity and fitness to plead.
- Dr Monaci can also carry out assessments in Italian.



Instructions from Claimants, Defendants and as a Single Joint Expert. Appointments within 2-4 weeks, reports produced in a further 2-4 weeks. Consulting rooms in Surrey, consultations available nationwide and home visits may be arranged.



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the BPS Qualification in Clinical Neuropsychology (QiCN)". "Therefore, the BPS DoN strongly recommends that all appropriately qualified Clinical Neuropsychologists should join the SRCN to support public safety. To refer to oneself as a Clinical Neuropsychologist, Consultant Clinical Neuropsychologist or to offer Clinical Neuropsychology services whilst not listed on the SRCN is acting against this professional & ethical guidance. Professionals undertaking QiCN training should always have their clinical neuropsychological work supervised by a member of the SRCN." ■

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