Clinical Psychology – what can it bring to a PI claim?

DR ALISON HARPER

HCPC REGISTERED BPS CHARTERED CLINICAL PSYCHOLOGIST

Overview

- How clinical psychology differs from psychiatry and other mental health professions
- Own background, training and experience
- How assessments are generally carried out – research, theory, experience
- Commonalities between therapeutic work and medicolegal work
- Differences (access to records etc, surveillance; malingering; other expert evidence)
- Assessment of malingering
- How to get the best out of experts

Psych = “related to the mind”

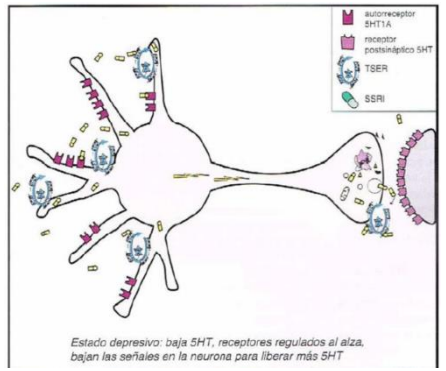
Psychiatry training

4-6 years medical degree and 2 foundation years

3 years specialist training (CT1-3) & 3 years higher training (ST4-6) in sub speciality (CAMHS, forensic, general adult, old age, LD)

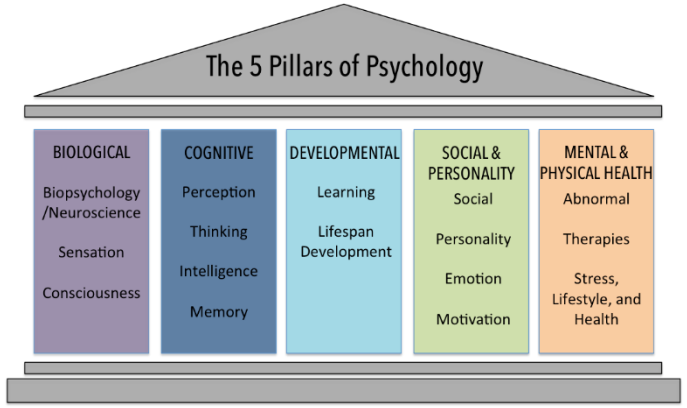
Royal College of Psychiatry Membership, knowledge of psychotropic medication and treatment

Generally see patients who have more severe disorders such as Bipolar Disorder, Schizophrenia and severe Anxiety Disorders – more work done in inpatient settings/ mental health tribunals



Clinical Psychology training

- 4 year undergraduate degree in psychology (cognition, developmental, social, personality, MH)
- 2+ years an assistant psychologist (research / clinical) + additional training (CBT)
- 3 years Doctorate in Clinical Psychology - Adult, CAMHS, LD, older adult, neuro.
- Registration with HCPC and chartered with BPS
- Mandatory supervision at all levels
- Trained in evidence-based psychological treatments:
- CBT, EMDR, IPT, Schema therapy, ACT, DBT for cPTSD)
- Generally work with non-psychotic illness



Overlap in practice

Rivers Centre: specialist trauma centre for NHS Lothian - training, assessment and treatment – largely PTSD and c-PTSD

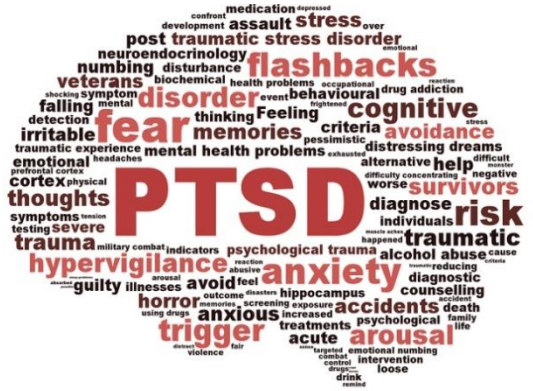
Clinical Psychologists x 3

Psychiatrist x 1

CBT therapist x 2

Counselling Psychologists x 2

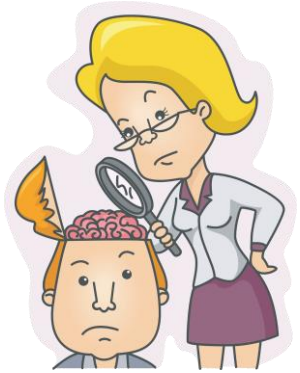
Art therapist x 1



NICE guidelines: tf-CBT, EMDR, DBT for c-PTSD (medication: sertraline/ paroxetine)

Own background and experience

- Qualified 2000; NHS - primary care and day patient, then PP and now run a training practice
- Working in medicolegal for over 15 years
- 1st court appearance 2012 – only 8 since then
- Personal injury
- Historic abuse
- Medical negligence
- Employment tribunal
- Family cases



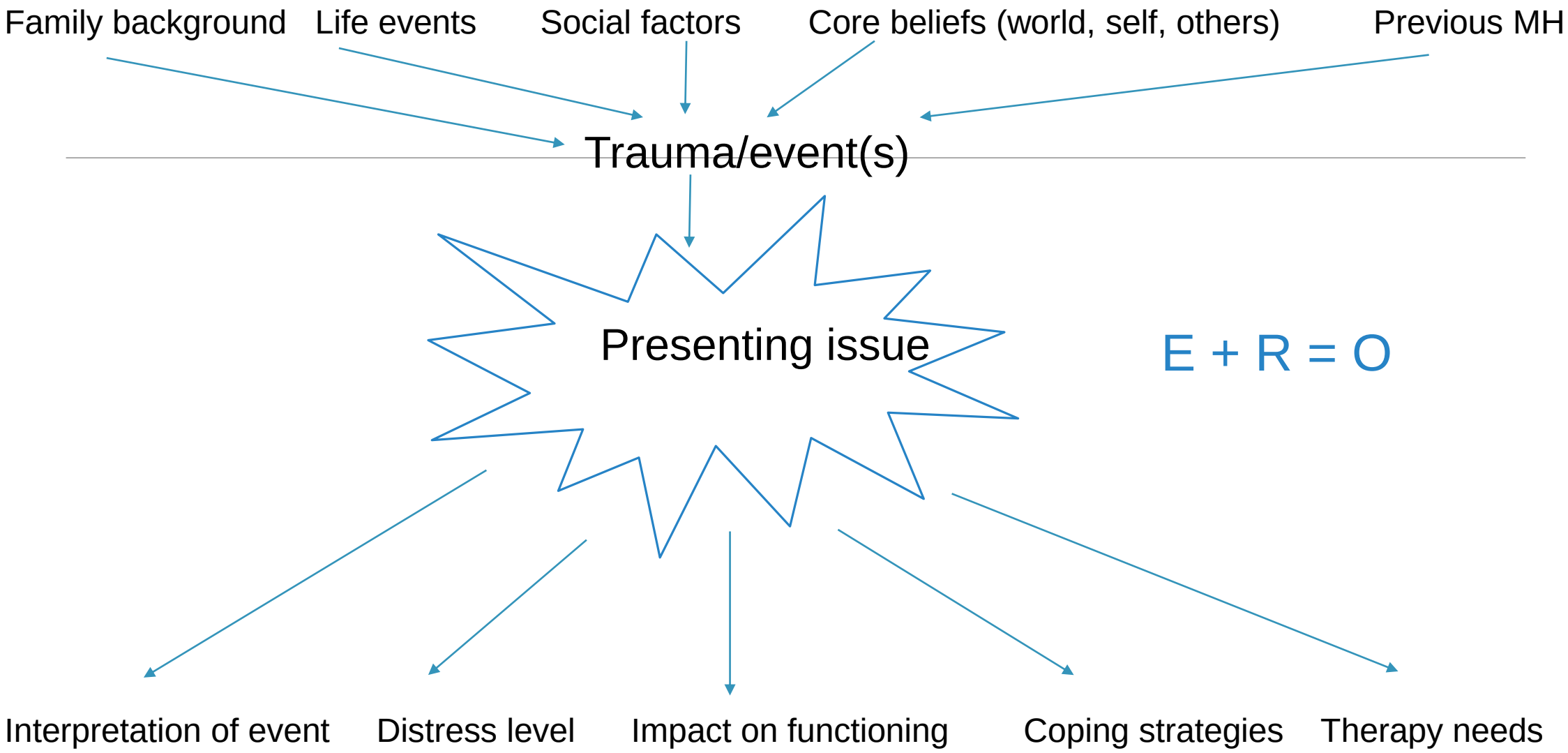
How we assess clients + come to an opinion

- Clinical Interview (is different to therapeutic practice in that it's one-off)

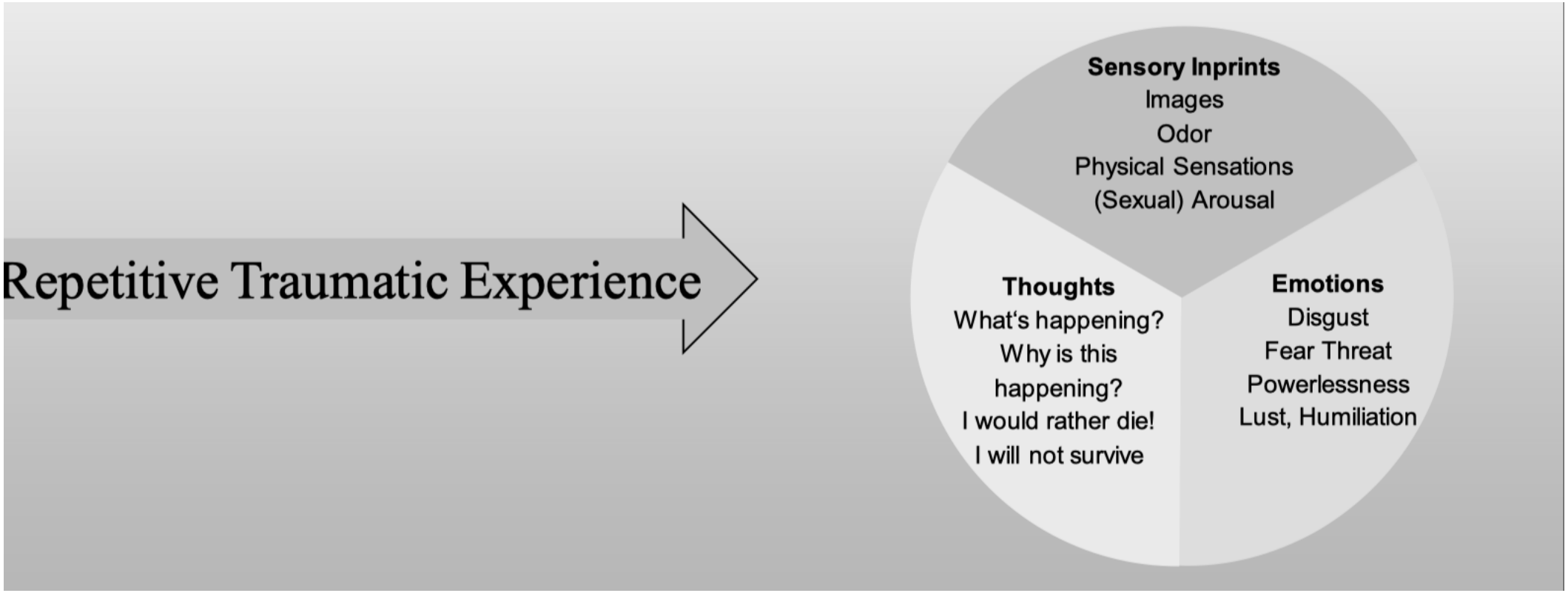
- Background history (story from beginning to now, previous mental health, relationships, other life stressors, social/occupational functioning pre incident

- Account of the accident/event(s), difficulties since (psychological and physical)

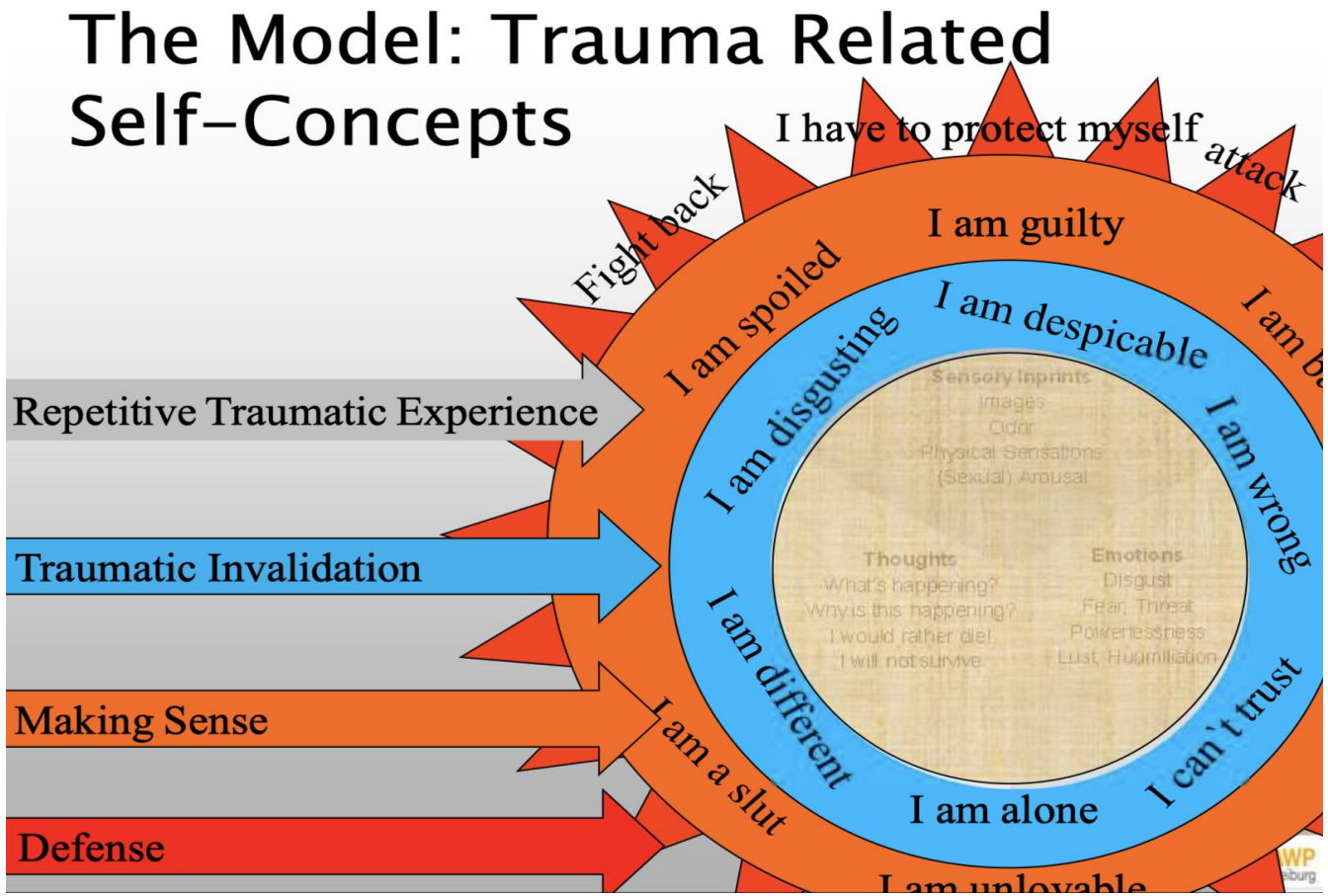
- Use of measures/rating scales: standardised, used routinely in clinical practice


Family background
Life events
Social factors
Core beliefs (world, self, others)
Previous MH
Trauma/event(s)
Presenting issue
E + R = O
Interpretation of event
Distress level
Impact on functioning
Coping strategies
Therapy needs

Use of knowledge: formulation in CSA



Formulation based on research + theory



Training helps us know how a client may present

For repetitive events the brain creates a network - association of neurons that activate all together – e.g.: piano playing is organised as network –automated

Trauma networks go back to time of trauma (e.g.: penetration at 8 years = pain in stomach – don't know it's penetration) – they not understand what they're experiencing – dissociate

Trauma networks are activated by cues – so emotion, cognition, behaviour triggered

Treatment: research + experience

Positive early experiences	Traumatic early experiences
Parent who can provide a safe base	Neglective/abusive/chaotic parent
Attuned parent holds child in mind & attends to needs	Can't hold child in mind or attend to needs
Child learns: Empathy Theory of mind Social Skills Self-regulation	Child does not learn: Empathy Theory of mind Social skills Self-regulation
Child gains a template of Healthy relationships	Child gains dysfunctional template of relationships
Choose relationships and lifestyle providing empathy and stability	Attracted to chaotic relationships and lifestyles

PI cases differ to therapy: malingering + secondary gain

“Intentional production of false or grossly exaggerated physical or psychological symptoms motivated by external incentives” (DSM-5)

Classifications of Malingering:

- Pure Malingering: clients fabricate symptoms that do not exist at all
- Partial Malingering: symptoms that do exist are exaggerated
- Misattribution: clients attempt to blame real symptoms on an un-related event

Extra information in PI cases

Review of other relevant sources of information: medical/psychiatric records, Human Resources, Occupational Health or other existing reports, witness statements

Key Questions:

- Does the clinical picture match collateral data? (were they or not at the event!)
- Are there discrepancies? (one page of missing medical records v account)
- If yes, can these be explained/understood?

Detection of malingering

- “Textbook” descriptions or “I’ll get my notes”
- Overly vague descriptions - or overly dramatic “story” descriptions
- Inconsistency in symptom presentation/narrative
- Over-idealised functioning before the trauma
- Non-disclosure of pre-existing mental ill-health/stressors, particularly if close in time
- Evasiveness
- Reluctance to allow discussion with third party to corroborate symptoms

Assessment of malingering

There are only two situations where malingering can be diagnosed with certainty:

1. The patient is caught out
2. The patient confesses

The fundamental problem of mental health diagnoses is that they rely, at least in part, upon what the patient says… we don't get the fingerprints and tattoos of Nicholas Rossi/ Arthur Knight

Malingering: the Case of Mr Grubb

"A recurring theme was the pursuer's lack of candour, with a focus on his lack of credibility and reliability. That undermined most of his case, including his position on causation. Although the lack of candour had not been enough to warrant depriving the pursuer of a finding on liability, it did play a material part in the pursuer obtaining only a modest award by way of damages relative to the sum sued for (£500,000), the pursuer's statement of valuation (£382,000) and eventual submission (£183,000). The pursuer achieved very limited success, approaching almost complete failure. The court could and should mark its disapproval of a claim presented with such a lack of candour and that could be reflected in the finding on expenses. The 2/3rds award reflected the defender's substantial success after proof"

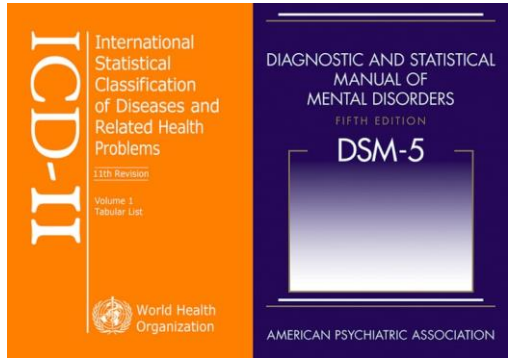
Clinical Examples of malingering

- The “let down by the records” malinger: needle phobic
- The “caught out” during assessment malinger: “can’t use my left arm” but then demonstrates
- The “caught out before or after assessment”: walking up the street; parking round the corner
- The “doesn’t match anything ever seen in practice” malingerer: c-PTSD from 2x corporal punish.

- The false accusation of malingering: CSA case with diagnosis of BPD + ”fabricating”

Opinion

- Formulation – based on the account, clinical experience and research evidence
- The psychological injuries sustained
- Diagnosis (ICD-11 or DSM-5-TR)
- The client's present condition
- The client's capacity for work
- Treatment received
- Recommendations for further treatment
- Prognosis



How to get the best out of your expert

- Pre-instruction discussion – are you the best person?

- There is no substitute for experience:

Case (2020): *"Dr L had not been in practice for the past 5 years. Dr L could not assist the court with current clinical experience… unfortunately, Dr L struggled to express her opinion… she considered the additional information in a vacuum and out of context… she changed her position, then changed her position again, and again, so that it became unclear what she was saying to the court"*

- 2014 - PTSD from ITU in burns victim

Give specific instructions + documents

- Specific questions to answer
- Complete set of medical records
- Other expert reports
- Any specific legal factors to consider? (secondary victim status)

Know that your expert is bound by clinical guidelines

Ensure objectivity and honesty

- Over-focus on % of reports done for pursuer v defender – 100% satisfaction is not a good sign!

- Ensure use of expert witness professional guidelines
- Duty is to the court, not to the client, solicitor, other third party
- Only comment on areas within your area of knowledge/expertise

BPS Guidelines: psychologists as Expert Witnesses - Best Practice Guidelines for Psychologists

Challenge your expert

- Why has information been included (e.g.: background history)?
- What does the literature say?
- Why would the other expert witness not be preferred?

Caution: DSM-5-TR and ICD-11

Changes over time: ICD in 1949; DSM in 1952 - e.g.: c-PTSD

Dudley Metropolitan Borough Council v Mailley (2022): hoarding disorder where claimant sought possession of house. *"The judge was not impressed that, simply because Hoarding Disorder was not included in ICD-10, a diagnosis could not be made"*

Experts may be talking about the same thing, just using different labels

Ensure your expert is prepared for court

- Revision – reports, records, other expert reports
- Up to date literature search and guidelines
- Pre-trial meetings
- Updated meeting with client

Thank you for Listening: Any Questions?

Contact Details

Alison Harper
Harper Clinical Psychology
w: www.harperclinicalpsychology.com
e: alison@harperclinicalpsychology.com
Tel: 0131 341 4898
Mob: 07960 900 965