

Liability for Diagnosing Malingering

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Malingering is a medical diagnosis, but not a psychiatric disorder. The label imputes that an evaluatee has intentionally engaged in false behavior or statements. By diagnosing malingering, psychiatrists pass judgment on truthfulness. Evaluatees taking exception to the label may claim that the professional has committed defamation of character (libel or slander) when the diagnosis is wrong and costs the claimant money or benefits. Clinicians may counter by claiming immunity or that the diagnosis was made in good faith. This problem has come into focus in military and veterans' contexts, where diagnoses become thresholds for benefits. Through historical and literary examples, case law, and military/veterans' claims of disability and entitlement, the authors examine the potency of the malingering label and the potential liability for professionals and institutions of making this diagnosis.

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La calunnia è un venticello. (Slander is a little breeze.)—
Don Basilio to Doctor Bartolo in *The Barber of Seville*,
Gioachino Rossini

Forensic practitioners are by law and tradition prohibited from concluding facts that are the domain of judges or juries. They state only opinions, in the form of written work product and testimony, based on medical evidence. Experts never say “guilty” or “not guilty” or form bottom-line judgments on liability. The overreaching witness risks the penalty for hubris: exclusion of testimony. Whereas experts express opinions within reasonable scientific certainty and swear to tell the truth, they have no purchase on truth as it is applied to legal matters: the ultimate issues. For example, they are barred from commenting directly on the veracity of a civil plaintiff, criminal defendant, or witness. That is considered an invasion of the domain of the judge or jury. Instead, the expert says whether statements are consistent with other evidence or congruent with psychiatric knowledge.

There are times, however, when the forensic psychiatrist can tiptoe over the border and state an opinion with devastating potency: that is, when making a diagnosis of malingering. Here, cloaked in diagnostic nomenclature, a mortal blow is delivered: “The person I evaluated is lying.” Game over; or is it? In this commentary, we explore the dimensions of diagnos-

ing malingering, harming evaluatees, and the risk of liability when the subject of the diagnosis fights back.

Defamation

False and harmful communication by mouth (slander) or media (libel), directed at persons other than the subject and causing harm to the subject, constitutes defamation and can be the basis for litigation. Though defamation may start as “a little breeze,” it can result in a tempest. Proof of defamation requires that words be both false and harmful and the act intentional. The aggrieved party must sometimes show restraint in pursuing legal redress. In 1895, when Oscar Wilde was consorting with the young son of the Marquess of Queensberry, the enraged father left a note at Wilde’s social club calling the writer a “sodomite.”¹ Wilde brought a private criminal complaint against the man. During the trial, Wilde, apparently scotomatous to the hazards of truth-telling, testified to what amounted to an admission of pederasty in his life (widely known) and in his fiction (*The Picture of Dorian Gray*, for example). His lawyer, sensing checkmate, withdrew:

[T]hose who are representing Mr. Oscar Wilde in this case had before them a very terrible anxiety. They could not conceal from themselves that the judgment that might be formed of that literature and of conduct which has been admitted, might not improbably induce the jury to say that when Lord Queensberry used the words “posing as a sodomite,” he was using words for which there was sufficient justification to entitle a father, who used those words under these circumstances, to the utmost consideration and to be relieved from a criminal charge in respect of that statement [Ref. 1, p 280].

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Wilde's calumny prosecution was dismissed. The tables turned, and he was convicted for indecency, spent two years in prison, and never published again. Wilde and the Marquess were deadly serious. Humorists, on the other hand, appear to have immunity when it comes to communication that is demonstrably facetious. For example, a 2014 American legal decision noted that hyperbolic or colloquial statements, understood as jokes, cannot be a basis for litigation.² If humorists have immunity from defamation claims, do psychiatrists enjoy the same benefit when they earnestly do their jobs?

Malingering

Psychiatric and many medical conditions can be malingered, whereby the feigned symptoms are consciously designed to achieve an end. In the dictionary definition, to malingering is "to pretend to be ill to escape duty or work."³ Synonyms for malingering include shirker, slacker, idler, layabout, dead-beat, and gold brick. In military settings, a person attempting to avoid service by feigning illness or disability or by a self-inflicted injury is subject to court-martial and punishment.⁴ Medical professionals must be vigilant for suspicious presentations. The threshold for reporting the problem, by making a diagnosis of malingering, is far from uniform.

Historical Examples

Suspicious presentations of illness have been known for ages.⁵ We see it in the story of Ulysses,⁶ who tried to avoid recruitment for an attack on Troy by feigning madness, but was called out on it:

And so when he learned that spokesmen would come to him, he put on a cap, pretending madness, and yoked a horse and an ox to the plow. Palamedes felt he was pretending when he saw this, and taking his son Telemachus from the cradle, put him in front of the plow with the words: "Give up your pretense and come and join the allies." Then Ulysses promised that he would come; from that time he was hostile to Palamedes [Ref. 6, Fable 95].

The detection of malingering received much attention in the 19th century. The British literature was keen on detection of feigned illness and other forms of deception.⁵ The focus was usually on members of the armed forces. Some European countries punished malingering, by disgrace, loss of privileges, corporal punishment, or even life in prison.⁵ During the American Civil War, many types of physical and psychological conditions were feigned.⁷ Keen, *et al.*,⁸

operating out of Philadelphia's Turner's Lane Hospital, summarized the problem this way:

The older soldiers are fast learning deceit, and, if we be not mistaken, the attempts to malingering are now much more frequent, and far more clever, than they were two years ago. . . . The great majority of malingers consists rather of men who exaggerate real maladies of trifling character, or who feign disease outright. Of the two classes, the first is the larger. The real depletion of our ranks is not so much by feigned epilepsies, paralyzes, and the like—we speak now of our own experience—as by these cases of disease, once severe, or always slight, to which men add invented symptoms, or continue to assert the existence of those which have passed away [Ref. 8, p 367].

Around the same time, the popularization of rail travel and injuries known as "railway spine" created ambiguity about the origin, pathogenesis, and authenticity of patients' complaints.^{9,10} Erichsen's 1867 work on railway spine noted the difficulty in making the diagnosis in mild cases, but he did not appear suspicious of patients' motives.⁹ He was likely in the minority of authorities, most of whom viewed railway spine as an opportunity for a citizen to sue a railroad.¹⁰

As we will illustrate, the label of malingering in a military setting can have devastating consequences for the soldier or veteran seeking compensation or relief from duty. British poet Wilfred Owen, who died in battle at the end of World War I, conveys a sense of the scorn and rejection aimed at military malingers in this excerpt from "The Dead-Beat"¹¹:

We sent him down at last, out of the way.
Unwounded;—stout lad, too, before the strafe.
Malingering? Stretcher-bearers winked, "Not half!"
Next day I heard the Doc.'s well-whiskied laugh:
"That scum you sent last night soon died. Hooray."

Advice to medical practitioners in early 20th century England implied that they enjoyed qualified immunity from liability when identifying malingers. In the following passage, we see the possibility of the alleged malingering accusing the examiner of something sinister, with malice erasing privilege¹²:

With regard to legal responsibility, the medical examiner need have no fear, for his position is absolutely privileged, so far as libel or slander is concerned; but, of course, privilege could not be pleaded if the examiner had been guilty of malice. Anything said in the witness-box is, of course, covered by the protection extended to witnesses, as well as any report written by him on the case, and any statement given to proper persons for the purpose of his proof of evidence [Ref. 12, p 17, emphasis added].

Prevalence of Malingering

The prevalence of malingering has been difficult to determine, and estimates have been subject to er-

ror. This miscalculation is reflected, for example, in the facetious title of an article by Young¹³: “Malingering in Forensic Disability-Related Assessments: Prevalence 15±15 percent.” Estimates suggest overrepresentation in forensic populations. For example, LeBourgeois *et al.*,¹⁴ reviewing malingering in forensic domains, note as much as 30 percent in disability evaluations and even more among Social Security claimants and criminal defendants.

During a 15-year surveillance of military service members (1998–2012), the incidence of malingering and factitious illness rose from 15.17 per 10,000 person-years in 1998 to 50.24 in 2000, and then down to 9.04 in 2007.¹⁵ These figures did not correlate with the onset of wars in Iraq and Afghanistan. However, a significant proportion of the 4,456 service members diagnosed with malingering were younger recruits, especially under age 20.

Veterans seeking compensation for posttraumatic stress disorder (PTSD) are often suspected of symptom exaggeration or fabrication, but a sample of 26 million military medical visits from 2001–2011 revealed only about 1,000 diagnoses of malingering.¹⁶ Persons with chronic pain complaints and financial incentive referred for psychological evaluation in one 10-year study had a 20–50 percent rate of malingering; workers’ compensation claims and the presence of an attorney were among the higher values.¹⁷

One current controversy surrounds mild traumatic brain injury (mTBI, concussion). When unaccompanied by radiological findings, the presentation is often regarded as suspicious. As Wortzel and Granacher¹⁸ recently have observed: “Litigants, attorneys, and medical experts can take advantage of the legitimate but widely disparate potential outcomes of TBI to misrepresent the implications of any given injury event, conflating the very favorable prognosis associated with concussive injuries with the potentially debilitating sequelae of TBI more generally” (Ref. 18, p 499). Expert witnesses who confront these issues scientifically, without malice, are expected to be shielded from claims of defamation.

Look Before You Label

Forensic evaluators are aware that subjects are not always truthful. Indeed, they believe that subjective clinical data must be viewed in the light of its overall contextual congruence, as a proxy for historical truth. They rarely accept everything an evaluatee says

at face value, but there is a differential diagnosis for untrue self-reporting that includes malingering, pathological lying (*pseudologia fantastica*), factitious disorder, confabulation, Ganser’s syndrome, personality disorder (borderline, antisocial, histrionic, and narcissistic), and delusions.¹⁹ Hall and Hall,²⁰ reflecting on the now-historical term “compensation neurosis,” identified over two dozen synonyms for it, suggesting that it is not entirely coextensive with malingering. An evaluatee may be sincere and convey veracity and may be inaccurate, but still not consciously design to deceive. For this reason, a label of malingering must be held in abeyance pending ample evidence.

Persons seeking disability benefits and criminal defendants wishing to avoid prosecution are at high risk for malingering. The American Academy of Psychiatry and the Law’s Practice Guideline for the Forensic Evaluation of Psychiatric Disability²¹ suggests psychiatrists always consider the possibility of feigned or exaggerated self-reporting. Because of the seriousness of the diagnosis, “the determination should therefore be based on convincing objective evidence” (Ref. 21, p S19). In the same vein, Knoll and Resnick²² observed:

An inaccurate diagnosis of malingering by an expert does a major disservice to justice and embarrasses the psychiatrist. The psychiatrist also is at risk of a lawsuit for defamation of character, in addition to malpractice. In ordinary circumstances, our opinions are given simply with reasonable medical certainty. Because of the serious legal implications of malingering, such a diagnosis should not be made unless there is a high degree of certainty [Ref. 22, p 624].

In the criminal case described by Knoll and Resnick, the defendant obstructed the legal process with behaviors mimicking incompetence and received an enhanced sentence because of it.²² They suggest going so far as to warn a suspected malingerer of a potential negative outcome. The AAPL Forensic Assessment Guideline²³ suggests that, when the warning is given, the psychiatrist document it in the informed consent section of the written report. Beyond this, the evaluator must adhere to objective truth telling and supportable evidence, rather than speculation or intuition.

Scott²⁴ has suggested using structured malingering assessments because of the complexity and gravity of such determinations. Added to the mix is the caution by Rogers and colleagues that malingering, viewed as an adaptation, is not simply “a stable trait or enduring characteristic of feigning individuals”

(Ref. 25, p 109); the adage “once a malingerer, always a malingerer” is not true. Not only is the diagnosis of malingering a moving target, but false positives can emerge when forensic evaluators are under pressure to apply the label.²⁶

What if malingering can be proved? Truth is a defense to a claim of defamation, as we recall the failed tack of Oscar Wilde. In a related scenario, malingerers, who may waste medical resources, can be charged with theft of service.²⁷ Health providers that are “covered entities” under the Health Insurance Portability and Accountability Act (HIPAA) are entitled to report crimes under 45 CFR 164.512(f)(5): “A covered entity may disclose to a law enforcement official protected health information that the covered entity believes in good faith constitutes evidence of criminal conduct that occurred on the premises of the covered entity.”²⁸ Appel²⁷ recently suggested that enhanced awareness of the law and anti-malingering statutes may be deterrents and could reduce malingering’s drain on resources.

Physicians and Malicious Labels

Name-calling and frank acts of defamation have enjoyed tactical use in the legal arena. Hayden²⁹ documents a 500-year tradition of immunity from claims of slander when a litigator defames opposing counsel, a litigant, or a witness. So, too, the expert witness, properly conducting an examination, should be shielded from harmful effects of diagnostic impressions on the evaluatee. Among the seminal cases supporting the freedom of expert witnesses comes from the Maryland Court of Appeals in their 1888 decision in *Hunckel v. Vonieff*.³⁰ The court said: “[I]n our opinion it is of the greatest importance to the administration of justice that witnesses should go upon the stand with their minds absolutely free from apprehension that they may subject themselves to an action of slander for what they may say while giving their testimony” (Ref. 30, p 501).

The Maryland Court of Appeals in 1989 looked at the boundaries of professional privilege.³¹ A psychologist was asked to perform a fitness-for-duty examination on a member of the horse mounted unit in a park police force. The clinical problems had been vague physical complaints, fear of horses, and anxiety attacks. The psychologist was struck by the officer’s seeming lack of cooperation with remediation and called him a malingerer and a pathological liar. The false symptoms, he said, were aimed at reassignment.

The officer sued for libel and slander, but the circuit court granted the defendant summary judgment. A special court of appeals reversed, and arguments were heard in Maryland’s Court of Appeals. The psychologist argued that he enjoyed absolute privilege, since the officer gave actual and implied consent for the examination. The officer argued that the psychologist went beyond the bounds of the type of conditional privilege in these situations. The court reasoned that the psychologist had at least qualified immunity, leaving open the possibility that he abused the privilege by communicating the information in reckless disregard of the consequences. Accordingly, the court concluded, the question of malice on the part of the psychologist should have been put to a jury.

A Pennsylvania superior court reasoned similarly in 1993 that defamation would arise only when there is “abuse of a conditionally privileged occasion,” in this case a defense medical examination.³² The court, finding for the defendant insurance company, defined abuse as occurring when the publication:

... is actuated by malice or negligence; is made for a purpose other than that for which the privilege is given; is made to a person not reasonably believed to be necessary for the accomplishment of the purpose of the privilege; or includes defamatory matter not reasonably believed to be necessary for the accomplishment of the purpose [Ref. 32, p 393].

In divorce and custody proceedings, with maledictions uttered regularly, there is immunity granted to expert witnesses and professionals within parameters. In a federal appeals case in 2001, the circuit court looked at a claim of interference with familial rights.³³ The appellant accused two court-appointed psychologists of poisoning his custody bid by misdiagnosing him on the basis of fabricated data. The court dismissed the claim, citing “absolute prosecutorial immunity” for court-appointed experts, who are not advocates, including for social workers in child custody and dependency matters.³⁴ In the above civil situations, there lacks uniformity on the question of professional immunity. In military and veterans cases, negative labeling can deeply affect lives.

PTSD and Malingering in the Military

Feigning illness to avoid military duty is a matter taken seriously within military mental health settings and courts.³⁵ The most prominent current concern is the diagnosis of posttraumatic stress disorder

(PTSD), including the validity of reported symptoms and the correct attribution of those symptoms to service-related trauma. One authority³⁶ parsed the problem along several axes:

Military law distinguishes malingering by type (feigning illness or intentional self-injury) and setting (deployed or in a hostile fire pay zone versus garrison or stateside). Punishments may be stratified, with greater punishments awarded for self-injury or malingering to avoid combat. Despite its status as a validated and prevalent psychiatric disorder, PTSD is often associated with malingering. Several motives include avoiding prosecution or punishment, obtaining disability compensation, or avoiding duty, including imminent or ongoing combat deployment” [Ref. 36, p 107].

Among the most salient problems in military and veterans’ benefits settings is the diagnosis of PTSD. Making the correct diagnosis depends on verification that the soldier experienced a traumatic event, that the event was service related, and that the symptoms reported align with Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria. Accordingly, the event in question must first be verified, which is standard procedure during applications for benefits. The well-known stumbling block has been that PTSD criteria, widely circulated, are mostly based on subjective symptoms. The symptoms are reported and recorded, and then become part of the medical record. Apart from identifying wholly fabricated claims (for example, no combat record), clinicians must differentiate authentic from exaggerated PTSD and to distinguish PTSD from adjustment disorder. From the soldier/veteran side, these are crucial, since benefits and payouts are dependent on the findings. The National Defense Authorization Act of 2008 codified into public law that a patient who develops PTSD as a result of active-duty service will receive at least a 50 percent disability rating, which equates with considerable financial compensation.³⁶

Falsely reporting PTSD symptoms is easy to do but difficult, at times, to detect. Navigating the differential diagnosis between true PTSD, exaggerated PTSD symptoms, and fabricated conditions has been difficult. Morel summarized it this way:

In addition to behavioral health treatment, patients diagnosed with PTSD may also be entitled to convalescence from the hardships of military duty, financial gain through disability pensions, and, in rare circumstances, possible exculpation for crimes by reason of diminished capacity. These benefits entice some military personnel to simulate PTSD. Hence, the nature of war can lead to genuine PTSD or the conscious simulation of symptoms of PTSD for secondary-gain [Ref. 37, p 3].

When the diagnosis is malingering, serious negative consequences ensue. Under the Uniform Code of Military Justice, Article 115, malingering can include feigning illness, physical disability, mental effort derangement, or intentionally inflicting self-injury for the purpose of avoiding work, duty, or service.³⁸ Confronting the malingerer in the clinical setting is often fruitless. Morel observed:

Indeed, some veterans arrive for disability pension examinations for combat-related PTSD with printed lists of the symptoms of PTSD that include real life examples of stressors. . . . Unfortunately, most mendacious individuals do not admit to malingering, even when confronted with transparent inconsistencies between their account of events and actual documented evidence [Ref. 37, p 8].

This difficulty may be why, before 2012, Army psychiatrists assessed PTSD claims on what was considered objective psychometric evidence. As we will see in the following situation, this tactic backfired because of overreliance on screening instruments.

The Madigan Army Medical Center Controversy

Several years ago, clinical screening procedures used at Madigan Army Medical Center (MAMC) in Tacoma, Washington, were called into question when hundreds of veterans seeking medical retirement were not diagnosed with PTSD. MAMC is one of the largest military hospitals on the West Coast. Opened in 1944, it was named after Colonel Patrick S. Madigan, known as “The Father of Army Neuropsychiatry,” the assistant to the Army’s Surgeon General from 1940 until 1943.³⁹ The questioned diagnoses involved reversal of PTSD diagnoses in 290 of 690 patients, affecting medical retirement benefits. The situation was publicized and came to the attention of U.S. Senator Patty Murray, who called for an investigation.⁴⁰ There had been speculation that MAMC’s top psychiatrist had suggested that each case of PTSD cost \$1.5 million and that alternate labels would result in designations of other designated physical and mental conditions discharges, wherein the veterans would not have been paid medical benefits.⁴¹ Because the soldiers had reported PTSD symptoms, the focus became clinicians’ disregard of the diagnosis or conclusions that some of the complaints were feigned.

The investigation was prompted in late 2011 when 14 soldiers filed separate complaints about the reversal of their PTSD diagnoses and, in some cases, being labeled as malingerers. Many of these soldiers claimed their symptoms were unfairly discounted,

and they were denied legitimate medical and financial benefits. The Army responded in February 2012 by investigating “diagnostic variance” at MAMC. The screening team conducting the original evaluations was organized by a forensic psychiatrist, who had used objective testing, such as the Minnesota Multiphasic Personality Inventory (MMPI) and Structured Interview of Reported Symptoms (SIRS)-2, as well as patient interviews.⁴⁰ These tests are designed to detect patterns of exaggerated answers that do not match actual psychiatric pathology. Because of false positives on these instruments, the reviewers determined, malingering was overdiagnosed. It seemed as if the clinicians relied more on symptom inventories than their own judgment.

Ultimately, the Army released new military guidelines for diagnosing PTSD in April 2012.⁴² These guidelines reject the methods used at MAMC, in particular the written tests designed to detect feigning. But feigning or poor effort, by themselves, are not malingering. The new policy states:

Although the influence of secondary gain is an important clinical consideration in the differential diagnosis, the diagnosis of malingering should not be made unless there is substantial and definitive evidence from collateral or objective sources that there are false or grossly exaggerated symptoms that are consciously produced for external incentives. Poor effort testing on psychological/neuropsychological tests does not equate to malingering, which requires proof of intent [Ref. 42, p 7].

All patients whose diagnoses had been reversed were offered re-evaluations; some had their PTSD diagnoses restored.⁴³ Others, whose diagnosis remained adjustment disorder, were relegated to reduced or no benefits.⁴⁴ Because adjustment disorder, by DSM criteria, does not persist beyond six months, veterans may be frozen out of service-related claims requiring PTSD.^{45,46}

Service-related trauma can lead to behavioral disturbances that can distract clinicians from PTSD, resulting in a label of antisocial personality and an other-than-honorable discharge. In March 2014, five Vietnam combat veterans brought a lawsuit against the Navy, Army, and Air Force, aided by volunteers from Yale Law School.⁴⁷ The plaintiffs received expedited action on their claims, ultimately gaining upgrades from their other-than-honorable discharge status and opening the door to other individual claims.⁴⁸ The complaint, in addition to detailing the plaintiffs’ narratives, outlines an important dynamic: how trauma-related behavioral distur-

bances can lead to other-than-honorable service discharges (Ref. 47, Complaint & Disposition). Having been filed in the DSM-5⁴⁹ era, the document urges: “Today, in recognition that PTSD can cause behavior that might otherwise appear as deliberate misconduct, the military’s own regulations require that members of the armed forces ‘reasonably asserting posttraumatic stress disorder’ receive a medical examination prior to administrative separation” (Ref. 47, Complaint, p 24).

Brannan v. Humphrey

The Georgia Department of Corrections executed Andrew Brannan on January 13, 2015.⁵⁰ An Army First Lieutenant serving in combat in Vietnam in 1970 and 1971, he had been convicted in the homicide of a deputy sheriff in 1998.⁵¹ His behavior at the time, captured on video, was manifestly disturbed (driving 98 mph, dancing in the street, irritable, and yelling, “Shoot me”). However, Mr. Brannan pulled a rifle from his vehicle and shot the victim nine times. He needed a medical basis for his behavior to reduce culpability.

At the guilt phase of the trial, there was testimony that the defendant, due to combat trauma in Vietnam, had PTSD, which was active at the time of the incident. According to the petition alleging ineffective assistance of counsel, the prosecutor referred to Mr. Brannan as a malingerer, having exaggerated his combat experience.⁵¹ The trial attorney used the testimony of three psychologists, not all familiar with all the facts of Mr. Brannan’s combat experiences but attesting to the genuineness of the PTSD in relation to the incident.⁵² Mr. Brannan was convicted. Then, in the penalty phase, only character witnesses were used. Apparently, the jurors did not give weight to the argument that PTSD and other mental disorders influenced the defendant’s behavior and recommended the death penalty. Perhaps they were influenced by the government’s trivialization of PTSD: “The prosecutor in his case made light of PTSD, commenting that ‘everybody’s got a little bit of PTSD. We’ve all been through some kind of trauma or another.’”⁵³ This type of argument, tending to dilute PTSD’s clinical reality, has, in our view, a pernicious effect on jurors’ capability of weighing the testimony.

In the subsequent appeals, including a claim of ineffective assistance of counsel, the Georgia and federal courts would not grant Mr. Brannan a new trial,

with the Eleventh Circuit Court of Appeals citing that the expanded arguments in postconviction were better than those at trial.⁵⁴ Ultimately, the Supreme Court declined to hear the case, leaving open the question of expanding the principle in *Ford v. Wainwright*⁵⁵ of not executing specified persons with mental illness.⁵⁶ The question has not changed since Mr. Brannan's case was reported in the *Journal* in 2010⁵⁷ and has continued to receive attention in legal commentary.⁵⁸ Perhaps, as Bordenave and Kelly⁵⁹ suggested before the Eleventh Circuit's decision, the reversal of death sentences would be burdensome and signal the end of the death penalty in America. Just as likely, Entzerth⁵⁸ points out, courts are unlikely to move in this direction until state legislatures do so. Whether the suggestion of defamation in Mr. Brannan's case can be linked to his execution is unknown, but the tactic of implying falsification of self-reported symptoms remains a potent rhetorical weapon.

Discussion

Diagnostic labels are interwoven within complex aspects of medical practice, from gateways for benefits to defamatory epithets. Labels of mental disorders can freeze a person's identity in a manner that seems to foreclose the possibility of change.⁵⁹ Reification of labels is in the culture and language; for example, "I am bipolar," "She's so OCD," or "He's on the [autism] spectrum." However, there are insidious consequences, as Grover observed: "[T]here exists no professional or scientific expertise sufficient to define, categorize, or describe the complexities of another's *personhood*" (Ref. 59, p 81, emphasis in the original). Calling someone a liar is an attack on personhood. We conclude that ethically conducted and unbiased diagnoses of malingering are within the shield traditionally offered to agents of the court. Because there is no gold standard for professional conduct or motives, however, there is the possibility of liability for defamation.

Although it was a victory for soldiers and veterans to see PTSD included in DSM-III,⁶⁰ we have seen here that a quieter war, that of thresholds for benefits and labeling, continued. The diagnosis of malingering has been used to invalidate and discredit persons, which may cross the border of clinical assessment into malice. Yet, like the diagnosis of PTSD, it is often based on the clinician's judgment. So complex is the methodological debate that a special session of

the American Academy of Clinical Neuropsychology addressed it.⁶¹ Examining symptom validity and effort, for example, the group underscored the importance of not jumping to conclusions:

When considering neuropsychological test performance, concerns regarding effort are frequently related to consideration of whether an examinee is malingering. However, simply equating "poor effort" with malingering is an oversimplification. . . . In some instances, examinee behavior (e.g., intentionally feigning deficits) may be for the purpose of meeting internal psychological needs (e.g., factitious disorder) or toward obtaining an external, material reward (e.g., malingering). In other instances, either an internal or external goal may be preeminent, or both may be equally important [Ref. 61, p 1097].

In addition to technical concerns in psychometric approaches, a problem encountered in the MAMC case through the overreliance on personality inventories, the conflation of "bad behavior" with malingering, is a special concern in military settings. We now appreciate that chaotic and aggressive behaviors can accompany PTSD and traumatic brain injury (TBI). Such behaviors, which otherwise violate the code of conduct or constitute criminality, distract the evaluator from incorporating them into the diagnosis of PTSD or TBI. This distraction leads to consequences including other-than-honorable discharges from the service and noneligibility for benefits. The U.S. Government Accountability Office (GAO) recently published recommendations directed at the Department of Defense (DOD) to correct the distortions in diagnosis that have led to negative consequences for service members.⁶² The GAO examined data from the DOD pursuant to the Carl Levin and Howard P. "Buck" McKeon National Defense Authorization Act for Fiscal Year 2015. Between 2011 and 2015, 91,764 service members had been separated for misconduct, including 62 percent who had a diagnosis of PTSD, TBI, or other condition within two years of separation. Of these, 57,141 (23 percent) received the other-than-honorable characterization of service, depriving them of veterans' health benefits.

In nonmilitary settings, where bad labels can cause harm, clinicians must not smugly diagnose malingering in persons who demand benefits, or worse, let negative countertransference creep in. As the neuropsychology group pointed out, it is the attributions that cause problems. That is, feigned symptoms or poor effort do not always indicate a clear ulterior motive. Without the documentation that the symptoms of PTSD are feigned and that the purpose is

conscious deception for identifiable benefit, the diagnosis of malingering may not be justified. To use the label when in doubt is a potential source of harm and must be avoided.⁶³ Thus, while forensic examiners may have immunity from liability in most cases, it is not an excuse to wield their swords wantonly.

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