

Psychiatric and psychological aspects of fraud offending[†]

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SUMMARY

There has been little research into the interaction between fraud offences and mental health. Fraud is perpetrated on a massive scale and a number of offenders will have psychiatric pathology either as a primary driver of the offence or as an associated phenomenon that will require psychiatric care and treatment. This article reviews the broad range of psychiatric conditions that have been associated with fraud offending, comments on management and discusses methods of psychiatric assessment in fraud offences.

DECLARATION OF INTEREST

None.

‘The second example was a typical case of pseudologia; the patient used to have periods when his fantastic abilities ran riot and he had once more committed a series of frauds. For three quarters of an hour, in the court over which von Lilienthal the famous criminologist was presiding, I described the romantic story of his life of crime. I also showed how the behaviour was limited to certain periods, how the offender seemed to be precipitated into it with headaches, etc., and drew the conclusion that one was dealing with a hysteric, a variation of personality, not a disease process. One could not free him from personal responsibility, at any rate at the beginning of the frauds, but the impression of some inner compulsion, made aesthetically convincing perhaps by my sensational description, led the court to acquit the man, contrary to expert opinion.’

(Jaspers 1913; quoted from 1963 reprint: p. 795)

Fraud is a huge problem. A report commissioned by the Association of Chief Police Officers (ACPO; Levi 2007) conservatively estimated that the cost of fraud to the UK economy in 2005 was around £13.9 billion, equivalent to around £330 a year for every man, woman and child in the UK. The report analyses financial damage but does not address the psychological trauma that fraud can inflict on its victims. Despite the extent of the problem, psychiatric and psychological research has paid little attention to the interaction between psychiatric pathology and syndromes that may drive fraudulent crime. Given the prevalence of offenders presenting with psychiatric/psychological problems (Singleton 1998), it seems logical that some fraudulent crimes involve offenders with psychiatric pathology.

In this article, we explore a number of psychiatric disorders and psychological problems that have been associated with fraudulent crimes, as well as institutional, social and therapeutic methods to manage and decrease the associated risks.

Definition

What do we mean by ‘fraud’? The following definition is taken from the National Working Group on Fraud (2012) on behalf of the Association of Chief Police Officers:

‘No precise legal definition of fraud exists; many of the offences referred to as fraud are covered by the Theft Acts in England and Wales, and under Common Law in Scotland. The term is used to describe such acts as deception, bribery, forgery, extortion, corruption, theft, conspiracy, embezzlement, misappropriation, false representation, concealment of material facts and collusion. Other offences are created by more sector-specific laws such as those that prohibit corruption or create offences related to companies or financial services, for example.’

Fraud can most simply be described as an act of deception intended for personal gain or to cause a loss to another party. The general criminal offence of fraud can include deception whereby someone knowingly makes false representation, they fail to disclose information or they abuse a position, as stated in the Fraud Act 2006, s. 1. However, although not explicitly stated in the Act, in reality the perpetrator need not gain material benefit from the fraud. Indeed, some fraudsters derive pleasure from witnessing their victim being deceived. In many cases, the complexity of the fraudulent behaviour attests to the fact that substantial emotional exchange takes place with the possibility of varying degrees of sadistic satisfaction; we will discuss this later.

The limited literature on fraud and its psychological drivers has outlined three elements of which it invariably consists: the perpetrator, the victim and a lack of safeguards to prevent the fraudulent transaction (Cohen 1979).

Any fraud can be conceptualised in the famous ‘fraud triangle’ of motivation, opportunity and rationalisation (Cressey 1973). This apparently simplistic model has in fact enabled the formulation of management strategies focused on each of these interdependent factors.

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[†]For a commentary on this article see pp. 193–197, this issue.

Motivation

'Motivation' for fraudulent activity includes: debt, a desire for material goods; uncontrolled gambling; and family loans. The 'reward' may not be financial or even material and can constitute a psychological pleasure, such as a 'high' from 'duping' unsuspecting victims.

Opportunity

'Opportunity' relates to the differing temporal and physical access to objects (either physical or psychological), as well as to whether the crime will be opportunistic or planned.

Rationalisation

Finally, 'rationalisation' refers to the way in which fraudsters tend to rationalise their deviant behaviour through a process known as neutralisation (Copes 2003; Piquero 2005), which, it has been argued, enables the placing of psychological distance between perpetrator and potential victim. Neutralisation relies heavily on cognitive distortions, including beliefs such as: 'I deserve this more than them' and 'they are stealing from others anyway'. Moreover, some fraudsters (particularly those who conduct a 'con' or 'scam' involving face-to-face contact) may take great pleasure in 'getting one over' on unsuspecting victims. In any fraudulent activity, it seems that there is a cognitive cost-benefit analysis and 'weighing up of the pros and cons', leading to the subsequent decision of whether to perpetrate the crime (Cornish 1986). With regard to Cressey's triangle, psychiatric/psychological factors mainly relate to motivation and rationalisation. However, it may be the case that if the accused had a mental illness at the time of the offence there is doubt as to whether that person (because of their mental illness) had the capacity to form criminal intent.

Statistics and demographics

The Fraud Act 2006 came fully into force on 15 January 2007 and altered the definition and coverage of fraud and forgery crimes. The Home Office reported the total number of fraud and forgery offences in England and Wales in 2008–2009 to be 163283, but noted that 'the measurement of fraud is challenging as fraud is known to be very substantially underreported to the police' (Walker 2009: p. 85). This number, however, represents one of the lowest recorded rates for 1999–2008 (although it does represent a 5% increase on the previous year). The bulk of these offences (122569) comprised 'fraud by false representation', defined as misleading another with the intention to gain or cause loss (Fraud Act 2006, s. 2).

Fraud and psychiatric illness

Fraud is perpetrated on a massive scale but most fraud appears to have no association with mental illness. Only a handful of individuals involved in fraud are assessed by psychiatric services. Therefore, the true extent of the contribution of mental illness is open to speculation. In addition, most of the literature collates case reports (further details available from the author). There are, however, a minority of cases linking psychiatric problems with fraudulent offending. It must be noted when making an association between fraud and psychiatric drivers that the disorders themselves do not fit easily into any overarching framework; they are, therefore, best explained in individual terms. Psychiatric motivators for the crimes, however, could be generalised into two drivers, either 'financial strain' or those enabling the individual to experience 'power/ego enhancement'. It is hoped that continued research will improve information collection, which in turn will assist classification and management as well as inform risk assessment.

Personality disorders

Certain personality psychopathologies have long been associated with theft/fraudulent crime, the most important being the cluster B personality disorders, especially narcissistic and antisocial personality disorders (Duffield 2001).[‡] Although narcissistic personality disorder is described only in DSM-IV (American Psychiatric Association 1994) and not in ICD-10 (World Health Organization 1992), it is widely recognised as a valid diagnosis within psychiatry. Personality disorders have been categorised as maladaptive, pervasive patterns of thinking, acting and feeling (ICD-10). When such patterns turn to criminal behaviour, the consequences can be catastrophic. Past cases (Kets de Vries 1989) and several recent high-profile fraud cases (Tempany 2010) have involved individuals whose observed behaviour was in keeping with that of a personality disorder.

Narcissistic personality disorder

The literature also describes a small, recalcitrant minority of senior executives in large corporations that were later revealed to show a number of traits consistent with an operational diagnosis of narcissistic personality; these include a grandiose sense of self and a lack of empathy, manifested in either an overt interpersonal 'attacking' style or covert 'backstabbing' politics (Kets de Vries 1989; Maccoby 2000; Goldman 2006). Such executives often have wildly inflated views of their own self-worth and demand undue admiration. This elevated self-image and feelings of entitlement create fertile

[‡]For a discussion of the nature of personality disorder, see pp. 162–172, this issue. Ed.

psychological compost for the application of rationalisation and neutralisation techniques to 'bend the rules' that individuals feel 'don't apply' to them (Piquero 2005). This 'ethical massaging' can lead to an abandonment of probity (Sims 2003). Other large-scale frauds have been exposed by rigorous auditing of financial houses during the recent economic downturn (Arvedlund 2009).

Antisocial personality disorder

The other personality disorder most associated with fraudulent behaviour is antisocial personality disorder, implicated mainly in low-grade offences, although it can occur in more complex frauds. Behavioural patterns common to fraud offending, such as 'deceitfulness' (as indicated by repeated lying, the use of aliases or conning others for personal profit or pleasure), constitute diagnostic criteria for the disorder (DSM-IV; American Psychiatric Association 1994). At the more extreme end of the antisocial scale is psychopathy as defined by the Hare Psychopathy Checklist – Revised (PCL-R; Hare 2006).

Traits such as risk-seeking behaviour, lack of empathy, coolness under pressure are sometimes perceived as positive characteristics in the world of high finance and the upper strata of criminal organisations (Goldman 2006; Babiak 2006). Although the exact prevalence rates for corporate psychopathy are difficult to obtain, a study looking at 203 corporate professionals (selected to participate in management development programmes) showed that the prevalence of psychopathic traits within that cohort was higher than that found in community samples (Babiak 2010). Psychopaths working in business can be seen as showing great leadership skill, although the cool exterior can conceal potentially destructive traits such as social indifference, parasitism and manipulation; if given the opportunity, these individuals can be particularly susceptible to fraudulent activity (Kets de Vries 1989; Carozza 2008). Recommendations for containing potential psychopaths at work include fostering a culture of openness, creating an ombudsman or anonymous hotline, cross-checking impressions of suspected executives with other colleagues who know the individuals well and, most importantly, being self-aware, because psychopathic individuals exploit weaknesses (Morse 2004).

Detection and treatment

Individuals showing gross personality disorder, whether they are 'white collar' or from a lower social demographic, should ideally undergo diversion to a personality disorder service specialising in the particular subtype. There are descriptions in the

psychodynamic literature of an approach to therapy with fraud offenders, but the evidence is limited to anecdotal case reports (Adshead 1997).

However, more severe psychopathy may be a barrier to psychological therapy. In an occupational context it can be harder to detect individuals with compensated personality disorders. Babiak & Hare (2006) have developed a new instrument, the B-Scan, for this purpose (www.b-scan.com). It was field tested on two groups: executives in a large marketing firm (judged by management to be good performers and to possess 'high integrity') and a comparison sample of 'economic' criminals (low moral integrity). This second group of individuals had been convicted of economic crimes such as fraud and embezzlement, and subsequently placed on probation. The instrument involves questions answered by the individual (the B-Scan Self-Report) and another set completed by the probation officer (B-Scan: 360). Results showed that the economic criminal sample (low integrity) scored significantly higher than the marketing sample (high integrity) on the B-Scan theoretical scales. It is hoped that the instrument could be used to detect 'corporate psychopaths' or individuals with psychological profiles that make them more likely to commit fraudulent activity (Morse 2004). We contacted Dr Paul Babiak (principal researcher), who stated that his team have recently found that both the B-Scan Self-Report and the B-Scan: 360 (rated by subordinates, superiors and/or peers) measure corporate psychopathy, demonstrating validity against the Hare Self-Report Psychopathy Scale (Paulhus 2012). Their results will be published in forthcoming articles.

Vignette 1: Narcissistic personality disorder as a defence

A 52-year-old chief executive officer fled to Australia following the breakdown of his finance company after colleagues became concerned about irregularities in legal documentation. Investigators later discovered that the company constituted several smaller 'funds' and comprised an intricate fraud. After several months of legal wrangling, the executive was expatriated to his home country and placed on remand. He was described by colleagues as being extremely grandiose, lacking empathy and displaying an insatiable need for admiration. His lawyer raised the defence of his not being culpable because he had a newly diagnosed narcissistic personality disorder and proffered the insanity defence. The prosecution rejected the defence and at trial the individual was found guilty on a majority. He was subsequently sentenced to a substantial period of imprisonment.

Malingering

When undertaking a psychiatric evaluation of an individual with reported psychiatric problems who

is accused of fraudulent activity, the possibility of feigned mental disorder must be considered. This may be seen as an extension of the ‘coming’ manipulative and deceptive behaviour captured on the Hare Psychopathy Checklist (Hare 2006). However, malingering (deliberately falsifying the symptoms of illness for secondary gain) can be more subtle, such as exaggeration of existing depressive symptoms or failure to make enough effort in a cognitive task, resulting in an artificially low IQ score. Forensic psychiatric assessments of fraud defendants involved in criminal proceedings are anecdotally reported as involving disputed allegations of malingering. A fuller discussion of malingering can be found in Halligan *et al* (2003).

There may be more substantial secondary gain in terms of delayed or abandoned prosecution if an individual is found unfit to plead at a criminal trial. However, detecting feigned mental disorder is far from straightforward. Malingered mental disorder commonly involves the presentation of atypical combinations of symptoms and a tendency to feign cognitive impairment. The use of standardised tests such as the Test of Memory Malingering (TOMM; Tombaugh 1997) and the Miller-Forensic Assessment of Symptoms Test (M-FAST; Jackson 2005) may be useful. The coin-in-the-hand test (Kapur 1994) is another useful screening tool for the detection of ‘faking bad’ on cognitive testing (Box 1). A common feature of these tests is an essentially easy cognitive task, which is presented to the patient as containing a degree of difficulty. A poor performance can then be more easily attributed to a deliberate attempt to fail the task. A finding at criminal trial that an individual has engaged in further deceptive behaviour (attempting to deceive mental health professionals) is potentially very damaging for the defendant’s case. Therefore, evaluations in criminal contexts must be conducted scrupulously and in accordance with guidelines for expert witnesses and criminal procedure rules. For

further clarification, see Rix (2008a,b). Issues of fitness to plead and legal process in fraud trials are discussed below.

Pathological lying

Some fraud offences may be associated with pathological lying (*pseudologia fantastica*). One of us (P.W.) has recently been involved in the assessment of a case involving a person assuming fraudulent identities which culminated in a cluster of fraud offences; these were later attributed to a probable pathological lying disorder. Pathological lying can occur as a symptom of an underlying disorder or as a distinct entity. However, its aetiology and nosological validity remain controversial. The main difference between a true and a pathological lie is found in the motivation. Normal lies tend to be motivated by an external goal, whereas pathological lies often bear no obvious benefit (Noyes 2011). Fraud offences involving the appropriation of identity (impersonating a police officer, doctor, etc.) are more likely to involve possible pathological lying, especially if the motivation for the behaviour is difficult to discern. For a comprehensive review of this subject see Dike (2005).

Habit and impulse control disorders

Certain ‘impulse control disorders’ such as pathological gambling (DSM-IV; American Psychiatric Association 1994) have been implicated in fraud and financial crime: the patient uses proceeds to fund a compulsive gambling habit.[§] Pathological gambling is defined in ICD-10 as a disorder involving ‘frequent, repeated episodes of gambling which dominate the individual’s life to the detriment of social, occupational, material, and family values and commitments’ (World Health Organization 1992); ICD-10 guidelines state that patients with this disorder may lie or break the law to obtain funding. A minority of fraud offences will, therefore, be driven by these types of psychiatric disorder. Although the use of this as a psychiatric defence is still controversial in many jurisdictions globally, it has been used in medico-legal cases as a basis for legal mitigation (Buchhandler-Raphael 2008).

Fraudulent behaviour associated with wider neuropsychiatric syndromes has also been described in the literature. Compulsive gambling as a consequence of uncontrolled administration of L-dopa has been responsible for a number of cases of significant overspending and compensatory financial larceny as a result. The exact mechanism for the gambling activity may relate to disproportionate stimulation of D₃ receptors in the limbic system, although the exact aetiology remains unknown (Dodd 2005).

[§]Gambling addiction is discussed on pp. 226–231, this issue. Ed.

BOX 1 Memory disorder or malingering? The coin-in-the-hand test

The coin-in-the-hand test is presented to participants in the form of an apparently difficult memory task. It requires them to remember in which of two hands the examiner has held a coin. After showing the coin for about 2 s in one hand, the participant is required to close their eyes and count backwards from 10. They are then asked to open their eyes and to indicate in which of the two clenched hands the coin is held. The examiner opens the hand

touched by the participant and also gives verbal feedback as to the correctness of the response. Ten such trials are given, with the coin being held in the right and left hands for an equal number of trials, these being randomly distributed. Virtually all people with genuine amnesia obtain a perfect score on performance, whereas those with suspected malingering perform at the chance or below chance level (Kapur 1994; Hanley 1999).

In the case of pathological gambling, the driving cause, whether pharmacological or psychological, should be sought. Management strategies have involved a decrease in dopamine agonists and/or L-dopa dosage in the case of pathological gambling in patients with Parkinson's disease (Dodd 2005). In the case of pathological gambling disorder (ICD-10, F63.0; World Health Organization 1992), management would include a psychological therapy targeted at the cognitive pathology and a further consideration of adjunctive treatment with antidepressant medication (Grant 2006).

Kleptomania

Kleptomania has long been implicated in theft, fraud and deception offences (James 2009); its central feature is theft. It is an impulse control disorder categorised in both ICD-10 and DSM-IV as 'A recurrent failure to resist impulses to steal objects that are not needed for personal use or for their monetary value' (World Health Organization 1992; American Psychiatric Association 1994). Like obsessive-compulsive disorder, there is a characteristic mounting anxiety before the act and dissipation of anxiety on its commission (Grant 2004). There is no specific evidence that people with kleptomania are more likely to engage in fraud. It is included here, however, because of its importance as a differential diagnosis when assessing people charged with fraud crimes (Grant 2004).

Psychosis

There is little evidence in the literature that psychotic disorders are drivers for fraudulent crime. Fraud may be committed as part of the affective disturbance in manic episodes and could possibly comprise part of a delusional system in psychosis that could motivate the individual to fraudulent activity; however, this would remain extremely rare. The chaotic presentation of many who experience florid psychotic symptoms would act as a significant obstacle to the planning necessary for fraud, especially in the case of moderate- to high-level fraudulent crimes. Moreover, in schizophrenic-type illnesses, negative symptoms (if present) and the accumulated cognitive deficits secondary to protracted bouts of illness would make this type of crime less likely. Nevertheless, there have been cases of subtle paranoia and delusional beliefs in the absence of more chronic negative symptoms leading to fraudulent behaviour (further details available from the author). It has also been known for people who have committed fraud to experience a psychotic breakdown after arrest. Brief reactive psychosis secondary to the stress of incarceration must be distinguished from malingering.

Intellectual disability

Intellectual disability has been implicated as a driver of some of the lower-grade opportunistic fraudulent/theft crimes. Milder forms of intellectual disability are particularly associated with crime (Hall 2000). The exact mechanism underlying this association is unknown but is probably due to increased psychiatric comorbidities such as conduct disorder, antisocial personality disorder and hyperkinetic disorder, a lack of awareness of societal norms and a diminished appreciation of the consequences of antisocial behaviour (Tonge 1999). Individuals with intellectual disability are also vulnerable to exploitation by more able fraudsters. It is especially important in this subgroup to explore 'suggestibility', which has been shown to have a negative correlation with IQ (Singh 1992), and whether suggestibility contributed significantly to involvement in the crime. Likewise, it would be important for informing subsequent interviews and police assessments.

Vignette 2: Suggestibility, intellectual disability and crime

A 19-year-old male heroin addict was arrested by police after being caught in a nightclub attempting to sell garlic pills as ecstasy tablets. On interview he appeared extremely suggestible and told police officers that he 'wanted to be part of the gang'. He was remanded in custody and seen by a psychiatrist, who consulted old records from his special needs school, which showed that he had an established IQ of 55. Previous probation reports demonstrated that he had been exploited by the same gang in a previous 'scam' and on further questioning it transpired that he was handing over profits from the sales to members of the gang in exchange for heroin. The defence requested the opinion of a consulting psychiatrist in intellectual disability. The psychiatrist completed a report outlining the accused's high degree of suggestibility (due to his intellectual disability) and probable exploitation. At trial, the judge placed him on a mandatory drug treatment programme.

Older people

Offending is generally very low in elderly populations. Elderly people with psychiatric illness are, because of their vulnerability, more likely to be victims of fraud than perpetrators. If a mental disorder is suspected and thought to have contributed to a fraud crime, exploration should be targeted at possible diagnoses of personality disorder or depression. Assessment of older individuals implicated in fraudulent behaviour would involve thorough assessment of their mental state and cognitive function, looking particularly at the possibility of dementia (Heinik 2004). These individuals are at increased risk of exploitation: there are numerous case reports of elder abuse in the

form of financial mismanagement (Rabiner 2005). Sometimes, people with dementia are accused of financial impropriety after becoming unwitting participants in frauds committed by their carers or legal guardians. More rarely, elderly relatives are used as 'fronts' for criminal activities perpetrated by their carers or legal guardians (in the form of these manipulating the elderly individual into making available bank accounts, for example, to be used for the laundering of money derived from crime).

Changes that may alert the healthcare provider to financial elder abuse include: abrupt changes in bank accounts or bank account details (including the movement of large sums of money into or out of the vulnerable adult's account); sudden changes to or establishment of wills; signatures on cheques or other legal instruments not resembling those of the patient; and signatures appearing when the person finds it difficult to write. There has been concern regarding the ability of medical staff to detect signs of elder abuse (McCreadie 2000). However, the Mental Capacity Act 2005 and Safeguarding Vulnerable Adults from Abuse (SOVA) procedures (Department of Health 2009) have made it harder for unscrupulous individuals to perpetrate these crimes and have provided new and robust legal mechanisms to manage the financial affairs of individuals at risk from exploitation.

Neurotic and stress-related disorders

Marital breakdown, job loss, divorce settlements and other catastrophic life events can cause unforeseen and severe financial strain on an individual, precipitating an acute stress or adjustment reaction which may drive the perpetration of a fraud (Kates 1990). Many otherwise law-abiding patients, if faced with these problems, turn to illicit substances or gambling in an attempt to assuage the stress of their situation, thereby creating a continued need for funding, eventually only satiated via an ongoing criminal lifestyle. Treatment and management for these people should be directed at the stress-inducing life event and the resulting illness. Acute stress reactions, post-traumatic stress disorder and depressive episodes have all been used as defences in criminal cases.

Vignette 3: Depression and embezzlement

After the death of her husband, a 48-year-old woman was thrown into protracted bereavement. Although she continued to work full time in an administrative job that she had held for 20 years, she struggled to repay her mortgage without the help of her husband's income and became anxious and depressed. In desperation, she began to siphon increasing amounts of money from her employer's account into a dummy account to help with repayments. She was arrested and charged with embezzlement after discrepancies

were found on a routine audit. The solicitor arranged a psychiatric assessment and she was found to have been depressed throughout the period of the embezzlement and had visited her doctor several times. Despite various pharmacological treatments, her mental state had remained depressed. She was convicted of the fraud. However, at sentencing (on the recommendation of the consulting psychiatrist) she was diverted to a psychiatric unit for treatment under the Mental Health Act 1983, s. 37.

Alcohol and drug dependence

Alcohol and drug misuse can have devastating effects on social functioning. Considerable financial strain can emerge after just a short period of dependence. Evidence points to substance misuse as a driver for crime in general, including fraudulent crime, either as a direct consequence of its action or more indirectly by placing the individual in financial debt and necessitating corollary crime to fund their spiralling habit (Bennet 1998). Most fraudulent crimes involving substance misuse take the form of acquisitive crimes of low complexity, for example, deception to obtain monies or benefit fraud. Antisocial personality disorder as a comorbid illness is overrepresented in this group.

The management of substance misuse leading to fraudulent crimes would focus on treatment of the dependence. If the individual is involved in criminal proceedings and the fraud is highly associated with drug dependence, the consulting psychiatrist may consider recommending the Drug Interventions Programme (DIP) or a Drug Treatment Order (DTO) – key strategies in the UK government's bid to reduce drug-associated crimes. This allows offenders whose crimes are related to drug misuse to forgo a custodial sentence and gain support and treatment to overcome their addiction.

Association of fraud and psychiatric illness

Fraudulent crimes and their possible psychiatric drivers can be grouped according to their likelihood of association (Table 1). In general, the more functionally damaging the illness, the more likely the fraudulent crime will be of a lower grade (less complex; opportunistic).

Academic fraud

There have been a number of high-profile cases of academic fraud in the press (Marris 2006). This type of fraud can have serious and destructive consequences, especially with regard to patient safety; some cases have resulted in serious professional misconduct hearings (Dyer 1997). The particular drivers for this type of fraud are mainly stress related, and an overwhelming determination to 'produce results' can leave some academics vulnerable to ethical disintegration.

The main problems described in the literature are falsification of results, statistical manipulation (including withholding data) and plagiarism. The exact prevalence is difficult to establish and varies between studies, although a study by Geggie (2001) looking at 197 newly appointed medical consultants found that 55.7% of them had observed academic misconduct and 5.7% had engaged in academic dishonesty. Given these rates it seems that, in keeping with the general prevalence rates of offenders in business, some perpetrators would display psychopathology. The most likely diagnosis is a stress-related disorder, although, as with high-level corporate frauds, any assessment of misconduct potentially leading to serious harm would require a thorough investigation for personality disorder pathology, particularly narcissistic and psychopathic (although this would remain extremely rare).

Assessment

Investigating a possible link between a fraud offence and any psychiatric/psychological disturbance requires a thorough analysis of all of the relevant documentation regarding the fraud. The psychiatric expert may want to request additional information such as financial reports, witness statements and police transcripts, which can be sought from the instructing solicitor (whether prosecution or defence). A complete psychiatric history should be taken and the patient's permission obtained for any medical notes with a bearing on the case; these may include general practice or inmate medical records (IMR) if the patient is on remand. It should be borne in mind that the location of the assessment, whether in a custody, remand or home setting, could influence the individual's willingness to divulge information. The purpose of the interview should be clearly explained, as should the fact that usual confidentiality rules do not apply. Consent should be sought from the patient for access to medical records and other information before the interview.

It may also be appropriate to see the individual several times to collect enough information and allow for changes in presentation and mental state. Equally, it may be important to advise the solicitor or barrister that additional tests are required, for example the Wechsler Adult Intelligence Scale – Revised (WAIS-R; Wechsler 1981), the Structured Clinical Interview for DSM-IV (SCID-II; First 1997) or the Minnesota Multiphasic Personality Inventory (MMPI; Dahlstrom 1975); this may require enlisting the help of a psychologist or other expert.

Serious cases are likely to involve a forensic accountant, especially if the fraud is particularly complex, although a solicitor or barrister

TABLE 1 The association of fraud and psychiatric illness

ICD-10/DSM-IV diagnosis	Level of fraudulent crime	Types of crime types where pathology may be present
Personality disorders: psychopathic/callous unemotional traits, narcissistic Malingering	Sophisticated/ complex, organised	Ponzi schemes ^a Complex corporate fraud (Enron, Anderson) West African advance fee 'scams' Pyramid schemes
Stress-related disorder Depression Antisocial personality disorder	Mid-level/ semi-organised	Inappropriate use of funds Diversion of liquid assets (embezzlement) Misappropriation Deception Internet fraud
Learning (intellectual) disability (mild/borderline) Psychosis (mania) Substance misuse Antisocial personality disorder	Low/opportunistic, minimal complexity	Credit card fraud Aliases Benefit fraud

a. A 'Ponzi' scheme is conducted much like a pyramid scheme: high returns are promised for investors and those joining the scheme early receive these high returns. But as no new money is introduced to the scheme, later investors receive no payout.

specialising in fraud may have the relevant skill to decipher the financial information. This is important in the psychiatric assessment as an appreciation of the complexity of the financial skill required to perpetrate the crime will establish whether the accused had the cognitive ability to carry out the fraud in its entirety. The assessing psychiatrist may also want to consider the possibility of malingering and normalised tests such as M-FAST or TOMM may be indicated.

The ongoing stress of custody or an impending trial and possible custodial sentence may create an unbearable pressure on the accused individual. This may precipitate a depressive episode, acute stress reaction or cause those with a personality disorder to decompensate, precipitating a risk of self-harm.

If the individual has a psychiatric diagnosis or there is evidence that psychiatric pathology was present at the time of the offence, the level of interaction with the offence should be clearly explained, including motivation. It is at this stage that the consulting psychiatrist may choose to comment on possible treatment options and management strategies, dependent on whether pathology is evident. The consulting psychiatrist must also be aware that their duty extends to an appearance in court if required to give verbal evidence (Rix 2008b).

Fitness to plead and legal process

Psychiatrists are routinely required to give opinions on fitness to plead and stand trial (Box 2). The most common issue in a fraud trial regarding fitness to plead is whether the defendant has the capacity to understand the proceedings and the evidence of a pending case. The defendant's ability may be

BOX 2 Fitness to plead and stand trial

The assessment of fitness to plead is governed by common law rules set out in *R v Pritchard* (1836). The assessment is whether the individual has the capacity to:

- understand the charge(s)
- instruct his/her legal advisors
- challenge jurors
- enter a plea
- understand the evidence

(Rogers 2008)

affected because of mental disorder. Fraud cases create very particular problems: complex fraud cases can last months or even years. They often involve large amounts of intricate evidence with multiple witnesses. The assessing psychiatrist will have to keep in mind that such trials can put incredible strain on counsel, defendants and jury, and often require prolonged concentration. An egregious example was the ‘Jubilee Line’ case in 2005 (*R v Rayment & Others*), which was disbanded after 21 months after incurring costs of more than £25 million. The collapse was due to a conflation of factors: large financial costs, inefficiency and, to a large extent, the substantial psychological and social stress placed on the jury, counsel and defendants because of the length and complexity of the trial (Wooler 2006).

To help a defendant to attain fitness, if it is in question, the psychiatrist may consider recommending to the court certain amendments to proceedings to make them more understandable and/or bearable (e.g., asking that the court sitting time is shorter to aid concentration). As already mentioned, a fraud case can also place additional demands on the assessing psychiatrist, who will have to gain an understanding of the evidence to assess whether the defendant will be able to follow the proceedings and understand the evidence. The evidence can often be extensive and complicated. If there are doubts about the cognitive ability of the defendant, the assessment may be helped by further psychometric tests. In complex fraud cases, the assessing psychiatrist will need to liaise more closely than usual with counsel and possibly other financial experts (such as a forensic accountant) to ensure that they have a firm understanding of the evidence and appreciation of the cognitive capacity needed to perpetrate the fraud.

The defendant may be feigning mental illness in a bid to subvert the criminal proceedings. The assessing clinician will have to be aware that those who have the capacity to commit complex frauds can also be adept at malingering (faking symptoms

or enhancing existing ones). Some possible signs of malingering are given in Box 3. When faced with potential malingering behaviour, the clinician will want to take a comprehensive history (detailing the onset and duration of symptoms), gain information (if possible) from a number of sources and look for discrepancies in the defendant’s observed behaviour and subjective accounts. If possible, standardised tests of malingering should also be performed.

It is our experience that quite bizarre presentations have occurred in the context of fraud trials, including apparent dissociative (conversion) disorders such as limb paralysis, mutism and blindness with no organic basis. It can often be difficult clinically to differentiate between frank malingering and possible dissociative processes, and the process often relies on the skill of the clinician, observations and standardised tests for malingering.

Evidence from tests of malingering has been admitted during criminal trials (Young 2009). However, the admissibility of such evidence in the jurisdictions of England and Wales depends on the trial judge and the admissibility of medical evidence is judged according to the *Turner* rule (*R v Turner* [1975] QB 834): ‘An expert’s opinion is admissible to furnish the court with information which is likely to be outside the experience and knowledge of a judge or jury. If on the proven facts a judge or jury can form their own conclusions without help, then the opinion of an expert is unnecessary’ (Mackay 1999). The situation in the USA (federal courts) is slightly different being governed by the ruling in *Daubert v Merrell Dow Pharmaceuticals, Inc* (1993). In the *Daubert* ruling, the US Supreme Court found that when US courts are dealing with the admissibility of scientific evidence they must take into consideration four factors: whether the evidence has been tested; whether it has been subjected to peer review/publication; whether the potential error rate is known; and the general acceptance of the evidence by the scientific community. Together these are known as the ‘Daubert factors’ or ‘Daubert test’. The Law Commission of England and Wales is currently looking into whether such a test of

BOX 3 Possible signs of malingered behaviour

- Marked contradictions between the observed behaviour/examination and reported symptoms
- Inconsistencies in the history and ongoing presentation
- Significant secondary gain
- Medico-legal context
- Bizarre or unusual symptoms that do not fit with a recognised disease pattern

scientific reliability would be useful in courts in England and Wales (Law Commission 2009).

The reliability of such evidence is paramount in decisions about admissibility. This can create significant problems with tests of malingering that have not in some cases been fully validated.

Vignette 4: Malingering to avoid conviction

A 42-year-old man working in a large hedge fund was arrested by the police and charged with fraud following a long investigation. While on remand he complained to prison staff that he was low in mood and when seen by the visiting psychiatrist he appeared sullen and was complaining about spectacular visual hallucinations, lack of memory and concentration, and even paralysis. Staff reported that when observed surreptitiously he appeared talkative and jovial with other inmates, read books into the small hours of the night, regained his ability to walk and did not appear to respond to the 'disturbing' visual hallucinations. After a substantial amount of evidence was collected, a meeting was held and the observations fed back to the prisoner. His symptoms disappeared the following day and he was tried and convicted of the fraud.

Summary

Most fraud offences have no relation to psychiatric pathology. Little attention has been paid to the association between fraud and psychiatric factors. This has resulted in a dearth of evidence about the possible psychiatric disorders associated with these crimes, the needs of these offenders when experiencing psychiatric pathology and, most importantly, the risks that they pose to society if left untreated. Personality disorder is the diagnosis most likely to be associated with fraud offenders, although stress-related disorders and substance misuse are also common, either in isolation or comorbid with a personality disorder. The assessment of fraud offenders is often challenging, placing additional demands on the psychiatrist in terms of complexity and diagnostic formulation. Greater research is being done and new tools are being developed to tease out the psychological factors involved in fraud. This article highlights a need for more research in this area and a greater recognition of psychopathology in fraud offenders. It also recommends that, because of the danger posed by those fraud offenders with psychiatric problems, current methods of assessing and managing fraud offenders require greater input from psychiatric services. Furthermore, it recommends that psychiatric input should be considered as part of the national fraud strategy.

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MCQ answers

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MCQs

Select the single best option for each question stem

1 According to Cressey, the three factors involved in a fraud offence are motivation, opportunity and:

- a suggestibility
- b psychopathy
- c greed
- d rationalisation
- e antisocial nature.

2 In a report by the Association of Chief Police Officers, the yearly cost of fraud to the UK economy has been estimated at:

- a £0.39 billion
- b £1.39 billion

- c £13.9 billion
- d £139 billion
- e £139 trillion.

3 A new test currently being validated to detect corporate psychopaths is called:

- a SIRS
- b B-Scan
- c TOMM
- d PCL-SV
- e M-FAST.

4 The following would not be a possible indicator of financial elder abuse:

- a abrupt changes in bank account details
- b sudden change in or establishment of a will

- c having several bank accounts
- d signature on a cheque not resembling that of the account holder
- e large sums of money moving into and out of the person's account.

5 An instrument that tests malingering is the:

- a MMPI
- b M-CAT
- c GSS
- d Neo-PI
- e coin-in-the-hand test.