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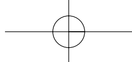
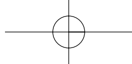


Feigned schizophrenia symptoms usually won't deceive the clinician who watches for clues and is skilled in recognizing the real thing.



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Faking it

How to detect malingered psychosis

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Reputed Cosa Nostra boss Vincent "The Chin" Gigante deceived "the most respected minds in forensic psychiatry" for years by malingering schizophrenia.[1] Ultimately, he admitted to maintaining his charade from 1990 to 1997 during evaluations of his competency to stand trial for racketeering.

A lesson from this case—said a psychiatrist who concluded Gigante was malingering—is, "When feigning is a consideration, we must be more critical and less accepting of our impressions when we conduct and interpret a psychiatric examination…than might be the case in a typical clinical situation."[2]

Even in typical clinical situations, however, psychiatrists may be reluctant to diagnose malingering[3] for fear of being sued, assaulted—or wrong. An inaccurate diagnosis of malingering may unjustly stigmatize a patient and deny him needed care.[4]

Because psychiatrists need a systematized approach to detect malingering,[5] we offer specific clinical factors and approaches to help you recognize malingered psychosis.

continued

Table 1

Common motives of malingerers

Motives	Examples
To avoid pain	To avoid: Arrest Criminal prosecution Conscription into the military
To seek pleasure	To obtain: Controlled substances Free room and board Workers' compensation or disability benefits for alleged psychological injury

WHAT IS MALINGERING?

No other syndrome is as easy to define yet so difficult to diagnose as malingering. Reliably diagnosing malingered mental illness is complex, requiring the psychiatrist to consider collateral data beyond the patient interview.

Malingering is the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives.[6] In practice, malingering commonly must be differentiated from factitious disorder, which also involves intentional production of symptoms. In factitious disorders, the patient's motivation is to assume the sick role, which can be thought of as an internal or psychological incentive.

Three categories of malingering include:

- pure malingering (feigning a nonexistent disorder)
- partial malingering (consciously exaggerating real symptoms)
- false imputation (ascribing real symptoms to a cause the individual knows is unrelated to the symptoms).[7]

Motivations. Individuals usually malinger to avoid pain (such as difficult situations or punishment) or to seek pleasure (such as to obtain compensation or medications) *(Table 1)*. In correctional settings, for example, inmates may malinger mental illness to do "easier time" or to obtain drugs. On the other hand, malingering in prison also may be an adaptive response by a mentally ill inmate to relatively sparse and difficult-to-obtain mental health resources.[8]

INTERVIEW STYLE

When you suspect a patient is malingering, keep your suspicions to yourself and conduct an objective evaluation. Patients are likely to become defensive if you show annoyance or incredulity, and putting them on guard decreases your ability to uncover evidence of malingering.[9]

Begin by asking open-ended questions, which allow patients to report symptoms in their own words. To avoid hinting at correct responses, carefully phrase initial inquiries about symptoms. Later in the interview, you can proceed to more-detailed questions of specific symptoms, as discussed below.

If possible, review collateral data before the interview, when it is most helpful. Consider information that would support or refute the alleged symptoms, such as treatment and insurance records, police reports, and interviews of close friends or family.

The patient interview may be prolonged because fatigue may diminish a malingerer's ability to maintain fake symptoms. In very difficult cases, consider monitoring during inpatient assessment because feigned psychosis is extremely difficult to maintain 24 hours a day.

Watch for individuals who endorse rare or improbable symptoms. Rare symptoms—by definition—occur very infrequently, and even severely disturbed patients almost never report improbable symptoms.[10] Consider asking malingerers

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Table 2

Clues to identify malingering during patient evaluation

Internal inconsistencies	Example
In subject's report of symptoms	Gives a clear and articulate explanation of being confused
In subject's own reported history	Gives conflicting versions
External inconsistencies	**Example**
Between reported and observed symptoms	Alleges having active auditory and visual hallucinations yet shows no evidence of being distracted
Between reported and observed level of functioning	Behaves in disorganized or confused manner around psychiatrist, yet plays excellent chess on ward with other patients
Between reported symptoms and nature of genuine symptoms	Reports seeing visual hallucinations in black and white, whereas genuine visual hallucinations are seen in color
Between reported symptoms and psychological test results	Alleges genuine psychotic symptoms, yet testing suggests faking or exaggeration

about improbable symptoms to see if they will endorse them. For example:

- "When people talk to you, do you see the words they speak spelled out?"[11]
- "Have you ever believed that automobiles are members of an organized religion?"[12]

Watch closely for internal or external inconsistency in the suspected malingerer's presentation *(Table 2)*.

MALINGERED PSYCHOTIC SYMPTOMS

Detecting malingered mental illness is considered an advanced psychiatric skill, partly because you must understand thoroughly how genuine psychotic symptoms manifest.

Hallucinations. If a patient alleges atypical hallucinations, ask about them in detail. Hallucinations are usually (88%) associated with delusions.[13] Genuine hallucinations are typically intermittent rather than continuous.

Auditory hallucinations are usually clear, not vague (7%) or inaudible. Both male and female voices are commonly heard (75%), and voices are usually perceived as originating outside the head (88%).[14] In schizophrenia, the major themes are persecutory or instructive.[15]

Command auditory hallucinations are easy to fabricate. Persons experiencing genuine command hallucinations:

- do not always obey the voices, especially if doing so would be dangerous[16]
- usually present with noncommand hallucinations (85%) and delusions (75%) as well[17]

Thus, view with suspicion someone who alleges an isolated command hallucination without other psychotic symptoms.

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Genuine schizophrenic hallucinations tend to diminish when patients are involved in activities. Thus, to deal with their hallucinations, persons with schizophrenia typically cope by:

- engaging in activities (working, listening to a radio, watching TV)
- changing posture (lying down, walking)
- seeking interpersonal contact
- taking medications.

If you suspect a person of malingered auditory hallucinations, ask what he or she does to make the voices go away or diminish in intensity. Patients with genuine schizophrenia often can stop their auditory hallucinations while in remission but not during acute illness.

Malingerers may report auditory hallucinations of stilted or implausible language. For example, we have evaluated:

- an individual charged with attempted rape who alleged that voices said, "Go commit a sex offense."
- a bank robber who alleged that voices kept screaming, "Stick up, stick up, stick up!"

Both examples contain language that is very questionable for genuine hallucinations, while providing the patient with "psychotic justification" for an illegal act that has a rational alternative motive.

Visual hallucinations are experienced by an estimated 24% to 30% of psychotic individuals but are reported much more often by malingerers (46%) than by persons with genuine psychosis (4%).[18]

Genuine visual hallucinations are usually of normal-sized people and are seen in color.[14] On rare occasions, genuine visual hallucinations of small people (Lilliputian hallucinations) may be associated with alcohol use, organic disease, or toxic psychosis (such as anticholinergic toxicity) but are rarely seen by persons with schizophrenia.

Malingerers report visual hallucinations more often than do persons with genuine psychosis

Psychotic visual hallucinations do not typically change if the eyes are closed or open, whereas drug-induced hallucinations are more readily seen with eyes closed or in the dark. Unformed hallucinations—such as flashes of light, shadows, or moving objects—are typically associated with neurologic disease and substance use.[19]

Suspect malingering if the patient reports dramatic or atypical visual hallucinations. For example, one defendant charged with bank robbery calmly reported seeing "a 30-foot tall, red giant smashing down the walls" of the interview room. When he was asked detailed questions, he frequently replied, "I don't know." He eventually admitted to malingering.

continued

Table 3
Uncommon psychosis presentations that suggest malingering

Hallucinations
- Continuous
- Voices are vague, inaudible
- Hallucinations are not associated with delusions
- Voices use stilted language
- Patient uses no strategies to diminish hallucinations
- Patient states that he obeys all commands
- Visual hallucinations in black and white
- Visual hallucinations alone in schizophrenia

Delusions
- Abrupt onset or termination
- Patient's conduct is inconsistent with delusions
- Bizarre content without disorganization
- Patient is eager to discuss delusions

Table 4

Clinical factors that suggest malingering

Absence of active or subtle signs of psychosis
Marked inconsistencies, contradictions
Patient endorses improbable psychiatric symptoms • Mixed symptom profile (eg, endorses depressive symptoms plus euphoric mood) • Overly dramatic • Extremely unusual ('Do you believe that cars are a part of an organized religion?') **Patient is evasive** or uncooperative • Excessively guarded or hesitant • Frequently repeats questions • Frequently replies, 'I don't know' to simple questions • Hostile, intimidating; seeks to control interview or refuses to participate **Psychological testing** indicates malingering (SIRS, M-FAST, MMPI-2)

SIRS: Structured Interview of Reported Symptoms
M-FAST: Miller Forensic Assessment of Symptoms Test
MMPI-2: Minnesota Multiphasic Personality Inventory, Revised

Delusions. Genuine delusions vary in content, theme, degree of systemization, and relevance to the person's life. The complexity and sophistication of delusional systems usually reflect the individual's intelligence. Persecutory delusions are more likely to be acted upon than are other types of delusions.[20]

Malingerers may claim that a delusion began or disappeared suddenly. In reality, systematized delusions usually take weeks to develop and much longer to disappear. Typically, the delusion will become somewhat less relevant, and the individual will gradually relinquish its importance over time after adequate treatment. In general, the more bizarre the delusion's content, the more disorganized the individual's thinking is likely to be *(Table 3, page 19)*.

With genuine delusions, the individual's behavior usually conforms to the delusions' content. For example, Russell Weston—who suffered from schizophrenia—made a deadly assault on the U.S. Capitol in 1998 because he held a delusional belief that cannibalism was destroying Washington, DC. Before he shot and killed two U.S. Capitol security officers, he had gone to the Central Intelligence Agency several years before and voiced the same delusional concerns.

Suspect malingering if a patient alleges persecutory delusions without engaging in corresponding paranoid behaviors. One exception is the person with long-standing schizophrenia who has grown accustomed to the delusion and whose behavior is no longer consistent with it.

WHERE MALINGERERS TRIP UP

Malingerers may have inadequate or incomplete knowledge of the mental illness they are faking. Indeed, malingerers are like actors who can portray a role only as well as they understand it. They often overact their part or mistakenly believe the more bizarre their behavior, the more convincing they will be. Conversely, "successful" malingerers are more likely to endorse fewer symptoms and avoid endorsing overly bizarre or unusual symptoms.[21]

Numerous clinical factors suggest malingering *(Table 4)*. Malingerers are more likely to eagerly "thrust forward" their illness, whereas patients with genuine schizophrenia are often reluctant to discuss their symptoms.[22]

Malingerers may attempt to take control of the interview and behave in an intimidating or hostile manner. They may accuse the psychiatrist of inferring that they are faking. Such behavior is

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rare in genuinely psychotic individuals. Although DSM-IV-TR states that antisocial personality disorder should arouse suspicions of malingering, some studies have failed to show a relationship. One study has associated psychopathic traits with malingering.[23]

Malingerers often believe that faking intellectual deficits, in addition to psychotic symptoms, will make them more believable. For example, a man who had completed several years of college alleged that he did not know the colors of the American flag.

Malingerers often hedge, give vague answers, or say 'I don't know' when pressed for details

Malingerers are more likely to give vague or hedging answers to straightforward questions. For example, when asked whether an alleged voice was male or female, one malingerer replied, "It was probably a man's voice." Malingerers may also answer, "I don't know" to detailed questions about psychotic symptoms. Whereas a person with genuine psychotic symptoms could easily give an answer, the malingerer may have never experienced the symptoms and consequently "doesn't know" the correct answer.

Psychotic symptoms such as derailment, neologisms, loose associations, and word salad are rarely simulated. This is because it is much more difficult for a malingerer to successfully imitate psychotic thought processes than psychotic thought content. Similarly, it is unusual for a malingerer to fake schizophrenia's subtle signs, such as negative symptoms.

PSYCHOLOGICAL TESTING

Although many psychometric tests are available for detecting malingered psychosis, few have been validated. Among the more reliable are:

- Structured Interview of Reported Symptoms (SIRS)
- Minnesota Multiphasic Personality Inventory, Revised (MMPI-2)
- Miller Forensic Assessment of Symptoms Test (M-FAST).[11]

SIRS includes questions about rare symptoms, uncommon symptom pairing, atypical symptoms, and other indices involving excessive symptom reporting. It takes 30 to 60 minutes to administer. Tested in inpatient, forensic, and correctional populations, the SIRS has shown consistently high accuracy in detecting malingered psychiatric illness.[24]

Two MMPI-2 scales—F-scale and F-K Index—are the most frequently used test for evaluating suspected malingering. When using the MMPI-2 in this manner, consult the literature for appropriate cutoff scores (see *Related resources, page 25*). Although the MMPI-2 is the most validated psychometric method to detect malingering, a malingerer with high intelligence and previous knowledge of the test could evade detection.[25]

M-FAST was developed to provide a brief, reliable screen for malingered mental illness. This test takes 10 to 15 minutes to administer and measures rare symptom combinations, excessive reporting, and atypical symptoms.[11] It has shown good validity and high correlation with the SIRS and MMPI-2.[26,27]

Bottom Line

To conclude with confidence that an individual is malingering psychosis, the psychiatrist must understand genuine psychotic symptoms and consider data beyond the individual's self-report. Assemble clues from a thorough evaluation, clinical records, collateral information, and psychological testing.

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CONFRONTING THE MALINGERER

If a thorough investigation indicates that a patient is malingering psychosis, you may decide to confront the evaluee. Avoid direct accusations of lying,[10] and give the suspected malingerer every opportunity to save face. For example, it is preferable to say, "You haven't told me the whole truth."

A thoughtful approach that asks the evaluee to clarify inconsistencies is more likely to be productive and safer for the examiner. When confronting individuals with a history of violence and aggression, have adequate security personnel with you.

Related resources

- Structured Interview of Reported Symptoms (SIRS). Available for purchase from Psychological Assessment Resources at www3.parinc.com (enter "SIRS" in search field).
- Graham JR. *MMPI-2: Assessing personality and psychopathology*. New York: Oxford Press; 2000. (Source of cutoff scores to use MMPI-2 scales [F-scale and F-K Index] to evaluate suspected malingering).
- Psychological Assessment Resources, Inc. Miller Forensic Assessment of Symptoms Test (M-FAST). Available at: www3.parinc.com (enter "M-FAST" in search field).

References

1. Newman A. Analyze this: Vincent Gigante, not crazy after all those years. *New York Times*, April 13, 2003.
2. Brodie JD. Personal communication, 2005.
3. Yates BD, Nordquist CR, Schultz-Ross RA. Feigned psychiatric symptoms in the emergency room. *Psychiatr Serv* 1996;47:998-1000.
4. Kropp PR, Rogers R. Understanding malingering: motivation, method, and detection. In: Lewis M, Saarini C (eds). *Lying and deception*. New York: Guilford Press; 1993.
5. Kucharski LT, et al. Clinical symptom presentation in suspected malingerers: an empirical investigation. *Bull Am Acad Psychiatry Law* 1998;26:579-85.
6. *Diagnostic and statistical manual of mental disorders (4th ed., text rev.)*. Washington, DC: American Psychiatric Association; 2000.
7. Resnick PJ. Malingering of posttraumatic stress disorders. In: Rogers R (ed). *Clinical assessment of malingering and deception (2nd ed.)*. New York: Guilford Press; 1997:130-52.
8. Kupers TA. Malingering in correctional settings. *Correctional Ment Health Rep* 2004;5(6):81-95.
9. Sadock BJ, Sadock VA. *Kaplan & Sadock's synopsis of psychiatry, 9th ed*. Philadelphia: Lippincott Williams & Wilkins; 2003:898.
10. Thompson JW, LeBourgeois HW, Black FW. Malingering. In: Simon R, Gold L (eds). *Textbook of forensic psychiatry*. Washington, DC: American Psychiatric Publishing; 2004.
11. Miller HA. *M-FAST interview booklet*. Lutz, FL: Psychological Assessment Resources; 2001.
12. Rogers R. Assessment of malingering within a forensic context. In Weisstub DW (ed.). *Law and psychiatry: international perspectives*. New York: Plenum Press; 1987:3:209-37.
13. Lewinsohn PM. An empirical test of several popular notions about hallucinations in schizophrenic patients. In: Keup W (ed.). *Origin and mechanisms of hallucinations*. New York: Plenum Press; 1970: 401-3.
14. Goodwin DW, Anderson P, Rosenthal R. Clinical significance of hallucinations in psychiatric disorders: a study of 116 hallucinatory patients. *Arch Gen Psychiatry* 1971;24:76-80.
15. Small IF, Small JG, Andersen JM. Clinical characteristics of hallucinations of schizophrenia. *Dis Nerv Sys* 1966;27:349-53.
16. Kasper ME, Rogers R, Adams PA. Dangerousness and command hallucinations: an investigation of psychotic inpatients. *Bull Am Acad Psychiatry Law* 1996;24:219-24.
17. Thompson JS, Stuart GL, Holden CE. Command hallucinations and legal insanity. *Forensic Rep* 1992;5:29-43.
18. Cornell DG, Hawk GL. Clinical presentation of malingerers diagnosed by experienced forensic psychologists. *Law Hum Behav* 1989;13:375-83.
19. Cummings JL, Miller BL. Visual hallucinations: clinical occurrence and use in differential diagnosis. *West J Med* 1987;146:46-51.
20. Wessely S, Buchanan A, Reed A, et al. Acting on delusions: I. Prevalence. *Br J Psychiatry* 1993;163:69-76.
21. Edens JF, Guy LS, Otto RK, et al. Factors differentiating successful versus unsuccessful malingerers. *J Pers Assess* 2001;77(2):333-8.
22. Ritson B, Forest A. The simulation of psychosis: a contemporary presentation. *Br J Psychol* 1970;43:31-7.
23. Edens JF, Buffington JK, Tomicic TL. An investigation of the relationship between psychopathic traits and malingering on the Psychopathic Personality Inventory. *Assessment* 2000;7:281-96.
24. Rogers R. Structured interviews and dissimulation. In: Rogers R (ed). *Clinical assessment of malingering and deception*. New York: Guilford Press; 1997.
25. Pelfrey WV. The relationship between malingerers' intelligence and MMPI-2 knowledge and their ability to avoid detection. *Int J Offender Ther Comp Criminol* 2004;48(6):649-63.
26. Jackson RL, Rogers R, Sewell KW. Forensic applications of the Miller Forensic Assessment of Symptoms Test (MFAST): screening for feigned disorders in competency to stand trial evaluations. *Law Human Behav* 2005;29(2):199-210.
27. Miller HA. Examining the use of the M-FAST with criminal defendants incompetent to stand trial. *Int J Offender Ther Comp Criminol* 2004;48(3):268-80.