Identifying Malingering with Dr. Philip Resnick

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Dr. Puder, Dr. Resnick, and Dr. Scott have no conflicts of interest to report.

In today's episode of the podcast, we are joined by Dr. Philip Resnick and Dr. Alex Scott as we discuss the topic of malingering.

Dr. Resnick is a professor of psychiatry at Case Western Reserve University School of Medicine in Cleveland, Ohio. He has provided consultation in many high profile cases including Jeffrey Dahmer, Timothy McVey, Andrea Yates, Scott Petersen, Brian Mitchell (kidnapper of Elizabeth Smart), Theodore Kaczynski (Unabomber) and Casey Anthony. He has written over 215 professional journal articles and book chapters and contributed two chapters to the Clinical Assessment of Malingering and Deception.

Dr. Scott also joins us from Case Western Reserve University where he is currently a fellow in forensic psychiatry.

Overview of Malingering

Malingering is the conscious misrepresentation of psychiatric symptoms for a secondary gain (such as hospitalization, obtaining disability benefits, avoiding criminal responsibility, proceedings or sentencing, or avoiding military service). Malingering can be differentiated from the misrepresentation of symptoms in factitious disorders; those with factitious disorders may exaggerate or feign symptoms for conscious or unconscious reasons and may not be seeking a tangible benefit. Malingering can have legal consequences for the deceiver, particularly in military settings.

Psychotic symptoms are commonly malingered via self-report or "acting erratically." Mental health professionals must have a clear and comprehensive understanding of genuine psychotic illness in order to detect malingering.

Genuine Psychosis

Psychosis is a complex state of behavioral and psychiatric symptoms that involves hallucinations, delusions, disorganized or bizarre behavior, and changes in speech and

socialization. Psychotic states are most commonly caused by schizophrenia spectrum disorders, mood disorders, intoxication, and neurologic conditions.

Hallucinations

The mere presence of one symptom of psychosis should not cause a to jump to a diagnosis of psychosis. In fact, these symptoms are not rare, with 10-15% of the population experiencing a hallucinatory phenomenon in their lifetime. It doesn't necessarily mean the person is psychotic, as there are many reasons to have non-psychotic hallucinations. An example is that between 25-35% of women who lose their husbands will see or hear their husband within six months of the death.

While a delusion is pathognomonic of psychosis, hallucinations (perceiving a stimulus that has no external basis outside the brain) are not pathognomonic for psychosis and many non-psychotic people experience hallucinations in settings of chronic stress, intoxication, or other neurologic illnesses. The most common type of hallucinations in psychotic disorders are auditory, although visual and tactile types also occur. Olfactory or gustatory types are not common, but, when present, are usually associated with medical causes or latent onset schizophrenia.

Several factors can point to genuine psychotic hallucinations. In those with chronic non-psychotic auditory hallucinations, the average age of onset is twelve; in contrast, those with psychotic auditory hallucinations develop them later (average age 21). Non-psychotic auditory hallucinations are more often friendly or encouraging in nature, whereas psychotic hallucinations of voices usually have a degrading, hostile, or paranoid quality. Understanding the qualities of both non-psychotic and psychotic hallucinations is paramount when trying to distinguish these from malingering hallucinations.

The content of auditory hallucinations is affected by the patient's cultural background, personal interests (e.g., a deeply religious person may be more likely to hear religious themes) and internal struggles (such as depression). Gender differences exist as well; in men, psychotic hallucinations may accuse one of having a homosexual orientation, while in women, hallucinations may accuse one of promiscuity or sexual immorality. In other words, the internal concerns come out in accusatory hallucinations.

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Patients experiencing genuine psychotic hallucinations present with commonalities such as:

- Intermittent rather than continuous hallucinations.
- 66% identify the person speaking
- 71% of those experiencing could recall the first time they heard the voices
- 75% of those experiencing could hear both genders
- 88% could hear both familiar and unfamiliar voices
- Only 7% are vague or inaudible (usually the voice is clear)
- Can be both internally and externally perceived by the patient, so this should not be a standard used to determine malingering.

Delusions

It is uncommon for a person to have psychotic hallucinations without the presence of delusions. Isolated hallucinations without any co-occurrence of delusions (or other symptoms of psychosis) should raise the level of suspicion for alternate explanations, including malingering. Additionally, the presence of multiple, atypical hallucinations should raise suspicion. When suspicion arises, psychological testing can help confirm the potential malingering.

Around 88% of those who experience hallucinations in genuine psychosis also experience delusions (an idiosyncratic fixed false belief that is not accounted for by one's own culture or religion). Command auditory hallucinations that occur with delusions can be more dangerous (leading to violence or suicide), which Dr. Resnick refers to as a "double distortion of reality."

Multiple studies have consistently reported that the single greatest risk factor for someone acting on dangerous command hallucinations is concurrent delusion. For example, if a person hears a voice out of the blue that tells them to kill their mother, their moral fiber would cause them to hesitate; but with a concurrent delusion that the mother is an evil wizardess, they are much more likely to act on that command hallucination than without it.

Within a forensic setting, most people operating under delusion would not try to hide their crime.

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Detecting Malingering

The incidence of malingering in medicolegal contexts has been difficult to estimate. Malingering should be suspected in medicolegal contexts and when there are atypical histories of symptoms given by patients. Those who malinger are, by definition, attempting deception and may therefore never "admit" to anyone about having done so after the fact. Malingering frequently co-occurs in those with a history of genuine psychiatric illness; with these patients, separating feigned from genuine symptoms can be challenging. Mere exaggeration of symptoms (e.g., in order to meet a certain clinical disability rating), is even more difficult to detect.

Many symptoms of psychosis can be simulated by trained actors and psychiatrists cannot independently verify one's experience of hallucinations or delusions. Thus, the more determined and careful the malingering patient presents themselves, the more difficult it will be to identify the phenomenon.

David Rosenhan's 1973 study involving the use of actor-patients asked to malinger symptoms of mental illness in order to gain psychiatric admission cast doubt on psychiatry's abilities to distinguish malingered from genuine psychosis. However, the study had several limitations, including the lack of involuntary patients, the difference in length of hospitalizations from 1973 to today (3-4 weeks as compared to 6-8 days today, leading to disproportionate interpretations), and the admittance to state hospitals instead of private hospitals, which have significant differences in and of themselves. Most importantly, Rosenhan has been accused of faking certain data within the study. These factors undermine the study's effectiveness in determining the diagnostic skills of the psychiatrists.

The apparent rate of potential malingering (not definite malingering) among persons seeking disability or worker's comp, for example, is anywhere between 8-40%. However, this number is based on tests such as the MMPI, which was developed based on clinical judgments of whether someone was malingering. There is the collective appearance of substantial malingering based on this single test, but the true incidence of malingering currently remains unknown. The MMPI may pick up more of the suspicion of malingering versus actual malingering.

Several psychometric tests are available to support a diagnosis of malingering. The Miller Forensic Assessment of Symptoms Test (M-FAST) is a popular screening tool with good reliability and validity, but should not be used on its own as the sole support for the diagnosis in the courtroom. Formal interview schedules such as the Structured Interview for Reported Symptoms (SIRS) and the Structured Inventory of Malingered Symptomatology (SIMS) are valid and reliable measures that can be used to help certify the diagnosis in legal contexts, and have good sensitivity and specificity even in evaluating those who have been coached on "beating the test."

Genuine Versus Malingered Suicidality

Potential malingering often occurs in repeat offenders who are looking for something, such as a warm place to stay (i.e., the hospital). People who are trying to gain admittance to a hospital know that threatening suicide is a definite way to secure admittance. Studies on distinguishing malingering suicidality from those who are genuinely suicidal found that there are many commonalities, such as homelessness, depression, and despair. The single differentiating factor was found to be that the malingerer is more often to make a conditional threat, such as, "If I'm not admitted, I'm going to kill myself." The person who is genuinely suicidal is much less likely make a conditional threat.

Malingered Psychosis Symptom Presentation

Positive symptoms (hallucinations, delusions) are more commonly malingered than are negative symptoms (withdrawal, isolation, disorganized thought processes). Those who malinger are more likely to over-exaggerate symptoms to a degree not typically seen in genuine illness (e.g., chronic, constant, and unremitting auditory hallucinations which are perceived as extremely loud). For example, it is not uncommon for someone to have the delusion they are Jesus Christ, but an over-exaggeration of this delusion would be coming to see us dressed in costume.

The malingered history of hallucinations may also include extremely rare or atypical features, such as only hearing voices from one side of the head, being woken from sleep by voices, and being asked discrete factual questions (hearing a voice ask, "When is your mother's birthday?"). Well-formed, vivid visual hallucinations are not common in genuine

psychosis. Malingered hallucinations and delusions are often incongruent with the affect or emotional state demonstrated by the patient.

Additionally, genuine symptoms of psychosis will remit only after weeks or months of treatment, while malingered symptoms may "clear up" after only a few days of treatment with antipsychotic medication.

Signs suggestive of malingering:

- Absence of active or subtle signs of psychosis
- Marked inconsistencies, contradictions
- More likely to volunteer symptoms of their illness
- Unlikely psychiatric symptoms
    - Contradictory symptoms
    - Overly dramatic symptom presentations
    - Rare symptoms and improbable symptoms
- Evasiveness or noncooperation in discussing psychotic symptoms
    - Excessively guarded or hesitant
    - Frequently repeated questions
    - Frequently replies "I don't know" to simple questions or offers evasive answers
    - Hostile, intimidating; seeks to control interview or refuses to participate
- In a malingering psychotic patient:
    - Derailment, neologisms, loose associations, word salad are rarely simulated.
    - They repeat a sentence back at you without tangential speech.
    - Those with real mental illness may be the most difficult to catch because they know what it feels like to have psychosis; they have been impatient and watched others and they have a history of a diagnosis.

How to Address Malingering

The diagnosis of malingering should not be made lightly. Best practice is to clearly document incongruencies and build a case over time. Contextual information (i.e., asking how the patient arrived at the evaluation) is important and can alert the clinician to have some degree of suspicion for malingering. Observational evidence, such as nursing documentation, collateral reports from family and friends, and outside medical records are

absolutely necessary to obtain. Documentation should reflect exact statements and observations of the patient, rather than clinician summaries. ("Patient reports auditory hallucinations," or, "Patient exhibits disorganized behavior.") DSM diagnoses using the *Unspecified* modifiers should be made, on a temporary basis, in uncertain cases.

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