Clinical Symptom Presentation in Suspected Malingerers: An Empirical Investigation

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To empirically investigate the usefulness and validity of clinical presentation and recent history variables in the detection of malingered psychiatric disorder, 30 criminal defendants involved in forensic evaluations, who had a documented history of psychiatric hospitalization preceding their arrest on the instant offense (low risk of malingering group) and 30 defendants who complained of psychiatric difficulties but had no history of psychiatric hospitalization or treatment (suspected malingering group) were studied. Each subject's mental status was rated, blind to psychiatric history, diagnosis, and psycholegal opinions, on a Likert-like scale for the uncommon nature of their symptom presentation. In addition, the final outcome of the court cases, whether they were found competent to stand trial, not guilty by reason of insanity, or evidenced diminished capacity was determined by obtaining the court disposition in each case. Based on the unusual nature of their presentation, the defendants suspected of malingering were discriminated from the low risk of malingering defendants with a 90 percent rate of correct classification. Suspected malingerers were found to evidence current psychiatric presentations inconsistent with their recent Global Assessment of Functioning, unusual symptom presentation, and hallucinatory experiences rated as atypical for psychiatric disorder. A high proportion of suspected malingerers were found competent to proceed. The results are discussed in terms of the usefulness of clinical identification of malingering.

The identification of defendants who are malingering or feigning psychiatric disorder is a complicated and difficult process. Differentiation, by forensic psychologists and psychiatrists, of those defendants who are feigning psychiatric symptoms from those with bona fide mental health difficulties has typically relied upon a combination of psychometric and clinical history/presentation variables. Psychometric approaches involving self-report inventories such as the MMPI/MMPI-2 have generally been shown to be useful tools in the assessment of potential malingering,[1–3] as have structured interview formats such as the Structured Interview

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of Reported Symptoms (SIRS) Scale.[4] Generally positive results have been reported for the Rey Fifteen-Item Test[5, 6] and forced choice procedures[7] for the detection of the malingering of cognitive deficits. In contrast, even though there has been much written regarding the usefulness of a variety of clinical presentation variables in the detection of malingering,[8–10] there are few empirical data supporting the validity or accuracy of clinical presentation or history variables in differentiating defendants with bona fide psychiatric disorder from those feigning mental illness. The exception is the research of Cornell and Hawk,[11] who found that those diagnosed as malingerers could be differentiated from psychotic patients on 14 clinical presentation variables including measures of general presentation, affect, hallucinations, delusions, and formal thought disorder. Several clinical presentation and history variables including unusual symptom presentation, unusual symptom combinations, hallucinations that are continuous or vague, an overzealous attempt to call attention to symptoms, and the absence of difficult-to-feign symptoms such as thought disorganization and affective lability have all been proposed as potential indicators of malingering.[9, 12] Inconsistencies between the defendant's recent history and functioning and current presentation are also factors that should alert the evaluator to possible malingering.

To empirically assess the usefulness of clinical presentation and history variables for the identification of malingered psychiatric disorder, we compared 30 forensic evaluation subjects who had a documented history of psychiatric hospitalization before their arrest on the instant offense, with a group of forensic evaluation subjects with no prior psychiatric history who reported a variety of psychiatric difficulties during the course of the evaluation process. On a series of Likert-like scales, we rated the mental status examination sections of their forensic reports, blind to the history of psychiatric treatment, diagnosis, and psycholegal opinions, for the degree to which their presentation represented commonly encountered psychiatric difficulties or unusual symptom presentations; whether the symptom combination was rare or commonly observed; whether reports of hallucinations comported with what is commonly observed in psychotic disorders versus reports of unusual hallucinatory experiences; whether the presence of thought disorder or affective symptoms was consonant with clinical complaints; and also the degree to which the current presentation was consistent with the global assessment of functioning within the year preceding arrest. Global Assessment of Functioning (GAF) in the last year was determined by collateral interviews with family members or others who had had extensive recent contact with the defendant.

Due to the secondary gains offered by a mental illness defense, it was assumed that subjects who had been diagnosed only after their criminal involvement represented a group at high risk for malingering. Subjects with documented histories of mental illness preceding the instant offense, however, were seen as more likely to have a *bona fide* psychiatric dis-

order. This distinction formed the basis for assignment into either the Honest Psychiatric Group or the Suspected Malingering Group.

Methods

The participants of this study were 25 male and 5 female defendants referred by the federal courts for competency to stand trial and/or criminal responsibility evaluations, who had a documented history of psychiatric hospitalization (the Honest Psychiatric Group) prior to their arrest on the instant offense. This group, deemed to be at low risk of malingering, was compared with a group of 25 males and 5 females who reported serious psychiatric symptoms with no preexisting history of psychiatric hospitalization or treatment, a group believed to be at high risk of malingering (Suspected Malingering Group). All subjects were charged and awaiting trial on federal felony criminal charges. The MMPI-2 results for each subject were reviewed after the completion of all clinical ratings. Thirteen percent of the Honest Psychiatric Group and 77 percent of the Suspected Malingering Group produced MMPI-2 profiles suggestive of malingering (i.e., F > 90, F–K > 13, Fb > 90).* No significant differences in age (Honest Psychiatric Group = 36.2 years, Suspected Malingering Group = 34.8 years, $p > .05$), years of education (Honest Psychiatric Group = 11.03, Suspected Malingering Group = 11.77, $p > .05$) or number of prior offenses (Honest Psychiatric Group = 6.90, Suspected Malingering Group = 2.67, $p > .05$).

The final diagnosis for each subject was collected from the forensic evaluation after completion of all clinical ratings. For the Honest Psychiatric Group, diagnoses included schizophrenia (n = 7), schizoaffective (n = 5), delusional disorder (n = 2), bipolar disorder (n = 3), major depression (n = 2), drug-induced psychotic disorders (n = 7), posttraumatic stress disorder (n = 1), and dysthymia (n = 2). Only one of the defendants in the Honest Psychiatric Group did not receive an Axis I diagnosis. In the Suspected Malingering Group, the final diagnoses arrived at during the forensic evaluation were drug abuse disorder (n = 17), dysthymic disorder (n = 2), no Axis I diagnosis (n = 7), schizophrenia (n = 2), brief reactive psychosis by history (n = 1), and organic mental disorder (n = 1). One of the Honest Psychiatric Group defendants had an Axis II diagnosis of antisocial personality disorder compared with 13 of the defendants in the Suspected Malingering Group. Two defendants in each group were diagnosed as suffering from borderline personality disorder. Five Honest Psychiatric Group defendants and two Suspected Malingering Group defendants had an Axis II diagnosis of personality disorder other than antisocial or borderline.

Clinical and social histories were gathered from interviews that varied in length

* The F and Fb scales are indices of responses that are infrequently seen in nonclinical populations, wherein exceedingly high scores suggest an attempt to deny psychopathology. The K scale is an index wherein high scores suggest attempts to deny psychopathology and low scores suggest a deliberate attempt to portray oneself in a self-deprecating or unfavorable manner. The F-K formula combines two of these indices into a single factor wherein high scores are seen as indicating the subject malingered psychopathology.

1.	Very Common Symptom Presentation	1	2	3	4	5	Very Unusual Symptom Presentation
2.	Very Common Symptom Combination	1	2	3	4	5	Very Unusual Symptom Combination
3.	Very Consistent With GAF	1	2	3	4	5	Very Inconsistent W/GAF
4.	Concordant Affective Presentation	1	2	3	4	5	Discordant Affective Presentation
5.	High Thought Disorganization	1	2	3	4	5	No Thought Disorganization
6.	Common Hallucinatory Experiences	1	2	3	4	5	Uncommon Hallucinatory Experiences

Figure 1. The Clinical Presentation Rating Scale.

between 2 and 12 hours. Records of prior hospitalization, criminal indictments, court orders, pretrial services reports, and investigative police reports were collected and reviewed as part of the forensic evaluations. Routinely, both the prosecuting and defense attorneys as well as family members were interviewed in order to gather corroborating clinical and social history and functioning information. The MMPI-2 was administered to all subjects. Other psychological testing included the Rorschach and neuropsychological measures, depending on the specifics of the case.

Upon completion of the forensic evaluation, the mental status section of each report was separated from the reports, coded, and reviewed by two experienced forensic psychologists blind to the defendant's history, diagnosis, psychological test results, or psycholegal opinions. Each subject's clinical presentation, as documented in the mental status section of the forensic report, was independently rated on a six-item Likert-like scale, the Clinical Presentation Rating Scale, developed specifically for this project, in terms of the common or unusual nature of their psychiatric symptoms and the degree to which their current psychiatric complaints were consistent with their recent psychosocial functioning, gathered from the collateral sources. Figure 1 presents the six-item Clinical Presentation Rating Scale.

Before rating the actual subjects of this study, the raters were trained by completing ratings on 20 subjects not involved in the study. Discrepancies were discussed and agreements reached regarding what constituted common symptom presentations for major Axis I psychiatric disorders and what constituted unusual or uncommon symptom presentations or combinations. Finally, the outcome of court proceedings—whether the defendant was found competent to stand trial, asserted a successful insanity defense or diminished capacity defense, or had

charges dismissed in relation to mental health issues—was gathered from the court, to provide some external validation of the categorization of subjects into groups.

Results

For subjects involved in this study, interrater reliabilities between the two forensic psychologists for each of the items on the Clinical Presentation Rating Scale were calculated using interclass correlations. The raters were highly reliable with interclass correlations of .97 for common/unusual symptom presentation, .97 for common/unusual symptom combination, .97 for presentation consistent with global assessment of functioning, .92 for consistent affect presentation, .97 for thought organization, and .96 for common/unusual hallucinatory experience. A Total Score was calculated by summing the ratings of the six items, yielding an interclass correlation of .98, and demonstrating a high level of agreement between raters on symptom presentation.

A Stepwise Fisher's Linear Discriminant Function analysis, using the Honest Psychiatric Group versus the Suspected Malingering Group as the criterion variables and each of the Clinical Presentation Rating Scale item scores averaged for the two raters as the predictor variables, was conducted to determine whether the two groups could be differentiated based on the item ratings. Stepwise procedures were used to determine the relative contribution of differences between groups and to identify the best predictors of group differences. Significant differences between groups on all of the Clinical Presentation Rating Scale items were demonstrated beyond $p < .0001$. The stepwise discriminant analysis was also significant (Wilks' $\lambda = .4715$, $(F, 1, 58) = 65.01$, $p < .0001$, squared canonical correlation = .6052). Three of the Clinical Presentation Rating Scale items were entered into the equation with Presentation Inconsistent with GAF entered first, Common/Unusual Hallucinatory Experiences second, and Common/Unusual Symptom Presentation third. Ninety percent of the subjects were correctly classified as belonging to either the Honest Psychiatric Group or the Suspected Malingerer Group based on the ratings on these three variables. These results demonstrate that even though significant differences between the Honest Psychiatric and Suspected Malingerer groups were observed on all rating scale items, these three variables represent the best predictors of group differences. The variables not entered into the discriminant equation were different between groups but did not add to discriminability, probably due to the redundancy between measures.

Finally, the percentages of subjects who were found incompetent to stand trial or asserted a successful insanity or other mental health defense for each group were calculated. All but one (97%) of the Suspected Malingerers were found competent to stand trial. Eleven (36%) of the Honest Psychiatric subjects were found incompetent, three (10%) were competent and asserted a successful insanity defense, one (3%) was competent and received a downward departure from the sentencing guidelines due to mental

health issues, and one (3%) had the charges dismissed in lieu of psychiatric treatment. Fourteen (47%) subjects in the Honest Psychiatric group were found competent and either did not raise or failed in raising a mental health defense. These results add to the validity of the selection criteria from group assignment.

Discussion

Even though there has been much written regarding the clinical assessment and identification of malingering of psychiatric disorder, to our knowledge there has been very little empirical research in this area. The results of the current study demonstrate that the clinical presentation of defendants involved in forensic evaluations can be rated reliably on clinical presentation variables that have long been assumed to be indicative of malingering. These clinical presentation variables differentiated suspected malingerers from honest psychiatric defendants with a high degree of accuracy. The best predictor of suspected malingering in this study was a current clinical presentation inconsistent with the defendant's highest level of functioning in the past year. That is, subjects who presented or complained of significant psychiatric difficulties, who were suspected of malingering, tended to evidence generally reasonable psychiatric adjustment in the last year, a historical presentation inconsistent with their presentation during the evaluation.

Suspected malingerers were distinguished from those with a history of psychiatric hospitalization by the unusual nature of their presentation and by hallucinatory experiences not commonly observed in clinical practice. Examples of unusual symptoms encountered in this study included reports of vague visual hallucinatory experiences such as "demons" or "shadows," being awakened from a sound sleep by auditory hallucinations, hallucinations that were continuous, and command hallucinations instructing the defendant to engage in criminal conduct. No subject attempted to malinger mania. Thought disorder was often absent and the affective presentation often inconsistent with other reported symptoms. Anxiety, depression, and hallucinations were commonly reported as coexisting in those suspected of malingering. In fact suspected malingerers tended to produce a litany of psychiatric complaints, a psychiatric smorgasbord as if they were overacting the part in an attempt to cover all bases and impress upon the evaluator the seriousness and severity of their psychiatric illness. In this regard, the present study also supported the observation that malingerers often go out of their way to call attention to their difficulties.

With highly acceptable accuracy, the experienced forensic evaluators in this study were able to identify suspected malingerers based upon the subjects' clinical presentation and recent history. Claims of current psychiatric difficulties inconsistent with recent psychosocial functioning, and reports of unusual hallucinatory experiences and uncommon symptoms appear to be strong indicators of malingering.

The current study provides empirical support for the validity of the clinical approach in the assessment and identification of malingering of psychiatric dis-

order in criminal defendants. It is potentially the case that defendants with unusual, rare, or atypical psychiatric disorders may display an unusual presentation that does not represent an attempt to malinger psychiatric disorder. The absence of a documented recent history of poor social functioning should not be seen as a definitive indicator of feigning, because first episodes and rapid onset of symptoms might produce current presentations inconsistent with recent functioning. Similarly, it is potentially the case that defendants who present with acute drug-induced psychotic disorders or psychotic symptoms secondary to neurological impairment may evidence unusual psychiatric symptoms that represent *bona fide* disturbances and not malingering. Suffice it to say that even in cases of suspected malingering, a comprehensive evaluation of these factors needs to be completed. Nonetheless, these factors generally appear to represent strong predictors of the malingering of psychiatric disorder.

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