Concealment of Psychopathology in Forensic Evaluations: A Pilot Study of Intentional and Uninsightful Dissimulators

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Dissimulation is the concealment of genuine psychiatric symptoms in an attempt to present a picture of psychiatric health. In this pilot study, the authors set out to demonstrate that defendants may conceal psychiatric illness even in forensic settings, contrary to their apparent self-interest. They reviewed their records for forensic assessments of dissimulators and malingerers and classified dissimulators as "intentional" or "uninsightful" depending on whether their concealment of symptoms appeared to be a volitional act or driven by a lack of insight. Although there were obvious diagnostic differences, the only other significant difference between malingerers and dissimulators was that malingerers were more likely to be facing charges related to financial crimes. Uninsightful dissimulators were significantly older than were intentional dissimulators. Uninsightful dissimulators were also more likely to be psychotic, particularly delusional and schizophrenic, than were intentional dissimulators. While forensic psychiatrists are vigilant in attempts to detect malingering, these data suggest that they should be equally vigilant regarding the possibility of dissimulation. Although further study is indicated, it appears that dissimulators are a heterogeneous group.

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Both clinical and forensic psychiatrists recognize that individuals whom they evaluate may be unreliable historians. Clinical psychiatrists are diligent in attending to the possibility that patients may not be forthcoming with all of their symptoms, beliefs, or personal history. For example, consider a clinician's skepticism about the claims of a delusional paranoid schizophrenic brought to a clinic by his concerned family members or about the denials of suicidal intent of a depressed patient brought to the emergency room for a drug overdose. Clinicians approach cases such as these recognizing that patients may withhold critical information about their psychopathology, whether because of paranoid fears, in response to voices they hear, covert suicidal intent, desires to appear "normal," or other motives.

Forensic practitioners approach evaluations with a somewhat different focus, colored chiefly by inclusion of strategies to detect the possibility of malingering. It is certainly reasonable to be skeptical of a forensic evaluee's claimed symptoms and complaints in light of the secondary gain attached to the outcome of the evaluation, whether it involves obtaining financial compensation or evading or minimizing criminal prosecution. However, the appropriate skepticism for a defendant's claims and the diligence necessary to detect malingering may in turn lead forensic examiners to adopt an unbalanced frame of reference. It is certainly true that malingerers attempt to feign or exaggerate their symptoms, and evaluators must expend extra time and energy to become convinced that a defendant's symptoms are genuine.

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However, an unforeseen casualty of this mindset is that it tends to overlook that mentally ill offenders are no more insightful when interviewed in a detention center than they would be during an interview in an outpatient psychiatric clinic or a hospital emergency room. In fact, one may even argue that a paranoid individual who breaks the law in response to his delusional beliefs may be even less likely to be forthcoming with his symptoms.

There are scenarios in which evaluators are attuned to the possibility of dissimulation. Flight surgeons commonly encounter aviators who seek to hide or minimize conditions that may lead to their being grounded. In forensic psychiatry, we are often faced with sex offenders who deny deviant forms of sexual arousal, which has necessitated the development of such tools as penile plethysmography and other measures.[1] However, these scenarios differ from those we are about to describe, in that sex offenders conceal psychopathology that would obviously impact negatively on their criminal cases. The subjects that we studied sought to hide psychopathology that might have provided them with insanity defenses, reduced the charges by providing evidence that their mental conditions prevented them from forming the requisite *mens rea* for their alleged offenses, or provided mitigating circumstances for sentencing.

Reflection on this problem led us to recall a number of similar cases in which defendants concealed psychiatric symptoms during forensic evaluations. Some defendants eventually acknowledged that they had concealed their symptoms intentionally. Others initially concealed psychotic symptoms and later revealed them but would not acknowledge having a mental illness. While recent AAPL Practice Guidelines[2] and other sources[3] have referred to a need to be cognizant of the latter scenario, we are unfamiliar with any data characterizing dissimulators, particularly on mentally ill defendants who intentionally conceal their symptoms. Based on these initial observations, we undertook a pilot study reviewing our records to learn more about this phenomenon. We selected malingerers as a comparison group, as malingering is also a phenomenon in forensic evaluations that involves a form of deception. In retrospect, we noted that the dissimulators' attempts to conceal their illnesses often initially presented as puzzling diagnostic cases that led us originally to consider malingering as part of the differential diagnosis. Thus, the comparison with the malingering group is based to some degree on our actual decision-making processes.

Methods

Subjects

The study included 27 cases from our criminal forensic files, with the exception of one juvenile case. All data were gathered from retrospective chart review; no subjects were interviewed for this study. All subjects' data were analyzed anonymously. Three of the authors are in private practice in the Southeast, while the fourth (D.M.B.) is a military forensic psychiatrist. All authors performed 50 to 80 forensic evaluations per year, including criminal, civil, and juvenile court matters, serving prosecution and defense in criminal matters and plaintiff and defense in civil matters. Two had fellowship training in forensic psychiatry (K.A.C., D.M.B.) and eight and seven years of experience, respectively. The remaining authors had 15 (P.M.A.) and 25 (W.B.) years of experience. Criminal and juvenile evaluations made up 55 to 90 percent of the authors' practices. As evaluators were called to testify in 20 to 30 percent of cases and worked for various parties, there was no evidence of any degree of bias.

Fifteen evaluees were classified as dissimulators and 12 as malingerers. Their cases were drawn from the following sources: Tennessee criminal ($n = 3$) and juvenile courts ($n = 1$); Federal court ($n = 1$); U.S. Navy ($n = 2$), U.S. Marine Corps ($n = 1$), U.S. Air Force ($n = 1$), and U.S. Army courts martial ($n = 1$); and Maryland criminal courts ($n = 17$). Demographic variables included age (range, 15 to 65 years), sex, and race (white or African American) of the defendant. Forensic variables included the defendant's charges and disposition of the case. Too few cases were resolved at the time of the study for any meaningful analysis of the disposition of the cases. Clinical variables included diagnoses, whether the defendant had a prior psychiatric history, the symptoms that dissimulators attempted to conceal and their apparent motivation for doing so, and the symptoms that malingerers attempted to feign and their reasons for malingering (uniformly to avoid prosecution). Consistent with the American Psychiatric Association's *Diagnostic and Statistical Manual*, Fourth Edition, Text Revision[4] (DSM-IV-TR), subjects were given

multiple diagnoses when diagnostic criteria were met.

Classification of Dissimulation

We had several requirements for the classification of dissimulators, the first of which was that the dissimulator had to deny being mentally ill and either fail to reveal or actively seek to conceal psychiatric symptoms at the initial stage of the evaluation process. We then classified dissimulators according to whether they acknowledged an active effort to deceive the evaluators into believing that they, the dissimulators, did not have psychiatric illness. Those who would acknowledge concealment of mental illness were classified as intentional dissimulators, and the remaining dissimulators were classified as uninsightful dissimulators. Uninsightful dissimulators appeared to lack insight into the fact that they were mentally ill. Some reverted to attempts to conceal their psychopathology in future interviews. Others no longer attempted to conceal their psychotic symptoms but would not acknowledge that they were mentally ill.

Discovery of Dissimulators

The discovery of dissimulators was a task that varied in difficulty. In each case, the dissimulator was eventually confronted with his or her dissimulation; none admitted it spontaneously. Several methods were helpful in detecting dissimulation. Some dissimulators had already undergone several psychiatric evaluations and had essentially prepared versions of events that omitted delusional material or other evidence of psychiatric illness. We found that interview techniques that led the dissimulator away from his or her previously rehearsed version of events were particularly helpful. For example, one author frequently asked to visit the defendant's cell during evaluations. During one evaluation, the author observed that the defendant had plugged his air conditioning vents with towels, leading to stifling conditions. When queried about his actions, the defendant began discussing an elaborate persecutory delusional system including beliefs that "nuclear, chemical, and biological warfare were being pumped in through the ventilation system." In another interview, a visit to the defendant's cell turned up a number of family pictures. When the author asked about them, the defendant began to reveal his delusional beliefs. Essentially, both of these defendants had prepared accounts of their activity at the times of the alleged offenses in which they omitted their delusional beliefs. However, each was unprepared to deal with inquiries from different approaches.

Some dissimulators revealed their symptoms after several hours of interviewing, despite their earlier efforts to conceal them. When faced with an opinion that their delusions were not factually true, these individuals generally would deny the delusional beliefs in later interviews, often contriving excuses for why they stated these delusional beliefs or why the evaluator had believed that they had made such statements. These dissimulators would often repeat this process with other interviewers, first concealing, then revealing, and then denying their delusional beliefs. It was particularly helpful that either witness statements or other records were available as corroboration that these dissimulators were suffering delusions.

Other dissimulators would deny hearing auditory hallucinations but would be observed by staff to be talking to themselves or otherwise responding to internal stimuli. At some point in the evaluation, these dissimulators admitted to experiencing auditory hallucinations. We acknowledge that there may have been a greater number who concealed their symptoms. We further acknowledge that this study is restricted to dissimulators that we were able to identify; others may have successfully concealed their symptoms.

Records were again helpful in detecting other dissimulators. Several sought to conceal that they had been intoxicated at the time of the offense, despite the fact that their intoxication may have negated the *mens rea* of the offenses with which they were charged. Another sought to conceal her history of dissociative identity disorder, which records helped to substantiate. Another dissimulator devised a complex scheme for concealing his cognitive deficits, memorizing as many as 300 vocabulary words in an attempt to conceal his deficits in reading, written expression, and receptive-expressive language deficits. His deficits were detected both by neuropsychological testing and his misuse and mispronunciation of several of the words that he had memorized.

We considered that some of the subjects whom we classified as dissimulators may have been sophisticated enough to malinger the presentation of dissimulation. However, prior records, corroborative accounts of witnesses, and neuropsychological test

Table 1 Frequency of Charges of Murder and All Violent Acts

	Malingerers	Dissimulators	$\chi^2(df = 1)$	p
Murder charges	7	5	1.68	NS
All charges of violence	10	14	0.68	NS
n	12	15		

results substantiated the dissimulators' illnesses and refuted the possibility of malingering.

Diagnosing Malingering

Malingering was diagnosed on the basis of clinical interview, psychological testing (including standard tools for diagnosing malingering such as the MMPI-2,[5] the Personality Assessment Inventory,[6] and the Structured Interview for Reported Symptoms[7]), and collateral history from witnesses. We acknowledge that this study included only malingerers whom we were able to identify.

Statistics

Statistics included *t*-tests for the means of two populations and chi-square tests. As defendants were often likely to carry more than one psychiatric diagnosis, chi-square tests were performed for the presence or absence of a condition, producing a two-by-two table for each.

Results

Malingerers Versus Dissimulators

Demographic Variables

There were no significant age differences between malingerers (30.5 ± 0.8 years) or dissimulators (38.7 ± 0.9 years) nor were there significant racial differences (8/12 African Americans and 4/12 whites among the malingerers and 9/15 African Americans and 6/15 whites among the dissimulators). A greater percentage of the malingerers were female (6/12 versus 2/15 for the dissimulators, $\chi^2 = 4.30$, $df = 1$, $p < .05$). In light of the small sample sizes, we have reserved speculation on the meaning of this finding until more data are available.

Table 2 Frequency of Financial Charges

	Malingerers	Dissimulators	$\chi^2(df = 1)$	p
Financial charges	3/12	0	4.22	<.05

Table 3 Diagnoses in Malingerers and Dissimulators

Diagnosis	Malingerers	Dissimulators
Schizophrenia	0	8
Schizoaffective	0	1
Bipolar	1	1
Brief psychotic episode	0	1
Any psychotic diagnosis	1	13
Antisocial PD	5	2
Any PD	10	3
Substance Abuse	5	3
Depression	0	1
Intoxication	0	2

Malingerers, $n = 12$; dissimulators, $n = 15$. PD, personality disorder.

Forensic Variables

There were no significant differences in the frequency of charges of murder or of all violent acts (including murder) between malingerers and dissimulators, as shown in Table 1. However, malingerers were more likely to be charged with financial crimes, such as misappropriation of government funds, fraud, and writing bad checks, as shown in Table 2. It should be noted that some defendants had multiple charges that may have included violent and nonviolent offenses.

Clinical Variables

Table 3 presents the diagnoses among malingerers and dissimulators. As expected, dissimulators were significantly more likely to have psychotic disorders, especially schizophrenia. In addition, dissimulators were more likely to have psychiatric histories. In contrast, malingerers were more likely have a diagnosis of personality disorder, especially antisocial personality disorder. Table 4 summarizes significant findings across the two groups. We did not find significant differences in rates of substance abuse disorders (Table 3).

Symptoms Involved in Deception

Dissimulators sometimes sought to conceal several different symptoms. Malingerers sometimes sought to feign several different symptoms. We found that

Table 4 Significant Differences Between Malingerers and Dissimulators

	Malingerers	Dissimulators	χ^2 $(df = 1)$	p
Psychosis	1	13	13.23	<.001
Schizophrenia	0	8	6.40	<.05
Prior psychiatric history	5	13	6.08	<.05
Any personality disorder	10	3	10.71	<.01
Antisocial personality disorder	5	1	4.73	<.05

Malingerers, $n = 12$; dissimulators, $n = 15$.

Table 5 Symptoms Involved in Deception

Deception	Malingerers	Dissimulators	$\chi^2(df = 1)$	p
Delusions	1	10	7.63	<.01
Cognitive deficits	7	1	7.37	<.01
Auditory hallucinations	5	3	1.30	NS
DID	1	1	0.03	NS

Malingerers, $n = 12$; dissimulators, $n = 15$. DID, dissociative identity disorder.

10 of 15 dissimulators sought to conceal delusions from evaluators, while 3 of 15 attempted to conceal auditory hallucinations. Two of the dissimulators sought to conceal that they were intoxicated at the time of the offense. One attempted to conceal cognitive deficits, one attempted to conceal a brief psychotic episode, and one attempted to conceal a history of dissociative identity disorder.

Malingerers most frequently attempted to malinger cognitive deficits (7 of 12) by faking such conditions as mental retardation, amnesia, or other deficits during neuropsychological testing. Auditory hallucinations were the next most frequently malingered symptom (5 of 12), followed by posttraumatic stress disorder (2 detailing a bogus history of trauma and flashbacks), delusions (1), and dissociative identity disorder (1).

Our findings indicated that there were significant differences between the symptoms that dissimulators sought to conceal and the symptoms that malingerers sought to feign. Specifically, dissimulators sought to conceal their delusions (10 of 15) significantly more frequently than malingerers faked having delusions (1 of 12). In contrast, malingerers attempted to feign cognitive deficits (7 of 12) significantly more frequently than dissimulators sought to conceal such deficits (1 of 15).

However, we did not find any significant differences between the number of malingerers who sought to fake auditory hallucinations (5 of 12) and the number of dissimulators who sought to conceal that they were suffering auditory hallucinations (3 of 15). We did not find a significant difference between malingerers attempting to fake dissociative identity disorder (1 of 12) and the number of dissimulators who sought to conceal the same disorder (1 of 15). These results are summarized in Table 5.

Subtypes of Dissimulators

We found that our dissimulators could be further classified as intentional dissimulators and uninsightful dissimulators. The five intentional dissimulators acknowledged their illnesses on confrontation and admitted to intentional deception for various reasons, including: desire to remain on military duty, desire to return home from a group home, preference for a defined prison term over an undefined term of hospitalization, and desire to avoid stigmatization (two subjects). The 10 uninsightful dissimulators all revealed some symptoms of psychopathology at one point or another but maintained throughout that they were not mentally ill. One of the uninsightful dissimulators believed that he deserved execution.

There were no significant differences in sex, race, criminal charges, disposition, or presence of prior psychiatric history between the two subgroups of dissimulators. Uninsightful dissimulators were significantly older (41.2 $\pm$ 1.3 years) than were intentional dissimulators (33.8 $\pm$ 3.3 years; $t = 4.93$, $df = 13$, $p < .01$).

Uninsightful dissimulators were more likely to suffer from schizophrenia (8 of 10) than were intentional dissimulators (0). Other diagnoses among uninsightful dissimulators included schizoaffective disorder–bipolar type (1), and bipolar disorder (1). Intentional dissimulators experienced brief psychotic episodes superimposed on borderline personality disorder (1), schizoaffective disorder with cognitive deficits superimposed on antisocial personality disorder (1), dissociative identity disorder (1), major depression and alcohol dependence with alcohol intoxication at the time of the offense (1), and polysubstance intoxication and substance-induced psychotic disorder (1). All of the uninsightful dissimulators were psychotic, whereas only three of five of the intentional dissimulators suffered from psychotic disorders. Similarly, all of the uninsightful dissimulators were delusional, whereas only one of five of the intentional dissimulators had delusions (the subject with schizoaffective disorder). The remaining two intentional dissimulators who had nondelusional psychoses were regarded as psychotically disorganized, although they did not appear to have elaborated delusions. There were no significant differences in the frequency of auditory hallucinations across subgroups. These results are summarized in Table 6.

Table 6 Diagnostic and Symptomatic Differences Between Subgroups of Dissimulators

	Uninsightful	Intentional	$\chi^2(df = 1)$	p
Psychosis	10	3	4.61	<.05
Delusions	10	1	10.91	<.001
Schizophrenia	8	0	8.57	<.01
Auditory hallucinations	3	0	0.63	NS

Uninsightful, $n = 10$; intentional, $n = 5$.

Discussion

While the issue of malingering has received a great deal of attention in forensic psychiatry, little or no attention has been given to the study of defendants who either seek to conceal genuine psychopathology from forensic evaluators or fail to reveal it. Our experience indicated that these cases may initially present puzzling diagnostic dilemmas that had us questioning whether we were faced with individuals who were genuinely mentally ill or malingering. Our findings suggest that the types of symptoms that such evaluees present may help guide the evaluator to the correct diagnosis. Specifically, we found that dissimulators tended to harbor delusions that they initially tried to conceal or otherwise did not reveal, while malingerers tended to feign cognitive deficits. We did not find that complaints of auditory hallucinations were particularly helpful in making this distinction.

We also found that malingerers were more likely to be charged with financial crimes, presumably because such offenses required a degree of mental organization that eclipsed the abilities of our subjects with genuine mental illness. We did not find that charges of violence were more common in either group. Our findings of diagnostic differences between the malingerers and dissimulators were generally as expected.

Our findings suggest that there are in fact two subgroups of dissimulators. We propose the terms intentional and uninsightful dissimulators for these two respective groups. Intentional dissimulators engage in the intentional concealment of psychiatric illness in an attempt to feign psychiatric health, despite knowledge that they have a psychiatric disorder. Intentional dissimulation is a conscious and rational choice motivated by external incentives, such as remaining eligible for employment or benefits or avoidance of stigmatization. Although we did not encounter them in this particular study, there are numerous other reasons that an intentional dissimulator may seek to conceal his or her psychopathology. Some may be aware that a not-guilty-by-reason-of-insanity (NGRI) acquittal may lead to indefinite commitment, which is less desirable to them than a finite sentence. With regard to competency evaluations, some states have such a backlog of those awaiting forensic hospital beds that the delay in waiting for a bed for competency restoration may eclipse the maximum sentence for the defendant's alleged crime. On a more basic level, smoking is forbidden in some jail mental health units, whereas it is permitted in the general population. Thus, a mentally ill offender may seek to conceal his or her psychopathology to remain in the general population and be allowed to smoke cigarettes.

Uninsightful dissimulators fail to reveal psychiatric symptoms or illness without the knowledge or insight that they have a psychiatric disorder. Even if this failure to reveal symptoms is an active choice by the uninsightful dissimulator, such dissimulation does not appear to be a rational choice. Uninsightful dissimulators suffered from either paranoid or grandiose delusions, both of which impaired their insight into their illnesses. Some also were observed responding to hallucinations, suggesting that command auditory hallucinations may play a role in their failure to be forthcoming about their symptoms.

As this is a pilot study, our results should be interpreted conservatively. Although our cases seemed relatively clear-cut in terms of intentional versus uninsightful dissimulation, one must consider that there is a continuum of degrees of insight that defendants have into their psychiatric illnesses. In our sample, we found a subgroup that fairly readily admitted to their concealment of psychiatric symptoms and a subgroup that adamantly maintained that they were not mentally ill. Clinical experience in nonforensic settings suggests that in fact there are also cases that fall in between, in which mentally ill individuals initially deny their illnesses but gradually gain insight as treatment and evaluation progress. Future research may help to determine the frequency of dissimulation and whether it is on a continuum rather than strictly divided into subgroups, as this study found.

Our findings reinforce the point that genuinely mentally ill individuals may commit crimes yet seek to conceal their illnesses, despite the seemingly obvious benefit that acknowledgment of illness could bring to their defenses. This study reminds us that there is nothing curative about being arrested for a crime when the accused suffers from mental illness. While malingering certainly occurs in forensic settings, the savvy examiner should remain cognizant that mentally ill individuals may be as guarded about their psychiatric conditions in jail as they would in a hospital emergency room when faced with involuntary admission.

While the benefit of an evaluator's alertness to the possibility of dissimulation for a mentally ill defendant is fairly obvious, the benefit to other segments of society is often overlooked. Currently, we are faced with a burgeoning population of mentally ill in correctional settings.[8] In an untreated state, many of these individuals pose a significant risk of violence to prison personnel and other inmates.

Furthermore, these individuals are often returned to the street in an untreated state, raising the risk that they will re-offend. It is noteworthy that most individuals found NGRI ultimately spend more time hospitalized than they would if they merely served their sentences.[9] In addition, NGRI acquittees are potentially followed up more carefully than are parolees. If we are seeking to protect society, it seems that hospitalization is more effective than imprisonment.

One of our cases illustrates the discrepant effectiveness of the two pathways for mentally ill offenders. The defendant was examined in a military prison after he was convicted of assault and battery at his duty station. The defendant subsequently assaulted guards in three separate military prisons while accumulating more than 200 additional conduct violations in a three-year period. The defendant was then evaluated for competency to stand trial and his mental state at the times of his most recent offenses. Interviews of the defendant and the guards provided evidence suggesting that the defendant suffered from paranoid delusions about the individuals whom he had attacked, although he adamantly denied the possibility that he had mental illness and opposed efforts to have a competency hearing. After being found incompetent to stand trial, he was sent to a federal correctional institution where the same aggressive behavior continued until he was medicated with valproic acid and haloperidol decanoate. Subsequently, his competency was restored. He was found NGRI and returned to the same institution for an additional two years before being discharged to a conditional release program. In contrast to his first three years of confinement, the defendant did not incur further conduct violations during this period, underlining the point that recognition and treatment of the defendant's illness clearly promoted the safety of all involved.

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