

PSYMALINGERING OF PSYCHOSIS IN CORRECTIONAL SETTINGS: DETECTION AND TREATMENT IMPLICATIONS

Melissa S. Caldwell, Ph.D.

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“There were no real demons, no talking dogs, no satanic henchmen. I made it all up via my wild imagination so as to find some form of justification for my criminal acts against society.”

-”Son of Sam: serial killer, David Berkowitz

In recent years, jails and prisons have seen a steady increase in incarceration rates, as well as an increase in the number of inmates exhibiting symptoms of mental illness. This phenomenon has been attributed to multiple factors including changes in legislation, as well as the deinstitutionalization movement (i.e., the policy of moving severely mentally ill patients out of public mental institutions and then closing down part or all of those institutions). Regardless of the causes, the medical and mental health professional faces numerous challenges in treating this growing population. These challenges include the high prevalence of substance abuse (estimates of greater than 80%) and the high risk for suicide among the inmate population due to the confluence of multiple life stressors. Compounding these challenges is the fact that situational factors make deception a very common behavioral feature among correctional clientele. Correctional settings are a virtual breeding ground for the phenomenon of malingering (i.e., the *intentional* production of false or grossly exaggerated physical or psychological symptoms, motivated by *external incentives*, i.e., secondary gain), particularly, the malingering of psychotic symptoms.

It has been estimated that upwards of 20% of those exhibiting mental health problems in correctional settings are malingering. This complicates the job of the correctional professional (mental health and medical practitioners) who, in determining the most appropriate course of intervention, must be able to distinguish between genuine mental illness and malingered presentations.

Many have wondered ‘what is it about correctional settings and its population that makes malingering so prevalent?’ Authors on this topic point to the unique experiences of inmates and underlying motivations. Malingering, as with other forms of deception, can be viewed as a type of approach versus avoidance strategy. In incarcerated populations, secondary gain (the critical determiner of whether the behavior can be defined as malingering) may be legal (forensic) or environmental (correctional) in nature and represents strategies of pleasure-seeking or pain avoidance. An inmate may feign psychosis in order to avoid criminal responsibility or to achieve transfer to the hospital as respite. In the past, practitioners adhered to the belief that people trying *to get drugs* don’t want to appear psychotic, but rather feign symptoms that are likely to get them a narcotic or stimulant. With the introduction of newer antipsychotic drugs, this previously-held belief is being called into question (e.g., abuse of quetiapine, aka in street jargon as “Susie Q,” “quell,” “baby heroin,” or simply “Q”).

The hallmark of malingering is *inconsistency*. As it is often difficult for someone to fake a limp over time (i.e., the person forgets to limp or limps with the wrong leg), so it is with the feigning of mental health symptoms. A patient may claim symptoms that are not consistent with genuine mental illness. For example, the patient may claim to experience visual hallucinations in black and white, when genuine hallucinations are generally seen in color. The patient may report that he/she “hear voices” continuously and has no coping strategies for managing the purported auditory hallucinations. Genuine psychosis is manifested by intermittent, rather than continuous, auditory hallucinations and the psychotic patient can generally verbalize strategies for diminishing the “voices.”

A patient’s self-report and his/her observed level of functioning may also show inconsistency. This would be the case when the patient reports “hearing voices,” but does not show signs of distraction (inconsistency in self report and observed behavior). Similarly, the patient may claim to be “paranoid,” which in and of itself conflicts with the very

definition of delusion, but behaves in a manner at odds with this claim (e.g., direct observation or staff reports shows the patient being social and interactive, laughing and playing cards, with other inmates).

There are numerous pitfalls in malingering assessment. Practitioners are reluctant to label a patient as a malingerer for many reasons. The following are three commonly cited reasons for reluctance: First, is the difficulty in proving malingering. To do so requires a firm grounding in the phenomenology of genuine mental illness, and a willingness to use resources (e.g., behavioral monitoring, review of historical data, testing) to buy time toward an accurate diagnosis. Second, is the fear of confronting the subject and creating possible embarrassment or provoking retaliation, such as lawsuits. Third, is the knowledge that malingering and genuine mental illness can coexist (i.e., partial malingering) and thus, the fear of denying a truly ill person medical care.

The necessity of assessing malingering represents a paradigm shift for many practitioners who traditionally have come to rely on truthfulness in clinical practice and struggle with the ethics of potentially “blacklisting” patients by documenting their suspicions. However, for many comes the realization that to ignore indicators of malingering comes with its own set of consequences. Failing to assess and document the presence of malingering has significant implications, not only for the care of the individual patient, but also for the larger patient population. Specifically, failure to identify the presence of malingering drains the medical, mental health, and correctional systems of resources (time, energy, and supplies) and thus, deprives the genuinely ill of the care they require. Additionally, ignoring the phenomenon may increase the likelihood of iatrogenic effects such as contributing to substance abuse, reinforcing negative behavior and exposing the patient to the potentially harmful side effects of unnecessary medications.

To approach the assessment process with confidence, there are several general issues to consider. First, you must know the illness you wish to diagnose or rule out. What are the criteria for diagnosis? How are the associated symptoms commonly presented? And what are unlikely manifestations? The better you understand the phenomenology of the genuine illness, the easier it will be to detect faked symptoms. Anchor the diagnosis of malingering on cues derived from research, not just one’s subjective impression, which has a high probability of error (e.g., pleasantness is often confused as honesty; eye contact is not a reliable indicator of truthfulness). Consider utilizing validated assessment instruments and peer consultation to increase confidence in the diagnosis. And finally, in deciding if a specific symptom is faked, the practitioner must look beyond general credibility issues (e.g., that just because the individual is a criminal, he/she must be a liar; or just because the individual lies, he/she must be malingering). The saying “trust no one, but give everyone the benefit of the doubt” is key to maintaining the necessary level of professional objectivity.

Selected References

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Dr. Caldwell is the Director of Mental Health Services for Advanced Correctional Healthcare, Inc. Readers may contact her at mcaldwell@advancedch.com