

Feigned symptoms among defendants claiming psychiatric problems: Survey of 45 Malingers

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Objective: In many jurisdictions, psychiatric problems are intended for commutation. Therefore, a forensic psychiatrist has an important role in detection of malingering. While several studies evaluate diagnostic tests, it is less known what symptoms are more likely to be imitated by malingers.

Method: In a prospective study 45 malingers, who were diagnosed according to interviews by two forensic psychiatrists, from defendants with a judicial order for evaluation of mental status and criminal responsibility during a period of eighteen months were examined in legal medicine center of Tehran. Participants were assessed in another interview to determine symptoms. Dichotomous symptoms in felony and misdemeanor groups were analyzed using fisher's exact test. The level of statistical significance was set at $P < 0.05$.

Results: Thirty-eight malingers were charged with misdemeanors and seven with felonies. Behavioral symptoms were most frequently faked by 35 participants (77.8%). Participants charged with criminal accusation had a significantly lower mean age ($P = 0.032$) and a higher level of education ($P = 0.008$) than other non-criminal defendants. A statistically significant increase in memory function problems was demonstrated in the misdemeanor group ($P = 0.040$). With regard to dual symptom imitation, statistically significant correlations were observed between thought content and perceptual symptoms ($P = 0.048$) for felonies and mood & affect and thought process symptoms ($P = 0.034$), mood & affect and behavioral symptoms ($P = 0.000$) and cognitive function and behavioral symptoms ($P = 0.039$) for misdemeanors. In general, many simulators attempted to mimic simple symptoms of behavioral disorders. Probably felony offenses need less accurate programming; therefore, their rates are higher in older, less educated participants.

Conclusion: This study demonstrated that differences between presenting symptoms among different offenses may not be useful in detection of malingering,; however, unusual dual symptom imitations may be useful, particularly when standard tests are not performed.

Key words: Forensic Psychiatry, Malingering, Deception, Interview

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Claim of psychiatric disorder has become an important basis for civil and criminal lawsuits as its diagnosis is based on interviews and many people are familiar with some psychiatric symptoms (1). Some malingers have been able to deceive the psychiatrists adeptly. The famous example was in Rudolf Hess case (Hitler's deputy fuehrer of the Nazi party) who claimed total amnesia in court, and the examiners concluded that his amnesia was genuine (2). True psychiatric patients and psychiatrists forfeit when others successfully fake psychiatric symptoms for evasion of responsibility (3). Therefore, it is important for forensic psychiatrists to narrow diagnostic criteria and to try to determine genuine and simulated symptoms.

Malingering is known as deceitful and dishonest simulation of an illness symptom for personal gain (4).

For diagnosis of malingering using Diagnostic and Statistical Manual of mental disorders, 4th ed, (DSM-IV), symptoms should be grossly exaggerated (5).

What surely specifies malingering from other psychiatric conditions is intentional deception for an external motivation (4, 6). These participants are often involved in malingering in attempts to achieve financial gain or legal responsibility and are usually awkward with interviews and reluctant to receive medical care (7, 8). In a study of 2155 mental illness claims, eleven percent of subjects received formal malingering diagnosis. The majority of malingers were those charged with kidnapping and robbery (28.4% and 21% respectively) and surprisingly the minority being malingers charged with murder (4.9%)(9). Psychiatric symptoms seem to be easy to mangle because there are no objective manifestations and the discovery of the false subjective psychological

claims such as suicidal attempts, anxiety, emotional numbing, and depression are difficult to certify. Thus, an important part of forensic psychiatry evaluation is the assessment of a purposeful culpable act and attempt to get away from the situation (1, 4, 10).

In one study, malingered symptoms in forensic and non-forensic cases were compared; and furthermore, mental disorders, cognitive impairments and clinical syndromes were evaluated in the two groups. Female malingerers showed simulations of medical problems about twice more than males, but less cognitive deficits were observed in female participants. Non-forensic cases mostly imitated mental disorders, but forensic cases frequently simulated medical problems and cognitive impairment symptoms (11).

Another study on clinical offenders referred for assessment of criminal responsibility or standing trial in an outpatient assessment, indicated that about 8% of participants feign psychiatric symptoms. Malingerers with lower levels of education were mostly accused of assaults than spoof compared to real psychotics. Sexual assaults, theft and physical attack were the most common reasons for juridical order of evaluation for those standing trial. Malingerers were mostly accused of numerous previous arrests because of aggressive action against individuals. Auditory hallucination and overemphasized behavior were feigned, but disproportionate effect, new word making, non-abstract thinking and diminished individual hygiene were rarely feigned (12).

In another study, 131 participants of the American Board of Clinical Neuropsychology, from diverse provinces, shared their practice on malingerers. Totally 33531 cases were evaluated over one year. Malingering was detected in 29% of self-injury cases, 30% of disability claimants, 19% of criminal and 8% of medical cases. The frequency of malingering did not differ significantly in diverse provinces. Self-injury and disability claimants, referred by the insurance companies were associated with higher amounts of malingering. Higher incidences of malingering in criminal cases consulted by the prosecutor were seen too (13).

In spite of doing many researches on detecting malingering, little is known about the frequency of faked symptoms by defendants charged with different crimes or those having a financial claim.

In many jurisdictions, psychiatric problems are intended for commutation. Therefore, a forensic psychiatrist has an important role in detection of malingering. While several studies evaluate diagnostic tests, it is less known what symptoms are more likely to be imitated by malingerers. In the present study, clinical symptoms faked by participants were investigated. Furthermore, this study comprises the determination of relation of symptom presenting patterns among various claims.

Materials and Methods

Participants and Procedure

This study was a prospective investigation of malingered psychiatric symptoms in Tehran. Tehran with approximately twelve million citizens is the largest city of Iran, with most of its population being immigrants. This study was conducted from February 2010 to September 2011. The participants were defendants with a judicial order of evaluation for mental status and criminal responsibility. These participants were evaluated by two forensic psychiatrists with a doctoral-level education in psychiatry and an experience of twelve-month training in forensics while not being aware of the purpose of the study, using American Psychiatric Association's Diagnostic and Statistical Manual 4th Edition Text revised (DSM-IV-TR) criteria for mental disorders.

Malingerers were diagnosed according to misattribution of symptoms, unusual hallucinations, distortion of notifications, fictions of complaints, and exaggeration of their symptoms. Subjects excluded from our study were those without definite diagnosis of at least one forensic psychiatrist, subjects with positive screening tests of alcohol and drug at the time of arrest, subjects with a history of previous imprisonment, illicit drug abuse, determined mental, neurological or psychiatric problems and those who received psychoactive medications. Finally, forty five malingerers were included and assessed in another interview by the head of forensic psychiatry center. Because of the legal order to evaluate mental status of the subjects and intentional faking symptoms to deceive forensic psychiatrists, informed consent was not obtained from the fakers taking part in our study. Ethical approvals for this study were obtained from Tehran University of Medical Sciences Research Ethics Committee prior to the launch of the study.

Measures and Statistics

Demographic variables were obtained from family reports (if accessible) and court reports about educational level, ancestry, marital status, and employment. Symptoms were documented using an absolute list of 31 symptom presentation variables after a research pre-testing. Similar items that were presented with low frequency were compounded into complex classes. The captions of manifestation used to construct the areas were (1) mood and affect, (2) thought content, (3) thought process, (4) perception, (5) cognitive function, and (6) behavioral disorder symptoms (14). Motivations of malingering were assessed according to the court order; and financial gain or relief from responsibility in a felony background was concluded. The categories of charged with felonies' versus 'not charged with misdemeanors' were analyzed in 2×2 contingency tables with Fisher's exact test due to small numbers of the felonies. The level of statistical significance was set at $P < 0.05$. The statistical analyses were carried out using the SPSS version 15.0 software.

Results

Characteristics of the defendants and statistical results comprising the two groups are demonstrated in table 1. No significant difference was observed between groups in sex, provenance, occupation and marital status, but the misdemeanor group was fairly less educated and contained proportionally more married urban subjects.

The mean age of the 45 defendants was 40.31 ± 15.12 years with the range of 19 to 76 years. Participants charged with criminal accusation had significantly lower mean age than other non-criminal defendants.

Forty-one defendants were male, and four female. There were 44 immigrants (28.9% rural, 68.9% urban), and only one participant was citizen of Tehran. Twenty four had nine years of education or less, three had bachelor's degree or higher. Those charged with criminal accusation had a significantly higher level of education. Sixteen were single, of whom only one was divorced;

and 20 were unemployed. Misdemeanors were comprised of one domestic disturbance, three illicit drug trafficking, four robberies, ten claims on insurance policies based on a traumatic event (especially a minor head trauma), and 20 fraud and felonies including three sexual assaults and four violent offences and murders.

Symptoms were assessed in six significant domains (14). Follow-up studies incorporated Fisher exact tests for each dependent variable reported in table 2. A

Statistically significant increase in memory function problems was demonstrated in the misdemeanor group regardless of time period.

Differences among the other 25 (including seven subgroups) and the six captions of variables were not statistically significant. Behavioral symptoms were the most commonly faked presentations. Table 3 demonstrates the concordant occurrence of feigned symptoms according to the denunciatory group of malingers.

Table 1: Background Information of felony and misdemeanor groups

Background Information	Felonies(n=7)	Misdemeanors(n=38)	Significance test
Sex (male/female)	7/0	34/4	Fisher Exact, P=1.000
Provenance (rural/urban)	0/7	13/25	Fisher Exact, P=0.089
Occupation (employed/unemployed)	5/2	20/18	Fisher Exact, P=0.437
Marital status (single/married)	4/3	12/26	Fisher Exact, P=0.225
Education (years)	10.8	6.6	T(2-tailed) , P=0.008
Age range (mean)	19-46 (30.4)	20-76 (42.1)	T(2-tailed) , P=0.032

Table 2: Clinical presentation variables

Descriptive criteria	Felonies (%)	Misdemeanors (%)	Total number of cases (%)	Fisher exact test
Mood & Affect Symptoms	5(11.1)	26(57.8)	31(68.9)	P=1.000
Depressed	4(8.9)	17(37.8)	21(46.7)	P=0.689
Agitated	2(4.4)	6(13.3)	8(17.8)	P=0.590
Disproportionate or define affect	1(2.2)	5(11.1)	6(13.3)	P=1.000
Thought content symptoms				
Obsession	2(4.4)	7(15.6)	9(20)	P=0.614
Perceptual symptoms	2(4.4)	13(28.9)	15(33.3)	P=1.000
Hallucination	2(4.4)	9(20)	11(24.4)	P=1.000
Pseudo hallucination	0(0)	4(8.9)	4(8.9)	P=1.000
Thought process symptoms	4(8.9)	17(37.8)	21(46.7)	P=0.689
Circumstantiality	1(2.2)	4(8.9)	5(11.1)	P=1.000
Confabulation	1(2.2)	1(2.2)	2(4.4)	P=0.290
Derailment	2(4.4)	7(15.6)	9(20)	P=0.614
Incoherence	1(2.2)	4(8.9)	5(11.1)	P=0.589
Cognitive function symptoms	4(8.9)	23(51.1)	27(60)	P=1.000
Memory	0(0)	16(35.6)	16(35.6)	P=0.040
Remote memory	0(0)	12(26.7)	12(26.7)	P=0.164
Recent memory	0(0)	14(31.1)	14(31.1)	P=0.081
Orientation	0(0)	7(15.6)	7(15.6)	P=0.574
Attention	3(6.7)	15(33.3)	18(40)	P=1.000
New learning ability	1(2.2)	16(35.6)	17(37.8)	P=0.227
Behavioral symptoms	5(11.1)	30(66.7)	35(77.8)	P=0.642
Altered level of consciousness (lethargy)	0(0)	2(4.4)	2(4.4)	P=1.000
Unusual dress	1(2.2)	5(11.1)	6(13.3)	P=1.000
Posture and motor behavior (Agitation, Restlessness, Bizarre posture)	4(8.9)	21(46.7)	25(55.6)	P=1.000
Unusual relation to people and things (Hostile, Dodge)	5(11.1)	26(57.8)	31(68.9)	P=1.000

Note. N value and percentages don't equal total of columns since some subjects had fake multiple symptoms.

Table 3: Concordant occurrence of the caption variables

Symptom concordance	Fisher's Exact test	
	Felonies	Misdemeanors
Mood & Affect / Thought content	1.000	0.656
Mood & Affect / Perceptual	1.000	1.000
Mood & Affect / Thought process	1.000	0.034
Mood & Affect / Cognitive function	1.000	0.481
Mood & Affect / Behavioral	1.000	0.000
Thought content / Perception	0.048	0.203
Thought content / Thought process	0.249	0.427
Thought content / Cognitive function	1.000	0.089
Thought content / Behavior	1.000	0.146
Perception / Thought process	0.429	0.307
Perception / Cognitive function	1.000	0.295
Perception / Behavior	1.000	0.407
Thought process / Cognitive function	1.000	0.100
Thought process / Behavior	0.143	0.053
Cognitive function / Behavior	1.000	0.039

With regard to concordant occurrence of two symptom domains (14), statistically significant associations were observed between the thought content and perceptual symptoms for felonies. Presenting other symptoms was not statistically significant for criminal cases. In misdemeanor group, more correlation was observed between two feigned symptom domains. Misdemeanor cases had significant correlations between moods & affect and thought process symptoms, mood & affect and behavioral symptoms as well as cognitive function and behavioral symptoms. Regarding the other symptoms, there were no statistically significant correlations between the groups.

Discussion

In the present study, we analyzed the characteristics of the most relevant symptoms of malingering among the Iranian population.

In Iran, no traditional use of tests as a part of a standard forensic psychiatric examination has been established; furthermore, the validity and reliability of such tests are not studied for Iranian population; thus, there has been no indication of applying such tests. However, longitudinal assessments made by forensic psychiatry experts with appropriate information for determining the diagnosis can be applicable in most cases (15). In this study, there were 45 participants with the diagnosis of malingering confirmed by two separate psychiatric interviews from February 2010 to September 2011. The mean age of participants was 40.31 ± 15.12 years which is higher than reported by American studies (16-18). In our study, we had no restrictions on major offenses, as investigation of more than a half of all cases was performed on fraud or plaintiffs who claimed psychotic problems to terminate financial contracts.

The male to female ratio in our study was 41:4, which reflects male predominance as female malingering of psychotic symptom is less common in our study group compared to other studies (17, 18). This could be explained by sample selection from inmates of province county jails in American studies compared

with some subjects in our study who were referred for outpatient evaluation. On the other hand, none of the women in our study were involved in complex felonies or criminal offences; and social rejection of psychotic patients, especially in Iranian women, probably leads to avoid resorting simulations of mental disorders even in prisoners. A relatively low education level of 7.25 years was observed; namely, in the seven criminal cases the education level was 10.8 years and in 38 misdemeanors, it was 6.6 years. In American malingers who were criminal defendants referred for evaluation of competency to stand trial or criminal responsibility (12), the mean level of education was 10.4 years which is similar to the seven criminal cases in our study. However, in another study carried out on adult inmates from maximum and minimum security jails in a rural southeastern county of the United States, malingers had lower level of education compared to the genuine patients (18).

The employed to unemployed ratio in our study was 25:20. Considering that the unemployment rate in Iran is about 11 percent, we could conclude that more unemployed individuals may be involved in criminal acts or attempt to commit fraud, and due to lack of adequate intelligence and genius, they often simulate psychotic symptoms poorly.

The majority of faked psychiatric symptoms are more frequent in urban population, with a rural to urban ratio of 13:32. This could be explained by less instability of social status in rural cases after immigration, probably because they are willing to do even hard jobs and live with fewer benefits. In comparison, in an American multi-center study examining base rates of malingering, differences were not significant in several locations (13).

Typically, the clinical symptoms and signs obtained in the psychiatric interview should be congruent and lead to a significant diagnostic approach. For example, perceptual symptoms such as auditory hallucinations and some delusional thoughts usually indicate schizophrenic disorders. Furthermore, mood symptoms, behavior disturbances and psychomotor activities are the most frequent symptoms in mood

disorders. Mood is a subjective symptom, but behavior disturbances or psychomotor activities are detected by psychiatrists during a psychiatric interview. A person with delusional disorder usually does not have a history of prominent auditory hallucination, and also, severe bizarre behaviors combined with depressed mood without other psychotic symptoms are rare, but faked symptoms do not usually introduce a known psychiatric diagnosis. For instance, a person may claim that he/she suffers from auditory hallucination but no abnormal behaviour may be observed. Some malingerers show mood disorder symptoms but cannot introduce congruent behaviour within psychiatric examination. The most common feigned psychotic symptoms in our participants were behavioral (77.8% of cases who charged with felonies or misdemeanors), mood & affect (68.9%), and cognitive function symptoms (60%). In another study focused on comparison of forensic and non-forensic malingerers, the most common symptoms feigned by forensic malingerers were medical syndromes or cognitive impairments (11), while the most common deceitful symptoms in criminal defendants referred for pretrial and outpatient evaluation of competency to stand trial or criminal responsibility were perceptual and auditory hallucination, followed by behavioral symptoms in Cornel and Hawk study (1989).

As the role of a previous consort with other vicious people or prisoners and learning psychotic symptoms from video films is more prominent in foreign studies, defendants may be familiar with the symptoms of mental disorders (2, 19). However, in our study we excluded subjects with history of imprisonment, illicit drug abuse, determined mental, neurological or psychiatric problems to make a relatively pure sample of participants without psychotic symptoms. In our study, participants often used simple methods such as refusing to answer questions during interviews, having unusual or bizzare behavior, or claiming depression or memory loss.

One of the most notable findings in our study was dual symptom imitation. In the two of seven criminal cases, defendants claimed obsession and, at the same time, hallucination and pseudo hallucination.

From 38 misdemeanors, 39.5% feigned mood & affect beside thought process disorder symptoms; 55.2% feigned cognitive function and mimic behavioral disorder symptoms; and 65.8% simulated mood & affect and behavioral disorder symptoms concurrently.

Limitations

This study had some limitations. The main restriction of this study was unavailability of standard tests to use in a control group. Sampling of this study was not randomized. It was conducted in one forensic psychiatry center in a legal institution. Therefore, the conclusions may not apply to other situations such as a forensic hospital, where the array of patients may be different.

Conclusions

In general, it seems that differences among presenting symptoms among different offenses may not be useful in detecting malingering. However, unusual dual symptom imitation may be useful, particularly when standard tests are not performed.

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Conflict of Interest

Authors declare that there is no conflict of interest associated to this study.

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