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Malingering in Correctional Settings

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Malingering, the fabrication or exaggeration of psychiatric symptoms for secondary gain, certainly occurs in prison. There is a strong desire to escape from culpability or win placement in a more tolerable setting. The clinician must be aware of this possibility so that scarce mental health resources will not be squandered on prisoners who are not suffering from any significant psychiatric disorder. On the other hand, over-utilization of such attributions as "malingering" or "no diagnosis on Axis I" by frustrated clinicians masks the presence of serious mental illness. The unfortunate result is under-diagnosis, which can lead to unfair punishment of prisoners whose unacceptable behaviors are actually driven by their mental illness. Of course, the ultimate tragedy is when over-concern about malingering leads mental health staff to miss what would otherwise be clear signs of an impending suicide. In this brief article, I will focus on malingering as it pertains to the diagnosis and treatment of mental illness in prison. Forensic evaluations for the courts involve other considerations, which will not be addressed here.

A Typical Yet Sad Scenario

Consider this all too familiar and true story: A prisoner had a history of serious mental illness prior to arrest, replete with multiple psychiatric hospitalizations and prescription of anti-psychotic and mood-stabilizing medications. The court that sentenced him had first ruled that he was incompetent to stand trial, and only after his condition improved with hospital treatment was he convicted and sent to prison. He did not receive psychiatric treatment in general population and proceeded to get into trouble. He broke rules, as people with mental illness are prone to do

(either because they do not fully grasp the rules, or they cannot control their rule-breaking behaviors, or they cannot control their temper, or even because they are vulnerable and get "suckered" by other prisoners). In any case, this hapless fellow wound up in segregation as punishment for rule violations and fighting. In segregation, he decompensated, experienced a re-occurrence of auditory hallucinations and displayed very regressed behavior. He was sent to a crisis unit where the less stressful conditions, including less caustic interactions with staff, permitted him to settle down and soon his symptoms subsided. Only then did the psychiatrist see him, probably wondered why the psychologist at the sending institution was wasting his time by transferring this non-psychotic and currently non-suicidal prisoner, and he diagnosed "No Diagnosis" and "malingering" on Axis I, and "Antisocial Personality Disorder" on Axis II. When the prisoner arrived back in the segregation unit at the sending institution, he was accused of "fooling" everyone into thinking he had been suffering from a bona fide psychiatric crisis. He soon accumulated several more disciplinary tickets.

This type of scenario is neither isolated nor rare. As I tour prisons in preparation for testimony in court about the quality of correctional mental health services, I encounter many individuals very much like this prisoner. Another example is the Montana case of Mark Edward Walker, reviewed in 5 CMH 33, 35 (September/October, 2003).

The suicide of a young person, who has not yet had an opportunity to sample much of life, is very tragic. The rate of suicide in prison is at least twice as high as that in the community. I have reviewed dozens of prison suicides in several states, and I usually discover notations in the chart that the prisoner is "merely manipulating to get attention," "malingering," or "no Axis I diagnosis, antisocial personality disorder on Axis II." In one case that I reported in *Prison Madness*[1], the C.O. on rounds passed the prisoner standing on his bunk with a noose around his neck, and instead of ringing the alarm, he calmly completed his rounds. After rounds he returned

to that prisoner's cell and found the man hanging and dead. In that case, there were recent prior notes in the prisoner's clinical chart that he was inappropriately seeking psychiatric help and didn't really suffer from any mental illness. Other cases may be less dramatic but just as lethal.

Credibility vs. Malingering

There is a difference between credibility and malingering. Credibility is about the truth or untruth of something we are told. Malingering is about the presence or absence of illness. Individuals who do not always tell the truth can also suffer from serious mental illness. People with serious mental illness, on average, are no different than the general population in their willingness to lie to protect themselves from negative consequences. Approximately the same proportion of both groups is willing to lie. Usually a person exaggerates or manipulates in order to achieve something that seems unachievable by any other means. Her credibility is suspect. But this does not mean that she is free of mental illness. A person could be manipulating or telling a lie or exaggerating symptoms, and at the same time be suffering from a serious mental illness or be authentically suicidal. That possibility too often is lost on custody and mental health staff who have decided at some point that the individual is BAD, not MAD, and "merely malingering" to escape the consequences of his badness.

The problem is magnified by the tendency in corrections today to think about badness and madness in terms of *either/or* dichotomies rather than *both/and* complexities. Are the prisoner's unacceptable acts the result of mental illness or merely reflections of his badness or antisocial personality? If the prisoner is BAD, he deserves to be punished. If he is MAD, for example truly suicidal or hearing voices commanding him to carry out illegal acts, he needs more intensive treatment, and there is some degree of mitigation for his bad acts.

Reality is a lot more complicated. Not only are people suffering from serious mental illness perfectly capable of manipulating and exaggerating symptoms, but often their tendency to do so is actually symptomatic of their mental illness. But when the staff decides that a prisoner is "malingering," his or her subsequent complaints about psychiatric problems and suicidal inclinations are not taken seriously.

A well-documented history of treatment for mental illness prior to incarceration creates at least an aura of authenticity to a prison inmate's likely mental illness. When such a prisoner has been seen in Observation for multiple suicide attempts or referred to a correctional psychiatric facility, it is highly likely that this inmate in fact suffers with serious mental illness and may also pose a likely risk of serious self-harm.

In fact, serious mental illnesses such as Schizophrenia, Bipolar Disorder and Major Depression all tend to reoccur intermittently. They follow a waxing and waning course throughout a lifetime. When someone with a history full of psychiatric breakdowns and treatment is sent to a segregated housing unit and then exhibits severe psychiatric symptoms, it is very likely he is experiencing an exacerbation of the mental illness, whether or not he also is being manipulative or exaggerating his symptoms at the same time. If the clinician diagnoses malingering and continues to prescribe strong anti-psychotic or mood-stabilizing medications, or continues to place the prisoner on suicide watch in Observation, then something is very wrong with this picture.

It is as if certain prisoners with a long history of documented serious mental illness were suddenly cured of that mental illness while incarcerated and now are symptomatic merely on account of their willful manipulations. There might be an occasional case where an individual had been erroneously diagnosed, civilly committed, medicated and assigned disability benefits

prior to incarceration, but it is simply not possible that a large number of people had everyone fooled for so long in the community as well as earlier in a prison term.

We know from a large amount of research in the social sciences that, in a "total institution" (prison, state psychiatric hospital, large group home), when mental health services are inadequate (for example, where mental health staff in Administrative Segregation Units find they must resort to seeing prisoners at their cell-fronts instead of taking the time to examine them in a confidential setting), people with bona fide psychiatric problems essentially have to create a ruckus in order to get the minimum level of care they need. In other words, they suffer from psychosis (and/or depression with suicidality) and they manipulate – it is not a case of either/or. The fact that someone suffers from a personality disorder, even antisocial personality disorder, does not in any way preclude his becoming depressed and presenting a serious risk of suicide.

To the extent a psychotic or truly suicidal prisoner feels he has to manipulate in order to make staff pay attention to his bona fide urgent needs, the mental health staff too often react strongly to the manipulation and look no further. This unfortunate reality is especially prevalent in isolated confinement units, where the conditions of confinement are so stressful that prisoners complain quite a bit and staff can become relatively inured to their complaints. The problem with the staff's excessive concern about being manipulated is that the harsh conditions of confinement and the lack of a real opportunity for the prisoner to develop a trusting confidential therapeutic relationship can lead to repeated suicide attempts and breakdowns in depressed and psychotic prisoners. Of course, I am highlighting here the cases where the treatment breaks down in this way. I am very aware that dedicated correctional mental health staffs work very hard to win the trust of the prisoners they treat, and they succeed at preventing suicides in very many instances. My concern here is the many cases where things have not gone as well.

Methods for Distinguishing True Mental Illness

There are tried and true methods for distinguishing between malingering and bona fide mental illness. For example, people who suffer from Schizophrenia not only hear voices, they also suffer from a pervasive thought disorder. It is quite easy for someone to falsely claim they hear voices, and many people who are trying to fake mental illness will make such a claim because they believe that hallucinated voices prove their madness. However, it would be much more difficult even for an accomplished actor to mimic for very long the loose and tangential associations and the bizarreness that are critical parts of the clinical picture of Schizophrenia.

It is relatively easy for a clinician to trip up a malingerer: "Do you see things as well as hearing voices?" Most hallucinations accompanying Schizophrenia are auditory. The malingering individual will either aver seeing things, which alerts the clinician to the possibility that this individual might say yes to anything the clinician suggests, or he will hem and haw and be very vague about his experience. Of course, the clinician needs to make allowance for the complexity of an illness like Schizophrenia – a certain percentage of people suffering from Schizophrenia actually do experience visual hallucinations. So the clinician needs to have a layered, complex method for assessing the prisoner's mental state.

The mental status examination is the "objective" component of a psychiatric or psychological evaluation, where the history, statement of current symptoms and description of current and past experience of reality constitute the "subjective" part of the examination. The clinician compares the objective mental status examination (what the psychiatrist observes) with the subjective history and reportage (what the examinee tells the clinician) and checks to see if there are inconsistencies. No matter how thoroughly a prisoner has studied the signs and symptoms of mental illness, there are noticeable inconsistencies in the way someone intent on

faking a mental illness or telling a false story presents the symptoms. Psychiatrists and psychologists are trained to discern the inconsistencies.

There are many other ways to assess the reliability of an interviewee. An overly dramatic presentation is suspect. So is blanket endorsement of all symptoms at once, or overt exaggeration, especially when the reported symptoms do not add up to a credible clinical picture. Wherever possible, information provided by the interviewee should be corroborated by documents and information from others. The internal consistency of the interviewee's story can be evaluated, and where there are inconsistencies, there may be distortions of the truth. The story an interviewee tells in the present can be checked against the story he has told others in the past. A variant of this approach is the repeated administration of a structured diagnostic interview, such as the Schedule of Affective Disorders and Schizophrenia, to test whether the individual's responses are consistent through several sittings.[2] The interviewee's intelligence must be taken into consideration – i.e., a very intelligent person is more capable of reading about a disease or syndrome and mimicking its signs and symptoms, whereas a less intelligent person is likely to make obvious mistakes in the process. The secondary gain (benefit of having more severe symptoms) can be assessed. I become skeptical when I interview a prisoner who has been diagnosed a "malingerer" and yet denies he is mentally disturbed, is quite resistant to mental health treatment, and does not want to be moved to a special housing unit for prisoners with psychiatric disabilities. Where is the secondary gain?

Richard Rogers' *Clinical Assessment of Malingering and Deception* provides a thorough review of the literature as well as a practical guide to the assessment of malingering.[3] He favors the Structured Interview of Reported Symptoms (SIRS), which he considers a very accurate tool for assessing malingering; however careful administration of this test requires at least 45 minutes per individual. I believe that what is learned from careful administration of the SIRS actually

overlaps to a great extent what a clinician can uncover in the process of taking a thorough history and conducting a rigorous mental status examination.

I find that psychological assessment instruments such as the MMPI-2, while potentially very helpful in theory, can be quite misleading in practice. I have reviewed tests administered by correctional psychologists who conclude that there is "no Axis I diagnosis" and the prisoner is "merely malingering," and yet when I review the raw test data I find statements that this profile is consistent with malingering or with confusion secondary to a psychotic thought process. In other words, the clinician could easily be putting forward a biased conclusion that is not entirely backed up by the raw data. In general, psychological assessment for the purpose of uncovering malingering is problematic. Inordinately high scores on the F or "Fake/Bad" scale of the MMPI-2, for example, might reflect malingering or exaggeration of symptoms, but could just as likely reflect gross mental disorganization on the part of a very disturbed individual, or even a failure to comprehend the test questions on the part of someone with a brain injury, limited education, or impaired intellectual function. In fact, there is a well-known class bias on the validity scales of psychological test instruments. The point, however, is if the psychologist who is interpreting the raw test data thinks in terms of "either/or" dichotomies such as MAD vs. BAD, and has grown excessively wary of prisoners who try to manipulate staff, then he or she brings a bias to the interpreting of ambiguous test results, and too often concludes the prisoner is "merely malingering."

The patient's current mental status is very important. However, if a prisoner is not hearing voices or is not suicidal at the time of a single interview or an admission to a treatment facility, this does not mean he or she is free of depression or psychosis. Suicide ideation and hallucinated voices come and go in the course of a lifetime mental illness such as a Major

Affective Disorder or Schizophrenia. Of course, in the final analysis, the diagnosis of mental illness is properly based on the entirety of available data and materials.

Over-Utilization of the Malingering Tag

If clinicians possess this many tools to properly assess malingering, why do we find so many cases in correctional settings where malingering is erroneously diagnosed while authentic mental illness or suicidality are under-diagnosed? After grappling with this problem for years, and meeting many well-meaning and quite competent correctional psychologists and psychiatrists who diagnose malingering and no mental illness in prisoners who clearly exhibit indisputable serious mental illness, I have concluded that an unfortunate combination of stigma, mental health staff trying too hard to fit in with the culture of security, relatively insufficient mental health resources and burn-out are the underpinnings of the widespread under-diagnosing. The result of either/or thinking in regard to the MAD vs. BAD dichotomy is that a group of prisoners are recognized as suffering from serious mental illness (typically the ones who do not create disciplinary problems), whereas another group (usually the ones who receive multiple disciplinary write-ups) are stigmatized as manipulators, malingerers and worse. Then, when a prisoner who has been stigmatized by being placed in the malingerer category complains of hearing voices or feeling suicidal, her concerns are minimized or ignored by an already skeptical staff.

The culture of security is a given in correctional settings. The security staff has the very difficult job of maintaining order and fostering the smooth operation of the facility. Of course, mental health staff must collaborate closely with security staff in order to safely engage in treatment while not interfering with operations. However, when mental health staff becomes taken over by the culture of security to the extent that

they forfeit their independent clinical stance, treatment is greatly compromised. Today, with a vast number of prisoners plagued by serious mental illness and requiring treatment, a certain degree of tension between security concerns and treatment concerns should be an integral and appropriate part of corrections. Working through and resolving this kind of tension is a critical ingredient in productive collaboration. To the extent mental health staff succumb to the culture of security and, for example, over-utilize diagnoses such as malingering, the prisoner who suffers from mental illness and breaks rules tends to be punished harshly instead of receiving urgently needed treatment.

In terms of mental health resources, there is this general pattern: The thinner the resources to treat prisoners with mental illness, the greater the tendency to diagnose malingering. After all, diagnoses such as "merely malingering" or "no diagnosis on Axis I" mean the prisoner will go essentially untreated and it will be left to custody staff to punish unacceptable behaviors, including self-injury. Conversely, where there are relatively adequate mental health services and adequate bed space at every level of care so that the clinician can easily transfer a disturbed prisoner to a mental health treatment program that fits the prisoner's condition and acuity, there is less need to resort to a diagnosis like malingering. Too often, the diagnosis is made to fit the resources rather than the resources being designed to fit the needs of the population.

The fourth background factor associated with the over-utilization of the malingering tag is burnout. The provision of mental health services in prison is fraught with difficulties and frustrations. Visiting prisoners in segregation and speaking through the bars or lexan partition is far from optimal. One wants to reach out and help, but often the context does not permit much in the way of a trusting therapeutic relationship. Where brief cell-front chats are all that time permits, there is a less than satisfactory connection between clinician and prisoner. Maslach and

Leiter[4] outline the evolution of burn-out in such a setting: first the staff feel that they are unable to provide the quality of service that they were trained and hired to provide, then the staff begin to distance themselves from the clients whose problems cannot be resolved, and finally the staff become less sensitive to the needs of those clients and blame them for the ineffectiveness of treatment. Indeed, when this unfortunate progression occurs in a correctional setting, there follows the labeling of the most frustrating and unappreciative prisoners as malingerers.

G. G. Hay found that 5 of 6 patients in whom he identified feigned psychosis eventually developed Schizophrenia.[5] Others have pointed out that the collection of signs and symptoms that are interpreted as malingering today might actually preview an impending psychotic decompensation or suicide. In any case, until there is more collaboration between custody and mental health staff in devising effective programs for difficult prisoners, until resources for correctional mental health services are enhanced so that all prisoners in need of it can be offered comprehensive mental health treatment, and until burnout is addressed and corrected; the erroneous attribution of malingering and the under-diagnosing of mental illness will continue to plague correctional mental health programs.

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