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Malingering in the correctional system: Does incentive affect prevalence?

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ABSTRACT

Incentives to malinger vary greatly dependent on the context, as does the prevalence. Malingering in the medico-legal context of the criminal courts is generally for one of two purposes: to present as incompetent to stand trial or to successfully plead not guilty by reason of insanity. Estimates of the prevalence of malingering in these contexts vary between 8 and 21%. The prevalence of malingering increases dramatically in a general offender sample, where the external incentive is likely to be substantially different. Malingering in this context can be as high as 56% and generally occurs to obtain a more desirable housing situation or desired medications. Our study examined data from two distinct samples to evaluate incentives to malinger: patients found incompetent to stand trial (IST) and sent to a state hospital for restoration and jail inmates seeking psychiatric services (JPS). Our results indicate that the rate of malingering in the IST sample was consistent with rates published in comparable samples (17.5%) and the rate for the JPS sample was substantially higher (64.5%). Only in the IST sample was rate of malingering associated with offense severity: patients found IST for murder and robbery evidenced malingering rates more than double the sample as a whole. Offense severity bore no relationship to malingering in the JPS sample.

1. Introduction

The malingering of mental illness for external incentive has been recognized for centuries. Odysseus feigned madness to avoid going to the Trojan War; Hamlet feigned madness to avenge the murder of his father; more recently, and with an external incentive commonly seen in forensic psychology, Randle McMurphy, the protagonist in "One Flew over the Cuckoo's Nest" feigned insanity to serve his sentence for statutory rape in a psychiatric hospital. Feigning is often used interchangeably with malingering although in fact the two concepts are different. According to the American Heritage dictionary, feigning is defined as "to represent falsely; to imitate so as to deceive" (Feigning, 2011) whereas malingering means "to feign illness or other incapacity in order to avoid duty or work" (Malingering, 2011). Other than deception, there is no inherent motivation contained in the definition of feigning. Some authors (Heilbronner et al., 2009; McCullumsmith & Ford, 2011) discuss the distinction between feigning and malingering in terms of the difference between detection and diagnosis. A clinician may know that a symptom is falsely produced (detection), but in order to diagnose (malingering), the external incentive for that production must be elucidated.

The "bible" of modern day psychiatry and psychology is the Diagnostic and Statistical Manual, which is currently in its fourth edition (DSM-IV TR; APA, 2000). Only two disorders in this manual involve the conscious production of symptoms: Factitious Disorder and Malingering. The DSM-IV TR states that Factitious Disorder is "characterized by physical or psychological symptoms that are intentionally produced or feigned in order to assume the sick role" (APA, 2000, p. 513). The oft-quoted definition of malingering as provided by the DSM-IV TR states "malingering is the intentional production of false or grossly exaggerated physical or psychological symptoms motivated by external incentives" (APA, 2000, p. 739). These external incentives can vary greatly, dependent on the context. While both disorders involve the intentional production of symptoms, either physical or psychological, the definitions imply that the clinician must be able to distinguish between a primary gain (being a patient and the intrinsic benefit that provides) versus secondary gain or external incentive (Scott & McDermott, 2013). In the psychiatric setting, external incentives can include the procurement of financial compensation (legal settlements or verdicts, worker's compensation, disability benefits); the obtainment of prescription medications; or commitment to a psychiatric facility in lieu of incarceration, as was the case with Mr. McMurphy. In DSM nosology, Factitious Disorder is a mental illness, whereas Malingering is classified as a "V-code" — other conditions that may be the focus of clinical attention.

Several theories have been proposed to provide an explanation for the potential motivations for malingering. The theory that has garnered the most acceptance is the adaptational model proposed by Rogers (1990, 2008). In this model, the malingerer is confronted with an adverse situation (e.g. an arrest for a third strike). The adaptational model suggests that under these circumstances, the defendant weighs his/her options and determines that malingering mental illness is the only method of avoiding conviction (in the above-noted situation). This model is appealing because of its ability to provide explanations

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for malingering under a wide variety of contexts. However, this explanatory model only provides an explanation for the behavior; it does not describe the specific incentives that motivate the behavior.

Incentives to malinger vary greatly dependent on the context, as does the prevalence. Malingering in the medico-legal context of the criminal courts is generally for one of two purposes: to present as incompetent to stand trial or to plead not guilty by reason of insanity. With both, feigning a psychotic disorder is the most likely method of success, although intellectual deficits can also meet the requirement for a qualifying mental disorder. Estimates for malingering in incompetence to stand trial evaluations have varied from a low of 8% (Cornell & Hawk, 1989) to a high to 17.4% (Rogers, Salekin, Sewell, Goldstein, & Leonard, 1998). A group of forensic psychologists estimated that malingering occurred in almost 16% of forensic patients and more than 7% of non-forensic patients (Rogers, Sewell, & Goldstein, 1994). Additionally, almost 21% of defendants undergoing evaluations of criminal responsibility engaged in or were suspected of engaging in malingering (Rogers, Seman, & Clark, 1986). Our data, presented at the American Academy of Psychiatry and the Law annual meeting (McDermott, Rabin, Scott, & Warburton, 2009), indicated that over 18% of patients found incompetent to stand trial were malingering their psychiatric symptoms on admission to an inpatient facility for restoration.

The prevalence of malingering increases dramatically in a general offender sample, where the external incentive is likely to be substantially different. In a medium security prison unit, investigators found a malingering rate of 32% based on psychological testing data (Pollock, Quigley, Worley, & Bashford, 1997). Norris and May (1998) found that between 45 and 56% of jail inmates requesting psychological services were malingering, dependent on the version of the assessment administered. In a study of male prison inmates claiming psychiatric symptoms, 46% were determined to be malingering (Walters, White, & Greene, 1988). The malingering rate for inmates was found to be 20% in a sample of emergency psychiatric referrals from a large metropolitan jail (Rogers, Ustad, & Salekin, 1998). In another study, the malingering rate of jail inmates receiving psychological services was 66%, although this number is much higher than other samples because only inmates suspected of malingering were referred for assessment (McDermott & Sokolov, 2009). Although not directly studied, the motivation for malingering may contribute to these vastly different prevalence rates. Walters (2006) notes that offenders may malinger for a variety of reasons, including for example relocation, attention or amusement. Perhaps in an effort to discourage malingering, the US Court of Appeals for the Eight Circuit Court in the case of US v Binion[1] imposed sentence enhancements as a result of malingering. Mr. Dammeon Binion was arrested for possession of a firearm by a convicted felon. During an evaluation for competence to stand trial, Mr. Binion was found to be malingering mental illness as a "form of recreation" (i.e. amusement). Although Mr. Binion pled guilty, he also was charged with obstruction of justice, which added to his sentence. In our experience, jail inmates malinger for one of two reasons: to secure desired medication or to transfer out of the general population (McDermott & Sokolov, 2009).

In civil proceedings, estimates are generally much higher than in criminal medico-legal contexts and financial incentives appear to drive this difference. Greiffenstein and Baker (2006) found a 37% base rate of malingering in individuals with mild head injury who were seeking compensation of some sort. Larrabee (2003) in a review of 11 studies, found a prevalence rate of malingering of 40% in 1363 patients who were seeking compensation for a mild head injury. In fact, Larrabee (2000) opined that the incidence of exaggeration of deficits in mild head injury patients seeking compensation was 10 times higher than the base rate for actual deficits. Although prominent in the literature, mild head injury is not the only disorder malingered for financial gain. Greve, Ord, Bianchini, and Curtis (2009) found a malingering rate between 20 and 50% for 508 patients complaining of chronic pain who were also seeking financial compensation. Schmand et al. (1998) found exaggeration of memory deficits in 61% of post-whiplash patients involved in litigation, as compared to 29% in an out-patient clinic. A study conducted by Frueh, Hamner, Cahill, Gold, and Hamlin (2000) indicated that approximately 30% of veterans seeking disability compensation for PTSD feign the disorder. In other types of disability claims, Griffin, Normington, May, and Glassmire (1996) found that nearly one in five social security disability claimants was malingering. Wierzbicki and Tyson (2007) determined that 43.5% of college students seeking a diagnosis of attention deficit–hyperactivity disorder (ADHD), learning disability (LD), or both in order to receive special accommodations under the American with Disabilities Act did not meet criteria for either diagnosis, suggesting that money is not the only incentive in disability claims.

Clearly the incentives for feigning illness or deficits vary greatly dependent on the context and the prevalence of malingering seems directly related to the strength of the incentive. In a meta-analysis of 32 studies of patients seeking compensation for pain (Rohling, Binder, & Langhinrischen-Rohling, 1995), the authors found large effect sizes for the relationship between extent of pain, treatment effectiveness and financial compensation. In a similar study focusing on closed head injury, Binder and Rohling, (1996) found a moderate effect size for compensation: patients with less severe injuries seeking compensation evidenced more abnormalities and disabilities. In a simulation study examining the incentives associated with malingered PTSD, Peace and Masliuk (2011) manipulated incentive (compensation, revenge, attention, and no incentive) and found that compensation and revenge produced the highest scores on symptom measures. Within the criminal context, there is evidence that offenders committing homicide offenses may be more likely to malinger (Taylor & Kopelman, 1984). In competence evaluations, there has been a suggestion that with more serious offenses where the trial procedures are likely to be complex, the standard for competence should be higher (Roesch, 1979; Roesch, 1989). However, research has suggested that defendants charged with minor offenses are more likely to be found incompetent (Rosenfeld & Ritchie, 1998; Warren et al., 2006) which may be related to the criminalization of the mentally ill or as a subversive mechanism to obtain services for a severely mentally ill individual. The relationship between malingering and severity of offense has never been directly studied.

In the past several years, the primary author has conducted clinical evaluations of offenders in two distinct contexts and for two divergent reasons: at Napa State Hospital in Napa, CA to determine if a patient sent as incompetent to stand trial was feigning mental illness or cognitive deficits and at the Sacramento County Jail in Sacramento, CA to determine if an inmate receiving psychiatric services was feigning his/her mental illness. This paper describes an analysis of the information collected in both contexts for the specific purpose of informing the literature regarding motivations to malinger in an offender population.

2. Method

The use of clinical data from both sites was approved by the appropriate committees, including the Sacramento County Jail Human Subjects Committee, the Human Subjects Committee at Napa State Hospital (NSH), the state (of California) Committee for the Protection of Human Subjects and the University of California-Davis (UCD) School of Medicine Institutional Review Board. A waiver of informed consent was granted to use the information collected at both facilities.

2.1. Incompetent to stand trial subjects

NSH is an approximately 1200 bed inpatient psychiatric facility located in northern California (CA). Eighty percent of the beds at NSH are dedicated to patients under forensic commitments, including Incompetent to Stand Trial (IST), Not Guilty by Reason of Insanity (NGRI), Mentally Disordered Offenders (MDO) and a small number