

## PART IV

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# Malingering in the Courtroom



## Seven Myths About Feigning

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Several years ago, we (the first and second author) were asked to serve as expert witnesses in a court case that involved a man who was accused of murdering his wife and young son. The defendant claimed he had stabbed the victims to death because voices in his head told him to do so. Because the court was not convinced that the man genuinely suffered from command hallucinations, we were asked to evaluate the authenticity of his hallucinations (Merckelbach, Peters, & Jelicic, 2011). After checking his medical records and the police file, we interviewed the defendant and administered a range of tests to him. Because feigners usually do not know what kind of symptoms true patients experience, we specifically asked the defendant whether or not he suffered from atypical and bizarre symptoms (of course we did not tell him that these symptoms were improbable symptoms). Our test battery included two symptom validity tests—instruments specifically designed to measure the validity of symptoms or test performance (Larrabee, 2012). The defendant's medical records showed that, in the years before the violent incident, he had visited his family doctor a number of times because of feeling depressed. And while awaiting his trial in prison, a psychiatrist diagnosed him with an affective disorder. Although he did have a history of mental illness, the interview and his tests results showed that the defendant probably was faking his command hallucinations. For one thing, he endorsed many rare or improbable symptoms such as “the voices in my head are always present” and “I just have to comply with the commands” during the interview, which is indicative of feigning (see Knoll & Resnick, 2008; Resnick, 2007). Furthermore, on both symptom validity tests the defendant had scores comparable to people who were instructed to feign mental illness. After confronting the defendant with our findings, he admitted that he had feigned his command hallucinations in the hope to be found not guilty by reason of insanity (NGRI).

People have different reasons for feigning mental illness. A small percentage of feigners pretend to suffer from a psychiatric disorder out of the unusual desire to be seen as a patient—a condition known as factitious disorder (Feldman, 2004).

Their primary goal is to get attention and sympathy from family, friends, and medical personnel. Factitious disorder is a poorly understood condition, but the research that exists shows that it is a psychiatric disease. For example, Lawlor and Kirakowski (2014) performed a text analysis on Internet communications of an online support group for people with factitious disorder and found that these people exhibit an addiction-like desire to occupy the sick role. Most of them were upset by this, felt guilt, and wanted to be treated. Note that most individuals feigning mental illness do not want to adopt the “sick role,” but engage in this type of deceptive behavior for external incentives (Pankratz, 1998; Young, 2014). People with dead-end jobs may pretend to have a disorder to obtain sickness benefits. Individuals who have been involved in a traffic or workplace accident may feign symptoms to receive insurance money. Some people may pretend to have symptoms to be prescribed psychoactive medications. Soldiers may feign mental illness to avoid certain military duties or to receive service-connected disability pensions. And individuals who are standing trial, just like the case described earlier, may pretend to suffer from a mental illness to reduce their criminal responsibility. People who have external reasons for feigning are often labeled *malingers*. Malingering is a deliberate act of deception, not a disease. Thus, malingering is not diagnosed, but detected. Psychiatric disorders are especially susceptible to feigning, because the diagnosis of such disorders usually relies on subjective symptoms reported by patients (Resnick, 2007). Also, it is good to realize that feigning is not an all-or-nothing phenomenon (Conroy & Kwartner, 2006). Although some individuals may fabricate a complete disorder, others will grossly exaggerate existing psychiatric symptoms.

As pointed out by Ornish (2001), individuals standing trial for a serious offense will do virtually anything to get the lowest punishment possible. Because psychotic disorders such as schizophrenia or schizoaffective disorder may lead to an NGRI verdict, feigning command hallucinations and other psychotic symptoms has some popularity among deceptive defendants (Chesterman, Terbeck & Vaughan, 2008). Posttraumatic stress disorder (PTSD) is often regarded as a mitigating circumstance by judges and juries. Therefore, some defendants—in particular those who have been involved in military operations—pretend to suffer from this trauma-related disorder (Hall & Hall, 2007). Although crime-related amnesia is not always considered a mitigating factor (cf. Tysse, 2005), a number of defendants feign loss of memory for their criminal offenses (Cima et al., 2002). They pretend to suffer from crime-related amnesia because they do not want to talk about shameful offenses such as sexually molesting children. Or they feign memory loss because it suggests that their criminal acts were impulsive, rather than conducted in a premeditated way (premeditated crimes are usually considered more serious than impulsive offenses). Occasionally, defendants will engage in feigning exotic disorders such as dissociative identity disorder or low serotonin syndrome (Ornish, 2001).

In recent years, feigning of mental illness has gained some attention among forensic (neuro)psychologists. At present, leading forensic (neuro)psychology journals regularly publish articles on this topic. Several books on feigning have

appeared (e.g., Kitaeff, 2007; Morel, 2010; Young, 2014), and a number of dedicated conferences on this issue have been organized (e.g., the 4th European Conference on Symptom Validity Assessment, which was held in 2015). Despite growing interest among mental health professionals, a number of misconceptions about feigning exist. This chapter describes seven myths pertaining to feigning. Most of them have been around in the psychiatric literature for more than a hundred years and can be traced back to the writings of 19th century German-speaking psychiatrists.

### MYTH ONE: FEIGNING CAN BE EASILY DETECTED USING A CLINICAL INTERVIEW

More than a century ago, German psychiatrists such as Falkenhorst (cited in Vyleta, 2007) believed that feigners could be detected by observing the way individuals move. Today, some mental health experts still adhere to that idea. Singh, Avasthi, and Grover (2007), for instance, wrote that: “In a malingerer, illustrators i.e. gestures that accompany speech are used less frequently; emblems i.e. gestures that communicate a specific meaning in a specific culture, may be discordant with spoken language, and manipulators i.e. movements involving self-grooming, scratching, pulling, rubbing another body part and use of props viz. a pen, are distinctly prolonged and frequently repeated by the subject” (p. 128). However, such indicators of feigning lack any empirical support. Feigning can be seen as a case of deception—it is deliberate falsification of symptom reports—and an extensive literature shows that non-verbal indicators provide, at best, very weak cues for detecting deception and most of the time they are not diagnostic at all (DePaulo et al., 2003).

In a classic study, Rosenhan (1973) had eight normal individuals—one psychology student, three psychologists, two physicians, and a housewife—admitted to psychiatric institutions. All of them claimed hearing voices during the intake procedure. Although they stopped complaining about hallucinations once admitted to the clinic, all of them were diagnosed with schizophrenia, were prescribed psychoactive medications, and had to stay in the hospital for a considerable time (9 to 52 days). More recently, Hickling, Blanchard, Mundy, and Galovski (2002) hired six actors and taught them how to feign PTSD. Subsequently, all six visited a clinic that specialized in diagnosing PTSD. None of them was labeled as a feigner. Rosen and Phillips (2004) identified 12 studies in which normal people instructed to feign a somatic condition were asked to visit a medical doctor. In all studies, physicians detected feigners at a very low rate, from 0% to 25%.

It should be mentioned here that one special interview technique does have some value in detecting feigning. This technique was employed in the case presented at the beginning of this chapter. As mentioned before, most feigners do not know exactly what kind of symptoms genuine patients experience. When confronted with improbable symptoms (i.e., symptoms that seem to pertain to a certain disorder but are hardly ever reported by bonafide patients), it is quite likely that feigners will confirm suffering from such symptoms. There is evidence

that endorsement of many unlikely symptoms is indicative of feigning (Knoll & Resnick, 2008; Resnick, 2007). The rationale behind this interview technique is also applied in a number of instruments designed to detect feigning (see the following).

### How to Detect Feigning?

As shown in the case described at the start of this chapter, symptom validity tests may be useful in detecting feigning. One such test is the Structured Inventory of Malingered Symptomatology (SIMS; Smith, 2008; Smith & Burger, 1997). The SIMS is a self-report instrument designed to screen for feigning of psychopathology and/or memory impairment. It consists of 75 items pertaining to feigning in five different areas including psychosis and depression. The idea behind the SIMS is that feigners are unfamiliar with how genuine symptoms manifest themselves. As a result, they tend to endorse atypical and bizarre symptoms that superficially may seem to be related to the condition they are feigning. A typical SIMS item is “There is nothing I can do, besides taking medication, that has any effect on the voices I hear.” By and large, the SIMS correctly identifies 95% of instructed feigners and labels 7% honest responders incorrectly as simulators (Van Impelen, Merckelbach, Jelicic, & Merten, 2014). Although these are not perfect statistics, they are substantially better than the detection rates that clinical interviews generate.

Another symptom validity test is the Amsterdam Short-Term Memory test (ASTM; Schmand, de Sterke, & Lindeboom, 1999). This test capitalizes on the fact that most feigners do not know that genuine neurological and psychiatric patients perform well on simple recognition tests. The ASTM consists of 30 items. In each item, the participant is presented with five printed words from the same semantic category (e.g., apple, peach, grape, pear, banana), which she or he has to read aloud and try to remember. Next, the participant is given a simple written addition or subtraction task (e.g.,  $27 + 15 = ?$ ), which she or he has to solve mentally. Finally, five words from the same semantic category as before are presented (e.g., apple, grape, melon, peach, kiwi). The participant has to indicate the three words that were also presented in the first series. The maximum score is 90 (30 items  $\times$  3 words correct). Scores below 85 points are considered to be indicative of aggravation or feigning of memory disturbances. About 90% of instructed feigners achieve such a low test score, while 7% of honest people will score below the cut off. Again, the detection rate is not perfect, but still better than what can be attained with clinical interviews.

But what if feigners have knowledge of psychopathology or memory disorders? Are they able to defeat tests such as the SIMS or ASTM? It appears that knowledge of mental disorders does not seem to undermine the efficacy of symptom validity tests to a large degree. In one study, mental health experts and laypeople were given the SIMS and asked to imagine that they were feigning psychosis because they were standing trial for a serious offense and wanted to avoid legal responsibility (Jelicic, Van Gaal, & Peters, 2013). Although the experts engaged in less

fragrant feigning on the SIMS than people without expertise in psychiatry, most participants (92%) were identified as feigners by this instrument, regardless of their knowledge of psychopathology. The reason for this is probably that instruments like the SIMS confront feigners with a calibration problem: On the one hand, they have to endorse a certain number of symptoms (otherwise they would appear to be healthy people), while on the other, they are afraid to go over the top.

Note that the SIMS and ASTM are not feigning tests, but symptom validity tests. Feigners will often perform in the abnormal range on these tests, but not all individuals with abnormal scores are feigners. Take for instance a nonmotivated patient with a high SIMS score who filled out the instrument in a random fashion. Such a patient is a sloppy respondent, not a feigner. As mentioned before, feigning pertains to exaggerating or fabricating symptoms to obtain a certain incentive. A high score on the SIMS does not reveal the motive for endorsing many symptoms. Because high scores may point to feigning, follow-up examinations (e.g., gathering collateral information) in patients with such scores is recommended. Such a detailed examination should make clear if a patient has something to gain by exaggerating or fabricating symptoms. It should be mentioned here that patients often strive for certain benefits without their therapists knowing this. Van Egmond, Kummeling, and Van Balkom (2005) asked psychiatric outpatients whether or not they expected to gain something from being a patient. A substantial minority (30%–40%) reported that this was indeed the case. They admitted that their patient status may help them to get a new home, sickness benefits, or a resident permit. Thus, it appears that psychiatric outpatients often have a hidden agenda that pertains to other ambitions than just recovering from their symptoms. This agenda may fuel symptom exaggeration and treatment stagnation (van Egmond & Kummeling, 2002). The link between feigning and poor therapeutic success—including lack of cooperation, high dropout rate, and increased healthcare utilization—has now been well documented (e.g., Anestis et al., 2015; Horner et al., 2014) and should in itself be sufficient reason to give high priority to the evaluation of feigning as a diagnostic option.

## MYTH TWO: FEIGNING IS RARE

Clinicians who do not use symptom validity tests will often fail to detect feigning of mental illness. As a consequence, they will think that only in rare cases will individuals pretend to have a psychiatric disorder. Just like the first misconception about feigning, this second myth also has old roots. In his monograph *Über Simulation von Geistesstörungen* (“On the simulation of psychopathology,” 1903), Carl Gustav Jung wrote that, during his long career, he spoke to thousands of people admitted to a psychiatric institution, and only 11 of them were feigners. German psychiatrist Többen (1935) also opined that feigning was rare. He studied 3,156 files of patients who were admitted to the clinic where he was working, and reported that only two of them were pseudo-patients. And Jung and Többen were not the only ones believing that feigning was rare; many old German psychiatrists thought that feigning of mental illness did not occur (cf. Siemens, 1888). To a

large extent, this belief was motivated by the fear of labeling truly sick people as malingerers, a practice that had been all too real in the pre-19th history of psychiatry (Ledebur, 2012). This fear is still with us today, and might explain why, for example, Yates, Nordquist, and Schulz-Ross (1996) found in their evaluation of 227 patients who attended the emergency department of a general hospital that 13% of them were suspected of feigning, while in their medical records this option was completely dropped. The forensic psychologist Lees-Haley has a completely different perspective on this: “If I think you are malingering, my job is to say so just as surely as I’m supposed to say so if I think you are suffering a major depression or have an IQ of 100. Those experts who avoid the term of malingering because it is ‘serious’—as if other diagnoses were not serious—are making a specious argument and failing to consider the impact of their statements on the victims of malingerers” (Heilbronner, 2005; p. 358).

Some contemporary authors also think that feigning hardly ever occurs. For example, in an editorial comment on functional complaints in children, neurologist Ramesh (2013) stated that feigning is rare. He backed this conclusion with a reference. The article Ramesh cited describes two cases of children with functional paralysis. Quite surprisingly, the term *feigning* is not mentioned in that article, although a hidden agenda was evidently present in both. Thus, it seems that the idea that feigners are rare is a commonly held belief in medicine not needing any further explanation. This view has been challenged by British psychiatrist Theodore Dalrymple (2012). Writing about people with disability and sickness benefits, he remarked that in 2006, at the height of a period of economic growth in the United Kingdom, there were 2.9 million people in that country who received benefits because they were unable to work due to illness. When the financial crisis broke out, the British government announced that all people receiving such benefits again had to undergo a medical evaluation. Because of this announcement alone, hundred thousands of them gave up their claims. After all people receiving benefits had been reevaluated, it appeared that only one in eight was deemed too ill to work. Dalrymple’s example suggests that, at least in the area of disability and sickness benefits, feigning is ubiquitous and costing society lots of money.

A recent criminal case from the Netherlands shows that, whatever its precise prevalence, feigning of mental illness has an enormous impact. In this case, two psychiatrists recruited dozens of potential pseudo-patients (Zweep, 2011). They were trained in how to fake depression or other disorders. Subsequently, they applied for disability and sickness benefits and were all seen by professionals. In about a third of the cases, the pseudo-patients had to talk to a psychiatrist (not the two instigators). With one notable exception, none of the professionals engaged in evaluation of the imposters was able to unmask the pseudo-patients. It took special police teams to identify feigning of psychiatric disorders in the imposters. In one hilarious case, a police observation team noticed how a man claiming major mental illness, incontinence, and severe immobility, jumped in his Mercedes car and drove to the beach for a long and agreeable walk on the boulevard. At the time we wrote this chapter, the court case against the two psychiatrists had just come to an end.<sup>1</sup> One of them was

given a 4-year prison sentence; the other received a fine and a 5-year suspension to work as a psychiatrist. The case against the pseudo-patients is still pending. The prosecutor announced that he would demand the imposters pay back 5.6 million Euros for wrongly received benefits. Although one could argue that this case is just an incident, it is in line with research in which large groups of patients were given symptom validity tests. For example, Dandachi-FitzGerald, Ponds, Peters, and Merckelbach (2011) administered the SIMS and ASTM to 183 outpatients of a mental health clinic. They found that 15 (8%) of their patients had abnormal scores on both tests. Although we do not know whether these patients had legal or economic reasons for their abnormal scores, other studies do shed more light on the motive for abnormal scores on symptom validity tests. In a study examining 125 people seeking financial compensation from the Dutch government for interpersonal violence, 23 (18%) of the claimants had dubious SIMS scores (Kunst, Winkel, & Bogaerts, 2011).

As mentioned, some defendants feign crime-related amnesia. Cima, Merckelbach, Hollnack, and Knauer (2003) administered the SIMS to a group of forensic mental health patients who claimed memory loss for their offense. They found that 50% of the patients had very high SIMS scores, that is, scores comparable to students who were asked to feign amnesia. Although this study suggests that—in criminal cases—feigning occurs on a large scale, it is not entirely clear how many defendants pretend to have a disorder. Mittenberg, Patton, Canyock, and Condit (2002) surveyed 144 American neuropsychologists about the base rate of feigning in legal cases. The respondents opined that feigning takes place in about 30% of civil law cases and 20% of criminal law cases. Because skilled feigners might be mistaken for genuine patients, these numbers are probably an underestimation of the problem. As Faust (1995, p. 255) remarked: “Doctor, each time you’ve been fooled, you don’t know, do you?” But even if feigning takes place in just 20% to 30% of all cases, it is clear that pseudo-patients frequently enter the legal arena.

### MYTH THREE: PEOPLE ARE UNABLE TO FEIGN SYMPTOMS FOR A PROLONGED PERIOD OF TIME

Conroy and Kwartner (2006) contended that intensive observation is the best way to detect feigning of mental illness. They argued that to maintain a consistent symptom pattern while being observed in a clinic is difficult even for the most adept feigner. The idea that feigning can be detected by in-patient observation is not new. The influential German psychiatrist Richard Von Krafft-Ebing (1885) wrote that feigners differed in one important way from actors: Actors can leave the stage after a few hours, while pseudo-patients must play their role for a much larger period of time. And sooner or later, feigners will be unmasked because they forget to play their role as a patient.

Many case reports show that people are able to convincingly feign a disorder for a prolonged period of time. Take, for example, the case of Welshman Alan Knight (Quinn, 2014). This 47-year old man not only pretended to be paralyzed and

suffering from epilepsy, every now and then he would slip into a coma. His wife was part of the conspiracy. She pushed Knight around in his wheelchair. For some time Knight managed to stay out of prison. He had been indicted because he had manipulated a demented neighbor into giving him thousands of pounds. Each time Knight had to appear in court, he had himself admitted to a hospital. The hospital doctors thought he was an exceptional case, but did not suspect feigning. Knight and his wife were caught when a CCTV camera spotted them shopping in a neighboring town: Alan Knight was maneuvering a full shopping cart—not exactly skills that can be observed in a person living in an almost vegetative state. At the moment he was unmasked as a feigner, Knight had played the role of a paralyzed epileptic for 2 years. There are more examples of long-term malingerers. The most famous one is probably Rudolf Hess, the high ranking Nazi official who first was held in captivity in England and later had to stand trial in Nuremberg. From February 1941 through February 1945, Hess claimed episodes of memory loss for vital parts of the recent German history in which he had played such a decisive role. Various psychiatrists interviewed Hess and came to the conclusion that his amnesia was genuine. Then, in February 1945, Hess declared in court that he had simulated his amnesia altogether. In letters to his wife, Hess explained that the role of an amnesic was a strategy so as to not having to share vital information with his interrogators (Douglas-Hamilton, 2010). Cases like Hess and Knight do not square with the idea of Von Krafft-Ebing and many others that feigners can convincingly play their role as a patient for only a limited period of time.

#### MYTH FOUR: FEIGNERS ARE ILL

If a patient has curious symptoms, the clinician will wonder about the origins of such symptoms. Sometimes symptom validity tests will be administered to such a patient. What does it mean if the patient scores in the abnormal range on such tests? Drob, Meehan, and Waxman (2009; p. 101) argued that, in cases of severe illness, patients will unintentionally show strange responses on symptom validity tests. A phenomenon labeled by the authors as “unconsciously determined distortion.” Such a term could have been put forward by antique German psychiatrists. Siemens (1883; p. 42), for example, wrote: “Wie oft kommen den Irrenartz Fälle vor, die wie Simulation aussehen und doch keine sind! Daher is gewiss a priori Krankheit anzunehmen” [How often does a psychiatrist see a case that looks like feigning but is not! One should first think of illness].

One could reason that the SIMS or the ASTM should not be administered to patients who suffer from an acute psychosis, advanced dementia, or a psychorganic syndrome. But why should these instruments be given to such patients in the first place? There is no doubt about the authenticity of their symptoms. If we exclude those patients, is it conceivable that patients will unconsciously endorse the fake symptoms listed on the SIMS? Or that they unintentionally will exhibit poor performance on the very easy trials of the ASTM? Based on experiments that show that negative expectations may lead to decrements in performance on neuropsychological tests, Silver (2012) argued that these questions should be answered

affirmatively. He pointed out that, if a clinician thinks a patient is severely ill, he will activate negative expectations in the patient's mind, which will then result in abnormal performance on symptom validity tests. There is indeed evidence for a performance-undermining effect of negative expectations, but the effect is rather small (Niesten, Merckelbach, & Dandachi-FitzGerald, 2015). From a scientific point of view, it is unlikely that such a trivial effect will affect a patient's performance in a way that he or she will score in the abnormal range on the SIMS or the ASTM. Note that speculating about "unconsciously determined distortion" may lead to circular reasoning: Because a patient is ill, she or he will score in the abnormal range on a symptom validity test. And because of this abnormal score on a symptom validity test, the patient must be ill. This circularity has been dubbed the *psychopathology-is-superordinate* fallacy, that is, the mistaken belief that abnormal scores on symptom validity tests are both caused by psychopathology and prove psychopathology (Merten & Merckelbach, 2013). It is a fallacy because we know that even young children and patients with serious brain damage are able to attain almost perfect scores on instruments such as the ASTM (Blaskewitz, Merten, & Kathmann, 2008; Rienstra, Spaan, & Schmand, 2010).

#### MYTH FIVE: MENTAL HEALTH PROFESSIONALS SHOULD BE KIND TO FEIGNERS

The idea that mental health professionals should be kind to feigners builds on the notion that feigners are ill. A professional affiliated with a Dutch center specializing in the treatment of medically unexplained symptoms stated: "An individual who feigns is ill. What does one win by saying: you are just a pretender? It will only cause resistance. Which will society ultimately cost more money (Mat, 2008; our translation)." This point of view can also be found in the scientific literature. Drob et al. (2009, p. 105), for example, stated that feigning of symptoms does not occur solely because of the patient, but emerges in the interaction with a suspicious mental health professional. The professional should not be hypervigilant and suspicious, but will have to respond in an empathetic way: "open to hearing his or her pain." Their opinion resembles the adage from antique psychiatrist Siemens that doctors should not act as police officers. This mentality may explain the findings from the study on emergency admissions to an American psychiatric hospital that was already mentioned. In that study, about 10% of the patients feigned psychiatric symptoms to get a bed and free meals, but none of them were reprimanded for their deceptive behavior (Yates et al., 1996).

Suchy, Chelune, Franchow, and Thorgusen (2012) decided to empirically test the effect of providing feigners with confrontational feedback on their poor test performance. They studied a group of patients with suspicious scores on a symptom validity test. Half of them did not receive any information about test performance, the others were confronted with their abnormal scores and were told that honest scores were important for the assessment. Next, all patients were again given psychological tests, including symptom validity tests. The group that was not given any information about their deviant symptom validity test scores continued

to exaggerate their complaints. The group that was informed about the abnormal symptom validity test score, however, ceased to exaggerate their symptoms.

Not confronting feigners with their behavior may contribute to symptom escalation, as feigners may come to believe their lies. Pseudo-patients know that exaggerating symptoms conflicts with their self-definition of being an honest person. Because most of them think that they are decent people, they will experience cognitive dissonance. A sympathetic and warm mental health expert will make this dissonance worse, because a feigner will realize even more that he is deceiving the professional and will feel guilt and shame about it. The best way to reduce feelings of dissonance is to engage in self-deception. Just as smokers often tell themselves that their chain-smoking grandfather reached the age of 92, feigners who are under the care of sympathetic professionals will start to believe that, in a way, they do have real complaints (cf. Merckelbach & Merten, 2012). Thus, a sympathetic way of dealing with feigners may add insult to injury, in the sense that it may lead to continued medical consumption by feigners.

#### MYTH SIX: FEIGNERS ARE PSYCHOPATHS

The belief that feigners have psychopathic or antisocial traits is a special variant of the idea that feigners are ill, but it also alludes to the myth that feigning is rare (“only in psychopaths”). The belief has been advocated by the successive editions of the *Diagnostic and Statistical Manual of Mental Disorders*, up to its fifth edition (DSM-5; American Psychiatric Association, 2013). Thus, the DSM-5 lists the presence of antisocial features in patients among the key indications that warrant heightened suspicion of malingering.

Some high-profile cases seemed to confirm the close link between psychopathy and habitual feigning. A fine example is the story of Vincent Gigante, a mafia boss, who started to walk around the neighborhood dressed in his bathrobe and muttering in himself whenever he had to stand trial. Renowned experts testified that Gigante suffered from psychosis and vascular dementia, and PET scans were shown in court to bolster these claims. However, later, Gigante admitted that he faked his mental illness in order to avoid conviction (Newman, 2003).

Notwithstanding its popularity, empirical support for the psychopathy-feigning link is conspicuously absent. Niesten, Nentjes, Merckelbach, and Bernstein (2015) conducted a thorough literature search by means of *Google Scholar* and identified 19 studies that explored whether psychopathic and antisocial behavior are related to malingering. Of these, 10 found an association—albeit a relatively weak one—8 did not find a relation, and 1 study produced conflicting results. Niesten, Nentjes, et al. (2015) found even less evidence for the idea that high levels of psychopathy or antisociality are associated with a greater proficiency in malingering. Rather, their empirical data show that feigning symptoms is to a large extent context dependent. The authors compared 12 prisoners and 70 forensic patients in a treatment facility with each other and found that, while levels of psychopathy were similar in both groups, 3 (25%) of the prisoners against 1 (1%) of the forensic patients engaged in feigning. This is not surprising when one considers that

prisoners might have more motives to feign symptoms. Thus, for prisoners but less so for forensic inpatients it may make sense to fabricate symptoms so as to be transformed to a psychiatric ward or to obtain psychotropic medication.

As pointed out by Niesten, Nentjes, et al. (2015; see also Van Impelen et al., 2016), a strong belief in the psychopathy-feigning link is not without practical consequences. It favors a highly selective use of symptom validity tests: They may be overemployed when psychopathy or antisocial features are present and underemployed in the absence of these features. Ultimately, this practice may lead to underestimating the scale on which feigning occurs.

### MYTH SEVEN: FEIGNERS ARE NOT FAKING GOOD

According to the bipolarity hypothesis (Greene, 2000), faking bad (fabricating or aggravating symptoms) and faking good (hiding symptoms) are two mutually exclusive categories. That is, people who feign are not expected to also engage in faking good. There is no solid evidence for this widespread idea. Thus, in the Niesten, Nentjes, et al. (2015) study cited, the prisoners sample engaged in both feigning symptoms and faking good.

The temporal patterns of faking bad and good testify as to the situational rather than characterological origins of feigning. Thus, during the pretrial phase, defendants may feign mental illness and cognitive impairments in an attempt to reduce their criminal responsibility. Once convicted, these same individuals may engage in faking good—downplaying their genuine symptoms—so as to acquire privileges, including parole. Likewise, plaintiffs involved in civil litigation may feign certain symptoms (e.g., circumscribed amnesia or PTSD) but at the same time emphasize their virtues and deny any substance abuse problems, so as to present to the triers of fact as a decent and healthy person (Merckelbach, Smeets, & Jelicic, 2009). The dynamics of faking bad and good have been understudied, and one reason for this is the mistaken belief that they never occur together and that when they occur, this is related to a low base-rate personality feature such as psychopathy.

### CONCLUSION

In contrast to what many mental health professionals believe, this chapter has shown that: (1) Clinical interviews cannot be used to detect feigning of psychopathology and cognitive impairments; (2) pretending to have a disorder is ubiquitous in forensic and general psychiatry; (3) people are able to feign for a prolonged period of time; (4) feigners are not ill; (5) mental health professionals should not be kind to feigners; (6) there is no exclusive feigning–psychopathy link; and (7) feigning and faking good may occur together.

There are many myths pertaining to psychology. Some years ago, Lilienfeld, Lynn, Ruscio, and Beyerstein (2009) debunked 50 of them. The misconceptions portrayed by Lilienfeld and colleagues are erroneous ideas about psychological concepts held by the general population. Because the myths discussed in this

chapter are held by mental health experts, they may be more harmful than wrongful ideas held by laypeople. Assume that a defendant has decided to feign a serious psychiatric disorder to avoid criminal responsibility. If this person is evaluated by a mental health expert who solely relies on clinical interviews to rule out the possibility of feigning, there is a substantial chance that the defendant may fool the expert and will be diagnosed with psychopathology. This defendant may receive an NGRI verdict and end up in a psychiatric facility instead of prison.

The authors recommend the use of symptom validity tests in all forensic mental health evaluations. Such tests should be used in all evaluations because even defendants with a history of mental illness may aggravate their symptoms. Although symptom validity tests are not perfect, they are much better in detecting feigning than clinical interviews. Because individuals with genuine psychopathology occasionally score in the abnormal range on a symptom validity test, labeling someone as a feigner can only be done when there is converging evidence for feigning. In the case described at the beginning of this chapter, there was substantial reason to believe that the defendant was feigning his command hallucinations. He endorsed many improbable psychotic symptoms and had abnormal scores on two symptom validity tests. Later, the defendant admitted that he, indeed, had feigned his command hallucinations.

The authors do not want to suggest that the work of all antique German scholars should be thrown in the garbage bin. For example, many ideas about memory put forward by Ebbinghaus in his opus magnum *Über das Gedächtnis* (“On memory”; 1885) are still correct. And much of what Münsterberg wrote about legal psychology in his classic book *On the witness stand* (1908) has withstood the test of time. However, the ideas of old German authors about feigning have proved to be myths and should be dismissed forever.

## NOTE

1. Dutch court cases ECLI:NL:RBROT:2016:5917 and ECLI:NL:RBROT:2016:5919.

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