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CASE REPORT

PSYCHIATRY & BEHAVIORAL SCIENCE

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Overlooking Feigning Behavior May Result in Potential Harmful Treatment Interventions: Two Case Reports of Undetected Malingering*

ABSTRACT: Clinicians tend to overestimate their ability to recognize feigning behavior in psychiatric patients, especially if it concerns patients who have been admitted for observation. Feigning can be either externally motivated (e.g., for financial compensation, known as malingering) or internally motivated (e.g., to assume the "sick role," known as factitious disorder). Persistent presentation of severe symptoms is usually associated with the factitious disorder. We present two patients with strong external incentives who consistently and convincingly feigned severe psychiatric symptoms during a protracted period of inpatient observation in a specialized center; both were engaged in a procedure for medical asylum. The first case presented with the clinical picture of a psychotic depression with severe motor symptoms, and the second case showed symptoms of a chronic post-traumatic stress disorder with secondary psychotic symptoms. Both cases were thoroughly investigated but feigning was overlooked, and unnecessary and harmful treatment interventions were given. To prevent iatrogenic damage, we recommend a critical attitude that takes malingering as an option into account in settings where patients are often involved in high stake legal procedures. A clinical sign that might indicate feigning is therapy-resistant symptoms. To rule out feigning a comprehensive, multimethod approach is required, but an active stance toward collateral information is essential. Specialized psychological tests may be useful for preliminary screening, but for their use in culturally diverse populations as in refugee mental health more research is needed.

KEYWORDS: forensic psychiatry, transcultural psychiatry, refugee mental health, symptom validity, symptom exaggeration, feigning, malingering

Despite advances made in the diagnosis and treatment of psychiatric disorders, considerable numbers of psychiatric patients suffer from symptoms that remain resistant to treatment (1). Patients in refugee mental health settings are no exception; psychiatric symptoms are prevalent in this group (2) and their symptom severity tends to increase when they become involved in legal procedures for asylum (3). Understandably, mental health professionals are concerned about the accessibility and quality of psychiatric care for this vulnerable group (4). With this in mind, specialized facilities for refugee mental health have been created in the Netherlands to which patients with therapy-resistant symptoms can be referred. The referral center described below had 32 beds and a staff consisting of two psychiatrists, three psychologists, two social workers, and two Dutch language teachers. Additionally, it included facilities for art, music, and occupational therapy. Although the majority of patients referred to such centers report traumatic events, most of them meet not only diagnostic criteria for PTSD (5), but may also suffer from other disorders, such as a psychotic disorder or an affective disorder. In a nontrivial minority, there is a comorbid personality disorder and/or a comorbid substance use disorder. Despite treatment in these specialized centers, some patients remain substantially impaired by their symptoms. As the procedure for asylum usually requires several transfers to other regions of the country, reallocation to regular care after treatment is often a time-consuming process, resulting in an average duration of an admission varying between 6 and 9 months.

In the two cases described below, a radical revision of the initial diagnostic classification was necessary due to clinicians overlooking feigning. Feigning is the deliberate fabrication or gross exaggeration of symptoms, regardless of possible motives. It is important to note that this definition rules out conversion disorder; although a physical cause is absent in conversion symptoms, they are not assumed to result from intentional production (6). Clinical entities that are associated with feigning are the factitious disorder and malingering. In factitious presentations, symptoms are feigned in the absence of obvious external rewards, but possibly out of some internal motivation, for example, to assume the "sick role." Although patients can be both

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*The presented vignettes describe cases of existing patients; care has been taken to prevent identification, but their case descriptions have not been adapted or changed otherwise for this purpose. As the referral center served as a center for research, all inpatients including the patients on whose cases the vignettes were based gave informed consent for use of their anonymized data for scientific purposes and publication. Their consent was witnessed and formally recorded.

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internally and externally motivated at the same time, a malingerer is exclusively motivated by an external incentive (5,7). Cases with consistent feigning of extremely serious symptoms are usually observed in factitious disorders (8). In the cases described here, both about a person seeking asylum, there was a potentially strong external incentive; both patients were involved in a procedure for medical asylum. In procedures for asylum, symptoms compatible with trauma are sometimes used to support the credibility of reports about human rights abuse and in case of a medical disorder, including mental disorders, a refugee status may be granted for humanitarian reasons, even if a previous request for political asylum was denied (9).

Case 1

A 56-year-old man seeking asylum in the Netherlands was admitted because of mutism and severe psychomotor retardation. According to his relatives, he already had symptoms in his country of origin. They reported that his sleep was frequently interrupted by nightmares and anxiety up to the point that he felt so tired that he hardly left his house anymore; apparently, the symptoms had started after a period of detention and torture. He also lost interest in his wife and children although, according to his relatives, he used to be a "real family man." After his arrival in the host country, he stayed in one of the centers where individuals seeking asylum in the Netherlands are housed pending their procedure. Here, his condition appeared to deteriorate following a negative decision on his application for asylum. He lost interest in life altogether and became apathetic until he was bedridden and no longer able to move or speak, having to be hand-fed by his relatives. At the time of his referral, a procedure for medical asylum had been started. On admission to the referral center, we saw a disheveled-looking man with long hair and an unkempt beard who did not react to any attempt to start a conversation. His face was frozen into an expression of fear and disgust and only after encouragements by his wife, and he was able to give a minimal nonverbal reaction. Examining his motor symptoms, we found active muscular resistance but no signs of passive rigidity such as extrapyramidal rigidity or waxy flexibility. There was a minimal contracture in the shoulder region, but no bedsores or signs indicating vegetative dysregulation. Later on, during his stay in the referral center, he appeared to be distracted by objects invisible to others.

On the basis of extensive laboratory analyses and neuroimaging of the brain, the referring psychiatrist had ruled out any somatic causes of his condition and had started treatment with serotonin reuptake inhibitors (SSRI) and later tricyclic antidepressants (TCA), without this having any therapeutic effect. In the referral center, benzodiazepines, lithium, and later antipsychotics were added to this regimen, under the provisional diagnosis of a psychotic depression with catatonic features.

Despite continuous attempts to activate the patient, he made no progress except that after a few months of admission, he was able to eat a few spoonsful of porridge by himself. Given these poor results, his medication was replaced by tranylcypromine and preparations were made to refer him for electroconvulsive treatment as a final attempt to improve his condition.

At this point, a staff member of the referral center happened to observe the patient, during a weekend outside the hospital. At this occasion, the patient was engaged in a lively conversation while having lunch with his family. Although his relatives denied any improvement of this sort, the observation was consistent with those of staff members of the asylum seeker center where the patient had initially lived. They had spotted the patient at night while moving around actively in his quarters, eating and drinking normally, but had failed to share this information with the staff of the referral center until they were specifically asked for it. After confrontation with this information, the patient immediately left the hospital and was lost for follow-up. In total, he had stayed in the referral center for four months.

Case 2

An unaccompanied female minor seeking asylum in the Netherlands was admitted because of disruptive behavior in the asylum seeker center. She was initially an illegal immigrant. However, an asylum procedure had been started on her behalf after she allegedly escaped from captivity and abuse by fellow countrymen in the host country. At the time of her referral, she was in procedure for medical asylum. In the ward, we saw a thin, soft-spoken, well-dressed girl presenting herself in a child-like manner but without evident psychiatric symptoms at that moment. During the ensuing admission, she generally behaved meek and submissive, but could suddenly become confused and agitated, inflict wounds to herself and damage hospital property, violently resisting attempts to control her behavior and apparently without any recollection of the incidents afterward.

During individual therapeutic sessions, assisted by a professional interpreter, she gradually revealed a string of dramatic events in her past that formed a pattern of severe and recurrent trauma. For example, she recalled witnessing the brutal murder of her parents as a young child and being raised by an older sister. Destitute, the girls survived by scavenging the dumping grounds of a large city. After the sister had been murdered as well, an elderly priest took her under his care, provided her with some money, and urged her to leave the country.

The therapist of the referral center was under the impression that a relationship of mutual trust was developing. Meanwhile, the symptoms of the patient deteriorated. She became agitated more often and started to show a preoccupation with religion and promiscuous behavior at the same time, absconding a few times in the company of unknown men. Under the provisional diagnosis of complex, early trauma with secondary psychotic features, antidepressants and atypical antipsychotics were added to her treatment. After this, her symptoms gradually improved, but she also started to gain weight at an alarming pace; by the time her disruptive behavior was mostly under control, she had become overweight, apathetic, and mostly dependent on others for her daily activities. She managed only short periods of furlough in the asylum seeker center on her own.

At this point, her legal representative reported that fellow countrymen were visiting her regularly during these furloughs, notably one elderly man. Suspicious of renewed sexual abuse, this man was confronted, upon which he identified himself as a close friend of the parents of the patient; he was even willing to share their telephone number. The collateral information provided by parents and a close friend converged to the conclusion that the girl was, in fact, a 24-year-old woman who used to be a skilled bank employee in her country of origin. She had been converted by a Western evangelical movement and travelled to the Netherlands by airplane to visit a religious conference. Soon after her arrival, she lost her documents. Being a friend of her parents, the elderly man had welcomed her into his family, where she stayed until she was taken into custody by the police one day and reported her escape from fellow countrymen. The

parents were from a middle-class family and had been in contact with their daughter all the time. Her sisters were all in good health. The family was very worried, but also grateful for her treatment.

The patient left the hospital after an admission of eight months and managed to live independently with the help of members of her religious community from her country of origin.

Clinical Observation as a Diagnostic Tool

In medicine, the error of treating a healthy person is preferred over the risk that treatment is denied to a truly ill patient (10). This is particularly the case in refugee mental health, where the conclusion that a person seeking asylum has no psychiatric disorder may in some cases result in the extradition of that individual (11). It is therefore understandable that professionals in such settings want to err on the safe side and are hesitant to question the veracity of symptoms and impairments presented by patients. In addition, mental health professionals tend to rely on clinical observation, but even clinically experienced judges are not very successful in differentiation between genuine and feigned symptoms (12).

The case vignettes presented above illustrate two points. First, even though admission and clinical observation are sometimes recommended in cases where feigning is suspected (13), prolonged inpatient treatment and observation in a specialized psychiatric clinic may not suffice to rule feigning in or out. Second, and most importantly, patients who exaggerate or feign symptoms are, apart from the possible benefits they derive from their behavior, at risk of unnecessary treatment and even iatrogenic damage. There is evidence that both protracted psychiatric admission and treatment may have negative outcomes in healthy people. A prolonged period of admission may induce demoralization and dependency and in the long run, may even promote behavioral disturbances rather than cure them (14). Although psychiatrists will prescribe types of medication with relative few side effects at the start of treatment, these are likely to be replaced by more hazardous drugs if symptom reports persist (15), as is often the case in patients who exaggerate or feign their symptoms. Even common side effects of psychiatric medication, such as weight gain, may eventually lead to complications, such as glucose-intolerance, hypercholesterolemia, and hypertension, which decrease life expectancy considerably (16).

Why is it that 24/7 clinical observation does not necessarily lead to straightforward conclusions when it comes to the detection of feigning? Genuine psychiatric disorders display a large diversity in course and presentation. For example, the absence of a classic sign such as waxy flexibility in the first case does not exclude a catatonic state. Further, catatonic stupor and mutism may well be interrupted by short periods of activation. Short intervals of relative competency may follow in patients who react to treatment with benzodiazepines (17) and sudden bursts of activity and agitation are inherent to catatonia itself, although these features are usually erratic (18). Likewise, the behavior of a traumatized patient, such as the patient described in the second vignette, may be highly variable. A meek and even submissive attitude may suddenly turn into a confused and agitated stance when triggered by events or circumstances that are reminiscent of prior trauma. Sometimes, the behavior may be counterintuitive. For example, some victims of sexual violence may show signs of promiscuity in the aftermath of their trauma (19).

Thus, the clinical pictures depicted in these vignettes were by no means exceptional for the referral center concerned. What makes these cases remarkable was that the clinical staff happened to stumble upon collateral information that was grossly incompatible with prior diagnostic conclusions. Inspection of the medical files of refugee patients referred to the specialized center in the 2008–2012 period ($N = 231$) showed that such collateral information was collected in less than 1% of the patients admitted to the center. Thus, the uncomfortable question can be raised in how many other cases exaggerated or feigned symptom presentation might have played a role.

The outcomes in the cases described above had a large impact on the professionals involved in their treatment, with emotions ranging from frustration and regret to disbelief. Frustration and regret because of the iatrogenic damage that the patients may have sustained during their admission, and disbelief because during an admission of several months, these patients, like many other patients who were admitted, consistently presented severe signs and symptoms entirely compatible with their diagnosis and an alleged trauma history.

Clinical Impression and Collateral Information

The self-reported trauma histories of patients who present with psychiatric symptoms may be difficult to verify and may not only serve the purpose of informing therapists but may also aim to influence legal procedures (e.g., asylum procedures and litigation claims). Further, patients who exaggerate or feign symptoms may need to maintain their symptom claims for a prolonged period of time. For example, in refugee mental health, procedures for asylum may take several years to be completed (20). In this setting, it is conceivable that psychiatrists will eventually resort to prolonged periods of admission and treatments with severe side effects and risks.

Clinicians may underestimate the prevalence of symptom exaggeration or feigning among psychiatric patients when these experts rely on clinical observation. That this prevalence may well be larger than is often assumed is suggested by rates of this behavior in samples that are in some respects (e.g., the presence of incentives) similar to the cases presented in our report. For example, reviewing the military personnel records of US veterans seeking treatment for combat-related PTSD, Frueh et al. (21) found no evidence of combat exposure in 59% of the records, whereas in 7%, there was not even documentation of Vietnam war-zone service. Mittenberg et al. (22) surveyed US neuropsychologists about base rates of symptom exaggeration and feigning. As a group, these experts typically rely on multiple methods (including psychometric tests) to determine the presence or absence of feigning. Their overall estimates ranged from 8% (for nonlitigating medical cases) to 30% (for disability or workers compensation cases). Admittedly, base rate estimates of feigning tend to vary due to conceptual and definitional ambiguities (23). Still, when these estimates are based on clinical impression alone, they might well be too low for certain settings (e.g., settings where patients are involved in legal procedures).

A Remedy?

To assess the possibility of feigning or exaggerated symptom presentation, a multimethod approach is needed. In neuropsychology, clinicians often adopt Slick et al.'s criteria to determine whether a patient engages in malingering (24,25). These criteria involve the presence of a substantial external incentive (criterion A); underperformance on psychometric tasks (criterion B); symptom over-reporting on psychometric tests, self-reports that are

discrepant with collateral information, and/or self-reports that are discrepant with observation (criterion C); and furthermore, behaviors meeting B or C should not be fully accounted for by psychiatric, neurological, or developmental factors.

As to criterion C, symptom validity tests (SVTs) may be used to screen for exaggerated or feigned symptom presentations (26). SVTs usually list bizarre or nonexistent symptoms and are based on the rationale that patients who exaggerate symptoms are likely to endorse rare or unlikely items as well. One example is the Structured Inventory of Malingered Symptomatology (SIMS), which is an inventory that consists of 75 rare or unlikely symptoms (27,28). Some translated versions of SVTs appear to be functioning well in populations for whom they were not originally developed (29), but in populations as culturally and linguistically diverse as patients in referral centers for refugee mental health, properly translated instruments are often unavailable. One possible way to circumvent this problem might be to resort to performance validity tests (PVTs), which correspond to Slick et al.'s B criterion. PVTs are based on the premise that patients who engage in symptom exaggeration will fail on cognitive tests with a very modest cognitive load. A good example is provided by Morel's Emotional Numbing Test (MENT), which is a simple forced-choice task developed to screen for exaggeration of trauma-related impairment (30). Importantly, tests such as the MENT have minimal verbal mediation, which reduces the risks of language difficulties distorting the test outcomes (31). Still, verbal mediation is only one of several factors affecting test outcomes in intercultural settings. Other factors, such as culturally related differences in test-taking attitude may be just as important as confounder (32). Therefore, separate validation of PVTs for diverse cultural or linguistic groups is an important endeavor for future research (33).

The importance of the Slick et al. criteria is that they encourage clinicians who work in settings with raised base rates of feigning to move beyond clinical intuition and to take other sources of information into account, including psychometric data and collateral data. To be sure, medical staff should not try to serve as private detectives and examining the Slick et al. criteria in each patient with external incentives and therapy-resistant symptoms is not necessary. In the first case that we described, just obtaining collateral information from staff workers in the asylum seeker center already turned out to be informative (34). In the second case, a high error score on the MENT, even though by itself no proof of feigning or exaggeration, could have alerted the clinical staff to this possibility at a much earlier stage (35) and might have prevented her subsequent exposure to a protracted period of admission and the side effects of antipsychotic medication. Thus, an open and active attitude toward collateral information may alert the clinician to the option of feigning, whereas a SVT or a PVT may serve as a preliminary screener before a decision to start more comprehensive investigations along the criteria of Slick needs to be made.

Conclusion

The take-home messages of our vignettes can be summarized as follows. First, patients may exaggerate or feign severe psychiatric symptoms consistently throughout a protracted admission in a specialized center without being detected. Second, this behavior may help patients to obtain certain external benefits, but it may also lead to unnecessary, potentially harmful treatment interventions. Third, to prevent these harmful interventions, clinicians who work in settings where patients are often involved in high stake legal procedures should be aware of malingering as a distinct possibility and be wary of their clinical judgement. Rather they should develop an attitude of respectful skepticism, which considers the option of feigning, and an active stance toward the collection of collateral information. Fourth, the detection of exaggeration or feigning requires a multimethod approach, yet such comprehensive approach is not necessary in all therapy-resistant cases with possible external incentives. High-risk patients may be screened with relatively simple psychometric measures to establish whether follow-up with a multimethod approach is indicated. No test or series of tests ever unequivocally proves feigning or the lack of feigning. For use of SVTs and PVTs in culturally diverse groups as in refugee mental health, more research is needed.

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