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PRACTICE

Assessment of Malingered Psychosis in Mental Health Counseling

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Malingering is the gross exaggeration or fabrication of physical and psychological symptoms for secondary gain. Though a client's potential secondary gain may be apparent to the counselor, determining the client's situational stressors and motivation for that gain complicates definitive detection of malingering. Adopting the adaptational model of malingering in assessment can reframe the deception and misrepresentation as possibly an adaptive way to meet basic needs. Because malingering is a diagnosis of exclusion, it must first entail differential diagnosis with somatoform and factitious disorders. Assessment requires a solid clinical background in understanding malingering response style, target symptoms, psychotic symptom manifestation, and the subsequent differentiation between genuine and malingered psychosis. This article provides practical strategies for detecting feigned psychotic symptoms and briefly surveys psychometric tools counselors can use to detect malingering.

Malingering is intentional and voluntary deception for external incentive—secondary gain—through fabrication or gross exaggeration of medical or psychiatric symptoms (American Psychiatric Association [APA], 2013). The criminological model used to explain malingering in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; APA, 2013; Rogers, 1997; Rogers, Sewell, & Goldstein, 1994) links antisocial personality disorder (APD) and forensics to malingering, increasing the potential that mental health counselors will make a pejorative diagnosis (Chesterman, Terbeck, & Vaughn, 2008; Cunnie, 1997; Rogers, 1997; Rogers, Sewell, & Goldstein, 1994; Spiggle & Hughes, 1998). Threats to therapeutic rapport (Berlin, 2007; Garriga, 2007; LeBourgeois, 2007; Rogers, 1997; Rogers, Kropp, Bagby, & Dickens, 1992) and development of counselor countertransference (Berlin, 2007; Stone & Boone, 2007) can arise in reaction to client malingering. To reduce these challenges to therapeutic rapport, counselors should conduct assessments of malingering that consider contexts where, rather than being

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antisocial or criminological behavior, malingering is an adaptive act (Rogers, 1997; Rogers et. al., 1994) or abnormal illness behavior in a vulnerable client who has limited resources (Broughton & Chesterman, 2001).

The malingering response style is not uncommon (Rogers, 2008a) and should be evaluated when there is potential for external incentive (Rogers, 2008a; Young, 2010) or the client attaches importance to the counselor's assessment (Hollender & Hirsch, 1964; Rogers, 2008a; Young, 2010). Because of its prevalence Resnick (1997) recommended that all clients be assessed for malingering. A comprehensive assessment includes a detailed record review, a thorough client interview, a mental status examination, collateral information, and possibly psychological testing. These aspects of assessment must be used together to improve detection outcomes because the core problem in detecting feigned psychosis is the lack of a standard—other than admission of deceit (Cornell & Hawk, 1989; Edens, Poythress, & Watkins-Clay, 2007).

This article helps mental health counselors to identify person-centered strategies for detecting and engaging malingered psychosis. Discussion of malingering conceptualizations, explanatory models, response styles, and symptom presentation will fortify these strategies and engender a more ethical assessment of suspected malingering. Case conceptualization and treatment outcomes are better, and the underlying need of the malingering client can be addressed. Four assessment instruments are briefly considered: the Structured Interview of Reported Symptoms (2nd ed.; SIRS-2; Rogers, Sewell, & Gillard, 2010); the Personality Assessment Interview (PAI; Morey, 2007); the Structured Interview of Malingered Symptoms (SIMS; Widows & Smith, 2007); and the Miller Forensic Assessment of Symptoms Test (M-FAST; Miller, 2001). The article concludes with discussion of ethical considerations in assessing and engaging with those suspected of malingering.

WHAT IS MALINGERING?

Current studies of malingering attempt to eschew the simple descriptive definition that has prevailed since it was codified in DSM III-R in 1980 (Broughton & Chesterman, 2001; Resnick & Knoll, 2008; Rogers, 1990a, 1990b, 2008a; Rogers, Bagby, & Dickens, 1992; Rogers, Salekin, Sewell, Goldstein, & Leonard, 1998; Rogers & Vitacco, 2002; Vitacco, 2008). Research has moved from description and case study to developing models to explain what motivates malingering and conceptualizing malingering as one of several response styles of deception. This section will review the *DSM-5* (APA, 2013) definition of malingering, models to explain motivation, and malingering as a response style.

The common clinical definition of malingering, found in the *DSM-5* (APA, 2013), is the intentional gross exaggeration or feigning of physical or psy-

chological symptoms for external incentive. This external incentive, *secondary gain*, influences behavior (Scott & McDermott, 2013). The *DSM-5* suggests suspicion of malingering for any combination of two or more of the following criteria: (a) medicolegal context suggesting external incentive (e.g., Social Security Disability medical examination); (b) incongruence between reported symptoms and client's observed presentation; (c) demonstrated treatment non-compliance and resistance to diagnostic assessment; and (d) character traits suggesting APD.

In differential diagnosis of the abnormal illness behaviors of malingering, factitious disorders, and somatoform disorders, counselors must evaluate how much the client's deceptive behavior is conscious and intentional (Wiley, 1998). Factitious disorders are characterized by falsification of psychological and physical symptoms to assume the sick role (APA, 2013). Though intentionally deceptive, with factitious disorder the client is not conscious of the motivation for the deception. Like factitious disorders, somatic symptom-related mental disorders require the client to assume the sick role; however, the client unconsciously and unintentionally produces the psychological or physical symptoms (APA, 2013). It is *conscious* deception for *intentional* secondary gain that warrants a malingering diagnosis. There was a push for *DSM-5* to embrace a dimensional approach to feigned behavior that incorporates current empirical research (Berry & Nelson, 2010; Cunniën, 1997). *DSM-5* groups disorders primarily characterized by somatic concerns into a new category called somatic symptoms and related disorders (APA, 2011, 2013). This category includes conversion and factitious disorders but not malingering. Because of the confluence of conscious and intentional behavior driven by external motivation, the *DSM-5* regards malingering as a state, not a trait, disorder (Fauteck, 1995); this requires a "V" code because it does not meet DSM criteria for a mental disorder (Waite & Geddes, 2006).

Explanatory Models

Rogers and his colleagues (Rogers, 1990a, 1990b; Rogers et al., 1994) conceptualized three models for explaining the motivation for malingering and subsequent response style: *pathogenic*, *criminological*, and *adaptational* malingering.

Pathogenic model. The pathogenic model hypothesizes that malingering behavior reflects underlying, undiagnosed psychopathology (Rogers, 2008a; Rogers, Gillis, & Bagby, 1990; Rogers et al., 1994). Jung (1957/1903) suggested that many people naturally fear being institutionalized; therefore, simulation of psychosis for hospitalization (to avoid incarceration or punishment) indicates mental degeneracy. Increasing simulation of psychosis creates the potential for real and significant psychological disturbance (Jung, 1957/1903). This model also asserts that feigned psychosis is an attempt to control genuine impairment.

As authentic psychosis intensifies, the malingering individual becomes less able to manage faked aspects of the illness (Rogers, 2008a; Rogers et al., 1994).

Though research has not validated the pathogenic model (Rogers, 2008a), researchers are examining connections between malingering and cognitive dissonance (Merckelbach & Merten, 2012). Deception of others generates cognitive dissonance because of the conflict between positive core beliefs of self and the awareness of contradictory negative behaviors (e.g., lying when one sees oneself as fundamentally honest). The malingering individual overcomes this dissonance by moving from other-deception to self-deception, internalizing the falsity as true. Self-deception of initially malingering behavior may explain the commonalities in the onset and course of abnormal illness behaviors that Jonas and Pope (1985) found.

Criminological model. The 1980 release of *DSM-III* established the criminological model as foundational to malingering through a focus on anti-social and legal issues (Rogers, 1997) arising from concerns about antisocial criminal defendants feigning insanity to evade punishment (Rogers, 2008a; Rogers et al., 1990; Rogers et al., 1994). The lack of empirical support for correlations between APD and malingering has been one of the strongest criticisms of the *DSM's* characterization of malingering (Chesterman et al., 2008; Cunnien, 1997; Poythress, Edens & Watkins, 2001; Rogers et al., 1994; Rogers et al., 1990); it has been called clinical intuition by some (Poythress et al., 2001). Rogers (1997) criticized the use in *DSM-IV* of uncooperativeness and treatment noncompliance as criteria for malingering because those who malingering often are highly cooperative and voluntarily seek treatment, though they do become uncooperative under more direct questioning. Those with psychopathic traits have been found to be no better at feigning psychopathology but more willing to try (Poythress et al., 2001). Malingering persons more often voluntarily discuss symptoms, unlike many individuals experiencing acute psychotic episodes who are often unwilling to participate in assessment or treatment (Resnick & Knoll, 2005). *DSM-5* retains the *DSM-III* and *DSM-IV-TR* criminological explanatory model and detection criteria for malingering.

Adaptational model. Adversarial situations imbued with significant personal investment can increase the potential to malingering (Rogers, 2008a; Rogers, Kropp, et al., 1992; Rogers et al., 1994). The choice to malingering entails a cost-benefit analysis to gauge whether it is necessary to malingering in an adversarial situation (Rogers, 1997). Rogers (2008a) named this the decision of *comparison predicted utility* and considered it an extension of decision theory (Rogers, 1990a).

This decision-making process is central to adaptational malingering. The model identifies three factors that raise the likelihood of malingering: an apparent adversarial situation, high personal stakes, and no viable alternatives (Rogers, 1990b; Vitacco, 2008). The adaptational model facilitates a broader

and more humanistic explanation of malingering and also minimizes counter-transference (Vitacco, 2008). It suggests a clinical framework for person-centered assessment of malingering because it evaluates a client's perception of alternatives, barriers, and objectives for meeting current needs (Rogers et al., 1994). Counselors should be aware that potential to malingering is not the act of malingering; many individuals encounter situations where there is opportunity for secondary gain (e.g., criminal or civil proceedings; Rogers, 1997). The counselor must also consider the secondary *losses* of a client (Scott & McDermott, 2013). Secondary losses result from a primary loss, such as debilitating illness or loss of a partner (Dersh, Polatin, Leeman, & Gatchel, 2005). The secondary losses can be loss of a job, housing, or a relationship. They cascade as the individual suffers the emotional distress of the primary loss. Behavior and engagement with others is shaped by this distress. Secondary losses typically have more influence on behavior than secondary gains as individuals attempt to return to prior healthy functioning (Dersh et al., 2005). However, the emotional distress and turmoil endured in chronic pain or illness can compel the individual toward secondary gains. The individual feels entitled to "get something back" for pain and suffering (Dersh et al., 2005).

Chronic illness can illustrate the difference between secondary gain and loss. Financial compensation can be viewed as the secondary gain for a person filing for Social Security Disability due to chronic illness. This person may feign or exaggerate illness to acquire undue financial compensation. He or she has no history of disability and after many years of occupational functioning seeks disability. However, in the case of secondary loss, the individual seeks compensation for the distress suffered even though the person may still be fit for employment. In each case there is exaggerated illness; however, the malingering resulting from secondary loss originates from the emotional turmoil of suffering multiple losses rather than an antisocial manipulation of Social Security.

Rogers (1997) asserted that the *DSM-IV* could not distinguish between explanatory (in this case, criminological) and detection models of malingering. In a forensic sample, Rogers (1990a) found that two or more *DSM-III-R* indicators were only 20.1% effective in detecting malingering and the other 79.9% were false positives. The prototypical analysis by Rogers et al. (1994) revealed that experts who adopted an adaptational approach viewed clients as more treatable than those who considered malingering to be fundamentally criminal and antisocial behavior.

A related concern in assessing potential malingering is counselor use of the ad hominem fallacy (Rogers & Vitacco, 2002). In this fallacy the counselor spuriously draws conclusions about a client's current behavior from that client's behavior in a possibly related situation. For example, individuals with criminal

history may be mischaracterized as malingering from having sought hospitalization for suicidal ideation.

Response Styles

Malingering is one of many response styles of deception that use an avoidance rather than an approach motivational strategy (Caldwell, 2009). A *response style* is the conscious and rational decision to disclose or deceive in high-stakes situations (Rogers, 2008a). Hall and Poirier (2001) outlined four basic response styles: honest, faking bad, faking good, and invalidation. Two additional styles—mixed and fluctuating—are variants of these four. All except the honest response have some level of deception, and even honest responding may have some degree of falsity that is not deliberate but a product of cognitive distortion or psychological distress. A client's response style is usually rational and influenced by interpersonal and situational variables (Rogers, 2008a). A person deliberately weighs response options in terms of personal needs and concerns. These needs can be situational, such as a homeless person seeking housing, or interpersonal, such as developing a beneficial relationship with a boss. Unlike the categorical approach (you either are or are not malingering) in the *DSM-IV-TR* (Berry & Nelson, 2010), counseling practice suggests that clients rationally decide what and how much to disclose (Hall & Poirier, 2001; Rogers, 2008a).

Clients who deceive choose target symptoms that will best satisfy their predetermined goals (Hall & Poirier, 2001). Target symptoms facilitate the faking of a particular disorder or condition. A target is the disorder feigned for secondary gain. For example, a litigant may fake cognitive impairment and disorientation to establish head trauma in a personal injury suit. Hall and Poirier (2001) listed six possible areas for symptom targeting: somatic, sensation, affect, cognitive, behavioral, and interpersonal. Target symptoms typically used in malingering psychosis should be considered when assessing possible symptom feigning.

DISTINGUISHING MALINGERED FROM AUTHENTIC PSYCHOSIS

The early research of Hollender and Hirsch (1964) distinguished “hysterical” psychosis from authentic psychosis (i.e., schizophrenic) by evaluating sudden symptom onset, grossly unusual psychotic symptoms, and incongruities between reported or presented symptoms, behavior, and affect. Rosenhan (1973) emphasized the challenges of differentiating between authentic and feigned psychosis in clinical practice: Eight pseudopatients alleging atypical auditory hallucinations were admitted to psychiatric hospitals with a diagnosis of schizophrenia. Each retained the core of individual life histories and immediately upon admission stopped feigning psychotic symptoms. The average

length of stay was 19 days; none were detected by staff, though many genuine psychiatric patients confronted them as dissimulators. Though Rosenhan designed the study to demonstrate the inability of mental health professionals to distinguish between sane and insane, Resnick and Knoll (2008) noted that the study has also “been used to question clinicians’ ability to detect feigned psychosis” (p. 53).

Walters et al. (2008) conceptualized three different domains of malingering behavior: psychopathology, medical complaints, and cognitive impairment. Each has its own detection strategies. Malingered psychosis, one of the more difficult malingered psychopathologies to detect (Rosenhan, 1973), appears to be more prevalent in forensic and mental health treatment settings (Resnick, 1984). The actual prevalence of malingered psychosis is not known (Resnick, 1997), but Rogers et al. (1994) estimated a prevalence of 15.7% in forensic settings and 7.4% for non-forensic settings.

Prevalence rates fluctuate according to context and incentive. For example, in general medical situations, an 8% malingering base rate can increase to about 30% when the external incentive is monetary (Mittenberg, Patton, Canyock, & Condit, 2002). Cornell and Hawk (1989) studied 324 criminal defendants referred for evaluation of competency to stand trial. Only 25 cases of malingered psychosis, approximately 8%, were diagnosed. Resnick (1997) questioned these results because (a) successful dissimulators were not included in the statistics, and (b) the low prevalence in non-forensic settings most likely reflected clinical failure to suspect malingered behavior. Results of a survey of hospital psychiatrists in an urban emergency room (Yates, Nordquist, & Shultz-Ross, 1996) were similar to Resnick’s. Of 227 patients seen during a two-month period, only 13% were strongly suspected of malingering, though none were diagnosed as malingering and fewer than half were directly confronted. The lack of a consistent standard for detecting feigned psychosis complicates counseling assessments (Cornell & Hawk, 1989), especially in high-stakes settings like psychiatric emergency rooms where assessment determines assignment of limited resources.

Counselors need to be familiar with the symptomatology of the schizophrenia spectrum and other psychotic disorders as described in *DSM-5* (APA, 2013) in order to recognize thought-disorder-based psychosis. The diagnostic criteria for schizophrenia will be used to illustrate the differential diagnosis of authentic and feigned psychosis. Schizophrenia is a heterogeneous clinical syndrome characterized by a collection of functionally impairing signs and symptoms related to a range of affective, behavioral, and cognitive dysfunctions (APA, 2013). In evaluating potentially feigned symptoms, counselors are advised to consider how the symptoms cluster and contribute to psychosocial impairment. Cornell and Hawk (1989) found that those who malingered showed a higher proclivity for endorsing bogus symptoms, suicidal ideation,

visual hallucinations, memory problems, and absurd replies that did not cluster toward any known DSM-III diagnosis. Resnick (1997) discouraged assignment of a Psychosis Not Otherwise Specified diagnosis until malingering has been ruled out. Since Psychosis NOS is no longer mentioned in DSM-5 (APA, 2013), this caution would extend to both the Other Specified or Unspecified Schizophrenia Spectrum and the Other Psychotic Disorder diagnoses. Counselors should first determine client motivation for deception — feigned psychosis is not implicitly malingered (Rogers, 1997).

Differential diagnosis of malingered and authentic psychosis requires examination of common symptoms of malingered psychosis. Five domains of abnormal functioning typify the schizophrenia spectrum and other psychotic disorders: hallucinations, delusions, disorganized thinking, abnormal or grossly disorganized motor behavior, and negative symptoms (APA, 2013). The first four are considered positive, as each distorts normal functioning. Negative symptoms diminish normal functioning and contribute substantially to the morbidity of schizophrenia (APA, 2013). Malingered psychosis leans toward positive rather than negative symptoms of schizophrenia (Resnick & Knoll, 2008). Since it is atypical for a client to report positive but not negative symptoms, this suggests malingering. Differentiating feigned from authentic psychotic symptoms requires comparing the client's positive and negative symptom presentation to typical symptom manifestation. (See the Appendix for a checklist of indicators.)

Positive Symptoms

Positive symptoms exist in one of two dimensions, psychotic or disorganization (Ivleva & Tamminga, 2009). The psychotic dimension includes the schizophrenia domains of delusions and hallucinations, the disorganization dimension the domains of disorganized speech and disorganized or abnormal motor behavior. An acute episode of schizophrenia usually occurs after a long period of negative or chronic symptoms (APA, 2013; Maxmen & Ward, 1995) without clear indication of when symptoms first manifested (Ivleva & Tamminga, 2009). The symptoms include magical thinking, ideas of reference, illusions, derealization, depersonalization, impaired functioning, poor hygiene, persecutory thoughts, and flat affect. Sudden onset of positive psychotic symptoms characterizing brief psychotic disorder in DSM-5 (at least one positive symptom lasting at least one day and less than a month without associated decrements in social functioning) is rare (Mamah & Barch, 2011) since brief psychotic disorder accounts for only 9% of first-onset psychosis (APA, 2013). The drama surrounding positive psychotic symptoms can obscure the history and presence of negative symptoms at onset (Lewis, Escalona, & Keith, 2009). Counselors should suspect possible malingering when a client reports abrupt onset of positive symptoms with no history of negative or chronic symptoms.

Psychotic dimension. Of those with schizophrenia newly admitted to psychiatric inpatient beds, 75% report hallucinations, usually consisting of only one sensory modality (Maxmen & Ward, 1995; Walsh, 2007). Visual hallucinations (VH) often accompany auditory hallucinations (AH; Lewis, Escalona, & Keith, 2009), which are the most common hallucination in schizophrenia and related disorders (APA, 2013; Ivleva & Tamminga, 2009). Tactile and olfactory hallucinations are rare. Lewinsohn (as cited in Resnick & Knoll, 2005) found that hallucinations tend to be intermittent and have an 88% correlation to existing delusions. Therefore, malingering is suggested if hallucinations are continuous or not associated with delusions. Malingering is also suggested if clients do not report using any strategies to cope with hallucinations. Individuals with schizophrenia can reduce the strength and severity of their hallucinations through activity, such as listening to radio or TV, changing posture, interpersonal contact, and taking medication (Resnick & Knoll, 2005). Though scared of their hallucinations in the early stages of the illness, clients with schizophrenia develop a variety of strategies to cope with them as the illness progresses (Resnick & Knoll, 2008).

Malingering individuals report VH much more often (46%) than psychotic individuals (4%; Cornell & Hawk, 1989). Of individuals with genuine psychosis, 24–30% experience VH but are disinclined to report (Cornell & Hawk, 1989). Genuine VH related to psychosis generally (a) are in color, (b) are of normal-sized people, (c) may appear suddenly, and (d) do not change if eyes are open or closed (Caldwell, 2009; Resnick, 1997). Resnick and Knoll (2005) advised clinicians to suspect malingering if the client reports atypical or dramatic VH, such as unformed hallucinations of flashing light and color (such as in neurological disorders) or people of non-normal size (Lilliputian-sized people are associated with alcohol use or organic disease). Neither is associated with schizophrenia.

Auditory is the hallucination type most characteristic of schizophrenia (APA, 2013). Goodwin, Anderson, and Rosenthal (as cited in Resnick & Knoll, 2005) found that AH usually present as clear; they are vague only 7% of the time. Familiar and unfamiliar voices populate 88% of AH, with 75% of clients hearing both female and male voices. The client usually regards AH as ego-dys-tonic (Resnick & Knoll, 2008) with its locus outside the head and separate from inner thoughts (APA, 2013). AH involving music are rare; they can indicate the onset of ear pathology. The cadence of hallucinated voices is typically normal and intensity ranges from whispers to shouts. Hallucinations usually manifest in complete sentences comparable to the client's own syntax (Resnick & Knoll, 2008). Thompson, Stuart, and Holden (1992) indicated that command hallucinations occur with both non-command hallucinations (85%) and delusions (7%). However, clients with schizophrenia can disobey command hallucinations, especially if dangerous (Resnick & Knoll, 2005). Pollock (1998) found

that command hallucinations in simulated psychosis are presented as terrifying and overpowering, leaving the individual unable to resist compliance. In this same study, however, those with genuine (or a history of) psychosis reported subjective control of command AH.

Malingered AH are often characterized by excessively dramatic commands and stilted language (Resnick, 1997), such as a rapist reporting voices commanding, "Go commit a sex offense" or a bank robber reporting AH demanding, "Stickup, stickup, stickup" (Resnick, 1997; Resnick & Knoll, 2008). The malingering person will also falsely state inability to resist the commands and they will be reported as continuous (Pollock, 1998; Resnick & Knoll, 2008). The malingering person will report voices as muffled, vague, or a wash of sound within the head. Hallucinations may be present without any associated delusion (Resnick & Knoll, 2005, 2008). Client culture must be considered in identifying hallucinations since acceptability and manifestation may differ (APA, 2013).

Delusions are false statements expressed (a) in an inappropriate context, (b) with inappropriate justification (Resnick, 1997), and (c) often from a misinterpretation of the client's experience or perception (APA, 2013). Individuals experiencing delusions cannot adequately justify their statements. Delusions vary in theme, content, degree of systemization, and relevance to the client. Higher intelligence usually correlates with a more sophisticated delusional system. Genuine delusions take weeks to develop or remit; those feigning psychosis generally report sudden onset or termination (Resnick, 1984; Resnick & Knoll, 2005, 2008). Unlike those with schizophrenia, malingering persons eagerly discuss the content of their delusions. Clients experiencing persecutory delusions are more likely to act on them than on any other delusion. Consequent paranoid behavior will be consistent with the content and theme of the delusion. Resnick (1997) suggested malingering should be suspected if the client endorses persecutory delusions without associated paranoid behavior. The more bizarre a delusion, the more disorganized the psychotic client's thinking. Malingering should be suspected when bizarre and atypical delusions present without disorganized thought (Resnick & Knoll, 2005). Incongruence between espoused paranoid thought and jovial peer interaction illustrates such an inconsistency (Caldwell, 2009).

Disorganization dimension. Disorganized thinking may be the most important characteristic of schizophrenia (Vahia & Cohen, 2011) and its absence when manifest hallucinations are reported should suggest malingering. Malingering of psychosis often narrowly focuses on the content rather than the process of schizophrenic thought. Consequently, there is little success in simulating the speech abnormalities found in disorganized schizophrenic thought: derailment, loose associations, tangentiality, neologisms, circumstantiality, alogia, and incoherence (APA, 2013; Maxmen & Ward, 1995; Resnick &

Knoll, 2008). To illustrate, the tangentiality of thought typical of schizophrenia is absent during an interview with a malingering person—perseverations are very difficult to feign (Resnick, 1984).

Endorsement of more extreme and bizarre positive psychotic symptoms is one strategy employed in malingering to intensify presentation of feigned symptoms (LeBourgeois, 2007). The malingering response style consequently appears excessively dramatic, with an eagerness to call attention to and discuss these exaggerated symptoms (Hall & Poirier, 2000; Resnick & Knoll, 2005). The poor insight exhibited by the majority of individuals with schizophrenia is characteristic of the illness, is not a coping strategy, and is predictive of non-adherence to treatment (APA, 2013). Those who malingering wish to be treatment-compliant (Rogers, 1997); however, although initially willing to discuss symptom manifestation, they become oppositional and evasive when questioned directly (Resnick, 1997; Resnick & Knoll, 2005; Rogers, 1997). The malingering client may also accuse the clinician of believing that the reported psychotic symptoms are fake—this is rare among those with are genuinely psychotic (Resnick & Knoll, 2008).

Negative Symptoms

Though negative symptoms (e.g., anhedonia, alogia, avolition) do not exist only with schizophrenia, their enduring presence occurs more often in schizophrenia, distinguishing the syndrome from other psychiatric illnesses (Lewis, Escalona, & Keith, 2009). *DSM-5* (APA, 2013) identifies avolition (lack of motivation) and diminished emotional expression (e.g., affective blunting) as prominent negative symptoms of schizophrenia. Affective blunting, in particular, can predict the degree of functional impairment in the client with schizophrenia (Lewis, Escalona, & Keith, 2009). Asociality (impaired relatedness) and alogia (poverty of speech) are both typified by reduction in behaviors that represent the negative symptomatology of schizophrenia (APA, 2013; Maxmen & Ward, 1995) and contribute to debilitating psychosocial decrements (APA, 2013). These subtle yet important signs of schizophrenia are virtually nonexistent in malingered psychosis and are instead replaced by the perceived bizarreness of schizophrenia's positive symptoms (Resnick, 1984; Resnick & Knoll, 2005). Flamboyant, eager, or highly social behavior is incongruent with these negative symptoms and should suggest possible malingering.

DETECTION THROUGH CLINICAL INTERVIEW

The presence of incongruent affect, behavior, and thought in reported psychosis should suggest malingering, especially when external motivation is identified. External motivation can be either secondary gain or secondary loss (Scott & McDermott, 2013). The counselor must adhere to an objective and

therapeutic interview even if malingering is suspected. Because some situations (such as crisis or brief counseling) preclude formal assessment or testing of malingering, counselors can use clinical assessment strategies to better detect malingering. Open-ended questions avoid coaching the client as to diagnostic criteria (Resnick & Knoll, 2005). Once the client has self-reported symptoms, the counselor asks more direct and focused questions to ascertain whether the stated symptoms are plausible (LeBourgeois, 2007). A common strategy is to ask about rare and improbable symptoms: Since psychotic individuals almost never endorse these symptoms (Resnick & Knoll, 2008), such questioning tests whether those suspected of malingering will do so. A sample question illustrative of an atypical delusion is "Have you ever believed that automobiles are members of an organized religion?" (Resnick, 1997). The diagnostic criteria for schizophrenia in *DSM-5* no longer require the prominence of marked hallucinations or bizarre delusions during an active phase (APA, 2013). This strengthens the strategy for detecting rare and improbable symptoms because bizarre delusions or marked hallucinations are no longer pathognomonic to schizophrenia. More direct questioning may prompt the client to fluctuate between response styles (Hall & Poirier, 2001), becoming more antagonistic, evasive, or vague (Hall & Poirier, 2001; Resnick, 1997; Resnick & Knoll, 2005; Rogers, 1997). The counselor can test for a change in the client's response style or breakdown in symptom presentation by prolonging the interview to test fatigue (Garriga, 2007). Malingering persons will have difficulty sustaining feigned symptoms indefinitely (Caldwell, 2009; Resnick & Knoll, 2005).

If possible, collateral information should be gathered from, e.g., interviews with family, treatment records, and police reports before the interview to help determine the validity of the symptoms reported (Resnick & Knoll, 2008; Wiley, 1998). LeBourgeois (2007) recommended allowing sufficient time to complete a comprehensive assessment. Less comprehensive histories, such as those obtained during crisis or brief clinical services, may make it more difficult to distinguish between malingering and factitious disorder (Yates et al., 1996).

Identifying inconsistencies between self-reported symptoms, client presentation, and collateral information is a core factor in detecting malingering (Caldwell, 2009; Resnick & Knoll, 2008; Waite & Geddes, 2006). A person attempting to deceive will most likely have practiced verbal content more than physical presentation (Wiley, 1998). Caldwell (2009) averred that assessment for inconsistency is the hallmark of malingering detection, though others note that inconsistency of responses or response style does not necessarily indicate malingered psychosis (Hall & Poirier, 2000; Rogers, 2008a). Furthermore, an instance of deception does not define the individual as an unchanging deceiver (Rogers, 2008a). The malingering individual may shift between symptom targets and response styles according to the contextual need (Rogers, 2008a) and attribute these inconsistencies to mental health problems (Hall & Poirier,

2000). Those malingering may also assume an air of detachment toward the counselor but display an affable appearance when leaving the counselor (Resnick, 1997).

Successful feigners of psychosis consciously avoid appearing too psychologically impaired, avoiding odd or bizarre symptoms and providing responses in interviews drawn from personal experience (Edens et al., 2001). Surprisingly, even those skilled at successfully malingering psychosis report doubts in malingering ability comparable to those who are unsuccessful (Edens et al., 2001). Counselor use of the assessment strategies described (especially prolonged observation and interviewing) may break down a client's confidence in malingering skill, which may undermine the client's malingering response style. (See the Appendix for a checklist of interventions.)

DETECTION THROUGH PSYCHOMETRIC ASSESSMENT

Since the late 1980s, Rogers has been instrumental in researching and defining reliable and validated psychometrics for detecting feigned symptoms. These tools primarily use a rare-symptoms strategy that Rogers (2008b) called the workhorse of detecting feigned mental disorder. However, no psychometric test can directly test for malingering because identification of external incentive requires counselor assessment. Though there are numerous psychometric tools that can determine the degree of honest responding, four are common to forensics practice: the Personality Assessment Inventory (PAI; Morey, 2007); the Structured Inventory of Malingered Symptomatology (SIMS; Widows & Smith, 2007); the Miller-Forensic Assessment of Symptoms Test (M-Fast; Miller, 2001, 2005); and the Structured Interview of Reported Symptoms (SIRS-2, 2nd ed.; Rogers et al., 2010). The first two are self-administered; the latter two are structured interviews.

Self-Administered Assessments

The PAI (Morey, 2007; Morey & Hopwood, 2006) is a 344-item self-administered assessment of adult personality that evaluates critical clinical variables. It takes about 50 minutes to complete and is written at a fourth-grade reading level. Though trained technicians can administer the self-report, only those trained in psychological test interpretation should interpret the results. The PAI, which has been standardized for those over age 18, comprises 22 non-overlapping full scales, including 4 validity scales, 11 clinical scales, and 2 interpersonal scales. The PAI professional manual provides interpretive guidelines, and interpretive software is also available.

The SIMS (Widows & Smith, 2007) screens for feigned or exaggerated psychiatric symptoms and cognitive dysfunction. This tool for adults 18 and over is written at a fifth-grade reading level and can be used in a variety of clin-

ical and forensic settings. The SIMS is not intended to diagnose feigning in isolation; it is used most effectively in initial screening to determine if additional testing is needed as part of a comprehensive evaluation. It does not preclude the presence of another disorder. It consists of 75 items in five non-overlapping scales. As with other psychometric tests, only trained professionals should administer and interpret the SIMS.

Structured Interviews

The M-Fast (Miller, 2001, 2005) is a 25-item structured interview intended as an initial tool to screen for malingered mental illness in both forensics and clinical settings. Its development specifically addressed the prevalence of illiteracy in forensic settings. Of the 25 items, 22 require an oral response (2 yes or no, 5 always, sometimes, or never; and 15 true or false) and 3 require the examiner to evaluate incongruence between the examinee's reported symptoms and presenting behavior. These items were derived from seven strategies to differentiate malingerers from honest responders. The strategies evaluate rare, exaggerated, or incongruent symptoms. Those who test positively on the M-Fast would then warrant more full assessment for malingering that would include further psychometric testing (e.g., SIRS-2), collateral information, and clinical interview.

The SIRS-2 (2nd ed.; Rogers et al., 2010) provides an objective measure for detecting feigned psychiatric symptoms for adults age 18 and over. The interview lasts 30 to 45 minutes, consists of 172 items, and must be administered by a SIRS-2-qualified professional. A structured interview was chosen over a self-report format for three reasons: (a) the varying strategies for detection of malingering produced too wide an array of responses and clinical judgment for a paper-pencil format; (b) a review of the clinical literature raised concerns about reliability due to variance in presentation; and (c) since the MMPI-2 already proved a reasonably reliable and valid self-report measure for determining some qualities of malingering (such as through the fake-bad scale), a structured interview afforded an additional tool in a multimodal assessment of malingering (Rogers, Gillis, Dickens, & Bagby, 1991). The interview measures malingering, dissimulation, feigning, and defensiveness on 8 primary scales related to symptom manifestation and 5 supplementary scales related to symptom and examinee presentation. Individual scales provide four classifications—honest, indeterminate, probable faking, and definite faking (Vitacco et al., 2008)—to minimize false positives (Rogers, Vitacco, & Kurus, 2010). Extensive forensics studies suggest that the SIRS may currently be the most valid and reliable tool for measuring malingering (Chesterman et al., 2008). The counselor must be aware that although the SIRS and the other psychometric assessments mentioned have been thoroughly tested in forensic settings, their predictive accuracy may be less in mental health settings (Edens et al., 2007).

DISCUSSION

Mental health counselors should initially conceptualize malingering as an adaptive response to emergent or fundamental needs. The pursuit of basic subsistence is an adaptational response to unsafe, harsh, and life-threatening conditions (Rogers, Kropp, et al., 1992; Rogers et al., 1994) rather than antisocial deceit and manipulation for secondary gain (Rogers, 2008a).

Rogers and Vitacco (2002) have challenged the construct of secondary gain on two grounds:

1. Potential to malingering should not be confused with malingering behavior. The willingness of an individual to benefit from undeserved gain cannot be an exclusive indicator of malingering (Rogers & Vitacco, 2002).
2. The magnitude of potential secondary gain does not correlate to an increase in malingering potential. Rogers and Vitacco (2002) dismissed this inference as unproven and possibly reflective of a clinician's own biases and personal issues.

Malingering challenges the underlying assumption of therapeutic rapport and congruence between an authentic client and an empathic counselor. Although client honesty in reporting symptoms and treatment need drive this relationship, there are very few completely honest therapeutic relationships (Rogers, 2008a; Wiley, 1998). The client might withhold difficult or embarrassing thoughts, behaviors, and history to avoid judgment, re-experiencing of trauma, or a documented record of mental illness. Counselors should not personalize deception (LeBourgeois, 2007; Rogers, 2008a) or immediately regard it as malingering. However, the counselor may hesitate to diagnose malingering due to guilt generated from self-reflection on possible countertransference (Berlin, 2007).

Caldwell (2009) identified three common reasons for reluctance to assign a malingering diagnosis:

1. Malingering is difficult to assess. Accurate diagnosis requires competence in assessing psychopathology, time, and a review of available resources, such as medical histories, collateral contacts, and testing instruments.
2. Some counselors fear legal retaliation by the client.
3. Awareness that genuine symptoms can be exaggerated instills discomfort in the counselor who seeks to avoid denying treatment to those who are truly ill. Neither quickness nor hesitance in determining

malingering behavior benefits the client, or the mental health system generally.

Adoption of the adaptational model for malingering rather than the criminological model will facilitate more accurate assessment and empathic interaction (Rogers, 1997). The adaptational model inherently considers the situational response of an individual, based on the observation that malingering is not a fixed trait but a contextual reaction (Rogers, Vitacco, & Kurus, 2010). The adaptational model is concerned to understand rather than to blame. When assuming an adaptational stance to the malingering response style, forensic experts view suspected malingering clients as more treatable—and not fundamentally antisocial (Rogers et al., 1994). Integrating empathy and desire for open dialogue into detection of malingering will hopefully create space for feigning clientele to share their true needs honestly (Hamilton & Feldman, 2007; Stone & Boone, 2007). Identifying the problem and referring the client to appropriate and needed social service agencies may help decrease inappropriate use of psychiatric and counseling services (Hamilton & Feldman, 2007), improve treatment outcomes, and free needed services for other clients (Caldwell, 2009).

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APPENDIX

Counselor Checklist for Detection of Malingered Psychosis

Indicators	Interventions
Self-report of rare and improbable psychotic symptoms	Review DSM for presentation of typical psychotic symptoms. Prolong assessment and observation to test persistence and consistency of symptoms. Avoid leading questions that suggest how symptoms typically present. Determine if symptoms cluster around one particular diagnosis.
Incongruities between self-reported symptoms and observable behavior/affect	If possible, observe client behavior and affect in milieu when clinical staff are not present. Evaluate for absence of disorganized thinking or flattened affect.
Vagueness about psychiatric history and symptom development	Review available medical records. Elicit client consent for collateral information. Ask specific open-ended questions.
Presence of external motivator (secondary gain)	Determine the significance of the assessment or intervention to the client (remember that presence of secondary gain or motivation to malingering does not in itself determine malingering.). Evaluate for possible connection between external motivator and assessment.
Inconsistency in response style exhibited during assessment	Evaluate client's possible avoidance or or anger at specific questioning.
Above indicators suggest malingering but unable to definitively determine	Incorporate psychological testing (SIRS-2, PAI, SIMS, M-Fast). Use adaptational model of malingering in clinical decision-making to determine what services to provide.