

How to Approach Malingering in the Forensic Setting

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EDITOR'S NOTE: The patient scenarios presented in this article are composite cases written to illustrate certain diagnostic characteristics and to instruct on treatment techniques. The composite cases are not real patients in treatment. Any resemblance to real patients is purely coincidental.

ABSTRACT: Malingering, the intentional production or exaggeration of symptoms for external gain, presents a significant diagnostic challenge in forensic psychiatry. Distinguishing malingering from genuine psychiatric illness is essential, as diagnostic errors can delay appropriate treatment, consume limited psychiatric resources, and affect legal proceedings. This article presents three clinical case vignettes illustrating different manifestations of malingering, including feigned psychosis and intellectual disability. Key diagnostic strategies include identifying inconsistencies between reported symptoms and observed behavior, evaluating symptoms across different contexts, obtaining collateral information, assessing potential external incentives, and using structured assessment and symptom validity measures. Familiarity with characteristic patterns of feigned symptoms and a systematic, multidisciplinary approach can improve diagnostic accuracy while ensuring appropriate treatment for patients with genuine psychiatric illness.

KEYWORDS: Malingering; forensic psychiatry; psychosis; symptom validity testing; feigned symptoms; forensic assessment

Malingering is defined as the intentional exaggeration or fabrication of physical or psychological symptoms for external gain, such as obtaining financial compensation, avoiding criminal responsibility, or securing shelter or medications.¹ The concept is distinguished from factitious disorder, in which symptoms are deliberately produced but the motivation is internal, often to assume the sick role or gain attention.^{1,2} It also differs from somatic symptom disorder and related disorders, where symptoms are experienced without conscious intent to deceive.¹ Although malingering can involve a wide range of presentations—including cognitive deficits, mood symptoms, or medical complaints—psychosis is the most frequently simulated condition in forensic psychiatry,³ given its potential legal implications. Thus, the critical element that sets malingering apart is the presence of conscious, purposeful deception in pursuit of external incentives.

Malingering has been described in the psychiatric and legal literature for centuries, with reports dating back to soldiers and prisoners feigning illness to avoid duty or punishment.⁴ In modern forensic psychiatry, systematic approaches to identifying malingering have been shaped by landmark reviews, emphasizing detection through improbable symptoms, inconsistencies, and atypical presentations.^{3,5} Subsequent authors have reinforced that while malingering may involve a wide range of symptom domains, the feigning of psychosis remains the most clinically relevant challenge in forensic settings.²

The consequences of misdiagnosing malingering—whether in one direction or the other—are profound. If a patient with genuine psychosis is mistakenly labeled as malingering, treatment delays can carry severe risks. Schizophrenia is among the most life-threatening psychiatric conditions, with individuals facing a lifetime suicide risk 20

times higher than the general population.⁶ Even while hospitalized, risk is not eliminated; psychiatric inpatients die by suicide at rates nearly 50 times greater than those seen in the community during the same period of observation.⁷ Risk escalates again after discharge. In the first 3 months following psychiatric hospitalization, suicide rates have been reported at 178 per 100,000 person-years—nearly 15 times the general rate.⁸ These statistics emphasize that timely and accurate diagnosis is critical, as withholding appropriate treatment may not only prolong suffering in the hospital but also worsen prognosis and increase vulnerability during the high-risk post-discharge period. Beyond suicide, untreated psychosis has been associated with more frequent relapses, longer hospitalizations, and reduced long-term functioning.⁹ Mislabeling psychosis as malingering therefore endangers both short-term safety and long-term recovery.

On the other hand, when a patient who is malingering is misdiagnosed as truly psychotic, the ramifications extend beyond the individual to the healthcare system and society at large. State psychiatric bed availability has dropped dramatically—now at around 11 beds per 100,000 population, far below the estimated need of 30 to 50 beds per 100,000 for individuals with serious mental illness.¹⁰ In many states, forensic patients occupy up to half of these already scarce beds.¹¹ This shortage has created long waitlists—sometimes lasting weeks to months—for patients in genuine need of secure psychiatric care.¹² As a result, patients with true psychosis may languish in jails, emergency departments, or on the streets without treatment.¹³ Untreated, they may deteriorate further, face victimization, or suffer worsening of medical and psychiatric comorbidities. Meanwhile, hospitals absorb the financial and logistical strain of caring for miscategorized patients—providing food, shelter, medications, and intensive observation—while staff face increased

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risks of burnout and workplace violence.^{14,15} Whereas violence in acute psychosis is often unintentional or self-directed, malingering occurs in populations with high rates of antisocial traits, where aggression may be used instrumentally to achieve goals. Empirical evidence supports this concern; a forensic inpatient study found that individuals identified as malingering were significantly more likely to commit assaults—and at higher rates—than matched genuinely ill patients, with younger age and co-occurring personality disorders amplifying the risk.¹⁶ Thus, misdiagnosing malingering as psychosis not only delays care for patients who truly have psychosis, but also reduces overall system capacity and introduces unique safety risks for staff and peers.

Recent studies suggest that malingering is relatively common in psychiatric and forensic contexts. Prevalence estimates vary depending on setting and methodology, but rates of 8% to 20% of psychiatric presentations in forensic settings have been reported, with even higher rates among incarcerated populations seeking mental health services.^{17,18} Detecting malingering remains challenging, but structured instruments provide clinicians with additional support. These include the Structured Interview of Reported Symptoms (SIRS), the Miller Forensic Assessment of Symptoms Test (M-FAST), and validity scales of the Minnesota Multiphasic Personality Inventory-2 (MMPI-2), each designed to identify improbable symptom patterns or inconsistencies.^{19,20}

In this article, we present 3 case vignettes illustrating the presentation and detection of malingering in forensic psychiatry. Each vignette is accompanied by practice points and clinical pearls to highlight practical strategies for assessment and management.

CLINICAL CASE VIGNETTE 1

Isabella was a 54-year-old Hispanic female individual who was admitted to a state forensic psychiatric hospital for evaluation of competency to stand trial after being charged with arson. She had no prior psychiatric history, no antipsychotic treatment, and no history of psychiatric hospitalization. Collateral review suggested longstanding oppositional and aggressive behavior during childhood, consistent with conduct disorder, though she had never been formally treated for any psychiatric condition.

Doctor: Can you tell me why you are here at the hospital?

Patient: Because my neighbor planted an antenna under the ground. It beams thoughts into my head, tells me what to do. They made me set that fire.

Doctor: When did you first notice this happening?

Patient: Hard to say. Some days it's there, some days not. They switch it on whenever they want. It comes and goes.

Doctor: How does this affect you on the unit?

Patient: It ruins my mind. I can't think straight, can't remember things. I'm basically disabled. My brain doesn't work anymore.

Doctor: Staff say you've been helping with laundry and cooking groups. Is that difficult for you?

Patient: (*pauses*) Not really. . . I just follow along. But I don't understand things like I used to.

Doctor: What do you do in the evenings?

Patient: Mostly sit in the dayroom. Sometimes I'll play cards with the others, keeps me busy. But my thoughts are scrambled, I swear.

Doctor: You've used some very specific legal terms when we've spoken about your case. How did you learn those?

Patient: I just picked things up. I know what I need to say so people understand my rights.

Her thought process remained coherent, linear, and goal-directed. At times she used precise legal terminology to explain why she believed her confession was invalid, despite simultaneously claiming confusion and disability. Nursing staff documented intact activities of daily living (ADLs), good hygiene, and active socialization. Inconsistencies were noted: delusional claims were most prominent during forensic interviews but absent in casual settings. Group leaders observed that she became less convincing as sessions continued, as if fatigued by maintaining the delusional narrative.

On structured testing, her first administration of the M-FAST suggested malingering, with elevations in improbable symptom endorsement. On repeat administration, she produced near-normal results, consistent with adaptation and learning from the prior test. While some evaluators recorded apparent delusional content, others noted her intact cognition and absence of psychotic features. Taken together, the abrupt onset and offset of symptoms, improbable content, intact functioning, and shifting test results suggested malingering rather than a primary psychotic disorder.

PRACTICE POINT: MALINGERING VS PSYCHOTIC DISORDERS

Abrupt and inconsistent symptom presentation across contexts—especially when symptoms intensify during forensic evaluations and diminish in everyday settings—should raise suspicion for malingering. In true psychotic disorders, delusions are typically sustained and persist across situations rather than appearing or disappearing rapidly.^{5,22} By contrast, malingered “delusions” often show on/off shifts tied to external incentives or the presence of evaluators. For hallucinations, the pattern differs; genuine auditory verbal hallucinations (AVH) commonly fluctuate and may lessen with distraction or engagement, whereas malingerers often report continuous, unremitting voices that are unaffected by context and invariably obeyed.^{5,22} Clinicians should compare reported symptoms with observed functioning and collateral staff reports, and consider structured measures (eg, M-FAST, SIRS, MMPI-2 validity scales); repeat testing may reveal adaptation of responses over time.^{19,20,21}

CLINICAL PEARLS

- Delusions vs AVH: Genuine delusions are usually sustained; rapid on/off shifts are atypical.^{5,21} Genuine AVH are often intermittent and can diminish with distraction; reports of constant, inexorable voices that never vary should raise concern for feigning.^{5,21}
- Function vs complaint: Contrast claimed impairment with observed functioning; intact ADLs and strategic activities can contradict reports of disability.^{17,21}

- Content vs process: Malingers may mimic psychotic content (bizarre themes) but rarely reproduce the disorganized thought process seen in true psychosis.⁵
- Context dependence: Feigned symptoms often peak in legal/forensic encounters and recede in routine settings.^{17,21}
- Use structured tools (and repeat them): M-FAST, SIRS, and MMPI-2 validity scales help detect improbable patterns, and re-administration can expose response adaptation.^{19,20,21}

CLINICAL CASE VIGNETTE 2

Fariq was a 33-year-old Somali man who presented to the hospital accompanied by police for “bizarre behavior” and making vague threats to pedestrians. During intake, officers stated he had a pending felony aggravated robbery charge and had an upcoming court date. Fariq stated that he had a history of psychiatric problems and had been seeing “gorillas and mushrooms” and other random things for the past couple of months. He denied any recent substance use and was not taking any medications. He was currently homeless and hungry.

Doctor: Fariq, tell me more about the things you’ve been seeing.

Fariq: (*leans back, sighs*) The gorillas, they follow me all the time. Big ones, purple sometimes. And mushrooms on the ground, in the sky even. No one else can see them. That’s why I can’t be out there on the street, it’s dangerous.

Doctor: That sounds very frightening. Do they ever talk to you or tell you to do things?

Fariq: (*grins*) No talking, just staring. Sometimes they dance, sometimes they disappear. But I can’t live like this man, I need Social Security, I need money, I have no home. I’m like an animal out here.

Doctor: You mentioned having psychiatric care before. Tell me more about that—do you know which hospitals or doctors you saw?

Fariq: Too many hospitals. I don’t remember. They said I had schizophrenia. . . or schizo-something. . . I definitely have something, I don’t know. . . I just know I’m too sick to go

back to court. If I go to jail, I’ll get hurt. . . or even worse. But if the judge knows I’m really sick, they’ll give me benefits.

Doctor: I see. And tell me again, when did you first start seeing these gorillas and mushrooms?

Fariq: Couple months ago, maybe years. They’re worse when I’m hungry. They remind me how bad my life is and how I can’t keep a job. I’m sick, I need help, I need money, and I’m not going back to prison.

Fariq denied suicidal or homicidal thoughts but stated, “I might hurt someone if I’m forced back on the street.” On mental status examination, his affect was labile, often smiling and joking when describing his supposedly terrifying hallucinations. Nursing staff later observed him relaxed, eating snacks, and socializing in the waiting area with no obvious signs of distress.

PRACTICE POINT: MALINGERING IN THE FORENSIC SETTING

Malingering is commonly seen in the forensic setting. An obvious secondary gain for patients in this population is the potential avoidance of jail or prison time. Additionally, malingering for financial gain and assistance, shelter, and food still need to be considered. As a clinician, use your clinical judgement and be aware of clear external incentives (which are sometimes explicitly stated, as in this case), inconsistencies in a patient’s stories, and unusual symptoms. In this patient’s case, bizarre hallucinations of vivid animals and mushrooms are not typical of primary psychiatric disorders such as schizophrenia. Malingering patients also tend to overemphasize their own psychosis or symptomology. In this case our patient states “I definitely have something, I don’t know. . .” All of these findings should raise suspicion for malingering.

CLINICAL PEARLS

- Malingering is not a primary psychiatric disorder and must be distinguished from other similar, true psychiatric disorders (ie, factitious disorder).
- Malingering is driven by secondary gain.
- Avoidance of legal punishment is a common incentive for malingering in forensic patients.

- Pay special attention to any reports of visual hallucinations.
- Visual hallucinations are commonly reported by malingers (up to 46%) and are often dramatic and atypical.²²
- Note behavior over time, especially when the patient is unaware that they are being monitored. Inconsistencies in mood, affect, and symptoms are often noted when the patient is unaware.

CLINICAL CASE VIGNETTE 3

Mr. T, a 26-year-old male individual, was admitted to a behavioral health facility for competency restoration in the context of charges of aggravated murder and aggravated robbery, with additional concern for possible intellectual disability.

Doctor: Mr. T, can you tell me why you’re here?

Mr. T: The voices talk to me all day and made me pick up charges. I did what the voices told me to do.

Doctor: Do you know what charges you’re facing?

Mr. T: (*shrugs*) Aggravated. . . robbery. . . murder.

Doctor: Do you think those charges are serious?

Mr. T: I don’t know. Ask the voices. I don’t know anything about competency.

Despite this limited presentation in the interview, staff observed a different picture. During a competency restoration bingo group, Mr. T won multiple rounds by accurately matching legal terms to definitions and correctly describing the 2 tiers of sentencing, as well as the timeframe for an F1 conviction. An adjunct therapist documented Mr. T as attentive and focused and noted that he clearly understood the material.

When asked about his education, Mr. T reported dropping out in eighth grade and vaguely recalled being in special education classes and having an individualized education program (IEP).

Doctor: Why were you in special education?

Mr. T: Not sure. I had an IEP but I can’t remember why.

Collateral records, however, showed frequent suspensions for fighting, truancy, and oppositional behavior, and an IEP written for aggression, defiance, and drug use.

Mr. T denied prior legal issues, but nursing notes recorded him pointing to another patient and saying, “I know that dude, we were in juvie together.” Records confirmed multiple juvenile adjudications (disorderly conduct, “unruly child”), time in a detention center, and later adult charges for drug possession and obstructing official business.

Substance use history was similarly inconsistent; he denied use, though records showed prior alcohol, cannabis, oxycodone and acetaminophen, and cocaine.

Across multiple evaluations by different examiners, Mr. T underwent the following assessments:

- Wechsler Adult Intelligence Scale–Fourth Edition (WAIS-IV): Scores consistently fell in the extremely low range. However, examiners noted him missing simple items while occasionally answering harder items correctly, raising concerns for deliberate underperformance.
- Test of Memory Malingering (TOMM): Performance was below chance levels, consistent with feigned impairment rather than genuine memory difficulty.²³
- Inventory of Legal Knowledge (ILK): Mr. T produced scores far below cutoffs expected even for individuals with intellectual disability (ID), giving nonsensical answers such as, “The prosecutor is the person who helps me get out of jail.”²⁴
- Evaluation of Competency to Stand Trial–Revised (ECST-R): During administration, Mr. T gave vague or incorrect answers during formal questioning, yet in informal settings demonstrated clear knowledge of courtroom procedures and sentencing.

Taken together, Mr. T’s history, behavioral observations, collateral records, and formal testing suggested malingering of ID. His pattern of inconsistent presentation, poor test validity, and contradictions between claimed deficits and observed functioning pointed toward deliberate exaggeration of impairment, likely

in an effort to avoid criminal responsibility or delay trial proceedings.

PRACTICE POINT: RECOGNIZING FEIGNED AUDITORY HALLUCINATIONS

Malingering of cognitive impairment or intellectual disability (ID) should be considered when an individual’s reported deficits are inconsistent with observed functioning, collateral information, or performance across settings. Individuals feigning impairment may intentionally provide incorrect answers to simple questions while demonstrating knowledge or abilities that exceed their claimed level of functioning. An inconsistent response pattern, including failure on relatively easy test items alongside correct responses to more difficult items, may also raise concerns regarding the validity of cognitive performance.²⁵

Objective measures of performance validity are particularly useful when intentional underperformance is suspected. For example, on forced-choice measures such as the Test of Memory Malingering (TOMM), scores that fall below chance are generally difficult to attribute to genuine cognitive limitations alone and may suggest the deliberate selection of incorrect responses.²³ Collateral records, behavioral observations, and repeated assessment across formal and informal settings are also essential, as discrepancies between claimed deficits and demonstrated abilities may become more apparent over time. When evaluating possible malingering of ID, clinicians should integrate test results with developmental history, adaptive functioning, educational records, and real-world functioning rather than relying solely on IQ scores.

CLINICAL PEARLS

- Use collateral records: School and legal documentation contradicted his self-report, highlighting the value of external verification.²⁶
- Employ validity measures: Tests like TOMM²³ and ILK²⁴ are specifically designed to expose noncredible responses.
- Compare across contexts: Formal vs. informal settings revealed a stark contrast in Mr. T’s legal knowledge.²⁶
- Examine response patterns: Inconsistent performance across simple and difficult

tasks is more telling than raw scores alone.²³

- Differentiate genuine vs feigned ID: True ID shows consistent, lifelong deficits; malingering fluctuates with circumstance.^{23,24}
- Consider external incentives: Serious legal charges provided strong motivation for feigning impairment.²⁶
- Keep the full picture in mind: His history of oppositionality and substance use also influenced presentation, underscoring the need for a multidimensional assessment.²⁶

CONCLUSION

Malingering presents a significant diagnostic challenge in forensic psychiatry, with profound consequences for both patients and systems of care. Misdiagnosing true psychosis as malingering risks delaying necessary treatment and increasing morbidity, while mislabeling malingering as genuine illness consumes scarce resources, jeopardizes staff and peer safety, and may compromise the justice system.

These vignettes illustrate the diversity of presentations that clinicians encounter, from improbable hallucinations to feigned ID to abruptly shifting delusional content. In each case, careful observation, attention to inconsistencies, and the use of structured assessment tools were key in identifying feigned symptoms. Collateral information, staff observations, and repeat testing further strengthened diagnostic clarity.

Ultimately, the detection of malingering requires both vigilance and nuance. While external incentives are often apparent, the subtleties of clinical presentation demand a systematic, multidisciplinary approach. Through ongoing education and familiarity with established detection strategies, clinicians can better navigate these complex presentations, ensuring appropriate treatment for those with genuine illness while preserving the integrity of forensic psychiatric practice.

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