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Feigned Psychosis—A Review of the Simulation of Mental Illness

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Summary: The literature on the simulation of psychosis is reviewed and six patients who were thought to be feigning a schizophrenic psychosis were studied. On follow-up, all but one of the patients became overtly schizophrenic. It is argued that the simulation of schizophrenia is a prodromal phase of the psychosis occuring in extremely deviant premorbid personalities.

The recent trial of Peter Sutcliffe (Lancet, 1981) focused attention on the possibility of the purposive feigning of mental illness. Opportunity was taken to review those patients admitted to a large department of psychiatry over a 12 year period who were thought to be simulating. The patients concerned appeared at the time to be deliberately pretending to a schizophrenic psychosis. Other patients with so-called hysterical psychosis or Ganser states were excluded from the study. The literature on simulation was well reviewed by Anderson *et al* (1959). They mentioned, in particular, Jung's classic essay (1903) in which several points were made which have since been repeated by other workers. Jung stressed the rarity of simulation in civilian practice, that it occurred in patients with pre-existing personality disorders and that confessions of simulation should be received with caution.

More recently there have been relatively few papers dealing with this topic. Waschspress *et al* (1953) described three cases in an army general hospital and one of these patients became overtly schizophrenic. Schneck (1970) draws attention to a novel by Andreyev (*The Dilemma*, 1902), in which a doctor who deliberately set out to feign madness ended up with the realisation that he was indeed ill. He thought that he simulated, but was really insane. Schneck refers to this mechanism as pseudo-malingering and looks on it as the prodroma of a genuine psychosis—a temporary ego supporting device.

Ritson and Forrest (1970) described 12 patients who "played schizophrenia". Three had had a previous schizophrenic episode but, having learnt their lines, decided to prolong their hospital stay purposely. The remainder, suffering from personality problems or disorder, often in the setting of intolerable social stress, "played psychotic" for various reasons. Ritson and Forrest emphasised the absence of a praecox feeling in the latter patients, the hysterical display of the symptoms and the fact that their peer group saw through them. Berney (1973), in a review of simulated illness, again makes the point that malingering may be a "last ditch attempt" to ward off the further disintegration of a genuine psychosis. Cheng and Hummel (1978) presented two cases of a "mental Münchausen syndrome". one of whom repeatedly simulated an acute psychotic state. Finally Pope *et al* (1982) identified a cohort of 9 patients with factitious psychosis from among 219 patients consecutively admitted for psychotic disorder. They conducted a four- to seven-year follow-up and stated that none of their patients went on to develop a typical psychotic disorder. However, there was a high psychiatric morbidity and poor social outcome due to the severity of the underlying personality disorder, and in that regard Pope *et al* felt that "acting crazy may bode more ill than being "crazy".

Method

The Department of Psychiatry at the University Hospital of South Manchester admits from a catchment area of approximately 200,000, and opened a full service to that area in 1972. The in-patient case register for the years 1972-1982 was searched for patients for whom the discharge diagnosis was simulation, and those patients who had been thought to be feigning psychosis were included in the study. The consultants working in the Department were also personally contacted for the names of such patients. This last is usually a highly unreliable procedure, but as such patients tend to be well remembered, it was thought worthwhile.

Follow-up was either by personal contact if the

patient still lived in the area or by postal enquiry if they moved away. One out-patient was also included for the purposes of the discussion.

Results

In total, six patients were found who satisfied the above criteria: five in-patients and the one out-patient. Four of the in-patients were followed-up personally and the fifth by postal enquiry. The out-patient was also personally contacted. The length of the follow-up period varied from three months to ten years.

The diagnosis in all but one of the patients had been changed to that of a genuine schizophrenic illness, with which the author was in complete agreement. The one patient (P.W.), for whom the diagnosis remained uncertain, is mentioned in more detail in the case summaries.

Illustrative case summaries

Case 1: M.A., female, was aged 24 when she first presented in 1973 following an overdose. She gave a history of recurrent overdoses and wrist slashing attempts since 1969, and on admission stated she was controlled by her dead sister who kept telling her to take her own life. Her family history was negative.

She was found to be carrying a list of Schneider's first rank symptoms (Schneider, 1959) in her handbag; she behaved bizarrely, picking imaginery objects out of the waste paper basket and opening imaginary doors in the waiting room. She admitted to visual hallucinations and offered four of the first rank symptoms on her list, but her mental state reverted to normal after two days. When she was presented at a case conference, the consensus view was that she had been simulating schizophrenia but suffered from a gross personality disorder; however, the consultant in charge dissented from that general view, feeling she was genuinely psychotic.

On follow-up this turned out to be the case. She was re-admitted in 1975, mute, catatonic, grossly thought disordered, and the diagnosis was changed to that of a schizophrenic illness. She has been followed up regularly since and now presents the picture of a mild schizophrenic defect state; she takes regular depot medication but still complains of auditory hallucinations, hearing her dead sister's voice. She is a day patient.

Case 3: G.W., a married woman of 24 with one child, was referred to the out-patient department in 1982, complaining of life-long feelings of inferiority and sensitivity to criticism. Mental state examination at that time was normal, family history negative. It was thought the diagnosis was that of a mild sensitive personality disorder, but with some attention-seeking traits. Arrangements were made to give her a short course of out-patient psychotherapy; she made a positive transference with the therapist concerned and became upset when he moved to another hospital. He started to receive bizarre letters from her containing indecipherable astrological diagrams and declaring her love for him. She was therefore reviewed in the outpatients by another psychiatrist who could still find no evidence of formal mental illness. It was noticed that some of her "crazy" letters were enclosed with completely normal covering letters and her husband stated that her behaviour at home was unremarkable. She admitted that she was trying to be of interest to the first psychiatrist and desperately wanted to contact him. The formulation at this time was that of deliberate attention-seeking behaviour with feigned madness; she was also seen by a consultant from another department who thought the diagnosis was that of gross hysterical behaviour.

However, her letters became more bizarre and she sent some to the editors of various women's magazines and also to Buckingham Palace. Some three months after she was first seen she suddenly left home, arrived in another city grossly thought disordered and clearly genuinely psychotic. At the time of writing she is an in-patient with a firm diagnosis of paranoid schizophrenia.

Case 4: P.W., who was a single girl of 23 and a student, was brought to the Casualty Department by the police in 1977 having been found sitting on her doorstep, wrapped in a blanket. She expressed ideas of a plot against her directed at making her fail her examinations. She stated she could not understand the meaning of words and could hear voices; over the following days, she admitted she had been fabricating madness, "you mustn't think I planned it in cold blood; I half convinced myself I am so confused, I don't know truth from lies any more". She gave a long history of pathological lying from the age of 10. For example she had told her school friends that she was going blind and later invented for her fellow students a county background, all of which was quite untrue. Shortly before admission, she had bandaged her head and told a reporter that she had been beaten up on her way back to her digs.

The police had questioned her and she fabricated the details of this story. There was a family history of her mother having had a nervous breakdown when she was pregnant with the patient, but no details were available of the diagnosis of that illness, if indeed it had occurred.

The discharge diagnosis was of personality disorder (pseudologica phantastica) with the stimulation of psychosis. She then moved to another part of the country and had further psychatric contact. Follow-up was carried out by writing to the psychiatrists recently

concerned with her care. It was reported in 1982 that the diagnosis was unresolved. Some of the psychiatrists who had seen her since 1977 had said she was definitely schizophrenic, others still thought she was "shaming mental illness". However, she was receiving very large doses of major tranquillisers – clopixol 200 mg i.m. weekly; haloperidol 20 mg tds and chlorpromazine 50 mg tds.

Discussion

With the exception of Ritson and Forrest's and Pope's papers, the literature on simulation emphasises its rarity. Ritson and Forrest included patients who had had a definite schizophrenic episode in the past, and not all their patients were followed up. Pope *et al* felt that factitious psychosis was not too uncommon. However, this difference of view may be more apparent than real and may be due to diagnostic differences between the USA and the UK. Case summaries were not included in their paper, but four of their patients were noted to be drug or alcohol abusers, and it may well be that in this country for these patients the diagnosis of simulated psychosis would not have been made.

Simulated psychosis is frequently suspected by nursing and junior medical staff, but experienced clinicians are much more reluctant to consider it. In the present study, the incidence was only of five patients out of all new admissions in the period under review, a number approximating 12,000, and as has been shown on follow-up, four became schizophrenic in time.

The incidence in forensic practice is higher. Mather, in his large series of 320 murderers, had three who feigned psychosis and remained sane after a 10-year follow-up, an incidence of 0.01 per cent. Similarly, it is not uncommon in forensic work to see patients who, having been definitely psychotic, on recovery claim that they had only been "acting insane".

The results of this study emphasise the point that even those patients who were thought to be simulating on their initial admission, became overtly schizophrenic with the passage of time. In this regard the possibility of pseudo-malingering as mentioned in the literature, seems as useful a concept as that of pseudo-neurotic schizophrenia. The one out-patient (G.W.)—Case 3, mentioned above—illustrated a not unusual onset of psychosis, with early pathoplastic colouring dominating the picture until unequivocal psychotic symptoms developed.

Similarly (P.W.), Case 4, had an extremely deviant premorbid personality characterised by years of pathological lying and gross attention-seeking behaviour. At the beginning of the illness it was these traits, highlighted and released by a possible early process, which dominated the clinical picture. Although, to date, a firm diagnosis of schizophrenia has not been made, the patient is receiving huge doses of major tranquillisers.

Usually the simulation of schizophrenia is simply the prodromal phase of genuine illness, albeit occurring on the basis of a markedly abnormal personality. It is argued here that, in ordinary clinical practice the diagnosis of simulation should be made with great caution unless an individual patient has a very clear-cut and obvious motivation. The majority of such patients will be suffering from the early stages of a genuine psychosis and should be managed accordingly.

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