

A Clinical Investigation of Malingering and Psychopathy in Hospitalized Insanity Acquittes

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This study compares Psychopathy Checklist-Revised (PCL-R) scores, DSM-III-R diagnoses, and select behavioral indices between hospitalized insanity acquittes (N = 18) and hospitalized insanity acquittes who successfully malingered (N = 18). The malingerers were significantly more likely to have a history of murder or rape, carry a diagnosis of antisocial personality disorder or sexual sadism, and produce greater PCL-R factor 1, factor 2, and total scores than insanity acquittes who did not mangle. The malingerers were also significantly more likely to be verbally or physically assaultive, require specialized treatment plans to control their aggression, have sexual relations with female staff, deal drugs, and be considered an escape risk within the forensic hospital. These findings are discussed within the context of insanity statutes and the relevance of malingering, psychopathy, and treatability to future policy concerning the disposition of insanity acquittes.

The description for malingering in the Diagnostic and Statistical Manuals of Mental Disorders (DSM)¹⁻³ has not changed substantially during the past 14 years. The diagnostic series does not offer criteria for a diagnosis of malingering, but rather offers the following four guidelines within which an evaluator might

suspect its presence: medicolegal context of presentation (e.g., the person is referred by an attorney to the clinician for examination); marked discrepancy between the person's claimed stress or disability and the objective findings; lack of cooperation during the diagnostic evaluation and in complying with the prescribed treatment regimen; and/or, the presence of antisocial personality disorder (ASPD).³ Since at least one of these factors is likely to be present in all forensic evaluations, malingering should always be ruled out. Twenty percent of forensic evaluations may involve malingering.⁴

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While studies have for the most part

focused on the accurate clinical identification of malingerers,⁵⁻⁹ less attention has been focused on their characteristics and motivations,⁴ or in the case of the not guilty by reason of insanity (NGRI) malingering, the effects of his behavior on the hospital milieu. In this study we present and discuss the clinical characteristics and institutional behaviors of a group of successful insanity malingerers (N = 18) when compared to a nonmalingering insanity acquittee group (N = 18). We predicted a positive and clinically important relationship between psychopathy¹⁰ and malingering. We hypothesized that psychopathy levels among the malingerers would be significantly elevated when compared to the nonmalingerers.

Methods

Subject Selection. Malingering Group

In order to obtain a "pure" sample of malingerers, we utilized three conservative inclusion criteria. Subjects did not have an Axis I psychotic diagnosis or psychotic symptoms (from history, substantiated by staff observation), they were not prescribed psychotropic medications, and they evidenced a documented history of self-reported exaggerating or malingering of mental disorder to gain access to the hospital. Typically, the original insanity evaluators at the time of trial differed in their forensic opinions. In retrospect none of these subjects met the legal criteria for insanity, but all were found insane.*

* The criteria for insanity in most of our subjects are spelled out in California Penal Code §25. The legal definition of insanity in California has followed the McNaghten standard for over a century, except for a

In June 1992 six staff psychologists at Atascadero State Hospital (ASH),[†] all of whom had worked at the facility five or more years, were asked to recall insanity acquittee patients who met the three inclusion criteria. Additional subjects were also solicited from the psychologist at the San Diego County Forensic Conditional Release Program. All psychologists were blind to our hypothesis concerning psychopathy and malingering.

Twenty-two subjects were identified. Archival Psychopathy Checklist-Revised (PCL-R)¹⁰ scores were available for 14 subjects. An additional three subjects' PCL-R evaluations were requested as part of their annual psychological assessment (after June 1992). Five subjects, however, were not available for interview and their records were not adequate for scoring the PCL-R. We found an additional subject in the San Diego County Conditional Release Program (archival PCL-R score), resulting in a final sample of 18 subjects.

Comparison Subjects Subjects were obtained from a larger research sample (E. Speth, A. Roske, C. Gacono, R. Hare, S. Hart, "The utility of the Psychopathy Checklist Revised in predicting violent behavior in an inpatient forensic setting: a prospective study," unpublished data, 1994) and selected from successive ad-

brief period (1978-1982) when the ALI standard was adopted.

† Atascadero State Hospital is located in Atascadero, California. It is the largest maximum security facility of its type on the North American continent (patient population is 960). In addition to NGRI (19.5%) commitments, the patient population comprises mentally ill prisoners (39%), patients deemed incompetent to stand trial (26%), mentally disordered sex offenders (3.7%), mentally disordered offenders (1.7%), sex offender treatment project participants (4.5%), and others (5.5%). For a thorough description of ASH, read Marques et al.¹¹

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missions of insanity acquittee patients to the hospital between November 18, 1993 and May 19, 1994 (N = 63). Of the 63 admissions, 31 were discharged prior to testing,[‡] 7 were suspected of malingering and therefore excluded, and 7 refused to participate. Eighteen subjects agreed to participate via informed consent and were included in this study. Each subject participated in a semistructured interview (E.S. or A.R.) for completing the PCL-R.

On the basis of substantial medical and legal records, the presence or absence of an Axis II ASPD diagnosis was determined by agreement of at least two clinicians for both malingerers (C.B.G. and K.S.) and comparison (E.S. and A.R.) subjects. Other Axis I and Axis II diagnoses were not subjected to interrater scrutiny, although they had been arrived at uniformly through several previous hospital evaluations and substantial collateral data.

Instrumentation The PCL-R¹⁰ was used to determine each subject's psychopathy level. The PCL-R has been found to be a reliable and valid instrument for assessing psychopathy in criminal and forensic psychiatric populations.¹⁰ Interrater reliabilities have ranged from .88 to .92, while test-retest reliabilities have ranged from .85 to .90.¹²

The PCL-R consists of two stable, oblique factors.¹⁰ Factor 1 is characterized by egocentricity, callousness, and remorselessness, and correlates with DSM-

III-R² narcissistic and histrionic personality disorders and self-report measures of Machiavellianism and narcissism.^{13, 14} Factor 2 is characterized by an irresponsible, impulsive, thrill-seeking, unconventional, and antisocial lifestyle and correlates most strongly with DSM-III-R² ASPD diagnosis, criminal behaviors, lower socioeconomic background, lower IQ, less education, and self-report measures of antisocial behavior.^{10, 13, §}

The PCL-R is a 20-item, 40-point scale. Scores are obtained from a semistructured interview and substantive historical data. When sufficient historical data are available, a reliable and valid score can be obtained from record review alone.¹⁵ A valid score, however, can not be made solely from a clinical interview.

When compared with nonpsychopaths (PCL-R score < 30), psychopaths (PCL-R score ≥ 30) are more violent,^{16, 17} more criminally active over their life span, evidence higher rates of recidivism, and are less responsive to treatment interventions.^{18, 19} Additionally, Rorschach findings²⁰ indicate that psychopathic ASPDs produce more indices associated with borderline personality organization,²¹ are more narcissistic,²² and show less attachment and anxiety²³ than nonpsychopathic ASPDs.

Analysis of Data Demographic, historical, and PCL-R data were analyzed descriptively (see Tables 1 through 5).

[‡] ASH is a maximum security institution. When clinically indicated, forensic patients not in need of high security are quickly transferred to lower security institutions. Such patients are generally less violent and less character disordered than the long term insanity acquittee patients who remain at ASH.

[§] Although ASPD correlates most closely with antisocial lifestyle (Factor 2), a subject must evidence sufficient traits from both factors of the PCL-R to be designated a criminal psychopath. Whereas 60 to 75 percent of any prison population can be expected to meet the criteria for ASPD, only 20 to 25 percent would meet the more stringent criteria for psychopathy.

Nonparametric procedures were used for comparisons between groups because of our small sample size and unequal distributions. Select demographic and historical data were compared with a goodness-of-fit chi-square analysis (χ^2). PCL-R item clusters, factor, and total scores were subjected to Mann-Whitney *U* analysis. Spearman's rho test was used to compute interrater reliability for the comparison subjects' PCL-R ratings.

Results. Demographics Seventy-two percent of the comparison subjects were white ($N = 13$), 17 percent black ($N = 3$), 5 percent Hispanic origin ($N = 1$), and 6 percent other ($N = 1$). Fifty percent of the malingerers were white ($N = 9$), 33 percent black ($N = 6$), 11 percent Native American ($N = 2$), and 6 percent Hispanic origin ($N = 1$). The mean age at the time of the offense was 33.5 years ($SD = 9.1$) for the comparison subjects and 29.3 years ($SD = 6.1$) for the malingerers. At the time of PCL-R evaluation, mean ages were 36.2 years ($SD = 7.7$, comparison) and 37.0 years ($SD = 7.4$, malingerers). The average intelligence level (as measured by the WAIS-R, Shipley, or KBit tests) was 99.9 ($SD = 16.4$) for the malingerers, while the mean educational level of the comparison subjects was 11.5 years ($SD = 1.5$).^{||} MMPI data, which were available for the malingerers only, yielded a mean standardized Scale 4 elevation (psychopathic deviate) of 79.8 ($SD = 13.05$).

Diagnosis As noted in Table 1, and consistent with the inclusion criteria for

Table 1
Insanity Acquittees Axis I
Diagnosis (DSM-III-R)

	Comparison Subjects		Malingers	
	%	(n)	%	(n)
Malingering	0		100	(18)
Substance abuse	77	(14)	94	(17)
Substance or alcohol abuse	88	(16)	100	(18)
Sexual sadism	0		22 ^a	(4)
Schizophrenia	39	(7)	0	
Schizoaffective	22	(4)	0	
Bipolar	6	(1)	0	
Organic	17	(3)	0	
Delusional	11	(2)	0	
Major depression psychotic	17	(3)	0	
Prescribed				
Neuroleptic	78	(14)	0	
Antidepressant	11	(2)	17	(3)
No medications	11	(2)	83	(15)

^a $\chi^2 = 4.50$, $df = 1$, $p < .025$.

the two groups, none of the comparison subjects had a diagnosis of malingering (DSM-III-R), while none of the malingerers had a diagnosis of psychosis. Among the comparison subjects, 39 percent carried a diagnosis of schizophrenia, 22 percent a diagnosis of schizoaffective disorder, and the remainder carried various other major mental disorder diagnoses. The majority of all the subjects met the criteria for substance or alcohol abuse (comparison group, 88%; malingerers, 100%). Sexual sadism was the only Axis I diagnosis subjected to between-group comparison. The malingerers were significantly more likely to receive this diagnosis ($\chi^2 = 4.50$, $df = 1$, $p < .025$).[¶]

^{||} IQ estimates were not available for the comparisons while education level was not available for the malingerers.

[¶] This finding may represent a Type I error and should be considered tentative, since expected values are < 5 .

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Table 2
Insanity Acquittees Axis II
Diagnosis (DSM-III-R)

Personality Disorder	Comparison		Malingers	
	Subjects			
	%	(n)	%	(n)
Antisocial (ASPD)	55	(10)	100	(18) ^a
Borderline (BPD)	6	(1)	17	(3)
Narcissistic (NPD)	0		6	(1)
Histrionic (HPD)	0		6	(1)
Paranoid (PPD)	0		6	(1)
Dependent (DPD)	6	(1)	0	
Not otherwise specified (NOS)	17	(3)	0	
None	22	(4)	0	

^a $\chi^2 = 10.25$, $df = 1$, $p < .005$.

All Axis II diagnoses for the malingers were within the DSM-III-R cluster B spectrum (Table 2), except for one subject who had a secondary diagnosis of paranoid personality (cluster A). Analysis of the ASPD diagnosis yielded a significant between-group difference ($\chi^2 = 10.25$, $df = 1$, $p < .005$). Although prevalent in both groups, ASPD was significantly less likely to occur in the comparison group (55%) than the malingers (100%).

Comparison subjects who met the criteria for ASPD ($n = 10$) received a PCL-R mean score of 27.7 (range 24–33.3) and a mean Factor 2 score of 15. Non-ASPD comparison subjects ($n = 8$) produced a PCL-R mean of 9.14 with a Factor 2 mean score of 5.50.

Offenses Table 3 lists committing offense categories for both groups. Malingers were significantly more likely to have a history of murder ($\chi^2 = 5.54$, $df = 1$, $p < .025$) or rape ($\chi^2 = 3.14$, $df = 1$, $p = .05$) than the comparison subjects.

Table 3
Committing Offenses for
Insanity Acquittees

	Comparison			
	Subjects		Malingers	
	%	(n)	%	(n)
Murder/attempted murder	17	(3)	39	(7)
History of murder	17	(3)	44	(8) ^a
Rape	6	(1)	28	(5) ^b
Rape with murder	0		11	(2)
Indecent exposure	6	(1)	0	
Assault/ADW/battery	44	(8)	28	(5)
False imprisonment	11	(2)	6	(1)
Burglary	11	(2)	17	(3)
Robbery	6	(1)	11	(2)
Arson/attempted	11	(2)	0	
Vehicle theft	17	(3)	0	
Reckless driving	6	(1)	0	
Use of destructive device	6	(1)	0	
Terrorist threats	6	(1)	0	
Nonviolent/no weapon	39	(7)	22	(4)

^a $\chi^2 = 5.54$, $df = 1$, $p < .025$.

^b $\chi^2 = 3.14$, $df = 1$, $p = .05$.

ADW, assault with a deadly weapon.

Other offense types were not statistically compared. Despite similar frequencies for assaults, those committed by the comparison group were less malicious and predatory²⁴ than the malingers' assaults. For example, one comparison subject was charged with assault with a deadly weapon when he tried to blow himself up in an apartment in which a roommate was asleep. We also note the finding that 39 percent of the comparison subjects' (compared to 22% of the malingers') committing offenses were nonviolent and without a weapon.

PCL-R Findings Interrater reliabilities for all PCL-R ratings (Table 4) were satisfactory. Two or more independent ratings were available for 12 (67%) of the

Table 4
PCL-R Scores for Insanity Acquittes

	Comparison Subjects		Malingers	
	Mean	SD	Mean	SD
Total score	19.4	(9.9)	34.9	(1.8) ^b
Factor 1 score	6.3	(3.9)	14.8	(1.0) ^b
Item clusters				
1/2	0.9	(1.1)	3.6	(0.7) ^b
4/5	1.5	(1.2)	3.9	(0.3) ^b
6/7/8	3.1	(1.8)	5.4	(0.5) ^b
Factor 2 score	10.6	(4.9)	15.8	(1.4) ^b
Item 10	1.3	(0.7) ^a	1.9	(0.2) ^c
Item cluster				
3/14/15	4.1	(1.7)	5.8	(0.6) ^d

^a 66% received a score of <2.

^b $p < .001$, Mann-Whitney U test and t test.

^c $p < .001$, t test; $p = .004$, Mann-Whitney U .

^d $p = .006$, Mann-Whitney U .

malingers. Three (15%) were equal, six differed by <2 points, and one (8%) by 3 points. Only the final average of raters' scores could be retrieved for the final six malingering subjects. These ratings were completed by K. Sheppard, J. R. Meloy, or C. B. Gacono, all of whom have extensive experience with the PCL-R. A. Roske and E. Speth had been trained in PCL-R administration and scoring by C. B. Gacono and demonstrated reliable scoring.²⁵ Subsequent analysis of nine consecutive ratings by E. Speth and A. Roske yielded a Spearman's rho of $r = .98$.

All PCL-R comparisons yielded significant differences. The malingers were more glib and grandiose (items 1 and 2, $p < .001$), more likely to exhibit patterns of pathological lying and manipulation (items 4 and 5, $p < .001$), and were more likely to exhibit shallow affect, lack of empathy, and lack of

remorse (items 6, 7, and 8, $p < .001$). Hence they produced greater Factor 1 scores (*aggressive narcissism*)²⁶ than the comparison subjects. They also produced significantly greater factor 2 PCL-R scores ($p < .001$), with elevated elements of an *antisocial lifestyle*,^{10, 26} anger (item 10, $p = .004$), and proneness to boredom, impulsivity, and irresponsibility (items 3, 14, and 15, $p = .006$). Greater variance in PCL-R scores was noted among the comparison subjects ($M = 19.4$, $SD = 9.9$) than the malingers ($M = 34.9$, $SD = 1.8$). As indicated earlier and to be expected within randomly selected insanity samples, the comparison subjects evidenced a bimodal distribution. The malingers were more homogeneous in degree of psychopathy.

Institutional Adjustment Consistent with previous studies assessing the relationship between psychopathy level and institutional adjustment,¹⁶ the insanity malingers created more management problems than the insanity comparison subjects (Table 5). They were more likely to be verbally or physically assaultive ($\chi^2 = 25.72$, $df = 1$, $p < .0005$), require specialized treatment plans for their aggressive behavior ($\chi^2 = 7.2$, $df = 1$, $p < .005$), have sexual relations with female staff ($\chi^2 = 8.68$, $df = 1$, $p < .005$), deal drugs ($\chi^2 = 8.24$, $df = 1$, $p < .005$), or be considered an escape risk ($\chi^2 = 28.8$, $df = 1$, $p < .0005$) than the comparison subjects. Although no comparable data are available for posthospital release, consistent with other studies of psychopaths,¹⁹ partial data (Table 5) suggest that malin-

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Table 5
Insanity Acquittes Institutional Adjustment

	Comparison Subjects		Malingers	
	%	(n)	%	(n)
Verbally/physically assaultive	17	(3)	100	(18)
Specialized treatment plan	0		35	(6)
Sexual with/married female staff	0		39	(7)
Drug dealing within the institution	0		44	(8)
Considered escape risk	11	(2)	100	(18)
Escaped	11	(2) ^a	17	(3)
Postrelease adjustment:				
Thirty-five percent (n = 7) of the malingers had been released to the community. Four eloped from their conditional release programs; the whereabouts of one is currently unknown.				

^a Both of the control subjects who had a history of escape also had an Axis II ASPD diagnosis. Their PCL-R scores were 24 and 32.6.

gers are poor candidates for conditional release.

Discussion

The relationship between psychopathy and malingering has received scant attention in the literature,^{27, 28} and is only obliquely referenced in the DSM-IV³ as an index of suspicion when considering the diagnosis of malingering. Likewise, research has primarily focused on psychometric methods to detect malingering in defendants entering certain pleas.^{29, 30}

In this study we demonstrate that when malingering is carefully defined, clinically verified, and used as an independent measure among hospitalized insanity acquittees, a number of important related

variables emerge among those who malingered: a greater likelihood of ASPD; a greater likelihood of a history of murder, rape, and other acts of predatory violence; a greater likelihood of severe, or primary, psychopathy; and a greater likelihood of institutional misbehavior.

We expected concordance for alcohol and substance abuse between our groups, given the ubiquity of these problems in forensic psychiatric populations¹⁴ and antisocial individuals³¹ (see Table 1). The absence of psychotic disorders among our malingering group was also expected, since this was an exclusion criterion.[#] The absence of psychotic disorders in insanity acquittees raises special legal and treatment issues³² irrespective of psychopathic traits. The significantly greater frequency of sexual sadism ($p < .025$), however, was a curious finding. It should be viewed with caution, since it may reflect a Type I error, but does raise some interesting clinical and legal issues. Despite the virtual absence of psychosis among sexually sadistic criminals,³³ there may be a perceptual inclination, perhaps a wishful projection, among both evaluators at the time of trial, and the trier of fact, to assume such defendants *must* have been "crazy" to do what they did. Perhaps forensic psychiatrists and psychologists are inclined to deny the existence of sexual sadism in the *absence* of a gross impairment in cognition or volition.

[#] We recognize that patients with Axis I psychotic disorders who exaggerate their symptoms in order to influence legal proceedings represent a third group worthy of empirical study. Although they are not the focus of this study, we would expect these individuals to manifest psychopathic traits, if not the full clinical syndrome. We leave this comparison, however, to future researchers.

Is the acquitted sexual sadist, given the absence of treatment for this paraphilia,²⁶ better contained in a forensic hospital than a prison, or is this a deprivation of the acquittee's individual liberties? Such issues warrant further consideration and research.

A finding of a significantly higher number of ASPD diagnoses among the malingerers than the comparison group ($p < .005$), with an incidence of 100 percent in the former, empirically supports the fourth suspicion index for malingering in DSM-IV, the presence of ASPD (see Table 2). To our knowledge, this is the first study that has used ASPD as a dependent variable when considering malingering, by purposefully excluding it in the definition of malingering. All the personality disorder diagnoses in this study were gathered from clinical record review, and were made prior to, and independent of, subject selection. Likewise, the presence of other cluster B personality disorders (borderline, histrionic, and narcissistic) and their overlap with ASPD is consistent with research³ and underscores the diagnostic importance of multiple personality disorder diagnoses if the threshold criteria are met for each disorder. One-third of the malingerers ($n = 6$) had another personality disorder in addition to ASPD.

The committing criminal offenses (Table 3) of the malingerers were more severe and violent than were those of the comparison group. Malingerers were more likely to have a history of murder ($p < .025$) and to have committed rape ($p = .05$). These findings suggest that severity of criminal history or instant of-

fense does not necessarily preclude a finding of insanity at the time of the crime, even if malingered. The severity of offense is also consistent with degree of psychopathy (see below), and highlights the importance of determining whether the instant offense was *predatory* or *affective*.^{24, 25} Psychopaths are more likely to be predatory in their violence, that is, planned, purposeful, and emotionless. The nature of their violence distinguishes them from nonpsychopathic criminals.^{17, 34-36} During insanity evaluations, a predatory offense should alert the examiner to the possibility of malingering and the probability of psychopathy.

The malingerers were significantly more psychopathic ($p < .001$) than the comparison group (see Table 4). The two factors that comprise psychopathy, aggressive narcissism and chronic antisocial behavior, were also significantly more prevalent among the malingerers ($p < .001$). This finding was expected, and hypothesized, since psychopaths will exhibit such behaviors as manipulation and deception that may serve them well in successfully procuring an insanity acquittal.³⁷ What is most remarkable is the finding that all the malingerers scored ≥ 30 on the PCL-R, placing them in the primary psychopathy range for research purposes. Only two of the comparison subjects elevated into the primary psychopathy range, and the distribution of psychopathy scores among this latter group was bimodal. This finding suggests that not only is ASPD a useful suspicion index for malingering, but the clinical measurement of psychopathy with a reliable and valid instrument such as the PCL-R pro-

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vides incremental validity for the diagnosis of malingering.²⁵ There are also several research studies which suggest a positive correlation between psychopathy and sadism, consistent with our sexual sadism findings noted above.³⁸⁻⁴⁰

The institutional misbehavior of the malingerers is an expected finding, since this form of antisocial behavior would quantitatively contribute to their psychopathy rating on the PCL-R, particularly factor 2.** The institutional behavior we found most compelling, moreover, was the sexual intimacy and/or marriage to female staff that was accomplished by 39 percent of the malingerers. We commend them for their tenacity, but not for their judgment. This remarkable finding contributes to two PCL-R criteria, promiscuous sexual behavior and many short-term marital relationships. These data should also forewarn clinicians in forensic hospital settings that psychopathic patients, even those who are identified as malingerers, may sexually and emotionally victimize unwitting female staff.²⁶

When an individual has been acquitted of a crime through a legal finding of insanity, he is usually committed to a hospital. The trier of fact has spoken, and there can be no reconsideration of the acquittal, even if subsequent clinical data point with certainty toward the successful fabrication of a mental disorder. The forensic mental health system is responsible

for the "treatment" of the individual, even if untreatable, and the "patient" usually remains under the jurisdiction of the court.⁴¹ On May 18, 1992 the U.S. Supreme Court added a legal wrinkle to this treatment conundrum. In *Foucha v. Louisiana*, 504 U.S. 71, the majority opined that a state could not constitutionally confine an insanity acquittee who was no longer mentally ill, even though he might still be dangerous. It was the combination of mental illness and dangerousness that allowed the confinement of the insanity acquittee. The *Foucha* case made more explicit the criteria for detention of insanity acquittees discussed earlier in *Jones v. U.S.*, 463 U.S. 354 (1983), but did not define mental illness, other than noting that the defendant did not have one, but instead had an "antisocial personality" (p. 75). Justice O'Connor, in a concurring opinion, did leave some room for dispositional maneuvering when she wrote that a state might be able to confine a nonmentally ill insanity acquittee if, "unlike the situation in this case, the nature and duration of this detention were tailored to reflect pressing public safety concerns related to the acquittee's continuing dangerousness" (p. 87).

We note several implications of our clinical findings in the context of *Foucha*: first, a diagnosis of malingering may provide sufficient factual basis for a *Foucha* motion by defense counsel for release of the insanity acquittee; second, the release of such a patient, likely to be psychopathic, poses a greater risk of dangerousness to the community than the nonpsychopathic insanity acquittee¹⁹; and third, the release of such a patient removes an

** These institutional findings may be (1) spurious due to the greater length of time for which the malingerers were incarcerated and hence subject to staff observation; or (2) consistent with the poor institutional adjustment reported for other groups of psychopathic offenders.¹⁰ We support the latter interpretation.

often impossible treatment burden from the hospital staff.

The diagnosis of malingering in the hospitalized insanity acquittee has important clinical and legal ramifications. On the one hand, it is likely accompanied by severe Axis II psychopathology, including measurable psychopathy, a violent criminal offense, and gross institutional misbehavior that put staff and other patients at risk. All of these findings, by implication, suggest a poor treatment prognosis. On the other hand, a diagnosis of malingering, in light of *Foucha*, may provide a legal remedy for the deprivation of liberty of such patients, accelerate their return to the community, and relieve the hospital staff of an impossible treatment burden. Such outcomes, however, are shadowed by the greater likelihood of subsequent criminal violence being committed by these individuals if they are, in fact, primary psychopaths.

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