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Malingering Uncommon Psychiatric Symptoms Among Defendants Charged Under California's ''Three Strikes and You're Out'' Law*

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ABSTRACT: This paper describes an epidemic of uncommon psychiatric symptoms among nine criminal defendants charged under California's new ''Three Strikes and You're Out'' law. The defendants were facing a minimum sentence of 25 years to life in prison. The defendants exhibited the following uncommon psychiatric symptoms: coprophagia (eating feces), eating cockroaches and many reported seeing little green men. The defendants, all of whom we believe were malingering, were evaluated by the authors for competency to stand trial. Thus far, eight of the nine defendants were found competent to stand trial; only one defendant was found incompetent to stand trial. The authors created a database which included information on the defendants from court documents and from our interview with the defendants. We summarized the data and outcomes of the cases. Also included is a brief review of the ''Three Strikes Law'' and a paradigm for how we ruled out relevant psychiatric diagnoses before we arrived at our opinion of malingering.

KEYWORDS: forensic science, forensic psychiatry, malingering, ''Three Strikes'' law, visual hallucinations, coprophagia

Forensic psychiatrists are often called upon to evaluate criminal defendants whom they suspect are malingering mental illness in a rational attempt to avoid or diminish punishment and delay trial. In 1994, California enacted the ''Three Strikes'' law, a law that invoked a minimum 25 years to life sentence for persons convicted of a third felony (1,2). After this law took effect, the authors evaluated nine criminal defendants for competency to stand trial. Each of these defendants was facing a minimum sentence of 25 years to life under the ''Three Strikes'' law. The nine defendants exhibited uncommon psychiatric symptoms, including coprophagia (eating feces), eating bugs and seeing little green men. The authors believe that laws that potentially result in extreme sentences for minor offenses, are likely to increase malingering, as defendants rationally attempt to avoid responsibility for their crime. It is our purpose to discuss the ''Three Strikes'' law and pertinent literature on malingering, and assist forensic evaluators in identifying those who malinger mental illness.

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Three Strikes Law

The authors believe that the implementation of the ''Three Strikes'' law is behind this epidemic of uncommon psychiatric symptoms we observed during competency to stand trial evaluations. ''Strikes'' are felony convictions for serious (possession of narcotics, burglary) or violent crimes. The ''Three Strikes'' law mandates that the first two strikes (felony convictions) must be for serious or violent felonies; however, the third strike can be for any felony (e.g., petty theft with a prior conviction) (3). The Rand Corporation estimated that this law would cost California $5.5 billion per year and they renamed the law, ''Three Strikes and We're Broke'' (4). In the case, People v. Romero (California Supreme Court), judges were given the power to dismiss prior strike convictions in the furtherance of justice, and by doing so, reduce sentences (5).

In 1993, in Petaluma, a small town in northern California, an 11-year-old girl named Polly Klaas was kidnapped from her bedroom. Polly Klaas' decomposed body was found in a field after the suspect's capture. The suspect, Richard Davis, was subsequently tried, convicted and sentenced to death (6). Investigation and background of the suspect revealed that Mr. Davis was a previously convicted felon and parolee, and had served multiple prison terms. The crime generated high publicity. The public outcry resonated when it became known to the public that Mr. Davis was previously convicted for a number of crimes and released into the community, thus allowing him to commit this heinous crime. Prior to the Klaas kidnap-murder, another young girl was killed under similar circumstances. Her father, Mike Reynolds, was instrumental in raising public awareness and subsequent enactment of the ''Three Strikes and You're Out'' law in March 1994 (7). In the same year, voters in California reaffirmed the ''Three Strikes'' law.

In 1995, in Los Angeles County, a previously twice-convicted felon was charged under the ''Three Strikes'' law and sentenced to 25 years to life imprisonment for a new conviction, taking a slice of pizza from a restaurant patron (8). Publication of such punishment caused a great fear in the hearts of inmates awaiting trial on three-strike cases in Los Angeles. This fear caused inmates to feign mental illness with the purpose of delaying trial, avoiding punishment or lessening their sentence.

Methods

Forensic psychiatric evaluations were conducted on 9 defendants in a private room in a courthouse lock-up. The beginning of the

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interview consisted of introductions by the examiner and a detailed explanation of the purpose of the interview, who appointed us, and that our opinion might not help them and we might even end up testifying against them. Often, upon entering the room with the defendants seated and one of their wrist's shackled to the wall, it was immediately apparent to the authors that some of the defendants appeared mentally disturbed; some were drooling, staring at the walls, or talking to themselves or to imaginary persons. When the defendants ignored our presence and did not respond to questioning, our next step was to ascertain whether they were deaf. Once we knew that they could in fact hear, if the defendants acted very confused, we tested orientation, then we asked about past and present psychiatric history.

Most defendants volunteered psychiatric symptoms, such as visual and auditory hallucinations. With the majority of the defendants, the authors requested that the defendant call the ''little men'' or any visual hallucination he was experiencing, into the examining room. Many defendants initially doubted whether they could command their visual hallucinations to spontaneously appear before us. We indirectly implied to them that some people who have visual hallucinations may be able to command the hallucinated objects (little green men) to appear before them. We then instructed the defendants to describe the hallucinated object and ask the ''little men'' such inane questions as the little man's shoe size, type of clothing, etc. Suggesting that one has improbable psychiatric symptoms is a commonly used tactic to assess for malingering (9).

Our task in these cases was neither to help or hurt the defendant's legal position. We took precaution in informing them in the beginning of the interview and during the interview that we may not be able to help them and our opinion might hurt their case. However, we added, our ability to possibly try to help them might depend on their providing us with information.

Many defendants mumbled incoherently to our comments. The authors responded to such mumbling by saying that we might not be able to help the defendants if they did not talk with us. The authors asked the defendants to help us in obtaining more information. We offered encouragement, (such as, ''I know you can help me more than you are helping me now''). With encouragement, most were able to express a desire to be hospitalized. We frequently confronted the defendants during the interviews by saying that the defendant ''could try harder'' to answer our questions. If the defendants continued their charade, we created a ''pressure situation'' in which we told them that our ability to do an unbiased evaluation might be hindered unless they were more helpful to us by answering our questions, and they had five minutes to start answering questions. We counted down the minutes. Often this moved defendants to answer more questions; however, none of the defendants admitted to faking any symptoms.

Historical information not gathered during the interview, was found by reviewing the court records which had probation officer reports, arrest records, competency reports, and minute orders. These records were reviewed as well as the notes taken during the interview in compiling the data. The data sheet consisted of demographic information, substance abuse history, arrest record, use of aliases, escape from custody, and past and current psychiatric treatment (documented or undocumented). We also collected information from the interviews, which included whether the defendants exhibited auditory and visual hallucinations, coprophagia, eating bugs, disorientation, amnesia, volunteering symptoms (paranoid delusions, hallucinations, suicidal ideation), ignoring our greetings/presence and expressing a desire to be hospitalized.

TABLE 1—*Outcomes (*N = *9).*

Competency			Sentence		
Competent	Incomp	Trial	Three to 16 years	Life Sentence	Pending
8*	1†	4	5	3	1

*One defendant was initially found incompetent by the court, but was returned from the hospital as malingering after a short hospital stay.

†This defendant was found incompetent to stand trial. He was facing a 100 year sentence. He had no prior psychiatric history and was being housed in the psychiatric module in the jail. He initially ignored our presence during the interview. He said he saw three little green men whom he could speak with. During an evaluation with another forensic expert, this defendant ate feces and explained to the expert that the feces was actually chocolate. The defendant was smearing feces in the jail, bus, and the courtroom. The judge made arrangements for this defendant to be found incompetent despite our report that he was malingering. He remains in the hospital.

Results

Our sample of nine criminal defendants were all male and had an age range of 21 to 40. Table 1 shows the outcomes of the cases in regards to the issue of competency, sentencing, and the need for a competency trial. Thus far, eight of the nine defendants were found competent to stand trial. One of these eight, competent defendants was initially found to be incompetent. This defendant had in the past been in the California Youth Authority, was a gang member and was charged with attempted murder. He had no prior psychiatric history, and was housed in the psychiatric module in the jail while awaiting trial. During the psychiatric interview, his grooming and hygiene were adequate. He ignored the examiners' presence, and claimed to see and speak with a little man in a black suit. He was disoriented and began drooling just prior to and during the interview. The authors opined that the defendant was malingering; however, two other forensic experts opined that he was severely mentally ill. The defendant was sent to a hospital for three months and then returned to jail. The staff at the state hospital determined that the defendant was indeed malingering.

In tallying up the individual expert opinions that were offered in these nine cases (including our own), there were 14 expert opinions that the defendants were malingering. This number does not include confidential expert opinions that were not rendered to the court by the defense counsel. Only two experts opined that the defendants were legitimately mentally ill. Four of the nine cases required trials to determine the issue of competency. In one case that required a jury trial, all three experts opined that the defendant was malingering; however, defense counsel still contested the issue, fueled by the fact that the defendant had slashed his wrist twice in the courtroom. This defendant had a past psychiatric history of treatment in a prison hospital for PCP-induced Hallucinosis. He was currently housed in the psychiatric module and prescribed Haldol. He had used aliases in the past. During the interview, the defendant initially ignored our presence and spontaneously spoke to a ''little green man'' named John. The defendant was disoriented and amnestic for details of the crime and facts, such as the name of his wife. During the first trial, the jury was hung on the issue of competency. The second jury found him to be competent. Subsequently, he was sentenced to 25 years to life.

Of the eight defendants who were found competent and sentenced, five were given sentences ranging from three to 16 years, two were given 25 years to life sentences, one was given 96 years to life. One case is pending. Four defendants received sentences

of under 10 years; they are an example of the flexibility that district attorneys and judges have in deciding whether to dismiss previous ''strikes'' and give lesser sentences.

Table 2 shows data regarding the historical information from the cases. Because malingering of major mental illness is more commonly seen in persons with Antisocial Personality Disorder (ASP), we specifically asked about the defendants' histories of juvenile delinquency, arrest records, and substance abuse (10). As seen in the table, the majority of the defendants had histories of substance abuse, and had an extensive arrest history which included a history of juvenile delinquency. Because antisocial persons are deceitful (lying is a trait of ASP), we looked at other instances when the defendants had attempted to deceive others, such as when they used aliases or attempted to escape while in custody or while being apprehended. We found that the majority of defendants had used numerous aliases and almost half had a history of escape. The majority of the defendants did not have a past psychiatric history; however, most of the defendants were being prescribed antipsychotic medication while in jail awaiting trial.

The authors assessed the defendants for the presence of certain signs and symptoms (listed in Table 3) during the psychiatric interview. Objective evidence of malingering includes withholding information, lack of cooperation, exaggeration of psychiatric symptoms, and having psychiatric symptoms that are inconsistent with symptoms of legitimate mental illness. We considered the above behavior patterns and findings to be objective evidence of malingering in an antisocial person who is facing a potential life sentence in prison, until proven otherwise (i.e., verified by past psychiatric records, third party history or legitimate signs, and symptoms of mental illness).

Table 3—The majority of the defendants behaved as if they were ''dumb and crazy;'' they initially ignored our presence/greetings (stared at the wall), were disoriented and amnestic, volunteered psychiatric symptoms (hearing voices and paranoia) and stated that they saw little green men. Only one defendant ate feces and another defendant ate several cockroaches in front of the authors. Despite being disoriented and claiming not to know their name or date of birth, the defendants were able to express a desire to be placed in a psychiatric hospital for treatment.

TABLE 2—*Historical findings (*N = *9).*

Use of aliases/aka	7
History of escapes	4
Juvenile delinquency	5
Past arrests (>5)	4
Substance abuse	8
Past psychiatric history	2 (1 was undocumented)
In jail psych. module	7
On antipsychotics in jail	8

TABLE 3—*Psychiatric interview findings (*N = *9).*

Ignores examiner's greetings/presence	5
Expresses desire to be in psychiatric hospital	7
Volunteers psychiatric symptoms	9
Reports seeing little green men	7
Coprophagia (eating feces)	1
Eats bugs	1
Disorientation to name, date, location, situation	8
Amnesia for relevant legal information	8

Discussion

If one divides the discussion into historical findings and mental status exam findings in this sample, the results support findings already known about malingering (11). Regarding historical findings, the defendants had high rates of substance abuse, antisocial personality disorder (extensive arrest records including juvenile delinquency), past incidents of deceit (aliases and escapes), and minimal prior psychiatric contact. They all had secondary gain in avoiding or delaying prosecution and were facing potentially lengthy prison sentences. The majority of the defendants were housed in psychiatric modules and prescribed antipsychotic medication. If one understands the way jails work, one knows that to be prescribed antipsychotic medication, one only needs to tell a jail psychiatrist that they hear voices; therefore, the fact that one takes antipsychotic medication in a jail does not give much credence to a diagnosis of genuine mental illness. Many parolees who we treat have told us that when they were in prison, they feigned hearing voices in order to get Thorazine to sedate them so they could sleep during the day. (See Table 4 for a copy of a contraband letter written by a female inmate, found in a women's prison which details how to malinger mental illness for the purpose of obtaining social security disability benefits when released from prison.)

Obtaining historical information from probation officer reports, court records and third parties often was the only source of reliable information. To have information documenting a history of escapes, use of aliases, substance abuse, extensive criminal history, and lack of any significant psychiatric history strengthened the opinion of malingering. One limitation of the study is that it is very difficult to obtain reliable past psychiatric history. Of note is that any history of past psychiatric hospitalizations should be explored to see if these were drug-related (i.e., Cocaine-induced Psychosis) and therefore not necessarily indicative of a chronic mental illness.

The findings from the mental status exam also support what is known about mental status findings common in persons malingering mental illness. In persons who malinger mental illness, the symptoms are presented dramatically, volunteered and influenced by suggestion (12,13). The two defendants who ate feces and/ or bugs in our presence, after having saved the feces or roaches for several days prior to our interview, were quite dramatic. Many defendants spontaneously stated that they were ''crazy,'' heard voices, and took Haldol. The examiners were able to suggest to the defendants that they could in fact call the ''little green men'' into the room. After the defendants had called the little green men into the examining room, we had them ask their little green friends many detailed questions; very commonly, the defendants provided answers to these questions as if they heard what the little green men were telling them.

The defendants commonly acted deaf and dumb (ignored our presence initially), and appeared grossly psychotic, intellectually impaired, and amnestic or delirious. It has been frequently stated in the literature on malingering that defendants act ''dumb and crazy'' because they believe that mentally ill people are ''dumb'' (9). The defendants appeared intellectually impaired; they could not add or subtract, did not know what glass or paper was made from, or the number of months or days in a year. Many defendants were able to recall historical events such as past jobs, names of antipsychotic medication, and names of prisons they had attended. They were amnestic primarily for events related to their legal case and competency issues; they frequently answered ''I don't know''

TABLE 4—*How to malinger.*

Letter from an inmate to another
Now concerning SSI, you want lifetime SSI, then you got to go with the Mental Health. First, you got to build up a history. This is how to do it. First you got to go to the psych doctor and tell him that you are always paranoid and feeling like your scared. Don't play it like your ''too'' crazy, but play it like you are edgy, uneasy. Tell him you would like some medication because you can't sleep, and when you do it is only for a couple of hours, waking up sweating, etc., scared. Your scared to attend yard because people are after you. Tell them you use to get that way when you were young. Pick a state other than California and tell them from age 10–14 you took psychiatric care. Make up a doctor's name. Believe me they don't check another state. Then tell them you started using cocaine and your fear attacks started getting worse. You thought it was only the cocaine. Then you quit cocaine for over three years, but you still can't shake the attacks. You feel the police is trying to get you to be killed. Some times your okay for awhile, but then sometimes you get to the point where you can't keep it under control. Now remember no crazy person feels they are crazy, so you can't go in there telling them your a nut because they will see through it. What you got to do is tell them the symptoms you are feeling, (fear, paranoia, hearing voices, hearing the people around you plotting, etc.) Now what _____ to do is get medication. Once you get any type of medication it becomes part of mental history. Once you get that, you bring such paper work to the mental health, or use it for when you apply for SSI (in here) before you leave. You can apply for SSI in here through the mental health Social Worker. First you have to be getting treatment, have pills prescribed, etc. See the psych regularly, say the medication is not working so you can get a higher dosage. Your never gonna take the pills. Put it under your tongue and spit it out. Give the doctor a spacey look, and always fumble your hands, or fidget around. Look over your shoulder etc. Tell them you also took medication when you were young. Tell them it was called Trilifon and Cogentin. Trilifon is an antipsychotic medication, Cogentin is a medication that doesn't allow you to have seizures or side effects. Tell him you were on it from 10–14, 32 mg of Trilifon and _____ mg of Cogentin. When you sound like you know what your talking about they give you that. If you don't know something just say you don't know or remember. This is a quick run down, what you don't understand ask me _____ you've got the whole concept. Here's what you would want to change your medication. The reason why it looks better for your case history. Because I show extensive case history. Like Thorazine wouldn't work so they tried a knew twist. Now what you want to start doing is getting copies of all your case history in your cell because when you do apply you don't have to try to get copies. It cuts the time process down. Also county jail mental health records can also be used. The more the better. Just start getting those records. Now don't _____ the psych people you want records just yet. First get'on it the ''new'' meds. Don't let him feel you want a specific brand, just say your other doctors was gonna switch you to Trilifon and Cogentin. A lot of time Thorazine is used for behavior problems. You don't want that. You want to be classified as a mental problem not behavioral problems. Now keep this, once you get out you can go the Department of Rehabilitation and show you are getting SSI. They will lend you money for clothes. Also they will help you get in some college or trade school. More money. But your plan is good. But get your history file. Get a couple of stamped envelopes and write the county jail asking for your mental health county files. Then send them a pre-stamped envelpe with your name and address on it. Or if you want, wait until you get your medication. Then after a short while, get the mental health worker to help get you your file from county and _____. Then ask her to get SSI form. She might say she doesn't know how but thats drama. Apply close to go days before release. You will also need a payee. All else you need to know, ask.

to such questions. Thus, their amnesia was selective and self-serving. They did not seem to know the charges against them, the potential sentence, or the roles of various courtroom personnel. One defendant (who was not included in the sample, but faced 25 years to life under ''Three Strikes'') claimed he did not know the role of a Judge. When he was asked if a Judge works in a supermarket, church, library or courthouse, he answered a library and stated that the Judge hands out books. Of note is that this defendant's court file revealed that two years before the instant case, this defendant had very successfully written sophisticated legal briefs while acting as his own attorney.

They also presented as if they were delirious; they were disoriented, saw butterflies on the walls, and incorrectly identified objects in the room. One defendant took off his shoe and dialed it as if it were a telephone and spoke into it. It is interesting to note that when the examiners asked the defendants where they wanted to go, many defendants (sometimes reluctantly) verbalized a desire to go to a specific psychiatric facility. This was despite the fact that many did not seem to know their own name or date of birth.

Malingering

Before discussing the differential diagnosis in the above cases and the paradigm for arriving at the opinion of malingering in these cases, we will discuss some terms and concepts in malingering. Malingering, as defined in DSM-IV, is the ''intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives such as avoiding work, obtaining financial compensation, evading criminal prosecution, or obtaining drugs'' (14). In an unpublished paper by Seymour Pollack, he writes that ''the legal model of malingering stresses the willful intent to deceive through the feigned sick role that is willfully manipulated for rational motives to create the false impression of disability. Under this model of malingering the crucial element of malingering is feigned disability, not feigned impairment.'' Malingering is not uncommon. In one study, 21% of criminal defendants assessed for insanity engaged in suspected or definite malingering (15). Confronting a defendant of suspected malingering can be hazardous to your health. This author called one suspected malingerer a liar and the defendant threatened to kill me and fought against his handcuffs to get at me. It is recommended to gently suggest to suspected malingerers that you believe they can help or assist the interviewing process more than they are currently.

Persons malinger mental illness for the following reasons (10): 1. To avoid punishment, responsibility or execution for a crime, or to render them worthy of mitigation of an assigned penalty. 2. To avoid military service or of a particularly hazardous duty. 3. Financial gain. 4. To facilitate transfer from prison to a hospital, from which a defendant may hope to escape, do easier time, or take advantage of the mentally ill inmates. 5. To gain admission to a hospital for free room and board, or to avoid police apprehension. 6. To obtain drugs to get high. This author has had numerous patients present at the walk-in clinic claiming that they lost their Ativan (benzodiazepine) and need more; I cannot recall one patient ever presenting to the walk-in clinic who claimed they lost their antipsychotic medication.

Detection of Malingering

Contrary to intuition and popular myth, facial expression and eye contact are poor indicators of truthfulness. It seems that children learn at a fairly early age how to control their facial expressions so as to conceal their emotions. The face is particularly adept at deception.

The clinician must rely primarily on interviewing skills to detect malingering. If your brother or sister who is an office worker, were to try to determine who is faking mental illness, they might as well toss a coin, i.e., they do little better than chance at lie detection.

Nevertheless, a number of clues exist, and properly applied, the authors think most will agree that knowledgable clinicians have a great advantage in detecting malingering (16).

Objective evidence of malingering includes: (From unpublished papers on malingering written for the USC Institute of Psychiatry and Law, by William Vicary, J.D., M.D. and Michael Maloney, Ph.D., 1980).

1. *Withholding Information*—The malingerer's memory often has remarkable gaps. The malingerer is wary and thinks that the less information the examiner has the better.

2. *Lack of Cooperation*—There is a fear that a rigorous evaluation will detect flaws in the feigned morbidity. The patient fails to follow medical instructions and exhibits an antagonistic attitude. They attempt to take control of the interview, and behave in an intimidating manner. They are likely to buy time when answering questions to give themselves time to think up the answer.

3. *Exaggeration*—In seeking to maximize his expected rewards, the malingerer describes his morbidity in no uncertain terms. He hears voices all the time, and believes everyone is trying to kill him. Malingerers often mistakenly believe that the more bizarre they appear, the more convincing they become.

4. *Inconsistency*—The malingerer acts normal when he is unaware that he is being observed. Speaking with staff who have a chance to observe the inmate is helpful in uncovering their behavioral inconsistency.

5. The symptoms of the malingerer are often inconsistent with legitimate mental illness. For example, a malingerer states that he does not recall his name or the date, but is able to recall other past events, e.g., that he takes Haldol 5 mg twice a day, and Cogentin 1 mg twice a day. Inability to recall one's own name signifies severe dementia or delirium; therefore, such a person should also be incapable of toileting, grooming or feeding themselves. The malingerer often confuses psychotic symptoms with cognitive impairments, and believes that a person who hears voices does not know what year it is. Malingerers have implausible memory failures. They feign global amnesia which is quite rare. Genuine organic amnesiacs tend to remember certain items of information that malingering individuals pretend to forget. Genuine amnesiacs generally remember the following: name, age, birthdate, address, mother's first name, sibling's first name, and what they had for breakfast.

Malingerers attempt to fake auditory and visual hallucinations. They pretend to talk to an imaginary person (green man) who they claim is present in the room. These authors suggested to the defendants that persons with mental illness could speak to the little green men in the room, and the defendants did this.

6. *Deception*—Background investigation sometimes reveals evidence of past deceit, such as use of aliases, escape from prison, or fictitious business degrees. It is not uncommon to find a pattern of antisocial, deceitful behavior. The current morbidity is yet another instance of this pattern and is itself replete with deception.

7. Malingering is harder to maintain over longer periods of time. Therefore, to increase the chances of detection of malingering, conduct a longer interview.

8. Malingerers are likely to have nonpsychotic motives and behavior in their offenses, such as killing to settle a grievance.

Unpublished research by Jane Goerss, Ph.D., at Patton State Hospital (PSH) has shown that there is a high frequency of malingering among defendants charged under the three strikes law, who were found incompetent to stand trial and sent to PSH. In their study, of 25 incompetent, three strike defendants they believed that 5 (25%) were definitely malingering and 7 (28%) were possibly malingering. Comparing these findings with their other studies, they found that among three strike candidates, the percentage of defendants found to be malingering is more than double that of defendants with any other possible sentence. The goal of their research is to assist court-appointed evaluators in detecting malingering.

Differential Diagnosis

In arriving at a differential diagnosis in our sample, we considered the various symptoms, which included ignoring our presence, visual and auditory hallucinations, coprophagia (eating feces), eating bugs, and cognitive impairment. These symptoms can occur in persons who are deaf-mute, or have Schizophrenia, Factitious Disorder, Mental Retardation, Dementia, or have Delirium (due to toxic substances or other medical condition). Of course, all of the symptoms are not typically seen in the same person. A literature search revealed that coprophagia has occurred (rarely) in persons with Dementia, Delirium, Schizophrenia, Bipolar Disorder, Obsessive Compulsive Disorder (OCD), and Mental Retardation (17–19).

Visual hallucinations (while awake) more commonly occur in organic conditions, such as delirium, alcohol or sedative withdrawal, hallucinogen ingestion, Parkinson's patients treated with levo-dopa, brain tumors or infarctions, and epilepsy (20). In delirium, Lilliputian hallucinations (visions of miniature persons) may occasionally occur and usually consist of brightly colored little people. The hallucination is usually brief and often nocturnal (21). One case in the literature described a 67-year-old man with a occipital lobe lesion who had visual field defects and the sensation of seeing little men or women, six to nine inches tall who were in constant pantomime motion. He was so intrigued by the images that he liked to watch the ''show'' for several minutes. It recurred every few hours over 48 hours (22). Raoul Leroy was the first alienist to take a scientific interest in diminutive hallucinations which he labeled ''Lilliputian'' in 1909. In his paper (1922), Leroy noted that Lilliputian hallucinations are not frequent in asylums and sometimes occurs in ''dementia precox'' at the beginning of the illness. He cited cases of Lilliputian hallucinations occurring in organic conditions, such as delirium, chronic alcoholism, head trauma with extradural hemmorhage, intoxication with drugs, and infectious states (23). In another paper in 1955, Goldin adds that Lilliputian hallucinations also occur in cases of cerebral tumors and epilepsy. He further noted that the hallucinations represent an intrapsychic conflict in which patients gain a feeling of power—of being like Gulliver and being able to dominate a situation. Or in the case of lonely patients, the hallucinations represent companions (24).

Finally, in his paper in 1961, Lewis described Lilliputian hallucinations occurring in persons with ''functional'' psychosis. He noted two different groups of hallucinations. One group had poorly formed, flatly colored people or objects that were vaguely referred to as ''they'' or ''personages.'' They were usually internalized and exited the body and engaged in activities. They are often identified with bodily functions such as digestion or moving limbs. In one case, he described a woman who believed that personages lived in her body and carried food in pails from her stomach to her intestines. (It should be noted that this patient was first admitted to a psychiatric hospital in 1939 at the age of 50. Eighteen years later she was readmitted and noted to be ''organic'' and suffering from loss of memory, perseveration, and brief attention span). The second group of hallucinations occurred in psychotic and borderline patients and resembled imaginary friends of childhood. They were brightly colored, given a proper name, and participated in goal-directed activities. They could be taken in through bodily

orifices and patients concealed their presence because of the fear of being labelled as ''crazy.'' A case was described of a woman with neurotic depression, ultimately treated successfully with ECT. The auditory hallucinations originated from her abdomen and became manifest when her son became deathly ill. She saw two heads in her abdomen that spoke to her (25).

Visual hallucinations can occur in schizophrenia, mania, or depression. Various authors state that visual hallucinations occur in schizophrenia rarely (26) or in up to 50% of patients (27). Visual hallucinations almost always accompany auditory hallucinations and tend to be in color and of normal sized people (10).

Our differential diagnosis included deaf-mute because some defendants did not speak or appear to hear our questions initially. Deaf-mute was ruled out easily by determining with repeated questioning that the defendant could in fact hear us, but initially chose not to respond. Conversion disorder causing muteness, in which one has psychological factors causing muteness, was not considered on the differential diagnosis. Most patients with conversion muteness attempt to communicate their needs in some way; these defendants initially ignored our presence.

We considered factitious disorder next. In a person with Factitious Disorder, the motivation is to assume the sick role without obvious external gain. Factitious patients gain an emotional reward in the hospital, in the form of attention and care, material comforts and abandonment of responsibility. There is conscious awareness of falsifying symptoms. The authors excluded Factitious Disorder because the defendants had rational motivation to falsify symptoms; they were trying to get into a psychiatric hospital to evade criminal prosecution. Additionally, the defendants did not have a past history of similar symptoms (28).

On our differential diagnosis in this sample was Schizophrenia. The diagnosis of Schizophrenia was excluded because persons with Schizophrenia rarely save bugs or feces for two days in order to eat them during a clinical interview. This is an example of opportunistic behavior in hopes of appearing mentally ill. Also, persons with Schizophrenia are cognitively intact. The nature of the hallucinations of little green men was inconsistent with Schizophrenia; persons with authentic Schizophrenia are not able to have intelligent conversations with little green men on command. Also, only one defendant had a documented past psychiatric history.

On our differential diagnosis was Delirium and Dementia, in which persons are disoriented and may experience hallucinations. The diagnosis of Delirium and Dementia was excluded because the defendants did not have a history of confusion or other cognitive disturbances prior to the arrest. They also did not suffer from any recent toxic ingestion, alcohol withdrawal, metabolic abnormality or Parkinson's Disease. Again, the visual hallucinations of little green men was inconsistent with a diagnosis of Delirium. Persons who have Delirium and see objects are too impaired to have intelligent conversations with these objects on command. Delirious and demented patients who are so impaired that they do not know their name, have poor grooming and hygiene. These defendants were well-groomed, capable of feeding themselves, and capable of finding their way to the interviewing room. Also, patients who are truly demented attempt to conceal their memory impairment by confabulating, in which they invent implausible, yet sincere answers to questions.

On our differential diagnosis was Mental Retardation. The diagnosis of Mental Retardation was excluded because the defendants did not have any prior record of mental retardation, such as Regional Center involvement. The court records, arrest reports, probation officer reports did not reflect that the defendant was intellectually impaired. There was an incongruity of past vocational and social performance with performance during the interview.

Finally, we considered the diagnosis of Amnestic Disorder, which is memory loss with otherwise preserved intellectual functioning. Genuine forms of amnesia to be distinguished from malingering include various forms of organic and post-traumatic amnesia and psychogenic or dissociative amnesia. Regarding psychogenic amnesia, we believed that the memory loss was not due to unconscious factors. Despite the fact that facing 25 years to life in prison is highly traumatic, we did not believe it was capable of creating a psychogenic fugue, and definitely not a cause of the confusion, hallucinations and loss of general knowledge (e.g., number of months in a year). Additionally, genuine organic amnesiacs have a documented history of head trauma or medical condition and memory loss is often part of a more pervasive cognitive decline. Genuine organic amnesiacs can also recall information such as their name, date of birth, age, and sibling's names and can repeat two digits (29,30).

Limitations of this research include that it was based on a small sample. Also, we did not examine malingering among truly mentally ill persons, which can be very difficult to detect. Court-appointed experts should be aware of countertransference towards persons with Schizophrenia who also have Antisocial Personality Disorder, because we may dismiss their genuine psychosis as an act. Additionally, it is also possible that a person who has a legitimate mental illness may malinger additional psychiatric symptoms. Therefore, one must not assume that a person who malingers one psychiatric symptom cannot have a mental illness.

In summary, the authors attempted to describe an epidemic of uncommon psychiatric symptoms in criminal defendants who were charged under California's new ''Three Strikes'' law. The defendants were each facing a minimum sentence of 25 years to life in prison; thus, they all had a secondary gain in malingering mental illness in an attempt to diminish or avoid punishment for their crimes. Thus far, the majority of these defendants have been found competent to stand trial and have been sentenced to state prison for sentences much less than the maximum sentence that could have been imposed. These defendants challenged the authors' ability to detect malingering and prompted us to write this paper.

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