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# Claimed Simulation of Insanity

## A Coping Strategy in Mania

T. R. SURESH and T. N. SRINIVASAN

The coping strategy of claimed simulation of insanity observed at the onset of psychotic episodes in a manic patient is reported here. There is a need for systematic research on coping strategies in affective psychosis in order to develop techniques to help contain or prevent relapses.

Research into coping strategies is increasingly interested in the ways in which people with serious life crises or handicaps learn to deal with them consciously and purposefully (Breier & Strauss, 1983). Until recently, coping strategies adopted by patients experiencing an episode of psychosis have not received much attention, but they are currently being systematically studied, focusing especially on how they can be applied in the management of the illness. Subjective perception of prodromal changes in vegetative and emotional functions have been observed in schizophrenic patients by Herz & Melville (1980), Heinrichs *et al* (1985), Brenner *et al* (1987), Häfner & Thurm (1987) and, in an Indian population, by Shuba Kumar *et al* (1989). These studies reported that a large proportion of their patients consciously adopted different coping strategies like internal dialogue, seeking a comforting relationship, social withdrawal, seeking treatment and self-adjustment of medication in an effort to ward off an impending relapse or exacerbation of the psychosis.

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Research into coping mechanisms has frequently concentrated on schizophrenic patients, those with psychoses like mania receiving little attention. Indeed, we could not find any literature dealing specifically with the issue of coping in mania. This prompted us to report the case of a man with manic psychosis who adopted the coping strategy of claiming simulation of insanity at the onset of both the psychotic episodes he experienced.

## Case report

Mr S, a 26-year-old man, was admitted for treatment after a four-day period of insomnia, overactivity, irritability and excessive spending of money. The illness was preceded by a quarrel with his brothers over an issue considered trivial by them. After this quarrel the patient warned his uncle, a confidant, that he was going to act mad from then onwards so that he could keep away from his brothers. His disturbed behaviour subsequent to this warning was believed by the family to be only an 'act'. When the patient's behaviour worsened and became uncontrollable after two days, professional help was sought. A diagnosis of manic disorder was made according to DSM-III criteria (American Psychiatric Association, 1980). The episode remitted in two weeks with the use of lithium carbonate and haloperidol. After discharge from the hospital, the patient was continued on lithium carbonate (serum lithium = 30.8 mEq/l). However, he did not attend regularly for follow-up sessions and was readmitted about a year later under similar circumstances – a claim that he was going to act mad, subsequent to a family argument over a petty issue, was followed by the development of features of a manic syndrome. During this episode, the family members did not believe the patient's assertion that he was acting mad, but took the claim itself as an indicator of another episode of illness and sought professional help the day after onset. Thus, they avoided much of the distress experienced during the initial episode. The patient responded well to the same treatment as followed previously and, at one year of follow-up, he was euthymic.

## Discussion

Dissimulation or 'playing down' the symptoms of an illness, considered by Slater & Roth (1977) to be a coping strategy, has been commonly observed in schizophrenics in clinical settings (Breier & Strauss, 1983). Slater & Roth (1977) point out that this dissimulation may take many interesting forms like the one described by Bleuler in which the patient insisted that he had only simulated the illness and that he was not actually ill. Jung stressed that such confessions of simulation by psychotic patients should be received with caution (Hay, 1983). Slater & Roth (1977) cite the classical, albeit controversial, example of Rudolf Hess, the Nazi war criminal, who, by this form of unusual behaviour, apparently prevented an array of international experts from reaching the obvious diagnosis. The phenomenon of dissimulation in the form of claimed simulation of insanity has been commonly observed during or after recovery from the illness. The reported case is thus of interest as the coping behaviour was the harbinger of each oncoming episode of psychosis.

Literature sometimes offers deeper insights than textbooks into the inner experiences of persons suffering from mental disturbances. With regard to coping strategies in psychotic illness a good example of this can be found in how Shakespeare's Hamlet attempted to deal with impending insanity by warning Horatio and Marcellus that he may have future occasion to act insane ("put an antic disposition on"; Bynum & Neve, 1985). This strategy was similar to the one observed in our patient, although it should be noted that the diagnosis of Hamlet's malady would probably have been depression.

The practical implications of understanding coping mechanisms in functional psychoses like mania, lie in their relevance to planning strategies for early detection, treatment and, possibly, prevention of a relapse of the illness. Chapman (1966) observed that self-monitoring of pre-psychotic affective signals appeared particularly helpful in alerting the patients to the ensuing psychotic decompensation. Such an early warning system could lead them to adopt necessary coping strategies. Although no such 'affective signals' were reported in our patient, it was possible that the patient sensed the psychological disruption occurring within him and, more or less consciously, attempted to cope with this by asserting that his future behaviour was going to be only an 'act'. This mechanism, by helping the patient falsely believe in his own assertion, seemed to have protected him, although only temporarily, from the distressing experience of a psychotic breakdown. Such coping behaviours would not only help the subject to take some ameliorative measures but could also alert the members of his or her social network to deal with the patient. This was illustrated in our report in which, when the patient made a claim of simulated psychosis for the second time, the family members, learning from a similar experience during the initial episode, made no delay in seeking psychiatric intervention. Any management plan utilising coping strategies should take into consideration the personal coping style of the given patient who, as in our case, might adopt the same or a similar behaviour every time he is in a crisis.

## Conclusion

Systematic research on coping strategies of patients with affective psychoses needs to be carried out, focusing particularly on developing methods to help contain or prevent relapses.

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# Reflections of the Self: Atypical Misidentification and Delusional Syndromes in Two Patients with Alzheimer's Disease

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Two patients with moderately severe AD, when asked directly, could identify their own images in a mirror, but also consistently misidentified their own reflections as that of another person. Both patients were paranoid and mildy depressed at times, but had no evidence of other concurrent psychotic symptoms. It appeared that mood substantially modified the nature of the symptom and the patients' reaction to it over time. These cases illustrate the ability of an organic symptom to be modified by a concurrent affective state, indicating the importance of the interaction between biological and psychological factors in the expression of such symptoms.

Psychotic symptoms are estimated to occur in 15–75% of patients with Alzheimer's disease (AD; Drevets & Rubin, 1989). Hallucinations and delusions are the most common of these symptoms, but misidentification syndromes such as Capgras' syndrome have also been reported (Drevets & Rubin, 1989). Other misidentification syndromes such as Frégoli syndrome (the belief that some familiar person has assumed the psychological identity of another, although the two are not physically alike) and the syndrome of subjective doubles have been reported primarily in patients with schizophrenia, but also in patients with organic brain disease (Joseph, 1986; Signer, 1987). It is not uncommon for AD patients to misidentify their own reflection in the mirror. Cases have also been described where patients may converse with the image in the mirror, and are unable to recognise it as their own (Rubin *et al*, 1988). Our cases are different, as the patients were able to identify their own reflections but yet frequently perceived in the reflection another person with a separate psychological identity from themselves. Our cases are also different from those where the patient recognises the image as that of the self

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