International Journal of Law and Psychiatry xxx (2015) xxx–xxx

Contents lists available at ScienceDirect

International Journal of Law and Psychiatry

Antisocial features and "faking bad": A critical note ☆

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ARTICLE INFO

Available online xxxx

Keywords:
Psychopathy
Antisocial personality
Faking bad
Malingering
Faking good
Cognitive dissonance

ABSTRACT

We critically review the literature on antisocial personality features and symptom fabrication (i.e., faking bad; e.g., malingering). A widespread assumption is that these constructs are intimately related. Some studies have, indeed, found that antisocial individuals score higher on instruments detecting faking bad, but others have been unable to replicate this pattern. In addition, studies exploring whether antisocial individuals are especially talented in faking bad have generally come up with null results. The notion of an intrinsic link between antisocial features and faking bad is difficult to test and research in this domain is sensitive to selection bias. We argue that research on faking bad would profit from further theoretical articulation. One topic that deserves scrutiny is how antisocial features affect the cognitive dissonance typically induced by faking bad. We illustrate our points with preliminary data and discuss their implications.

1. Introduction

Terms like malingering, symptom exaggeration, feigning, simulation, and faking bad are often used as loose equivalents. The Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV TR) defines malingering as "the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives" (American Psychiatric Association, 2000; p. 739). It stresses that clinicians should suspect malingering when two or more of the following conditions are present: The symptoms are reported within a forensic context, they contrast sharply with objective findings, there is lack of cooperation during diagnostic evaluation, and/or the patient meets criteria for antisocial personality disorder (ASPD). The new edition of the DSM (i.e., the DSM-V) does not contain substantial revisions of how it portrays malingering (American Psychiatric Association, 2013; p. 726–727; see for a critical analysis: Rogers, 2008; Berry & Nelson, 2010; Bass & Halligan, 2014). The DSM's description of malingering has been characterized as a criminological model, because it assumes that malingering is "an antisocial act that is likely to be committed by antisocial persons" (Rogers, 2008; p. 9). Given that the DSM is a widely used and highly influential source, the conceptual and empirical underpinnings of its criminological typology of malingering warrant critical reflection, which is the aim of the current article. We will employ the term faking bad rather than malingering because the latter term assumes the presence of independent evidence that exaggerated symptom reports are motivated by external incentives (Bass & Halligan, 2014). Yet, such evidence is not always available.

The detection of faking bad is a challenge for clinicians. Unstructured interviews generally yield low detection rates, meaning that many cases will be missed if clinicians solely rely on their subjective judgment (e.g., Rosen & Phillips, 2004). Indeed, intuitive clinical judgment yields detection rates of faking bad that are comparable to the disappointingly low hit rates (i.e., <60%) found for intuitive judgment in the broader deception–detection literature (Vrij, 2000). Against this backdrop, a wide array of tests has been developed that intend to provide an indication of the credibility of symptom reports. When employing these instruments, empirically based cut-offs aid in determining whether symptoms are likely to be genuine or not (Merten & Merckelbach, 2013). A reasonably high diagnostic accuracy can be obtained when multiple detection tests are combined. Two response styles have been identified as targets of these dedicated detection tools: Exaggeration of symptoms and intentional underperformance (Dandachi-FitzGerald, Ponds, Peters, & Merckelbach, 2011; Iverson, 2006; Van Oorsouw & Merckelbach, 2010). Thus, patients who engage in faking bad may claim an abundance of atypical symptoms on specialized self-report questionnaires such as the Structured Inventory of Malingered Symptomatology (SIMS; Smith & Burger, 1997; see for other examples Table 1), and/or they may tend to perform extremely poorly on simple cognitive tasks such as the Test of Memory Malingering (TOMM; Tombaugh, 1996; see for other examples Table 1).

☆ The research was partially funded by a grant from the Netherlands Organisation for Scientific Research (NWO; grant 4006-11-001).

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http://dx.doi.org/10.1016/j.ijlp.2015.03.005
0160-2527/

Table 1
Summary of studies examining psychopathy, ASPD and faking.

Study	Year	Subjects	Psychopathy & ASPD instruments	Faking bad/good instruments	Statistics	Findings/conclusion	Link yes/no
Prevalence studies for faking in psychopathy ($n = 5$)							
Kucharski et al.	2006	$N = 188$ male criminal defendants	PCL-R	MMPI-II, PAI, SIRS	ANOVA	High psychopathy group scored higher on MMPI-II subscales than low/medium groups; MMPI-II F: F (2,189) = 8.43, $p < .01$, MMPI-II F–K: F (2,189) = 10.20, $p < .01$, MMPI-II Fb: F (2,189) = 5.99, $p < .01$, MMPI-2 F(p): F (2,189) = 7.19, $p < .01$; the PAI Negative Impression-scale: F (2,164) = 6.63, $p < .01$; and the sum of SIRS scales: F (2,107) = 6.18, $p < .01$.	Yes
Cima et al.	2008	$N = 118$ controls and 34 prison inmates	PPI	SS-R	Pearson correlations Chi-square	Psychopaths did not exhibit more faking good than non-psychopaths.	No
Freeman and Samson	2012	$N = 300$ non-incarcerated community members	SRP-III	IM subscale	Correlations	Higher psychopathy was associated with lower faking good, $r = -.55$, $p < .01$.	No
Heinze and Vess	2005	$N = 392$ male hospitalized forensic patients	PCL-R	MMPI-II	Chi square	Those scoring high on the PCL-R more often engaged in faking bad than those scoring medium or low on the PCL-R, $\chi^2 = 6.95$, $df = 2$, $p = .03$.	Yes
Cima and Van Oorsouw	2013	$N = 31$ male prison inmates	PPI (Factor 1 and 2)	SIMS	Correlations	PPI-1 was unrelated to faking bad, while PPI-2 was related to faking bad, $r = .44$, $p < .05$.	Yes/No
Prevalence studies for faking in ASPD ($n = 4$)							
Grillo et al.	1994	$N = 90$ personal injury claimants	MCMI-II	MMPI-II	Correlations	The antisocial subscale was correlated with several MMPI-II subscales. MMPI-II F: $r = .26$, $p < .01$, MMPI-II K: $r = -.44$, $p < .001$, MMPI-II L: $r = -.30$, $p < .01$, MMPI-II F–K: $r = .42$, $p < .01$, MMPI O–S: $r = .35$, $p < .001$.	Yes
Delain et al.	2003	$N = 64$ criminal forensic participants	RRF	TOMM	Chi square	Those who scored below the cut-off of the TOMM ($n = 25$) more often met ASPD criteria than controls ($n = 31$), $\chi^2 = 3.86$, $df = 1$, $p = .05$.	Yes
Sumanti et al.	2006	$N = 233$, compensation claimants	PAI (ANT-subscale)	Rey 15-item test, Dot-counting test, PAI-NIM, PAI-MAL, PAI-RDF	Correlations t-tests	Only significant for PAI-NIM, $t = 50.28$, $p < .05$., indicating that subjects who scored above the PAI-NIM cut-off, and thus engaged in faking bad, also scored higher on antisociality.	Yes/No
Pierson et al.	2011	$N = 71$ forensic patients with/without ASPD	SCID-II	SIRS	Chi square	ASPD individuals did not score higher on SIRS than those without ASPD.	No
Deceptive ability studies ($n = 6$)							
Boone et al.	1995	$N = 154$ litigation subjects	MCMI	Rey 15-item testDOT-counting test	Kruskal–Wallis analyses	No difference in antisocial scores between those failing and passing faking tests.	No
Edens et al.	2000	$N = 143$ students tested twice: once instructed to fake bad and once honest	PPI	MMPI-psychoticism scale, DPS, Validity scales of the PPI	Group comparisons were difficult due to skewness of data. Groups.	Psychopathic traits were not associated with passing fake bad subscales.	No
Poythress et al.	2001	$N = 55$ Male prison inmates Half instructed to fake bad. Other half was clinically judged to be malingering	PPI	SIMS, SIRS, PAI	Correlations	Psychopathy was unrelated to successfully faking bad.	No
Book et al.	2006	$N = 201$ students instructed to fake good ($n = 96$) or fake bad ($n = 105$)	LSRP	HPSI	ANOVA	Psychopathic traits were unrelated to faking bad. Those who were caught faking good did display lower total psychopathy scores, F (1,92) = 8.72, $p < .01$.	Yes/No
MacNeil and Holden	2006	$N = 200$ students instructed to fake bad/good	PPI	HPSI, BIDR, PRF-D	t-tests	Most findings were not significant. However, higher scores on the PPI subscale Machiavellian Egocentricity were related to faking good on, HPSI: $t = 2.78$, $p < .01$; IM: $t = 2.56$, $p < .05$; DFA: $t = -2.17$, $p < .05$, while higher scores on PPI Blame Externalization were related to faking good on, HPSI: $t = 3.96$, $p < .001$; IM: $t = 2.06$, $p < .05$; DFA: $t = -1.98$, $df = 198$, $p < .05$.	Yes/No
Marion et al.	2012	$N = 465$ undergraduates and 122 male criminal defendants	PPI-R, TriPM, LSRP, PCL-R	MMPI-2-RF, SIRS	Hierarchical regression analysis	Those high on psychopathy were not better at faking bad than those low in psychopathy. In contrast, individuals high on callous–unemotional–aggressive-traits were worse at avoiding detection.	No

Notes. ASPD = Antisocial Personality Disorder. Instruments to assess psychopathy/ASPD: MCMI-II = Millon Clinical Multiaxial Inventory-II. RRF = Standardized Record Review Form (for current DSM diagnoses. PCL-R = Psychopathy Checklist-Revised. PAI = Psychological Assessment Inventory (Antisocial subscale). PPI (-R) = Psychopathic Personality Inventory (Revised). SCID-II = Structured Clinical Interview for DSM-Axis II diagnoses. SRP-III = Self-Report Psychopathy Scale-III. LSRP = Levenson Self-Report Psychopathy scale. TriPM = Triarchic Psychopathy Measure. Measures to detect faking: MMPI-II = Minnesota Multiphasic Personality Inventory-II, MMPI-2-RF = Restructured Form. TOMM = Test of Memory Malingering. PAI = Psychological Assessment Inventory, PAI-NIM = Negative Impression Scale, PAI-MAL = Malingering Index, PAI-RDF = Rogers Discrimination function. SIRS = Structured Interview of Reported Symptoms. SS-R = Supernormality Scale-Revised. IM = Paulhus Deception Scales; Impression Management Scale. SIMS = Structured Inventory of Malingered Symptomatology. DPS = Dissimulation Potential Scale. HPSI = Holden Psychological Screening Inventory. BIDR = Balanced Inventory of Desirable Responding. PRF-D = Personality Research Form Desirability Scale.

Please cite this article as: Niesten, I.J.M., et al., Antisocial features and "faking bad": A critical note, *International Journal of Law and Psychiatry* (2015), http://dx.doi.org/10.1016/j.ijlp.2015.03.005