CHAPTER 1

An Introduction to Response Styles

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Complete and accurate self-disclosure remains a rarity even in the uniquely supportive context of a psychotherapeutic relationship. Even the most involved clients may intentionally conceal and distort important data about themselves. Baumann and Hill (2016) found that outpatient clients sometimes did not divulge personal matters related to sexual experiences, substance abuse, and relationship experiences. Despite imagining positive gains from such personal disclosures, many clients elected not to be fully forthcoming about deeply personal issues. Deceptions in therapy are not relegated to undisclosed personal issues. In surveying 547 former or current therapy clients, Blanchard and Farber (2016) found that many minimized their distress (53.9%) and symptom severity (38.8%). Regarding their therapists, appreciable percentages resorted to deceit in pretending to like their comments/suggestions (29.4%), overstating the effectiveness of therapy (28.5%), and pretending to do homework or other actions (25.6%). Even more concerning was the frequency of these therapy-focused deceptions, which occurred moderate or greater amounts of time. To put these findings in context, therapists also vary considerably in their numbers and types of self-disclosures (Levitt et al., 2016).

Deceptions routinely occur in personal relationships, including intimate relationships, with relatively few (27%) espousing the belief that complete honesty is needed for a successful romantic relationship (Boon, & McLeod, 2001). Interestingly, these authors found that most persons believe they are much better (Cohen's $d = 0.71$) than their partners at "successful" (undetected) deceptions. Even in intimate relationships, willingness to self-disclose is variable and multidetermined (Laurenceau, Barrett, & Rovine, 2005). Romantic partners may have implicitly understood rules about what dishonesties may be allowed in their intimate relationships (Roggensack & Sillars, 2014).

Beyond therapy and relationships, deceptions commonly occur in the workplace, including the concealments of mental disorders. Most of the 17 to 20% of employees affected by mental disorders annually elect not to disclose their conditions due to public stigma or more specific concerns about potential damage to their careers (De Lorenzo, 2013). A national survey of professionals and managers by Ellison, Russinova, MacDonald-Wilson, and Lyass (2003) has important implications for understanding individuals' disclosures and deceptions regarding mental disorders. The majority of these employees had disclosed their psychiatric conditions to their supervisors and coworkers. However, many disclosures were not entirely voluntary (e.g., they were given in response to pressure to explain health-related absences), and about one-third regretted their decisions because of negative repercussions. Moreover, the degree of self-disclosure (e.g., diagnosis, symptoms, or im-

pairment) and the timing of the disclosures were highly variable. Nondisclosing employees were typically motivated by fears of job security and concerns about stigma. What are the two key implications of the study by Ellison et al.? First, decisions about response styles (disclose or deceive) are often rational and multidetermined; this theme is explored later in the context of the adaptational model. Second, these decisions are often individualized responses to interpersonal variables (e.g., a good relationship with a coworker) or situational demands (e.g., explanation of poor performance). This model of complex, individualized decisions directly counters a popular misconception that response styles are inflexible trait-like characteristics of certain individuals. For example, malingerers are sometimes misconstrued as having an invariant response style, unmodified by circumstances and personal motivations.[1]

Decisions to deceive or disclose are part and parcel of relationships across a spectrum of social contexts. For instance, impression management plays a complex role in the workplace, especially with reference to what has been termed *concealable stigmas*. Jones and King (2014) provide a penetrating analysis of determinants for whether employees disclose, conceal, or signal (i.e., "testing the waters," p. 1471) about themselves (e.g., gender identity) and their own personal experiences (e.g., childhood traumas). Most individuals engage in a variety of response styles that reflect their personal goals in a particular setting. Certain behaviors, such as substance abuse, may be actively denied in one setting and openly expressed in another. Social desirability and impression management may prevail during the job application process but later be abandoned once hiring is completed.

Clients in an evaluative context may experience internal and external influences on their self-reporting. Within a forensic context, for example, clients may respond to the adversarial effects of litigation—sometimes referred to as the *lexogenic* effects—in which their credibility is implicitly questioned (Rogers & Payne, 2006). As observed by Rogers and Bender (2003), these same clients may also be influenced internally by their diagnosis (e.g., borderline personality disorder), identity (e.g., avoidance of stigmatization), or intentional goals (e.g., malingering). By necessity, most chapters in this volume focus on one or more response style within a single domain (e.g., mental disorders, cognitive abilities, or medical complaints).

In summary, all individuals fall short of full and accurate self-disclosure, irrespective of the social context. To be fair, mental health professionals are often not fully forthcoming with clients about their assessment and treatment methods (Bersoff, 2008). In providing informed consent, how thoroughly do most practitioners describe therapeutic modalities, which they do *not* provide? This question is not intended to be provocative; it is simply a reminder that professionals and their clients alike may not fully embrace honesty at any cost.

In the context of clinical assessments, mental health professionals may wish to consider what level of deception should be documented in their reports. One reasoned approach would be to record only *consequential* deceptions and distortions. For instance, Norton and Ryba (2010) asked coached simulators to feign incompetency on the Evaluation of Competency to Stand Trial—Revised (ECST-R; Rogers, Tillbrook, & Sewell, 2004). However, many simulators could be categorized as *double-failures*; they failed to elude the ECST-R Atypical scales (i.e., screens for possible feigning) and also failed to produce anything more than normal to mild impairment (i.e., they appeared competent) on the ECST-R Competency scales. What should be done with such inconsequential distortions? In this specific case, the answer may be characterized as straightforward. Simply as screens, the ECST-R Atypical scales cast a wide net, so that few possible feigners are missed. As a result, no comment is needed, because substantial numbers of genuine responders score above the cutoff scores.

The general issue of inconsequential deceptions should be considered carefully. Simply as a thought experiment, two extreme alternatives are presented: the taint hypothesis and the beyond-reasonable-doubt standard.

1. *Taint hypothesis:* Any evidence of nongenuine responding is likely to signal a broader but presently undetected dissimulation. Therefore, practitioners have a professional responsibility to document any observed, even if isolated, deceptions.
2. *Beyond-reasonable-doubt standard:* Invoking the stringent standard of proof in criminal trials, only conclusive evidence of a response style, such as feigning, should be reported.

Between the extremes, practitioners need to decide on a case-by-case basis how to balance the need to document sustained efforts regarding a particular response style with the sometimes very serious consequences of categorizing an examinee as a nongenuine responder.

In forensic practice, determinations of malingering are generally perceived as playing a decisive role in legal outcomes, because they fundamentally question the veracity and credibility of mental health claims. While it is likely that some genuinely disordered persons may attempt to malinger, the question remains unanswered[2] whether fact finders simply dismiss all mental health issues as unsubstantiated. Mental health professionals must decide what evidence of response styles should be routinely included in clinical and forensic reports. Guided by professional and ethical considerations, their decisions are likely to be influenced by at least two dimensions: (1) accuracy versus completeness of their conclusion, and (2) use versus misuse of clinical findings by others. For example, a forensic psychologist may conclude that the examinee's false denial of drug experimentation during his or her undergraduate years is difficult to establish and potentially prejudicial to a posttraumatic stress disorder (PTSD)-based personal injury case.

As an introduction to response styles, this chapter has the primary goal of familiarizing practitioners and researchers with general concepts associated with malingering and deception. It operationalizes response styles and outlines common misconceptions associated with malingering and other forms of dissimulation. Conceptually, it distinguishes explanatory models from detection strategies. Because research designs affect the validity of clinical findings, a basic overview is provided. Finally, this chapter outlines the content and objectives of the subsequent chapters.

FUNDAMENTALS OF RESPONSE STYLES

Basic Concepts and Definitions

Considerable progress continues to been made in the standardization of terms and operationalization of response styles. Such standardization is essential to any scientific endeavor for ensuring accuracy and replicability. This section is organized conceptually into four categories: nonspecific terms, overstated pathology, simulated adjustment, and other response styles.

Nonspecific Terms

Practitioners and researchers seek precision in the description of response styles. Why then begin the consideration of response styles with nonspecific terms? It is my hope that moving from general to specific categories will limit decisional errors in the determination of response styles. As a consultant on malingering and related response styles, I find that a very common error appears to be the *overspecification of response styles*. For instance, criminal offenders are frequently miscategorized as malingerers simply because of their manipulative behavior, which may include asking for special treatment (e.g., overuse of medical call for minor complaints) or displaying inappropriate behavior (e.g., a relatively unimpaired inmate exposing his genitals). When disabled clients express ambivalence toward clinical or medical interventions, their less-than-wholehearted attitudes are sometimes misconstrued as prima facie evidence of secondary gain (see Rogers & Payne, 2006).

The working assumption for errors in the overspecification of response styles is that practitioners approach this diagnostic classification by trying to determine which specific response style best fits the clinical data. Often, this approach results in the specification of a response style, even when the data are inconclusive, or even conflicting. As outlined in Box 1.1, a two-step approach is recommended.

This approach asks practitioners to make an explicit decision between nonspecific or general descriptions and specific response styles. Clearly, conclusions about specific response styles are generally more helpful to clinical conclusions than simply nonspecific descriptions. Therefore, nonspecific descriptions should be considered first to reduce the understandable tendency of overreaching data when conclusions about specific response styles cannot be convincingly demonstrated.

Nonspecific terms are presented in a bulleted format as an easily accessible reference. Terms are defined and often accompanied with a brief commentary:

- *Unreliability* is a very general term that raises questions about the accuracy of reported information. It makes no assumption about the individual's intent or the reasons for inaccurate data. This

BOX 1.1. Two-Step (General–Specific) Approach for Minimizing Overspecification

1. Do the clinical data support a nonspecific (e.g., "unreliable informant") description?
2. If yes, are there ample data to determine a specific response style?

term is especially useful when faced with conflicting clinical data.

- *Nondisclosure* simply describes a withholding of information (i.e., omission). Similar to unreliability, it makes no assumptions about intentionality. An individual may freely choose whether to divulge information, or alternatively, feel compelled by internal demands (e.g., command hallucinations) to withhold information.
- *Self-disclosure* refers to how much individuals reveal about themselves (Jourard, 1971). Persons are considered to have high self-disclosure when they evidence a high degree of openness. It is often considered an important construct within the context of reciprocal relationships (Hall, 2011). A lack of self-disclosure does not imply dishonesty but simply an unwillingness to share personal information.
- *Deception* is an all-encompassing term to describe any consequential attempts by individuals to distort or misrepresent their self-reporting. As operationalized, deception includes acts of deceit often accompanied by nondisclosure. Deception may be totally separate from the patient's described psychological functioning (see dissimulation).
- *Dissimulation* is a general term to describe a wide range of deliberate distortions or misrepresentations of psychological symptoms. Practitioners find this term useful, because some clinical presentations are difficult to classify and clearly do not represent malingering, defensiveness, or any specific response style.

Overstated Pathology

Important distinctions must be realized between malingering and other terms used to describe overstated pathology. For example, the determination of malingering requires the exclusion of factitious presentations (see Vitacco, Chapters 5, Yates, Mulla, Hamilton, & Feldman, Chapter 11, this volume). This subsection addresses three recommended terms: *malingering, factitious presentations,* and *feigning.* It also includes three quasi-constructs (secondary gain, overreporting, and suboptimal effort) that should be avoided in most clinical and forensic evaluations.

Recommended terms to categorize overstated pathology:

1. *Malingering* has been consistently defined by DSM nosology as "the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives" (American Psychiatric Association, 2013, p. 726). An important consideration is magnitude of the dissimulation; it must be the fabrication or *gross* exaggeration of multiple symptoms. The presence of minor exaggerations or isolated symptoms does not qualify as malingering. Its requirement of external incentives does not rule out the co-occurrence of internal motivations.

2. *Factitious presentations* are characterized by the "intentional production or feigning" of symptoms that is motivated by the desire to assume a "sick role" (APA, 2000, p. 517). However, the description of the motivation is no longer specified; DSM-5 (APA, 2013, p. 324) offers only the following: "The deceptive behavior is evident even in the absence of obvious external rewards." Thus, the diagnosis of factitious disorders does not preclude external incentives but rather requires some unspecified internal motivation. This nonexclusion of external motivations makes sense, since internal and external motivations can often co-occur (Rogers, Jackson, & Kaminski, 2004).

3. *Feigning* is the deliberate fabrication or gross exaggeration of psychological or physical symptoms, without any assumptions about its goals (Rogers & Bender, 2003, 2013). This term was introduced because standardized measures of response styles (e.g., psychological tests) have not been validated to assess an individual's specific motivations. Therefore, determinations can often be made for feigned presentations but not their underlying motivations. To underscore this point, psychological tests can be used to establish feigning but not malingering.

Several terms that are common to clinical and forensic practice lack well-defined and validated descriptions. This absence stems from either the lack of clear inclusion criteria, or the presence of multiple and conflicting definitions. Three terms to be avoided in clinical and forensic practice are summarized:

1. *Suboptimal effort* (also referred to as *incomplete* or *submaximal* effort) is sometimes misused as a proxy for malingering (Rogers & Neumann, 2003). However, this term lacks precision and may be applied to nearly any client or professional (see Rogers & Shuman, 2005). The "best" effort of any individual may be affected by a variety of internal (e.g., an Axis I disorder or fatigue) and external (e.g., client-perceived adversarial context) factors.

2. *Overreporting* simply refers to an unexpectedly high level of item endorsement, especially on multiscale inventories. It has also been called *self-unfavorable reporting.* Practitioners sometimes erroneously equate it with feigning. However, this descriptive term lacks clarity with respect to its content (i.e., socially undesirable characteristics, as well as psychopathology). Moreover, it has been used to describe both deliberate and unintentional acts (Greene, 2000).

3. *Secondary gain,* unlike the other unacceptable terms, does have clear definitions. Its inherent problem for professional practice, however, stems from the presence of conflicting meanings (Rogers & Reinhardt, 1998). From a psychodynamic perspective, secondary gain is part of an unconscious process to protect the individual that is motivated by intrapsychic needs and defenses. From a behavioral medicine perspective, illness behaviors are perpetuated by the social context (e.g., health care providers), not by the individual. From a forensic perspective, individuals deliberately use their illness to gain special attention and material gains.

Mental health professionals bear an important responsibility to use professional language that is clearly defined. Ambiguous terminology (e.g., *suboptimal effort, overreporting,* and *secondary gain*) adds unnecessary confusion to clinical and forensic assessments. Moreover, the misuse of professional language may lead to grievous errors in adjudicative settings, such as the courts.

Simulated Adjustment

Three closely related terms are used to describe specific response styles that are associated with simulated adjustment. *Defensiveness* is operationalized as the masking of psychological difficulties, whereas the other two terms apply more broadly the concealment of undesirable characteristics.

1. *Defensiveness* is defined as the polar opposite of malingering (Rogers, 1984). Specifically, this term refers to the deliberate denial or gross minimization of physical and/or psychological symptoms. Defensiveness must be distinguished from *ego defenses,* which involve intrapsychic processes that distort perceptions.

2. *Social desirability* is the pervasive tendency for certain individuals to "present themselves in the most favorable manner relative to social norms and mores" (King & Bruner, 2000, p. 80). It involves both the denial of negative characteristics and the attribution of positive qualities (Carsky, Selzer, Terkelsen, & Hurt, 1992). Not limited to psychological impairment, social desirability is a far more encompassing construct than defensiveness. Social desirability and its concomitant measurement should be carefully distinguished from defensiveness.

3. *Impression management* refers to deliberate efforts to control others' perceptions of an individual; its purposes may range from maximizing social outcomes to the portrayal of a desired identity (Leary & Kowalski, 1990). Impression management is often construed as more situationally driven than social desirability. It may often involve a specific set of circumstances, such as personnel selection (see Jackson & Harrison, Chapter 28, this volume). It can vary dramatically based on cultural expectations (Sandal et al., 2014). Although research studies often assume that impression management involves only a prosocial perspective, individuals may use this response style for a variety of purposes, such as hypercompetitiveness or "playing dumb" (Thornton, Lovley, Ryckman, & Gold, 2009).

Preferred terms for simulated adjustment are likely to vary by the professional setting. Clinically, *defensiveness* is often the more precise term to describe an individual's minimization of psychological difficulties. Importantly, this term applies to the concealment of psychological impairment rather than efforts to simulate a superior psychological adjustment (see Lanyon, 2001). At least theoretically, well-adjusted persons cannot engage in defensiveness.

In many professional contexts that include clinical settings, efforts at self-presentation are likely to involve the concepts of *social desirability* and *impression management.* For research on social interactions, impression management is most versatile in describing different roles on a continuum from prosocial to antisocial. As a cautionary note, practitioners and researchers often need to examine the specific simulation instructions, because these terms are often used interchangeably as "fake-good" (Viswesvaran & Ones, 1999).

Other Response Styles

Several additional response styles are not as well understood as malingering, defensiveness, and other approaches previously described. Four other response styles are outlined:

1. *Irrelevant responding.* This style refers to a response style in which the individual does not become psychologically engaged in the assessment process (Rogers, 1984). The given responses are not necessarily related to the content of the clinical inquiry. This process of disengagement may reflect intentional disinterest or simply carelessness. Occasionally, patterns emerge, such as the repetitive selection of the same option or an alternating response pattern (see commentary by Godinho, Kushnir, & Cunningham, 2016).

2. *Random responding.* This style is a subset of irrelevant responding based entirely on chance factors. A likely example would be the completion of the Minnesota Multiphasic Personality Inventory–2 (MMPI-2) in less than 5 minutes. In this instance, the individual has probably read only a few of its 567 items and completed the remainder without any consideration of their content.

3. *Acquiescent responding.* This style is commonly referred to as "yea-saying," which is rarely experienced in its pure form (i.e., indiscriminately agreeing). Rogers, Sewell, Drogin, and Fiduccia (2012) examined acquiescent responding among pretrial detainees. Only 3% showed even a moderate level of acquiescence, but it did not occur most of the time. As an important distinction, acquiescence is clearly distinguishable from social desirability (Gudjonsson & Young, 2011).

4. *Disacquiescent responding.* As the opposite of acquiescence, this style is characterized as "nay-saying." When used on scales focused on psychopathology, such as the MMPI-2, disacquiescence essentially eliminates elevations on feigning indicators (Burchett et al., 2016) and presumably for clinical scales. The reason appears to stem from the comparatively few inverted items (i.e., false responses signifying psychopathology).

5. *Role assumption.* Individuals may occasionally assume the role or character of another person in responding to psychological measures. For example, Kroger and Turnbell (1975) asked undergraduates to simulate the role of commissioned officers in the air force. This response style is poorly understood but potentially important.

6. *Hybrid responding.* This style describes an individual's use of more than one response style in a particular situation (Rogers, 1984). For example, clients may evidence honest responding about most facets of their lives but engage in defensiveness with respect to substance abuse. Hybrid responding underscores the importance of considering response styles as adaptable and potentially transitory.

Domains of Dissimulation

Response styles are almost never pervasive. For example, malingerers do not feign everything from viral infections to intellectual disabilities. A convenient framework for understanding and assessing response styles is the concept of domains. As I describe in detail in Chapter 2, this volume, three broad domains encompass most attempts at dissimulation: (1) feigned mental disorders, (2) feigned cognitive abilities, and (3) feigned medical complaints/symptoms. These domains are essential to assessment of response styles, because detection strategies are rarely effective across these three domains.

Common Misconceptions about Malingering

Malingering is unique among response styles in its number of associated myths and misconceptions. Rogers (1998; Rogers & Bender, 2013) outlined common fallacies about malingering held by both practitioners and the public. Common misconceptions are summarized:

- *Malingering is rare.* Some clinicians simply ignore the possibility of malingering, perhaps erroneously equating infrequency with inconsequentiality. Large-scale surveys of more than 500 forensic experts (Rogers, Duncan, & Sewell, 1994; Rogers, Salekin, Sewell, Goldstein, & Leonard, 1998) suggest that malingering is not rare either in forensic or clinical settings.[3] When the outcome of an evaluation has important consequences, malingering should be systematically evaluated. Its professional neglect is a serious omission.

- *Malingering is a static response style.* Some practitioners use—at least implicitly—the flawed logic, "Once a malingerer, always a malingerer." On the contrary, most efforts at malingering appear to be related to specific objectives in a particular context. For example, descriptive data by Walters (1988) suggest that inmates rarely feign except when hoping to achieve a highly desired goal (e.g., a single cell based on psychological reasons); among those applying for parole, many inmates understandably manifest the opposite response style (i.e., defensiveness). As a corollary to static response style, researchers have sought to establish personality characteristics linked to ma-

lingering (e.g., antisocial features; see Kucharski, Falkenbach, Egan, & Duncan, 2006).

- *Malingering is an antisocial act by an antisocial person.* This common misperception is perpetuated by DSM-5, which attempts to use the presence of antisocial personality disorder (ASPD) as a screening indicator for malingering. As I detail in Chapter 2 (this volume; see the section "Conceptual Issues"), this serious error arises from confusing *common characteristics* (e.g., criminality in criminal settings) with *discriminating characteristics,* which consistently differentiate malingerers from nonmalingerers.

- *Deception is evidence of malingering.* This fallacy is apparently based on the erroneous and illogical notion that "malingerers lie; therefore, liars malinger." Egregious cases have been observed in which the clients' marked minimization of symptoms (i.e., defensiveness) was misreported by a practitioner as evidence of malingering. More commonly, deceptions by manipulative inpatients or treatment-seeking inmates are mistakenly equated with malingering (Vitacco & Rogers, 2010).

- *Malingering is similar to the iceberg phenomenon.* Like the taint hypothesis, this misconception appears to be based on the theory that any evidence of malingering is sufficient for its classification. The erroneous assumption appears to be that any observable feigning, similar to the visible tip of an iceberg, represents a pervasive pattern of malingering.

- *Malingering precludes genuine disorders.* An implicit assumption is that malingering and genuine disorders are mutually exclusive. This common misconception can sometimes be detected by a careful record review. The typical two-step sequence begins with description of all symptoms as genuine. After the determination of malingering, all symptoms are dismissed as bogus. A more nuanced approach is to doubt, if not discount, all genuine impairment once any feigning has been observed; this negative bias has been observed with the previously noted taint hypothesis and performance validity (see Rogers, Chapter 2, this volume).

- *Syndrome-specific feigning scales measure syndrome-specific malingering.* Intuitively, mental health professionals—like all persons—would like to assume that names of psychometric scales accurately reflect their descriptions. As a straightforward example, research participants asked to feign somatic problems score high on the MMPI-2-Restructured Form (MMPI-2-RF) Fs (Infrequent Somatic Responses). Wouldn't that indicate Fs measures feigned somatic complaints? When using Fs cutoff scores, a very different picture emerges; it is much more likely to identify feigned mental disorders than feigned somatic complaints (Sharf, Rogers, Williams, & Henry, 2017). Clearly, syndrome-specific feigning scales must be able differentiate designated syndrome-specific feigning from generic feigning.

- *Malingering has stable base rates.* As reported by Rogers et al. (1998), marked variations are observed in the base rates (i.e., *SD* = 14.4%) for malingering across forensic settings. Even within the same setting, marked variations are likely to occur depending on the referral question and individual circumstances. Within the forensic context, the motivation to malinger is dramatically lower for a child custody determination than for an insanity case. Moreover, the assessment process itself also affects applicable base rates. When malingering measures are used with all referrals, the base rate is likely to be relatively low (e.g., 10–30%) even in forensic settings. However, when validated screens (e.g., the Miller Forensic Assessment of Symptoms Test [M-FAST]) are used to identify possible malingerers, the base rate is likely to exceed 50%. Finally, efforts to "correct" base rates in malingering studies often make unbuttressed assumptions, such as the stability of sensitivity.[4]

The additive effects of multiple misconceptions may fundamentally damage clinicians' abilities to evaluate malingering and render sound judgments. The effects of inadequate evaluations can be profound for misclassified malingerers and other affected parties. When untested hunches supersede science, then the professional standing of mental health specialties is called into question.

CLINICAL AND RESEARCH MODELS

Motivational Basis of Response Styles

This section introduces a clinical framework for understanding response styles, such as malingering. Because most response styles are conceptualized as deliberate efforts, individual motivations become a central concern. The motivational basis for response styles, sometimes referred to as *explanatory models,* has far-reaching implications for clinical and forensic practice. As summarized in the subsequent paragraphs, decisions to dis-

simulate, such as acting in socially desirable ways or feigning medical complaints, can be viewed in terms of their predicted utility. Often, selection of a particular response style is based on the options available and the desired outcome.

The general category of simulated adjustment is likely the most common constellation of response styles, and it encompasses defensiveness, impression management, and social desirability. For example, the minimization of suicidal ideation may serve twin goals, each with its own predicted utility: the maintenance of a positive image and the minimization of social sanctions (e.g., civil commitment). Predicted utilities may focus on others or be predominantly self-focused. As an example of the latter, a male executive may not want to acknowledge his depression, because to do so would be a personal sign of weakness. While it is possible that such defensiveness is unconscious (see, e.g., the Self-Deceptive Enhancement scale; Paulhus, 1998), data suggest that individuals can deliberately modify their "self-deceptive" responses to achieve a desired goal (see Rogers & Bender, 2003).

Within the general category of overstated pathology, conceptual and empirical work has focused primarily on malingering. Again, the prevailing model relies on expected utility. Described as the adaptational model, malingerers attempt to engage in a cost–benefit analysis in choosing to feign psychological impairment. In an analysis of malingering cases from 220 forensic experts, the cost–benefit analyses within adversarial contexts were prototypical of malingerers (Rogers et al., 1998). Two other explanatory models have been posited for malingering: pathogenic and criminological (DSM-5).

Influenced by psychodynamic thinking, the pathogenic model conceptualizes an underlying disorder as motivating the malingered presentation (Rogers, Sewell, & Goldstein, 1994). The malingerers, in an ineffectual effort to control their genuine impairment, voluntarily produce symptoms. As their condition deteriorates, they presumably become less able to control the feigned disorders. A distinctive feature of the pathogenic model is this prediction of further deterioration. While immediate recovery following litigation is uncommon (i.e., accident neurosis; see Resnick, West, and Payne (2008), research does not support this "further deterioration" hypothesis. Prototypical analysis (Rogers et al., 1998) of the pathogenic model indicated that it is not representative of most malingerers, especially those found in a forensic context.

DSM classifications (American Psychiatric Association, 1980, 1987, 1994, 2000, 2013) have adopted the criminological model to explain the primary motivation for malingering. Its underlying logic is that malingering is typically an antisocial act that is likely to be committed by antisocial persons. Whether this logic is persuasive, empirical data (Rogers, 1990) strongly questioned whether its current operationalization in DSM-5 as four indicators (i.e., forensic context, antisocial background, uncooperativeness, and discrepancies with objective findings) is useful. When DSM indices are evaluated in criminal forensic settings, they are wrong approximately four out of five times. According to Rogers and Shuman (2005), the DSM indicators should not be used even as a screen for potential malingering, because they produce an unacceptable error rate.

The fundamental problem with the criminological model is that it relies on common rather than distinguishing characteristics of malingering (see Rogers, Chapter 2, this volume). Most malingerers in criminal forensic settings have antisocial backgrounds and are participating in a forensic consultation. However, the same conclusion is true for many nonmalingering individuals with genuine disorders. Therefore, the criminological model is not useful with criminal forensic and correctional settings. It has yet to be tested with other populations, where it may be less common yet still not distinguish characteristics of malingerers.

Returning to predominant predicted-utility model, Lanyon and Cunningham (2005) provide an elegant example of how this model can apply across both domains and response styles. Simulators may attempt to maximize the predicted utility of their efforts by using both overstated pathology (e.g., malingering psychiatric symptoms and health problems) and simulated adjustment (e.g., exaggerating their personal virtues). The latter response style may serve two-related goals: (1) enhance the credibility of the disability claim (e.g., good citizens do not file false insurance reports) and (2) emphasize the magnitude of the purported loss (e.g., the avoidable suffering of an upstanding citizen).

Overview of Research Designs

Many skilled practitioners and experienced researchers benefit from a quick overview of research designs as they related to response styles. This brief section highlights key differences in designs and their relevance to clinical practice; for a more

extensive treatment of response styles, see Rogers (Chapter 30, this volume). Together with Rogers (Chapter 2, this volume), this summary should facilitate the sophisticated use of response style measures presented in subsequent chapters.

Four basic research designs are used in most studies of response styles (see Table 1.1). Two basic designs complement each other with their respective strengths: Simulation designs can provide unparalleled control over internal validity, whereas known-group comparisons are unequalled in their consideration of external validity (Rogers & Gillard, 2011). Because of the challenges in establishing the independent categorization required for known-group comparisons, two other designs have been introduced. These designs differ markedly in methodological rigor, from patently simplistic (i.e., differential prevalence design) to potentially sophisticated (partial criterion). The following paragraphs describe these four basic designs and provide salient examples of how each may be misused by clinicians.

Simulation Design

Most research on response styles relies on simulation designs that use an analogue design, which may be augmented by additional samples (see Rogers, Chapter 29, this volume). As noted in Table 1.1, this research often has excellent internal validity, using standardized methods and relying partly on an experimental design, with the random assignment of participants to different experimental conditions. In most malingering studies, for example, community participants are randomly assigned to feigning and control (honest) conditions. To address the critical issue (genuine vs. feigned disorders), the feigning group is typically compared to a nonrandom clinical sample of convenience.

The inclusion of clinical comparison groups can become more challenging for research on simulated adjustment. For example, Stein and Rogers (2008; Stein, Rogers, & Henry, Chapter 8, this volume) found that face valid screens may appear to be highly effective when administered to self-disclosing substance abusers, but understandably, fail utterly when completed by denying substance abusers. For parents in child custody disputes, the key issue in establishing clinical comparison groups is how to distinguish "normal" parents presenting with social desirability from psychologically impaired parents engaging in defensiveness.

The lack of an operationalized, clinical comparison sample represents a fundamental flaw in simulation research. This fundamental flaw is summarized in Box 1.2, which illustrates how simulation research can be confounded by the absence of relevant clinical samples. For feigning, MMPI-2 research has clearly demonstrated that patients with genuine PTSD can demonstrate extreme elevations on the F scale when responding honestly (Rogers, Sewell, Martin, & Vitacco, 2003). For denied psychopathy, offenders can easily suppress their psychopathy scores on self-report measures below the levels found in undergraduates (Kelsey, Rogers, & Robinson, 2015). In both examples, the failures to include relevant clinical comparison groups represent fundamental oversights in methodology.

Known-Groups Comparisons

This design has been increasingly implemented, spurred by rigorously validated measures for feigned mental disorders (e.g., Structured Interview of Reported Symptoms [SIRS and SIRS-2]) and a very stringent detection strategy for feigned cognitive impairment. Regarding the latter, the detection strategy of *significantly below chance performance* (SBCP; see Chapter 2) can provide compelling data on feigning. To minimize misclassifications, it is critically important to remove an indeterminant group, which in this case includes protocols from slightly below to slightly above chance performance. Performance in this indeterminate range may reflect severe impairment, disengagement (e.g., filling in responses without reference to the test items), or feigning.

As noted in Table 1.1, known-groups comparisons should strive for high classification rates (≥ 90%) in order to earn the designation of "known groups." In doing so, the removal of too-close-to-call cases is essential to minimize both measurement and classification errors (see Rogers, Chapter 2, this volume). It is also imperative to completely mask researchers administering the target measures from any data about known groups. Otherwise, the study fails because of criterion contamination.

Differential Prevalence Design

Because of challenges in establishing known-groups comparisons, this design attempts to substitute an expedient proxy, such as referral status for well-established criteria. As a common example, researchers might lump all clients with litigation

TABLE 1.1. Researching Response Styles: An Overview of Basic Designs

1. Simulation research
   a. *Description*. Analogue research randomly assigns participants to different experimental conditions. Results are typically compared to relevant clinical groups.
   b. *Internal validity*. Strong: Procedures include standardized instructions, operationalized conditions, incentives, and manipulation checks.
   c. *External validity*. Weak: Participants do not face the often grave circumstances and consequences of succeeding or failing at a particular response style.
   d. *Classification*. Effectively tested: With cross-validation, the accuracy of classification can be evaluated against the experimental condition for specific response styles.

2. Known-groups comparison
   a. *Description*. The objective is the establishment of highly accurate (≥ 90%) independent classifications of known groups in clinical or other professional settings. Initially, experts using the state-of-the-art methods were used to establish known groups. More recently, rigorous measures of response styles have been implemented with one important caveat: An indeterminant group must be excluded, so that a rigorous standard (≥ 90%) for classification can be achieved (Rogers & Gillard, 2011).
   b. *Internal validity*. Comparatively weak: Researchers have no control over experimental assignment or investment in the investigation (e.g., manipulation checks). However, standardized procedures with aprioristic decision rules can provide systematic data.
   c. *External validity:* Exceptionally strong: The participants, settings, issues and incentives are consistent real-world considerations.
   d. *Classification*. Effectively tested: With cross-validation, the accuracy of classification can be evaluated for specific response styles, often by using rigorous measures and excluding an indeterminate group.

3. Differential prevalence design
   a. *Description*. Based on assumed incentives, greater numbers of a broadly defined group (e.g., litigation) are presumed to have a specific response style when compared to a second group (e.g., nonlitigation).
   b. *Internal validity*. Weak: Researchers have no control over experimental assignment or other standardized procedures.
   c. *External validity*. Weak to moderate: Participants are often involved in real-world consultations facing important consequences. These consequences could possibly influence the decision to engage in a specific response style. However, the complete lack of any independent classification of response styles stymies the ability to test its effectiveness. When tested empirically, differential prevalence design has produced unacceptably weak effect sizes (e.g., MMPI-2 meta-analysis on feigning yielded a mean *d* of merely 0.43; Rogers, Sewell, Martin, & Vitacco, 2003).
   d. *Classification*. Untestable: Without knowing group membership, the accuracy of classification is impossible to establish.

4. Partial criterion design[a]
   a. *Description*. By using multiple scales or indicators, researchers seek to increase the likelihood of an accurate classification. The goal is to achieve a moderate level of classification, perhaps ≥ 75%. As a partial criterion, it sacrifices accuracy for more expedient research.
   b. *Internal validity*. Weak: Researchers have no control over experimental assignment or other standardized procedures.
   c. *External validity*. Moderately strong when conducted with the appropriate clinical samples. The participants, settings, issues and incentives fit real-world considerations.
   d. *Classification*. Variable: The greatest risk is false positives, because an unknown percentage of classified dissimulators (e.g., deniers of substance abuse) do not warrant this classification.

[a]The partial criterion design was previously described as a "bootstrapping comparison" (Rogers, 2008).

BOX 1.2. Examples of Flawed Simulation Designs

1. Feigning studies without clinical comparison samples: Researchers do not know whether elevations whether feigners' scores are any different from genuine responders with severe disorders.
2. Studies of psychopathy on self-report measures without a clinical comparison group of defensive psychopaths. Researchers do not know whether their confidentiality-protected responses have any practical relevance to psychopaths practicing general deception or goal-oriented defensiveness.

into a "suspected feigning" group and all nonlitigating clients into a "genuine" group. Such simplism should not be tolerated in clinical research, although it may play a marginal role in advancing theory.[5]

The fundamental and fatal weaknesses of differential prevalence design can be convincingly illustrated with respect to interpersonal violence. Research (e.g., Whiting, Simmons, Havens, Smith, & Oka, 2009) has clearly supported the intergenerational influences on violence. But, put bluntly, would any self-respecting professional use childhood victimization with violence as an expedient proxy for categorizing all childhood victims as violent persons? However, this use of an expedient proxy is still occasionally applied to feigning; that is, all litigation equals faking, and all nonlitigation equals honest responding.

Why should the differential prevalence design be categorically excluded from the classification of response styles? Even when base rates and results appear to be favorable, the fatal weakness of this design prevents its clinical use. For example, using a high estimate of malingering for forensic referrals (32%)[6] does not help. It is unlikely but possible that 0.0% of malingerers were identified (i.e., all high scores are false positives); it is also as possible but even less likely that 100% of malingerers were identified. On average, we would expect that about two-thirds (100% – 32% = 68%) of the so-called "malingerers" would be wrongly classified.

Partial Criterion

Researchers often provide an external criterion that is limited in its accuracy. Clearly, such research should not be equated with a known-groups comparison, simply because the accuracy of the classification is not known. Formerly, this design was termed "bootstrapping comparison" (using one measure to improve another measure; see Rogers, 1997).

More recently, Rogers and Bender (2013) recommended a more descriptive name: *partial criterion* design. As noted in Table 1.1, the external measure should have moderately good classification abilities, perhaps ≥ 75%. Rather than simply using the term *external criterion* for all levels of accuracy, researchers are provided with two designations: known-groups (high accuracy in group membership) and partial criterion (perhaps ≥ 75% accuracy in group membership). Because of its limited accuracy, the partial criterion design should not be used to evaluate utility estimates.

Some readers may wonder whether both terms are really needed. As a brief illustration of the issue, Tarescavage and Glassmire (2016) described their design as a "criterion groups" comparison in examining sensitivities between the SIRS and SIRS-2. However, their primary "criterion" measure consisted of a brief feigning screen, specifically, the M-FAST (Miller, 2001). Given the purpose of the M-FAST as a screen, the designation "partial criterion" design would have accurately described this study.

Determinations of response styles represent a complex, multifaceted process that includes domains, detection strategies, and measures. A critical first step in mastering assessment methods is the accurate identification of the four basic designs for dissimulation research. Knowledge of these designs allows practitioners to develop a sophisticated appreciation of empirical findings and their clinical relevance. In addition to understanding their respective strengths, mental health professionals must also be able to recognize faulty designs for clinical classification (i.e., the differential prevalence design) and flawed applications to dissimulation research.

LOOKING FORWARD

This book is organized into six major sections that provide a logical progression in the examination of malingering and other forms of deception. Although chapters vary substantially in their content and scope, a unifying theme is the integration of research, theory, and clinical practice. As will become evident, chapters vary in their success at achieving this integration. This variability accurately reflects the strengths and weaknesses in our

knowledge of response styles. For example, hundreds of studies have examined feigned mental disorders. In contrast, denial of medical complaints is a vast but largely uncharted territory. Understandably, the integration of research and clinical practice will be substantively different between well-established (e.g., feigned mental disorders) and recently considered (e.g., denial of medical complaints) areas of dissimulation research.

The overriding goal of most chapters is the provision of clear, usable information that impacts directly on professional practice and clinical research. Whenever possible, specific guidelines are provided regarding the clinical applications of particular measures, scales, and detection strategies. Some dissimulation scales are especially useful for the *ruling in* (i.e., identification and classification) specific response styles. Other scales may serve an important purpose for the *ruling out* one or more response styles. When accomplished efficiently, such measures are very useful as screens. Despite our positive focus on advances in the assessment of response styles, we also consider common missteps and inaccuracies that may lead to grievous errors in the determination of dissimulation.

Part I, Conceptual Framework, comprises the first four chapters, which operationalize response style terms and provide a conceptual basis for remaining chapters. The centerpiece of Chapter 2 is the description of detection strategies that are organized by response styles and domains. This examination of detection strategies constitutes the essential template for the remaining chapters. As evidence of its growing importance, Chapter 3 delves more closely into different neuropsychological models of feigning. Finally, Chapter 4 recognizes transnational growth in dissimulation research, examining issues of language and culture, and their effects on the assessment of response style.

Part II, Diagnostic Issues, comprises nine chapters that address a range of disorders and syndromes for which dissimulation can become a central concern. Chapter 5 provides a broad and valuable overview of specific syndromes and clinical conditions that are frequently associated with dissimulation. Chapters 6 through 13 examine specifically diagnostic categories in which response styles are often considered, especially when consultations have significant financial or forensic relevance. Feigned psychosis (Chapter 6) and denied psychopathy (Chapter 9) represent critically important issues, especially in forensic assessments. Chapters 7 and 10 address very different aspects of traumatic events that may profoundly affect neurocognitive functioning as well as produce psychological reactions, such as PTSD. Chapter 8 is essential to most professional practices, given the nearly endemic substance abuse and its widespread denial. Chapter 11 focuses on near-neighbor comparisons in distinguishing factitious presentations from the closely related construct of malingering. Finally, Chapters 12 and 13 broaden the scope of response styles to consider conversion disorders and deceptive medical presentations.

Part III, Psychometric Methods comprises five chapters. Given the breadth and sophistication of dissimulation research, multiscale inventories and feigned cognitive impairment are covered in multiple chapters. In particular, each area is subdivided into two chapters: MMPI-2 and MMPI-2-RF (Chapter 14), and the Personality Assessment Inventory and other inventories (Chapter 15). Likewise, cognitive feigning is organized into two chapters: memory and amnesia (Chapter 17), and neuropsychological measures (Chapter 18). Finally, Chapter 16 covers the controversies and clinical data concerning response styles and the use of projective methods.

Part IV, Specialized Methods, also comprises five chapters. The usefulness of physiological and other standardized measures is considered in relationship to lie detection (Chapter 19) and sexual deviation (Chapter 21). With continued controversies, Chapter 20 discusses the usefulness and limitations of clinical methods used for the recovery of early memories. Finally, structured interviews (Chapter 22) and brief measures (Chapter 23) make substantial contributions to the assessment of response styles.

In Part V, Specialized Applications, chapters are devoted to specific populations and applications. Youth (Chapter 24) and custody and family issues (Chapter 25) are discussed in relationship to response styles. Chapter 26 examines how law professionals learn and are sometimes misled with respect to malingering. Regarding deception and the workplace, Chapter 27 examines this broad and challenging topic, whereas Chapter 28 deals specifically with law enforcement.

Part VI, Summary, has an integrative goal of bringing together common and diverse findings across the considerable array of chapters. Chapter 29 summarizes the key conclusions and provides useful guidelines for conducting evaluations of response styles. Chapter 30, presents detailed guidelines—when empirically warranted—on recommended practices for researching malingering and deception. Importantly, it seeks to improve

our research methods to more effectively study the complex issues surrounding dissimulation.

NOTES

1. As an implicit example, a report of malingering during adolescence was used as "evidence" decades later to corroborate the current classification of malingering.

2. Kirkley (2008) represents a rare attempt to examine the effects of a malingering classification within the context of a disability case. She found that testimony on malingering strongly affected the damage awards but not the decision itself.

3. The two surveys of mostly forensic psychologists yielded similar data for forensic (Ms of 15.7 and 17.4%) and nonforensic (Ms of 7.2 and 7.4%) referrals. However, the percentages for nonforensic cases may be skewed higher, because forensic practitioners often consult on nonforensic issues that are still highly consequential to clients (e.g., insurance disability claims).

4. These efforts implicitly assume that sensitivity is a stable estimate, whereas positive predictive power (PPP) is not. Although PPP does vary in relationship to base rates, sensitivity also evidences nonsystematic variability).

5. More precisely, this design would be best used to discount a hypothesized relationship if predicted findings are not observed.

6. Rogers et al. (1998) used estimates from 221 highly experienced forensic experts. For forensic referrals, the 32% prevalence assumes a rate that is approximately one standard deviation *above* the Rogers et al. average (M = 17.44%, SD = 14.44%).

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