COMMENTARY

Assessment of Malingering among Servicemembers with a Focused Examination of Explanatory Models

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Umbrasas briefly mentioned established models of malingering that sought to understand the driving motivations for feigning mental disorders. He used these models as a point of departure to consider the unique experiences and enduring challenges of active and retired servicemembers. For military malingering, he identified acute distress malingering and disability malingering with the former occurring within the first five years and the latter after a military career had been established. To provide a strong foundation, this commentary revisits three explanatory models of malingering (i.e., pathogenic, criminological, and adaptational) that have been empirically tested. Of these, the adaptational model appears the best suited in the military context to explain nongenuine responding because most mandatory evaluations carry highly negative consequences, such as seriously damaging future careers in the armed forces. Most examinees would be seen as denying and defensive, however, the polar opposite of malingering. When symptoms are eventually reported, Umbrasas acknowledges the temptation to consider this atypical presentation as possible evidence of malingering. We concur with Umbrasas's conclusion that such an extrapolation would be generally unwarranted. In summary, the overriding goal of this commentary is to understand Umbrasas's thought-provoking contributions to military malingering in the larger landscape of explanatory models of malingering.

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In this issue, Umbrasas[1] provides a thought-provoking analysis of malingering among active and retired servicemembers. It emphasizes delayed symptom reporting and considers whether it constitutes a heightened likelihood or actual indicator of malingering by servicemembers. His article also features explanatory models of malingering, which attempt to determine the underlying motivation that leads to malingering at a particular time and applied to a specific context. Established explanatory models of malingering, chiefly the Rogers prototypical approach,[2,3] are mentioned but not directly addressed. Umbrasas is clearly interested in addressing new conceptualizations that are not yet empirically tested. For example, there are no references, either conceptual or empirical, for the major section on disability malingering.

We describe this article as thought-provoking because it directly challenges military practitioners to consider whether malingering among active servicemembers should be indiscriminantly amalgamated with all other forms of malingering, or whether it deserves its own consideration. Clearly, Umbrasas presented a compelling case for the latter. He describes how active military service poses singular stresses, including high operational tempo, unpredictability, and, especially, deployments. On this final point, combat and peace-keeping missions frequently entail enduring uncertainties, combat traumas, and dangerous experiences often resulting in casualties. Providing a potential framework for military malingering (e.g., adversarial circumstances, discussed later), the Umbrasas article details toxic leadership, which may

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contribute to a culture of distrust characterized by indifferent, even abusive, military leaders.

This commentary is organized into three brief sections with the first examining established explanatory models of malingering. The second section utilizes these established models in a review of Umbrasas's approach to military malingering. The commentary then succinctly addresses concerns related to delayed symptom reporting.

Explanatory Models of Malingering

Umbrasas takes a mostly fresh viewpoint in exploring two explanatory models for military malingering. First, acute distress malingering is viewed in the context of disciplinary actions as "adaptive behavior in a high-stake adversarial situation" (Ref. 1, p 188). Second, disability malingering is conceptualized as an exit strategy via medical retirement that is motivated by the "potential for monetizing increased disability" (Ref. 1, p 189). Our commentary adopts a more conservative approach than Umbrasas. It introduces long-standing explanatory models, setting the stage for examining their applicability to military malingering.

More than three decades ago, Rogers[4] first postulated three explanatory models of malingering (i.e., pathogenic, criminological, and adaptational), based largely on the scattered literature of the time, to directly address the question "why does malingering occur?" (Ref. 4, p 184). Thus, these three models considered the primary motivation for engaging in malingering as an intentional response style.[5] With some success, these models have also been applied to the denials and dissimulations of sex offenders,[6,7] as well as factitious presentations (i.e., Munchausen by proxy[8] and factitious psychological presentations[9]). As the earliest paradigm, the pathogenic model postulated that an underlying mental disorder was the primary force in the formation of malingering behavior.[2] As the impairment worsened, it predicted that voluntary fabrication of symptoms would gradually devolve into involuntary production, eventually to the point that malingering no longer occurred. In sharp contrast to the pathogenic paradigm, a highly influential criminological model was inferred directly from the DSM-III's four indicators for when malingering should be strongly suspected.[10] As observed by Rogers,[4] the common theme of the criminological model is "badness"; specifically "a bad person (APD [antisocial personality disorder]), in bad circumstances (legal difficulties) who is performing badly (uncooperative)" (Ref. 11, p 7). For the criminological model, malingering is conceptualized as a goal-driven deception by antisocial persons seeking undeserved gains, such as the avoidance of criminal or administrative sanctions.

Most recently, Rogers[5] developed the adaptational model typically applied to high-stakes settings, which were viewed or experienced by examinees as adversarial. Using a cost–benefit analyses, malingering may have been seen as the best alternative in terms of both potential outcome and likelihood of success. Depending on the individual's level of insight, a decision to malinger could be complex and may even include factors such as the would-be malingerer's estimation of an evaluator's assessment skills.[12] The adaptational model has been applied in several diverse professional contexts, including medical practice[13] and jail detainees.[14]

Across the three explanatory models, Rogers and colleagues[3] provided systematic prototypical analysis (i.e., independent expert ratings regarding the importance of specific descriptors to a particular construct) of malingering for both forensic and nonforensic malingerers. The prototypical data concerned three major domains: feigned mental disorders, feigned cognitive impairment, and feigned medical presentations. Overall, the pathogenic model consistently proved the least prototypical, failing to produce any average ratings in the moderate range (i.e., 4 to 5 on a 7-point scale). In contrast, Rogers *et al.*[3] found that cost–benefit analysis (a core component of the adaptational model) produced the highest level of prototypicality across three domains with forensic referrals. For referrals of servicemembers,[1] military evaluators may wish to query suspected malingerers about the likelihood of different outcomes should they respond candidly, malinger, or deny symptoms or impairment. Such examinations may help to reveal persons' motivations and their corresponding decisions via a cost–benefit analysis.

A central question involves how to assess a cost–benefit analysis based on interactions with examinees when malingering is suspected. It would likely be helpful to consider different response styles for cost–benefit analysis, perhaps beginning with denials, before moving on to malingering, and genuine responding. This order makes sense given the frequency of denial and defensiveness in adversarial contexts,[15] such as administratively initiated military

evaluations.[16] It also provides a balanced perspective of under-reporting and over-reporting. For under-reporting, practitioners may wish to begin with a nonjudgmental comment followed by three questions. Consider the following statement, "Some persons we evaluate do not want to share emotional concerns and deny their psychological problems." To delve into the cost–benefit analysis, questions for the examinee might include: What are your thoughts about that approach? If someone like yourself were to try it, what would be the chances of succeeding? Or, alternatively, the chances of getting caught and being in more trouble? The same process and questions could also be applied to over-reporting: "Some persons we evaluate want a good outcome for their emotional and mental problems, even if they need to report fake symptoms and greatly exaggerate their impairment." Our advice is simply to ask examinees about their motivations rather than rely solely on our own suppositions.

The three explanatory models of malingering have less prototypicality when applied to nonforensic domains (which may include many military evaluations).[8] Nonetheless, two pronounced features were mostly present in nonforensic settings: an unwillingness to accept any personal responsibility for their malingering presentations, and thus, no feelings of guilt at these concerted deceptions. In such cases, the malingering appeared to be situationally driven for persons generally lacking in long-term general life goals.[17]

Umbrasas's Military Malingering

Umbrasas[1] tackled two explanatory models of military malingering by contrasting two ends of the career spectrum. Acute distress malingering was applied to junior servicemembers with generally less than five years in the service and with a history of re-occurring disciplinary problems. In contrast, disability malingering was applied to medical retirements, which may occur at any time in military service but appeared in this article to be limited to less than 15 years (see Table 5 in Ref. 1). As a result, the models do not capture other salient reasons for military malingering (e.g., avoiding the rigors of deployment, and, especially, serious combat risks) and they do not apply to military careerists exceeding 15 years.

Aligned with the adaptational model, Umbrasas's most consistent theme involved the potentially adversarial nature of the military structure and provision of health care to servicemembers. Addressing the latter, Umbrasas acknowledged a nonbeneficent role intentionally adopted by some mental health providers who "may have idiosyncratic motives or experience organizational pressure to refrain from making certain diagnoses" (Ref. 1, p 182). Viewed from an interactional perspective, any modeling of deception by evaluators may substantially contribute to nonforthcoming communications by examinees. This point is exemplified in correctional settings where the correct diagnosis of certain disorders (e.g., impaired sleeping) are administratively disallowed because of institutional concerns regarding medication-seeking motivations.[18]

Stigmatization has continued to play a central role in creating an adversarial context for mandatory evaluations of servicemembers. In a systematic review of 111 investigations, Hom and her colleagues[19] detailed a range of stigma-related reasons for active servicemembers not to seek treatment. As a result of the military structure, substantial percentages of active-duty servicemembers expressed multiple perils of seeking mental-health treatment (each ranging from 16.2 to 49.9%), which included harming their military careers, being blamed for their disorders, and diminishing the confidence of leaders in their service capabilities. Of a more personal nature, they were also motivated by self-stigmas such as embarrassment or being seen as weak. Such external risks as damages to military careers and direct blame from leaders are compelling examples of major adversarial consequences in high-stakes contexts.[20] As previously noted, however, the motivation would likely eliminate malingering (i.e., simulated impairment) in favor of defensiveness (i.e., simulated adjustment).

Citing the Army Profession and Leadership Policy,[21] Umbrasas noted toxic leadership as a common military stressor related to inexperienced, indifferent, or abusive leaders. Under such stress, servicemembers might well be highly motivated to use malingering adaptively as the best short-term alternative to extremely adversarial circumstances. Umbrasas cited only the Army Profession and Leadership Policy on this crucial point.[21] Although the manual described destructive leadership, it did not delve into the depth and breadth of this potentially catastrophic problem, nor did it offer data about its prevalence. As a result, it is not clear to what appreciable extent, if any, poor leadership may motivate military nongenuine responding in light of severe adversarial contexts.

We categorize Umbrasas's military models differently for acute distress malingering and disability

malingering. The acute phase appears to have merged elements of the criminological and adaptational models. Regarding the former, disciplinary problems were stressed, even to the point that a punitive administrative discharge may be considered, which demonstrably underscored the cumulative effects of military misconduct. On this point, Umbrasas described acute-phase malingerers on several occasions as serving "the functional purpose of frustrating the military justice process" (Ref. 1, p 188). This choice of terminology with its antisocial intent is clearly aligned with the criminological model. At other times, however, Umbrasas favored the adaptational model of malingering at the acute phase. He described acute malingering "as a type of adaptive behavior in a high-stakes adversarial situation where servicemembers have no other viable options to exercise" (Ref. 1, p 188) with a cite to Rogers's early work.[22] With these two divergent explanatory models, one reasonable assessment approach might be to consider both, with the relative emphasis being identified on a case-by-case basis.

For disability malingering, the adaptational model undoubtedly predominated for military malingering. In the context of military retirement, the functional purpose was described as maximizing benefits by increasing the disability ratings until 100 percent disability is achieved. As insightfully noted by Umbrasas,[1] however, this cost–benefit analysis might well deter potential malingerers. He provided the following analysis if malingering were detected: "Servicemembers seeking secondary gain in this situation would conceivably jeopardize their lucrative and certain pension for an uncertain gambit related to disability" (Ref. 1, p 190). Thinking more broadly, Umbrasas elaborated on long-range goals that could be jeopardized with unsuccessful military malingering. Some career servicemembers may have further professional aspirations, because of their highly sought security clearances, to work as civilians for the Department of Defense.

The pathogenic model of malingering was not examined in Umbrasas's explanatory approach to military malingering. It is conceivable that panic reactions of combat posttraumatic stress disorder may become overwhelming when a further deployment has been ordered considering that high perceived threat has been reported among servicemembers.[23] Rather than evoking the pathogenic model of malingering, however, such severe reactions might better be conceptualized as genuine responding to extreme stressors. As a result, we concur with the article's deemphasis of the pathogenic model.

Delayed Reporting of Symptoms

Umbrasas[1] cited a 1984 literature review by Rogers[24] to conclude a "sudden onset" was a key feature "in classic models of malingering" (Ref. 1, p 184) but tempered that conclusion by affirming that "weighing a delayed report of symptoms too heavily as a sign of malingering can result in an erroneous clinical decision" (Ref. 1, p 184). This view of sudden onset as a key feature was likely overstated because this early review by Rogers found only a few case studies (the weakest type of empirical research) to support this notion. Moreover, subsequent research on the Structured Interview of Reported Symptoms[25] (SIRS) found that the suddenness of presentation (onset and resolution) was much less effective at detecting malingering than other scales and detection strategies, resulting in its being dropped from the SIRS[26] and being excluded from its second edition, the SIRS-2.[27]

Commonsensically, the equating of delayed symptom reporting with a sudden onset seemed highly problematic at best. It may be true in occasional cases when examinees improbably claimed an "overnight" appearance of symptoms of considerable severity.[28] With unhurried, open-ended questions, it would be much more likely that symptoms were present for some time but not reported until circumstances or priorities had changed. Umbrasas helpfully provided examples for genuine symptom delay, such as dysfunctional coping mechanisms, repression, and an understandable reluctance to self-disclose.[1]

Denial of both symptoms and psychological impairment should be considered from an adaptational model,[11] but logically, as evidence of defensiveness which has been viewed as the polar opposite of malingering for more than three decades.[11,29–31] As a practical result, defensiveness with its minimization of psychological difficulties has continued to be completely at odds with efforts to malinger. Rather than alleviating suffering, defensiveness would result in further exposure to trauma and other stressors.[32] Within the general category of "simulated adjustment," defensiveness refers to "the concealment of psychological impairment" (Ref. 31, p 7).

To provide a broader context, it should be observed that other authors have already tried for several decades to apply past evidence of defensiveness to

current conclusions about malingering.[16] For example, the standards for malingered neurocognitive dysfunction (MND) included denials of past psychiatric history as current criteria of feigned cognitive impairment.[33] More recently, the MND criteria[34,35] were tightened, apparently in response to scholarly criticism.[36] Based on this revision, past defensiveness can only be used as an indicator of current malingering when the denials were documented in medical records despite a "long-standing history of mental health problems" (Ref. 35, p 754). On this point, Umbrasas did not provide any specific guidance on how past defensiveness should be documented to be considered as a factor in assessing current acute distress malingering. If the current MND standards were applied to military presentations, then many cases would not be applicable because they were characterized by only brief periods of active service and limited mental health treatment. It is our view that any consideration of past defensiveness must seriously consider the MND and other relevant literature.

Delayed symptom reporting should not be utilized either as an indicator or even a screen for military malingering for three important reasons. First, sudden onset (an ineffective indicator of malingering) is very different from delayed symptom reporting. Second, defensiveness (i.e., the minimization of psychological symptoms and impairment) is the complete opposite of malingering and obviously lacks the same external motivation. Rather than avoiding trauma and stressors (e.g., potential motivation to malinger), defensiveness prolongs them (e.g., further deployments). Third, it requires inferential leaps across time (i.e., the extended past to the present) and often domains (e.g., feigned mental disorders to feigned cognitive impairment).

Concluding Thoughts

Umbrasas[1] should be credited for shining a light on largely unseen matters of malingering as applied to active and retired servicemembers. He clearly understands the nonaccepting views of mental disorders in the military, even when entirely genuine and fully consistent with the rigors of deployment, captured in the common phrase "suck it up." Moreover, when malingering is strongly suspected because of an atypical presentation, he highlights the need to remain open to the possibility of genuine explanations for such presentations. These insights alone have made this article a valuable contribution.

We have examined Umbrasas's two explanatory models of military malingering in the light of established explanatory models of malingering. The adaptational model of malingering was the strongest fit with its cost–benefit analysis when faced with adversarial circumstances. In contrast, the criminological model offered peripheral insights, whereas the pathogenic model was essentially noncontributory. Empirically, the next step would be to systematically evaluate prototypical ratings by experts in military malingering that would build from these established models as well as the insightful contributions offered here by Umbrasas.

References

1. Umbrasas KV. Explanatory models differentiating servicemember malingering from delayed symptom report. J Am Acad Psychiatry Law. 2022 Jun; 50(2):182–93
2. Rogers R, Sewell KW, Goldstein A. Explanatory models of malingering: A prototypical analysis. Law & Hum Behav. 1994; 18 (5):543–52
3. Rogers R, Salekin RT, Sewell KW, *et al*. A comparison of forensic and non-forensic malingerers: A prototypical analysis of explanatory models. Law & Hum Behav. 1998; 22(4):353–67
4. Rogers R. Models of feigned mental illness. Professional Psychology: Research and Practice. 1990; 21(3):182–8
5. Rogers R. Development of a new classificatory model of malingering. Bull Am Acad Psychiatry Law. 1990; 18(3):323–33
6. Rogers R, Dickey R. Denial and minimization among sex offenders: A review of competing models of deception. Annals of Sex Research. 1991; 4(1):49–63
7. Sewell KW, Salekin RT. Understanding and detecting dissimulation in sex offenders. In Rogers R, editor. Clinical Assessment of Malingering and Deception, Second Edition. New York: Guilford Press; 1997. p. 328–50
8. Rogers R. Diagnostic, explanatory, and detection models of Munchausen by proxy: Extrapolations from malingering and deception. Child Abuse Negl. 2004; 28(2):225–38
9. Velsor S, Rogers R. Differentiating factitious psychological presentations from malingering: Implications for forensic practice. Behav Sci & L. 2019; 37(1):1–15
10. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Third Edition. Washington, DC: American Psychiatric Association; 1980
11. Rogers R. Introduction. In Rogers R, editor. Clinical Assessment of Malingering and Deception, Second Edition. New York: Guilford Press; 1997. p. 1–19
12. Rogers R, Pan M, Drogin EY. Response styles within the forensic context: Conceptual issues and assessment methods. In DeMatteo D, Scherr K, editors. The Oxford Handbook of Psychology and Law. New York: Oxford University Press; 2021
13. LoPiccolo CJ, Goodkin K, Baldewicz TT. Current issues in the diagnosis and management of malingering. Ann Med. 1999; 31 (3):166–73
14. Pilkington AK. Selected variables as predictors of malingering among Wayne County jail inmates [unpublished doctoral dissertation]. Detroit, MI: University of Detroit Mercy; 1997
15. Merten T, Rogers R. An international perspective on feigned mental disabilities: Conceptual issues and continuing controversies. Behav Sci & L. 2017; 35(2):97–112

16. Resnick PJ, West SG, Wooley CN. The malingering of posttraumatic disorders. In Rogers R, Bender SD, editors. Clinical Assessment of Malingering and Deception, Fourth Edition. New York: Guilford Press; 2018. p. 188–211
17. Walters GD. Assessing dissimulation and denial on the MMPI in a sample of maximum security, male inmates. J Pers Assess. 1988; 52 (3):465–74
18. Vitacco MJ. Syndromes associated with deception. In Rogers R, Bender SD, editors. Clinical Assessment of Malingering and Deception, Fourth edition. New York: Guilford Press; 2018 p. 83–97
19. Hom MA, Stanley IH, Schneider ME, *et al*. A systematic review of help-seeking and mental health service utilization among military service members. Clin Psychol Rev. 2017; 53:59–78
20. Ghahramanlou-Holloway M, Koss K, Rowan A, *et al*. Retrospective and prospective examination of outpatient mental health utilization and military career impacts. Stigma and Health. 2019; 4(2):143–51
21. Department of the Army. Army Regulation 600-100: Army Profession and Leadership Policy [Internet]; 2017. Available from: https://armypubs.army.mil/epubs/DR_pubs/DR_a/pdf/web/ARN3758_AR_600-100_FINAL_WEB_.pdf. Accessed November 24, 2021
22. Rogers R. Clinical Assessment of Malingering and Deception, Second Edition. New York: Guilford Press; 1997
23. King LA, King DW, Vogt DS, *et al*. Deployment Risk and Resilience Inventory: A collection of measures for studying deployment-related experiences of military personnel and veterans. Military Psychology. 2006; 18(2):89–120
24. Rogers R. Towards an empirical model of malingering and deception. Behav Sci & L. 1984; 2(1):93–111
25. Rogers R, Bagby RM, Dickens SE. Structured Interview of Reported Symptoms (SIRS) and professional manual. Lutz, FL: Psychological Assessment Resources; 1992
26. Rogers R, Gillis JR, Dickens SE, *et al*. Standardized assessment of malingering: Validation of the Structured Interview of Reported Symptoms. Psychological Assessment: A Journal of Consulting and Clinical Psychology. 1991; 3(1):89–96
27. Rogers R, Sewell KW, Gillard ND. Structured Interview of Reported Symptoms, Second Edition (SIRS-2) and professional manual. Lutz, FL: Psychological Assessment Resources; 2010
28. Conroy MA, Kwartner PP. The definition of malingering. Applied Psychology in Criminal Justice. 2006; 2(3):29–51
29. Rogers R. Introduction. In Rogers R, editor. Clinical Assessment of Malingering and Deception. New York: Guilford Press; 1988. p. 1–9
30. Rogers R. An introduction to response styles. In Rogers R, editor. Clinical Assessment of Malingering and Deception, Third Edition. New York: Guilford Press; 2008. p. 3–13
31. Rogers R. An introduction to response styles. In Rogers R, Bender SD, editors. Clinical Assessment of Malingering and Deception, Fourth Edition. New York: Guilford Press; 2018. p. 3–17
32. Tanielian T, Jaycox L. Invisible wounds of war: Psychological and cognitive injuries, their consequences, and services to assist recovery [Internet]; 2008. Available from: https://apps.dtic.mil/sti/pdfs/ADA494242.pdf. Accessed November 26, 2021
33. Slick D, Sherman E, Iverson G. Diagnostic criteria for malingered neurocognitive dysfunction: Proposed standards for clinical practice and research. Clinical Neuropsychologist. 1999; 13(4):545–61
34. Slick DJ, Sherman EMS. Differential diagnosis of malingering. In Carone DA, Bush SS, editors. Mild Traumatic Brain Injury: Symptom Validity Assessment and Malingering. New York: Springer; 2012. p. 57–72
35. Sherman EMS, Slick DJ, Iverson GL. Multidimensional malingering criteria for neuropsychological assessment: A 20-year update of the malingered neuropsychological dysfunction criteria. Arch Clin Neuropsychol. 2020; 35(6):735–64
36. Bender SD, Frederick R. Neuropsychological models of feigned cognitive deficits. In Rogers R, Bender SD, editors. Clinical Assessment of Malingering and Deception, Fourth Edition. New York: Guilford Press; 2018. p. 42–60