Explanatory Models Differentiating Servicemember Malingering from Delayed Symptom Report

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The military mental health clinic is a medico-legal setting that provides servicemembers with treatment, administrative, and forensic services. Clinicians must be vigilant for malingering in this setting but flexible enough to recognize genuine symptoms. This task is often complicated by servicemembers' delayed report of symptoms. Three explanatory models are proposed that distinguish delayed report from malingering: genuine delayed report of symptoms, acute distress malingering, and disability malingering. These explanatory models improve clinician objectivity and offer a systematic understanding of these different presentations.

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The United States military provides servicemembers access to a comprehensive mental health system. Servicemembers utilize this system to receive treatment and to satisfy administrative and occupational requirements, such as when consolidating disability ratings or receiving fitness-for-duty evaluations. Servicemembers presenting for these varied reasons are often served in the same clinics and by the same pool of mental health providers. Thus, the military mental health setting operates as both a clinical and a medico-legal setting. This arrangement creates a situation where providers must remain vigilant for malingering while being flexible enough to recognize genuine treatment needs.

The diagnostic task is complicated by the fact that servicemembers may not express symptoms in a typical fashion. Servicemembers may delay seeking mental health services for a number of reasons, only to present for services after considerable time has passed from the start of their symptoms. Other servicemembers may use mental health services for secondary gain, such as when seeking an increase in disability ratings or when attempting to frustrate disciplinary action. Furthermore, mental health providers may have idiosyncratic motives or experience organizational pressure to refrain from making certain diagnoses.[1–4] This complex decision-making milieu requires considerable clinical skill to avoid facile conclusions about servicemember presentations. Because clinical skill alone, however, is often insufficient for distinguishing complex symptom presentations from dissimulation, methodologies that assist in clinical judgment have great importance.[5]

Prototype methods, such as explanatory models, are helpful in clarifying ill-defined clinical presentations.[6–8] No explanatory models currently exist for classifying servicemembers who present to mental health providers for genuine treatment and those who present for secondary gain. General models of malingering, although informative, do not sufficiently capture the uniqueness of the military population. Certain presentations common among servicemembers, such as delayed treatment seeking, may be classified as a sign of malingering according to classic models of dissimulation. Yet studies of servicemembers returning from Iraq and Afghanistan show that the majority of servicemembers who screen positive

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for mental disorders express no interest in seeking treatment for their symptoms at the time of the screening.[9,10] These servicemembers may be viewed with suspicion if they seek treatment after time has passed from their deployment. Clinicians may wonder "why now" regarding the timing of their presentation. These clinicians must use their own experience and clinical judgment to determine who may be seeking secondary gain and who genuinely wants treatment. This approach is fraught with danger, however, because individual providers may not have the training and experience to classify complex symptom presentations appropriately.[11] The combination of increased potential for secondary gain and atypical, but genuine, symptom presentations among servicemembers necessitates models to assist with the objective classification of servicemembers presenting for services.

The models proposed in this article are based on extrapolations from current models of dissimulation, as well as literature on stress, psychiatric disorder, and clinical observation of servicemember treatment-seeking behavior. Three explanatory models are proposed: genuine delayed report of symptoms, acute distress malingering, and disability malingering. These models may serve as prototypes for understanding servicemember presentations and aid in the accurate classification of servicemember behavior.

Diagnostic Vigilance and Flexibility

Atypical clinical presentations among servicemembers naturally raise suspicion for malingering because psychiatric disorders portend significant secondary gain in the military.[12–16] A service-connected diagnosis of posttraumatic stress disorder (PTSD), for example, is a lucrative incentive for malingering.[16–17] A 100 percent disability rating from the Veteran's Administration (VA) for PTSD results in $2,400 per month plus medical benefits.[16] A 50 percent disability rating for PTSD results in $1,700 per month plus medical benefits.[17] Servicemembers may estimate that establishing a PTSD diagnosis while in the military increases their chances of disability once out of the military and this may be related to exaggeration or fabrication of symptoms. Indeed, Matto *et al.*[18] suggests that those with combat-related PTSD report increasingly worsening symptoms until they reach 100 percent disability, at which time treatment utilization drops off substantially.

Establishing whether a servicemember qualifies for disability because of a mental health diagnosis is a lengthy process that is beyond the scope of first-line treatment providers who work with servicemembers on a day-to-day basis. First-line treatment providers, however, can ratify diagnoses that may lead to increased disability benefits by assigning the diagnosis at each visit. The cumulative documentation makes the diagnosis difficult to dispute should the servicemember begin formal disability evaluations inside or outside of the military.

The VA has its own system independent of the military for determining disability that relies partially on clinical records from the military. The VA often contracts the disability evaluation to an assessment service outside of the agency to control for the ethics problem of dual government agencies conducting disability evaluations for the same person. The VA utilizes an "at least as likely as not" standard for disability, which is a low burden of proof to establish disability. Disability is also based on functioning rather than a stressor's severity. A diagnosis of PTSD obtained when on active duty and a report of ineffective coping may thus encounter a low burden of proof in a nonadversarial context, possibly increasing the chances of being granted disability.

Studies that examine the dissimulation of PTSD indicate that the disorder is easy to feign. Burges and McMillan[19] reported that subjects without a sophisticated understanding of PTSD can reliably identify PTSD symptoms. In their study, 136 college students were given a vignette of a traumatic event and were asked to identify the symptoms that led to the person's PTSD in the story. Participants were excluded if they had a degree in psychology, were trained in medicine, or if they or anyone they knew were diagnosed with PTSD. In another study, Lees-Haley and Dunn[20] examined the degree to which 97 undergraduates in an Introduction to Psychology course were able to respond to symptom questionnaires in the pathological direction. They found that 98.9 percent of their participants identified enough symptoms to qualify for criterion B of the disorder, and 95.7 percent identified enough symptoms to qualify for criterion D.[20] Other disorders, such as traumatic brain injury, were also effectively simulated. For example, 63.3 percent of participants correctly identified a substantial number of brain injury symptoms.[20] In addition, studies of servicemembers in the medical retirement process for brain injury

indicate that 35 to 54 percent fail performance validity tests (PVT) during neuropsychological evaluation.[21] A setting that hosts compensable mental health disorders, easy-to-feign symptoms, and a high volume of failed validity tests may increase provider vigilance for symptom dissimulation.

A potential marker for symptom dissimulation is delayed reporting. Delayed reporting may be mistaken for a sudden onset of symptoms, which is a key feature in classic models of malingering.[22] According to clinical decision-making models, a sudden onset of symptoms plus environmental incentives meets the threshold for suspecting malingering.[23] Clear incentives for malingering exist in the military; yet, weighing a delayed report of symptoms too heavily as a sign of malingering can result in an erroneous clinical decision. A comprehensive review of 111 studies pertaining to military mental health found that servicemembers refrain from treatment for many reasons.[24] Servicemembers view treatment seeking as possibly leading to blame, differential treatment, loss of leader confidence, and loss of advancement opportunities.[24] In addition to specific career concerns, a general stigma against mental health treatment still exists in the military that interferes with timely access to treatment.[24] Although many reasons explain why servicemembers delay treatment, a servicemember who reports years of symptomology during a first visit may nevertheless be viewed with suspicion for the duration of treatment.[25]

A common example of delayed report of genuine symptoms is the servicemember who seeks mental health care for years of untreated symptoms during the transition out of the military. Although clinicians may reasonably wonder why the report takes place at that time, the nature of the presentation should not be seen as *prima facie* evidence of malingering. This is because servicemembers commonly seek health care during their transition out of the military. Servicemembers who leave the military through a medical retirement are even encouraged by health care providers, lawyers, and disability specialists to report their symptoms openly to ensure they are documented for retirement purposes. The routine nature of documentation seeking in military health care is common to other areas of health care. Servicemembers, for example, routinely seek documentation and treatment of orthopedic problems. This serves as a bridge for continued treatment when the servicemember separates from the military.[26,27] In a military mental health setting, however, this type of help seeking may be met with provider vigilance and seen as an attempt to make unjustified compensation claims. The lack of explanatory models pertaining to servicemember treatment seeking in a military mental health context may result in facile conclusions about the merits of the symptom report. For servicemembers seeking mental health services near the end of their time in the military, failure to identify accurately symptoms incurred on active duty may result in a worsening clinical condition, increased barriers to receiving treatment when out of the military, and possibly misclassification of their condition as malingering.

Servicemembers with a substantial amount of time in the military (e.g., more than 15 years) are more likely to have had military experiences sufficient to produce psychiatric symptoms. These servicemembers will have worked under an elevated baseline of stress and will have increased potential for exposure to traumatic events and other contributors to psychopathologic responses. Table 1 lists stressors inherent to the military lifestyle that are commonly experienced by servicemembers throughout their time in the military. Table 2 lists effects of stress on the central nervous system that may be induced by military stress.

Stress is a psychobiological response to perceived threatening stimuli. The military stress listed in the tables below do not occur in isolation; rather, military stress represents a constant feature of the military lifestyle. Certain stressors may represent more stress at certain periods of time, as, for example, when deployment stress predominates over other forms of stress. Many of these stressors are present at the same time and often for prolonged periods. Military stress is sufficient to stimulate stress-related physiology, pathophysiology, and attendant clinical manifestations. The potential for more significant stress-related symptom constellations also exists as when servicemembers have chronic PTSD or major depression that has been masked or tolerated by the servicemembers' environments.

Servicemember Explanatory Models

Genuine Delayed Symptom Report

Servicemembers may genuinely seek treatment years after the beginning of their symptoms. Servicemembers may find that they have reached a

Table 1 Common Military Stressors

Military Stress	Description
High Operational Tempo (OPTEMPO)[28,29]	Excessive work Short notice changes to plans Continuous operations Day-to-day demands Long-range work requirements Perception of work overload Separation from family Decreased communication with family
Unpredictability[28,30–37]	Rapid mobilization Phone or internet unavailability Stand-by status Reception by the public
Deployments[10,38–41]	Combat missions Humanitarian missions Peace-keeping missions Austere environments Servicemember casualties Human remains Death of enemy combatants Civilian noncombatant casualties Life threatening experiences
Training[42–46]	Novelty Inability to anticipate requirements Time management pressure Sleep deprivation Inexperience with roles and responsibilities Continuous stress Physical exertion
Toxic Leadership[47]	Inexperienced managers Late decisions Frenzied, micromanaged climate Indifferent leaders Abusive leaders Culture of distrust

stage in their careers where they are no longer concerned about the perceived impact of mental health treatment on their careers. Servicemembers may also genuinely want to seek treatment after their time on active duty and go to the mental health clinic seeking a bridge to treatment in the civilian world. Service members, furthermore, may seek treatment because their coping resources are exhausted. Service members whose coping resources are exhausted may see mental health treatment as having less of a career impact than not seeking treatment.

The servicemember nearing regular retirement, or who has substantial time in the military (e.g., more than 15 years), is a prototype of the genuine delayed treatment seeker. The symptoms exhibited by individuals in this group may have a clear onset and connection to the military. Servicemembers may report chronic stress or extreme stress that began in the military and can be localized to a specific event or period of time. This might be expressed as a kinetic deployment, working under high-pressure situations, or working for toxic leadership. A number of traumatic events or possible precipitants to distress may be noted in their clinical histories. They may have come close to seeking treatment at various times but ultimately chose not to. The servicemembers' reports of symptomatology may show evidence of temporary reprieves from distress or impairment that vary with their duty assignments or life circumstances. The servicemembers' chronic symptoms are likely apparent during clinical interview, as is a clear history of attempts to cope with the symptoms.

Although servicemembers exhibit a broad spectrum of coping abilities, servicemembers experiencing distress are known to use dysfunctional coping mechanisms.[60–63] The dysfunctional coping mechanisms commonly employed by servicemembers who experience increased mental health complaints are denial, avoidance, and distraction. These are considered ineffective methods of coping because they do not move individuals toward resolution of their problems.

Servicemembers who rely on these coping mechanisms are likely aware of their distress. They may have denied that they have a real problem despite mounting evidence suggesting otherwise. This may be evidenced by recurring problems with family or chronic problems in the workplace. Substance use, such as alcohol, may have been used to facilitate avoidance and distraction. This may have left the servicemember appearing to have a primary alcohol use disorder. The servicemember's pattern of alcohol consumption may reflect a pattern of isolation rather than socialization.

Clinical history may reveal that these servicemembers experienced ongoing distress or impairment in their day-to-day functioning. Emotional dysregulation may have been apparent but tolerated or masked by the environment. Servicemembers, depending on rank or position, may have been able to leave work when distress levels became unbearable. Similarly, symptoms such as irritability and aggression may have been masked by the nature of their work. For example, servicemembers who were drill instructors may have been able to express aggression in a manner consistent with the nature of the work and the environment. Likewise, servicemembers in leadership positions may have been permitted more latitude in

Table 2 Stress Effects on Central Nervous System

Central Nervous System	Effects	Clinical Manifestation
Amygdala[47–50]	Hypersensitivity to stimuli coupling with dACC	Hypervigilance Enhanced responses to future stress Poorly regulated fear response
HPA Axis[51–54]	Overexposure to glucocorticoids Altered gene expression Loss of negative feedback mechanism Sensitization to stimuli Habituation to cortisol or overproduction of cortisol	Depression Panic Obsessive-compulsive symptoms Fatigue
Hippocampus[55]	Atrophy of Ammon's Horn Reduced excitability Inhibited neurogenesis Decreased hippocampal volume	Decreased declarative, contextual, and spatial memory
Allostasis[51,52,56,57–59]	Allostatic overload Inability to maintain homeostasis Wear and tear of physiological systems Neuronal remodeling	New stress baseline Inefficient management of stress response Obesity Cognitive impairment

dACC = dorsal anterior cingulate cortex
HPA = hypothalamic-pituitary-adrenal

their expression of anger. When feeling too activated, servicemembers in these roles could close the doors to their offices or simply excuse themselves from the workplace. Others may have accommodated, and ultimately enabled, the servicemember's dysfunction.

Even considering symptom masking, the irritability, aggression, and other symptoms may be seen as excessive for the environment. Peers may have remarked to these servicemembers that their behavior is excessive. Other drill instructors may have told the servicemember to tone down the behavior in question. Peers in leadership positions may question the necessity of the servicemember's style of discipline. Servicemembers who are part of close-knit teams may have experienced an intervention by their teammates. For servicemembers with higher rank, such as Majors and Lieutenant Colonels, others may note their lack of presence as they throw themselves into their work as a distraction from their symptoms. Higher-ranking servicemembers may refer to themselves as functional alcoholics as their lives become oriented around avoidance behavior, such as excessive work and alcohol.

Although inefficient, coping mechanisms such as denial and avoidance may persist for years. Chronic reliance on inefficient coping mechanisms is commonly seen in clinical practice. For instance, chronic alcoholics may go through their whole lives denying they have an alcohol problem despite signs of deterioration and eventual debilitation. Vietnam veterans are known to have avoided awareness of their symptoms and the need for treatment for decades.[64] Clinical interviews with servicemembers who genuinely delayed reporting symptoms will reveal a good understanding of the course and progression of their problems. They possess a rich phenomenology of their symptoms but may not readily want to discuss it. When they are comfortable talking, they have a "where do I begin" quality that reflects the depth and intricate interrelationships between their symptoms and their lives.

Servicemembers may also use more developmentally mature ways of dealing with their negative emotional experiences. The defense mechanism of repression is one example. Repression is considered a common way of dealing with distress.[65] Repression results in the disjunction of cognition and affect related to an experience so that the cognitive representation is not present in the person's awareness, though the emotion related to the event is perceptible to varying degrees.[66] Repression is common throughout the military. A common injunction expressed throughout the military when confronted with distress, discomfort, or misfortune is "suck it up."[67] This injunction normalizes repression in that servicemembers should just take in whatever distress occurs and not think about it. With repression, "if you cannot bear it, forget it."[65] Servicemembers may therefore become accustomed to repressing disconcerting phenomena. Repressing a large volume of intolerable affect leaves servicemembers vulnerable to compromise formations

manifested in, among other things, psychiatric symptoms.[68] For example, the military environment stimulates drive derivatives that cannot be expressed and therefore favors repression. It would be self-destructive if a servicemember were to meet aggression with aggression when dealing with others of higher rank; such drive derivatives must be repressed, only to influence psychological functioning in other ways.[68] With time, a person's repression of events can become more accessible and leave the person with previously buried problems to deal with.[65]

Servicemembers who have spent significant time in the military will likely have experienced loss, whether of a fellow servicemember they knew or even of an aspect of their own identity. This loss requires mourning. Although loss and mourning are universal experiences, military service may result in complications of mourning that have clinical implications. For instance, traumatic and sudden loss are known to complicate the mourning process, and these losses are more likely to occur during combat deployments. Servicemembers who experience traumatic losses with no time to address them may become perennial mourners who cannot complete the mourning process. They ultimately cannot assimilate the object representation of the lost object into their self-representation.[69] Servicemembers who cannot complete the mourning process may have inner dialogues with the lost person or they may possess linking objects, or externalized introjects, and keep them close to their person. For instance, servicemembers may carry the picture of the lost person in their phone and routinely refer back to the picture years after the loss, or they may wear bracelets with the names of close servicemembers who were killed in combat. Servicemembers with problems related to mourning may eventually seek mental health services for feelings of chronic depression.

Working under chronically elevated stressful conditions may also foster atypical symptom presentations that do not follow the expected course and progression of certain disorders. These stress symptoms are the result of allostatic load and the underlying dysregulation of the neurohormonal system. Consistent with the literature pertaining to stress effects on the central nervous system, the chronically stressful nature of the military may have a neurobehavioral effect on servicemembers. Chronic stress dysregulates functioning of the amygdala, hippocampus, and cortisol responsivity. Servicemembers exposed to chronic or extreme stress may respond with habituation of cortisol production, while others may respond with cortisol hyperproduction.[70] This pattern of response to persistent stress may contribute to the emergence of psychopathology. For instance, overproduction of cortisol may be associated with melancholic depression, panic, obsessive-compulsive disorder, and sleep disturbance, while underproduction of cortisol may be associated with atypical depression and fatigue.[59] A persistent hyperarousal symptomology is also seen with amygdala dysregulation, contributing to a sense of impending doom, generalized anxiety, and depression.[71] A key factor in psychopathologies induced by persistent stress is that the homeostatic function is dysregulated, resulting in an inability to return to an appropriate set point.

Other stress-related manifestations of psychological decline may be noticed. The hippocampus plays an important role in cognitive functions, most notably memory. Persistent stress causes dysfunction of the hippocampus that might appear as memory deficits. Hyperarousal symptoms may also affect concentration and attention. Servicemembers may thus present with symptoms that resemble attention deficit disorder but have no history of ADHD. Patients may attempt to understand these cognitive problems as a function of a history of undetected ADHD or a past mild traumatic brain injury.

Chronic stress may thus exhibit wear and tear on servicemember psychological functioning that approximates common disorders. For instance, a servicemember at age 35 may present for the first time with symptoms of attention deficits and memory problems, or a servicemember may present with significant hyperarousal symptoms but no persistent re-experiencing. Similarly, an individual with hyperarousal symptoms may evidence increasing irritability and anger that may be perceived as a manifestation of a personality disorder. The late presentation of these symptoms may draw provider suspicion because it can be seen as an attempt at seeking disability. Specifically, the late presentation of hyperarousal symptoms may appear to be an attempt to claim PTSD. Cognitive complaints may appear to be an attempt to claim traumatic brain injury. These symptoms, however, are typical of stress-related pathology. Their late presentation may reflect the course and progression of an underlying stress response dysregulation rather than an attempt at feigning or malingering.[72]

In addition to the effects of chronic stress, servicemembers nearing the end of their service face a life

crisis that is imbued with a great deal of psychological significance, a loss of identity. The age ranges from which people typically join the military is the upper end of Erikson's stage of identity versus confusion.[73] People at this stage seek bolstering of their self-esteem, the settling on an occupational identity, and the identification with a larger group. Their search for, and consolidation of, an identity is a common reason for joining the military.[74] When servicemembers leave the military after many years of service, they often experience a shock to their identity.[75] The servicemembers furthermore will not take their identity as an active duty servicemember with them when they leave the military; rather, they become veterans. The self-esteem bolstering achievements, status, and kinship are left in the military. Servicemembers therefore face identity confusion when they leave the military. This may be an anxiety-provoking process for servicemembers. Oftentimes servicemembers are aware of the impending threat to their identity. The anxiety related to identity confusion may amplify other stresses in the servicemember's life (e.g., financial, relational, or familial) and constitute a reason for seeking mental health treatment.

The identity crisis faced by servicemembers at this stage may occur in tandem with another life cycle crisis, that of intimacy versus isolation.[73] Servicemembers with significant time in the military may be married or in a relationship, yet their capacity for intimacy may be a source of distress. The military demands more than a "nine-to-five" mentality. This often leads to the military's needs being constantly in the room with the couple. The servicemember's intimacy with a spouse is often negatively affected by this addition to their relationship, resulting in a lack of depth in the relationship. The reality of increased intimacy with one's spouse may be a source of distress for the servicemember. Servicemembers may have less insight about this process and only begin to notice an increase in relational discord as the couple begins to focus more exclusively on their future without the military.

In summary, clinicians evaluating and treating servicemembers who report atypical or delayed symptoms should remain open to the possibilities that servicemembers had symptoms that they chose to deal with on their own or were willing to forego treatment because of career interests. Seeking treatment nearing the end of military service may be a reflection of the servicemember's belief that such treatment will no longer harm career interests, or it may be intended to serve as a preliminary means to treatment once out of the military. There is also the possibility that servicemembers are simply unable to cope sufficiently with their symptoms and seeking treatment is seen as less damaging than not seeking treatment. A clinical interview is sufficient to make this determination. Table 3 list characteristics of genuine delayed report of symptoms.

Table 3 Characteristics of Genuine Delayed Symptom Report

Significant time in military (> 15 years)
Exposure to chronic or traumatic stress
History of ongoing coping attempt
Awareness of distress
History of deliberate avoidance of treatment
Hyperarousal symptoms
Cognitive complaints
Anxiety due to identity
Anxiety due to increased intimacy
Mourning processes
Peer and family concerns
"Where do I begin?" quality

Acute Distress Malingering

Acute distress malingering may occur among servicemembers facing disciplinary problems and the possibility of an expeditious discharge. This type of malingering can be seen as a type of adaptive behavior in a high-stakes adversarial situation where servicemembers have no other viable options to exercise.[23] Servicemembers displaying this pattern of behavior are more likely to be seen during a mental health evaluation pursuant to a punitive administrative separation. Servicemembers with this behavior set may also preemptively make a mental health appointment before being sent for the evaluation.

Acute distress malingering serves the functional purpose of frustrating the military justice process. The servicemembers most likely to be involved in acute distress malingering are junior enlisted or junior noncommissioned officers. Servicemembers in these categories generally do not have substantial time in the military, perhaps five years or less. These servicemembers have a concept that the military cannot precipitously separate servicemembers who have mental health conditions, such as PTSD. This concept may come from public discourse on how the military erred by punitively discharging servicemembers who had service-connected problems and has since taken great measures to prevent future occurrences of erroneous separations.[76] This concept may

also be informed by knowledge of military policy that mandates cases of PTSD and other major mental disorders be routed to the medical retirement process. Thus, servicemembers facing punitive administrative discharge may frustrate the process by having their cases routed for medical retirement review concurrent with, or in lieu of, the disciplinary proceeding. Alternatively, servicemembers may attempt to mitigate punishment by appearing to be part of a protected group; that is, one with a major mental disorder such as PTSD.

Servicemembers in this category may be unsophisticated malingerers. They may excessively acquiesce to a review of symptoms. Basic symptom screens may be elevated across all measures. They may report stereotyped symptoms without context or examples. For instance, they may say that they have to sit with their back to the wall in restaurants in an attempt to simulate PTSD symptoms, but there may be a poverty of content with their symptom experience. They cannot elaborate on a Criterion A event for PTSD. The onset of their symptoms is unclear. The servicemembers will not be able to describe a history of coping with their symptoms. Although they may appear anxious and restless, their symptoms of anxiety are caused by their circumstance at the time and not a history of psychological disorder. They may amplify their current state of anxiety and conflate their current level of distress with their psychosocial history. This is an attempt to give the appearance that they have experienced distress for a long time. These servicemembers guard against providing a chronology of symptoms, coping history, and level of functioning.

Servicemembers in this group may, concurrent with their report of symptoms, attempt to evoke sympathy from clinicians. They may appear opportunistic in their description of occupational and social problems. They may have a tendency to include all experiences they can think of. Their descriptions of events may be seemingly normal occurrences colored by their affect at the time of report. For instance, they may report how they believe they are being singled out, but they do not describe specific details of unfair treatment. These servicemembers may cite a list of perceived hardships during the evaluation to evoke sympathy and possibly trigger a medical retirement review.

This group of servicemembers can be classified as malingering according to the description of malingering proposed by the American Psychiatric Association.[77] According to this description, malingering occurs when a person intentionally proffers symptoms that are grossly exaggerated or false for the purposes of secondary gain. Servicemembers in this category present to mental health as a medico-legal client. The secondary gain is avoidance or mitigation of punishment. Symptoms may appear fabricated, or real symptoms such as anxiety may be amplified and misattributed to a chronic problem. Table 4 lists characteristics of acute distress malingering.

Table 4 Characteristics of Acute Distress Malingering

< 5 years in military
Disciplinary problems
Acquiescence to symptom review
Decreased content associated with symptoms
Normal occurrences presented as evidence of disorder
Acute anxiety
Overly inclusive quality of reported symptoms

Disability Malingering

Servicemembers undergoing medical retirement are a heterogeneous group. Servicemembers may be medically retired for a range of conditions, such as amputated extremities, night blindness, and a range of mental health disorders including PTSD. Servicemembers undergoing medical retirement may be combat veterans with many years of service or new recruits whose disqualifying medical conditions were discovered during initial entry training.

Medical retirement from the military is a lengthy process that involves a number of evaluations and opinions from different professionals. Depending on the servicemember's condition, its connection to the military, and responses to treatment, the servicemember may be recommended for retirement with disability. PTSD is a specific mental health condition that yields a high amount of disability value. In addition to monthly payments and medical benefits from the federal government, many states offer a range of additional benefits, such as tax breaks and educational benefits, for veterans considered 100 percent disabled.

Servicemembers malingering a mental health disorder may not be in the medical retirement process for mental health problems. These servicemembers may become aware of the potential for monetizing increased disability as they interact with health care providers, disability specialists, lawyers, and other servicemembers in the medical retirement process. Their first contact with mental health providers may be during the medical retirement process. These

Table 5 Disability Malingering

< 15 years in military
Medical retirement
First visit to mental health during medical retirement
Stereotyped symptoms
Decreased content associated with symptoms
Emphasis on a single event as the cause of symptoms

servicemembers may not have a history of mental health treatment. Servicemembers in this group may appear well versed in medical terminology and may even use medical terminology in their descriptions of their problems. Although not sophisticated malingerers, these servicemembers may have knowledge of psychiatric symptoms and even psychometric tests used during evaluations.

The functional purpose of disability malingering is to increase disability ratings. A high disability rating disorder, such as PTSD, may therefore be the target of malingering. Servicemembers in this group may or may not have experiences consistent with Criterion A for PTSD. If an event is reported as traumatic, there may be an absent or unpersuasive peritraumatic experience associated with the event. Servicemembers in this group may present a single experience that they amplify as the source of their problems. They may appear to have a story they want to tell. It may be the single experience that they want to bring to the mental health provider's attention. They attribute a singular experience to the cause of their illness. Their symptom presentation may be temporally unrelated to their reported trauma. Their office visit may also appear perfunctory, as though they are exercising an option rather than seeking alleviation of distress. They may report stereotyped symptoms with an inability to express a phenomenology related to the symptoms. These servicemembers may exhibit discordance between their report and their presentation. They may not have the persistent negative affective tone often observed with PTSD and other mental disorders. Validity indicators on psychometric tests may be significantly elevated. Table 5 lists characteristics of disability malingering.

Discussion

Servicemembers' complex and varied mental health presentations, and the medico-legal nature of the military mental health clinic, necessitate clear distinctions between genuine symptoms and malingering. The aim of the models presented here is to reduce erroneous classification of servicemembers who delay their report of genuine symptoms, and to help providers understand two types of malingering that occur in a military context. The seriousness of the malingering classification requires attribution to be made cautiously and with respect for the individual and for the profession.[78]

These explanatory models offer a first step in understanding servicemembers' complex motivations for delaying treatment or for malingering. The major features of the prototypes described in this article may be especially helpful to clinicians who have little experience working with symptom dissimulation and servicemembers. The clinical implications are important as these models may improve the accuracy of clinical judgments. Correct classification of servicemember presentations will lead to more accurate documentation that may follow the servicemember to treatment providers, such as in the VA, once out of the military. Misunderstanding of a servicemember's delayed report of symptoms as fabricated or exaggerated may lead to true psychopathology being omitted from the servicemember's record, thus hampering care or even rightful disability compensation.

The record for servicemembers with significant time in the military who delay report of symptoms does not favor secondary gain. These servicemembers are eligible for a regular military retirement. This retirement is lucrative and certain. Servicemembers seeking secondary gain in this situation would conceivably jeopardize their lucrative and certain pension for an uncertain gambit related to disability. If malingerers are considered rational actors who adapt to their situation to maximize their net gain, then servicemembers eligible for regular retirement would not malinger because they stand to benefit more from their regular retirement. By malingering, these servicemembers may also unnecessarily complicate their postmilitary lives. Servicemembers who earned a regular retirement from the military are careerists who may have continued professional aspirations after the military. They may hold security clearances and intend to work within the sphere of the military industry as a civilian employee. Malingered psychopathology would potentially interfere with their postmilitary aspirations.

A clinical interview will reveal whether servicemembers' delayed reports of symptoms are genuine. Servicemembers with genuine symptoms can articulate

their experiences with chronic and traumatic stress. They will likely have a career-centric explanation for not seeking treatment sooner. Their histories may entail voluminous information.

The malingering groups, by contrast, are driven by adaptation to the environment; that is, avoiding punishment or increasing compensation. The clinical interview will reveal a dearth of psychologically salient material. Unlike the delayed report group that has overlapping experiences of stress and trauma, the disability malingering group will provide a single event that unfolds like a story. The acute distress malingering group will provide a number of experiences that bear no resemblance to trauma. The malingering groups will be eager to talk but not have much to say. They will excessively acquiesce to the clinician's review of symptoms. The observation that both types of malingerers report stereotyped symptoms, but with poverty of content, is consistent with the literature on feigning. The lack of a context, chronology, and history of coping helps distinguish servicemembers who are malingering from those with genuine symptoms.

Practitioners can benefit from clarifying whether external incentives exist, such as when referrals are received within the context of disability or disciplinary matters. First-time referrals who are in the medical retirement process may require clarification of their reason for the visit and goals for treatment. Practitioners should be aware that those who are malingering may simply want a diagnosis entered in their records. Practitioners will also benefit from attunement to whether a single cause is being offered by the patient for the presenting problem and whether the history of symptomology is congruent with the presumed etiology. For patients referred within a disciplinary context, practitioners may note profound elevation of symptoms that is incongruent with the patient's history and level of functioning.

Future research should empirically test these explanatory models. Research might also add to these models by case study material of servicemembers who malinger. Future research might propose models of servicemembers whose misconduct was considered the product of their mental health condition and distinguish those servicemembers from servicemembers who malinger.

Limitations

These explanatory models are not absolute. Servicemembers may have clinical presentations that do not conform to these formulations. For example, a servicemember with significant time in the military may malinger psychopathology. Servicemembers may also present to mental health during a punitive separation from the military and have a significant mental health history that was never disclosed. This is also true for servicemembers in the medical retirement process. These possibilities require the flexible application of the models. Another limitation is that these models have not been empirically tested.

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