Perceptions of Malingering or Factitious Disorder by Army Behavioral Health Providers

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Abstract

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Introduction:

The topic of malingering or factitious disorder in the military population generates strong opposing viewpoints within the military medical community. As a result, the estimated frequency of malingering in this population ranges widely from “rare” to a “majority of claimants seeking disability compensation.” Even though we do not know the specific rate of malingering in the United States Military, there is evidence that malingering is significantly underdiagnosed in this population. The reason for this potential under-diagnosis is unknown.

Objective:

This study explored this topic by examining the perceptions of military behavior health providers on malingering within the military healthcare community. Greater understanding potential factors contributing to the thoughts and diagnosis of malingering can potentially

prevent provider burnout, identify potential need for additional training, and provide improved medical care to service members diagnosed with malingering or factitious disorder.

Methods:

We surveyed all military health providers who see Active Duty Soldiers. From December 2015 to Jan 2016 emails were sent to the each installation behavioral health representative who forwarded a link of the survey to all individual behavioral health providers at their installation. These surveys collected demographics including the type of behavioral health professional, active duty status, training level, location, type of practice, and history of deployment. They also included the ProQOL burnout scale and measured the perceptions of malingering and factitious disorder.

Results:

502 subjects responded with a response rate of 42%. On average each behavioral health provider estimates seeing 8.34 cases of malingering or factitious disorder each year but diagnoses only 0.68 cases. Additional analysis reveals that each provider provider does not diagnose 7.698 cases of conditions involving intentional patient deceptionin the last year (95% CI 6.32-9.08, p-value <0.001). Multivariate analysis shows that factors associated with increased diagnosis of malingering/factitious disorder include inpatient setting (β 4.411, 95% CI 0.019-8.802), p-value 0.049), and increased burnout scores on the ProQOL instrument (β 0.406, 0.203-0.610, p-value <0.001). No differences were seen between different types of behavioral health professional, active duty status, deployment history, training level, location, or type of practice (other than inpatient). Lack of evidence/difficulty proving, policy and pressure from above, being unsure of the diagnosis, and fears of a negative impact on the provider made up 2/3 of the qualitative open-ended responses that explain the diagnostic

gap but only the perception of policy and pressure from above (β 8.659, 95% CI (4.77-12.55), p-value <0.001) and politics (β 8.975, 95% CI (2.54-15.41), p-value 0.006) were significantly associated with this outcome.

Conclusions:

Our findings support the current literature that the diagnosis of malingering and factitious disorder is minimized by Army behavioral health providers. This study estimates that up to 14,500 Soldiers are not accurately diagnosed with malingering or factitious disorder every year in the Army medical system. Inpatient setting and increased burnout are all associated with greater rates of perception and diagnosis. Perceptions of politics and policy/pressure from above were factors that were significantly associated with a diagnostic gap. As this is the first study that has examined this finding in the United States Military, we strongly suggest additional studies to examine the effect that this diagnostic gap can have on the system, on other patients, the iatrogenic impact on the Soldiers themselves, and overall military readiness.

Disclosure

MAJ Schnellbacher has no financial conflict that relates with the research or its findings.

The opinions expressed herein are those of the author and do not represent an official position of the U.S. Army or Department of Defense.

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Chapter 1: Abstract

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Chapter 2: General Background

Background

The topic of malingering or factitious disorder in the military population can generate strong opposing viewpoints in the military medical community. One reason for this polarization is that malingering by its very nature is almost impossible to directly study because of the potential deception of the participants. This is one reason why the estimated frequency of malingering in this population ranges widely from "rare"[1] to the "majority of claimants seeking disability compensation."[2,3]

Even though we do not know the specific rate of malingering in the United States military, there is evidence that malingering is significantly underdiagnosed in the this population. Clinicians only diagnosed malingering in only more than a thousand cases of the 28 million health care visits to the military medical system from 2006 to 2011 (half of these were diagnosed by behavioral health clinics).[4] This rate is much less than even the most conservative 1% malingering rate thought to be present in the civilian population.[5]

Whether malingering is under or overdiagnosed is unknown, due to a lack of studies on the validity of the diagnosis and the absence of good quality descriptive incidence studies in well defined populations. The reason for this potential under-diagnosis is unknown. Providers might set a very high threshold when diagnosing malingering to minimize the impacts of erroneous diagnosis. The diagnosis of malingering can be administratively and politically burdensome and might be avoided by strained military behavioral health providers. Additionally, malingering carries significant legal implications in the military and providers might not want to subject their patients to this additional stressor. Finally, malingering is a diagnosis that is likely to result in challenges or dissolution of the therapeutic relationship. Since malingering may co-exist with other mental disorders, loss of the therapeutic alliance can have a profound negative effect on clinical care of the individual being accused of (or diagnosed) with this label.

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[1] OTSG/MEDCOM Policy Memo 12-035, Policy guidance on the Assessmet and Treatment of Post-Traumatic Stress Disorder (PTSD), 10 April 2012

[2] Frueh BC, Grubaugh AL, Elhai JD, Buckley TC: US Department of Veterans Affairs disability policies for posttraumatic stress disorder: administrative trends and implications for treatment, rehabilitation, and research. American Journal of Public Health 2007; 97(12): 2143-5

[3] Frueh, BC, McNally, RJ. Why are Iraq and Afghanistan War veterans seeking PTSD disability compensation at unprecedented rates? Journal of Anxiety Disorders 27 (2013: 520-526.

[4] Lander, R. Gregory, Williams, Lisa Banks. Relevance and characteristics of Military Malingering. Military Medicine, 2013; Vol 178, 1:50-54

[5] Benjamin James Sadock, Virginia Alcott Sadock, Pedro Ruis (editors). Kaplan & Sadock's comprehensive textbook of psychiatry 9th edition. Philiedelphia PA.. Lippincott Williams & Wilson, 2009

With that being said, the underdiagnosis of malingering can potentially cause dramatic individual and systemic consequences. A missed diagnosis expose the service member to potentially harmful and unneeded treatments,[6] lead to iatrogenic impairment, or distract from an underlying psychiatric diagnosis.[7] Furthermore, not diagnosing identified malingering can also impact other patients by taxing limited medical resources,[7] and cause service members with "real" pathology to disassociate from medical care.[7] Finally, non-diagnosis can lead to other systemic issues including dramatically increased long term economic costs[8], negatively impact systemic research on PTSD treatments,[9] and decreased military readiness.

Problem Statement

No studies have examined the perceptions of military behavioral health providers about malingering or factitious disorder. Furthermore training on diagnosing and managing these conditions are not available for military providers.

Purpose of the Study & Significance

Instead of investigating potential incidence rates of malingering, this study will only focus on military behavioral health provider's perceptions of malingering. By better understanding trends of provider perceptions, the army can provide appropriate training and appreciate potential factors related to malingering diagnosis. Furthermore, better understanding of the perceived rates of malingering within the military community could help understand the potential factors contributing to the thoughts of malingering, determine if additional training would be beneficial to prevent provider burn out, and provide improved medical care to both service members and their families.

Specific Aims/Research Questions

The primary objective is to better understand behavioral health provider's perspectives regarding malingering/factitious disorder including the percentage of behavioral health providers that feel that patients are malingering.

Specific Research Questions:
-What percentage of military behavioral health providers feel that patients are malingering?
-What is the relationship between provider characteristics (level of expertise, burnout, etc.) and malingering?
-What perceptions prevent a provider from diagnosing this condition when they believe it is present?

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[6] Schnellbacher, S and Sullivan, R. *Forensic and Ethical Issues in Military Behavioral Health: Chapter 15: Malingering and Factitious Disorders.* 2015. Borden Books

[7] Electronic Code of Federal Regulations. Title 38, Chapter I, Part 4. Current as of May 7, 2015. http://www.ecfr.gov/cgi-bin/text-idx?rgn=div5&node=38:1.0.1.1.5#se38.1.4_11

[8] Taylor S, Frueh BC, Asmundson GJ. Detection and management of malingering in people presenting for treatment of posttraumatic stress disorder: methods, obstacles, and recommendations. J Anxiety Disord. 2007;21(1):22-41. Epub 2006 May

[9] Malone RD, Lange CL. A clinical approach to the malingering patient. J Am Acad Psychoanal Dyn Psychiatry. 2007 Spring;35(1):13-21. PubMed PMID: 17480185.

-Do military behavioral health providers desire additional training on malingering and factitious disorder?

Hypothesis

-Providers are not diagnosing malingering or factitious disorder as frequently as it is encountered.
-Providers with greater experience will be more likely to diagnose malingering or factitious disorder.
-Providers with burnout will also have a higher association with increased diagnosis of malingering

Chapter 3: Definition of Key Terms & Literature review

Definition of Key Terms

Behavioral Health Provider-In the military, mental health providers are called behavioral health providers to try and minimize the stigma of seeking services. Essentially, these are providers that focus on psychological and emotional well-being. Typically these providers are psychiatrists, psychologists, social workers, or psychiatric nurse practitioners, but there are small populations of other kinds of professions that also treat these conditions.

Burnout-Work related fatigue that impairs a provider's ability to deliver effective care. This can often manifest itself with feelings of exhaustion, decreased work satisfaction and purpose, and perceptions of decreased impact. It is also associated with decreased ability to empathize and experiencing potential secondary trauma from patients.

Deployment-The movement of Soldiers to a location where they can engage in effective military operations. From a civilian perspective this is synonymous with "going to war." It is important to remember that Soldiers have different roles, can be deployed in different locations, and at different times. As a result, no two deployments are the same.

Factitious Disorder-Factitious disorder describes the intentional fabrication of medical symptoms for reasons other than external gain.

Malingering-Malingering is the intentional fabrication of medical symptoms for the purpose of external gain.

Psychologic Testing-Standardized measures that assess mental abilities or attributes. Normally psychologic testing is performed by psychologists.

Veteran-Individual that has served in the armed forces.

Literature Review

The diagnosis of malingering or factitious disorder in the military population generates strong opposing viewpoints within the military community. The purpose of this study is to assess the perceptions of malingering within this population by military behavioral health providers. If the perceptions of malingering are high this may potentially impact the quality of care given. With this information we will be able to understand the potential factors contributing to the thoughts of malingering, determine if additional training would be beneficial to prevent provider burn out, and provide improved medical care to service members diagnosed with malingering or factitious disorder.

Malingering can occur to gain external financial benefit, to avoid work, or to avoid legal consequences. The incidence of malingering is increased in patients with legal issues (20%)[10,11] and disability (between 30 and 40%)[12,13] in the civilian population.

Malingering can happen in a variety of military settings, from faking illness to get out of work to lying about psychiatric symptoms as a result of a legal consequence. Because of the strong correlation between the military medical system and the VA disability system, malingering a disease for a disability rating is a common association of the words "military malingering." Because of a lack of physical symptoms, the mental health diagnosis of PTSD is a disease is frequently involved in this discussion.

The topic of malingering or factitious disorder in the military or veteran population can generate strong opposing viewpoints in the military medical community. One reason for this polarization is that malingering by its very nature is almost impossible to directly study because of the potential deception of the participants. This is one reason why the estimated frequency of malingering in this population ranges widely from "rare"[14] to the "majority of claimants seeking disability compensation."[15,16]

Even though we do not know the specific rate of malingering in the United States military, there is evidence that malingering is significantly underdiagnosed in the military population. One study found that only 5,311 Soldiers were diagnosed with malingering between the years of 1998 and 2012.[17] Another study determined that clinicians diagnosed malingering in only more than a thousand cases of the 28 million health care visits to the military medical system from 2006 to 2011 (half of these were diagnosed by behavioral

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[10] Sadock BJ, Sadock VA, Ruis P, Kaplan HI, eds. *Kaplan & Sadock's Comprehensive Textbook of Psychiatry*. 9th ed. Philadelphia, PA: Lippincott Williams & Wilkins; 2009: 2480.
[11] Rogers R, Shuman DW. *Conducting Insanity Evaluations*. 2nd ed. New York, NY: Guilford, 2000.
[12] Bass C, Halligan PW. Illness related deception: social or psychiatric problem? *J R Soc Med*. 2007;100:81–84.
[13] Mittenberg W, Patton C, Canyock EM, Condit DC. Base rates of malingering and symptom exaggeration. *J Clin Exp Neuorpsychol*. 2002;24:1094–1102.
[14] OTSG/MEDCOM Policy Memo 12-035, Policy guidance on the Assessment and Treatment of Post-Traumatic Stress Disorder (PTSD), 10 April 2012
[15] Frueh BC, Grubaugh AL, Elhai JD, Buckley TC: US Department of Veterans Affairs disability policies for posttraumatic stress disorder: administrative trends and implications for treatment, rehabilitation, and research. American Journal of Public Health 2007; 97(12): 2143-5
[16] Frueh, BC, McNally, RJ. Why are Iraq and Afghanistan War veterans seeking PTSD disability compensation at unprecedented rates? Journal of Anxiety Disorders 27 (2013: 520-526.
[17] Armed Forces Health Surveillance Center (AFHSC). Malingering and factitious disorders and illnesses, active component, U.S. Armed Forces, 1998-2012.

health clinics).[18] These rates are much less than even the most conservative 1% malingering rate thought to be present in the civilian population.[19] In comparison in Iancu, et al surveyed physicians in the Israel Defense Forces in 2003 and found that those physicians believed that every 4th Israeli Soldier was malingering.[20] Similarly, Rogers and Shuman's *Conducting Insanity Evaluations* documents this malingering rate could be 5 times higher in the military than civilian populations.[2]

The concept of malingering in the military of veteran population is not new. The term itself first appears in a French dictionary in the 1800s and was defined as a "soldier who feigns sickness or induces or protracts an illness to avoid his duty."[1] In 1983, a case report series described veterans reporting PTSD symptoms and military experiences that were found to be inaccurate.[21] In 1996, Mossman reported the perspective that veterans have clear financial incentives to "be ill, disabled, and unemployed." He classified the VA disability system as "counter-therapeutic" and believed it encouraged veteran's perceptions of sickness, diminished personal responsibility, and damaged treatment relationships.[22] A separate study this same year showed that there was more abnormality and disability in mild head trauma patients who had financial incentives even though they had less severe injuries.[23]

In 2006, Resnick (one the most respected forensic psychiatrists in the country) published an article about malingered PTSD. His recommendation was for the psychiatrist to make the diagnosis of PTSD from multiple data sources including a comprehensive evaluation, psychiatric testing, and external data sources. He also reported the most common motivation for malingered PTSD is financial gain. He also believed that the "psychiatrist bears considerable responsibility to assist society in differentiating true PTSD from malingering" because it not only involves financial fraud, but also wastes limited mental health resources, leading to negative consequences for the entire mental health system.[24]

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[18] Lander, R. Gregory, Williams, Lisa Banks. Revalence and characteristics of Military Malingering. Military Medicine, 2013; Vol 178, 1:50-54

[19] Benjamin James Sadock, Virginia Alcott Sadock, Pedro Ruis (editors). Kaplan & Sadock's comprehensive textbook of psychiatry 9th edition. Philielphia PA.. Lippincott Williams & Wilcons, 2009

[20] Lulian Lancu, et al. Attitudes towards malingering: A study among general practitioners and mental Health officers in the military. Med Law (2003) 22:373-389

[21] Sparr L, Pankratz LD. Factitious posttraumatic stress disorder. Am J Psychiatry. 1983 Aug;140(8):1016-9. PMID: 6869583

[22] Mossman D. Veterans affairs disability compensation: a case study in countertherapeutic jurisprudence. Bull Am Acad Psychiatry Law. 1996;24(1):27-44. PMID: 8891320

[23] Binder LM, Rohling ML. Money matters: a meta-analytic review of the effects of financial incentives on recovery after closed-head injury. Am J Psychiatry. 1996 Jan;153(1):7-10. PMID: 8540596

[24] Knoll JL, Resnick PJ. The detection of malingered post-traumatic stress disorder. Psychiatr Clin North Am. 2006 Sep;29(3):629-47. PMID: 16904503

The same year Hall agreed that physicians need to distinguish legitimate PTSD symptoms from faked or embellished presentations. He also recommended the use of interview techniques, psychiatric testing, and sources of collateral information.[25]

Psychologic testing is the administration of standardized tests or questionnaires in order to gain more information about the individual's psychopathology or characteristics. In order to be valid, these tests are first given to thousands of individuals who have, and do not have specific psychological conditions. These responses are analyzed and can be applied to other people who later take the test. The MMPI-2, SIMS, and SIRS test are very common psychologic tests that are administered in the setting of potential malingering or factitious disorder.[26] A review of the literature reveals a strong cohort of professionals who report that neuropsychological testing is effective in identifying malingering. In 2008, Freeman tested veterans presenting for treatment at a VA residential PTSD treatment program. 53% of these individuals showed clear symptom exaggeration by SIRS criteria and the SIRS scores "correlated significantly with reported PTSD symptom severity."[17] Another study published in 2012, individuals in the midst of a military disability evaluation (54%) were significantly more likely to fail a psychologic test (the Word Memory Test) compared to individuals who had clinical symptoms but were not in a medical board (35%).[27] In 2010, Tolin reported an additional validity study for the use of the MMPI-2 test in the detection of PTSD evaluations in veteran populations, even with different rates of symptom over-exaggeration.[28]

One of the researchers who has dramatically increased attention on this topic, is Dr. Frueh, a well published psychologist in the VA. In 1996, he noted that compensation seeking among veterans was associated with significantly increased over-reporting on psychologic testing without an increased frequency of PTSD Diagnosis.[29] The next year he again looked at compensation seeking status in veterans seeking PTSD treatment. He once again found that "compensation-seeking veterans endorsed dramatically higher levels of psychopathology

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[25] Hall RC. Malingering of PTSD: forensic and diagnostic considerations, characteristics of malingerers and clinical presentations. Gen Hosp Psychiatry. 2006 Nov-Dec;28(6):525-35. PMID: 17088169

[26] Freeman T1, Powell M, Kimbrell T. Measuring symptom exaggeration in veterans with chronic posttraumatic stress disorder. Psychiatry Res. 2008 Apr 15;158(3):374-80. doi: 10.1016/j.psychres.2007.04.002. Epub 2008 Feb 21. PMID: 18294699

[27] Armistead-Jehle P, Buican B. Evaluation context and Symptom Validity Test performances in a U.S. Military sample. Arch Clin Neuropsychol. 2012 Dec;27(8):828-39. doi: 10.1093/arclin/acs086. Epub 2012 Oct 9. PMID: 23047953

[28] Tolin DF, Steenkamp MM, Marx BP, Litz BT. Detecting symptom exaggeration in combat veterans using the MMPI-2 symptom validity scales: a mixed group validation. Psychol Assess. 2010 Dec;22(4):729-36. doi:

[29] Frueh BC, Smith DW, Barker SE. Compensation seeking status and psychometric assessment of combat veterans seeking treatment for PTSD. J Trauma Stress. 1996 Jul;9(3):427-39. PMID: 8827647

across measures and produced sharply elevated "fake-bad" validity indices."[30] In 1999, he analyzed a cohort but separated out "extreme exaggerators" (using the MMPI-2) were much more likely to be associated with compensation seeking.[31] In 2003, Frueh retrospectively analyzed 320 adult male combat veterans who were consecutively evaluated between 1995 to 1999. In this analysis, he compared their clinical evaluations, their psychologic testing, and compensation status. Like before, Frueh concluded that the "VA disability compensation incentives influence the way some veterans report their symptoms when they are being evaluated for PTSD."[32] In 2004, he analyzed the association between compensation seeking and health care utilization but did not find a significant association between these variables.[33] In 2007, Frueh published a frank article questioning the disability policies of the veterans administration given signs of potential exploitation and the potential iatrogenic cause of delayed PTSD recovery.[6] Specifically, he noted that from 1999 to 2004, the number of veterans receiving VA disability payments increased 79.5% compared to other disability increase of 12.2% and that the total payments for PTSD rose 148.8% while other disability categories only rose 41.7%. He also reported a pattern where Veterans self-reported PTSD symptoms worsen over time until they reach 100% disability, at which point there is an 82% decline of mental health services (without a change in use of VA medical health services). He also states that only around 50% of veterans who apply for PTSD disability claims are actually seeking psychiatric treatment at the time of their disability application submission. Approximately 25% of files disability application files were found lacking compelling evidence of combat exposure. Frueh estimated the possible potential fraud costs of malingered PTSD to be up to 19.8 billion a year. Most importantly Frueh emphasized that continued disability inhibits remission and relapse of this disease process.[6] The number of veterans with disability for PTSD has increased almost fivefold in the last 13 years to approximately 650,000 individuals.[34]

Another different cohort of individuals publishing on this topic have an opposite viewpoint and have sparred with Frueh in the literature. These individuals feel that the surge in PTSD disability ratings are secondary to a decade of conflict and combat exposure. In contrast to Frueh, they report that individuals who received disability were more likely to productively engage in therapy and do not feel that the VA disability policies caused any iatrogenic prolongation of PTSD duration. Finally, they believe that the overreporting seen in

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[30] Frueh BC, Gold PB, de Arellano MA. Symptom overreporting in combat veterans evaluated for PTSD: differentiation on the basis of compensation seeking status. J Pers Assess. 1997 Apr;68(2):369-84. PMID: 9107014

[31] Gold PB, Frueh BC. Compensation-seeking and extreme exaggeration of psychopathology among combat veterans evaluated for posttraumatic stress disorder. J Nerv Ment Dis. 1999 Nov;187(11):680-4.

[32] Frueh BC, Elhai JD, Gold PB, Monnier J, Magruder KM, Keane TM, Arana GW. Disability compensation seeking among veterans evaluated for posttraumatic stress disorder. Psychiatr Serv. 2003 Jan;54(1):84-91.

[33] Grubaugh AL, Elhai JD, Monnier J, Frueh BC. Service utilization among compensation-seeking veterans. Psychiatr Q. 2004 Winter;75(4):333-41.

[34] Zarembo A. As disability awards grow, so do concerns with veracity of PTSD. LA Times. August 3, 2014.

psychiatric testing by many veterans might have another cause other than frank malingering. The most publicized response to Frueh, came from Marx et al. in 2008 and included additional and sometimes contradictory information to Frueh's findings.[35] In this response, the authors point out that the mental health utilization increases in veterans who receive disability for PTSD, medical and mental health utilization increase after filing a disability claim,[36] engagement in services is sustained after claim determination,[26] treatment outcomes are the same between outpatients who receive disability compensation and those that do not receive compensation, and that a detailed review only showed 0.6% of service connected PTSD cases were potentially fraudulent. They also feel that the indicators of significant overreporting seen in psychiatric testing in veterans[37] has not been "validated in relation to assessment of PTSD outside of a forensic setting" and that "symptom exaggeration may be as much a sign of severe distress as psychiatric comorbidity as malingering.[25]

Additionally, numerous studies have described the false positives, false negatives, and appropriate uses of psychologic testing. In 1995, Viglione documented the use of the MMPI to detect suspected malingering within a group of 121 enlisted men. In this test false positives and false negatives were present.[38] In 1997, Trueblood published a study to evaluate neuropsychologists ability to detect malingering vs. true disease. While the study did show that neuropsychogists can detect malingering in "obvious cases" there was a 10% false negative and 8% false positive rate. In 2011, Willis presented a case series of three individual's who failed neuropsychologic evaluation effort measures as a result of neuropsychiatric impairment instead of intention.[39] Recently, in 2014, Gass normed the FBS scale of the MMPI-2 in over 300 veteran patients and found that its use is more limited in the veteran setting because of some of the norms in the sample population. Later that year, Marcopulos, published results of another performance validity test, that despite faring well overall, also had false positives and negatives. These articles are a good representative of the numerous publications in the literature in that they emphasize that any test has false positives, false negatives, and appropriate times for use.[40]

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[35] Marx BP, Miller MW, Sloan DM, Litz BT, Kaloupek DG, Keane TM. Military-related PTSD, current disability policies, and malingering. Am J Public Health. 2008 May;98(5):773-4; author reply 774-5. doi: 10.2105/AJPH.2007.133223. Epub 2008 Apr 1.

[36] Spoont MR1, Sayer NA, Nelson DB, Nugent S. Does filing a post-traumatic stress disorder disability claim promote mental health care participation among veterans? Mil Med. 2007 Jun;172(6):572-5.

[37] Freeman T1, Powell M, Kimbrell T. Measuring symptom exaggeration in veterans with chronic posttraumatic stress disorder. Psychiatry Res. 2008 Apr 15;158(3):374-80. doi: 10.1016/j.psychres.2007.04.002. Epub 2008 Feb 21. PMID: 18294699

[38] Viglione DJ Jr, Fals-Stewart W, Moxham E. Maximizing internal and external validity in MMPI malingering research: a study of a military population. J Pers Assess. 1995 Dec;65(3):502-13. PMID: 16367712

[39] Willis PF, Farrer TJ, Bigler ED. Are effort measures sensitive to cognitive impairment? Mil Med. 2011 Dec;176(12):1426-31. PMID: 22338360

[40] Marcopulos BA, Caillouet BA, Bailey CM, Tussey C, Kent JA, Frederick R. Clinical decision making in response to performance validity test failure in a psychiatric setting. Clin

Another source of information that is needed to truly understand the issue of malingering in the military are the policies that affect its diagnosis and the potential of malingered PTSD. In 1996, the VA changed its disability computations to say that if a mental disorder develops in service as a result of a highly stressful event, the rating agency will assign a rating of at least 50% and will schedule an examination within a 6 month period following a veteran's discharge to determine if a change in evaluation is needed.[41] Because evaluations rarely decrease a Soldier's disability rating, this means that all diagnosis of PTSD are at least given a 50% rating instead of the standard disability system based off of functional impairment (In 2012, only 0.33% of veterans saw a reduction in their ratings for PTSD.[25]). The VA made more changes in 2010 when it required that the VA would not need any evidence of a traumatic experience. In addition, the VA allowed PTSD if the trauma claimed by a veteran was just fear of hostile activity in a combat zone.[42] After the changes, the number of new PTSD claims rose more than 60%.[25]

The United States Army has also significantly changed its PTSD policy. In 2012, the army released policy guidance on the assessment and treatment of PTSD. In it, the army addressed the topic of malingered PTSD by stating "These conditions [including malingering] are often perceived as judgmental or pejorative, can result in [Uniform Code of Military Justice action], and/or can influence how other medical care providers approach or treat patients when they see one of these diagnoses in the problem list. Patient-centered care within a culture of trust requires that care providers focus on patients' primary concerns, and these diagnosis, when inappropriately used, can damage therapeutic rapport and interfere with successful care." They then instructed clinicians to "not diagnose malingering unless there is substantial and definitive evidence from collateral or objective sources that there are false or grossly exaggerated symptoms that are consciously produced for external incentives. Poor effort testing on psychological/neuropsychological tests does not equate to malingering, which requires proof of intent, per OTSG/MEDCOM Policy 11-076. In addition, this diagnosis requires the signatures of two credentialed care providers, including a supervisor, Department Chief, or Deputy Commander for Clinical Services." During the USAMEDCOM Behavioral Health Training Day, on 12 June 2012, providers were told "We must approach with a Soldier-centered focus that provides Soldiers the benefit of the doubt." They also said that "We cannot assume there is purposeful secondary gain or malingering. Army BH professionals diagnose and treat and should not be in an adversarial role with the patient in

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Neuropsychol. 2014;28(4):633-52. doi: 10.1080/13854046.2014.896416. Epub 2014 Mar 31. PMID: 24678658

[41] Electronic Code of Federal Regulations. Title 38, Chapter I, Part 4. Current as of May 7, 2015. http://www.ecfr.gov/cgi-bin/text-idx?rgn=div5&node=38:1.0.1.1.5#se38.1.4_11

[42] DEPARTMENT OF VETERANS AFFAIRS. Stressor Determinations for Posttraumatic Stress Disorder
Federal Register Volume 75, Number 133 (Tuesday, July 13, 2010): 38 CFR Part 3. RIN 2900-AN32. Accessed May 10, 2015. http://www.gpo.gov/fdsys/pkg/FR-2010-07-13/html/2010-16885.htm

terms of disability process." Finally, they did say that "behavioral health providers on the whole do support the patient/Soldier on face valu
e and advocate in every way for them, however we lose credibility with both medical personnel and line units when we fail to properly investigate and obtain collateral information."[43] Because providers frequently do not have access to collateral or objective sources, and are not given time or resources to pursue diligent investigations, this policy significantly disuades providers from pursuing a malingering diagnosis.

These policies have created tremendous debate among military and veteran behavioral health providers. One provider wrote in a time article "Automatically giving a 50% disability rating for PTSD no matter how mild or severe the symptoms are… Creates a major incentive to get that diagnosis-and keep it… For a private, that works out to about $1000 a month… Some argue that this automatic disability is not helpful. It creates an incentive for all military members to get the diagnosis of PTSD, rather than depression or anxiety. It also creates a disincentive to getting better… Does one diagnosis deserve more than schizophrenia, bipolar disorder, or depression?"[44] The same article included another provider's response "Why wouldn't we expect to see epidemic rates of PTSD in a force at war for 10 years with unprecedented deployment and combat exposure. Why should we be so carefully scrutinizing the diagnosis of mental illness after deployment, when we continue to happily overlook obvious mental illness as we screen for deployability?"[34] Other providers have specifically described the VA disability system being full of "collusive lying" and described significant institutional barriers to making accurate assessments. In his paper he specifically referenced an email from a VA chief psychologist instructing staff members not to diagnose malingering or "make any comments that appear to question patient's reports of trauma.[25,45]

In short, a detailed review of military and veteran malingering indicates that there are two separate perspectives represented in the literature. One group indicates that this condition exists and is a concern. This group seems to be motivated by concerns of secondary impacts of military malingering-primarily a potential interference in treatment and prolonged disability and the depletion of resources from an already taxed health care system. Another group does not feel that military malingering happens is not a large concern. They attribute the increase in PTSD disability claims to 10 years of war and do not feel that overreporting or poor effort during psychiatric testing is necessarily associated with malingering in the military population.

Instead of investigating potential rates of military malingering, this study will only focus on military behavioral health provider's perceptions of malingering. By better understanding

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[43] USAMEDCOM. Exerpts form USAMEDCOM Behavioral Health Training Day. 12 June 2012

[44] Ritchie EC. The Unintended Consequences of the Current PTSD Diagnosis. Time Nov. 27, 2012. Accessed May 10, 2015. http://nation.time.com/2012/11/27/the-unintended-consequences-of-the-current-ptsd-diagnosis/

[45] Russo, A. Assessing Veteran Symptom Validity. Psychological Inquiary and Law. June 2014, Volume 7, Issue 2, pp 178-190

trends of provider perceptions, the army can better appreciate potential factors related to malingering diagnosis, reconsider policies, and recommend appropriate training. In addition, a better snapshot of military behavioral health provider perceptions, might give better understanding regarding the differences in opinion in the medical literature regarding this topic.

Chapter 4: Methods and Study Design

Research Design

The research was an observational epidemiologic mixed methods cross sectional study.

Overview

Behavioral health providers that work in the Army Military System were asked to complete a survey regarding their perspectives of malingering within the military. The survey included non-identifiable demographic information, a validated scale to measure provider burn out, and questions regarding the provider's perceptions of malingering similar to the survey performed in the Israeli Defense Forces by Iancu in 2003.

The link to the anonymous survey was distributed through the OTSG behavioral health consultants and the installation directors of psychologic health to all behavioral health providers in the Army medical system. This was the only way of selectively delivering the survey to behavioral health providers actively treating Soldiers in the Army health system. The survey utilized the surveymonkey platform and the voluntary and anonymous nature of the survey was emphasized. Data collection lasted from December 2015 to January 2016 and included at least 3 prompts for participation by the target population.

Sampling and Participant Identification

Inclusion criteria included all behavioral health providers that had treated active duty Soldiers in the past year. No exclusion criteria were present.

Because there was no consolidated master list with the contact information of behavioral health providers working within the Army's medical system, study subjects had to be contacted through an intermediary. Every military installation had a Director of Psychological Health (IDPH) that was responsible for all of the behavioral health care that occurs at that location. These individuals also had the contact information for every behavioral health provider at their own duty station. To send the survey to potential participants, an email was sent with a link to the survey for the IDPH to forward to personnel at their location.

A large segment of behavioral health providers were targeted for this study across the military enterprise because treatment practices can vary significantly by location. In addition, another survey of a similar population had a response rate of 22%.[46] Sampling the maximal population of providers was done to compensate for potential lower response rates and potential installation treatment patterns.

As this was a cross-sectional study there was no control group or group allocation.

See Appendix 1 for more information on sampling methods.

[46] Jones, Stephen L. Medical Corps Newsletter: MC Survey. March 2016

Informed Consent
When participants accessed the survey monkey site, they were first provided informed consent with strong emphasis about the voluntary and anonymous nature of the study. The informed consent specified that the study assesses the perceptions of behavioral health providers in the military health system. The informed consent did not specifically mention the topic of malingering or factitious disorder so as to not alter the responses to the burnout survey.

See Appendix 2 to see a copy of the informed consent.

Instrumentation
The survey consisted of three components: A demographic section, a burnout inventory, and questions regarding malingering perceptions. No mention of malingering was made until the third section to minimize any impact on the burnout inventory response. See Appendix 3 to see a copy of the survey instrument.

Demographics collected included the type of behavioral health professional, active duty status, the provider's experience level, the type of location of practice, the type of practice, and the history of deployment.

The second phase of the instrument used a validated burnout scale, the ProQOL scale.[47] It was chosen as it is an freely available validated scale that measures provider burnout and was normed on "people who work in helping professions that respond to individual, community, national, and even international crises. The population of helpers sampled were found in health care, social service workers, teachers, attorneys, police officers, firefighters, clergy, airline and other transportation staff, disaster site clean-up crews, and others who offer assistance at the time of the event or later." The average score on the burnout scale is 22. About 25% of people score above 27 and about 25% of people score below 18. A score of below 18, is thought to reflect "positive feelings about your ability to be effective in your work." A score above 27, can be associated with feelings of ineffectiveness.

The last phase of the instrument asked questions regarding malingering similar to Iancu et al in 2003.[20] We first asked how many cases of malingering or factitious disorder the participants perceived in the past year. We then asked the participants to estimate how many cases they actually diagnosed with these conditions. Finally we also asked why there was a difference between the last two responses if they were not the same. Three other questions regarding malingering perceptions and the need of training were also asked.

Validity

The study was designed to minimize potential issues with reliability and validity.
As all of the subjects will be taking the same survey, reliability issues from having different populations in different study groups will not occur. Reliability also was addressed when we

[47] B. Hudnall Stamm. 1997-2005. *Professional Quality of Life: Compassion Satisfaction and Fatigue Subscales. R-IV (ProQOL)*. http:??www.isu.edu/~bhstamm.

defined our terms so every provider would be using the same operational definition of factitious disorder or malingering.

There was a potential selection bias identified with survey administration-providers who are busier (and perhaps more burnt out) could be less willing to participate in an optional research study. Unfortunately, there is no way of avoiding that potential selection bias in an ethical manner other than advertising the short nature of the survey. We also tried to keep the study short to minimize the effects of participant fatigue as they took the survey. Hopefully the survey's shortness also minimized the effect of drop outs as it is possible that busier providers (who might be more burned out) might discontinue a long study. Finally, we tried to minimize the possible confounding effects of history. If we first asked about malingering, providers could have answered the burn out questions differently if they did not feel that there is a relationship between the two variables.

Unfortunately, there are more potential issues with validity of the study. Even though it has face validity, it is unknown how much a provider's perception of malingering and diagnosis rates relate to the real world, but as the actual rates of malingering are impossible to measure, provider perceptions are likely the closest we will come to reality. With that being said, because the study was sent to the entire population of army behavioral health providers, the results will likely adequately reflect the reality of these provider's perceptions regarding malingering and factitious disorder. The survey also incorporated previous validated scales of burnout and was also modeled after a successfully completed study performed by the Israeli military several years ago.

Primary Outcome Measures

The primary variables that were measured include the number of perceived cases of malingering seen during the past year, how many cases were actually diagnosed, and a qualitative explanation why a difference exists. In addition a burnout survey was utilized to measure provider burnout.

Number of perceived cases of malingering seen during the past year-The measurement was collected from all participants. It was intended to be normed by practice volume when incorporating the full time equivalent measure collected in the demographic section. This variable was correlated with demographic variables to ascertain if there is a relationship between the factors and the perception of malingering. While this measure very directly measures provider opinions, perceptions can be flawed and might not directly reflect actual measures of malingering in the military. With this being said, the characteristics of malingering prevent the actual measurement of its incidence or prevalence and a provider's perception seems like a relevant indicator that could reflect on the underlying issue.

Number of cases diagnosed in the past year-This number was compared to the number of perceived cases to see if there is a difference between these variables. It is also the variable that was correlated with the thematic classifications. Similar to the last variable, a provider's recollection of how many cases of malingering he has diagnosed might not reflect the actual amount. With this being said, there is not any other way of collecting this information and

correlating it with an individual provider's perceptions while maintaining the anonymous nature of the study (and facilitating self-report given the political sensitivity of this topic).

Qualitative explanation why a difference might exist-The patients had a section to free text any reasons that there might be a difference between their perceptions and diagnosis. We coded and scored these responses to make them organized so it could be incorporated with the rest of the data analysis. Two coders coded the data. After the data was coded all answers were compared. All discrepancies between these two coders were then discussed and a consensus was reached. Once again, this is the only way of collecting this information and correlating it with an individual provider's perceptions and demographics.

Burnout survey-The burnout survey was a previously validated scale called the PROQOL (professional quality of life) scale. We gave this test before the other measures to minimize possible bias that could be introduced if reversed. It was a 30 question survey and took significant time of the participants, but is worth it as it is a previously validated burnout scale.

Sample Size/Power Estimates

We surveyed all providers in this setting due to concerns about response rates within a busy population. We wanted to make the survey available to all providers in the enterprise as there can be significant differences in local behavioral health practice. Furthermore, we needed to be sure that the sample size was large to minimize the ability to identify specific respondents. As the entire population was surveyed, power estimates were not performed before data collection.

Data Collection and Data Analysis

Data was collected on the Surveymonkey platform. The data was exported to an excel file where it was prepared for statistical data analysis.

The primary investigators completed the data analysis with support from a statistician from the University of Washington's school of public health. A T-test was used to compare the means of perceived vs. diagnosed perception and linear regression was used to look for correlations between the demographic variables, burnout scale, and malingering responses.

The open ended qualitative responses were examined by two investigators. The investigators first analyzed the first 100 responses and identified 15 themes (see Appendix 4 for categories and example statements and Appendix 5 for all statements and thematic assignments). All responses were then categorized into these themes by each investigator. Each categorization was compared and every discrepancy was discussed until consensus was reached. Linear regression was then used to analyze the relationship between these themes and the number of cases that were perceived but not diagnosed.
All statistics done with SPSS Version 22

Ethics

As it was a voluntary anonymous survey with minimal risk to the subjects, our survey qualified for exempt research status. No specific benefit was seen for the subjects, but the study could lead to a better understanding of the perception of malingering in the military

population which could lead to training opportunities for providers and improved medical treatment for service members. There were no risks foreseen for the completion of an anonymous voluntary online survey.

Logistic and Practical Considerations

Because of the political issues involved, the research first needed to have approval at the local level. After it was approved by the Military Treatment Facility leadership, it was then presented to the OTSG Behavioral Health Service Line where the study was also approved.

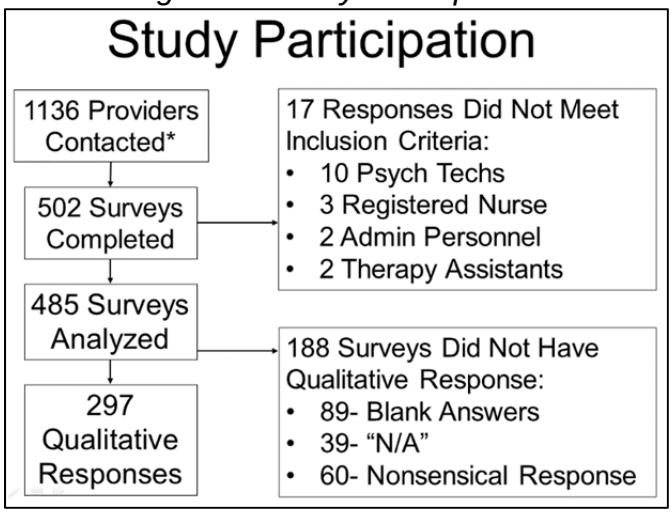
Chapter 5: Results

Study Participation

Because of the survey distribution methods the exact number of individuals who received the survey is unknown but we know that no more than 1136 providers were sent an email with a link to the study. 502 of these subjects chose to participate in the survey (42% response rate). This also represents 27% of the total population of behavioral health providers seeing active duty Soldiers in the military system.

Of the 502 surveys that were completed, 17 responses did not meet the inclusion criteria. Of the 485 remaining surveys, only 297 participants provided an analyzable response to the open ended question (*See Figure 1*).

Figure 1: Study Participation



Demographics

The study demographics showed that 55.3% of our population had doctoral degrees (32.9% psychologists and 22.5% psychiatrists) and 31.8% of our population were prescribers (9.3% psychiatric nurse practitioners and 22.5% psychiatrists). Social workers consisted 35.3% of the participant population. Approximately 43% of our respondents were active duty. In addition, a great percentage of our population had significant experience in the field with over 53.7% of participants having over 10 years of experience. 3.5% of respondents were still in graduate medical education, 3.1% were within one year of graduation, 10.6% were between 1 and 3 years after graduation, 12.9% will be between 3 and 6 years, and 16.2% were between 6 and 10 years of graduation. 53.8% of the participants worked in a large medical center, 33.2% of respondents worked in a smaller MEDDAC, and 11.1% worked in a FORSCOM unit. The large majority of participants also worked in an outpatient setting (87.6%). 18.6% of respondents worked in an inpatient environment, 7.6% worked in an

intensive outpatient program, 9.1% worked in substance abuse, 7.0% worked in forensics, 4.7% worked in a warrior transition battalion, 5.6% worked with medical boards, 3.3% worked with traumatic brain injury treatment, 6.0% worked in neuropsychology, and 6.0% worked in primary care. 38.5% of respondents have deployed in the past (*See Table 1*). As there are no official measures of behavioral health provider demographics in the military health system, it is difficult to compare these results to the reference population, but the results are at least subjectively similar to the reference population. In addition, the results are fairly similar to the demographics of a study with similar methodology used in 2003 which had 34% psychologists, 41% social workers, 13% psychiatrists, and 12% other. They also had a civilian rate of 70% and 28% active duty. Finally the mean experience level was 17.5 years in that study. The slight increase of psychiatrists and active duty participants in my study might be because the primary investigator is an active duty psychiatrist.

Table 1: Participant Demographics

		Number	Percent
Type of Provider			
	Psychiatric Nurse Practioner	45	9.3
	Psychiatrist	109	22.5
	Psychologist	159	32.9
	Social Worker	171	35.3
Active Duty Status			
	Active Duty	210	43.3
	Civilian	272	56.1
Training Level			
	Still in graduate medical education	17	3.5
	Within one year of graduation	15	3.1
	Between 1 and 3 years after graduation	51	10.6
	Between >3 and 6 years after graduation	62	12.9
	Between >6 and 10 years after graduation	78	16.2
	More than 10 years after graduation	259	53.7
Location			
	At a Medical Center	261	53.8
	At a Medical and Dental Activity Center	161	33.2
	In a FORSCOM unit	54	11.1
Type of Practice			
	Outpatient	425	87.6
	Inpatient	90	18.6
	IOP	37	7.6
	Substance Abuse	44	9.1
	Forensics	34	7.0
	WTB	23	4.7
	Med Board	27	5.6
	TBI	16	3.3
	Neuropsych	18	3.7
	Primary Care	29	6.0
History of Deployment		186	38.5
Wants training to identify malingering?		337	73.1
Wants training to manage malingering?		375	77.3

Primary Outcome Measure: Perceptions of Malingering

The respondents reported an average of 8.34 cases (SD 15.788, IQR 1-9.5) of malingering or factitious disorder every year while diagnosing a mean of 0.68 cases (SD 3.730, IQR 0-0). A paired T-test was used to compare these groups and found a difference of 7.698 (95% CI 6.32-9.08) and were very significantly different (P-value <0.001).

Secondary Outcome Measure: Burnout measures

On average the ProQOL instrument revealed normal levels of compassion fatigue, burnout, and secondary trauma symptoms in our respondents. The level of compassion fatigue was 36.78 (SD 10.840, IQR 33-44) with a "normal" range of 33-42. The burnout score was 19.61(SD 7.975, IQR 14-25) and a normal range of 18-27. Finally the secondary trauma symptoms score was 8.62 (SD 6.892, IQR 4-12) and a normal range of 8-17.

Factors related to numbers of cases of malingering perceived

Demographics and burnout scores were analyzed using linear regression. The only factors that were significantly associated with the numbers of malingering and factitious disorder cases perceived were working in an inpatient environment (β 4.411, 95% CI (0.019-8.802), p-value 0.049) and burnout score (β 0.406, 95% CI (0.203-0.610), p-value <0.001). Civilian status was negatively associated with perceived intentional deception (β -3.283) but did not reach significance (p-value 0.177). Neuropsychology (β 7.587) and a history of deployment (β 3.584) were positively associated with malingering and factitious disorder but these also did not reach significance (p-values of 0.122 and 0.065 respectively).

Table 2: Factors Related to Number of Malingering Cases Perceived

Factors related to # of cases of malingering seen			
	Beta	95 CI	Sig.
Occupation:	-0.5	(-2.3-1.3)	.586
AD vs. Civ	-3.3	(-8.1-1.5)	.177
Training Level	0.1	(-1.3-1.6)	.846
Institution	0.4	(-1.9-2.8)	.713
Outpatient	2.3	(-2.5-7.1)	.349
Inpatient	4.4	(0.0-8.8)	.049
IOP	-2.8	(-9.0-3.4)	.375
Substance Abuse	3.8	(-2.2-9.7)	.217
Forensics	2.8	(-4.0-9.6)	.417
WTB	3.6	(-4.0-11.1)	.356
Med Board	4.8	(-2.7-12.3)	.207
TBI	1.5	(-7.8-10.8)	.749
Neuropsych	7.6	(-2.0-17.2)	.122
Primary Care	2.0	(-4.3-8.3)	.533
Deployed	3.6	(-0.2-7.4)	.065
Burnout	0.4	(0.2-0.6)	.000

Qualitative Reasons for Non-diagnosis

Respondents open ended responses were classified into 15 different thematic responses. When analyzing the open ended responses, perceptions of not having enough evidence to prove (94/366 or 25.7% of responses), perceptions of policy and pressure from above (19.7%), perspectives of not being 100% sure of the diagnosis (11.2%), and a perceived negative impact on the provider (10.7%) made up more than 2/3 of provided responses. Other factors reported include having a role not to diagnose, if another diagnosis was present, negative impact on the patient, the belief that there is no clinical utility to diagnose malingering, a perception of politics associated with the diagnosis, the difficulty of the diagnosing malingering process, having strong personal beliefs about the topic, the need to give Soldiers the "benefit of the doubt," and the experience level of the provider were also mentioned (*see Table 3*).

Table 3: Open Ended Responses that Explain Diagnostic Gap

Not enough evidence/difficult proving	94	19.4%
Policy and pressure from above*	72	14.8%
Unsure of diagnosis	41	8.5%
Negative impact on provider	39	8.0%
Role not to diagnose	33	6.8%
Another Diagnosis present	28	5.8%
Negative impact on patient	25	5.2%
No clinical utility	24	4.9%
Politics*	23	4.7%
Difficuly process	21	4.3%
Personal beliefs	12	2.5%
"Benefit of Doubt"	8	1.6%
Experience level of provider	5	1.0%
Other	20	4.1%
Did Not Answer	189	39.0%

When we used linear regression to compare these factors with the non-diagnosis of perceived malingering or factitious disorder, perceptions of policy & pressure from above (β 8.659, 95% CI (4.77-12.55), p-value <0.001) and politics (β 8.975, 95% CI (2.54-15.41), p-value 0.006) were both significantly associated with a diagnostic gap. The factors of complicated process (β 5.569), negative implications on the patient (β 5.495), and negative implications for the provider (β 3.567) demonstrated a tendency but did not actually achieve a level of significance (p-values of 0.094, 0.068, and 0.170 respectively) (*see Table 4*).

Table 4: Factors that are Related to Diagnostic Gap

Factors related to difference			
	Beta	95% CI	Sig.
Policy/Pressure from Above	8.7	(4.8-12.6)	0.000
Another Diagnosis	2.8	(-2.7-8.4)	0.321
Experience Level	4.2	(-10.4-18.7)	0.575
Role not to diagnose	-1.3	(-6.5-3.9)	0.626
Politics	9.0	(2.5-15.4)	0.006
Benefit of Doubt	-0.8	(-10.9-9.3)	0.874
Unsure	-0.4	(-5.1-4.3)	0.867
Process	5.6	(-1.0-12.1)	0.094
No clinical utility	-0.9	(-7.0-5.2)	0.778
Personal beliefs	-1.7	(-10.0-6.7)	0.696
Negative for provider	3.6	(-1.5-8.7)	0.170
Negative for patient	5.5	(-0.4-11.4)	0.068
Not enough evidence/difficult	2.1	(-1.3-5.5)	0.225
Other	-1.1	(-7.7-5.6)	0.754

Training

The study also revealed that 73.1% of providers requested additional training to identify malingering and 77.3% wanted training to manage malingering behaviors.

Chapter 6: Discussion and Conclusions:

Introduction

Our response rate of 42% did not reach the ideal >60% threshold, but it was greater than a recent high visible survey recently given to the same population (response rate of 22%) and was also greater than a published study using from 2003 that used similar methodology (response rate of 26%).[48] Furthermore the response rate was likely greater than reported as several of the sites forwarded the survey to an email distribution list that included providers that had already moved to another installation or included providers that were not eligible to complete the survey. The respondents gave good representation of the primary behavioral health provider types serving in the military health system (psychologists, psychiatrists, social workers, and psychiatric nurse practitioners). Of note, the respondents were mostly more experienced with the majority having >10 years of post-graduate experience. The locations of practice in the survey (54% MEDCEN, 33% MEDDAC, and 11% FORSCOM) and the overwhelmingly outpatient practice also generally reflected the distribution of the reference population. Interestingly, the population as a whole scored within the "normal" range of the ProQOL burnout scale. Finally, 48.3% were active duty and 38.5% of the respondents had a history of deployment.

Contemplation of Findings

78% of respondents perceived malingering or factitious disorder in their patients in the last year and only 17% reported actually diagnosing either of these conditions. These responses indicate that the incidence of malingering or factitious disorder in the active duty Soldier are likely greater than the "rare" frequency occasionally quoted in the literature.

Our findings strongly support the current literature that the diagnosis of malingering and factitious disorder is minimized by Army behavioral health providers. Assuming a mean of 8.34 perceived cases a year and 1,888 behavioral health providers, behavioral health providers in the military health system perceive an estimate of 15,745 cases of intentional deception in the past year. In practical terms, this means that an individual provider likely encounters malingering or factitious disorder a little more than once every two months.

Assuming a mean of 0.68 diagnoses and 1,888 behavioral health providers in the army medical health system, providers estimate that they diagnose 1,284 cases of malingering or factitious disorder in the military health system each year. This estimate is 3.6 times higher than the numbers of cases reported in the study that searched for this diagnosis in the military electronic medical record from 1998-2012 (which had an average of 354 cases diagnosed annually). This increase could potentially come from the inclusion of factitious disorder or could be a bias of self report.

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[48] Wilk J, West J, Duffy F, Herrell R, Rae D, Hoge C. Use of Evidence-Based Treatment for Posttraumatic Stress Disorder in Army Behavioral Healthcare. Psychiatry 76(4) Winter 2013. 336-348

Given the estimate numbers of cases perceived compared to the perceptions of diagnosis, it is reasonable to estimate that 14,534 cases a year are not diagnosed with malingering or factitious disorder when the provider perceived these conditions were actually occurring. While this estimate includes both factitious disorder and malingering, factitious disorder is a condition that is seen more frequently in consultation liaison psychiatry instead of the standard outpatient or inpatient psychiatric practice that was the primary population surveyed in this study. Furthermore, the perceptions of policy/pressure from above and politics do not significantly relate the diagnosis of factitious disorder. For these reasons, it is likely that the majority of these cases represent malingering instead of factitious disorder. In addition, it is also possible that these cases include civilian dependents or retirees, but incentives for malingering in the military system are minimal for these populations. Finally, it is extremely important to mention that there is potential overlap in these cases as one provider might perceive malingering or factitious disorder in a patient that is also being treated by another provider who has the same perceptions. Given the complete anonymous nature of the survey, it is impossible to evaluate for potential clustering or overlap of the study responses.

Of note, as both the distribution of the perceptions and diagnosis of malingering and factitious disorder were significantly skewed, the values are primarily accurate when predicting prevalence with a population instead of expecting how many cases an individual provider is likely to perceive or diagnose.

The primary hypothesis of increased perceptions of malingering being associated with increased education and experience were not supported by the study results. Similarly, the factors of active duty status and deployment history also did not reach significance, but did at least approach significance to the level where it is reasonable to continue to investigate these factors in future studies.

The hypothesis that an increase in provider burnout would be associated with an increased perception of malingering was supported. For each increase in the ProQOL burnout score, a provider perceives approximately 0.4 additional patients malingering or having factitious disorder yearly. An increase from the 25% to the 50% of burnout score corresponds with an additional 2.0 perceived cases and an increase from 50% to the 75% corresponds with an additional 2.4 perceived malingering or factitious disorder patients yearly. As this is an epidemiologic cross sectional study it is extremely important to emphasize that the direction of this relationship is unclear. It is unknown whether the burnout causes increased perceptions or if the increased perceptions of malingering and system characteristics increase burnout perceptions.

One factor that was found to be associated with increased perceptions of malingering was practicing in an inpatient psychiatric environment. Multivariable analysis reveals that working in an inpatient environment is associated with an increased perception of 4.411 additional

cases of intentional fabrication. There is the possibility that an inpatient physician might have increased perceptions of burnout. This in combination with a wide confidence interval (0.019-8.802) might indicate the presence of multicollinearity affecting the multivariate analysis. With this being said, the perception of an additional 4 cases of malingering makes sense as inpatient hospitalization allows providers to monitor patients over long periods of time and note presentation inconsistencies in various settings.

After the open ended responses provided by respondents were categorized into themes (see Appendix 4 & Appendix 5) it became obvious that four themes encompassed 2/3 of all open ended responses: Not enough evidence / difficulty to prove, perceptions of policy & pressure from above, being unsure of diagnosis, and negative impact on provider. When the factors were analyzed politics and perceptions of policy/pressure from above were the responses that were significantly associated with not diagnosing cases of perceived malingering or factitious disorder. Of note, the factors of politics and perceptions of policy/pressure from above are normally not associated with factitious disorder and this might be an indicator that malingering is the condition of intentional deception that is being most referenced by the study population. Each of these factors, when perceived are associated with 8-9 patients not being diagnosed.

Perceptions of negative impact on the patient, a difficult or onerous process, and negative impact on the provider trend towards significance but did not attain significance in this study (p-values of 0.068, 0.094, and 0.17). These factors would be very reasonable to include in future studies.

Interestingly, ¾ of providers desire additional training to identify and manage malingering patients. Any time a provider requests additional training when they already have a busy practice it typically reflects a significant need.

Recommendations for Future Research

As no other research in this area has been performed, additional studies to examine the prevalence of malingering and factitious disorder in the military medical system are warranted as well as additional investigation into the effects of possible minimization of diagnosis. There are also numerous potential related investigations that can be pursued. It would be very easy to incorporate other branches of the United States Military and compare them to the perceptions that Army behavioral health providers have. In addition, the perceptions of primary care providers could be another very interesting comparator.

Additional research to investigate the roles of active duty status and deployment history on the perceptions on malingering would also be worthwhile. Similarly, investigating relationships between perceptions of negative impact on the patient, a difficult or onerous process, and negative impact on the provider and the malingering diagnostic gap could also reveal other factors that are important in this process.

Finally, better understanding the characteristics of the malingering threshold, a point where a provider will diagnose a perceived case of malingering could also be extremely informative.

Assumptions & Limitations

There are several significant limitations to this study. The most significant limitation is the potential of recall bias. Just because a provider has a perception of diagnosing or not diagnosing a condition does not necessarily reflect reality. With this being said, the nature of malingering and factitious disorder prevent the direct study or measurements of these conditions, and examining the perceptions of providers is likely the best way that we have to better understand this disease.

Furthermore, a response rate of 42% allows potential responder bias. It is likely that this limited response actually minimized the perceptions of malingering or the malingering gap detected by this study as providers who are more burned out are less likely to participate in an additional anonymous voluntary survey, especially if they do not know if it evaluates malingering. It is also valuable to understand that the response rate is likely actually higher than what was reported back to the investigator as many of the sites also forwarded the survey to people that did not meet inclusion criteria or who had already moved to a different location.

Another significant limitation to the study is the grouping the two conditions of intentional deception together in the primary outcome measure. As mentioned above, while this estimate includes both factitious disorder and malingering, factitious disorder is a condition that is seen more frequently in consultation liaison psychiatry instead of the outpatient/inpatient psychiatric practice that was surveyed in this study. In addition, the open ended responses that were significant for not diagnosing a condition (policy/pressure from above and politics) do not have a significant relationship to factitious disorder in clinical practice. With this being said, it is impossible to know how many cases of intentional deception were factious disorder instead of malingering.

Similarly, the study also did not differentiate between active duty service members, civilian dependents, or retirees. This makes it more difficult to estimate the systemic and individual impacts of non-diagnosis. While it is possible that these cases also include civilian dependents or retirees, the military system typically separates its patient care into active duty and dependent service lanes and the inclusion criteria mandated the providers had seen active duty patients in the last 12 months.

Implications

An annual rate of 14,500 cases of intentional deception could easily cause significant strain on a medical system and the care we give other patients, not to mention a potential iatrogenic impact on the patients themselves. The extent of these impacts have not yet been

studied. An exact impact or cost to the system cannot be determined at this time until utilization rates of this population and the percentage of this population in the disability system can be determined. Assuming an overlap of 25% of cases, and a conservative estimate of 30% in the disability system with an average of 50% disability (and no dependents) the yearly cost of non-diagnosis could be estimated at a $32.7 million annuity in perpetuity. These assumptions are solely based on provider experience as there are no studies that document the frequency of disability evaluations in individuals that malinger, the percentage of overlap of malingering cases, or the average disability rating in this population. With this being said, malingering is known to occur more frequently in the disability evaluation population and the most frequent malingered mental illness in the military is essentially automatically associated with at least a 50% disability rating. Another cost of malingering is the tremendous impact of military readiness of these cases of intentional deception. This effect is is less easy to quantify but could easily be substantial. Similarly, the levels of iatrogenic impairment associated with a malingered psychiatric diagnosis in these 14,500 cases is difficult to determine.

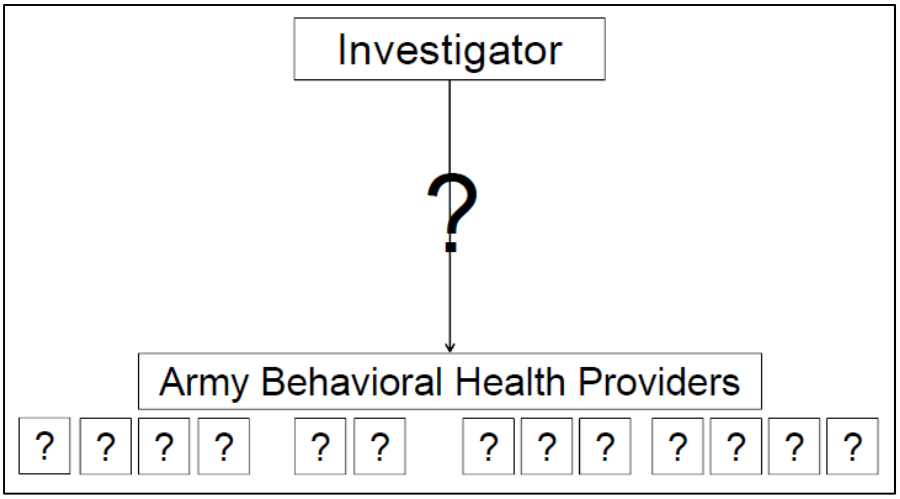
This study also indicates that provider's diagnostic accuracy and practices are impacted by perceptions of politics and policy and pressure from above. Additional clarification of the Army's policy on this topic could potentially be beneficial. Additionally, exploration to see what can be done to insulate providers for potential political pressure that could affect the integrity of their diagnostic formulations might be an additional consideration. Finally, if 3/4 of the providers desire additional training about the identification and management of malingering, optional online training provided by OTSG that gives CME credit could help address this concern.

Conclusion

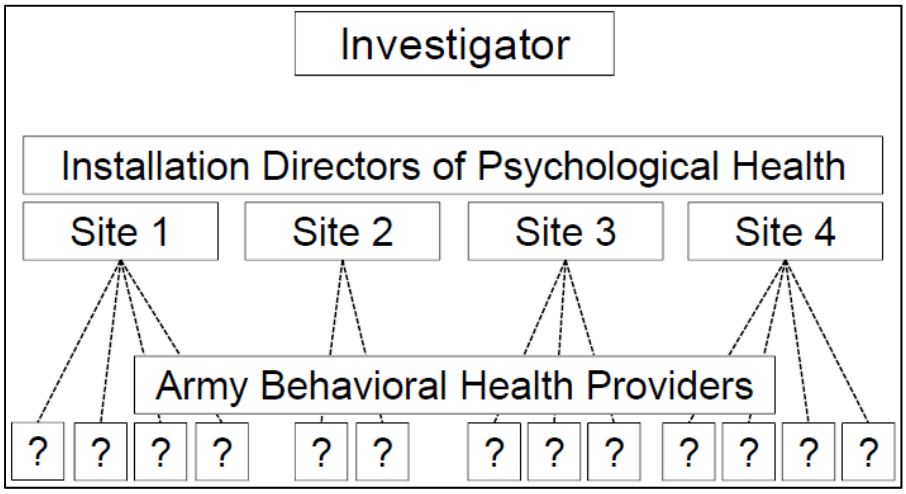
This study estimates that in the Army Medical System, behavioral health providers perceive 14,500 cases of malingering or factitious disorder every year that are not diagnosed with these conditions. This diagnostic gap can cause significant impact on the system, on other patients, and on the Soldiers themselves. The analysis of factors that affect the perception of malingering in Soldiers indicate that working in an inpatient environment and scoring higher on a burnout inventory are associated with higher perceived burnout. The perceptions of politics and policy/pressure from above are significantly associated with a diagnostic gap of not diagnosing malingering when it is perceived to be present. Additional study is needed to better understand this phenomena, the significant impacts that this can have on an individual patient, other patients in the medical system, the medical system as a whole, and military readiness.

Appendix 1: Sampling Methods

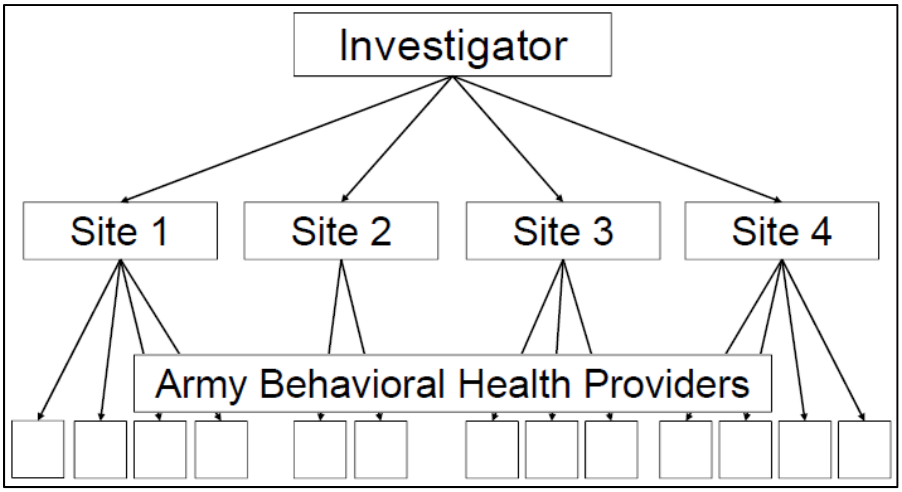
Unfortunately, the army does not have any master list of behavioral health providers that work in the military health system.



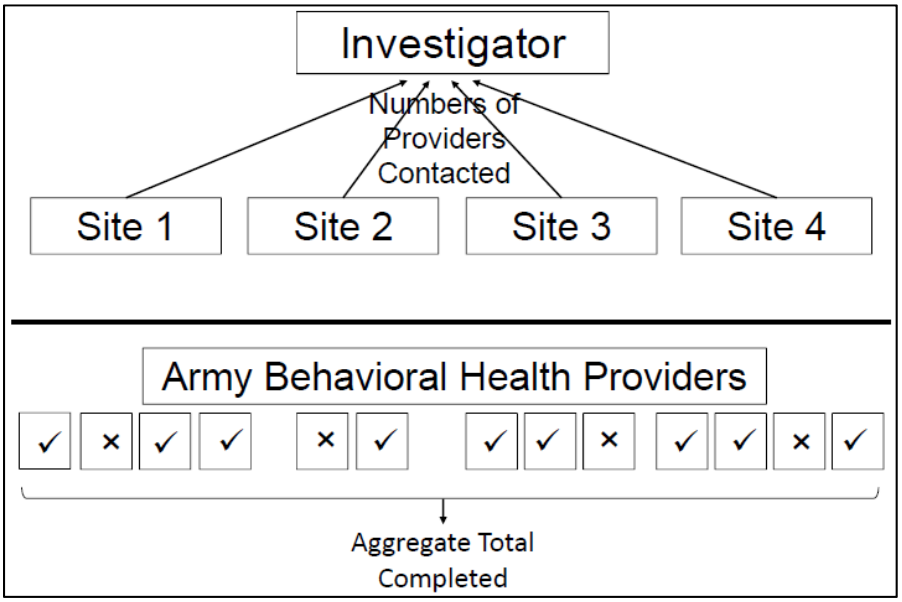
They do however, know the contact information of Installation Directors of Psychological Health (IDPH) that do know the names of behavioral health providers at their respective locations.



By sending the survey to all of the Army's IDPH's and requesting the forward of the survey to providers at their location, theoretically all providers in the military had an opportunity to participate in the survey.



The sites were then queried regarding the numbers of subjects that were provided the study and this number could be compared to the total number or survey's completed.



In the study, no more than 1136 providers were sent an email with a link to the study. 502 of these subjects chose to participate in the survey. This was a 42% response rate and reflected 27% of the total population of behavioral health providers seeing active duty Soldiers in the military system.

Response

$$\frac{\text{Aggregate Total Surveys Completed}}{\text{Numbers of Providers Contacted*}} = \frac{\text{502 Surveys Completed}}{\text{1136 Providers Contacted*}} = \text{42\% Response Rate}$$

$$\frac{\text{Aggregate Total Surveys Completed}}{\text{Numbers of Providers in Army*}} = \frac{\text{502 Surveys Completed}}{\text{1888 Providers in Army*}} = \text{27\% of Total Population Responded}$$

Appendix 2: Informed Consent

Behavioral Health Provider Perspective

Madigan Army Medical Center
RESEARCH STUDY INFORMATION
SHEET

This voluntary and anonymous research study is being conducted at Madigan Army Medical Center assessing the perceptions of behavioral health providers in the military health system. MAJ Sebastian Schnellbacher, MC, is the Principal Investigator.

Why is this study being done?
Researchers want to understand demographic traits and the perspectives of military behavioral health providers regarding some behavioral health conditions.

Will you be included?
If you treat or evaluate the behavioral health conditions of military service members you are eligible to participate in this study. Your participation is completely voluntary! Furthermore this survey is completely anonymous and we are not able to track your participation in any way. Deciding not to participate in this study will NOT influence your employment.

What is expected?
If you agree to participate, you will be asked to fill out a survey that will take 5-10 minutes to complete. We ask that you answer the questions as accurately as possible

How long will it take?
Your study participation is over when you complete the survey. This will likely take 5-10 minutes.

Will I benefit from participating?
You will not personally benefit from taking part in this study, but the information may improve the understanding of your perspectives regarding certain medical conditions.

What are the risks to this study?

There are no known risks associated with the survey. Your answers are not able to be linked to you in any way.

Confidentiality/Privacy of your identity?

No protected health information or identifiable information will be collected in the survey. Please do not write your name on the survey so that your responses remain completely anonymous. You will not be linked in any way to the study or any publications that may result from this research.

Can I choose to be part of the study?

Yes, it is your decision to complete the survey or not.

Can I change my mind and withdraw?

Yes, you can stop the survey at any time.

Contact Information:

If you have questions about the study contact the Principal Investigator, MAJ Sebastian Schnellbacher, MC at pager 253 291-2071. For questions about your rights as a research participant, contact the Madigan Department of Clinical Investigation, telephone 253-968-0149, or the Madigan Staff Judge Advocate Office, telephone 253-968-1525.

Appendix 3: Survey Instrument

Behavioral Health Provider Perspective Survey

General

The first section consists of 7 demographic questions.

The second section consists of a 30 question pre-validated scale

The last section asks 6 questions about your perspectives regarding some behavioral health diagnoses.

It is estimated that this survey will take 5-10 minutes.

1. I am a:

- ○ Psychiatric Nurse Practitioner
- ○ Psychiatrist
- ○ Psychologist
- ○ Social Worker
- ○ Other (please specify)

2. I am a(an):

- ○ Active Duty Soldier
- ○ Government Employee
- ○ Contractor

3. **I am:**

- ○ Still in graduate medical education
- ○ Within one year of graduation
- ○ Between 1 and 3 years after graduation
- ○ Between >3 and 6 years of graduation
- ○ Between >6 and 10 years of graduation
- ○ More than 10 years after graduation

4. **I work:**

- ○ At a Medical Center (MEDCEN)
- ○ At a Medican and Dental Activity Center (MEDDAC)
- ○ In a FORSCOM unit

5. **I work in the following areas (check all that apply):**

- ○ Outpatient
- ○ Inpatient
- ○ Intensive Outpatient Program
- ○ Substance Abuse
- ○ Forensics
- ○ Warrior Transition Population
- ○ Medical Boards
- ○ Traumatic Brain Injury Treatment
- ○ Neuropsychologic Testing
- ○ Primary Care Clinic
- ○ Other (please specify)

6. **Have you deployed in the past?**

- ○ Yes
- ○ No

7. **How many FTE (full time equivalents) of direct patient care do you provide?**

Part 2 of 3
30 question scale (broken into 5 sections with identical answer

Treating people puts you in direct contact with their lives. As you probably have experienced, your compassion for those you treat has both positive and negative aspects. We would like to ask you questions about your experiences, both positive and negative, as a behavioral health provider.

Consider each of the following questions about you and your current situation. Select the number that honestly reflects how frequently you experienced these characteristics in the last 30 days.

8. Question 1-6 / 30: How often in last 30 days

	Never	Rarely	A Few Times	Somewhat Often	Often	Very Often
I am happy.	○	○	○	○	○	○
I am preoccupied with more than one person I treat.	○	○	○	○	○	○
I get satisfaction from being able to treat people.	○	○	○	○	○	○
I feel connected to others.	○	○	○	○	○	○
I jump or am startled by unexpected sounds.	○	○	○	○	○	○
I feel invigorated after working with those I treat.	○	○	○	○	○	○

9. Question 7-12 / 30: How often in last 30 days

	Never	Rarely	A Few Times	Somewhat Often	Often	Very Often
I find it difficult to separate my personal life from my life as a behavioral health provider.	○	○	○	○	○	○
I am losing sleep over tramatic experiences of a person I treat.	○	○	○	○	○	○
I think that I might have been "infected" by the traumatic stress of those I treat.	○	○	○	○	○	○
I feel trapped by my work as a behavioral health provider.	○	○	○	○	○	○
Because of my treating others, I have felt "on edge" about various things.	○	○	○	○	○	○
I like my work as a behavioral health provider.	○	○	○	○	○	○

10. Question 13-18 / 30: How often in last 30 days

	Never	Rarely	A Few Times	Somewhat Often	Often	Very Often
I feel depressed as a result of my work as a behavioral health provider.	○	○	○	○	○	○
I feel as though I am experiencing the trauma of someone I have treated.	○	○	○	○	○	○
I have beliefs that sustain me.	○	○	○	○	○	○
I am pleased with how I am able to keep up with treating techniques and protocols.	○	○	○	○	○	○
I am the person I always wanted to be.	○	○	○	○	○	○
My work makes me feel satisfied.	○	○	○	○	○	○
I like my work as a behavioral health provider.	○	○	○	○	○	○

11. Question 19-23 / 30: How often in last 30 days

	Never	Rarely	A Few Times	Somewhat Often	Often	Very Often
Because of my work as a behavioral health provider, I feel exhausted.	○	○	○	○	○	○
I have happy thoughts and feelings about those I treat and how I could help them.	○	○	○	○	○	○
I feel overwhelmed by the amount of work or the size of my caseload I have to deal with.	○	○	○	○	○	○
I believe I can make a difference through my work.	○	○	○	○	○	○
I avoid certain activities or situations because they remind me of the frightening experiences of people I treat.	○	○	○	○	○	○
I am proud of what I can do to treat.	○	○	○	○	○	○

12. Question 24-30 / 30: How often in last 30 days

	Never	Rarely	A Few Times	Somewhat Often	Often	Very Often
As a result of my treating others, I have intrusive frightening thoughts.	○	○	○	○	○	○
I feel "bogged down" by the system.	○	○	○	○	○	○
I have thoughts that I am a "success" as a behavioral health provider.	○	○	○	○	○	○
I can't recall important parts of my work with trauma victims.	○	○	○	○	○	○
I am a very sensitive person.	○	○	○	○	○	○
I am happy that I chose to do this work.	○	○	○	○	○	○

Part 3 of 3
Perspectives on Malingering and Factitious Disorder

For the purpose of this survey:
-Malingering will be defined as fabricating or exaggerating the symptoms of mental or physical disorder for secondary gain.
-Factitious disorder will be defined as fabricating or exaggerating the sympoms of a mental or physical disorder for reasons other than secondary gain.

13. How many cases of malingering or factitious disorder do you think you have seen in the past year?

14. How many of these cases did you diagnose with malingering or factitious disorder?

15. If there is a difference between the last two questions, can you please describe why:

16. What are common signs/symptoms that might cause you to consider the diagnosis of malingering or factitious disorder?

17. Would you like more training to identify malingering or factitious disorder in the military population?

○ Yes

○ No

18. Would you like more training to provide ideal management for malingering or factitious disorder patients in the military population?

○ Yes

○ No

Appendix 4: Thematic Categories and Example Statements

1	**Policy and Pressure From Above**	
		Told not to diagnose
		Policy
		"not allowed"
		Discouraged by supervisors
		Pressured to not diagnose
		Pressured to diagnose PTSD
2	**Another Diagnosis Provided**	
		Soldier is still in need of help
		Another Diagnosis Provided
3	**Experience Level**	
		Does not feel experienced or trained to diagnose
4	**Role not to diagnose**	
		Not primary clinician
		Not primary role to diagnose
5	**Politics**	
		Politics
6	**"Benefit of the Doubt"**	
		"Benefit of the Doubt"
7	**Unsure clinical Picture**	
		Complicated case
		Unsure clinical Picture
8	**Cumbersome Process**	
		Cumbersome Process
9	**No Clinical Utility**	
		Unsure clinical benefit
		No point to diagnose
		Addressed clinically
10	**Personal Beliefs**	
		Malingering doesn't happen
11	**Negative Implications for the Provider**	
		No support
		System will hang out to dry
12	**Negative implications for the patient**	
		Legal Implications
		Could hurt soldier
13	**Not enough evidence/difficut to prove**	
		Not enough evidence
		Hard to prove
		Not enough documentation
14	**Other**	
15	**Did not answer Question**	

Appendix 5: Open-ended Statements and Thematic Classifications

If there is a difference between the last two questions, can you please describe why:	Coded
0	15
0	15
0	15
Although I see malingering, its not politically acceptable to dx	5
Suspicions, not confirmation	13
#13 very few, if any. # 14 none; no clear indicators of malingering	13
3 patients were already diagnosed with MDD & psychosis that I picked up and after 3 visits called them on their behavior and they admitted to me they were malingering. I was also told for legal purpose not to diagnose malingering.	1,9,12
45% of my caseload are malingering; I do not dx malingering bc of politics and instead use Feared Condition Not Demonstrated Re: Q17, the military doesn't want us to have more training on identification - the majority of providers pay no heed to iatrogenic disability and we make people worse colluding with their bullshit because of politics and the system's preference we stick our heads in the sand about a VERY REAL outcome when you incentivize people to have BH conditions	5,14,1
A diagnosis requires more evidence and corroboration than a simple clinical impression, and it carries more negative consequences. Some of those cases were forensic so the weight of the diagnosis was too great in those cases.	13,12
A patient will complain and MAMC will not support you if you make those diagnoses.	11
A person can be malingering but still have other primary psychiatric conditions that require care and attention	2
A serious charge.	12
absence of proof	13
Adjustment Disorder more often used than other dx.	2
All cases have been more maligering in nature (secondary gain).	15
already had the diagnosis when I saw them	14
Army & VA system rewards malingering and punishes providers who give the dx	1,11
Army has discouraged the diagnosing of these d/o unless one is absolutley sure. It is difficult to be sure on these diagnoses so I have not made them officially, though I document discrepancies in SM report in the medical record	1,13
Attending preferred not to utilize diagnosis of 'malingering' or 'factitious disorder' in a couple of cases. Other cases were previously diagnosed, yet attendings chose to continue treatment for likely fabricated symptoms for safety reasons.	1,11
Because a diagnosis was not necessary for the work that I was doing with the person and I would have needed corroborating information (that I didn't want to seek out) to make the diagnosis.	4, 9,13
Because frequently, there is significant pathology. There is so much secondary gain in the military system to be as sick as possible, that there is little reward to	2

get better.	
Because have been warned to never give this dx without irrefutable evidence, which I did not have	1,13
Because I was not 100% sure it was a case of malingering vs. conversion disorder	7
Because I was told that only a forensic psychologist can diagnosis these two disorders	1,4
Because I was uncertain	7
Because it is hard to prove.	13
because sometimes there is no clear way to prove it, and though they may be exaggerating in one instance that doesn't mean they aren't suffering from real distress or coping skills, or PD.	13,2
Because that wasn't the focus of treatment	9
Because the Army has taught us not to diagnose with malingering--even if we see it.	1
Because the ones who appeared to be malingering also had a BH diagnosis, and I used that diagnosis.	2
Because then OTSG will do a 15-6 or flag me as they have done to others. I have no faith in the Army, our current TSG or Command climate to support psychiatrist telling the truth	11
belief that MEDCOM does not support this diagnosis among its providers.	1
believing more than likely someone has one of these diagnoses versus diagnosing them as definitely having one of these diagnoses.	7
BLUF: it depends on existing EHR documentation, and the burden of proof will need to come from the provider considering a change in diagnosis(es). Also the litigious nature of events that can follow a change in diagnosis(es) discourages providers to make an appropriate change due to the involvement of the IG, chain of command, SJA, IDES, congressional inquiries, and other non-DoD-affiliated veterans organizations. For many, it is the path of least resistance to move the SM through IDES, especialy now that IDES timeliness has improved.	11,8,1,13
Both above are politically incorrect Dx and patient will just go to another provider for desired diagnosis.	5, 14
Brief contact with patient with suspicion, usually in inpatient or consult.	4,7
brief work in a civilian setting/I work with children/teens	4
Burden of proof to diagnose malingering; kick back from a system that doesn't want to acknowledge it exists	1,13
Can't be positive I am right, system does not reward provider for sticking out his neck	13,11
CH/ADOL/FAM provider. Not my area of expertise.	4
clients were walk-ins	4,7
Clinic policy. no support for openly addressing malingering.	1,11
clinically non-therapeutic, I am focused on their functioning rather than playing at private investigator.	9

Co-morbid condition with substance abuse, presence of Axis II	2
Conversion Disorder Dx instead.	2
could not be sure and only saw him two times	7
Culture in military behavioral health to shy away from diagnosing malingering. Fear of repercussions if SM gets ahold of the record.	1,11
Current polictical environment drives practice; won't be supported by higher command; needed more concrete evidence to fit the Slick criteria.	1,5,11,13
Current policy impedes clinicians from making the diagnosis.	1
Definitely diagnosing malingering in the medical record requires some certainty that must be confirmed by multiple sources, not just my clinical judgment. Psychological and neuropsychological test is used to confirm the criteria for diagnosis.	13
diagnosing conservatively and/or lack of supporting evidence	7, 13
Diagnosing malingering is professional suicide. I did it once and was called on the red carpet over and over again as soon as the "patient" got even more vocal with demands.	11
Diagnosis does not serve a practical purpose and is risky to make within a MEDCOM environment. Additionally, malingers may malinger and at the same time have real issues. A diagnosis of malingering may lead less complex thinkers on the matter to draw conclusions that prevent treatment of the legitimate issues.	9, 11, 2, 12
diagnosis implies a degree of certainty about intent that I do not possess.	7
diagnosis is unsupported by leadership. The threshold for the diagnose in the military is beyond what is necessary, mostly due to politics. Malngering is more prevalent than PTSD, without a doubt.	1,11,5
diagnosis was confirmed with testing for diagnostic clarification	14
Did not continue working with the others long enough to diagnose.	4,7
Did not have strong enough evidence; also, they were apparently exaggerations of true symptoms deserving treatment.	13,2
Did not have the testing to back up and concerned about repercussions if patient obtains a copy of records	13,11
Didn't have enough evidence to prove one of the cases.	13
Didn't see it at the time, only later.	7
Difference in opinion between treatment team members	7
Difficult tease out and prove.	13
difficult to prove	13
difficult to prove	13
Difficult to prove malingering, no command support for the diagnosis.	13,11
Difficult to prove, didn't make a difference to the work I was doing, not worth the stress of making the dx - any or all of the above. I was an adjunct provider also & by the time I saw the person they had already gotten their benefits or whatever their gain was.	13,9,8,4
Difficult to prove/support malingering, too much secondary gain	13
difficult to substantiate	13

difficult to tease out the difference	7
Documentation of proof may limit the ability to diagnose. Additionally, units may consider UCMJ action for a diagnosis of Malingering.	13,12
don't fell secure in answering this question	11
don't have sufficient evidence to back it up	13
Don't have sufficient evidence to prove or not worth the trouble, i,e, wouldn't change the overall plan	13,9,8
Due to culture and policy, the diagnosis is non-therapeutic completely harmful both to the patient and the system and therefore it is avoided for safety reasons	1,9,11,12
Due to political pressure and fear of congressional investigation even when there is strong evidence for malingering it is usually not directly addressed in the record.	1,5,11
dx in situations with clear or corrobarating evidence vs clinical judgement	7
dx would be detrimental to other aspects of patient care	12
dxing is difficult, but I put ample documentation in my note to show what I was talking about.	13
Either inherited or suspected FD, but did not meet dx criteria	7
Even patients who may feign illnesses demonstrate a symptom requiring treatment	9,2
Even when i may suspect malingering or a factitious disorder, i believe it can be a cry for help and therefore in need of a therapeutic intervention.	2
exageration of symptoms for meb	15
exaggerating or fabricating BH symptoms to get out of work	15
fear of repercussions/lack of leadership support for anything that displeases a patient. Also some cases are more embellishing or they have a "real" dx (like depression or a pd) but are feigning symptoms of a more highly compensated dx	11, 7
fearful of political and professional consequences that could result in the use of those diagnoses	11,5
feigning to assume a sick role versus feigning for secondary gain	15
Follow the data. If there is no objective evidence, move forward.	13
further clinical evaluation resulted in a rule out	14
Given the model that I operate out of I do not have lengthy periods of times to test out all hypotheses; I pass those cases on to traditional BH services.	4,8
gut vs. empirical proof	13
Hard to prove, carries significant stigma and potential consequences, could be wrong	13,12,7
Hard to prove, pressure from the top to not dx these.	13,1
Hard to prove, was seeing them for treatment not evaluations	13,9
Have worked in a forensic hospital and have idrectly observed malingering.	15
Have you seen this disorder and how often have diagnosed the disorder	15
having experienced/seen vs having diagnosed it	15
higher does not like to see those kinds of diagnosis	1
How many I think I saw and how many were diagnosed	15

I am a behavioral health consultant and deferred diagnosis to specialty behavioral health	4
I am currently assigned to admin duties	15
I am not allowed to correctly diagnose individuals pursuing secondary gains due to the political climate of the Army and DOD	1,5
I am not in a position to diagnose	4
I am not the primary care EBH provider giving the diagnosis. At IOP we follow the diagnosis primary EBH provider.	4
I can usually disabuse those patients of their agenda before coming up with a diagnosis	14
I did not diagnose the SM with the diagnosis they presented with as I felt symptoms were exaggerated but did not feel it warrnanted diagnosis of malingering. The second patient I realized was exaggerating symptoms upon releasing him/her from my care.	10
I did not have enough information to diagnose the SM with malingering (i.e. they dropped out of treatment, never showed for psych testing, etc.)	13
I do not think they were fabricating outright. the best clinical dispostion was made without need of charges	9,12
I documented in my notes complete discritions of inconsistencies and red flags, but did not give a definitive diagnosis due to risk to the soldier and not having enough information for a definitive diagnosis	12,13
I don't diagnose these disorders based on hunches or partial information, so unless I have clear evidence of these disorders (which is rare) I do not diagnose them	7,13
I don't screen for either.	10
i felt the pateint was too young to give that DX	14
I give Soldiers who have deployed the 'benefit of the doubt.'	6
I give the patient the benefit of the doubt, as instructed by OTSG	1,6
I give them the benefit of doubt and diagnose Adjustment Disorder	6
I have diagnosed malingering in the past with substantial documentation and direct clinical observations which also illustrated motivation for specific gain. Without that I don't make the diagnosis. I've never diagnosed factitious disorder.	13
I have had no cases of factitious disorder. Malingering is difficult to definitively prove; it is also a legal term with UCMJ consequences. Unless it is grossly obvious or the patient directly tells me they are fabricating/exaggerating symptoms for a specified gain, I will withold judgment on the veracity of their symptom presentation/severity. I will however note my observations, inconsistencies in patient's self-report, and clinical hypotheses in my documentation.	13,12,6
I have managed those cases. They were not my cases.	4
I never will. It is not socially or "politically" accepted	5, 11
I only conduct VA and TDRL evaluations; while I think that people are overexaggerating their symptoms (a type of malingering), I believe they have some genuine distress and are exaggerating because they are frightened of	2, 4

leaving the military.	
I only diagnosed 3 of the 100 and eventually took two of those diagnoses back. The military system and the MEB providers pushed back and forced me to change it.	8,1
I only had one encounter with the individual	4,7
I provide brief interventions and education only and would not feel comforatable making diagnosing these disorders based on my brief interactions	4,7
I put the behaviors in the 'wording' of the assessment rather than make a diagnosis. The diagnosing of facticious disorder could be harmful to the few who 'appear' to be facticious but are rather 'avoiding' or other behaviors. So, err on the side of hope for the SM rather than a harsh sentence because there are so many variables to a SM who has traumatic war experiences. If they come right out and say they are looking for a medical discharge and want to document as the reason for their visit instead of seeking care to get help overcoming their SXS. Then a closer look at facticious disorder is warranted. A lot of SM's don't know the way to present their SXS and feel they are being facticious but are just no longer 'sucking it up'. If the SM has PTSD the overall presentation will be clear. If I state that he/she is avoiding work and wants out of the military that could be avoidance as well as facticious. I describe the behaviors I see objectively and the determination puts it all together for the overall diagnostic impressions.	12
I referred them to the psychologist for MMPI, and then talked to them about what the results might mean in their situation.	4
I see secondary gain on a regular basis, motivated by a system that pays people to be sick, but I can't prove it.	13
I stayed focused on the issues presented. The individual(s) had legitimate BH concerns.	2,9
I try not to diagnose anyone with malingering because there is always an underlying reason they are looking for secondary gain. Many times I feel that reason is a cry for help and therefore do not use malingering often.	2, 10
I want to avoid legal ramifications, and I might be wrong	12,7,11
I wasn't able to see the patient on a regular enough basis but my clinical judgment was that they were malingering	4
I work in social work services. BH does the diagnosing of MH disorders generally	4
I work with a lot of trainees and often I think they are just putting on about suicidality to get out of the military, but its rare I can prove it and do a ch 11 rather than EPTS	13, 8
If I saw it, I would do the work to diagnose.	14
If people are avoiding, they often have other reasons.	10
I'm not the main provider, not enough time with patient	4
I'm still assessing (also I don't see AD very often, mainly non-AD)	14

Impairment of mission, daily functioning was not absolutely apparent; testing did not appear to be useful due to patient's lack of interpersonal insight	7,9
Informed only PHd or MD could DX this in the Army	1,4
Insufficient evidence to confirm, so did not diagnose	13
intent	15
It generally is more exaggeration than malingering, presumably because an MEB was being pursued. So secondary gain might have influenced reports of symptom severity; plus, the system will hang you out to dry if you diagnosed even genuine malingering	7, 11
It is difficult to prove and nearly impossible to follow through with administrative actions.	13,8
It is entirely difficult to prove malingering; I do not feel equip to make the proper diagnosis	13,3
It is frowned upon to diagnosis malingering	1
It is hard to prove with behavioral health if the person is exagerating their symptoms for secondary gain. There are times when I feel a lot of patients are presenting for secondary gain.	13
It is hard to prove, and system does not support making diagnosis	13,11,1
It is verbotten	1
It is very difficult to prove and never happens in my experience	13, 10
It was a grey area -- the person was exaggerating for secondary gain but had genuine symptoms.	7,2
It was more of a suspicion than an actual diagnosis	7
It was suspected but not confirmed	13
It would be countertherapeutic (could lead to empathic failure and acting out by patient), against policy, and it would create conflict/waste time available to care for other patients.	9,1,8,12
it's frowned upon to dx with malingering	1
I've been told not to diagnose malingering	1
Lack of evidence, just my clinical judgment	13
leave it to BH providers for objective diagnosis	3,4
leave it to the medboard to make that decision.	14
limited scope of practice in primary care	4,3
local policy requires psych-testing to valdate dx	1
malinger is medico-legally risky	11
malingering - secondary gain; factitious - sick role	15
Malingering = identifiable external gain; Factitious Disorder = internal gain	15
malingering as a diangosis is hard to prove, and not generally accepted in this population due to the negative connotation of calling a servicemember a liar, essentially.	13,5
Malingering can be part of Adj d/o w/MDEC, I don't always feel compelled to parse them out. Q13 says "think", not how many I gave a diagnosis to. I don't always dx what I think. Plus, dx of malingering, you got to back that up, can't always back that up by what you "think".	2,13

Malingering diagnosis takes multiple providers and time to ensure accuracy	8
Malingering dx requires OTSG approval along with substantial evidence which, most providers (outside of neuropsych) do not have the time, resources, or access to be able to gather.	1,8,13
malingering exists but difficult to defend as a dx	13
Malingering has been difficult to prove as a diagnosis and requires the signature of two providers, which is also difficult to obtain. Also, the medical system does not favor providers who utilize malingering as a diagnosis. The system protects the diagnosed patient far more than it protects the provider.	13,8,11,1
Malingering is a legal term, factitious disorder is the clinical diagnosis. Malingering requires secondary gain, factitious disorder does not.	12
Malingering is a UCMJ offense	12
malingering is difficult to prove so no dx was given	13
Malingering is hard to prove though secondary gain might be assumed.	13
Malingering is more calculated and concious	15
Malingering not a focus of treatment	9
malingering requires a higher burden of proof than clinical intuition.	13
MEDCOM restrictions on the diagnosis of malingering	1
military discourages these Dx	1
military guidance to avoid this diagnosis as determining intent is difficult	1,7
Military restrictions on diagnosising malingering. It is not codified but the Culter and Climate supercede any regulation!	1
more in-depth assessment was needed to validate	13
More trouble than it is worth	8,11
My perception is that malingering is difficult to prove if diagnosed and I did not see anyone that I would consider with a factitious disorder.	13
My thinking it is so based on a couple of sessions is not fair to attach the label. I see pt's typically 2 - 3 visits and they fly on to US.	4,7
n/a	15
N/A	15
n/a	15
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na	15
NA	15
na	15
need definite evidence	13
Need proof of that, because if you are wrong, the consequences for the future care of this person are bad. And, one was not my patient. I just point on discrepancies.	12,4,13
No	15
no	15
no	15
no	15
no because it's my preception.	10
no definitive evidence, more of a suspicion or gut feeling	13
No diagnosis	15
No difference	15
None	15
not 100% sure of malingering or facticious	7
not allowed to diagnose malingering because you can't ever prove it	1, 13
Not always necessary to diagnose to address. This type of behavior is common has ben seen relatively routinely neing in a FORSCOM unit and can often be	9

addressed adequately	
not applicable	15
Not clear cut enough to dx but more observable	7
not completely sure pt was malingering	7
not enough corroborating evidence	13
Not enough data from appointment to support test results, having no objective testing, unable to observe over time, and not enough corroborating information (various points of input)	13
Not enough time to thoroughly investigate to establish the diagnosis	8
not fully evidenced	13
Not in a forensic role, so clinical repercussions (e.g. lost rapport, potentially not supported by department) did not outweigh potential benefits.	4,11
Not in the space allowed. It's verboten, impossible to prove, often suspected. Many patients lie.	1, 13
not my role to diagnosis, chronic pain has magnifiers for desire to obtain medications and compensation, and been referred many in the past year	4
Not part of duty	4
Not politically correct to call a 'spade a spade.' Command will push back. Member will run to the press. No one wants to believe SM are lying to increase their disability payments. Part of the job I do not like. If the general public knew the extent of it they would be outraged.	1,5,11
Not politically feasible	5
Not sure I understand the intent of the question. Of course, there is a difference.	15
Not the primary provider	4
observation vs direct care	15
often it is a grey area that is more involved with exaggeration rather than outright complete malingering	7
one believes their is truly something wrong, the other fakes behavior for gain	15
One question is asking me what I think and the last question is asking how many I have diagnosed	15
One was diagnosed by another provider, the other was a suspicious case, but not likely to be able to be proven.	13
only aspects make me think malingering or over-exaggerating, not full criteria for factitious disorder	7
Other diagnoses were used.	2
Other providers saw the patients; difficult to diagnose	7
OTSG has provided guidance that individuals will be taken at their word. Additionally, many reasons to exagerate symptoms. These lables do not alway discribe the cinical picture acuratly.	1,6,9
OTSG said we should not diagnosis this	1
OTSG supports patient-centered care; the patient's subjective experience is paramount. Thus it requires monumental effort, data collection, collaboration with providers to justify how the objective assessment is contradictory to the	6,8,13

patient's subjective report of symptoms.	
Patient admitted to lying about a situation in the one who was diagnosed. No definitive evidence in the other cases	13
Patients seen were when providing coverage or at initial evaluation, thus I didn't make such a diagnosis	4
People exaggerate but in order to give the malingering diagnosis I have to be certain and malingerers rarely return if I am unwilling to give a hoped for diagnosis.I just tell them on the spot I'm not convinced the symptoms as reported warrant a diagnosis.	7,
Perhaps malingering is too strong a word - exaggerating is likely closer to the truth - I did not diagnose because the Army was treating them both so poorly that the Army actually created a trauma experience	10
Political climate	5
political ramifications and time burden responding to reprisals	1,5,8,11
political reasons, MEDCOM stance on "benefit of doubt" >>> truth	5,6
Politically incorrect and my own biases lead me to doubt. No extensive training for this diagnosis.	3,5,14,10
Politics	5
politics, unable to diagnose due to system restrictions and political implications	5,8,1
Potential for harm to Soldier discourages formal diagnosis	12
Pressure to not diagnose, Pressure to take Soldiers at their word	1,6
Proving malingering is a very labor intensive and stressful process and some patients are very good actors and players. In a cost-benefit analysis in this case, there was no clear win.	8,13,9
Psychological testing allows me to provide evidence of over-reporting but a diagnosis of malingering is a political bomb.	5
Public opinion and Army policy will not allow diagnosing a soldier with malingering, especially after they have deployed	5,1
Question 13 refers to your intial clinical impression but question 14 has to do with in depth anaylsis to ascribe a dianosis.	15
Question was "do you think". My intuition told me that the presentation was disingenuous or had secondary gain. I chose to document purely on what I saw and what was reported. My impressions, though also documented, when combined with the observations and report did not meet criteria for the diagnosis.	13
referred for psych testing	13
Regulations make it too difficult to make a malingering diagnosis stick. Not worth the effort.	1,8
relatively new	3
RTD of SM after assessment of no actual BH concern	9
secondary gain does not apply in factitious disorder	15
secondary vs. primary gain	15
see above	15

Seen but did not diagnose	15
Severity	14
soldiers I would have diagnoses requested to be transferred to other providers and were subsequently found to be retainable for MEB and/or Chaptered out of the military.	14
Some malingering may not equate to a diagnosis	10
Some presenting symptoms are not fully understood or appreciated by military command and/or personnel. Some behaviors are not condoned for any reason, however, they are symptomatic, rather than deliberate. Disagreement of diagnosis and motivations are difficult for some to conceptualize	1,7
some soldiers come to BH because they want out of the Army; they don't have a disorder but they endorse symptoms that they think will get them chaptered for BH reasons	15
Sometimes it is a secondary issue to a primary diagnosis. Sometimes those symptoms stem from personality disorders.	2
Sometimes the degree of the fabrication of sxs is not so severe as to warrnant and may fall w/i potential variables in presentation of sxs. I only identify the very obvious and blatant.	7
staff does not want to put this on the chart	1
Stigma about the diagnosis	12
Stigma assiciated with it.	11
stigma clearly associated with questioning SM's symptoms	1,11
still assessing	14
strongly discouraged from using those dx	1
Sure...I don't treat many patients given my position, but there are many folks who exaggerate symptoms for whatever reason. I wouldn't diagnose those folks with malingering; rather, I would just consider it part of human nature. Malingering in my opinion is the much more deliberate intention to manifest symptoms. The political and social climate really prevent providers from diagnosing malingering. If you diagnoses malingering, it's about two weeks before you get a call from the ombudsman, congressional representative, media, etc.	1,5,10,11
Suspect secondary gain but can't verify	13
suspect versus actually diagnosis or meeting the criteria	13
Suspected, not confirmed through testing or unable to complete/terminate treatment due to PCS	13
Suspecting malingering is different than having sufficient evidence to diagnose. Also a person may have the diagnosis but be malingering the extent of the symptoms	13,2
suspicion versus certainty	13
system does not allow for it	1
That is not how the military describes malingering and the patient did meet criteria for a DSM diagnosis (mental health disorder).	1,2
The Army does not want you to diagnose this condition	1
The biggest difference is a suspicion of having the disorder versus actually	15

diagnosing it.	
The case was very complicated, with a variety of providers working on the case, and a long history of treatment.	7
the cumbersome process to use the dx malingering	8
The diagnosis doesn't necessarily help them.	9
The difference would be thinking someone is malingering but not actually diagnosinig it.	14
The justifications required to diagnosed aren't recognized by the ARMY with LCSW (I'm not "qualified" to diagnose and have to have a PhD or MD support)	1,4
The one is suspect	15
The ones that actually have an mental health diagnosis, but also greatly exagerate, are not diagnosed with malingering. those who have no deployments, or obviously lie about their experiences, and there is evidence that their functioning is very good - those get dx with malingering.	2
The only way to diagnose malingering is by self admission of the patient. This is rare.	13
the other pt was diagnosed initially by another provider	14
the person was being removed from the army alreadyl	14
The politcally correct enviroment we live and work in does not always allow us to always call things as we see them.	1,5
The pt. exaggerated on the MMPI. After confrontation in session he was able to understand that he was exaggerating/not understanding his symptoms	14
The SM had already been diagnosed with another condition by another provider. I worked with the patients in a group but did not do the formal diagnosis.	2,4
there are cases with aspects of malingering but the patient still has probable adjutment issues	2
There are many BH patients who I feel are exaggerating symptoms whether it be to avoid some sort of work duty, get better ratings on MEB/ VA claim or for medicaitons. It is very difficult to descern, I and I only diagnose with malingering or facticious when I have substantial evidence as I do not want to do any harm to the patient.	13,12
There is a big difference between diagnosing someone with malingering or factitious disorder and believing they are exaggerating or lying about their symptoms.	10
There is a difference between what I believe to be happening and what I can prove to be happening. In the cases where I can't specifically prove malingering, it is too risky to my career and license to make any claim at all, so I have left it undocumented, but have included language in the note to indicate my concerns and suspicions, but have left them at concerns and suspicions.	13,11
There is almos always a degree of psychological distress that someone is experiencing. That is what we are trained to treat. Sometimes its inflated and that is the only way that people know how to communicate their needs. BUT, rarely, is there someone COMPLETELY playing the system. Most people have genuine dysfunction in some realm of their life.	9,2
there is no benefit to diagnose a person with such a condition.	9

There is pressure to not diagnose this	1
there must be sufficient evidence to diagnose either of those.	13
There was no way to prove that it was truly for secondary gain for the first case. The second, there was the idea of being a patient that was appealling to her, but once again lack of medical supporting documentation to show it is factitious.	13
There were less patients that I diagnosed with these disorders that I believe actually met the criteria. It is difficult to provide adequate documentation to support the diagnosis- and the documentation has to be very supportive.	13
There will be no consequence	14
There would be significant adverse consequences to diagnosing malingering; it is not allowed within the Army. I would not diagnose this because I suspect it would have negative implications on my credentials and perhaps my license. I don't believe the hospital would support the diagnosis (to include our legal services) if a soldier called it into question (e.g., via congressional inquiry). I believe we've had some strong messages that diagnosing malingering is never acceptable following the fusion cell debacle. I understand the cause for a change, but the pendulum has swung too far in the other direction at this point.	11,1
These disorders are poorly defined and understood.	10
They did have issues, just not the ones they wanted me to diagnose	2
they often had another diagnosis such as occupational problems, adjustment disorder, insomnia or substance use disorder which I was treating. I would just not give the diagnosis they seemed to be looking for and would explain why	2
This diagnosis for my treatment purposes is not as relevant	9
THIS DIAGNOSIS IS NOT ENCOURAGED WITHIN THE FIELD	1
those who wish to "fake" a condition for monetary gain and those who are "convinced" they have something wrong with them which might be psychosomatic.	2
Unable to prove	13
Unable to prove malingering	13
Uncertainty in diagnosis	7
unclear intent of patient's inaccurte reporting, recommendations from leadership not ot give these diagnoses, concern for professional license	1,11,7
unrelated; i didn't understand the FTE question but it made me put a number; i work full time, primary mission is clinical care	15
unsure since I primarily work with couples	15
Use of psychiatric diagnosis to support punitive legal action	12
Utilizing Slick criteria. Not always able to prove all of them.	13
Very conservative about diagnosing Malingering/factitious disorder. Thought more cases were, but not 100% sure enough to give the diagnosis.	7
Very difficult to prove/substaintiate exageration of symptoms for secondary gaines.	13
volition	15
Was discouraged by higher ups to not give a malingering diagnosis.	1
We are cautioned about the legal aspects of Malingering.	1, 12

We are not allowed to diagnose malingering or factitious disorder	1
We can't prove it! Think of the press!	13,5,11
We do not diagnose with malingering	1
We feel pressured to give the diagnosis of PTSD even if patients lie	1
We have been directed not to use the "malingering" term and it's just doesn't appear to be supported by our higher ups	1, 11
We ususally get them psych testing by clinical psychologist. That is their role. Very hard to decern a malingering Dx as most providers know.	4, 13
We're no allowed to diagnose anyone with malingering	1
when SM feel disrespected and shamed by the system they may seek compensation out of cynicism...I look for that	15
While I may feel that a patient is malingering, we have been informed to not diagnosis them with this diagnosis, thus most of my patients that likely are malingering are never diagnosed as such	1
With respect to malingering, you're having to establish a clear link from concscious behavior to secondary gain. Good luck on that.	7
Without proof of malingering, I am open to risk to my career. I am not confident my chain of command will support me.	11
Worrying about malingering gets in the way of treating people who need help. Im really not overly concerned about in therapy and the Army should stop worrying about those few bad apples to and start actually trying to take care of the ones who do need it. Just like the Army to worry over and try to fix the little problem instead of fixing the huge one.	9
wouldn't want to lose my job for telling the truth	11
Yes	15
yes - motivation of sick role - interpersonal benefit - factitious - external incentives - malingering	15
Yes - one is actually diagnosing the d/o versus just "seeing" the d/o in a SM.	15
Yes - thinking and diagnosing are very different	14
yes .. i conceptualize malingering as a diagnosis of exclusion and that is challenging due to variables such as comorbidities and personality organization in context of limited availability and resources (such as psych testing). I have encountered patients with symptoms of somatic exaggeration or preoccupation, but none in the past year who meet diagnostic criteria for FD.	13,8
yes, because of ability to do so	15
yes, malingerers feign diagnoses and people with factitious disorder lie	15
yes, malingering is "faking" a disorder in order to get something in return, Factitious Disorder is for the attention of being sick	15
yes, Malingering is intentional and factitious is not	15
Yes, while I suspect it's malingering, there are many times that the systemic requirements to diagnose it interfere. Additionally, there are many different reasons why someone may be feigning symptoms, so this adds another barrier to diagnosing.	1,8,2

yes, with factitious d/o a d/o is present and they symptoms are exaggerated. with malingering oftentimes all of the symptoms are made up	15
Yes, you can suspect malingering but because of the stigma of diagnosis in the military and what happens to the service member after I did not diagnose this.	12
Yes. In the past, I've suspected a patient or two was malingering, but the evidence was not convincing enough as to warrant the diagnosis.	13
Yes. I am taught to be extremely cautious with placing that diagnosis in patient chart without being extremly confident that is true diagnosis. Those two diagnosis can have harsh consequences on future care of these patients. For example, other providers not taking patient seriously.	1,7,12
Yes. Malingering has secondary gain. Factitious disorder has a primary goal of being the patient.	15
yes. there is a difference between clinical impression and substantial supporting data to give someone a diagnosis that has potential effects on career	13,12
you know why.....	15
You often have a lot of obvious evidence (including objective measures) to support exaggeration, with clear context of secondary gain, but these are not sufficient alone, or at least discouraged in regulation as the sole basis for diagnosis of malingering.	1,13