Curr Psychiatry Rep (2016) 18: 105
DOI 10.1007/s11920-016-0740-z

Identifying and Managing Malingering and Factitious Disorder in the Military

Sebastian Schnellbacher[1] · **Heather O'Mara**[1]

Published online: 17 October 2016

Abstract Malingering is the intentional fabrication of medical symptoms for the purpose of external gain. Along similar lines as malingering, factitious disorder is the intentional creation or exaggeration of symptoms, but without intent for a concrete benefit. The incidence of malingering and factitious disorder in the military is unclear, but likely under reported for a variety of reasons. One should be aware of potential red flags suggesting malingering or factitious disorder and consider further evaluation to look for these conditions. A deliberate and intentional management plan is ideal in these cases. Furthermore, a multi-disciplinary team approach, a non-judgmental environment, and the use of direct but dignity sparing techniques will likely be most "successful" when confronting the patient with malingering or factitious disorder.

Keywords Malingering · Factitious disorder · Military

Introduction

Malingering is the intentional fabrication of medical symptoms for the purpose of external gain [1]. One of the first definitions of "malingering" is found in a nineteenth century French dictionary as "a soldier who feigns sickness or induces or protracts an illness to avoid his duty" [2]. In the modern military, this external gain can manifest with time off work, deployability status, assignment limitations, duty restrictions, or monetary (disability) compensation. Within the US Military, this condition has been medically documented from before the civil war [3], throughout the World Wars [4], the Vietnam and Korean era [5], and also during recent conflicts.

In the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), factitious disorder is classified under the section on Somatic Symptoms and Related Disorders [1]. This is notable as there is a significant difference between factitious disorders and somatic symptom disorders. While individuals with somatoform disorders do not purposefully exaggerate or "fake" their symptoms, those with factitious disorders consciously deceive. Factitious disorders can be further broken into factitious disorder imposed on self and factitious disorder imposed on another (formally known as Munchausen disorder) [1]. Those with factitious disorder have no clear "external gain" from their falsification of symptoms and often deceive to assume a sick role. This distinguishes this disorder from malingering as individuals who malinger deceive for specific identifiable external gain. Of note, malingering is not classified as a mental illness.

The topics of malingering and factitious disorder generate strong debate within the military and veteran medical communities. The estimated frequency of malingering in these populations range widely from "rare" [6] to the "majority of claimants seeking disability compensation" [7, 8•]. The lack of any definitive objective assessment and deception on the part of the patient makes the diagnosis and management of this condition challenging. Furthermore, possible legal ramifications from a diagnosis of malingering carry additional challenges for the military medical and legal communities.

This article is part of the Topical Collection on *Military Mental Health*

✉ Sebastian Schnellbacher
sebastian.r.schnellbacher.mil@mail.mil

Heather O'Mara
heather.m.omara.mil@mail.mil

[1] Faculty Development Fellowship, Madigan Army Medical Center, 9040 Jackson Ave, Tacoma, WA 98431, USA

Epidemiology

It is difficult to establish the exact incidence of malingering in the US military. A 2013 retrospective chart review from 1998 to 2012 found that 5311 service members were diagnosed with malingering or factitious disorder as the primary diagnosis. This equates to an incidence rate of 2.82 diagnoses per 10,000 person years. In this population, 82.5 % ($n = 4380$) had only one encounter that recorded a diagnosis of malingering or factitious disorder. Three percent of these diagnoses occurred during deployments. Of the remaining cases, 7 % were diagnosed during hospitalizations, and 93 % during outpatient visits. This study noted higher (unadjusted) rates in recruits, service members under age 20, and the junior enlisted. Of the 4359 cases recorded in military treatment facilities that classified the types of services provided, 42.9 % were in psychiatric or mental health care settings, and 30.2 % were diagnosed in primary care [9•]. Another study reviewed outpatient encounters from 2006 to 2011 in the Northern Regional Medical Command. During this period, 1074 service members were diagnosed with malingering or factitious disorder over a period of 28,065,568 clinical encounters [10•]. These rates are much less than even the most conservative 1 % malingering rate thought to be present in the general population [2]. In comparison, Iancu et al. surveyed physicians in the Israel Defense Forces in 2003 and found that those physicians believed that every fourth Israeli Soldier was malingering [11]. Moreover, Rogers and Shuman's Conducting Insanity Evaluations documents that the malingering rate could be five times higher in the military than civilian populations [12].

Schnellbacher (2015) reports that the "reason for this potential under-diagnosis is unknown but likely multifactorial. 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. Finally, malingering carries significant legal implications in the military and providers might not want to subject their patients to this additional stressor" [13••].

Malingering and Post-Traumatic Stress Disorder in the Military

Post-traumatic stress disorder (PTSD) is the most common disorder associated with malingering in the military. In the past, the military required verification of combat exposure as part of the PTSD medical board process, but policies changed several years ago, instructing providers to base diagnosis almost entirely on a patient's self-report. As the diagnosis currently relies almost entirely on a self-report, it can be very susceptible to fabrication [14, 15]. In addition, veteran affairs (VA) policies make this specific disease more attractive to malingering. Unlike any other mental or physical diagnosis, any mental disorder that develops as a result of a highly stressful event will be assigned at least a 50 % disability (with a follow-up after a veteran's discharge to determine if a change is needed) [16]. As these evaluations rarely decrease the disability rating (in 2012, only 0.33 % of veterans saw a reduction in their ratings for PTSD [17]), this means that nearly all diagnosis of PTSD and other combat-related mental health conditions are at least given a 50 % rating instead of the standard VA disability system based off of functional impairment.

Diagnosis

Cost/Benefit Analysis

It is vital that one understands the possible benefits and risks when considering a diagnosis of malingering in a service member. On the one hand, the diagnosis of malingering can lead to legal or administrative consequences, undermine a patient's rapport with their provider, increase political stress for the medical system, and most importantly, if misdiagnosed could prevent a service member from accessing necessary treatment and support.

However, missing the diagnosis of malingering, can expose the service member to potentially harmful treatments [18], lead to iatrogenic impairment, or distract from an underlying psychiatric diagnosis [13••]. Frequently not diagnosing identified malingering can also impact other patients by taxing limited medical resources [16], and causing service members with "real" pathology to disassociate from medical care [13••]. Finally, not diagnosing malingering can lead to other systemic issues including decreased military readiness [19], impact systemic research on PTSD treatments [16], and lead to long-term economic costs [18].

Because of the potential harm of misdiagnosis, the diagnosis of malingering or factitious disorder should not be made lightly. In 2015, Schnellbacher et al. recommended that in a normal clinical environment, this condition should not be considered unless a provider first encounters malingering "red flags" [13••]. It is also advisable that providers making this diagnosis be experienced or very familiar with mental health disorders and the potential implications of this condition.

Red Flags (see Fig. 1)

There are several malingering red flags that a patient might display that would indicate that increased consideration and evaluation of malingering is warranted. These red flags fall into categories of abnormal presentation style, atypical symptoms, internal inconsistencies, and external inconsistencies

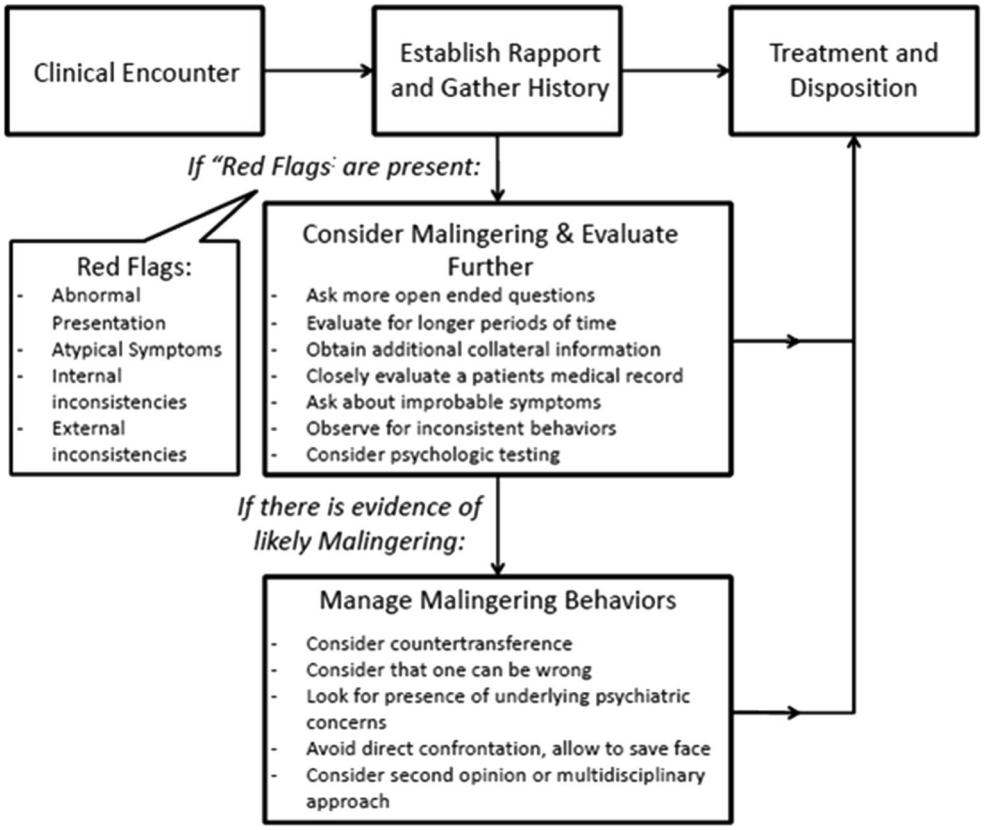

Fig. 1 Evaluation of malingering and red flags

[13••]. In order to best identify these flags, the provider should have an intimate familiarity with the typical presentation of the feigned disease [19].

A patient's style of presentation can occasionally reflect a pattern of malingering. For example, if a patient uses specific diagnostic terminology [14] (ex., describes having a "markedly diminished interest in activities") or reports symptoms in a clearly defined clinical order it [20] can raise suspicion [13••]. Similar suspicions might arise if a patient "readily brings up potentially distressing or embarrassing symptoms" [13••] or experiences with the provider, especially if a strong rapport has not been established [20, 21••]. Some patients who malinger do not show distress when discussing symptoms that normally elicit this reaction (ex., when describing graphic nightmares or intrusive hallucinations). Another example of an atypical presentation would be changes in cooperativeness and openness in an interview, especially when asked about specifics of symptom patterns or when encountering an inconsistency. Furthermore, deceptive reports tend to be more vague or conclusory in nature (a patient saying "I have PTSD and nightmares" but not being able to elaborate details when asked open-ended questions) [21••]. Finally, repetitive use of the exact same phrases or descriptions also can hint at rehearsal and potential deception [13••].

Atypical psychiatric symptoms by themselves do not indicate malingering, but do increase its likelihood. These symptoms differ by the feigned diagnosis but in general are more dramatic and more extreme in nature. Malingered symptoms also tend to be less variable and do not improve over time [18]. Furthermore, patients with true symptomatology can generally describe what they do to mitigate or improve their symptoms [14].

In PTSD, for example, there are several characteristics that are considered atypical. The most extreme atypical characteristics include reports of extreme and unusual traumas [14, 20], exaggerated frequent flashbacks, the need to act out on feelings of anger [14], and complete dissociation. Other atypical symptoms include a pattern of blaming others, glorifying one's own actions, a lack of survivor guilt, anger towards authority figures (instead of against themselves or their symptoms), not avoiding environmental stimuli that is associated with the trauma (including computer games or combat-related movies), having guilt to generalized rather than specific episodes, and maximizing impact of the trauma on one's life [5, 14].

Internal inconsistencies in a patient's history can also reveal possible deception [19, 21••]. These inconsistencies frequently manifest when additional history is collected over multiple encounters but can also occur if a patient presents a complicated history. One common example could be a patient's casual report about plans for the weekend that clearly conflict with their previous reported symptoms or level of impairment

[21••]. Other examples could be a history that is not consistent over time and different encounters.

Finally, external inconsistencies can also highlight the possibility of deception [21••]. A patient's history might contradict information provided you by the patient's chain of command [20], the patient's medical record (a long history of opioid prescriptions for example) [20], a service member's military records (awards, deployment history, etc.) [5, 20], or most commonly inconsistencies between a patient's self-report and directly observed behaviors [13••, 18]. Casual comparison of the patient during times that they are not being evaluated (observing the affect and behaviors of a patient in a waiting room compared to in the session) can frequently uncover malingering. At times, it can be easier to monitor a patient's behaviors during an inpatient setting. One case report described how a longer psychiatric hospitalization allowed for sufficient documentation and saved the VA from paying an estimated US$650,000 in fraudulent disability compensation [22].

Schnellbacher and Sullivan describe the difficulties of following the *DSM-5* recommendation to consider "malingering when a medico-legal context of presentation or a strong external motivator (such as financial gain) exists" [13••]. They report that this red flag "is difficult to apply in the military because every medical encounter, especially any encounter that describes a serious behavioral health condition, can be associated with significant long-term financial compensation." As a result, the authors normally do not utilize possible financial gain as a red flag for malingering in a typical *clinical* military medical encounter [13••].

Evaluation of Malingering: (see Fig. 1)

Once malingering red flags are encountered, it is a provider's responsibility to fully evaluate for this condition.

The first step is to obtain more detailed history with a greater emphasis on open-ended questions [5, 13••, 18]. It is extremely important this be conducted in an "objective manner, free of skepticism" [18, 21••]. If possible, collecting this prolonged history over more than one session can also help detect deception [19].

A patient's self-report can be supported by gathering additional collateral information [14, 20]. A soldier's chain of command is an extremely helpful and rich source of information that is normally not available in non-military psychiatric practice. Care should be taken to preserve the patient's confidentiality in these situations [13••]. A soldier's military records can confirm deployments, awards, and previous injuries. Similarly, a soldier's medical records can also confirm deployments (location of care), previous injuries, symptom pattern (a patient started reporting a dramatic increase in PTSD symptoms the day after receiving a DUI), and response to treatment. Non-response to evidence-based therapies and a lack of improvement over time should also raise suspicions [21••].

After red flags have been identified, a provider should actively look for other red flags that could also be present. One way to accomplish this is to unobtrusively observe a patient for inconsistent behaviors [20]. Over the course of an interview, a provider can easily evaluate a patient's ability to concentrate. A patient's engagement with other patients in the dayroom can reveal patterns of avoidance, hypervigilance, and irritability. If in an inpatient setting, a patient's sleep patterns can also be recorded. Other red flags can be garnered by actively asking about improbable symptoms [13••, 14]. This can be made more successful by asking about improbable symptoms in between several typical ones or by asking a leading question to make improbable symptoms seem more normal ("Are you left handed or right handed? Well in that case I assume that you hear the voices mainly from the right side of your body…") [13••]. Specific improbable symptoms that can be asked to patients with possible PTSD include having flashbacks that involve only one sensory modality [5], impulsive traveling, the decreased need for sleep, etc [14].

Psychologic testing is another important modality in the comprehensive evaluation of malingering. This can include simple in-office intelligence testing and effort measures but should ideally involve collaboration with a psychologist who has experience using objectively validated psychologic measures.

There are several techniques that can be used in a clinical encounter to screen for possible deception. Because many individuals assume that mental health patients have decreased cognitive abilities, malingering patients will occasionally answer simple questions (From what animal do we get milk? Who is the current president? What is 16 + 5?) incorrectly [13••]. A more subtle in-office screen would be based on memory recall. First, a provider gives a patient a list of 10 words and gives them a minute to memorize them. Next, the provider will give a list of 20 words, half of which were the words that the patient was previously asked to memorize. Random chance alone indicates that the patient should achieve at least 50 % correct. If significantly less than this is correct, there is a good likelihood that the patient is "intentionally giving poor effort" [5, 13••]. The Miller-Forensic Assessment of Symptoms (MFAST) is a screening tool for malingering that takes less than 10 min to complete and can also be utilized in a clinical encounter [14, 18, 21••].

There are numerous validated objective measures that can be used to assess for possible deception. Common tests include the Minnesota Multiphasic Personality Inventory—Second Edition (mainly the F and F-K scales), the Structured Interview of Reported Symptoms (SIRS), the Structured Inventory of Malingered Symptomatology (SIMS), and the TSI (Trauma Symptom Inventory) [5, 14, 15, 18, 20, 21••]. Results from these validated instruments

can objectively support clinical suspicion of deception. These tools are not recommended to determine malingering in isolation and are most effective when used in conjunction with a thorough psychiatric assessment.

Management

If a provider determines that the overall evidence shows that a patient is over-exaggerating or feigning symptoms it is often helpful to deliberately plan and prepare for future treatment.

It is first important to manage one's own countertransference [19]. It is vital to acknowledge that one's clinical suspicions could be wrong [13••] and that the patient is probably in some kind of significant distress [13••]. One should review the clinical picture again to minimize the chance for misdiagnosis and to further identify an underlying psychiatric condition. It can be helpful to ask a colleague to review one's findings to verify that the provider's clinical suspicions are reasonable.

It can also be constructive to consider possible underlying motivations that a specific patient might have to deceive (ex., concerns of being able to provide for family, fears of being killed or loosing family while deployed, desire to stay away from one's unit, etc.) [18]. This exploration not only allows for increased provider empathy but also allows a provider to better detect other stressors or psychiatric condition. Better understanding also maximizes the chance of successful patient engagement and treatment.

It is generally accepted that direct confrontation with the patient is counter-therapeutic [12, 16]. When this occurs, patients often become *more* invested in displaying and reporting feigned symptoms [13••, 14]. There are several techniques that can be used to allow a malingering patient to save face; all work better when the clinician is sympathetic and understanding [14, 21••]. A multi-disciplinary team approach can also be helpful [18].

One technique is to tactfully and non-judgmentally present inconsistencies to the patient and offer a face-saving way out of the interaction [13••, 14, 18, 19]. Several example scripts are as follows:

> The good news is that you don't have PTSD. I understand that you were very concerned about the possibility of this diagnosis. The symptoms that you described and your overall clinical presentation are not consistent with this diagnosis. Sometimes other issues are at play that can cloud a clinical picture. Sometimes these issues are stressful and can cause or worsen symptoms. At other times issues can frequently lead to exaggeration of symptoms. What I am most concerned about, however, is the symptoms you described as PTSD can frequently mask other psychologic distress. If it is ok, I'd like to talk with you some more and see how we can best help you. (Modified from Taylor 2006)

> The good news is you don't have PTSD or any other clinical disorder. At the same time it seems that you're quite unhappy about your life and are under a lot of stress. Although it is not appropriate to treat you for PTSD, I'd be quite happy to work with you and see if we can find ways of helping reduce stress and increase the amount of happiness in your life. (Modified from Taylor 2006)

> Your scores on the objective psychologic testing strongly correlate with symptom exaggeration. I've found that many of my patients who are in a situation similar to yours are just trying to communicate how sick they are and how much help they need. My problem is that there is so much noise that you are reporting to me it is hard for me to hear and focus on the issues you are most troubled by. I was wondering if you can help me with that." (Modified from Schnellbacher 2015)

Another technique, the "double blind technique" informs the patient that if they have genuine symptoms, they should improve with evidence-based treatment. This technique is not as desired as it can expose patients to treatments with potential harm.

Regardless of the technique, providers should be prepared for a possible negative reaction to the encounter [14, 18]. While some discussions lead to a positive therapeutic understanding, others can lead to agitation, threats of the inspector general investigations, hospital command complaints, and threats by the patient to call their government representatives. Many of these responses can be mitigated by maintaining a calm demeanor and offering to look up contact information to help facilitate communication. This negative reaction can also be minimized by proactively involving a patient advocate and/or offering a second opinion through standard institution processes. This demonstrates that one's actions are in line with hospital policy and that one is willing to support further evaluation on this issue if the patient desires. Some patient's reactions might involve extreme agitation, personal threats, or physical safety concerns towards the provider. Awareness of signs of patient escalation and following one's institution's agitated patient standard operating procedures can help mitigate this concern.

Malone reminds us that malingering symptoms "frequently abate only after the desired outcome has been achieved, or the effort is clearly seen as futile by the patient. It may therefore become necessary to point out the negative consequences of persisting in an unsuccessful attempt to deceive and to offer the patient an opportunity to avoid them. Obviously, the more the behavior has been reinforced, either earlier in the current episode or in prior episodes, the more likely it is to persist or recur" [19]. Phrasing this reminder in a supportive way is often more effective ("I know that to this point you have not known that you are engaging in a UCMJ violation, but I am

concerned that if this behavior persists you could bring on additional stressors. Instead, I would like to help you manage the stress you already have.").

Legal Ramifications

The Uniform Code of Military Justice (UCMJ) is the foundation of military law in the USA and applies to service members in the Air Force, Army, Navy, Marine Corps, and Coast Guard. Article 115 of UCMJ addresses malingering: "Any person subject to this chapter who for the purpose of avoiding work, duty, or service (1) feigns illness, physical disablement, mental lapse or derangement; or (2) intentionally inflicts self-injury… The essence of this offense is the design to avoid performance of any work, duty, or service which may properly or normally be expected of one in the military service. Whether to avoid all duty, or only a particular job, it is the purpose to shirk which characterizes the offense. Hence, the nature or permanency of a self-inflicted injury is not material on the question of guilt, nor is the seriousness of a physical or mental disability which is a sham. Evidence of the extent of the self-inflicted injury or feigned disability may, however, be relevant as a factor indicating the presence or absence of the purpose." Punishment for this offense depends on the severity of illness or inflicted injury and occurrence in a hostile fire zone or time of war. Simply feigning illness physical disablement, mental lapse, or derangement could result in dishonorable discharge, forfeiture of all pay and allowances, and confinement for 1 year. In the most severe cases, intentional self-inflicted injury in a hostile fire pay zone or in time of war could result in dishonorable discharge, forfeiture of all pay and allowances, and confinement for 10 years [23]. While there are several cases that have been successfully argued and subsequently charged under Article 115 [24], providers are often discouraged by legal counsel to recommend commanders pursue these charges. Speculatively, this hesitation may stem from the difficulty in "proving" these charges and the potentially negative "political storm" that may ensue.

Way Ahead

Additional research to better understand provider perspectives of malingering and factitious disorder in soldiers is greatly needed.

Conclusion

Malingering and factitious disorder have been described as intentional deception, and in the case of malingering, done with the intent for external gain. In the patient-provider relationship, one would like to think their expertise and provided services are being sought for physical, mental, and emotional benefit. However, one must also be alert to the possibility that the patient may be seeking services for alternative reasons. Being vigilant to potential "red flags" may prompt further evaluation for possible malingering or factitious disorder. If fully evaluated and suspicions confirmed, providers can then proceed to management. A multi-disciplinary team approach, creating a non-judgmental environment, will likely be most "successful" in confronting the patient's undesired behaviors.

Compliance with Ethical Standards

Conflict of Interest The authors declare that they have no conflict of interest.

Human and Animal Rights and Informed Consent This article does not contain any studies with human or animal subjects performed by any of the authors.

References

Papers of particular interest, published recently, have been highlighted as:
- • Of importance
- •• Of major importance

1. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 5th ed. Arlington, VA: American Psychiatric Publishing; 2013:309–327, 726–727.
2. 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.
3. Anderson DL, Anderson GT. Nostalgia and malingering in the military during the Civil War. Perspect Biol Med. 1984;28(1):156–66.
4. LUDWIG AO. Malingering in combat soldiers. Bull U S Army Med Dep. 1949;9(Suppl):26–32.
5. Hall RC, Hall RC. Detection of malingered PTSD: an overview of clinical, psychometric, and physiological assessment: where do we stand? J Forensic Sci. 2007;52(3):717–25.
6. OTSG/MEDCOM Policy Memo 12–035, policy guidance on the assessment and treatment of post-traumatic stress disorder (PTSD), 10 April 2012.
7. 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. Am J Public Health. 2007;97(12):2143–5.
8. • Frueh BC, McNally RJ. Why are Iraq and Afghanistan war veterans seeking PTSD disability compensation at unprecendented rates? J Anxiety Disord. 2013;27:520–6. **Perspective regarding increase malingering rates in the military and veteran population**.
9. • Armed Forces Health Surveillance Center (AFHSC). Malingering and factitious disorders and illnesses, active component, U.S. Armed Forces, 1998–2012. MSMR. 2013;20(7):20–4; discussion 23–4. **Study that utilized the military's EMR to report malingering diagnosis rates**.
10. • Lande RG, Williams LB. Prevalence and characteristics of military malingering. Mil Med. 2013;178(1):50–4. **Study that utilized the military's EMR to report malingering rates**.

11. Iancu I, Ben-Yehuda Y, Yazvitzky R, Rosen Y, Knobler HY. Attitudes towards malingering: a study among general practitioners and mental health officers in the military. Med Law. 2003;22(3): 373–89.
12. Rogers R, Shuman DW. Conducting insanity evaluations. 2nd ed. New York: Guilford; 2000.
13.•• Schnellbacher S, Sullivan R. Forensic and ethical issues in military behavioral health: chapter 15: malingering and factitious disorders. In: Borden books. 2015. **Good discussion on identification and management of malingering**.
14. Knoll J, Resnick PJ. The detection of malingered post-traumatic stress disorder. Psychiatr Clin North Am. 2006;29(3):629–47.
15. Guriel J, Fremouw W. Assessing malingered posttraumatic stress disorder: a critical review. Clin Psychol Rev. 2003;23(7):881–904.
16. 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.
17. Zarembo A. As disability awards grow, so do concerns with veracity of PTSD. LA Times. August 3, 2014.
18. 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.
19. Malone RD, Lange CL. A clinical approach to the malingering patient. J Am Acad Psychoanal Dyn Psychiatry. 2007;35(1):13–21.
20. Ingram TA, Dowben JS, Froelich KD, Keltner NL. Biological perspectives: detecting malingering of post-traumatic stress disorder (PTSD) in adults. Perspect Psychiatr Care. 2012;48(2):70–5.
21.•• Ali S, Jabeen S, Alam F. Multimodal approach to identifying malingered posttraumatic stress disorder: a review. Innov Clin Neurosci. 2015;12(1–2):12. **Good review to identify malingering in a general population**.
22. Furse SP, Azad A, Joshi KG, Faubion MD. Prolonged hospitalization and diagnostic clarification saves U.S. Air Force $650,000 in unwarranted disability payments. Mil Med. 2010;175(1):viii.
23. Article 115. Malingering, US Code Service. 10 USCS § 915, Title 10. Armed Forces, Subtitle A. General Military Law, Part II. Personnel, Chapter 47. Uniform Code of Military Justice, Subchapter X. Punitive Articles, § 915.
24. Ritchie C. Malingering and the United States military. In: Lande RG, editor. Principles and practice of military forensic psychiatry. Springfield: Charles C Thomas; 1997. p. 129–30.