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PTSD Disability Assessment

From 1999 to 2010, the number of Veterans of the United States military receiving compensation from the Department of Veterans Affairs (VA) for service-connected PTSD increased 222% to 386,882. This dramatic and rapid increase in the rate of diagnosed service-connected PTSD has intensified longstanding concerns that the VA's disability policies, procedures, and treatment programs promote compensation-seeking and illness behavior, while diminishing engagement in treatment because Veterans fear loss of compensation.

In this issue of the *PTSD Research Quarterly*, we explore the topic of the VA's disability evaluation for PTSD. More specifically, we review existing research that has examined the current assessment practices of PTSD compensation and pension (C&P) examiners and whether the VA's current policies and procedures promote secondary gain, illness behavior, and poor participation in treatment. We also review some existing work on the concern of symptom exaggeration and malingering among Veterans seeking service compensation for PTSD.

Current Assessment Practices

Following PTSD's entry into the diagnostic nomenclature, researchers and clinicians developed a multitude of reliable and valid questionnaires and structured interviews to aid in the assessment of the disorder. With so many evidence-based assessment tools available, clinicians have no legitimate excuse for not using them in their practice. This is particularly the case in PTSD C&P examinations, where the use of reliable and valid instruments may mean the difference between whether or not a Veteran obtains compensation for his or her PTSD. Despite the wide availability of evidence-based assessment

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tools and what may be at stake in these examinations, the available research suggests that many PTSD C&P examiners do not use such instruments. Specifically, in a study in which Jackson et al. (2011) surveyed 138 mental health professionals who conduct PTSD C&P examinations for the VA, only a small percentage of respondents reported that they regularly used standardized diagnostic interviews (ranging from 5% to 10%, depending upon the instrument). Fifty-nine percent of respondents rarely or never used any testing, and less than 1% reported using any functional assessment scales in their examinations. In addition, only 20% of participants stated that standardized clinical interviews are necessary for accurate PTSD assessment, and only 41% reported that psychological testing is necessary. Also, one-quarter of the surveyed PTSD C&P examiners reportedly believed that a considerable number of Veterans seeking compensation for service-related PTSD exaggerate their symptom reports, whereas another quarter of the sample believed that a similar number of Veterans seeking compensation minimize their PTSD symptoms. These results were consistent with those of another study that showed that treating clinicians viewed patients' engagement in treatment more negatively when they were seeking compensation for their PTSD than when they were not (Sayer & Thuras, 2002).

Effects of VA Policies and Procedures

A report by the Department of Veterans Affairs, Office of Inspector General (2005), supported the concern of some that service-connected disability for PTSD rewards illness behavior and diminishes engagement in treatment because Veterans fear loss

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of compensation. Specifically, the report stated that a significant number of Veterans may participate in treatment for the purpose of receiving compensation, only to drop out once they have obtained the maximum level of disability compensation allowed. However, other empirical studies do not necessarily corroborate this finding. Fontana and Rosenheck (1998) reported that, over a 1-year period, compensation-seeking did not negatively affect treatment outcome for outpatients. For inpatients, however, extremely long hospitalizations negatively affected the relation between compensation-seeking and treatment outcome. The authors suggested that this may be due to the more extreme psychopathology among these patients, or that such long stays necessitated an increase in compensation, simply as a matter of policy, due to extended absenteeism. Importantly, Fontana and Rosenheck also found no difference between the groups in treatment outcomes among individuals in shorter-stay inpatient programs, and found better outcomes among service-connected and compensation-seeking PTSD outpatients.

Sayer et al. (2004) reported that rate of mental health service use increased among those Veterans who received VA disability benefits for military-related PTSD, relative to those who did not receive such benefits. Specifically, the proportion of Veterans using mental health services after receiving benefits doubled over a 3-month period. Although the sample for this study was relatively small ($N = 452$) and restricted geographically to the Midwest, these results suggest that VA disability awards may have a positive influence on treatment-seeking among those with military-related PTSD.

Results of this study were corroborated by Spont, Sayer, Nelson, and Nugent (2007), who showed that, among a group of Veterans filing PTSD disability claims with the VA, medical and mental health service use increased after filing a disability claim compared with the pre-application period. The authors also found that increased use of mental health services was sustained after claim determination only for those Veterans whose claims were approved. These investigators also found that mental health service use before the disability examination was associated with an increased likelihood of claim approval. The authors concluded that, among Veterans with PTSD, disability system participation may both promote and be promoted by participation in the VA's mental health care services.

Sayer et al. (2007) also examined predictors of mental health service utilization among Veterans filing claims for VA disability benefits for PTSD. Results of this study showed that significant predictors of mental health care utilization were younger age, marital status, and dependence on public insurance. PTSD symptom severity and level of functional impairment did not predict treatment use, although those in treatment reported greater symptoms and disability compared with those who were not in treatment. The authors stated that the results suggest that there are multiple determinants of treatment service use among Veterans. Importantly, symptom exaggeration and potential malingering were not assessed in this study, and so there is no way to determine the effects of these factors on mental health service use among this sample. This study is also limited by its small, homogeneous sample and exclusion of other factors that might be important in determining mental health service use among PTSD disability-seeking Veterans.

In a prospective study, Spont, Sayer, Nelson, Clothier, Murdoch, and Nugent (2008) observed that an upcoming disability examination was associated with small but significant increases of PTSD symptoms among Veterans filing a claim for PTSD. Employment and income status moderated changes in PTSD symptom severity, such that participants who were unemployed and had lower incomes evidenced greater increases in PTSD symptoms than those who were employed and had higher incomes. Again, this association was associated with lower income and unemployment. In another prospective study, Sayer, Spont, Nelson, Clothier, and Murdoch (2008) observed that among Veterans who were no longer compensation-seeking (e.g., compensation was granted), there was no expected decline in symptoms or increase in treatment drop-out rate.

Finally, in a recently published study, Murdoch et al. (2011) studied the long-term outcomes related to receiving VA PTSD disability benefits. Results of this study showed that, 10 years later, Veterans who received such benefits showed greater PTSD symptom reductions and less poverty and homelessness than Veterans who were denied such benefits.

Concerns about Symptom Exaggeration and Malingering

Findings from studies over the past decade or so have provided mixed evidence regarding the concerns about PTSD symptom invalidity among compensation seekers or receivers. In one of the earliest studies on this topic, Smith and Frueh (1996) used the MMPI-2 to classify Veterans seen in a PTSD clinic into "exaggerators" and "non-exaggerators." Exaggerators exhibited more psychiatric comorbidity and scored higher on other indices of psychopathology; however, they did not differ on compensation-seeking status. A follow-up study by Gold and Frueh (1999), using stricter criteria for exaggeration, found that exaggeration was associated with compensation-seeking, but was no longer associated with comorbidity. Higher scores on the MMPI-2 F scale, an indicator of exaggerated response, have also been associated with increased (actual) symptomatology. For instance, a study by Franklin, Repasky, Thompson, Shelton, and Uddo (2002) found that compensation-seeking Veterans with elevated MMPI-2 F scores were not purposely exaggerating their symptoms, or attempting to deceive assessors, but rather were experiencing extreme distress. Later, Frueh et al. (2003) observed that compensation-seeking Veterans exhibited higher scores on measures of psychopathology, even while controlling for income level. Furthermore, compensation-seeking Veterans also scored higher on MMPI-2 validity scales and were more likely to be classified as exaggerators. DeViva and Bloem (2003) also found exaggeration on the MMPI-2 was associated with higher scores on measures of psychopathology, but not compensation-seeking. Similarly, neither compensation-seeking nor exaggeration was associated with treatment outcome. Grubaugh, Elhai, Monnier, and Frueh (2004) observed higher scores on the MMPI-2 F scale among compensation-seeking Veterans, but no differences in healthcare utilization among the compensation-seeking and non-compensation-seeking groups. This suggests that even if some Veterans exaggerated claims, they were also motivated to obtain treatment for their difficulties. Arbisi, Murdoch, Fortier, and McNulty (2004) compared Veterans undergoing C&P exams with high and low scores on the MMPI F(p) scale, detecting no difference in award decisions or healthcare utilization, and although available,

these scores were not routinely considered in the final determination of PTSD compensation. This may have been because they were deemed inaccurate upon interview, or were simply overlooked, though they appear to have been used more often in cases in which the determination was a PTSD diagnosis.

Finally, Freeman, Powell, and Kimbrell (2008) reported that 53% of treatment-seeking (especially compensation-seeking) Veterans exaggerated symptoms or malingered on psychological tests. The tendency to exaggerate symptoms, as assessed by an interview measure, was associated with elevated PTSD symptoms but not with elevations in other forms of psychopathology among Vietnam Veterans. Freeman et al. suggested that, even among other decidedly subjective mental disorders, PTSD is a condition that is especially likely to be exaggerated. Importantly, though, service-connected PTSD was no more common among Veterans who exaggerated symptoms than it was among Veterans who did not exaggerate. This finding is inconsistent with the hypothesized negative impact of VA psychiatric disability policies.

Unfortunately, due to limitations in current measurement and methodology as well as the fact that, as would be expected, self-identifying malingerers are extremely rare, direct evidence regarding the prevalence of malingering or exaggeration among Veterans who are applying for or who have received service connection for PTSD does not exist. Prior estimates have only been based on conjecture, case examples, or small-scale convenience samples. In what may be the strongest evidence regarding the validity of estimates of military-related PTSD, an internal study conducted in 2005 by the VA Office of the Inspector General (OIG) showed that, out of 2,100 reviewed service-connected PTSD cases, only 13 (0.6%) were potentially fraudulent. The results of this study by the VA suggest that malingered PTSD is not nearly as prevalent as what others have suggested. These VA findings were corroborated by Dohrenwend et al. (2006), who found no evidence of malingering and virtually no evidence of attempts to inflate disability claims.

Conclusion

In summary, the most recent studies suggest that, although many PTSD compensation and pension examiners note the importance of testing and are concerned about exaggeration or outright malingering of PTSD symptoms, the overwhelming majority of them are not using standardized, psychometrically sound assessment instruments to assess PTSD in their compensation and pension examinations. More research is needed to better understand the disconnect between examiner attitudes and practices. In contrast to concerns by some in the community, the balance of research suggests that VA disability policy and practices may not promote secondary gain and illness behavior. However, additional research with larger representative samples is needed to determine if there are specific situational and/or characterological factors that might influence this association.

Finally, research has provided mixed evidence regarding the concerns about PTSD symptom invalidity among compensation seekers or receivers, and the exact prevalence of malingering or exaggeration among Veterans who are applying for or who have received service connection for PTSD is still unknown. Unquestionably, some Veterans are enticed by the prospect of steady and substantial income, and some may indeed inflate the

extent to which they may suffer from PTSD symptoms in order to receive compensation. However, more research is needed to determine the true extent to which this occurs. Future research has enormous potential to shape policy in this area as well as to affect the lives of countless Veterans.

FEATURED ARTICLES

Arbisi, P. A., Murdoch, M., Fortier, L., & McNulty, J. (2004). **MMPI-2 validity and award of service connection for PTSD during the VA Compensation and Pension evaluation.** *Psychological Services, 1*(1), 56-67. doi: [10.1037/1541-1559.1.1.56](https://doi.org/10.1037/1541-1559.1.1.56). From an initial pool of 699 Minnesota Multiphasic Personality Inventory-2s (MMPI-2s) obtained as part of the Department of Veterans Affairs (VA) Compensation and Pension (C & P) examinations for PTSD, the authors selected individuals with raw scores above 7 on the Frequency Psychopathology (F(p)) scale. The high F(p) group was matched to individuals with scores of 2 or less on the F(p) scale, and MMPI-2 interpretations, rates of disability awards for PTSD, and subsequent health care utilization were compared. The majority of psychological reports in the high F(p) group failed to indicate that the claimant's MMPI-2 appeared invalid. Moreover, there was no significant difference in rates of disability awards for PTSD or health care utilization across groups.

Department of Veterans Affairs. Office of the Inspector General. (2005). **Review of state variances in VA disability compensation payments.** (#05-00765-137). Washington, DC: Department of Veterans Affairs.

DeViva, J. C., & Bloem, W. D. (2003). **Symptom exaggeration and compensation seeking among combat veterans with posttraumatic stress disorder.** *Journal of Traumatic Stress, 16*(5), 503-507. doi: [10.1023/A:1025766713188](https://doi.org/10.1023/A:1025766713188). Combat veterans seeking treatment for PTSD tend to report high levels of psychopathology on self-report instruments. The purpose of the current archival study was to replicate research on the relationships among symptom exaggeration, attempts to obtain compensation, and treatment outcome on the Beck Depression Inventory, the Mississippi Scale for Combat-Related PTSD, and selected MMPI-2 and MCMI-II subscales. Results indicated that symptom exaggeration as defined by an MMPI-2 F-K index over 13 was related to higher scores on all scales examined. Compensation seeking was not related to assessment scores or exaggeration. Neither compensation seeking nor exaggeration was related to treatment outcome. Limitations of the study and implications for future research are discussed.

Dohrenwend, B. P., Turner, J. B., Turse, N. A., Adams, B. G., Koenen, K. C., & Marshall, R. (2006). **The psychological risks of Vietnam for U.S. veterans: A revisit with new data and methods.** *Science, 313*(5789), 979-982. doi: [10.1126/science.1128944](https://doi.org/10.1126/science.1128944). In 1988, the National Vietnam Veterans Readjustment Study (NWRs) of a representative sample of 1200 veterans estimated that 30.9% had developed PTSD during their lifetimes and that 15.2% were currently suffering from PTSD. The study also found a strong dose-response relationship: As retrospective reports of combat exposure increased, PTSD occurrence increased. Skeptics have argued that these results are inflated by recall bias and other flaws. We used military records to construct a new exposure measure and to cross-check exposure reports in diagnoses of 260 NWRs veterans. We found little evidence of falsification, an even stronger dose-response relationship, and psychological costs that were lower than previously estimated but still substantial. According to our fully adjusted PTSD rates, 18.7% of the veterans had developed war-related PTSD during their lifetimes and 9.1% were currently suffering from PTSD 11 to 12 years after the war; current PTSD was typically associated with moderate impairment.

Fontana, A., & Rosenheck, R. (1998). **Effects of compensation-seeking on treatment outcomes among veterans with posttraumatic stress disorder.** *Journal of Nervous and Mental Disease, 186*(4), 223-230. doi: [10.1097/00005053-199804000-00004](https://doi.org/10.1097/00005053-199804000-00004). The desire to acquire or increase financial compensation for a psychiatric disability is widely believed to introduce a response bias into patients' reports of their symptoms and their work performance. The hypothesized effects of compensation-seeking in inhibiting improvement from treatment are examined. Data from outpatient ($N = 455$) and inpatient ($N = 553$) programs for the treatment of

posttraumatic stress disorder and associated disorders in the Department of Veterans Affairs were used to compare outcomes for veterans who were and were not seeking compensation. Outcome was measured as pre/post improvement in symptoms and work performance over the course of 1 year after the initiation of treatment. No compensation-seeking effect was observed among outpatients, but a significant effect was found for some inpatients. The effect for inpatients was manifested essentially by patients in a program type which was designed to have an extremely long length of stay, thus triggering a virtually automatic increase in payments. Like outpatients, inpatients in programs with a moderate length of stay did not manifest a compensation-seeking effect on improvement. Although not permitting a definitive explanation, the preponderance of the evidence favors the overstatement of symptoms rather than either the severity or the chronicity of the disorder as the most likely explanation for the compensation-seeking effect that was observed. For patients treated in standard outpatient and short-stay inpatient programs, compensation does not seem to affect clinical outcomes adversely.

Franklin, C. L., Repasky, S. A., Thompson, K. E., Shelton, S. A., & Uddo, M. M. (2002). **Differentiating overreporting and extreme distress: MMPI-2 use with compensation-seeking veterans with PTSD.** *Journal of Personality Assessment*, 79(2), 274-285. doi: 10.1207/S15327752JPA7902_10. The purpose of this study was to examine overreporting on the Minnesota Multiphasic Personality Inventory-2 (MMPI-2; J. N. Butcher, W. G. Dahlstrom, J. R. Graham, A. Tellegen, and B. Kaemmer, 1989) in compensation-seeking veterans with PTSD. A sample of veterans tested during a VA hospital compensation and pension exam were given the MMPI-2 and measures of PTSD, depression, and combat exposure. 127 veterans' (121 males and 6 females, mean age 52.8 yrs) MMPI-2s were included in the analyses and had a primary diagnosis of PTSD. Using the Infrequency-Psychopathology, F(p), scale to distinguish overreporting from distress, it was found that 98 veterans elevated profiles due to distress, whereas 29 elevated due to overreporting, F(p) below and above 7, respectively. Differences between groups on MMPI-2 clinical scales and the other measures were assessed. Implications of these findings for assessing veteran response style and using the MMPI-2 with a PTSD population are discussed.

Freeman, T. W., Powell, M. D., & Kimbrell, T. A. (2008). **Measuring symptom exaggeration in veterans with chronic posttraumatic stress disorder.** *Psychiatry Research*, 158(3), 374-380. doi: 10.1016/j.psychres.2007.04.002. Veteran subjects with chronic, combat-related PTSD are frequently used as research subjects in the study of PTSD. However, questions have consistently been raised regarding PTSD symptom exaggeration in veteran populations due to the relationship between PTSD symptoms and disability payments within the Veterans Affairs (VA) system. We used a variety of standardized forensic instruments frequently utilized in measuring symptom exaggeration – including the MMPI-2, the Structured Interview for Reported Symptoms (SIRS), the Structured Inventory of Malingered Symptomatology (SIMS), and the Miller Forensic Assessment Test (MFAST) – to examine symptom report in a group of veterans presenting for treatment at a VA residential PTSD treatment program. The majority of Vietnam veteran subjects in our study (53%) exhibited clear symptom exaggeration by SIRS criteria. Within the entire subject group, total SIRS scores correlated significantly with reported PTSD symptom severity as measured by the Clinician Administered PTSD Scale (CAPS).

Frueh, B. C., Elhai, J. D., Gold, P. B., Monnier, J., Magruder, K. M., Keane, T. M., & Arana, G. W. (2003). **Disability compensation seeking among veterans evaluated for posttraumatic stress disorder.** *Psychiatric Services*, 54(1), 84-91. *Objective:* This study sought to further examine the relationship between compensation-seeking status and reporting of symptoms among combat veterans who were evaluated for PTSD. *Methods:* Archival data were drawn for 320 adult male combat veterans who were consecutively evaluated at a Department of Veterans Affairs (VA) PTSD outpatient clinic from 1995 to 1999. The veterans were compared on variables from their clinical evaluation, including diagnostic status and self-report measures such as the Minnesota Multiphasic Personality Inventory-2, which includes scales designed to detect feigned or exaggerated psychopathology. *Results:* Compensation-seeking veterans reported significantly more distress across domains of psychopathology, even after the effects of income had been controlled for and despite an absence of differences in PTSD diagnoses between groups. However, compensation-seeking veterans also were much more likely to

overreport or exaggerate their symptoms than were non-compensation-seeking veterans. *Conclusions:* This study provided further evidence that VA disability compensation incentives influence the way some veterans report their symptoms when they are being evaluated for PTSD. These data suggest that current VA disability policies have problematic implications for the delivery of clinical care, evaluation of treatment outcome, and rehabilitation efforts within the VA.

Gold, P. B., & Frueh, C. B. (1999). **Compensation-seeking and extreme exaggeration of psychopathology among combat veterans evaluated for posttraumatic stress disorder.** *Journal of Nervous and Mental Disease*, 187(11), 680-684. doi: 10.1097/00005053-199911000-00005. We extended the work of Smith and Frueh (1996) by evaluating whether combat veterans classified as "extreme exaggerators" were more likely to be compensation-seeking, and to report greater levels of psychopathology across self-report instruments than "nonexaggerators." Of 119 veterans who completed the Minnesota Multiphasic Personality Inventory-2 (MMPI-2) at an outpatient PTSD clinic, 26 (22%) and 17 (14%) were identified as extreme exaggerators using two MMPI-2 validity indicators with stringent cutoffs ($F-K \geq 22$; $F(p) \geq 8$). These veterans were much more likely to be compensation seeking and scored much higher on self-report measures of various psychological symptoms than non-exaggerators, despite having lower rates of PTSD diagnoses and similar rates of other comorbid diagnoses. Findings suggest that the validity indices of the MMPI-2 can play a critical role, as a screening instrument, in identifying veterans who may be exaggerating their psychopathology to gain disability compensation.

Grubaugh, A. L., Elhai, J. D., Monnier, J., & Frueh, B. C. (2004). **Service utilization among compensation-seeking veterans.** *Psychiatric Quarterly*, 75(4), 333-341. doi: 10.1023/B:PSAQ.0000043509.18637.3b. To examine the relationship between compensation-seeking status, symptom reporting, and healthcare utilization among combat veterans presenting for a PTSD evaluation, archival data for 68 veterans was drawn from electronic medical records for which compensation-seeking status was available. Consistent with previous findings, self-reports of distress and validity scale indices on the Minnesota Multiphasic Personality Inventory-2 (MMPI-2) were higher among compensation-seeking (CS) veterans than noncompensation-seeking (NCS) veterans despite a lack of difference in actual PTSD diagnoses. However, no significant differences emerged between these two groups on healthcare utilization indices. Although exploratory analyses did not yield significant group differences on various healthcare indices, there was a trend for CS veterans to use PTSD services more, suggesting the need to further explore utilization patterns among these groups.

Jackson, J. C., Sinnott, P. L., Marx, B. P., Murdoch, M., Sayer, N. A., Alvarez, J. M., et al. (2011). **Variation in practices and attitudes of clinicians assessing PTSD-related disability among veterans.** *Journal of Traumatic Stress*, 24(5), 609-613. doi: 10.1002/jts.20688. One hundred thirty-eight Veterans Affairs mental health professionals completed a 128-item PTSD Practice Inventory that asked about their practices and attitudes related to disability assessment of PTSD. Results indicate strikingly wide variation in the attitudes and practices of clinicians conducting disability assessments for PTSD. In a high percentage of cases, these attitudes and practices conflict with best-practice guidelines. Specifically, 59% of clinicians reported rarely or never using testing, and only 17% indicated routinely using standardized clinical interviews. Less than 1% of respondents reported using functional assessment scales.

Murdoch, M., Sayer, N. A., Spont, M. R., Rosenheck, R., Noorbaloochi, S., Griffin, J. M., et al. (2011). **Long-term outcomes of disability benefits in U.S. veterans with posttraumatic stress disorder.** *Archives of General Psychiatry* 68(10), 1072-1080. *Context:* Most studies examining the clinical impact of disability benefits have compared aid recipients with people who never applied for benefits. Such practices may bias findings against recipients because disability applicants tend to be much sicker than never-applicants. Furthermore, these studies ignore the outcomes of denied claimants. *Objective:* To examine long-term outcomes associated with receiving or not receiving Department of Veterans Affairs (VA) disability benefits for PTSD, the most common mental disorder for which veterans seek such benefits. *Design:* Comparison of outcomes between successful and unsuccessful applicants for VA disability payments. Because we could not

randomize the receipt of benefits, we used exact matching by propensity scores to control for potential baseline differences. We examined clinical outcomes approximately 10 years later. *Setting and Participants*: Stratified, nationally representative cohort of 3337 veterans who applied for VA PTSD disability benefits between January 1, 1994, and December 31, 1998. *Main Outcome Measures*: Assessment on validated survey measures of PTSD; work, role, social, and physical functioning; employment; and poverty. We compared outcomes with earlier scores. Homelessness and mortality were assessed using administrative data. *Results*: Of still-living cohort members, 85.1% returned usable surveys. Symptoms of PTSD were elevated in both groups. After adjustment, awardees had more severe PTSD symptoms than denied claimants but were nonetheless more likely to have had a meaningful symptom reduction since their last assessment (-6.1 vs -4.4 ; SE, 0.1; $P = .01$). Both groups had meaningful improvements of similar magnitude in work, role, and social functioning (-0.15 vs -0.19 ; SE, 0.01; $P = .94$), but functioning remained poor nonetheless. Comparing awardees with denied claimants after adjustment, 13.2% vs 19.0% were employed ($P = .11$); 15.2% vs 44.8% reported poverty ($P < .001$); 12.0% vs 20.0% had been homeless ($P = .02$); and 10.4% vs 9.7% had died ($P = .66$). *Conclusions*: Regardless of claim outcome, veterans who apply for PTSD disability benefits are highly impaired. However, receiving PTSD benefits was associated with clinically meaningful reductions in PTSD symptoms and less poverty and homelessness.

Sayer, N. A., Clothier, B., Spont, M., & Nelson, D. B. (2007). **Use of mental health treatment among veterans filing claims for posttraumatic stress disorder.** *Journal of Traumatic Stress, 20*(1), 15-25. doi: 10.1002/jts.20182. This study examines predictors of current mental health service use in a sample of 154 veterans filing claims for Veterans Affairs (VA) disability benefits based on PTSD. Our conceptual framework was the behavioral model that classifies predictors of service utilization into predisposing (background), enabling (e.g., insurance) and need (e.g., symptoms) factors. Slightly more than half of the PTSD claimants were receiving mental health treatment at the time of claim initiation. Mean symptom levels were clinically significant in both users and nonusers of mental health treatment. In a multivariate logistic regression analysis, mental health treatment use was associated with younger age, marriage, and dependence on public insurance. Implications for future research are discussed.

Sayer, N. A., Spont, M., & Nelson, D. B. (2004). **Disability compensation for PTSD and use of VA mental health care.** *Psychiatric Services, 55*(5), 589-589. Presents a letter to the editor on concerns about the influence on PTSD treatment of disability compensation for PTSD through the Department of Veterans Affairs (VA). The main concern is that the compensation program may create an incentive for veterans to exaggerate symptoms or even malingering. Some have claimed that malingering is rampant and that those who engage in this behavior drop out of PTSD treatment once they are awarded benefits. The authors examined the effects of obtaining VA disability benefits for PTSD on participation in VA mental health treatment in a large Midwestern region. They found that the rate of mental health service use increased after PTSD disability benefits were awarded. The authors examined variation in service use as a function of the PTSD disability rating. The rate of mental health service use increased as disability level increased. These findings suggest that VA disability awards for PTSD may provide an impetus for veterans to enter VA mental health treatment at an intensity level commensurate with their disability rating. The increase in mental health service use is consistent with cross-sectional research demonstrating that veterans with VA disability benefits are more likely to use VA services.

Sayer, N. A., Spont, M., Nelson, D. B., Clothier, B., & Murdoch, M. (2008). **Changes in psychiatric status and service use associated with continued compensation seeking after claim determinations for posttraumatic stress disorder.** *Journal of Traumatic Stress, 21*(1), 40-48. doi: 10.1002/jts.20309. This study examined changes in psychiatric status and use of VA mental health services after the adjudication of Department of Veterans Affairs (VA) disability claims for PTSD in a sample of 101 veteran claimants. Hypotheses were based on the premise that the claims process may create incentives for veterans to demonstrate illness. After the PTSD claim determination, half the sample had filed or planned to file a claim for a rating increase or an appeal and thus remained compensation seeking. Contradicting the authors' hypotheses, psychiatric status did not improve

and treatment drop-out rates did not increase among veterans who were no longer compensation seeking after the claim determination. Results have implications for the design and direction of future research.

Sayer, N. A., & Thuras, P. (2002). **The influence of patients' compensation-seeking status on the perceptions of Veterans Affairs clinicians.** *Psychiatric Services, 53*(2), 210-212. The study compared clinicians' perceptions of three groups of veterans with PTSD: those seeking compensation for PTSD, those not seeking compensation, and those certified as permanently disabled and thus not needing to reapply for benefits. The study subjects were 50 clinicians working in specialized PTSD programs of the Department of Veterans Affairs. The clinicians had a more negative view of the treatment engagement of veterans who were seeking compensation and of clinical work with these patients than they did in the case of the other two groups. The longer clinicians had been working with veterans who had PTSD, the more extreme were these negative perceptions. Most clinicians expressed a belief that the pursuit of service connection for PTSD has a negative impact on the therapeutic relationship and on clinical work in general.

Smith, D. W., & Frueh, B. C. (1996). **Compensation seeking, comorbidity, and apparent exaggeration of PTSD symptoms among Vietnam combat veterans.** *Psychological Assessment, 8*(1), 3-6. doi: 10.1037//1040-3590.8.1.3. We evaluated whether veterans who apparently exaggerate their symptoms are more likely to be (a) seeking disability compensation or (b) suffering from more comorbid pathology than nonexaggerating veterans. Fifty-four of 145 (37%) veterans with posttraumatic stress disorder who completed the Minnesota Multiphasic Personality Inventory—2 [(J. N. Butcher, W. G. Dahlstrom, J. R. Graham, A. Tellegen, & B. Kaemmer, 1989)] were identified as apparent exaggerators, with F (Frequency) - K (Correction) > 13 . These participants scored higher than nonexaggerators on self-report measures of various psychological symptoms but were no more likely to be seeking compensation or to have comorbid substance use or other anxiety disorders. Affective disorder was overrepresented among apparent exaggerators, however. Findings support the hypothesis of increased comorbidity among symptom exaggerators as measured by the $F - K$ index but not the commonly held belief that symptom exaggerators are more likely to seek compensation.

Spont, M. R., Sayer, N. A., Nelson, D. B., Clothier, B., Murdoch, M., & Nugent, S. (2008). **Does clinical status change in anticipation of a PTSD disability examination?** *Psychological Services, 5*(1), 49-59. doi: 10.1037/1541-1559.5.1.49. Although there has been considerable research on forensic aspects of disability evaluations for mental health claims, there has been little focus on the clinical impact of disability system participation. Using a prospective design, we examined whether disability system participation affected psychiatric symptom and disability levels in claimants filing for VA disability benefits on the basis of PTSD. Claimants had high levels of PTSD symptoms and disability at the time of claim initiation. Modest increases in illness severity were observed at the time of the disability examination. Factors associated with symptom change were income level and employment status. Negative expectations about the disability claims process were associated with severity of PTSD symptoms, but not with change in symptom levels over time.

Spont, M. R., Sayer, N. A., Nelson, D. B., & Nugent, S. (2007). **Does filing a post-traumatic stress disorder disability claim promote mental health care participation among veterans?** *Military Medicine, 172*(6), 572-575. This study examined the impact of participation in the Department of Veterans Affairs (VA) disability system on health care use by veterans filing disability claims on the basis of PTSD. VA administrative databases were used to examine health care use in 3-month intervals before, during, and after veterans' filing of PTSD disability claims. Subjects were all veterans using some VA health care who filed PTSD claims between 1997 and 1999 in a large Midwestern region. PTSD claimants used more medical and mental health services after filing a disability claim, compared with the pre-application period. Continuation of elevated mental health care use after claim determination occurred only for those veterans whose claims were approved. Use of VA mental health care before the disability examination was associated with an increased likelihood of claim approval. For veterans with PTSD, disability system participation may both promote and be promoted by receipt of mental health care.

ADDITIONAL CITATIONS

Frueh, B. C., Grubaugh, A. L., Elhai, J. D., & Buckley, T. C. (2007). **U.S. Department of Veterans Affairs disability policies for posttraumatic stress disorder: Administrative trends and implications for treatment, rehabilitation, and research.** *American Journal of Public Health, 97*(12), 2143-2145. doi: 10.2105/AJPH.2007.115436.

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