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A Practical Guide to Conducting VA Compensation and Pension Exams for PTSD and Other Mental Disorders

Mark D. Worthen · Robert G. Moering

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Abstract Despite being one of the most common forensic mental health evaluations, no article has ever appeared in a peer-reviewed journal describing how to conduct US Department of Veterans Affairs (VA) mental health compensation and pension examinations. This article rectifies that paucity of information. We outline the legal framework, ethical considerations, and administrative challenges inherent in these evaluations. We provide separate guidelines for private practice clinicians and VA staff or contractors. We pay special attention to the multiple sources of collateral information available for these exams and how to access relevant records. The article alerts examiners to the possibility that they might face resistance from VA officials if they screen for and assess symptom exaggeration or feigning and that they could encounter VA-imposed restrictions on time allotted for exams. Specific suggestions are made for different types of exams: Initial Post-traumatic Stress Disorder (PTSD), PTSD Review, Initial Mental Disorder, and Mental Disorder Review.

Keywords PTSD · Veterans Affairs (VA) · Compensation and pension (C&P) examination · Disability Benefits Questionnaire (DBQ)

In the US Department of Veterans Affairs (VA) 2010 Fiscal Year, 60,535 veterans began to receive VA disability benefits for mental disorders (Veterans Benefit Administration, 2010). The majority of those veterans received a compensation and pension examination (C&P exam) at a VA facility or a contract provider's office.

Beginning in 2011, private providers (primarily psychologists and psychiatrists although other mental health professionals are eligible[1]) will be able to conduct some C&P mental disorder exams with the advent of the VA's new Disability Benefits Questionnaire (DBQ) system.

To date, there are no articles published in peer-reviewed journals that describe how to conduct VA mental health-related compensation and pension exams. Our intention is to rectify the lack of peer-reviewed information by outlining a recommended procedure for conducting four different types of C&P mental disorder exams. The article also addresses legal, ethical, and administrative concerns that arise with these often complex forensic evaluations.

Notice This article and the recommendations or opinions stated herein should in no way be construed to reflect the opinions or beliefs of the US Department of Veterans Affairs or the US government. The opinions expressed in this article are the authors' alone.

M. D. Worthen (✉)
Compensation & Pension Program, Charles George VA Medical Center, Department of Veterans Affairs,
1100 Tunnel Road,
Asheville, NC 28805-2576, USA
e-mail: mark.worthen2@va.gov

R. G. Moering
Compensation & Pension Office, James A. Haley Veteran's Hospital, Department of Veterans Affairs,
Tampa, FL, USA

[1] The Mental Disorders DBQ form states: "In order to conduct an **initial** examination for mental disorders, the examiner must meet one of the following criteria: a board-certified or board-eligible psychiatrist; a licensed doctorate-level psychologist; a doctorate-level mental health provider under the close supervision of a board-certified or board-eligible psychiatrist or licensed doctorate-level psychologist; a psychiatry resident under close supervision of a board-certified or board-eligible psychiatrist or licensed doctorate-level psychologist; or a clinical or counseling psychologist completing a one-year internship or residency (for purposes of a doctorate-level degree) under close supervision of a board-certified or board-eligible psychiatrist or licensed doctorate-level psychologist. In order to conduct a **review** examination for mental disorders, the examiner must meet one of the criteria from above, OR be a licensed clinical social worker (LCSW), a nurse practitioner, a clinical nurse specialist, or a physician assistant, under close supervision of a board-certified or board-eligible psychiatrist or licensed doctorate-level psychologist." (emphasis added). See: http://www.vba.va.gov/disabilityexams.

The four types of exams covered in this article are:

- Initial Post-traumatic Stress Disorder (PTSD)
- PTSD Review
- Initial Mental Disorder
- Mental Disorder Review

Legal Framework

Like all forensic mental health evaluations, VA compensation and pension exams exist within a legal framework, i.e., a collection of statutes, regulations, and case law that determine the referral questions asked of examiners; outline the procedures veterans must follow to establish a disability claim; describe how evidence is weighed; govern who may conduct these exams; and otherwise define the C&P exam process. Understanding the legal landscape is important for examiners because referral questions often directly or indirectly reference statutes or regulations, case law can dictate the content of an exam report and the rules of evidence used to evaluate the adequacy of an examiner's documentation and rationale (*Nieves-Rodriguez v. Peake*, 2008), and one's ethical code might require it.[2]

Brief Legal History

Although providing monetary benefits for US veterans dates back to the Revolutionary War (Ridgway, 2011), contemporary veterans compensation law has its roots in 1917 amendments to the War Risk Insurance Act of 1914 (Economic Systems Inc., 2004), which provided compensation to World War I veterans for "average impairment in earnings capacity." That phrase, "average impairment in earnings capacity" is important because the 1917 laws represented a shift from gratuity payments (awarding benefits as a "thank you" to veterans for their service) to an indemnity model that compensates veterans for functional impairments that adversely affect their ability to work (Economic Systems Inc., 2004).

Mental health professionals interested in conducting C&P exams need to keep that distinction in mind because a crucial issue for them to address in their exam report is the extent of the veteran's occupational impairment. In this regard, C&P exams are similar to Social Security disability evaluations in that occupational impairment is the focus (Foote, 2008). Also, some examiners seem to mistake VA compensation as an *entitlement* program, i.e., one that awards benefits for a veteran's service in a combat zone when, in fact, it is an *indemnity* program in which the VA provides benefits to veterans who have suffered occupational impairment as a result of their psychological injury.

Currently, the statutory authority for regulations governing the VA's compensation program comes from Title 38 of United States Code. Regulations are primarily found in 38 Code of Federal Regulations (C.F.R.), Part 3 and Part 4. A comprehensive review of veterans law (statutes, regulations, and case law) is beyond the scope of this article (but see Ridgway, 2011 in this issue). Instead, we will focus on important differences between the legal parameters governing the adjudication of veterans' disability claims and the legal contours of more traditional forensic mental health evaluations.

Unique Legal Parameters

The most important difference to understand is that proceedings regarding VA compensation and pension claims are intentionally informal and nonadversarial ("Proceedings before VA are *ex parte* in nature …"; Procedural Due Process and Appellate Rights, 38 C.F.R. § 3.103, 2010), and they are "uniquely pro-claimant" (*Hodge v. West*, 1998). Table 1 provides a comparison between the types of evaluations with which most forensic psychologists and psychiatrists are familiar and the VA compensation and pension examination.

Legal Language Required

When asked to provide a medical opinion (even if the examiner holds a non-medical degree, the opinion still is referred to as a "medical" opinion), examiners must use specific language, based on the legal requirements in veterans compensation cases. Specifically, examiners must use one of the following phrases when writing their opinion (Department of Veterans Affairs, 2001):

- "Is due to" (100% assure)—the phrase "caused by or the result of" seems to be an acceptable alternative based on our experience (it is often the phrase suggested in exam requests from the Veterans Benefits Administration (VBA))
- "More likely than not" (greater than 50%)
- "At least as likely as not" (50%)
- "Not at least as likely as not" (less than 50%)—the less cumbersome, "is less likely than not" appears to be an acceptable alternative based on our experience
- "It is not due to" (0%)
- I cannot formulate an opinion without resorting to mere speculation

[2] American Psychological Association Ethical Standard 2.01 (f) reads, "When assuming forensic roles, psychologists are or become reasonably familiar with the judicial or administrative rules governing their roles." (American Psychological Association, 2002).

Table 1 Differences between the legal parameters governing typical forensic mental health evaluations versus VA compensation and pension examinations

	Typical forensic mental health evaluations	VA compensation and pension examinations
Relationship of the parties	Adversarial	Ex Parte[a]
Standard of proof	"Beyond a Reasonable Doubt," "Clear and Convincing Evidence," or "Preponderance of the Evidence" (51% probability or greater)	Equipoise—"at least as likely as not" (50% or greater chance)[b]
Level of formality	Formal	Informal[c]
Obligation of the government	In criminal cases, the government represents the people and vigorously prosecutes persons accused of crimes	The government must help a claimant develop his or her case[d]
Side favored?	Neither side is favored over the other	If there is doubt about a decision, benefit of the doubt goes to the veteran[e]
Right to representation	Defendants in criminal cases have a right to be represented by an attorney, even if they cannot afford one. In civil matters, litigants have the right to be represented, although payment can be an issue for many lower and middle class litigants	Claimants have a right to representation by an attorney only after a claims decision has been made and the veteran has filed a Notice of Disagreement.[f,g] The attorney's fee can be paid from a "past due" lump sum amount, if benefits are awarded[h]
Recording of evaluation sessions	In some forensic evaluation contexts, audio or video recordings are permissible and even encouraged	Veterans do not have a right to record their C&P examinations[i]
Responsibility to obtain records	The attorney or forensic mental health professional must obtain records he or she deems necessary to conduct a thorough evaluation	The Veterans Benefit Administration is required by law to assist veterans by seeking to obtain all relevant government and private records that might further the veteran's claim[j]
Rules of evidence	Federal Rules of Evidence or State Rules of Evidence	The Federal Rules of Evidence do not apply to veterans cases but "…the rules on expert witness testimony provide useful guidance…"[k]

[a] Latin, "On one side only." Done by, for, or on the application of one party alone. http://legal-dictionary.thefreedictionary.com/ex+parte

[b] "… when a veteran seeks benefits and the evidence is in relative equipoise, the law dictates that veteran prevails." *Gilbert v. Derwinski*, 1 Vet. App. 49 (1990)

[c] Although a case becomes progressively more formal as it moves up the chain of appeals from the VA Regional Office, to the Board of Veterans Appeals, to the Court of Appeals for Veterans Claims, etc. See Fig. 2 for a graphic describing the appeals process for veteran's disability benefits claims

[d] "The Secretary must make reasonable effort to assist claimant in obtaining evidence necessary to substantiate the claimant's claim for benefits under a law administered by the secretary." (Duty to Assist Claimants, 38 U.S.C. §5103A, 2010)

[e] "When there is an approximate balance of positive and negative evidence regarding any issue material to the determination of a matter, the Secretary shall give the benefit of the doubt to the claimant." (Claimant Responsibility; Benefit of the Doubt, 38 U.S.C. § 5107(b), 2010)

[f] Payment of fees for representation by agents and attorneys in proceedings before agencies of original jurisdiction and before the Board of Veterans' Appeals, 38 C.F.R. § 14.636(c) (2010)

[g] However, veterans can receive assistance in developing their claim from a Veterans Service Organization such as Disabled American Veterans, Vietnam Veterans of America, or American Legion (not an exhaustive list)

[h] Payment of fees for representation by agents and attorneys in proceedings before Agencies of Original Jurisdiction and before the Board of Veterans' Appeals, 38 C.F.R. § 14.636(g)(2) (2010)

[i] Vet. Aff. Op. Gen. Couns. Prec. 04-91 available at http://www4.va.gov/ogc/docs/1991/PREC_04-91.doc

[j] 38 U.S.C. § 5103A; See also *Moore v. Shinseki*, 555 F. 3 d 1369 (2009), wherein the Court held that a veteran's military psychiatric hospitalization records should have been obtained by the VA as part of its duty to assist and see also *Golz v. Shinseki*, 590 F.3 d 1317 at 1323 (2010): "[t]he legal standard for relevance requires VA to examine the information it has related to medical records and if there exists a reasonable possibility that the records could help the veteran substantiate his claim for benefits, the duty to assist requires VA to obtain the records"

[k] *Nieves-Rodriguez v. Peake* (2008)

Thus, if an examiner concludes that a veteran suffers from PTSD because of traumatic events he or she endured during wartime, the examiner will usually opine, "It is at least as likely as not that the veteran's PTSD was caused by or the result of his claimed traumatic stressors." Note that the "at least as likely as not" phrase encompasses the evidentiary standard of *equipoise*, i.e., if the evidence is at equipoise (50/50 chance) then benefit of the doubt goes to the veteran (*Gilbert v. Derwinski*, 1990).

Adjudication and Appeals Process

Laypersons, i.e., trained VA staff with the VA's VBA, adjudicate compensation claims filed by veterans. If a veteran is found to have a service-connected mental disability, he or she is assigned a "rating." These ratings represent the percentage of impairment in the Veteran's average earnings capacity. A Rating Schedule for mental disorders (Fig. 1) guides the rating decision. A Veteran's rating determines the kind and amount of benefits he or she receives, both monetary and access to other services.

If a veteran wishes to appeal a decision made by the VBA, he or she can file a Notice of Disagreement requesting that the case be reviewed. If the disagreement regarding a VBA rating is not resolved at the VBA level, then the veteran can appeal his or her case to the Board of Veterans Appeals, which is administratively housed within the Department of Veterans Affairs. If a veteran disagrees with a decision by the Board of Veterans Appeals and he or she meets the legal requirements, then they can appeal their case to the Court of Appeals for Veterans Claims, a US federal court that has jurisdiction over these matters. Further appeals can be made to the Federal Circuit Court and to the Supreme Court of the United States (see Fig. 2).

General Considerations for All Types of Exams

Disability Benefits Questionnaire

Beginning in 2010, the VBA and the Veterans Health Administration (VHA), which are both components of the US Department of Veterans Affairs (VA), launched the use of DBQs. The DBQs are designed to streamline the claims rating process by the VBA. They are much shorter than the previous worksheets or templates, which, in the case of mental health-related C&P exams, were detailed outlines for a comprehensive mental health evaluation report (Department of Veterans Affairs, 2001).

The VA released the DBQs for mental health-related disorders in 2011. There are DBQs for Initial PTSD, Review PTSD, Other Mental Disorders (Initial and Review exams use the

Fig. 1 General rating formula for mental disorders (*Schedule of ratings—mental disorders*, 38 C.F.R. § 4.130, 2010)

GENERAL RATING FORMULA FOR MENTAL DISORDERS
(SCHEDULE OF RATINGS—MENTAL DISORDERS, 38 C.F.R. § 4.130, 2010)

Total occupational and social impairment, due to such symptoms as: gross impairment in thought process or communication; persistent delusions or hallucinations; grossly inappropriate behavior; persistent danger of hurting self or others; intermittent inability to perform activities of daily living (including maintenance of minimal personal hygiene); disorientation to time or place; memory loss for names of close relatives, own occupation, or own name ……..100%

Occupational and social impairment, with deficiencies in most areas, such as work, school, family relations, judgment, thinking, or mood, due to such symptoms as: suicidal ideation; obsessional rituals which interfere with routine activities; speech intermittently illogical, obscure, or irrelevant; near-continuous panic or depression affecting the ability to function independently, appropriately and effectively; impaired impulse control (such as unprovoked irritability with periods of violence); spatial disorientation; neglect of personal appearance and hygiene; difficulty in adapting to stressful circumstances (including work or a worklike setting); inability to establish and maintain effective relationships 70%

Occupational and social impairment with reduced reliability and productivity due to such symptoms as: flattened affect; circumstantial, circumlocutory, or stereotyped speech; panic attacks more than once a week; difficulty in understanding complex commands; impairment of short- and long-term memory (e.g., retention of only highly learned material, forgetting to complete tasks); impaired judgment; impaired abstract thinking; disturbances of motivation and mood; difficulty in establishing and maintaining Effective work and social relationships ……..50%

Occupational and social impairment with occasional decrease in work efficiency and intermittent periods of inability to perform occupational tasks (although generally functioning satisfactorily, with routine behavior, self-care, and conversation normal), due to such symptoms as: depressed mood, anxiety, suspiciousness, panic attacks (weekly or less often), chronic sleep impairment, mild memory loss (such as forgetting names, directions, recent events) 30%

Occupational and social impairment due to mild or transient symptoms which decrease work efficiency and ability to perform occupational tasks only during periods of significant stress, or; symptoms controlled by continuous medication 10%

A mental condition has been formally diagnosed, but symptoms are not severe enough either to interfere with occupational and social functioning or to require continuous medication 0%

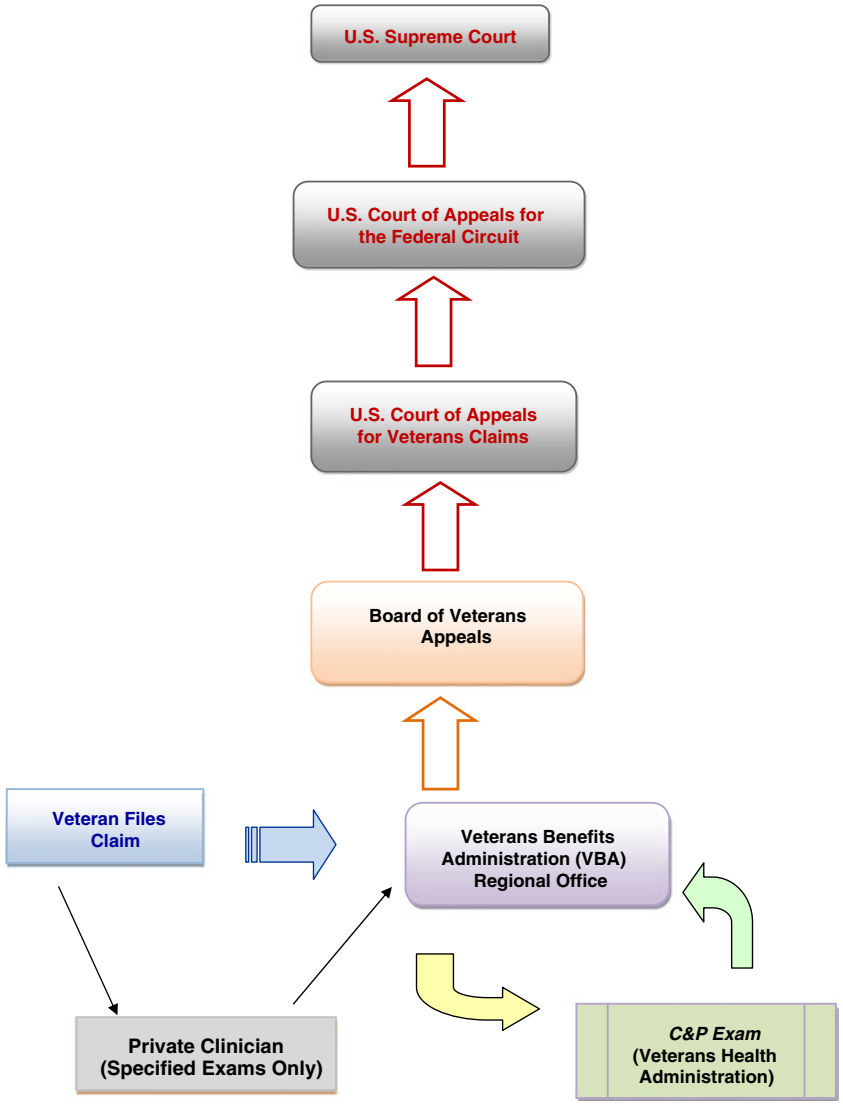

Fig. 2 The VA compensation & pension adjudication and appeals process

same form), and Eating Disorders. VA employees and contractors can access the DBQs online via the Compensation and Pension Records Interchange (CAPRI). Private clinicians will be able to access the DBQs (for which they are authorized to complete) via the VA website.[3]

Beguiling Appeal of the DBQ's Brevity

We recommend that examiners exercise caution about simply responding to the DBQ items without supplementing that information with the kind of details usually found in a comprehensive psychological or psychiatric evaluation report. We offer this recommendation for three reasons:

1. Veterans have been known to file licensing board complaints against examiners. If the examiner does not write a detailed report, it will be hard to prove that he or she conducted a comprehensive, competent evaluation.
2. Section 9.01 of the American Psychological Association (2002) Ethical Principles indicates that psychologists should base their opinions "on information and techniques sufficient to substantiate their findings." The only way to show that an examiner's conclusions were indeed formed accordingly is to *document* what the examiner did and why he or she reached those conclusions.
3. The federal courts evaluate examiner's reports based on Rule 702 of the Federal Rules of Evidence (*Nieves-Rodriguez v. Peake*, 2008). Specifically, they look to see that:

   (a) The testimony is based upon sufficient facts or data.
   (b) The testimony is the product of reliable principles and methods.

[3] http://benefits.va.gov/TRANSFORMATION/disabilityexams/

(c) The expert witness has applied the principles and methods reliably to the facts of the case (note that when the court refers to "testimony," they mean the examination report, and when they refer to an "expert witness," they mean the examiner).

It would be very difficult for a judge to ascertain if an examiner based his or her conclusions (as listed on the DBQ) "upon sufficient facts or data" if those facts and data are not documented. And it would be hard for a judge to determine if an examiner "applied the principles and methods reliably to the facts of the case" without a thorough report.

The DBQ's Symptom Checklist

One section of every mental health-related DBQ is a symptom checklist where, for example, examiners are asked to check off a box if a veteran has "depressed mood" or "anxiety." Unfortunately, the DBQ does not provide any guidance with regard to how one determines the level of symptom frequency, severity, or duration required to endorse a given symptom. Thus, for example, if a veteran reports that she feels "a little depressed" once or twice a week, it is not clear if the examiner should check off the "depressed mood" box or not.

We suggest that examiners endorse a symptom if it causes significant functional impairment. In the example given above, being "a little depressed" once or twice a week would probably not cause significant functional impairment; therefore, the "depressed mood" box should not be checked. On the other hand, if a veteran's depressed mood caused them to disengage from meaningful social interactions and to become isolated, then the box should be checked. This functional impairment approach to DBQ symptom endorsement is consistent with the overarching purpose of a C&P exam, i.e., to determine if a veteran suffers from a service-connected mental disability that causes him or her significant social and occupational dysfunction.

Fields Not Present on the DBQ

DBQs do not provide designated space for reporting the results of psychological testing, and there is no mention of the role of validity assessment (screening for dissimulation or response bias) on the DBQ. However, we suggest that examiners not interpret this absence as an indication that psychological testing and screening for dissimulation should not be conducted. On the contrary, we highly recommend, as we detail later in this article, that examiners screen for dissimulation using psychological tests and other methods. Examiners can report the results of such assessments in the "Remarks" section of the DBQ.

Private Practice Clinicians

VA policy allows private psychiatrists and psychologists to complete DBQ forms (and conduct evaluations) for Review PTSD and Initial and Review Mental Disorder exams (as well as Eating Disorder exams, although these are rare). However, private clinicians should consider the following points before agreeing to conduct a C&P exam for a veteran.

DBQ Form

First, the DBQ form is deceptively simple. Beware of the temptation to tell a veteran that you can interview him or her in a standard 50-min session and then check off the DBQ boxes. Remember that you are providing an evaluation report for legal purposes when you complete and sign a DBQ. These are forensic disability evaluations, and you should approach them as such. It is entirely possible that a state licensing board governing the practice of any of the mental health professions would object to the brevity implied by the DBQ format—especially if a Veteran complained to the Board that the report was inadequate in some manner.

Record Review

Like all forensic evaluations, you should review relevant records (Ciccone & Jones, 2010; Bush, Connell, & Denney, 2006), ideally before evaluating the veteran. The need for records poses a unique challenge for private clinicians because, unlike VA practitioners, they do not have access to VA computerized medical records. In the case of VHA employees or contractors, medical records from both the Veteran's post-military and military years either are available in the VHA's computerized medical records system or provided in paper format by the VBA prior to the Veteran's C&P exam appointment. In contrast, private practitioners must obtain signed consents for release of information forms from the veteran, send a medical records request to each VA medical facility at which the veteran has received treatment, and wait to receive those records before concluding the evaluation (note that the private practitioner might also be able to request the medical records from the Regional Office of the Veterans Benefits Administration that is handling the veteran's claim).

In addition, the private practitioner will also want to request copies of all of the information in the veteran's VBA Claims File (also referred to as the "C-file"). Some information within the C-file may not be relevant to the instant examination, but we do not recommend trying to determine in advance what records are important, as it is impossible to know what is contained in the C-file.

The veteran's C-file will often contain crucial information such as his or her written statement requesting an increase in benefits (which is the usual reason for a Review exam); collateral statements from the veteran's spouse, friends, employer, or others; a copy of the previous C&P exam report; private medical records obtained by the VBA; the veteran's military personnel records; the veteran's service treatment records (often referred to as the service treatment records (STRs) or service medical records (SMRs)); the veteran's "stressor statement" (in PTSD cases, a written description of the stressor that led to the development of PTSD); remand orders from the Board of Veterans Appeals; and more, as detailed by Moering (2011, in this issue).

Note that the VA does not require that an examiner review the claims file in order to complete a DBQ (a C-file review *is* required in Initial PTSD cases but private practitioners are not permitted to conduct those exams). The courts have also found that review of the C-file is not absolutely necessary in all cases (*Nieves-Rodriguez v. Peake*, 2008).[4] We make the above recommendations for two reasons: (a) Professional standards of practice suggest that record reviews are an essential component of a psychiatric disability evaluation (American Academy of Psychiatry and Law, 2008), and (b) it is in the veteran's best interest that all available information be reviewed by the examiner.

Payment

Third is the matter of payment. Private practitioners should have a payment agreement for the veteran to sign, an established rate for forensic evaluations, and a pre-determined policy regarding the timing of payments, e.g., whether a retainer fee is expected or one bills the client after the report is complete (which is usually not a wise practice since you might have to release your report even if you have not been paid).

Note that the Department of Veterans Affairs does not pay for these exams. You must collect payment from the veteran, unless you are performing the evaluation pro bono.

Time Allotted for Exam

Fourth is the amount of time the private practitioner will want to allow for the evaluation. We recommend *at least* 3 h for all aspects of the exam (review of records, psychological testing, meeting with the veteran, writing the report). Some practitioners routinely plan on spending six or more hours for forensic disability evaluations.

Veteran's Right to Exam Results

Fifth, the private practitioner should understand that veterans have a right to their C&P exam results, including a copy of your evaluation report and the DBQ. This is particularly true since the veteran is paying for the evaluation.

Send the DBQ to the VBA

The purpose of completing the DBQ is to provide the information to the VBA for assistance in making a rating decision. Therefore, one should ask the veteran to sign a release of information form allowing the private practitioner to send the DBQ to the VBA Regional Office handling the veteran's claim. The veteran should know which office is handling his claim or one can find the mailing address via an Internet search. Fax numbers for each Regional Office are available on the VA website.[5]

Do Not Complete DBQs for Patients

Seventh, we strongly recommend not completing a DBQ for a veteran the private practitioner is seeing for psychotherapy or psychiatric treatment as it will create the awkward position of a dual role relationship with the patient, viz., psychologist or doctor *and* independent evaluator (Greenberg & Shuman, 1997; Strasburger, Gutheil, & Brodsky, 1997; Greenberg & Shuman, 2007). The VA also discourages its treating providers from completing DBQs.[6]

Time Allotted for Exam

VA facilities and contractors vary significantly in the amount of time they allot for mental health-related C&P exams. Some VA facilities expect an Initial PTSD exam to be conducted, records reviewed, and report written in 1 h. Others allow 2, 3, or 4 h. The VA is under tremendous pressure from veterans groups and Congress to speed up the time required to process a veteran's claim for service-connected disability benefits and to work through a backlog

[4] But note that the Court also wrote: "This is not to say that particular medical information contained in a claims file might not have significance to the process of formulating a medically valid and well-reasoned opinion. As with any expert opinion, the factual premises of a medical opinion are certainly subject to examination. Many times those facts can be found in the information contained in the claims file. Critical pieces of information from a claimant's medical history can lend credence to the opinion of the medical expert who considers them and detract from the medical opinions of experts who do not." (*Nieves-Rodriguez v. Peake*, 22 Vet. App. 295 at 306, 2008).

[5] http://benefits.va.gov/TRANSFORMATION/disabilityexams/fax_numbers.asp

[6] VHA Directive 2010-045 states, "*For mental health-related DBQs that are made available for providers not functioning as C&P examiners and to maintain the integrity of the patient–provider relationship, it is recommended that a Veteran's treating provider not complete the DBQ*." (italics in original). Available at: http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2298.

of claims. Unfortunately, this pressure has led some VA facilities to demand that examiners complete exams so quickly that quality is bound to suffer. This is not simply our opinion. An independent, widely respected organization, the Institute of Medicine came to a similar conclusion and recommended that the VA allow examiners in PTSD cases sufficient time to consistently conduct thorough, accurate evaluations (IOM (Institute of Medicine) and NRC (National Research Council), 2007). The courts also insist on an adequate exam, as expressed in *Green v. Derwinksi* (1991):

> We believe that fulfillment of the statutory duty to assist here includes the conduct of a thorough and contemporaneous medical examination, one which takes into account the records of prior medical treatment, so that the evaluation of the claimed disability will be a fully informed one (*Green v. Derwinksi*, 1991).

The time allowed to conduct a C&P exam is an ethical issue for many examiners. For psychologists, we highly recommend reviewing Standard 9.01, Bases for Assessments, of the Ethical Principles and Code of Conduct (American Psychological Association, 2002). If the psychologist has concerns about being able to comply with the requirements of that Standard because of time constraints, he or she might want to make their concerns about the time restriction known, in writing, to their supervisor and save documentation of this communication (see Standard 1.03, American Psychological Association, 2002).

Examiners might also want to advocate within their VA facility for more time for exams. If a disgruntled veteran files a complaint with an examiner's licensing board because of an allegedly inadequate report, the examiner will be in a better position to defend him or herself if they can document their adherence to ethical principles of their profession and their advocacy for more time to be allotted for mental health-related C&P exams.

Forensic Nature of the Exam

Although it is probably clear to most readers, we should emphasize that C&P exams are forensic mental health evaluations. The term "forensic" does not mean "crime-related" or "what you see on CSI." Rather, the origin of the term comes from the Latin, *forēnsis*, meaning "public, of a forum." Definitions of "forensic" include:

> Relating to or dealing with the application of scientific knowledge to legal problems. <*forensic* medicine> <*forensic* science> <*forensic* pathologist> <*forensic* experts> (http://www.merriam-webster.com/dictionary/forensic)

> Relating to the use of science or technology in the investigation and establishment of facts or evidence in a court of law (http://www.answers.com/topic/forensic)

Forensic Psychiatry is defined as: "a medical subspecialty that includes research and clinical practice in the many areas in which psychiatry is applied to legal issues" (American Academy of Psychiatry and Law at http://www.aapl.org/org.htm).

Forensic Psychology is defined as: "the application of the science and profession of psychology to questions and issues relating to law and the legal system" (American Board of Forensic Psychology at http://www.abfp.com).

In order to determine if VA disability evaluations are forensic in nature, one need only ask: "Are C&P exams intended to help answer legal or clinical questions?" Clearly the answer is that VA disability evaluations are conducted to help answer legal, not clinical, questions. As discussed earlier in this article, the questions one is asked for a C&P exam come specifically from US statutes, regulations, and case law. For example, beginning in July of 2010, C&P examiners have been asked in PTSD exams if a veteran's stressor is related to "the veteran's fear of hostile military or terrorist activity." This question did not arise because of clinical concerns but because of a change in the Federal Regulations governing these exams.[7]

Given that C&P examinations are clearly forensic mental health evaluations, clinicians who conduct these exams will probably want to familiarize themselves with basic principles of forensic psychology or forensic psychiatry. See "Appendix" at the end of this article for suggested readings.

Review of Records

In this section, we will discuss various sources of background information about the veteran available via print or electronic records. How one obtains this information will depend on whether one is a VA employee (or contractor) or a private clinician.

Claims File

The veteran's claims file or "C-file" potentially contains extremely valuable information. One advantage of conducting C&P exams is that the VBA has usually done a fair amount of background research and data collection regarding a veteran's claim before the examiner receives the case.

[7] Federal Register: July 13, 2010 (Volume 75, Number 133) [Rules and Regulations] [Page 39843–39852] From the Federal Register Online via GPO Access [wais.access.gpo.gov] [DOCID:fr13jy10-13]

A corollary disadvantage is that the C-file often contains an abundance of information, consisting of hundreds (or even thousands) of pages. Nonetheless, it is incumbent upon the examiner to review the C-file. Full-time C&P examiners have an advantage because they become adept at knowing which pages of documents they can skim or skip but even then, reviewing the entire C-file can take a fair amount of time (which is one reason why allotting only an hour or two per exam is unwise). Important information to look for in a C-file includes the following:

Veteran's statements Some veterans pen statements regarding their mental disorder and the effect it has on their life. Whether in response to VA forms (such as *Statement in Support of Claim for Service Connection for PTSD*, VBA Form 21-0781) or in hopes of supporting their claims, these veterans' statements are an important part of the official record. They also are important because, under the stress of a C&P exam, some veterans forget to mention a traumatic event, symptom, or functional deficit that might prove crucial to their case.

Collateral statements, including "buddy letters" Veterans often ask family members or friends to write statements in support of their claim. Some such letters can be heart-wrenching as they describe in everyday language the functional deficits the Veteran has suffered as a result of PTSD or other mental disorder. Clearly, since the emphasis of the C&P exam is on social and occupational impairment, such information is vitally important. A particular type of statement that one might hear a veteran make reference to is a "buddy letter," which is a letter or statement written by a fellow service member, often describing a stressor that (reportedly) led to the development of the veteran's PTSD, although a buddy letter can also describe symptomatic and functional changes noticed by the fellow service member.

Personnel records Unfortunately, not all C-files contain military personnel records, but when they do, it is important to compare the veteran's documented tour of duty with the information he or she provides in an interview. In most instances, the Veteran's personnel records will match his or her accounting of events, which enhances the Veteran's credibility. Performance evaluations (both before and after a claimed stressor), reports of disciplinary actions, training records, and other historical information may also reflect favorably on a Veteran's claim. Nonetheless and as an example, each of the authors has had occasions when a Veteran claimed to have experienced a traumatic stressor in a specific location, on a specific date, but their personnel record indicated that were stationed at a completely different location at that time. Other types of discrepancies in the historical record also may give rise to a conclusion that it is "less likely than not" that a nexus exists between a veteran's service and his or her claimed injury.

DD-214 The DD-214 is a Department of Defense form that shows the dates of the veteran's military service, their rank at discharge, medals and other awards, official MOS (Military Occupational Specialty), and service branch. The DD-214 is usually found on the right flap of the C-file. Again, discrepancies between claimed and actual military roles, the nature of military discharge, and service dates can be garnered from the DD-214.

Private medical records As noted earlier, the VA has an obligation to help a veteran obtain records that might support his or her claim. This assistance often involves obtaining copies of a veteran's private medical records, which can contain vital information, e.g., symptoms, diagnoses, descriptions of functional impairments, course of an illness, etc. Although specialists' records (e.g., from a dermatologist) are not as likely to contain relevant information, one should at least skim those documents as there may be relevant information regarding psychiatric symptoms causing somatic problems (e.g., skin rash secondary to stress). But carefully read primary care physicians' notes as they often contain important information about a veteran's psychosocial functioning.

VA medical records Some veterans will have lengthy VA medical histories, but it is important to review those progress notes and other records too, particularly those from mental health and primary care providers. This review can take some time, sometimes even an hour or two, but it remains a critical part of the evaluation process (and, yet again, another reason to allow sufficient time for these exams).

Previous C&P exam reports When conducting a Review exam, one should always review past mental health-related C&P exam reports, partly because a crucial question for Review exams is whether or not the veteran's symptoms and functional abilities have changed since the last exam. Also at least skim non-psychiatric medical C&P exam reports for relevant psychosocial information. Reports from physical medicine, i.e., Traumatic Brain Injury exams and General Medical exam reports, and reports from neurologists require closer review because they likely will contain relevant psychosocial and medical information.

Service treatment records One of the most critical pieces of information is the veteran's history of medical treatment while in the military, since the *sine non qua* of these evaluations is whether or not a mental disorder developed while the veteran was in the military (although see the caveat below). Older records, e.g., Vietnam War era STRs (also

sometimes referred to as SMRs) are infamous for containing scanty mental health information, but you never know when you might discover something relevant in a review of those yellowed pages. Operation Enduring Freedom—Afghanistan and Operation Iraqi Freedom veterans are likely to have more relevant information in their STR folder because of advancements in electronic medical records systems, mental health screening, and mental health awareness in recent years.

Keep in mind that absence of mental health records in a veteran's STRs does *not* negate receipt of a service-connected disability award. In fact, the vast majority of Vietnam veterans with successful service-connected PTSD claims were not diagnosed with a mental disorder during their military service. For one thing, PTSD was not a recognized diagnosis in the 1960s and 1970s. Also, recall that, for PTSD claims, a 2010 regulations change means that veterans need only demonstrate that they were in a war zone for their stressor to be conceded by the VA. The examiner must still determine if the veteran's report of the stressor is credible.

Military Records Missing Due to 1973 Fire

Although some veterans claim their service records were destroyed in the July 1973 fire at the National Personnel Records Center in Missouri, research has indicated that the only records affected by the fire were US Army personnel who were discharged between November 1912 and January 1960 and US Air Force personnel who were discharged from September 1947 to January 1964 (Stender & Walker, 1974). Additional research has indicated that 94% of those records destroyed in the fire have been reconstructed. The fire did not affect records of military personnel serving in combat in Vietnam (McNally, 2003).

C-File Not Provided

Unfortunately, even VA-employed examiners are sometimes not provided the veteran's C-file. In such cases, one must always consider whether or not to insist on receipt and review of the C-file before concluding an examination. While some exams can be completed without the C-file, e.g., Review exams in which abundant clinical information is available via medical records, one should always consider the possibility that a crucial piece of information will be missed without receipt and review of the C-file.

Computerized Patient Record System

Most VA examiners are familiar with the Computerized Patient Record System (CPRS) so we will not spend time reviewing its features. Instead we will simply offer two suggestions: (1) Be sure to set the date range for Notes to as far back as the veteran has been seen at your facility so that you review all the relevant progress notes and (2) check the previous Global Assessment of Functioning (GAF) scores under Reports > Clinical Reports > Outpatient Encounters/GAF Scores. Also note that previous C&P exams can sometimes be found under Reports > Clinical Reports > Comp & Pen Exams.

VistaWeb

VistaWeb is an online medical records database accessible by VA employees that contains medical records from the Department of Defense (DOD) and other VA facilities (CPRS contains records from one's own VA facility only). VistaWeb is available from within CPRS on the upper right portion of the screen, immediately above the "Remote Data" button. Although one can use the "Remote Data" feature to access DOD and VA medical records, VistaWeb provides a superior user interface and, it seems, more comprehensive information.

Specific areas within VistaWeb that you will probably want to check include Progress Notes, Visits/Admissions, Discharge Summaries, GAF Scores (under Outpatient Encounters/GAF), and Consults, although we recommend exploring the other categories as this is not an exhaustive list. Previous C&P exams can be found under either Progress Notes or Visits/Admissions.

CAPRI

The CAPRI electronic records system is available to VA staff and is another way to access medical records, including VistaWeb, as well as VBA documents. The CAPRI system provides the ability to search all of the local VA medical records for a specific word or phrase (e.g., "PTSD" or "suicidal ideations"). The search feature is found under the "Clinical Documents" tab.

Informed Consent

Ethical standards of most mental health professions require that patients or evaluees receive informed consent prior to the initiation of a mental health evaluation (e.g., for psychologists, Standard 9.03 of the Ethical Principles; American Psychological Association, 2002). For your protection, we recommend documenting the veteran's informed consent by having him or her sign a form to that effect. An informed consent document also helps orient the veteran to the exam, prevents misunderstanding, reduces the likelihood of a post-exam complaint, and communicates respect to the veteran.

Here are some items to consider as part of your informed consent document:

- Identify your profession. For example, if you are a psychiatrist, it might help the veteran to know that you are a medical doctor because then he or she knows that you will be knowledgeable about the complications of an illness such as diabetes.
- Describe your relationship to the veteran, i.e., as an independent evaluator, not a treating clinician.
- Explain how the results of your examination will be communicated and to whom a report will be sent and how the veteran can obtain a copy of the report.
- Explain limits to confidentiality.
- Clarify the purpose of the evaluation.
- Warn the veteran about the negative consequences of symptom exaggeration or fabrication.
- Describe the potential risks associated with the evaluation, namely experiencing painful emotions.
- Provide information about mental health resources should the veteran experience distress as a result of the exam.
- Encourage the veteran to ask questions about the consent form and include an item in the form that documents this opportunity.

See Fig. 3 for a sample consent form. That sample is simply one of many ways to document informed consent.

Stressful Nature of the Exam

For many veterans, a C&P exam is a stressful and upsetting experience. For example, in PTSD cases, the examiner asks the veteran to describe the traumatic events that (reportedly) led to the development of PTSD. As one veteran remarked, "You're asking me to talk about the stuff I spend every day trying to forget." Our recommendations are to:

- Include a statement in your consent form that acknowledges the stressful nature of the exam.
- Provide the veteran with a Veteran's Helpline card[8] should he wish to talk with someone after the exam (mention that you provided the card in your consent form).
- Also tell the veteran verbally that you understand that parts of the exam might be stressful or upsetting and that you will try to keep those aspects of the exam as brief as possible, although you will also give the veteran ample time to describe his or her experiences.
- Inform the veteran that he is free to request a break at any point during the exam process.
- Respond to emotional distress with measured empathy. By "measured" we mean that since this is not a psychotherapy session, you do not want to respond in such a way that would convey that you are there to provide ongoing counseling. At the same time, you do not want to come across as uncaring as such a response would not only be disrespectful, a non-empathic response also might cause the veteran to withdraw emotionally and not share with you the full impact of his mental disorder (s), thus providing an incomplete view of the veteran's impairment.

Political Climate at the Department of Veterans Affairs

Clinical Versus Forensic Orientation

VA mental health examiners work for the VHA. The VHA mission is to "Honor America's Veterans by providing exceptional health care that improves their health and well-being" (http://www.va.gov/health/aboutVHA.asp). There is no official mission statement for the mental health-related C&P exam process, but if one was to create such a statement, it might be something like: "To provide evidence-based mental health assessments of veterans claiming service-connected disabilities in order to help the Veterans Benefits Administration make accurate benefit determinations." Clearly, these missions are not the same. VA employees who conduct C&P examinations (full-time C&P examiners or mental health treatment providers who are required to complete C&P examinations as extra duty) should bear this difference in mind. Some VA officials (VHA and VBA) do not appear to understand this distinction and assume that C&P examiners are providing health-care services to veterans. This lack of understanding can create tensions when, for example, examiners talk about the importance of screening for significant symptom exaggeration or feigning.

In fact, the VA has terminated the contract of at least one C&P examiner because she screened for symptom exaggeration and feigning (Poyner, 2010). VA officials at her site told this psychologist that "the use of instruments designed to detect feigning 'do not give the veteran the benefit of the doubt'." (Poyner, 2010, p. 131). This stance by at least these VA officials might reflect a misguided notion that C&P examiners are supposed to be providing clinical services, when, in fact, they are performing a forensic mental health assessment function.

This political opposition to the assessment of feigning is not universal across VA facilities. However, if you encounter

[8] You can order cards at http://www.suicidepreventionlifeline.org/Materials/Default.aspx or, if you are affiliated with a VA Medical Center, from that Center's Suicide Prevention Coordinator.

Fig. 3 Sample consent form

Compensation & Pension Exam Consent Form

I understand that:

1. I will receive a psychological evaluation (exam) from Jane Doe, Psy.D., a clinical psychologist.
2. Dr. Doe works for the Veterans Health Admini stration (VHA), which is part of the VA (Department of Veterans Affairs).
3. The purpose of this exam is to provide the Veterans Benefits Administration (VBA), which is also part of the VA, with information they need to make a decision regarding my claim for Compensation & Pension (C&P) benefits.
4. I am not a patient or client of Dr. Doe. I will not be receiving counseling or psychotherapy from Dr. Doe. The only reason for this exam is to conduct a psychological evaluation for Compensation & Pension (C&P) purposes.
5. If I want to receive mental health treatment from the Veterans Health Administration, I can call any VA medical center or clinic to request an appointment.
6. This exam and its contents are private and confidential *except* under the following circumstances:
    a. If I am in imminent danger of harming my self or another person, Dr. Doe must take whatever steps necessary to prevent harm and this might mean breaking confidentiality.
    b. If I share information that would lead a reasonable person to suspect that a child or disabled adult is being abused or neglected then Dr. Doe must report that information to Protective Services.
    c. If I appeal my case to the Federal courts, some aspects of this exam could become a matter of public record.
7. Dr. Doe will write an exam report and send it to the VBA Regional Office that is handling my claim.
8. A copy of the exam report will be placed in my VHA electronic medical record.
9. I must be honest in answering questions on all psychological questionnaires, tests, and interviews during this exam. Any attempt to exaggerate or fabricate symptoms of mental disorders could have negative consequences for my claim.
10. This exam might be stressful for me. I might feel upset (sad, anxious, irritable, depressed, etc.) as a result of answering questions during the exam.
11. Dr. Doe has given me a *National Suicide Prevention Lifeline Card*, which has a phone number I can call if I feel suicidal or overwhelmed.
12. I am entitled to Travel Pay for this exam, even if I am not currently service-connected. [Go to the Travel Office before you leave to receive your payment.]
13. If I had any questions about this consent form, I have asked them and Dr. Doe has answered them to my satisfaction.

PRINT Name _____ _____ _____

SIGN Name _____ _____ _____

Today's Date ____ _____

such opposition, be prepared to explain in careful detail the importance of screening for exaggeration and feigning on empirical, ethical, professional, and public policy grounds. Empirical evidence for significant symptom exaggeration and feigning in these and similar disability exams is abundant; see "Screening and Assessment of Exaggeration and Feigning" section below for details.

From a professional perspective, examiners have an obligation to conduct a fair, balanced, and impartial evaluation. A misguided attempt to "give the veteran the benefit of the doubt" ignores the facts, namely that there is an incentive to exaggerate or feign given the monetary reward for successfully fooling an examiner and receiving disability benefits. To ignore this incentive is naïve and unscientific as it denies the abundant scientific evidence to the contrary. The DSM-IV even contains a warning about the potential for symptom exaggeration or feigning when diagnosing PTSD: "Malingering should be ruled out in those situations in which financial remuneration, benefit eligibility, and forensic determinations play a role." (American Psychiatric Association, 2000, p. 467).

From an ethical perspective, consider the APA Ethics Code guideline that "[p]sychologists' work is based upon established scientific and professional knowledge of the discipline" (Standard 2.04; American Psychological Association, 2002). It is clearly established in the scientific literature (see below for citations) that a high percentage of compensation-seeking veterans over-report symptoms of mental disorders. Thus, if one ignores that scientific evidence, then one is not basing one's work on "established scientific and professional knowledge."

From a public policy perspective, a failure to screen for exaggeration and feigning potentially wastes taxpayer dollars and contributes to the national debt by awarding underserved benefits (which can include not only tax-free cash payments but also free healthcare and educational funds for

a veteran's children). Equally important, allowing undeserving veterans to receive disability benefits dishonors those veterans with genuine disabilities.

Opposition to Psychological Testing

Examiners might also encounter resistance to the use of *any* psychological testing by VA officials who claim that it is unnecessary. If you face such opposition, you might inquire of the VA official if he or she also tells physicians whether or not they are allowed to utilize medical tests (e.g., labs, sleep studies, or X-rays) in their C&P examinations. Asking such a question might expose a bias against psychological testing, which seems to be based on prejudice, not science (see the "Psychological Testing" section below for additional information).

The Possible Iatrogenic Effects of the VA Disability Program

Some have argued that the VA compensation program unwittingly discourages and impedes treatment progress by veterans with mental disorders, particularly PTSD (Mossman, 1994; Frueh, Grubaugh, Elhai, & Buckley, 2007; Satel, 2011). Some VA-affiliated psychologists disagree with this argument (Marx et al., 2008; also see the response by Frueh, Buckley, Grubaugh, & Elhai, 2008). Our main point here is that examiners should be aware of this controversy because they may well notice that many of the veterans they evaluate do not seem to have benefitted from psychiatric and/or psychological treatment. If such a potentially puzzling pattern is observed, bear in mind that it may occur because of the VA program's built-in incentive to remain sick in order to receive disability compensation, as opposed to the treatment approach itself being ineffective.[9]

Screening and Assessment of Exaggeration and Feigning

There is abundant research literature demonstrating that compensation-seeking veterans exhibit high rates of symptom over-reporting (Calhoun, Earnst, Tucker, Kirby, & Beckham, 2000; Dalton, Tom, Rosenblum, Garte, & Aubuchon, 1989; DeViva & Bloem, 2003; Freeman, Powell, & Kimbrell, 2008; Frueh, Gold, & de Arellano, 1997; Frueh et al., 2003; Smith & Frueh, 1996; Sparr & Pankratz, 1983). However, it is important to keep in mind that it is often difficult to discern a veteran's reason(s) for over-reporting symptoms. In particular, one should not necessarily assume that because a veteran over-reported symptoms that he or she intended to feign a mental disorder.

There are various reasons why a veteran might over-report symptoms. For example, Frueh, Hamner, Cahill, Gold, and Hamlin (2000) suggested that Vietnam War veterans might exaggerate symptoms during a C&P exam because of:

- The severity of their illness—"…the combination of psychiatric comorbidity, interpersonal maladjustment, symptom chronicity, and degree of trauma exposure" all contribute to symptom over-reporting (Frueh et al., 2000, p. 859).
- Generalized distress—"…acute levels of perceived global distress lead veterans to overestimate their actual level of psychopathology across multiple domains…" (Frueh et al., 2000, p. 861)
- Sociopolitical considerations:
  - "Vietnam veterans … experienced unique pressures and traumas while in a war zone … and were caught in a period of social transition and stress upon return from the war." (Frueh et al., 2000, p. 867)
  - Similarly, Hyer et al. (1988) suggested that one reason for symptom over-reporting:

> …might be that Vietnam combat veterans are just now 'learning' to respond to years of dormant thoughts and feelings about their condition. During this dissonance reduction process they are 'seduced' into exaggeration, overreports, and even factitious reports when confronted with their pathology. In a sense they must make an effort to 'really' be a Vietnam veteran again and must sell themselves and their helpers. Given that many other veterans are also involved in this process, this can become a 'cathartic or contagion process,' where the facts and fiction are interchangeable.

- Compensation-seeking status—some veterans believe that they must "really make their case" when being evaluated for compensation and pension purposes. They therefore unconsciously over-report psychological symptoms (Frueh et al., 2000, p. 863).

Similarly, Franklin et al. (2002) conducted research on MMPI-2 scores of veterans undergoing a C&P exam. Their results suggested that "…a majority of veterans with elevated F scale scores are not intentionally overreporting their symptoms, but likely are achieving high elevations due to extreme distress" (Franklin et al., 2002, p. 283). They classified 77.2% of their sample (consisting of all MMPI-2 profiles with $F \geq 80$ and consistent responding) as belonging to an "extreme distress" group ($Fp \leq 6$) and 22.8% to an "over-reporting" group ($Fp \geq 7$).

[9] However, one should note that recent research indicates that in general, VA compensation recipients with PTSD experience "clinically meaningful reductions in PTSD symptoms and less poverty and homelessness" (Murdoch et al., 2011, p. 1072).

Given these multiple reasons for over-reporting, one might reasonably ask, "How can one best differentiate symptom over-reporting due to 'extreme distress' or related reasons from over-reporting due to an intentional attempt to exaggerate symptoms or outright feign a mental disorder?" We offer the following suggested protocol to help answer this question.

Screening and Assessment for Exaggeration and Feigning: Suggested Psychometric Protocol

1. Administer the MMPI-2 or PAI. The MMPI-2 has been found to better discriminate between genuine and feigning groups in simulation designs (Eakin et al., 2006; Lange et al., 2010); therefore, it is the preferred instrument. Examiners who use the PAI might consider supplementing it with a feigning-specific screener such as the Miller Forensic Assessment of Symptoms Test (M-FAST; Miller, 2001; Guy, Kwartner, & Miller, 2006) or the Structured Inventory of Malingered Symptomatology (SIMS; Widows & Smith, 2005). If you use the SIMS, be sure to use the higher cutoff score recommended in research by Wisdom, Challahan, and Shaw (2010). The remainder of this suggested psychometric protocol will assume use of the MMPI-2.
2. Compare the MMPI-2 validity scale scores you obtain to the classifications listed in Table 2. You will need to decide if you want to use the *Intermediate* or *Conservative* cut scores.
   (a) One or more scales in the *Conservative Cut* range represents very strong evidence of symptom exaggeration to the point that making an accurate mental disorder diagnosis is unlikely.
   (b) One or more scales in the *Intermediate Cut* range represent strong evidence of symptom exaggeration. However, if you want to obtain additional psychometric evidence, you might consider administering the Morel Emotional Numbing Test for PTSD (MENT; Morel & Shepherd, 2008a, b; Messer & Fremouw, 2007), M-FAST, or the Structured Interview of Reported Symptoms (SIRS; Rogers, Bagby, & Dickens, 1992) or SIRS-2 (Rogers, Seward, & Gillard, 2010). If using the SIRS, we strongly encourage you to familiarize yourself with recent research on the SIRS (e.g., Rogers, Payne, Berry, & Granacher, 2009a; Rogers, Payne, Correa, Gillard, & Ross, 2009b; Green & Rosenfeld, 2011) and the SIRS-2 (DeClue, 2011), i.e., do not rely solely on the manual for guidance.

This psychometric protocol has an empirical basis, e.g., the Table 2 *Conservative Cut* scores are based on scores at or above the 99th percentile for a large general clinical sample (Greene, 2008; Table 10.13, p. 180) and 2.0 standard deviations above the mean score for genuine PTSD patients (Resnick, West, & Payne, 2008; Table 7.5, p. 119). Thus, the Table 2 cut scores take into account the tendency of combat veterans with PTSD to elevate MMPI-2 validity scales (Frueh et al., 2000; Franklin et al., 2002; Resnick, West, & Payne, 2008). Note that the *Conservative Cut* scores are, indeed, very conservative scores. For example Arbisi, Ben-Porath, and McNulty (2006) found that lower cut scores successfully differentiated compensation-seeking veterans instructed to answer MMPI-2 items honestly versus those instructed to exaggerate PTSD symptoms and avoid detection. Rubenzer (2009) is another resource to consult as the author recommends a specific response-style battery to assess for feigned PTSD.

Table 2 MMPI-2 validity scale scores: screening for exaggeration or feigning

MMPI-2 scale	Normal	Extreme distress	Intermediate cut	Conservative cut
F	≤80	81–117	118–129	≥130 (raw≥32)
FB	≤80	81–117	118–139	≥140 (raw≥24)
F-K	≤11	12–20	21–26	≥27
F(p)	≤69	70–98	99–105	≥106 (raw≥9)
Ds	≤79	80–96	97–106	≥107 (raw≥40)

F Infrequency, *FB* Back-Page Infrequency, *F-K* Dissimulation Index (Gough, 1950), *F(p)* Infrequency-Psychopathology (Arbisi & Ben-Porath, 1995), *Ds* Gough Dissimulation Scale (Gough, 1954)

All values are T-scores except for F-K values which are raw scores. Raw scores are provided for the "conservative cut" level since T-scores in this range are not provided on standard MMPI-2 computer-generated reports. The "extreme distress" level indicates a range of scores which suggest that the individual probably endorsed more symptoms or problems than they actually experience, but this over-endorsement is most likely due to "extreme distress" (Franklin, Repasky, Thompson, Shelton, & Uddo, 2002) or what is often referred to as a "cry for help" response set (Graham, 2006). Note that the values given are higher than those in Graham (2006) because this table takes into account the tendency of genuine PTSD patients to elevate MMPI-2 validity scales at higher levels than other clinical populations, as discussed by Frueh, Hamner, Cahill, Gold, and Hamlin (2000) and Franklin et al. (2002). The "intermediate cut" scores are at least at the 98th percentile for a very large clinical sample (Greene, 2008, Table 10.13, p. 180) and 1.5 standard deviations above the mean for genuine PTSD samples (Resnick, West, & Payne, 2008, Table 7.5, p. 119). The term "intermediate cut" is from the Resnick et al. (2008) chapter. The "conservative cut" scores are at or above the 99th percentile for a very large clinical sample (Greene, 2008, Table 10.13, p. 180) and at least 2.0 standard deviations above the mean for genuine PTSD samples (Resnick, West, & Payne, 2008, Table 7.5, p. 119). The term "conservative cut" is from the Resnick et al. (2008) chapter. All of these MMPI-2 scales, except for Ds, have been validated as efficient for the detection of symptom exaggeration for combat veterans undergoing evaluation for PTSD (Tolin, Steenkamp, Marx, & Litz, 2010). The authors of that study found that the Ds-r scale was not a good discriminator; they did not evaluate the longer Ds scale, which has proved to be a good discriminator in other studies (e.g., Wetter, Baer, Berry, Robison, & Sumpter, 1993)

Unless there is substantial evidence in favor of the claimed diagnosis, we suggest listing in the diagnosis section of the DBQ, "No Diagnosis on Axis I (V71.09)" or "Diagnosis Deferred on Axis I (799.9)" if any of the MMPI validity indices are in the *Conservative Cut* range of Table 2. If any of the validity scales are in the *Intermediate Cut* range, you will need to decide if such scores prevent you from rendering an accurate diagnosis or not. We cannot offer a definitive answer regarding whether to use the *Intermediate Cut* MMPI-2 cut scores because reasonable arguments can be made for and against regarding the *Intermediate Cut* scores as representing significant over-reporting or exaggeration.

In the preceding paragraph, we used the phrase "substantial evidence in favor of the claimed diagnosis." By "substantial evidence," we mean one or more of the following:

- The veteran sought mental health treatment for the claimed (or similar) condition well in advance of filing a claim for disability benefits.
- The veteran was diagnosed with the claimed (or similar) mental disorder while in the military.
- The veteran presents collateral statements from disinterested parties (i.e., people who do not benefit if the VBA determines the veteran has a service-connected disability), which convincingly describes symptoms consistent with the claimed disorder and these symptoms began during or shortly after military service.

In general, individual examiners should determine for themselves a method to determine if the veteran's over-reporting is due to generalized distress or related factors or if the veteran's symptom over-reporting is in a range associated with significant exaggeration or feigning of mental disorders. The above protocol is simply one way to accomplish this goal.

Whatever you do, do not ignore elevated validity scale indices. Unfortunately, ignoring this evidence happens fairly often, as evidenced by research conducted by Arbisi et al. (2004), which found that C&P examiners very frequently did not comment at all on MMPI-2 profiles which produced Fp scores above 7. One would have expected these C&P examiners to interpret an Fp>7 score and explain its implications for the examination and to, at least in some cases, conclude that they could not render an accurate diagnosis with this evidence of symptom exaggeration. However, Arbisi et al. (2004) found that there were no differences in diagnosis or service connection status between veterans with problematic MMPI-2 profiles (Fp>7) and those with clearly valid profiles (Fp≤2).

Screening and Assessment for Exaggeration and Feigning: Interview Approaches

A substantial literature exists regarding interview strategies for detecting feigning or malingering, particularly when it comes to PTSD cases (Hall & Hall, 2007; Guriel & Fremouw, 2003; Resnick, West, & Payne, 2008; Taylor, Frueh, & Asmundson, 2007; Knoll & Resnick, 2006; Rogers, 2008; Simon, 2003). We highly recommend that the reader consult the aforementioned references for detailed guidance, but some general interview guidelines from this literature include the following:

- Remain "…composed, impartial, and respectful…" (Knoll & Resnick, 2006, p. 639).
- Ask open-ended questions and let the veteran talk. Malingerers or exaggerators will often eventually contradict themselves, whereas genuine patients will not (Hall & Hall, 2006, p. 531). In this regard, also "…avoid leading questions that give clues to correct responses" (Resnick, West, & Payne, 2008, p. 117).
- Understand that discussions of combat-related trauma can, understandably, be very emotional for the veteran and the examiner. While one should not ignore the presence of strong affect, one should also remain objective and not let one's natural response, e.g., empathy and a desire to "help" the veteran, rule the day when it comes to diagnosis and an opinion regarding service connection (Knoll & Resnick, 2006, p. 639).
- Ask the veteran to provide specific examples of symptoms. It is harder to describe specific instances of a symptom than it is to recite a symptom (remember that PTSD symptom lists are ubiquitous on the Internet and elsewhere), although one should keep in mind that genuine PTSD patients sometimes have difficulty describing specific symptoms because of the emotionally charged nature of their experience and a tendency to avoid exposure to such affect.
- During the interview, look for behavioral manifestations of the alleged disorder, e.g., irritability, inability to focus, or exaggerated startle response with claimed PTSD (Resnick, West, & Payne, 2008, p. 117).

Screening and Assessment for Exaggeration and Feigning: Clinical Signs

The literature references cited in the above section also contain descriptions of clinical signs of significant exaggeration or feigning. Again, we recommend that the reader consult those sources for detailed guidance. Table 3 provides an example of some of these clinical signs, although note that these indicators have not been empirically validated.

Screening and Assessment for Exaggeration and Feigning: Diagnostic Decisions

What should an examiner do, in terms of a diagnosis, if the examination reveals signs of significant exaggeration or

Table 3 Clinical indicators of malingered combat-related PTSD

Genuine PTSD	Malingered PTSD
Minimize relationship of problems to combat	Emphasize relationship of problems to combat
Blame self	Blame others
Dreams: themes of helplessness, guilt	Dreams: themes of grandiosity, power
Deny emotional impact of combat	"Act out" alleged feelings
Reluctant to discuss combat memories	"Relish" discussing combat tales
Survivor guilt relates to specific incidents	Generalized guilt over surviving war
Avoidance of environmental stimuli	No avoidance of environmental stimuli
Anger over helplessness	Anger toward authority

The above chart was originally published in Resnick, West, and Payne (2008, p. 126), reprinted by permission. The original authors of the chart caution that "[t]he clinical indicators for malingered combat-related PTSD are based primarily on individual case reports and anecdotal descriptions… [t]hus they should be considered tentative and must be weighed along with the totality of the available data" (Resnick, West, & Payne, 2008, pp. 125–126)

Table 4 Potential evidence for a diagnosis of malingering

Strongly suggestive but not definitive signs of malingering
Veteran claims he or she cannot work but he or she engages in a wide range of social and recreational activities
Significant exaggeration of mental disorder symptoms that is not due to extreme distress or other factors, e.g., MMPI-2 validity indices in the "conservative cut" range (see Table 2) or SIRS classification in the feigning range
Reliable collateral source describes the veteran functioning well with only mild symptoms
History of deceit in order to obtain financial gain, e.g., conviction for embezzlement
Veteran states that he has applied for Individual Unemployability "because I need more money" with no explanation as to why he is so disabled that he cannot work
Definitive signs of malingering
Veteran admits to fabricating symptoms in order to receive compensation benefits
Videotape of veteran that clearly contradicts reported symptoms. For example, veteran claims mental disorder and a back injury that requires him to always use a wheelchair. He presents to the exam in a wheelchair. He is subsequently observed and videotaped trotting to his car in the VA parking lot (this example is based on an actual exam the second author conducted)
Personnel records contradict the veteran's statements about his tour of duty, e.g., a veteran states he participated in the defense of a US Embassy (that subsequently caused PTSD) but personnel records show he was never stationed at that embassy
Veteran scores above chance level on a symptom validity test, e.g., a score of 37 or above on the MENT

feigning? As noted above, usually the best course of action is to list "No Diagnosis on Axis I (V71.09)" or "Diagnosis Deferred on Axis I (799.9)"; explain your reasons for not being able to determine a diagnosis; and indicate in your *Medical Opinion* section that you cannot formulate an opinion without resorting to mere speculation (one of the legally preferred phrases as discussed earlier in this article). Understand that the courts are not particularly fond of use of the phrase "cannot formulate an opinion without resorting to mere speculation" (*Jones v. Shinseki*, 2010) and that jurists expect the examiner to thoroughly explain *why* he or she cannot form an opinion without resorting to mere speculation.

On relatively rare occasions, you might have enough evidence to assign a diagnosis of Malingering (V65.2) on Axis I. Table 4 provides examples of such evidence. We highly recommend that examiners take a very conservative approach with regard to diagnosing a veteran with Malingering given the potentially significant repercussions from assigning an erroneous diagnostic label.

Overemphasis on Symptom Exaggeration and Feigning?

As discussed previously, some VA officials look askance at examiners who screen and assess for symptom exaggeration or feigning. Anecdotally, one of the criticisms the authors of this article have heard is "you are focusing too much on malingering." In fact, some readers of this article might be thinking, "They are spending a lot of time discussing symptom exaggeration and feigning." We believe that this emphasis is appropriate for the following reasons:

- There is so much resistance to screening for dissimulation within the VA that we feel compelled to make a strong, detailed case for its importance.
- There is abundant research evidence that compensation-seeking veterans frequently over-report symptoms, often to a significant degree. While a good portion of these veterans elevate validity indices due to "extreme distress" or related reasons, there are still a significant minority of veterans who over-report symptoms to such a high degree that the "extreme distress" hypothesis breaks down as a reasonable explanation for them. In fact, even in their article arguing for an understanding of the "extreme distress" phenomenon, Franklin et al. (2002) noted that 22.8% of their sample elevated Fp above 7 and were not included in the "extreme distress" group due to this psychometric evidence of probable exaggeration.
- If over 20% of veterans in a C&P sample (Franklin et al., 2002) showed signs of symptom exaggeration—to an extent that their self-report of PTSD or other mental disorder symptoms probably should be considered

suspect—then one must consider the implications of ignoring the possibility that over 20% of individuals presenting for a mental health-related C&P exam are unlikely to have a service-connected disability. If those claimants are not identified as significantly exaggerating or feigning and they are subsequently awarded compensation benefits, we dishonor all the veterans with genuine disorders as well as waste billions of dollars of US taxpayers' money over the lifetime of those benefits.

Importance of Consulting the Research Literature

Not only is it sound professional practice to keep up with the scientific research literature in one's discipline, the courts have emphasized the importance of C&P examiners consulting the research literature when appropriate. For example, in *Jones v. Shinseki* (2010), the court wrote "The examiner may also have an obligation to conduct research in the medical literature depending on the evidence in the record at the time of examination" (*Jones v. Shinseki*, 2010).

Meeting with the Veteran

Ideally, one should have completed a record review prior to meeting with the veteran. Such a review is not always possible in advance but even a quick scan of the veteran's medical records and C-file will help you identify potentially important issues. Some familiarity with a veteran's case also helps you build rapport with the veteran.

Orientation to the Exam

When you first meet with the veteran, after introducing yourself and welcoming him or her to your office, we recommend the following seven steps to orient the veteran to the examination: First, confirm the identity of the veteran by asking him or her to recite their full name, date of birth, and Social Security number. Also look at their photo ID to insure that their picture looks reasonably similar to their appearance in your office. In some VA facilities, identity confirmation has already been conducted by front office staff.

Second, tell the veteran your understanding of the purpose of their appointment, e.g., "My understanding is that you are here for a Compensation and Pension examination for PTSD." The appointment letters veterans receive are sometimes not specific about the type of exam they will be receiving. Some veterans have several exams scheduled, e.g., General Medical, Audiology, etc., so to prevent confusion, it helps to clarify from the beginning what type of exam you will be conducting.

Third, provide a brief description of the examination procedures. For example, you might say:

> The examination is divided into two parts; first you will complete some psychological questionnaires or psychological tests. This will be done partly on a computer in another room and partly via paper and pencil forms in my office. The second part of the exam consists of an interview in which I will be asking you about your upbringing, your military experience, and, especially, about the type of symptoms you've been experiencing and how they have affected your functioning.

Fourth, let the veteran know that he or she can request to take a break at any time, that they are free to ask questions at any point in the exam process, and that if they are accompanied by their spouse or other family member or friend that you can also interview that person if they wish (provided you are given time for such interviews at your facility).

Fifth, review the limits of confidentiality with the veteran.

Sixth, tell the veteran that aspects of the exam might be emotionally upsetting or painful. Explain that you will try to keep those aspects of the interview as brief as possible but that you want to make sure that you obtain all the relevant information that is important to adjudicating their claim. Provide the veteran with a Helpline card so they have an available resource at hand should they feel upset and wish to speak with a supportive professional or paraprofessional after the exam.

Seventh, have the veteran review and sign your Informed Consent document. Emphasize that they should take their time to review the document and ask any questions they might have about it.

Collateral Interviews

When they first are called to your office, some veterans will be accompanied by their spouse or other family member and will ask you if that person can come in with them. Our view is that is usually quite helpful to have such a person accompany the veteran during the orientation to the exam. This procedure allows the family member to benefit from the orientation in a manner similar to the veteran, e.g., they will have a general idea of what their loved one will be doing during the exam, they will understand the limits of confidentiality, and they will understand that their veteran might experience some emotional discomfort during the exam. Allowing a spouse or family member to accompany the veteran for the orientation can also communicate respect to the veteran and an acknowledgement that their family is a very important part of their life.

In most instances, a veteran's spouse or other family member can convey important information that frequently serves to support the veteran's claim. Therefore, if at all

possible, we highly recommend that examiners interview spouses or other family members.

Unfortunately, some VA facilities allot such a small amount of time to conduct the C&P exam that conducting collateral interviews is not possible. This unfortunate circumstance is yet again another reason why examiners should be given sufficient time to complete a comprehensive C&P examination.

For those examiners who are given sufficient time to conduct a thorough exam, some prefer to conduct collateral interviews with the veteran present, while others prefer to interview the spouse or family member separately. Pros and cons of each approach are outlined in Table 5. Given that neither approach offers a clear-cut advantage over the other, Rosales (2011) recommends a combined approach in which the examiner talks with the veteran and his or her significant other together during the orientation part of the exam, then interviews the veteran separately and the significant other separately, and finally, brings them both back into the office at the end to see if they have any questions or final comments.

Psychological Testing

Many examiners report resistance from VA officials regarding the use of *any* psychological testing during C&P exams. We will therefore outline some advantages of employing psychological questionnaires or tests during C&P exams.

Accurate as Medical Tests In general, psychological tests are as accurate as medical tests (Meyer et al., 2001). In fact, these authors found in their meta-analytic study that the validity of the MMPI-2 F scale ranks highly among all medical tests. The authors of the referenced article point out that "clinicians who rely exclusively on interviews are prone to incomplete understandings" (Meyer et al., 2001, p. 128).

Screening for Dissimulation As discussed above, screening for significant symptom exaggeration or feigning is crucial for any forensic evaluation where substantial healthcare and financial benefits can be awarded. Psychological tests such as the MMPI-2 and the SIRS have proven to possess highly accurate classification rates (Tolin et al., 2010; Rogers et al. 2009a), whereas an individual clinician's classification accuracy has almost never been subject to scientific study. Additionally, we know that in general actuarial judgment outperforms clinical judgment (Dawes, Faust, & Meehl, 1989).

Psychological tests also effectively identify individuals who are under-reporting symptoms. Such minimization of problems can be difficult to detect during a clinical interview.

Diagnostic Hypotheses Psychological testing can be particularly helpful in generating hypotheses regarding diagnoses that might not be readily apparent upon clinical interview.

Personality Descriptions Similarly, psychological tests such as the MMPI-2 and PAI often produce detailed descriptions of personality, which can be relevant to hypotheses regarding possible personality disorders or traits negatively impacting the veteran's social or occupational functioning.

Symptom Severity Since psychological tests are norm-referenced, they can help the examiner ascertain how severe a veteran's symptoms are. For example, if during the clinical/diagnostic interview a veteran reports mild depressive symptoms but his PAI DEP scale is elevated at a T-score of

Table 5 Advantages and disadvantages of conducting collateral interviews with or without the veteran being present

Veteran present during collateral interview: advantages	**Veteran present during collateral interview: disadvantages**
Can assess via behavioral observation, the type and quality of interaction between the veteran and his or her spouse or other family member	The spouse might have given different descriptions of a veteran's symptoms and functional impairments if he or she had been interviewed separately, i.e., the collateral interview will be "contaminated"
Spouses or other family members often can elaborate on or correct a veteran's imperfect memory of events	Some examiners have had veterans file licensing board complaints against them because they were displeased with the examiner's recommendations. The presence of a spouse during the entire interview could bolster the veteran's claim in such a situation, which could be potentially unfair to the examiner
Some veterans feel quite anxious during an exam and the presence of a spouse or family member helps to reduce their anxiety	Some veterans will feel inhibited and will be less likely to talk about marital problems, for example, if their spouse is present
	The veteran and spouse may disagree and even argue with each other, which takes up precious time
Interviewing collaterals alone: advantages	**Interviewing collaterals alone: disadvantages**
The examiner can compare the collateral interview with the interview of the veteran to look for consistencies or inconsistencies	Conducting separate interviews takes more time
The spouse or family member might feel more open to discuss marital or other family problems if the veteran is not present	Some veterans will be less forthcoming without their spouse being present due to anxiety, limited social skills, or memory problems

85, that disparity might indicate that the veteran is underreporting his psychiatric symptoms. Identifying such underreporting is important since it might indicate that the veteran is also minimizing functional impairments, which if not identified as such could result in a lower disability rating and fewer benefits for the veteran.

Cognitive Functioning Deficits in cognitive functioning are often directly related to social and occupational impairment (McLennan, Mathias, Brennan, Russell, & Stewart, 2010). It is therefore important to at least screen for mild cognitive impairment using an instrument such as the Montreal Cognitive Assessment (Nasreddine et al., 2005).

Occupational and Social Functioning Although the VBA tends to focus on a veteran's GAF score, research suggests that the GAF scale lacks concurrent validity (Roy-Byrne, Dagadakis, Unutzer, & Ries, 1996) and predictive validity (Moos, McCoy, & Moos, 2000), probably in large part because the scale conflates psychiatric symptoms with social and occupational functioning (Niv, Cohen, Sullivan, & Young, 2007). The concerns about the use of the GAF scores for C&P exams are great enough that Miller, Wolf, Martin, Kaloupek, and Keane (2008) asserted that results of their research

> …should raise concern about the VA's reliance on the GAF as a benchmark for the assessment of PTSD-related functional impairment. … If VA C&P determinations are to be based on the level of functional impairment produced by PTSD, then multidimensional measures of impairment, disability, and quality of life should be incorporated into assessment strategies so that the many important domains of functioning that can be adversely affected by the disorder are evaluated (Miller et al., 2008, p. 368).

Thus, research indicates that the GAF scale by itself does not provide a valid assessment of functioning. Psychometric instruments are available that measure social/occupational impairment and quality of life, which will be reviewed below. C&P examiners are well advised to consider using them given the crucial role of psychosocial functioning in a veteran's disability rating.

Conclusion Regarding Psychological Testing Thus, there are several reasons why psychological testing can be very helpful in C&P exams. It is generally best to conduct such testing prior to one's interview of the veteran so that hypotheses generated by the test results can be investigated further. At some VA centers, veterans complete psychological testing, administered by a trained paraprofessional, several days before their interview with the C&P examiner. Such an arrangement maximizes the time examiners can spend interviewing veterans and collateral sources and reviewing relevant records.

Mental Status Exam

Information obtained during a standard psychiatric/psychological mental status exam (MSE) is very important, in part because several of the symptoms mentioned in the Rating Schedule pertain to items evaluated in a MSE, such as memory, abstraction ability, orientation, delusions, hallucinations, etc. We recommend that clinicians review guidelines for conducting a thorough MSE, e.g., Andrews (2008), if they do not conduct them as a routine part of their practice.

Psychosocial History

Of course, taking a good developmental history is an important part of any comprehensive mental health evaluation. Aspects of a veteran's psychological and social history that are particular important for C&P exams include:

- Traumatic events prior to or after military service and the effects of such events on the veteran's psychological, social, and occupational functioning
- Any history of substance abuse or dependence prior to military service
- Signs or symptoms of a personality disorder prior to military service
- The veteran's peer relationships, intimate/marital relationships, recreational pursuits, and, especially if possible, occupational functioning prior to military service

Current Psychosocial Functioning

A description of a veteran's interpersonal, recreational, and occupational activities is a crucial aspect of a C&P exam. Often this is best done by quoting the veteran directly. For example, asking him or her about the number and quality of their friendships might yield a response such as, "I really don't have any friends, just associates really. But I don't really trust any of them." If you have already established, based on earlier interview questions, that such a veteran had good peer relations as a child and adolescent, but since his return from Vietnam in his young 20s he has not had close friends, then this information adds credence to the veteran's claim that PTSD has impaired his social functioning. Conversely, a veteran who reports several friendships, multiple social activities, and rewarding recreational pursuits probably has not suffered significant psychosocial impairment as a result of a reported mental disorder.

Ideally, one should also measure psychosocial functioning using norm-referenced, reliable instruments with

demonstrated validity. Such instruments provide the opportunity to compare a veteran's functioning with the general public or specific groups, e.g., psychiatric patients. We list below some such instruments to consider.

Psychosocial Functioning Assessment Instruments

Quality of Life Inventory

The Quality of Life Inventory (QOLI) measures life satisfaction in 16 different areas, e.g., Health, Self-Esteem, Money, Work, Love, Children, Home, etc. (Frisch, 1994). It yields a raw score along with conversions to T-scores and percentile scores. The manual provides interpretive summaries for four levels: very low, low, average, and high quality of life. An advantage of the QOLI is that one can determine a veteran's overall quality of life as compared to the general population. When veterans score in the very low or low range, such a result supports their claim that a mental disability has impaired their quality of life. When veterans score in the average or high range, one begins to wonder how impaired their functioning could be if they enjoy relatively good life satisfaction.

The reliability and validity of the QOLI are very good and well-established in the research literature (Frisch, Cornell, Villanueva, & Retzlaff, 1992; Frisch, 1994; Frisch et al., 2005; McAlinden & Oei, 2006). The QOLI is used in a wide variety of scientific studies (e.g., Lopez et al., 2011; Thomas, Skilbeck, & Slatyer, 2009; Petry, Alessi, & Hanson, 2007). It is relatively brief and self-administered, and it measures both the importance of a given domain to the individual as well as subjective satisfaction. As with any psychological test result, QOLI scores and resulting descriptive interpretations should not be used as the sole basis for one's assessment of a veteran's psychosocial functioning.

World Health Organization Disability Assessment Schedule—II

The World Health Organization Disability Assessment Schedule—II (WHODAS-II), also referred to as WHODAS 2.0, has the potential to be quite useful in C&P exams because it is a reliable and valid measure of disability (Ustün et al., 2010). Unfortunately, the WHODAS website (http://www.who.int/icidh/whodas/) has not been updated in 10 years. One of the difficulties caused by this lack of an update is that normative data are not available for the WHODAS, unless you decide to use the instrument for a research study and register with the World Health Organization. Even if you can access the normative data, scoring of the WHODAS-II requires the use of a statistical scoring package such as SPSS (Ustün et al., 2010), which most examiners do not have access to.

Inventory of Psychosocial Functioning

The Inventory of Psychosocial Functioning (IPF) is a new instrument being developed by the VA's National Center for PTSD (B. Marx, personal communication, April 4, 2011). Advantages of the IPF include the fact that it was developed based on input from focus groups of veterans, the normative sample is composed of veterans, and it measures psychosocial functioning across seven domains: marital or other romantic relationships, family, work, friendships and socializing, parenting, education, and self-care. The initial validation study on the IPF will be completed soon, with the results being published shortly thereafter, and the instrument will also then be available for examiners to use.

Functional Assessment Inventory

The Functional Assessment Inventory (FAI) is a behaviorally anchored, counselor-rated measure of an individual's work-related functional capacities developed at the University of Minnesota's Department of Physical Medicine and Rehabilitation (Crewe & Athelstan, 1984). It is used by vocational rehabilitation counselors to determine eligibility and to develop rehabilitation plans for individuals with disabilities.

Factor analytic research with the FAI has identified six factors for the instrument:

- Adaptive behavior—level of social support, perception of capabilities and limitations, ability to effectively interact with employers and co-workers, judgment, and the congruence of behavior with rehabilitation goals
- Cognition—learning ability, ability to read and write in English, memory, and spatial reasoning
- Communication—vision, hearing, speech, language functioning, and personal appearance
- Motor functioning—upper extremity functioning, hand functioning, motor speed, ambulation, or mobility
- Physical capacity—capacity for exertion; endurance; loss of time from work for medical, therapeutic, or personal reasons; access to job opportunities; and need for special working conditions
- Vocational qualifications—stability of condition, work history, acceptability to employers (physical, demographic, or historical characteristics), job-specific skills, economic disincentives (e.g., may lose benefits if take a job), and work habits.

The factor analytic structure of the FAI differs to some extent depending on which disability group (e.g., mentally retarded, orthopedic) one examines. The factor definitions listed above are for psychiatric patients, as described in research by Neath, Bellini, and Bolton (1997).

Descriptive statistics (means, standard deviations) are available for psychiatric patients seeking vocational

rehabilitation services (Neath et al., 1997; Bellini, Bolton, & Neath, 1998). Thus, an examiner can compare a veteran's FAI scores with a psychiatric normative sample.

Advantages of the FAI include the fact that it is available at no cost (a simple Internet search will lead you to the manual and forms) and its content is more specific to the question of employability. Disadvantages of the FAI include the fact that there are no veteran normative samples to date and the predictive validity of the instrument with regard to VBA rating decisions is not known.

Specific Exam Considerations

Initial PTSD Exams

PTSD is the third most prevalent VA service-connected disability (based on the number of veterans receiving benefits), preceded only by tinnitus and hearing loss (Veterans Benefits Administration, 2010). Initial PTSD exams are the most common mental health-related C&P exam. We recommend that examiners consult the suggestions for conducting mental health-related C&P exams in general, as discussed earlier in this article, and consider the following recommendations for Initial PTSD exams in particular.

Open-Ended Questions

Before proceeding with a detailed PTSD diagnostic interview, it is best to ask open-ended questions, which allow the veteran to describe experiences in their own words and which do not clue the veteran to the fact that you are asking questions related to a PTSD diagnosis (Knoll & Resnick, 2006). These questions can be asked during the mental status exam or when screening and assessing for comorbid mental disorders. Here are some examples of open-ended questions examiners might ask:

- "What is your normal sleep pattern?"
- "What is your sleep like in general?"
- "During the daytime, what types of problems or concerns do you have for yourself?"
- "What kinds of things do you find yourself thinking about during the daytime or when you are trying to go to sleep?"
- "What are your interactions like with family, neighbors, co-workers?"
- "You have applied for service connection for PTSD. Tell me what it is like for you to have PTSD."
- "You mentioned having problems with anger, what happens when you get angry?"

If questions like these are asked during the mental status exam or during a general diagnostic interview, the veteran will usually not know that you are asking about potential PTSD symptoms. Our experience is that veterans with genuine PTSD will usually answer questions like those presented above in the affirmative. For example, when asked, "Are you bothered by unwanted thoughts which keep coming back to you and you can't get out of your mind?" they will respond with answers such as, "Yeah, thoughts about the war … I keep thinking about it even though I don't want to." The minority of veterans who are exaggerating or feigning symptoms will often not answer open-ended questions in the affirmative but, once a PTSD-specific diagnostic interview has begun, will suddenly endorse symptoms they had previously not mentioned.

Assessing Comorbid Disorders

Psychiatric comorbidity is common with veterans suffering from PTSD (Ginzburg, Ein-Dor, & Solomon, 2010; Gros, Simms, & Acierno, 2010; Stecker, Fortney, Owen, McGovern, & Williams, 2010). It is therefore very important to screen for and assess other mental disorders as part of an Initial PTSD exam. Some examiners use a structured diagnostic interview for this purpose, such as the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I; First, Spitzer, Gibbon, & Williams, 2002) or the Schedule for Affective Disorders and Schizophrenia (Endicott & Spitzer, 1978), since such interviews exhibit greater reliability and validity (diagnostic accuracy) than unstructured interviews (Miller, Dasher, Collins, Griffiths, & Brown, 2001; Rogers, 2001). Structured interviews generally take longer than unstructured interviews so their use is proscribed for some examiners working on strict time restrictions.

Specialized Testing for Feigned PTSD

The MENT is symptom validity test specifically designed to detect individuals attempting to feign PTSD and was developed with a VA population (Morel & Shepherd, 2008a, b; Messer & Fremouw, 2007). We recommend that examiners consider using the MENT in Initial PTSD exams, along with the other measures mentioned earlier, e.g., the MMPI-2. Some examiners have worried that veterans might have read about the MENT on the Internet (or have learned about it from other veterans) and subsequently know how to answer the test items so as to not appear as if they are feigning. However, we suspect that the percentage of examinees who have garnered detailed information about the test is relatively small.

There is another concern about the MENT, namely that it is not yet known how many combat veterans with genuine

PTSD intentionally perform poorly on the test because they naively believe that they are "supposed to" fail the test because they have PTSD. This concern is similar to that with the MMPI-2 validity scales, i.e., either due to "extreme distress" or a belief that they must "prove their case" many *genuine* PTSD patients significantly elevate MMPI-2 validity scales (Frueh, Hamner, Cahill, Gold, & Hamlin, 2000; Franklin et al., 2002). Our anecdotal experience is that some veterans produce a MENT score above the recommended cutoff when all other evidence indicates they have genuine PTSD and we wonder if there is a subset of veterans who—despite warnings about the negative consequences of exaggeration or feigning—nonetheless feel compelled to underperform on the MENT out of a misguided notion that genuine PTSD patients should "fail" this particular test.

Because of this concern, we recommend the following with regard to the MENT:

- Adopt a conservative cutoff score. We recommend a score of 18 since that was the mean score of the malingering sample in the research used to develop the MENT.
- Do not conclude that a veteran is exaggerating symptoms or feigning PTSD if the MENT is the only indicator of dissimulation.

Structured PTSD Diagnostic Interview

As noted above, well-researched psychiatric structured interviews are more reliable and valid than unstructured interviews, and this is also true for PTSD diagnostic interviews (Weiss, 2004; Erbes, Dikel, Eberly, Page, & Engdahl, 2006). We therefore recommend that examiners employ a structured PTSD interview as part of their Initial PTSD exam. There are several reliable and valid instruments available, e.g., the SCID-I PTSD module, the PTSD Symptom Scale-Interview Version (Foa & Tolin, 2000), and the Clinician-Administered PTSD Scale for DSM-IV (CAPS; Blake, Weathers, Nagy, & Kaloupek, 1995; Weathers, Keane, & Davidson, 2001). The CAPS is the most commonly used instrument in the VA (it was developed by the VA's National Center for PTSD) and is the easiest to use for most VA staff because the CAPS interview form, manual, and training videos are all available at no charge on the VA intranet website (http://vaww.ptsd.va.gov/Assessment.asp).

In addition to its superior reliability, validity, and availability, we recommend using the CAPS because it helps the examiner to:

- Assess both symptom *frequency* and *severity* using reliable rating methods.
- Clarify diagnostic criteria, e.g., ascertaining the veteran's emotional response to the trauma (DSM-IV Criterion A2).
- Differentiate symptoms, e.g., discerning whether reported flashbacks occur during waking hours or only in dreams.
- Determine how and to what extent symptoms interfere with functioning (which is very important for rating purposes).
- Determine the duration of symptoms
- Identify "hidden" symptoms, e.g., suppressed anger.
- Rate the extent to which symptoms are trauma-related or not, e.g., apathy (loss of interest in previously enjoyed activities) is a PTSD symptom but it also can occur for other reasons such as depression.
- Clarify when symptoms began (symptom onset) and how long they have lasted (symptom duration).
- Rate subjective distress, impairment in social functioning, and impairment in occupational functioning.
- Indicate if there are any factors present that affect the validity of the veteran's responses.
- Assess associated PTSD symptoms, e.g., survivor guilt or derealization.

These CAPS advantages lead to more accurate diagnoses. Accuracy can also be fine-tuned by considering the use of one of several scoring methods for the CAPS. Nine scoring methods, or rules, have been described in the literature, each of which demonstrates good to excellent reliability (Weathers, Ruscio, & Keane, 1999). However, each of the rules differs with regard to their sensitivity, specificity, and the extent to which they can be considered lenient or strict with regard to the ultimate diagnostic decision. We agree with the aforementioned authors that "it is incumbent on test users to select the most appropriate scoring rule for a given assessment task and to explicitly identify and defend their choice" (Weathers, Ruscio, & Keane, 1999, pp. 130–131).

For example, one might argue that for Initial PTSD exams the "SCID Symptom-Calibrated" rule is ideal because it combines the highest sensitivity (0.91) with the best specificity (0.84), possesses the highest negative predictive value (0.89), and has the highest diagnostic efficiency (0.88). In addition, the rule is in the middle of the leniency to strictness dimension.

On the other hand, some examiners might choose to utilize the "F1/I2" scoring rule because it is one of the most lenient of the nine possible scoring rules (Weathers et al., 1999). As such, the "F1/I2" scoring rule allows for the examiner to interpret the results of the CAPS with more benefit of the doubt for the veteran. The most important point is that all examiners should read the Weathers, Ruscio, and Keane (1999) article and decide which scoring rule they believe best fits for a C&P exam.

Subsyndromal Post-traumatic Stress

After conducting a detailed PTSD assessment, you might discover that the veteran does not meet all DSM-IV

diagnostic criteria for PTSD but he or she does experience post-traumatic stress symptoms to such a degree that they cause him or her significant distress or functional impairment. Such cases have been referred to in the literature as "subsyndromal post-traumatic stress disorder" (Pietrzak, Goldstein, Malley, Johnson, & Southwick, 2009) or "subthreshold post-traumatic stress disorder" (Yarvis, Bordnick, Spivey, & Pedlar, 2009). The appropriate DSM-IV diagnosis in these instances is Anxiety Disorder Not Otherwise Specified.

False Attribution

Some Initial PTSD exams involve veterans who have come to believe they have PTSD when, in fact, they do not have the disorder. Based on anecdotal experience, these veterans usually do not significantly over-report symptoms of PTSD or other mental disorders. They often do not know a lot about PTSD, e.g., what causes it or all of its symptoms.

These veterans have often learned a little about PTSD from the popular media, friends, or veteran service officers. They know PTSD involves stress experienced during deployment in a combat zone, and they know they were deployed to a combat zone. Lately they have been feeling depressed or anxious. They begin to think they might have PTSD. After all, the diagnosis seems to make sense, i.e., they experienced stress, they believe that deployment-related stress can cause PTSD, they feel bad (depressed, anxious); therefore, they conclude that they might very well have the disorder. The fact that there is so much media attention about soldiers suffering from the disorder adds to their belief that they have it. They consequently file a PTSD claim with the VBA.

Such individuals are exhibiting what might be called "false attribution", i.e., in an effort to explain their current problems, they falsely attribute the cause of their depression or anxiety to their wartime service.[10] This process is often completely innocent, and the veteran is neither fabricating a mental disorder nor lying about the cause of their psychic distress. They genuinely believe that their current difficulties were caused by their military service.

We mention this type of case for two reasons: First, if examiners do not conduct a detailed PTSD diagnostic interview, they might misdiagnose such a veteran as suffering from PTSD when, in fact, they have a depressive or anxiety disorder that is not service-connected. Second, if an examiner does conduct a detailed PTSD diagnostic interview and discovers that the veteran does not meet the diagnostic criteria for the disorder, he or she might leap to the conclusion that the veteran is trying to feign PTSD when this is not the case.

Fear of Hostile Military or Terrorist Activity

On both the *Initial* and *Review* DBQs for PTSD, examiners are asked whether or not the claimed stressor (that led to the development of PTSD) is related to the Veteran's fear of hostile military or terrorist activity. The legal phrase "fear of hostile military or terrorist activity" can be confusing. On its face, it seems that one must determine if the veteran is currently afraid of hostile military or terrorist activity. However, some veterans with PTSD may respond, if asked, "No, I'm not afraid of that" (or words to that effect). In such instances, should the examiner then answer "No" to the "fear of hostile military or terrorist activity" question?

That would not be the correct response because the phrase "fear of hostile military or terrorist activity" has a very specific meaning. VHA Information Letter 10-2010-016 (October 14, 2010) states:

> 'Fear of hostile military or terrorist activity' means that a Veteran experienced, witnessed, or was confronted with an event or circumstances that involved actual or threatened death or serious injury, or a threat to the physical integrity of the Veteran or others and the Veteran's response to the event or circumstances involved a psychological or psycho-physiological state of fear, helplessness, or horror. The event or circumstances include, but are not limited to, the following:
>
> (1) Actual or potential improvised explosive device;
> (2) Vehicle-embedded explosive device;
> (3) Incoming artillery, rocket, or mortar fire;
> (4) Small arms fire, including suspected sniper fire; or
> (5) Attack upon friendly aircraft.

Readers will recognize that this definition incorporates criterion A of the DSM-IV diagnostic criteria for PTSD. Of course, if an examiner has diagnosed a veteran with PTSD, the veteran will, by definition, have met criterion A. Therefore, in most instances if an examiner has diagnosed a veteran with PTSD, the examiner should answer "Yes" to the "fear of hostile military or terrorist" question.

The Information Letter also seems to specify combat-related incidents as part of the definition of the phrase. Therefore, if the PTSD stressor involved a non-combat incident, e.g., the veteran was assaulted by another service member, an examiner would answer "No" to the "fear of hostile military or terrorist" question. In such instances, a "No" answer will not necessarily preclude the receipt of compensation benefits.

[10] Note that "false attribution" is different from "false imputation." The latter term refers to attributing current mental disorder symptoms to an alleged stressor when the individual knows that such a causal connection does not exist (Resnick, 1997).

PTSD Review Exams

PTSD Review exams are conducted for three reasons:

- The veteran has requested an increase in his or her rating percentage (asserting that their functional abilities have deteriorated due to their mental disability).
- The veteran has filed a claim for Individual Unemployability (asserting that they are unable to work because of their mental disability).
- The Veterans Benefits Administration has requested an exam. There are some detailed regulations that govern when the VBA may request a PTSD Review exam but discussing them is beyond the scope of this article.

If the veteran's Initial PTSD exam report reflects a thoroughly conducted examination, particularly with regard to a review of the claims file, then a PTSD Review exam will require somewhat less time to complete than an Initial exam. However, it has been our experience that the evaluation conducted by the Initial examiner often does not include a thorough review of the claims file. In those cases, a Review exam takes just as long as an Initial exam.

We recommend that examiners conduct a PTSD Review exam in a manner similar to an Initial PTSD exam with the following exceptions:

- If it is clear from the Initial PTSD exam report that the examiner thoroughly reviewed the Claims File, then you will not need to repeat such a thorough review.
- If the Initial PTSD exam report contains a well-developed psychosocial history for the veteran, you do not need to also take a detailed developmental history.
- Whereas the Initial PTSD exam focuses on whether or not the veteran has PTSD and, if so, whether or not it was caused by his or her military service, the PTSD Review exam focuses on the veteran's symptoms and functioning since the last exam.

Importance of Temporal Focus

Review PTSD examinations are specifically focused on the changes in social and occupational functioning, as well as symptom frequency and severity, since the last C&P examination. However, it has been our experience that veterans will frequently discuss PTSD-related symptoms from 10, 20, or 30 years ago rather than focusing on those symptoms having occurred since they were last evaluated. For example, when discussing problems related to anger, a veteran may admit to difficulty with anger. When asked to describe the anger, they relate a story about getting into a fight with a neighbor or co-worker, but further discussion of the fight reveals that the incident occurred in the 1970s when the veteran first came back from Vietnam. When redirected to describe *current* behaviors related to anger, the veteran might respond that they walk away from incidents they know will cause them to become angry. The intensity of this symptom (anger) is clearly different between these two responses, highlighting the importance of ascertaining the exact time frame of reported symptoms.

Psychological Assessment of Dissimulation

Examiners sometimes wonder if psychological testing for symptom exaggeration or feigning is necessary for Review exams. We believe such screening is important in Review exams because the veteran could exaggerate symptoms in an attempt to garner a benefits increase. In addition, if the Initial PTSD examiner did not conduct screening for symptom exaggeration or feigning, then the possibility exists that the veteran might not truly suffer from PTSD. Plus, psychological testing occasionally identifies veterans who are under-reporting symptoms. We therefore highly recommend that examiners conduct psychological testing for response style in Review exams as well.

Importance of a Detailed PTSD Diagnostic Interview

Examiners also sometimes wonder if a detailed PTSD diagnostic interview is necessary for Review exams. We believe it is for two reasons: First, VBA raters must determine if a veteran's condition has worsened since the last exam in order to increase his or her rating percentage. They therefore need to compare symptom severity and, especially, functional impairment from the time of the last exam to the present. VBA raters are not able to conduct such a comparison if the Review examiner does not provide sufficient information about the veteran's current symptomatology and functional impairments. A detailed PTSD diagnostic interview, e.g., using the CAPS, is the best way to solicit information from the veteran about his or her current PTSD symptoms and related functional impairments.

Second, the DBQ for PTSD Review exams specifically asks examiners to list the PTSD symptoms a veteran currently experiences. If an examiner does not conduct a diagnostic interview, he or she will not be able to provide that information and the DBQ will be insufficient.

Initial Mental Disorder Exams

Initial Mental Disorder exams are in many ways quite similar to Initial PTSD exams in that the examiner is asked if (a) the veteran suffers from the claimed disorder(s) and (b) if the claimed disorder(s) were incurred during or aggravated by military service. It is important to note that military service does need to have *caused* the mental disorder; the

disorder need only have *begun* during a veteran's military service (or have been aggravated by military service). In addition, the current mental disorder must be the same disorder from which the veteran suffered during his or her military service. For example, if a veteran had an adjustment disorder in response to a specific stressor during military service, he or she would not be eligible for compensation if he or she developed an adjustment disorder in response to a different, post-service stressor.

On the other hand, If Army doctors diagnosed a veteran with major depressive disorder (MDD) during his or her military service and the veteran submits a claim for MDD 8 years post-service, then the examiner must determine if the veteran's current MDD is the same illness that he or she suffered from during military service or if it is a completely new disorder. Given that MDD often reoccurs (Mueller et al., 1999; Solomon et al., 2000) and given the equipoise doctrine, most examiners would probably conclude in such a case that it is at least as likely as not that the veteran's current MDD is a continuation of the in-service illness.

A common reason for requesting an Initial Mental Disorders exam is that the veteran claims that a service-connected medical condition, e.g., diabetes or chronic back pain, has caused them to develop a mental disorder such as depression. Such a claim is possible because if a service-connected medical condition causes a second illness then that second disorder is compensable (*Disabilities that are proximately due to, or aggravated by, service-connected disease or injury*, 38 C.F.R. § 3.310, 2010).

Secondary condition cases are challenging because there is often more than one possible cause for the veteran's mental disorder. In such cases, it is important to conduct a detailed psychosocial history, particularly for the time period preceding and after the development of the medical condition. In this way, the examiner can identify potential causes of the veteran's mental disorder, in addition to the medical illness. Once other potential causes are identified, the examiner should ask open-ended questions about the effects of the event or circumstance on the veteran. It is also often helpful to draw a time line depicting such events, along with the time of the diagnosis of the medical condition and the first appearance of mental disorder symptoms. See Fig. 4 for an example of such a time line.

Mental Disorder Review Exams

Mental Disorder Review exams are quite similar to PTSD Review exams in that the primary question is "How has the veteran's psychological condition changed since the last exam?" As before, it is important to screen for symptom exaggeration or feigning and to conduct a thorough diagnostic interview with an emphasis on both symptoms and functional impairments caused by those symptoms.

Mental Disorder Review exams should be conducted in a manner similar to the Initial Mental Disorder exam with the following exceptions:

- If it is clear from the Initial Mental Disorder exam report that the examiner thoroughly reviewed the claims file then you will not need to repeat such a thorough review.
- If the Initial Mental Disorder exam report contains a well-developed psychosocial history for the veteran, you do not need to also take a detailed developmental history.

Other Exams

Other types of exams that are beyond the scope of this article include:

- *Individual Unemployability*—as a result of a service-connected mental disability, is the veteran unable to establish and maintain gainful employment? This question is usually asked as part of a Review exam.
- *Financial Competence*—is the veteran (or a dependent of a deceased veteran) capable of appropriately managing their benefits payments? All DBQs ask examiners to determine if a veteran is capable of handling his benefit payments appropriately, but this determination generally does not require a specialized financial competency

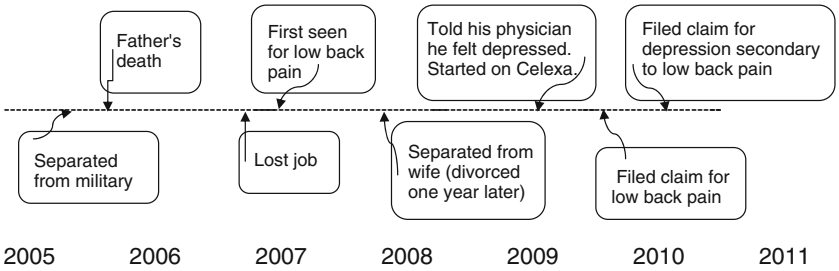

Fig. 4 Time line of a hypothetical initial mental disorders case in which the veteran has filed a claim for depression secondary to chronic low back pain

evaluation. However, there are instances in which the VBA asks for a C&P exam specifically because there is some question about the individual's ability to manage their finances, e.g., a veteran with dementia or a gambling addiction or an adult child of a deceased veteran who has a developmental disability.

- *Eating Disorders*—this type of exam has its own DBQs (Initial and Review). They should be conducted similar to a Mental Disorder exam, preferably by an examiner with experience assessing individuals with an eating disorder.
- *Military Sexual Trauma or Personal Assault*—these are special types of PTSD examinations in which a veteran reports that he or she was sexually or personally assaulted during their military service. There are some unique aspects to these exams which unfortunately space limitations prohibit us from covering; however, the following website contains some pertinent information: http://vbaw.vba.va.gov/bl/21/rating/rat06h.htm.
- *Iatrogenic Harm from VA Treatment*—if a veteran is harmed by treatment at a VA healthcare facility, any resulting disease or condition is compensable. These cases usually involve non-psychiatric medical conditions but on rare occasions psychological injury is alleged.
- *Cause of Death Opinion*—a surviving spouse may file for VA benefits (Dependency Indemnity Compensation) if he or she believes their spouse's death was a direct result of their service-connected disability (e.g., a veteran service connected for major depression commits suicide). These cases require an opinion if the veteran's death is at least as likely as not a result of his or her service-connected disability.

Conclusion

VA Compensation & Pension examinations present challenges to even experienced forensic mental health professionals because of their complexity, unique legal parameters, amount of material to review, the political climate at some VA facilities, and insufficient time to complete a thorough exam at some locations. Nonetheless, these are very important evaluations since they involve the lives of men and women who have sacrificed much to protect and defend their country. We owe it to veterans and the American taxpayers to provide consistent, reliable, and accurate mental health-related C&P exams, and we hope this article plays at least a small role in achieving that objective.

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Appendix: Recommended Resources

Mental Disability Evaluations in Particular

American Academy of Psychiatry and the Law (2008). AAPL practice guideline for the forensic evaluation of psychiatric disability. *Journal of the American Academy of Psychiatry and the Law*, *36*(4), S3–S50. Available at: http://www.jaapl.org/content/36/Supplement_4/S3.full.pdf

Association of VA Psychologist Leaders (AVAPL) electronic email list for VA mental health compensation and pension examiners and other interested parties. To subscribe write to webmaster1@avapl.org

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Foote, W. E. (2008). Evaluations of individuals for disability in insurance and Social Security contexts. In R. Jackson (Ed.), *Learning forensic assessment (international perspectives on forensic mental health)* (pp. 449–479). New York: Taylor & Francis Group.

Gold, L. H., & Shuman, D. W. (2009). *Evaluating mental health disability in the workplace: Model, process, and analysis*. New York: Springer.

Forensic Mental Health Evaluations in General

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The Veteran's Experience

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