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# Psychological Evaluations of Veterans Claiming PTSD Disability with the Department of Veterans Affairs: A Clinician's Viewpoint

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From a clinician's viewpoint, there are several reasons to be concerned about the diagnostic evaluation practices and processes currently in place for veterans claiming Post Traumatic Stress Disorder (PTSD) disability with the Department of Veterans Affairs (VA). In this brief commentary, I provide an overview of these concerns. First, I provide the clinical context for my perspective as a VA "outsider" hired to serve as a neutral consultant. As a licensed psychologist in private practice, I have conducted approximately 1,000 mental health evaluations for the Social Security's Department of Disability Services over the past 9 years. Approximately 2 years ago, I contracted with VA to conduct compensation and pension evaluations with military veterans seeking VA disability benefits for PTSD and/or Traumatic Brain Injury (TBI). Since that time, I have conducted well over 100 diagnostic or follow-up evaluations of veterans who have submitted claims to be compensated for these disorders.

As noted in the Diagnostic and Statistical Manual of Mental Health Disorders-Fourth Edition (*DSM-IV*), there is an a priori importance of assessing for malingering in diagnostic cases where there may be an incentive to feign or exaggerate mental illness. As such, my evaluations of individuals, civilians, or veterans claiming mental illness for which they may receive disability benefits have always included the use of at least one malingering instrument to aid in determining the veracity of a claimant's account—especially when objective and/or collateral information are inconsistent with subjective report.

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The issue of symptom exaggerating or feigning is a concern the VA is fully aware of. In an address sponsored by the University of Michigan Medical School, the Ann Arbor VA, and the Michigan Psychiatric Society, Sheila Rauch, Ph.D., director of the Veterans Affairs Returning Veterans' Mental Health Program in Ann Arbor Michigan, acknowledged that veterans "may overreport to get service-related disability." She recommended that VA clinicians actively assess for malingering among veterans seeking disability benefits and services (Rauch 2010).

Also acknowledging the issue of malingering, the Executive Director for the National Center for Posttraumatic Stress Disorder, US Department of Veterans Affairs, Matthew J. Friedman, M.D., Ph.D., advises that clinicians evaluating veterans use a structured interview in assessing for PTSD (Friedman 2009). He recommends the Clinician Administered PTSD Scale (CAPS) as the "gold standard" and notes that it includes an assessment of "behavioral anchors" (not just self-report). Oddly, however, in the 100 plus cases referred to me by the VA, most with already established diagnoses of PTSD, the CAPS was never referenced in any of the documentation I reviewed for any of the cases. Furthermore, the VA never asked or suggested that it be used in my evaluations.

Federal oversight agencies have raised concerns about potential for fraud and abuse in veterans' PTSD disability claims (Department of Veterans Affairs Office of Inspector General 2005; United States Government Accountability Office 2007). In 2006, the VA became concerned about the increasing number of veterans claiming PTSD and filing for compensation (Levin 2006). They commissioned a report from the Institute of Medicine (2007), which met in committee to consider issues related to the diagnosis of PTSD. Interestingly, one member of the committee, Darrel Regier, M.D., executive director of the American Psychi-

atric Institute for Research and Education, made the comment (cited in Levin 2006): "Part of the reason for asking that clinically well-trained people evaluate patients is to avoid *over-diagnosing* people faking PTSD (emphasis mine)." Clearly, this is both a clinical, and political, issue.

With respect to the assessments I have conducted for service-connected PTSD and/or TBI, the outcomes of an astonishingly large number of these evaluations point to findings of symptom feigning that clearly meet the diagnostic criteria for Malingering (*DSM-IV*). I rarely diagnose veterans with malingering, secondary to political ramifications, as well as a direct prohibition from the VA. However, I have become increasingly disturbed by the number for whom, as a function of a clinical interview, review of collateral information, and the outcome of structured testing, the finding of symptom feigning is simply unavoidable.

A review of the literature in this area demonstrates that I am not alone in identifying this problem. Empirical studies consistently support the high prevalence of symptom exaggeration and malingering in veterans seeking disability benefits (Fairbank et al. 1983; Freeman et al. 2008; Frueh et al. 2003, 2000; Sparr and Pankrantz 1983) and highlight the problematic nature of the VA's disability policies for PTSD (Frueh et al. 2007; Mossman 1996). And yet, with respect to testing for malingering, in all of the clinical cases I have reviewed, there were only two occasions where a malingering screen was even considered by VA practitioners and only one that was actually conducted.

A crucial aspect of assessing for PTSD is the review of collateral information, particularly medical and mental health records. I often spend up to 2 hours reviewing such documentation. I have found that initial VA evaluations for PTSD usually are limited to a list of face valid PTSD symptoms to which the veteran answers "yes" or "no." Almost universally, the answers to these questions are endorsed in the clinical direction, which then results in a diagnosis of PTSD. There are virtually never notations of any objective observations or other data points to support or refute the presence of reported symptoms, nor is there any objective information regarding the reported traumatic military events that claims are based on. Indeed, I have found that, in the aggregate, claims of PTSD symptomotology are accepted as fact—even when they are unsupported by collateral information or other objective findings. Even more troubling is the fact that disconfirming facts or information that contradicts a diagnosis of PTSD is routinely ignored in the clinical case documentation that I have reviewed.

It seems likely that political sensitivities trump accurate psychiatric diagnoses in veterans evaluated for PTSD disability claims within the VA system. Although I have received previous accolades on the thorough and well-supported nature of my clinical evaluation reports, I was recently advised by VA that my services were no longer needed for the express reason that, because I use malingering instruments in my evaluations, I presume all veterans to be malingering. Specifically, I was advised that the use of instruments designed to detect feigning "do not give the veteran the benefit of the doubt." Furthermore, I was informed that an indeterminate number of the veterans I had previously assessed and found to not meet the diagnostic criteria for PTSD would be rescheduled with another psychologist for a repeat evaluation.

Based on my clinical experience, a "benefit of the doubt" mindset demonstrates that an underlying political climate influences what are otherwise supposed to be objective and professional assessments of psychiatric disability claims. It is problematic that the VA sends veterans to highly trained, objectively-focused psychologists, but apparently prefers psychologists base their "findings" on less than scientific bases—bases that seem grounded in misplaced benevolence and/or political expediency, rather than empirical data. The result, in my opinion, is that millions of dollars may be awarded to veterans who do not actually have the disorder for which they are compensated. Also troubling is the money wasted re-evaluating veterans who have already been, often erroneously, diagnosed with PTSD or TBI in an initial "checklist" interview, with the VA simply wanting a rubber-stamp approval by an outside psychologist. This kind of tacit (or in my case not-so-tacit) expectation poses serious ethical concerns for professionals such as myself, and undermines the integrity of the VA system and its disability adjudication processes. Altogether, these concerns also suggest that limited VA resources are routinely wasted or misallocated, and are therefore diverted from serving the needs of those who should truly be service-connected for mental illnesses, courageous men and women who have given so much to our country and deserve the services and benefits the VA system was designed to provide.

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