

**COMPENSATION AND PTSD:  
CONSEQUENCES FOR SYMPTOMS  
AND TREATMENT**

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Individuals with PTSD can apply for compensation through various systems, depending on the circumstances in which the precipitating trauma occurred. For instance, in the United States, military veterans with service-related PTSD may apply for compensation from the Department of Veterans Affairs (VA); citizens with PTSD related to work trauma may apply for compensation through their state's workers' compensation program; and individuals with PTSD stemming from others' willful acts or negligence may bring tort suits against the responsible parties. Since its introduction into the DSM III, PTSD has probably become the most common psychiatric condition for which individuals seek compensation.

Disability programs differ in terms of eligibility, claim processes, and benefits. Nevertheless, they share the laudable goals of providing compensation for losses and, if not precisely restoring injured individuals' health and functioning, then at least limiting further declines. But do these programs achieve these goals? The main reason for questioning the therapeutic value of compensation programs is that compensation may have the unintended effect of discouraging recovery. Concern about the financial gain inherent in disability programs has a long history and is not specific to PTSD. However, because many PTSD sufferers seek compensation, practitioners, researchers, and policy makers whose work involves PTSD need an understanding of research in this area.

In this review, we discuss published studies examining the consequences of compensation seeking and claim settlement on PTSD and mental health treatment, as well as methodological issues and gaps in the literature. Most studies have focused either on veterans seeking compensation for military-related PTSD through the VA or on

civilians involved in litigation for motor vehicle collisions. Generally, VA studies have examined male veterans seeking compensation specifically for combat-related PTSD, while civilian-based studies include both men and women, but tend not to specify the diagnostic condition for which claimants sought benefits. Because it is not possible to randomize individuals to compensation condition, all these studies are observational.

***Compensation Seeking and Symptom Reporting***

With few exceptions (Smith & Frueh, 1996; DeViva & Bloem, 2003), research indicates that PTSD and other symptom levels are higher among trauma survivors seeking compensation than among those who are not seeking compensation. This pattern has been observed in personal injury litigants (Blanchard et al., 1996; Blanchard et al., 1998; Ehlers et al., 1998), Israeli soldiers (Solomon et al., 1994) and American military veterans (Frueh et al., 2000). Reasons for this pattern are uncertain, but there are at least three plausible, nonmutually-exclusive explanations. The first and most obvious possibility is that trauma survivors who file claims are more psychiatrically impaired than those who do not. We refer to this as the disability hypothesis. From this perspective, the above mentioned group-difference in symptom reporting reflects real differences in trauma-related symptoms and impairments. Consistent with this hypothesis, Solomon and colleagues (1994) reported that Israeli war veterans who sought compensation experienced more severe combat trauma and subsequently displayed more psychiatric impairment than matched veterans who did not seek compensation.

The second possibility is that individuals seeking compensation exaggerate trauma-related symptoms to establish a basis for their claims or to maximize payments. We refer to this as the financial gain hypothesis. This is the hypothesis that has received the most investigation. Consistent with this proposition, in a series of studies Frueh and colleagues found that male combat veterans seeking compensation for PTSD were more likely to produce MMPI-2 validity scale scores suggestive of extreme exaggeration compared to their non-compensation-seeking counterparts

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(see Frueh et al., 2000, for a review). In one study Frueh and colleagues observed this pattern among veterans who were seeking VA compensation for any (physical and/or psychiatric) condition (Frueh et al., 2003). Across these studies, about 20% of compensation-seeking veterans produced extreme scores on MMPI-2 validity scales. Lees-Haley (1997) observed a similar rate of possible symptom over-reporting in a relatively large sample of personal injury litigants. However, some VA studies failed to replicate this finding (Smith & Frueh, 1996; DeViva & Bloem, 2003).

Several methodological issues should be considered in evaluating research in this area. First is the definition of symptom exaggeration. Across studies investigators use different MMPI-2 indicators of exaggeration and, as demonstrated by Franklin and colleagues (2003) in a sample of compensation-seeking veterans, the rate of symptom exaggeration varies by validity index. Next is study design and sampling. The VA studies used cross-sectional designs and non-representative samples of treatment-seeking veterans. Therefore, selection biases and confounding cannot be ruled out. Last is the definition of compensation seeking. Investigators have used varying, study-specific definitions of compensation seeking (e.g., Blanchard et al., 1996; Fontana & Rosenheck, 1998), which limits comparability of findings. Furthermore, to form their compensation seeking group, investigators often combine individuals at different stages of the claims process. For example, stages of the VA claims process include: (a) intention to file, (b) claim submission, (c) claim settlement, and for a subset of those with settled claims, (d) appealing a denied claim or (e) pursuit of a rating increase. Sayer and colleagues (in press) discuss the need for research to determine whether combining individuals at different stages of the claims process into one compensation-seeking group is warranted.

It has also been proposed that compensation-seeking patients will fail to benefit from PTSD treatment because of the need to demonstrate illness. Research does not support this premise in its simplest form. Taylor and colleagues (2001) examined compensation issues in a study of response to cognitive behavioral therapy for PTSD secondary to motor vehicle collisions. They found that pending litigation and receipt of payment did not impact PTSD treatment outcomes. Similarly, compensation-seeking status did not impact outcomes among male VA inpatients receiving residential treatment for combat-related PTSD (DeViva & Bloem, 2003). Both of these studies may have been under-powered to examine the effect of compensation seeking on outcomes. In a large VA PTSD program evaluation, Fontana and Rosenheck (1998) found that compensation seeking did not have a deleterious effect on outcomes among outpatients or inpatients in programs with medium lengths of stay. However, it did inhibit outcomes among inpatients in programs with extremely long lengths of stay (100 days on average) that automatically triggered in-

creased compensation payments during the veteran's hospitalization. These findings suggest that the effect of compensation seeking may vary by context. In this study, those pursuing and receiving VA compensation for any psychiatric disorder were classified as compensation seeking. The differential effects of compensation seeking and claim settlement on treatment outcomes, therefore, could be distinguished.

A third possible explanation for higher self-reported psychological symptoms among claimants is that the claim process may act as a stressor that triggers genuine symptom increases. We refer to this as the stress hypothesis. Claim processes are often time-consuming, protracted and, at least from the claimant's perspective, adversarial (Bryant et al., 1997; Mayou et al., 1997). For PTSD sufferers, the claim process may also serve as a reminder of the precipitating trauma, particularly if it requires a PTSD examination. The stress hypothesis has not been tested directly. However, some research suggests that negative beliefs about the claims process (including the PTSD compensation exam) impact symptom-reporting among VA PTSD claimants. Sayer and colleagues (2004b) found that veterans who held more negative claim-specific beliefs soon after filing their PTSD claim had more severe symptoms the day of their actual PTSD exam. These findings suggest more research is needed to understand the claims process from the perspective of the claimant him- or herself.

Research on compensation seeking and PTSD symptom-reporting has focused primarily on financial incentives. However, money may not be the only or most important factor motivating trauma survivors to seek compensation. For example, some work suggests that VA PTSD claimants, personal injury litigants and sexual violence survivors may use claims processes for acknowledgement of their suffering and relief from self-blame (Des Rosiers et al., 1998; Mayou, 1995; Sayer et al., 2004a). Sayer et al. (2004a) found that veterans valued compensation for PTSD for symbolic reasons more frequently than for financial benefit, although there was an inverse relationship between income and the perceived importance of financial benefit. These few studies suggest that compensation for trauma-related problems may have an under-appreciated symbolic value. Also unexamined are the possible social and system factors influencing compensation seeking. That is, PTSD sufferers may seek compensation at the behest of significant others and medical professionals, as has been found among individuals with psychiatric disorders seeking Social Security disability benefits (Estroff et al., 1997).

#### *Claim Settlement, Symptom Course and Treatment*

Most research on the effects of claim settlement has examined corollaries of the financial gain hypothesis. Terms like "accident neurosis" and "litigation neurosis" convey the belief that claimants report distress and functional difficulties to obtain compensation and that symptoms will abate after the claim settlement, regardless of

outcome (Miller, 1961). This proposition has been examined in prospective studies. Studies of personal injury litigants found that, for the most part, symptoms do not disappear after claim settlement (Blanchard et al., 1998; Bryant & Harvey, 2003; Mayou, 1995) and that symptom trajectories did not vary by compensation-seeking status (Blanchard et al., 1998). However, trends suggest that those with pending claims may be more distressed and impaired than those with resolved claims and those who never filed suits (Blanchard et al., 1998). These differences may have reached statistical significance in larger samples. Persistence of PTSD symptoms and disability after claim settlement was also observed in studies of Israeli and American military veterans (Sayer et al., in press; Solomon et al., 1994).

It has been proposed that veterans use VA mental health services to establish a basis for their PTSD claims and then drop out once their claim is adjudicated. Published studies do not support this supposition. In a study of 771 veterans seeking compensation for PTSD, Spoo et al. (2007) found that veterans used more mental health services while they were seeking compensation for PTSD relative to a pre-claim baseline period. After claim resolution, the rate of service use remained significantly elevated relative to baseline among those with awarded claims. Further, higher PTSD disability ratings were associated with more mental health service use among awardees (Sayer et al., 2004c). A separate prospective study of former PTSD claimants, half of whom were in treatment at the time of claim initiation, found that dropout rates did not increase after claim settlement (Sayer et al., in press). Similarly, in a civilian sample, Bryant and Harvey (2003) observed that comparable proportions of patients with pending and settled claims participated in psychotherapy.

Very few studies have examined the possible differential effect of claim award versus claim denial on psychiatric status or other outcomes. In a large, representative sample of former VA PTSD claimants, PTSD symptom severity was only slightly reduced among those with denied claims compared to those with successful claims, but those with denied claims had poorer work, role, social, and physical functioning (Murdoch et al., 2005). These findings demonstrate that veterans remained symptomatic and impaired after claim settlement. Furthermore, veterans with denied claims, while not qualifying for VA PTSD compensation, may still need mental health and other services. Research is needed to determine whether those with denied claims are as likely as those with awarded claims to receive appropriate health care.

### Summary

The view that claimants exaggerate PTSD symptoms to obtain benefits and are "cured" by claim resolution is overly simplistic. While compensation-seeking individuals may be more psychiatrically symptomatic than their non-compensation-seeking counterparts, most do

not overreport their symptoms. Furthermore, available evidence suggests that former claimants continue to suffer from PTSD and functional problems and do not drop out of treatment. The few studies examining compensation and treatment outcome suggest that compensation seeking does not dampen PTSD treatment outcome in most contexts. Research examining compensation-seeking effects, however, is limited by use of study-specific definitions of compensation seeking that have not been empirically validated. On the other hand, differences between compensation-seeking and non-compensation-seeking individuals warrant further study, including invalid symptom profiles in a sizeable minority of compensation-seeking veterans evaluated for PTSD treatment and trends that suggest those with pending claims may have more distress and impairment than those with resolved claims. Importantly, there remain significant gaps in the literature, including the systematic study of motivations other than financial gain, the effect of compensation on individuals with sources of traumatic stress other than combat and motor vehicle collisions, and the long-term effects of claim award and denial on symptoms, functioning and treatment outcomes. Women have also been grossly understudied in the VA studies. In sum, research is needed not only to more conclusively determine whether participation in compensation programs has therapeutic or anti-therapeutic effects on the development and maintenance of PTSD, but also to identify for whom, under what conditions, and in what contexts these effects are likely to occur.

## ABSTRACTS

BLANCHARD, E.B., HICKLING, E.J., TAYLOR, A.E., LOOS, W.R., FORNERIS, C.A., & JACCARD, J. (1996). **Who develops PTSD from motor vehicle accidents?** *Behaviour Research and Therapy*, 34, 1-10. Within 1 to 4 months of their motor vehicle accident (MVA), we assessed 158 MVA victims who sought medical attention as a result of the MVA. Using the Clinician-Administered PTSD Scale, we found that 62 (39%) met DSM-III-R criteria for PTSD. Using variables from the victim's account of the accident and its sequelae, pre-MVA psychosocial functioning, demographic variables, pre-MVA psychopathology and degree of physical injury, we found that 70% of the subjects could be classified as PTSD or not with 4 variables: prior major depression, fear of dying in the MVA, extent of physical injury and whether litigation had been initiated. Using multiple regression to predict the continuous variable of total CAPS score, as a measure of post-traumatic stress symptoms, we found that 8 variables combined to predict 38.1% of variance (Multiple R = 0.617).

BLANCHARD, E.B., HICKLING, E.J., TAYLOR, A.E., BUCKLEY, T.C., LOOS, W.R., & WALSH, J. (1998). **Effects of litigation settlements on posttraumatic stress symptoms in motor vehicle accident victims.** *Journal of Traumatic Stress*, 11, 337-354. In order to investigate the effects of the initiation of

litigation and its settlement on victims of motor vehicle accidents (MVAs), we followed up 132 MVA victims from an initial assessment 1 to 4 months post-MVA for 1 year. Of the 67 who had initiated litigation, 18 (27%) settled within the 12 months, while 49 still had litigation pending; 65 never initiated litigation. Those who initiated litigation had more severe injuries and higher initial levels of posttraumatic stress (PTS) symptoms. All 3 groups improved in major role function and had reduced PTSD symptoms over the 1 year follow-up. Those whose suits were still pending, as well as those whose suits had been settled, showed no reduction in measures of anxiety or depression, whereas the nonlitigants did show improvement on these measures.

BRYANT, B., MAYOU, R., & LLOYD-BOSTOCK, S. (1997). **Compensation claims following road accidents: A six-year follow-up study.** *Medicine, Science, and the Law*, 37, 326-336. Systematic information was obtained on 96 subjects who were all those seeking compensation from a cohort of 172 consecutive road accident injury victims. Subjects were interviewed immediately after the accident, and again at three months and one year. Further telephone or postal information was obtained about compensation proceedings for up to six years.

Compensation proceedings were often prolonged and final settlements were modest and late in relation to the losses suffered. Awards were largely used to make up financial losses. However, they failed to meet needs, especially the considerable early financial problems. There was no evidence that subjects exaggerated their losses; many preferred not to claim or to settle early. There was no evidence that settlement was followed by significant change in clinical state. There was considerable dissatisfaction with the procedures for obtaining compensation. Subjects were often more concerned with recognition of their distress and suffering than with the size of financial settlements. Seeking compensation was not a major predictor of medical and social outcome.

BRYANT, R.A., & HARVEY, A.G. (2003). **The influence of litigation on maintenance of posttraumatic stress disorder.** *Journal of Nervous and Mental Disease*, 191, 191-193. This study describes a prospective investigation of motor vehicle accident (MVA) survivors who were assessed for acute stress disorder within 1 month of their MVA and again 6 months and 2 years post-MVA. Acute stress disorder describes posttraumatic symptoms that occur in the initial month after a trauma. Prospective studies indicate that 80% of people with acute stress disorder still display PTSD 6 months posttrauma, and approximately 70% still suffer PTSD 2 years posttrauma. On the basis of earlier studies of civilian trauma populations, we predicted that compensation settlement would not significantly influence PTSD status.

EHLERS, A., MAYOU, R.A., & BRYANT, B. (1998). **Psychological predictors of chronic posttraumatic stress disorder after motor vehicle accidents.** *Journal of Abnormal Psychology*, 107, 508-519. A prospective longitudinal study assessed 967 consecutive patients who attended an emergency clinic shortly after a motor vehicle accident, again at 3 months, and at 1 year. The prevalence of PTSD was 23.1% at 3 months and 16.5% at 1 year. Chronic PTSD was related to some objective measures of trauma severity, perceived threat, and dissociation during the accident, to female gender, to previous emotional problems, and to litigation. Maintaining psychological factors, that is, negative interpretation of intrusions, rumination, thought suppression, and anger cognitions, enhanced the accuracy of

the prediction. Negative interpretation of intrusions, persistent medical problems, and rumination at 3 months were the most important predictors of PTSD symptoms at 1 year. Rumination, anger cognitions, injury severity, and prior emotional problems identified cases of delayed onset.

FONTANA, A., & ROSENHECK, R. (1998). **Effects of compensation-seeking on treatment outcomes among veterans with posttraumatic stress disorder.** *Journal of Nervous and Mental Disease*, 186, 223-230. The desire to acquire or increase financial compensation for a psychiatric disability is widely believed to introduce a response bias into patients' reports of their symptoms and their work performance. The hypothesized effects of compensation-seeking in inhibiting improvement from treatment are examined. Data from outpatient (N = 455) and inpatient (N = 553) programs for the treatment of PTSD and associated disorders in the Department of Veterans Affairs were used to compare outcomes for veterans who were and were not seeking compensation. Outcome was measured as pre/post improvement in symptoms and work performance over the course of 1 year after the initiation of treatment. No compensation-seeking effect was observed among outpatients, but a significant effect was found for some inpatients. The effect for inpatients was manifested essentially by patients in a program type which was designed to have an extremely long length of stay, thus triggering a virtually automatic increase in payments. Like outpatients, inpatients in programs with a moderate length of stay did not manifest a compensation-seeking effect on improvement. Although not permitting a definitive explanation, the preponderance of the evidence favors the overstatement of symptoms rather than either the severity or the chronicity of the disorder as the most likely explanation for the compensation-seeking effect that was observed. For patients treated in standard outpatient and short-stay inpatient programs, compensation does not seem to affect clinical outcomes adversely.

FRUEH, B.C., ELHAI, J.D., GOLD, P.B., MONNIER, J., MAGRUDER, K.M., KEANE, T.M., & ARANA, G.W. (2003). **Disability compensation seeking among veterans evaluated for posttraumatic stress disorder.** *Psychiatric Services*, 54, 84-91. *Objective:* This study sought to further examine the relationship between compensation-seeking status and reporting of symptoms among combat veterans who were evaluated for PTSD. *Methods:* Archival data were drawn for 320 adult male combat veterans who were consecutively evaluated at a Department of Veterans Affairs (VA) PTSD outpatient clinic from 1995 to 1999. The veterans were compared on variables from their clinical evaluation, including diagnostic status and self-report measures such as the Minnesota Multiphasic Personality Inventory-2, which includes scales designed to detect feigned or exaggerated psychopathology. *Results:* Compensation-seeking veterans reported significantly more distress across domains of psychopathology, even after the effects of income had been controlled for and despite an absence of differences in PTSD diagnoses between groups. However, compensation-seeking veterans also were much more likely to overreport or exaggerate their symptoms than were non-compensation-seeking veterans. *Conclusions:* This study provided further evidence that VA disability compensation incentives influence the way some veterans report their symptoms when they are being evaluated for PTSD. These data suggest that current VA disability policies have problematic implications for the delivery of clinical care, evaluation of treatment outcome, and rehabilitation efforts within the VA.

FRUEH, B.C., HAMNER, M.B., CAHILL, S.P., GOLD, P.B., & HAMLIN, K.L. (2000). **Apparent symptom overreporting in combat veterans evaluated for PTSD.** *Clinical Psychology Review*, 20, 853-885. Psychometric studies have consistently shown that combat veterans evaluated for PTSD appear to overreport psychopathology as exhibited by (a) extreme and diffuse levels of psychopathology across instruments measuring different domains of mental illness, and (b) extreme elevations on the validity scales of the MMPI-MMPI-2, in a "fake-bad" direction. The phenomenon of this ubiquitous presentational style is not well understood at present. In this review we describe and delineate the assessment problem posed by this apparent symptom overreporting, and we review the literature regarding several potential explanatory factors. Finally, we address conceptual and practical issues relevant to reaching a better understanding of the phenomenon, and ultimately the clinical syndrome of combat-related PTSD, in both research and clinical settings.

MAYOU, R., TYNDEL, S., & BRYANT, B. (1997). **Long-term outcome of motor vehicle accident injury.** *Psychosomatic Medicine*, 59, 578-584. *Objectives:* To define the psychological outcome at 5 years of a sample of non-head-injured motor vehicle accident victims and identify baseline predictors. *Method:* Self-report questionnaires were completed by 111 consecutive subjects who had been injured in a motor vehicle accident 5 years earlier and who had been assessed previously in a prospective 1-year study. *Results:* Although most subjects reported a good outcome, a substantial minority described continuing social, physical, and psychological difficulties and a quarter of those studied suffered phobic anxiety about travel as a driver or passenger. There was little change in quality of life outcome and effects on travel between assessments at 3 months, 1 year, and 5 years. The prevalence of PTSD remained approximately 10% throughout the follow-up: most early cases had remitted by 5 years, and a similar number of delayed new onsets had occurred between 1 year and 5 years. PTSD at 5 years was predicted by physical outcome and by postaccident intrusive memories and emotional distress. There were no significant associations with outcome. Trends for a poor outcome in claimants, especially those not settled at 5 years, may be due to their having more serious physical problems. *Conclusion:* Psychological complications are important and persistent after injury in a motor vehicle accident, are associated with adverse effects on everyday activities, and pose a challenge for consultation-liaison psychiatry.

MURDOCH, M., HODGES, J., COWPER, D., & SAYER, N. (2005). **Regional variation and other correlates of Department of Veterans Affairs disability awards for patients with posttraumatic stress disorder.** *Medical Care*, 43, 112-121. *Background:* PTSD is a chronic disabling condition affecting more than 600,000 United States veterans and is the most common psychiatric condition for which veterans seek Veterans Affairs disability benefits. Receipt of such benefits enhances veterans' access to Veteran Affairs health care and reduces their chance of poverty. *Objectives:* We sought to determine whether previously identified regional variations in PTSD disability awards are explained by appropriate subject characteristics (e.g., differences in PTSD symptomatology or dysfunction) and to estimate the impact of veterans' PTSD symptom severity or level of dysfunction on their odds of obtaining PTSD disability benefits. *Research Design:* We used a mailed survey linked to administrative data. *Subjects:* Subjects included 4918 representative, eligible men and women who filed PTSD disability claims between 1994 and 1998. *Results:* A total of 3337 veterans returned useable surveys (68%). Before adjustment, PTSD disability claims approval rates ranged from 43% to 75% across regions. After adjustment, rates ranged

from 33% to 72% ( $P < 0.0001$ ). Severe PTSD symptoms were associated with greater odds of having PTSD disability benefits ( $P < 0.0001$ ). Unexpectedly, poorer functional status was associated with lower odds of having benefits ( $P < 0.0001$ ). On average, clinical differences between veterans who did and did not have PTSD disability benefits were small but suggested slightly greater dysfunction among those without benefits. *Conclusions:* An almost twofold regional difference in claims approval rates was not explained by veterans' PTSD symptom severity, level of dysfunction, or other subject-level characteristics. Veterans who did not obtain PTSD disability benefits were at least as disabled as those who did receive benefits.

SAYER, N.A., SPOONT, M., & NELSON, D. (2004a). **Veterans seeking disability benefits for post-traumatic stress disorder: Who applies and the self-reported meaning of disability compensation.** *Social Science and Medicine*, 58, 2133-2143. Assumptions about the characteristics and motivations of individuals pursuing disability status are well known. However, policy, programming, and interventions need to be based on information about the actual sociodemographic characteristics of disabled individuals, as well as their goals in seeking disability status. In this study, we focus on veterans seeking disability compensation for PTSD from the United States Department of Veterans Affairs. We present information on their life circumstances and their self-reported reasons for valuing the obtainment of veterans' disability status on the basis of PTSD. There was considerable variability in the background of veterans seeking disability status on the basis of PTSD. Of concern, only about half of these individuals were receiving any mental health treatment at the time of application. Most claimants reported seeking disability compensation for symbolic reasons, especially for acknowledgement, validation, and relief from self-blame. Reasons having to do with improved finances were less frequently endorsed, although the importance of obtaining improved solvency through disability status decreased as income increased. The sense of investment in obtaining a sense of self-acceptance and acceptance from others through disability status varied by sociodemographic variables. Overall, findings suggest that individuals seeking disability benefits may have unmet mental health care needs, and that policy makers, investigators, and providers should consider material benefit as one of many possible reasons for engaging in a disability compensation system.

SAYER, N.A., SPOONT, M., NELSON, D.B., CLOTHIER, B., & MURDOCH, M. (in press). **Changes in psychiatric status and service use associated with continued compensation seeking after claim determinations for posttraumatic stress disorder.** *Journal of Traumatic Stress*. This study examined changes in psychiatric status and use of VA mental health services after the adjudication of Department of Veteran Affairs (VA) disability claims for Posttraumatic Stress Disorder (PTSD) in a sample of 101 veteran claimants. Hypotheses were based on the premise that the claims process may create incentives for veterans to demonstrate illness. After the PTSD claim determination, half the sample had filed or planned to file a claim for a rating increase or an appeal and thus remained compensation seeking. Contradicting our hypotheses, psychiatric status did not improve and treatment drop out rates did not increase among veterans who were no longer compensation seeking after the claim determination. Results have implications for the design and direction of future research.

SAYER, N.A., SPOONT, M., NELSON, D.B., & NUGENT, S. (2004b). **Development and psychometric properties of the Disability Application Appraisal Inventory.** *Psychological Assess-*

ment, 16, 192–196. This article describes the development and psychometric properties of an inventory to assess cognitive appraisal of the Department of Veterans Affairs (VA) disability application process, the Disability Application Appraisal Inventory (DAAI). Participants were 439 veterans seeking disability status for PTSD through the VA and subgroups from that sample. The 3 DAAI scales assess (a) understanding of the disability application process (Knowledge scale) (b) expectations specific to the process (Negative Expectations scale) and (c) investment in obtaining disability status (Importance scale). The scales are internally consistent and largely uncorrelated. Test-retest correlations are adequate for the Negative Expectations and Importance scales. Evidence of factorial and construct validity is presented.

SOLOMON, Z., BENBENISHTY, R., WAYSMAN, M., & BLEICH, A. (1994). **Compensation and psychic trauma: A study of Israeli combat veterans.** *American Journal of Orthopsychiatry*, 64, 91-102. The precursors and outcomes of compensation-seeking in Israeli war psychiatric casualties were examined. Findings suggest that compensation was sought by veterans who had experienced the most severe traumas and had subsequently developed the most severe symptoms and functional limitations. Reported range and severity of symptoms and functional limitations did not diminish with compensation.

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

TAYLOR, S., FEDOROFF, I.C., KOCH, W.J., THORDARSON, D.S., FECTEAU, G., & NICKI, R.M. (2001). **Posttraumatic stress disorder arising after road traffic collisions: Patterns of response to cognitive-behavior therapy.** *Journal of Consulting and Clinical Psychology*, 69, 541-551. Road traffic collisions (RTCs) are common precipitants of posttraumatic stress disorder (PTSD). Two preliminary studies suggest that cognitive-behavior therapy (CBT) is, on average, effective in treating this disorder, although the major patterns of treatment outcome remain to be identified. Such outcomes might include treatment response, partial response, and response followed by relapse. To identify these patterns, 50 people with RTC-PTSD completed a 12-week course of CBT, with outcome assessment extending to 3-month follow up. Dynamic cluster analyses revealed 2 replicable patterns of outcome: one for responders (n = 30) and one for partial responders (n = 20). Partial responders, compared with responders, tended to have

more severe pretreatment numbing symptoms and greater anger about their RTC, along with lower global levels of functioning, greater pain severity and interference, and greater depression and were more likely to be taking psychotropic medications. Responders and partial responders did not differ in homework adherence, number of sessions attended, therapist effects, or stressors occurring during therapy or in the presence or absence of RTC-related litigation. Implications for enhancing treatment outcome are discussed.

## CITATIONS

### Annotated by the Editor

DES ROSIERS, N., FELDTUSEN, B., & HANKIVSKY, O.A.R. (1998). **Legal compensation for sexual violence: Therapeutic consequences and consequences for the judicial system.** *Psychology, Public Policy, and Law*, 4, 433-451.

Using results from surveys of crime victims, the authors consider the potential for the civil legal process to have therapeutic effects on victims by affirming that they have been wronged and giving them a way to be heard. The authors discuss adjustments to the process that would promote such benefits.

DEVIVA, J.C., & BLOEM, W.D. (2003). **Symptom exaggeration and compensation seeking among combat veterans with posttraumatic stress disorder.** *Journal of Traumatic Stress*, 16, 503-507.

In a study of combat veterans seeking treatment for PTSD, compensation seeking was not related to scores on symptom measures or to MMPI indices for symptom exaggeration. Neither compensation seeking nor exaggeration was related to treatment outcome.

ESTROFF, S.E., PATRICK, D.L., ZIMMER, C.R., & LACHICOTTE, W.S. (1997). **Pathways to disability income among persons with severe, persistent psychiatric disorders.** *Millbank Quarterly*, 75, 495-532.

The authors examined the relations of labeling, impairment, and needs/resources to receipt of Social Security Disability Income in a sample of 169 persons with psychiatric disorders. Individuals with more severe disorders who are psychologically and financially dependent on families were more likely to become recipients of disability income.

FRANKLIN, C.L., REPASKY, S.A., THOMPSON, K.E., SHELTON, S.A., & UDDO, M. (2003). **Assessment of response style in combat veterans seeking compensation for posttraumatic stress disorder.** *Journal of Traumatic Stress*, 16, 251-255.

This study examined assessment of over-reporting of symptoms across MMPI-2 validity scales. The number of veterans classified as having an over-reporting response style differed depending on which scale was used, highlighting the importance of using multiple validity scales to measure response style.

LAFFAYE, C., ROSEN, C.S., SCHNURR, P.P., & FRIEDMAN, M.J. (2007). **Does compensation status influence treatment participation and course of recovery from post-traumatic stress disorder?** *Military Medicine*, 172, 1039-1045.

A review of empirical literature indicated that veterans who are seeking or have been awarded compensation participate in

treatment at similar or higher rates than do their non-compensation-seeking counterparts. Veteran treatment outcome studies produced either null or mixed findings, with no consistent evidence that compensation-seeking predicts worse outcomes. Studies of MVA survivors found no association between compensation status and course of recovery. The authors make recommendations to strengthen future research in this area.

LEES-HALEY, P.R. (1997). **MMPI-2 base rate for 492 personal injury plaintiffs: Implications and challenges for forensic assessment.** *Journal of Clinical Psychology, 53*, 745-755.

In a study of 230 male and 262 female personal injury plaintiffs, MMPI validity measures suggested possible malingering on approximately 20 to 30% of the profiles but the majority of profiles were valid. Validity problems discussed include attorney coaching and the congruence of plaintiff personality characteristics with the demand characteristics of litigation.

MAYOU, R. (1995). **Medico-legal aspects of road traffic accidents.** *Journal of Psychosomatic Research, 39*, 789-798.

This paper gives an introductory review of issues and presents findings from a prospective study of the medical, psychological and quality of life outcome of road traffic accidents which included a three-year follow-up of those seeking compensation.

MILLER, H. (1961, April 1). **Accident neurosis.** *British Medical Journal, 1* (5230), 919-925.

A lecture describing attributes of numerous cases seen in the author's psychiatry practice, and their progress in treatment over time, this article is one of the earliest writings about the relationship between psychiatric problems and litigation after work and traffic accidents.

SAYER, N.A., SPOONT, M., & NELSON, D.B. (2004c). **Disability compensation for PTSD and use of VA mental health care.** *Psychiatric Services, 55*, 589.

The authors described effects of obtaining VA disability benefits for PTSD on participation in VA mental health treatment in a large Midwestern region. The rate of mental health service use increased after PTSD disability benefits were awarded and was also positively related to level of disability.

SAYER, N.A., & THURAS, P. (2002). **The influence of patients' compensation-seeking status on the perceptions of Veterans Affairs clinicians.** *Psychiatric Services, 53*, 210-212.

Fifty clinicians working in VA PTSD programs reported on their perceptions of how compensation-seeking influenced clinical progress. Most clinicians had a more negative view of the treatment engagement of veterans who were seeking compensation and of clinical work with these patients than they did with veterans who were not seeking compensation.

SMITH, D.W., & FRUEH, B.C. (1996). **Compensation seeking, comorbidity, and apparent exaggeration of PTSD symptoms among Vietnam combat veterans.** *Psychological Assessment, 8*, 3-6.

The authors found evidence of greater comorbidity among symptom exaggerators as measured by the MMPI-2 F-K index but the results did not support the commonly held belief that symptom exaggerators are more likely to seek compensation.

## SEARCHING THE LITERATURE

You can use the PILOTS Database to find literature on "Compensation and PTSD." The best way is to select the descriptors from the PILOTS Thesaurus that best match your area of interest.

All publications indexed in the PILOTS Database deal with some aspect of the mental-health sequelae to traumatic events. You can restrict your search to articles in which PTSD is specifically mentioned by typing **DE=PTSD\*** into the Search box. Using **PTSD (DSM-IV)** will narrow your search results to those publications in which the DSM-IV definition of PTSD is used. (You can also use DSM-III, DSM-III-R, ICD-9, and ICD-10 in this way.)

The PILOTS Database has descriptors for specific types of compensation: **Victim Compensation** refers to government provision of financial reimbursement for their losses to victims of violent crime, **Workers Compensation** covers state programs for persons injured in the course of their employment, and **Veterans Benefits** covers programs to provide compensation, pensions, and/or treatment to former military personnel, for both service-connected and non-service-connected conditions. The descriptor **United States Department of Veterans Affairs** identifies publications that deal specifically with VA policies and programs.

You can find relevant papers on legal aspects of the compensation question with the descriptor **Tort Actions** and the narrower term **Assessment of Damages**. A related term, **Disability Evaluation**, deals with the methods and instruments used for this purpose. And the question of whether participation in compensation programs has therapeutic or anti-therapeutic effects is covered by the descriptor **Therapeutic Jurisprudence**.

Using these descriptors will allow you to find papers on these topics regardless of the actual terminology employed by their authors. You will find a complete systematic table of PILOTS Database descriptors, with an extensive alphabetical index to the PILOTS Thesaurus, in the *PILOTS Database User's Guide*. It's on our website, at [http://www.ncptsd.va.gov/ncmain/ncdocs/nc\\_prod/Users\\_Guide80912.pdf](http://www.ncptsd.va.gov/ncmain/ncdocs/nc_prod/Users_Guide80912.pdf).

## THE EVALUATION DIVISION OF THE NATIONAL CENTER FOR PTSD The Northeast Program Evaluation Center

The Evaluation Division of the National Center for PTSD is a sub-component of the Northeast Program Evaluation Center (NEPEC) and an affiliate of the New England Mental Illness Research, Education and Clinical Center (MIRECC). Robert Rosenheck, MD, is the director of NEPEC, and Alan Fontana, PhD, is the leader of its PTSD program evaluation efforts. The Evaluation Division is responsible for evaluating and monitoring the delivery of service to veterans with PTSD nationally across the Veterans Health Administration (VHA), in specialized PTSD programs, among PTSD specialists, in general mental health programs, and in non-mental health programs. In the *Long Journey Home* series of annual reports, NEPEC provides a systematic accounting of the structure, process, and outcome of treatment for what has grown to number more than 350,000 veterans per year, and especially those who are treated in inpatient, residential, and outpatient specialized PTSD programs. The FY 2006 report prepared by Fontana and colleagues was the 15th in the series. While NEPEC exclusively conducts program evaluations to help guide the development of VA PTSD programs, and does not conduct research, some NEPEC staff are also affiliated with the New England MIRECC and through that affiliation conduct more-focused studies on central aspects of PTSD treatment in VA. These studies have addressed the effectiveness and cost of alternative service models for PTSD, determinants of satisfaction and outcome among veterans treated for PTSD in VHA, changing patterns of demand for PTSD treatment by veterans of different eras, differences on processes and outcomes of treatment for different ethnocultural groups, and other issues.

In addition to its evaluation of PTSD programs, NEPEC evaluates specialized VA programs for home-

less veterans, the Mental Health Intensive Case Management (MHICM) program, VHA work restoration programs, and residential rehabilitation and treatment programs; and it publishes the annual mental health report card.

In the early 1990s, as VHA's national network of specialized PTSD programs was being developed, a series of multi-site outcome studies were conducted of newly established specialized PTSD programs and involved outcome data spanning as much as two years on 1,300 intensively monitored veterans. These evaluations demonstrated the effectiveness of the new PTSD Clinical Teams program (PCTs). Perhaps more importantly, data were gathered on almost 800 patients treated in inpatient and residential PTSD treatment programs and showed that short-term inpatient and residential treatment was as effective and as much as \$18,000 per year less costly than traditional specialized inpatient PTSD Units, many of which were based on a 90-day cohort-model of treatment. In part, as a result of these studies, the structure of VA treatment for PTSD was substantially transformed to emphasize outpatient care as well as a short-term and residential model of inpatient care.

Further outcomes monitoring evaluations of over 3,000 veterans per year treated in specialized intensive PTSD programs have shown that benefits in PTSD outcomes on standard measures have been stable or improving during the years of major transformation of VA treatment of PTSD.

The most recent reports show that the percentage of veterans who served in the US military in Afghanistan or Iraq since September 11, 2001, entering PCT treatment is about 11% of all new veterans seen by the PCTs. Another recent study compared current Iraq/Afghanistan veterans with Persian Gulf and Vietnam veterans.

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