



Re-evaluating disability assessment in war veterans with posttraumatic stress disorder

Procena tačnosti dijagnoze invaliditeta kod ratnih veterana sa posttraumatskim stresnim poremećajem

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Abstract

Background/Aim. Sometimes war veterans may resort to such strategies as producing exaggerated symptoms and malingering in order to obtain material compensation rights. The aim of this study was to assess the accuracy of the diagnosis of posttraumatic stress disorder (PTSD) on the basis of which war veterans were entitled to a financial compensation due to their disability. **Methods.** The diagnoses of 259 war veterans were re-evaluated. Veterans were previously diagnosed by a psychiatrist on local level, while regional state medical commission determined the degree of disability and the right to a financial compensation. A team of experts, consisting of psychiatrists with research experience in the field of traumatic stress and who were trained to use a structured interview for PTSD, conducted the evaluation of medical data from veterans' military records. The diagnostic process was conducted using the standardized diagnostic interview (Clinician-Administered PTSD Scale – CAPS), after which the diagnosis was reaffirmed or reviewed. This influenced disability status and consequential financial compensation. **Results.** There was a remarkable difference between the first diagnos-

tic assessment of PTSD, conducted by the psychiatrists on local level, and the second evaluation conducted by the team of experts. In more than half of 259 veterans (52.1%) diagnosed with PTSD in the first assessment the diagnosis was not confirmed. The diagnosis was confirmed in 31.7% of veterans. Those veterans who were diagnosed with lifetime PTSD (7.3%) should also be treated as accurately diagnosed. This means that a total of 39% of the diagnoses were accurate. The rest (8.9%) were diagnosed with other diagnoses, but not PTSD, as was the case in the initial assessment. **Conclusion.** The possibility for war veterans to obtain the right to disability and financial compensation due to a diagnosis of PTSD might interfere with the proper diagnostic assessment and thus the treatment outcome. During the procedures for the obtention of these rights, exaggeration or simulation of symptoms are common. The quality of the diagnostic assessment of PTSD can be improved by applying evidence-based standardized procedures.

Key words:
veterans; stress disorders, post-traumatic; work capacity evaluation; socioeconomic factors.

Apstrakt

Uvod/Cilj. Ratni veterani ponekad mogu pribegavati preuveličavanju simptoma i simuliranju da bi ostvarili pravo na materijalnu kompenzaciju. Cilj rada bio je da se izvrši procena tačnosti dijagnoze posttraumatskog stresnog poremećaja (PTSP) na osnovu koje su ratni veterani ostvarili pravo na invalidsku finansijsku kompenzaciju. **Metode.** Ponovna procena dijagnoza obavljena je kod 259 veterana rata. Kod svih veterana PTSP dijagnostikovao je psihijatar na lokalnom nivou, a zatim su regionalne lekarske komisije određivale stepen invalidnosti i pravo na finansijsku kompenzaciju. Ekspertski tim psihijatara sa istraživačkim iskustvom iz oblasti traumatskog stresa i obrazovanih za

korišćenje strukturisanog intervjuja za PTSP, vršio je procenu svih medicinskih nalaza i podataka iz vojne evidencije ratnih veterana. Dijagnostička procena vršena je primenom strukturisanog dijagnostičkog intervjuja za PTSP [(Clinician-Administered Post-Traumatic Stress Disorder – PTSD Scale (CAPS)] nakon čega je potvrđivana ili revidirana dijagnoza, što je uticalo i na promenu statusa invalidnosti i efekata kompenzacije. **Rezultati.** Nađena je značajna razlika između prve dijagnostičke procene PTSP koju je izvršio psihijatar na lokalnom nivou i druge procene, koju je izvršio ekspertski tim psihijatara. Od 259 ispitivanih veterana, dijagnoza PTSP nije potvrđena kod više od polovine (52,1%). Dijagnoza je potvrđena kod 31,7% veterana, a kod 7,3% postavljena je dijagnoza prebolovanog PTSP, što znači da su

i oni tačno dijagnostikovani tokom prve procene, tako da je dijagnoza potvrđena kod 39% veterana. Kod ostalih veterana (8,9%) dijagnostikovani su drugi mentalni poremećaji a ne PTSP, kao što je bio slučaj kod prve dijagnostičke procene. **Zaključak.** Mogućnost da ratni veterani ostvare finansijsku kompenzaciju i pravo na invaliditet zbog dijagnoze PTSP može da remeti adekvatnu dijagnostičku procenu, a time i ishod lečenja. U toku procesa za ostvarivanje ovog prava često se može uočiti pre naglašavanje ili simu-

lacija simptoma. Iz studije se može zaključiti da se kvalitet dijagnostičke procene PTSP i posledična invalidnost mogu poboljšati primenom standardizovane dijagnostičke procene zasnovane na dokazima.

Ključne reči:

veterani, ratni; stresni poremećaji, posttraumatski; dijagnoza; sposobnost, radna, ocena; socioekonomski faktori.

Introduction

War in former Yugoslavia (1991–1995) is a paradigm of traumatic experience which has led to a severe disruption in mental health not only in war veterans, but also in refugees and the entire population^{1,2}. Research of effects of the air bombing of Federal Republic of Yugoslavia (FRY) in 1999 by NATO forces conducted on 434 civilians has shown that it is in fact personality characteristics that bear a much greater influence on the prediction of traumatic reactions rather than the intensity of experienced stress³.

Clinical experience with posttraumatic stress disorder (PTSD) diagnosis has shown, however, that there are differences among individuals regarding the capacity to cope with catastrophic stress. Therefore, while most people exposed to traumatic events do not develop PTSD, others develop full symptoms of the disorder. Such observations have prompted the recognition that trauma, like pain, is not an external phenomenon that can be completely objectified. Like pain, the traumatic experience is filtered through cognitive and emotional processes before it can be appraised as an extreme threat. Due to differences among individuals, the thresholds in trauma patients are also different⁴. Research has consistently shown that PTSD is associated with impairments in functioning across a number of psychosocial domains. Such impairments are common among populations at a high risk for PTSD, such as military personnel involved in combat⁵.

Many PTSD veterans seek compensation for the traumatic experience they have been exposed to quite different forms of benefits: financial compensation, early retirement or other types of social protection⁶. Receiving the compensation, however, raises doubts that traumatized person's reported levels of distress are motivated by material gain. Therefore, compensation motive is likely to augment symptomatology and relates to the concept of "secondary gain". This is why PTSD is more connected to law than any other disorder. "Non-psychiatric" incentives (desire for material gain or desire to avoid legal responsibility) are present in the legal system and they put in question the validity of PTSD diagnoses^{7,8}.

An issue of special importance is delayed PTSD. Researches show that these cases are often connected to symptom exaggeration and malingering in order to obtain material compensation rights^{9–11}.

The aim of the study was to re-evaluate initial PTSD diagnoses set on local level.

Methods

At the request of the Ministry of Labor and Social Policy which was verifying the validity of disability retirement schemes obtained due to a PTSD diagnosis, team of expert psychiatrists from the Clinic for Psychiatry of the Military Medical Academy (MMA) in Belgrade reevaluated the initial PTSD diagnoses. The obtained results were then compared.

The study included 259 veterans from the entire Serbian territory, who participated in former Yugoslavia wars from 1991 to 1995 and in the NATO bombing in 1999. All of them were diagnosed with PTSD by a psychiatrist on the local level, while a regional medical commission determined the degree of disability on the basis of which veterans obtained the right to a financial compensation and early retirement due to disability. Until the second diagnostic assessment their invalidity lasted on the average [mean \pm standard deviation (SD)] 7.8 ± 2.8 years (range, 0–19 years). Re-evaluation of the diagnosis was conducted at the Psychiatric Clinic of the MMA between the 2010 and 2013. A team of experts consisted of military psychiatrists with clinical and research experience in the field of traumatic stress and who were also educated to use Clinician-Administered PTSD Scale (CAPS). Sociodemographic data on marital and family status, education and the social and professional functioning before and after the war was collected through a clinical interview, as well as data on physical and mental health. Veterans' medical records were thoroughly examined, with a special emphasis on data regarding veterans' war participation and above all their traumatic war experiences. The diagnostic assessment of PTSD was done in accordance with the DSM-IV classification of mental disorders because a structured clinical interview CAPS based on this classification was used^{12,13}. The results were presented through descriptive statistics (average and median values), paired sample *t*-test, tabular representations and the use of the appropriate statistical software tools.

Results

The group of 259 war veterans was examined, all male, with the mean age (\pm SD) of 43.8 ± 8.7 years. Most of them participated as reserve soldiers (91.5%), were married (84.6%) and had secondary level education (83%). As for their employment status, 52.9% were employed, 27.4% unemployed and 11.6% retired. The majority of veterans par-

participated in the war during NATO bombing (54.1%), followed by the participants of 1991–1995 wars (21.2%), and only 9 (3.5%) of them participated in both wars. The number of PTSD diagnoses after the first diagnostic assessments conducted by the psychiatrists on the local level is remarkably different from the ones set by the team of experts who conducted re-evaluation. Namely, all 259 subjects were diagnosed with PTSD in the first assessment. The diagnosis was confirmed in 31.7% of veterans. Given that additional 7.3% of them were diagnosed with lifetime PTSD, it means that 39% in total had correct diagnosis. More than half (52.1%) of veterans have not had their diagnoses confirmed (the rest are 39% with the confirmed diagnosis, and 8.9% having other disorders). Mean CAPS intensity score (\pm SD) was 57.2 ± 12.6 for current PTSD and 45.2 ± 7.7 for lifetime PTSD (Table 1). After looking into complete medical records of 105 study participants, the average rate of attendance of medical appointments was calculated for the period prior to and after establishing their eligibility for disability status. It was found that the average attendance rate had dropped significantly after veterans obtained rights to financial and disability compensation [mean \pm SD (after/before) = $1.5 \pm 4.4/11.8 \pm 10.6$; $t_{(104)} = 9.11$, $p < 0.01$].

ing PTSD is more subjective than it is the case with many other disorders that the United States Department of Veteran Affairs benefits for¹⁴.

For compensation purposes, disability is a socially created administrative category. Each disability-compensating scheme is based on the system of rules and the process of assessment. Most systems require medical records documenting physical or mental medical conditions, as well as an administrative rating of the severity of that condition in terms of the loss of ability to work. Compensation is most often proportional to the loss of potential earnings and depends on the level of funding set aside for each specific program.

Many of the issues identified can be addressed by a targeted allocation of time and resources needed for a thorough PTSD clinical examination. This measure will facilitate: more comprehensive and consistent assessment of veterans' reporting exposure to trauma; conduct of standardized psychological testing where appropriate; more accurate assessment of the social and vocational impacts of identified disabilities; evaluation of any suspicious malingering or dissembling using strategies such as standardized tests (where appropriate) and clinical face-to-face assessment; more detailed documentation of claimant's condition to inform rater's decision and an

Table 1
Posttraumatic stress disorder (PTSD) diagnosis reassessment and Clinician-Administered PTSD Scale (CAPS) intensity score in 259 veterans

Diagnosis	Veterans	
	n (%)	CAPS intensity score $\bar{x} \pm SD$
Non-diagnosed	135 (52.1)	
Current PTSD	82 (31.7)	57.2 ± 12.6
Lifetime PTSD	19 (7.3)	45.2 ± 7.7
Other diagnoses	23 (8.9)	
Total	259 (100)	

\bar{x} – mean; SD – standard deviation.

Discussion

The results of this study show a remarkable inconsistency in diagnostic assessment of PTSD conducted by the two separate groups of psychiatric specialists. War veterans, all 259 of them, have been first diagnosed by psychiatrists on the local or regional level, while the second re-evaluated, diagnosis was rendered by the team of experts at the MMA. The aim of this re-evaluation was to establish the presence of the PTSD diagnosis, determine the severity of PTSD symptoms, and establish a logical relationship between the exposure to military stressors and PTSD symptomatology. The PTSD diagnosis was confirmed in 82 (31.7%) of the participants, whereas 19 of them (7.3%) were diagnosed with the lifetime type of PTSD.

Determining the ratings for mental disabilities in general and for PTSD specifically is more difficult than for other disorders because of the inherently subjective nature of reporting the symptoms. In particular, compensation claims for PTSD have attracted attention because of the increasing numbers of claims in recent years and also because diagno-

informed, case-specific determination of whether re-examination is appropriate and, if so, when; evaluation of inter-rater reliability and generate information that can be used to promote the accuracy and validity of ratings¹⁵.

In most part, the inconsistency found in this study is owed to the fact that the second diagnostic procedure involved a standardized, structured interview, unlike the initial diagnosis. The most recent studies suggest that, although many PTSD compensation and pension examiners note the importance of testing and are concerned about exaggeration or outright malingering of PTSD symptoms, the overwhelming majority of them are not using standardized, psychometrically sound assessment instruments to assess PTSD in their examinations for compensation¹⁶. The second reason is the inadequate or insufficient overview of collateral information obtained from military files, on the basis of which one can confirm or question the severity of traumatic events that preceded the development of the disorder. Many veterans with PTSD diagnosis were not actually exposed to traumatic stressors of war, did not participate in combat, and some did not even witness any traumatic events whatsoever.

Similar study results have been found in Croatian and American war veterans, where it became clear that the diagnostic process involved the use of a structured diagnostic procedure and an insight into the military files⁸. For 32% of war veterans who were treated in hospital conditions, their files showed no record of any participation in combat or exposure to other severe war stressors¹⁷.

Apart from the abovementioned causes regarding structured interviews and military files, it is also possible that the initial group of psychiatrists did not pay enough attention to the effects of secondary gain. Patients' exaggeration of reported symptoms can also influence the psychiatrist into rendering the false positive diagnosis. Thus, exercising the legal right to compensation leads to a doubt regarding the traumatized person's reported level of distress and whether or not the patient was motivated by financial gain^{18,19}.

This doubt is augmented by the presence of the so-called "compensational neurosis", a phenomenon firstly recognized in victims of railway accidents, whose ailments never had any organic basis. After the First World War the possibility of early retirement due to "shell shock" was often questioned, as it was apparent that this caused symptoms to be exaggerated. This led to a proposition that in future war situations this disorder would not be financially compensated, which did happen eventually in Germany after the Second World War. It was claimed that, as soon as trial was over, symptoms of the so-called "compensational neurosis" in patients disappeared. This oversimplified claim was eventually discredited²⁰.

The augmentation of psychiatric symptomatology is indeed motivated by the possibility of obtaining different forms of compensation. However, the very act of attending trial can aggravate the primary PTSD symptoms and cause a re-traumatization process. The demand that PTSD patients express and relive their trauma history prevents the characteristic efforts to avoid speaking and/or thinking about it. This can in turn lead to the revival of intrusive thoughts and high irritability. The anamnestic process comprises various dilemmas for forensic experts looking into PTSD. However, the well-known tendencies of patients' avoidance of painful past experiences lead to symptoms that are actually present to be unrightfully neglected.

On the other hand, a direct research into the diagnostic criteria of PTSD can motivate the patient to give a series of answers to direct and suggestive questions that would lead to an easy diagnosis²¹. After the diagnostic criteria have become available through medical publications and word of mouth, there is little that can be done to prevent a motivated individual with a compensation goal to understand exactly which symptoms need to be reported in the attempt to be diagnosed with PTSD.

Our study shows that there is high probability that veterans who sought psychiatric aid were indeed motivated by financial gain, which was apparent in the number of visits they made to their doctor until they received clearance for financial gain. The second possible cause of discrepancy between the two psychiatric assessments is the time lapse between them. The re-evaluation was done between 2010 and 2013, whereas the initial assessment in most cases was immediately after the wars of 1991–1995 and 1999. The severity and course of PTSD change over time, with some studies proving that as many as 50–60% patients reach full recovery^{22,23}. In this study we have found that only 19 veterans (7.3%) had lifetime PTSD, which confirms the conclusion that the majority of study participants were motivated by financial gain not because their mental health was impaired, but because of the very fact that they had participated in the war.

Conclusion

The inconsistent psychiatric diagnostics of PTSD may be the consequence of differences or inadequacies in the diagnostic process. Objective evaluation of this disorder in war veterans needs to involve, first and foremost, assessment of war stressors they have been exposed to, and analysis of additional information in their military files. For valid assessment of the presence (and severity) of the symptoms, raters need to apply structured standardized interviews and/or assessment scales. They should also be aware of the fact that assessments of functionality and/or disability are often under the threat of false positives led by patients' exaggeration motivated by material benefits. For PTSD to be diagnosed definitively and correctly, it is crucial to merge all the assessment factors into the coherent diagnosis.

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Received on January 24, 2015.

Revised on May 3, 2015.

Accepted on June 24, 2015.

Online First May, 2016.