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Assessing Veteran Symptom Validity

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Abstract The accurate assessment of veteran symptom validity is a type of disciplined and reasoned inquiry towards the truth. This inquiry includes a two-part recognition (1) that assessing veteran truthfulness is properly part of accurately assessing veteran symptoms and (2) that the institutional environment must allow such inquiries to proceed unimpeded. This article identifies the institutional and veteran-based threats to the accurate assessment of veteran truthfulness, with suggestions on managing the former and discerning the latter. Starting with a description of the conflicting ethical-moral and utilitarian-political forces inherent in the Department of Veteran Affairs (VA), this article describes how these forces act to undermine the accurate assessment of veteran symptoms via both institution-wide systemic practices and local medical center-specific pressures towards collusive lying. It then details a strategy for accurately assessing and responsibly reporting the validity of veteran symptoms using Lonergan's fourfold method for conducting an inquiry towards the truth. Finally, it illustrates how responsibly assessing veteran symptom validity within VA is fundamentally a matter of personal integrity since there is no judicial overview and few external consequences. It argues that the assessment report is a moral action that constitutes examiners as conscientious to the degree that they attend or fail to attend to the data of experience, are intelligent or obtuse in forming insights, are reasonable or unreasonable in their judgments, and are responsible or irresponsible in their actions.

Keywords Ethics · Veterans · Assessment · Symptom validity

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> "Be attentive, Be intelligent, Be reasonable, Be responsible."
> Bernard Lonergan (1972, p. 53)

Introduction

The accurate assessment of veteran symptom validity is a type of disciplined and reasoned inquiry towards the truth. This inquiry moves from active attention to the data, to insight or the intelligent determination of meaningful connections among the data, and then to reasoning or the critical weighing of the truthfulness of these insights. This inquiry ends with the responsible reporting of the results, as they are judged true. This inquiry towards truth includes a two-part recognition that (1) assessing veteran truthfulness is properly part of the data for inquiry, judgment, reflection, and responsible action, and (2) this process assumes an environment that allows for an inquiry toward truth to proceed unimpeded.

Purpose and Scope

The purpose of this article is to identify the institutional and veteran-based threats to the accurate assessment of veteran symptom validity. It starts with describing the oft-conflicting ethical-moral and utilitarian-political factors on which veteran healthcare and compensation are founded. Following this, it presents several institutional issues inherent to the Department of Veteran Affairs (VA) that may undermine the accurate assessment of veteran symptoms, with suggestions on how to manage these. It then discusses how to assess veteran symptom validity using a multi-method strategy informed by Lonergan's (1972, 1992) method for conducting and inquiry towards truth.

The scope is limited. First, the literature on symptom validity has increased exponentially in the past decade,

preventing more than a presentation of key ideas and reference to important studies. Second, this article focuses on the assessment of symptom validity as it relates to psychological symptoms. The validity assessment of neuro-cognitive symptoms is covered elsewhere in numerous publications (see for example Boone 2013; Rogers 2012). Third, there is no attempt to differentiate assessments done within the Veteran Health Administration (VHA) from those done for the Veteran Benefit Administration (VBA) since (a) symptom validity assessment strategies are the same, (b) many veterans are enrolled in both systems (see Frueh et al. 2003), and (c) assessments initiated within either system are increasingly available within the other (Russo 2013).

The examples are real, taken either from the professional, peer reviewed literature or from documented and verified accounts of trusted colleagues. Examples using patient material passed review by the VA privacy office. The examples are illustrative but may not be representative. Many veterans come to the VA honestly seeking healthcare or compensation for injury sustained serving in the military. However, others commit fraud, costing the VA hundreds of millions of dollars each year (VAOIG 2005). The VA Office of Inspector General's (VAOIG 2012) Semi-Annual Report to Congress as well as its Monthly Highlights (e.g. VAOIG 2013) document numerous accounts of non-veterans caught pretending to be wounded veterans, non-combat veterans caught pretending to be wounded combat veterans, as well as veterans caught submitting false documentation all in order to obtain undeserved healthcare and compensation benefits. For a flagrant example, see United States v. Roberts (2008).

Ethical Versus Political Foundations of Veteran Healthcare and Compensation

Psychologists assessing veteran symptom validity within the VA system may be unaware of the conflicting philosophies upon which veteran healthcare and compensation were founded, and how this can impact their ability to accurately assess veteran symptoms. These conflicting philosophies fall under two broad categories, ethical-moral responsibilities (see Russo 2013) and powerful political-utilitarian factors (see Ridgway 2011).

Ethical-Moral Responsibilities

The ethical-moral foundation of veteran healthcare and compensation recognizes that people form communities for safety and security, and are obligated to care for those injured protecting that safety and security. From this viewpoint, veteran healthcare and compensation are fundamentally about justice, with the recognition of a reciprocal responsibility between veteran and community. Specifically, "the community obligates itself to provide healthcare or disability benefits on the basis of competent professional assessment of true need and merit, and individuals obligate themselves to honestly represent true need and merit" (Russo 2013, p. 19).

The community also obligates VA psychologists and consultants, as part of this system of reciprocal responsibility, to determine when veteran need and merit are honestly represented. This responsibility is codified under numerous Federal and professional standards (see Russo 2013). For example, as Federal employees, VA psychologists are obligated to "disclose waste, fraud, abuse and corruption" (5 CFR § 2635.101). In addition, "attempts to cover up knowledge of fraud, for example by intentional misrepresentation in assessment reports, may be colluding in fraud" (Russo 2013, p. 21; also see 18 USC § 1001 and § 1035). As professionals, VA psychologists and consultants are bound by the ethics and codes of conduct of their professional societies, most notably, that of the American Psychological Association (APA). VA psychologists and consultants are ethically obligated to "promote accuracy, honestly, and truthfulness" and are never permitted to "engage in fraud, subterfuge, or intentional misrepresentation of fact" (APA 2002.)

Political-Utilitarian Factors

However, as Ridgway (2011) detailed in a sobering historical account, the development of the VA system was more often a result of utilitarian concerns and political pressures, rather than ethical-moral obligation. "For much of the nation's history," Ridgway noted, "veterans' benefits…had a strong political element focused on swaying veterans' votes rather than providing for veterans' needs" (p. 164.). Decisions were made based on pressure from veterans' groups, who had a "commitment to defending veterans' status as a special political identity" (p. 176), and by politicians "fearing backlash at the polls from angry veterans" (p. 180). As former VA Secretary Anthony Principi (2013) recently stated, "the enumeration of benefits has evolved far beyond the nation's obligation to those who became ill or injured while in service" (p. A15).

Early benefits were seen as gratuities, and during the late 1800s, benefits resembled "a political patronage system as much as they did a public benefit system" (Ridgway 2011, p. 164). It was not until 1919 that Congress used compensation to categorize benefits as an indemnity for loss rather than a gratuity. Another 70 years would pass before the Veterans Judicial Review Act of 1988 created judicial review of veterans' benefits claims. However, as Ridgway noted, this "merely added a court to provide oversight to an adjudication process that had evolved during more than two centuries of 'splendid isolation' from the legal system" (p. 136).

Institution-Based Influences on Symptom Assessment

The resulting veteran healthcare and compensation systems remain a compromise of ethical-moral and political-utilitarian forces. A consequent of this compromise is that VA psychologists may find threats to the accurate assessment of veteran symptom presentation emerging as much from institutional forces as from non-credible veteran responses (see Russo 2013). These institution-based threats are of two broad types, systemic issues and collusive lying.

Systemic Issues

A prime example of how systemic issues affect symptom validity assessment can be found in the lack of accountability inherent in the current VA disability system. The VA disability system is unique in being pro-veteran and "paternalistic" (Bosely and Hennings 2013, p. 66). According to the Veterans Claims Assistance Act of 2000, VA is obligated to assist veterans in developing all facts concerning a claim. The adjudication process uses a uniquely favorable standard of proof, that of benefit of doubt, rather than the more common preponderance of evidence standard. In others words, "VA will only deny a claim if the weight of the evidence is *against the claim*" (Riley 2010, p. 14, emphasis added). Hearings are ex-parte and non-adversarial; there are no opposing parties, cross-examinations are not permitted, and proceedings are not bound by legal rules of evidence (38 CFR § 20.700). VA psychologists do not testify, and there is little interaction between psychologists and adjudicators (Bosely and Hennings 2013; Ridgeway 2012). There is no Daubert-type standard to insure that evidence is trustworthy, there are no safeguards to guarantee that clinicians are informed experts or that proffered "expert opinions" are scientifically sound, nor is there a judicial process to guarantee that clinical evaluations were conducted free from coercion or threat.

The results, as Russo (2013) summarized, are that VA clinicians may fail to assess the validity of symptom presentation, fail to follow best practice guidelines, and fail to use standardized, psychometrically sound assessment instruments since they practice largely without consequence. VA psychologist often lack training in writing adequate disability-related opinions (Ridgeway 2012), and in such basics as understanding and using military service data records (Moering 2011). In addition, inaccurate VA claims are processed despite "errors related to inconsistent or insufficient training," costing VA millions of dollars in overpayments (House Committee on Veterans Affairs 2012).

A second example of how systemic issues affect symptom validity assessment is the recent trend in VA's excluding any mention of symptom exaggeration or malingering from its current training and practice guidelines. Prior to 2010, VA clinician training in conducting disability assessments explicitly cautioned clinicians that they were obligated to report "misrepresentation of fact" or malingering when either was "detected or suspected" (VBA 2007, p. 21). However, the words "malingering" and "misrepresentation of facts" do not appear in the current VA disability training modules, in effect since 2010 (see also Russo 2013).

A comparison of the 2002 and 2010 best practice guidelines for assessing PTSD finds a similar pattern. The 2002 manual (Watson et al. 2002) noted the importance both of psychometric assessment where there are "findings of questionable validity" (p. 18), as well as the need for examiners to "make complex judgments about potential malingering" (p. 21). However, the 2010 best practice guidelines (VA/DOD 2010) make no mention of symptom validity or malingering. This omission is consistent with the emphasis on veteran self-report despite the growing research literature showing that patient self-report is of questionable reliability and validity, and the literature showing that clinicians "are generally unable to detect malingering without the use of specific methods" (Chafetz 2011, p. 241). For example, in a 2011 review of the PTSD and mild traumatic brain injury literature, Carlson et al. found that relying on retrospective self-report may be "invalid or inaccurate" (Carlson et al. 2011, p. 104) and leads to an "overestimation of TBI and PTSD" (p. 110).

Collusive Lying

While systemic issues are endemic to VA, some clinicians face administrative prohibitions directed against the accurate assessment of veteran symptom validity (Poyner 2010). When rationalized as giving veterans the "benefit of the doubt," this blinds a knowing eye from the facts that some veterans feign injury for compensation, and that all VA staff are obligated to report fraud. These administrative prohibitions are forms of collusive lying. In his 1991 study, *The Prevalence of Deceit*, anthropologist Frederick Bailey wrote:

> "Collusive lying occurs when two parties, knowing full well that what they are saying or doing is false, collude in ignoring the falsity. They hold it between them as open secrets. They may do so voluntarily or because one party compels the other to go along with the pretense." (p. 35)

Poyner (2010), for example, described how, during her brief career as a contract psychologist hired to conduct VA disability evaluations, she rarely diagnosed malingering due to "direct prohibition from the VA" (p. 131). Her work with the VA came to end because she used "instruments designed to detect feigning" purportedly because they did "not give the veteran the benefit of the doubt" (p. 131). Colleagues report similar prohibitions. Consider, for example this email from a former VA chief psychologist to psychology staff:

> "Please do not use the diagnosis of malingering. If the testing shows sub-optimal performance, please defer the diagnosis. Also, we need to focus ONLY on the test materials and not make any comments that appear to question patients' reports of trauma" (caps in the original; source withheld).

Serious threats to symptom validity assessment also occur when administrators directly tamper with patients' records. Consider the example of administration's removing a diagnosis of "r/o malingering" as well as multi-page sections of the assessment supporting that diagnosis because it "put the patient in a bad light" (source withheld).

Managing Institutional Threats to Symptom Validity Assessment

The primary goal in managing institutional threats to symptom validity assessment is to create and maintain an environment in which clinicians can report accurate and competent clinical findings free from collusive pressures to misrepresent results. A professional, measured, and, whenever possible, collaborative approach is best.

However, when faced with truth-adverse situations, advanced preparation is advised. Wise VA psychologists know policy and regulation, use written informed consent as well as written post-assessment feedback (Russo 2013), track the types of assessments they perform and the rate at which intentional sub-optimal performance (e.g. factitious disorder and/or malingering) is diagnosed, and promptly correct inaccurate representations of their work.

Enlisting the help of others is preferable to taking on issues of collusive lying alone. Orders to falsify diagnoses, tampering with patient records, and coercive supervisory practices are unethical; such practices violate VA policy and possibly Federal statute. Psychologists may seek help from their VA ethics committee, Equal Employment Office, Union, and professional society for help on how to proceed. Recourse to the VA inspector general stops coercive and unethical practices, but this remedy is best employed only when other means fail, with one exception. When malingering veterans attempt to harm innocent others, as in the example below, this should trigger an immediate call to the VA police and the VA OIG hotline. It is a federal crime to assault or threaten to assault a federal employee as an act of retaliation "against such person on account of the performance of official duties" (18 USC § 115 2006).

Veteran Specific Symptom Validity Assessment

Managing institutional threats to symptom validity assessment does not insure competent clinical work, but it does allow competent clinicians to work. For competent clinical investigation of symptom validity, I recommend using Canadian philosopher Bernard Lonergan's (1972, 1992) generalized empirical method. According to Lonergan's generalized empirical method, four interactive, cognitional structures operate in all human knowing of reality. These include data gathering, forming insights, validating the insights, and acting on the results. As Hanson (2003, p. 830) stated, "This cognitional structure is natural and inherent in everyone, but rarely recognized formally." The generalized empirical method also subsumes such neuropsychological models as the hypothesis testing and best fit models (DeClue 2002), since both rely on assessment of data, forming hypotheses, and confirm the hypotheses, although with differences in how this is done.

At the first or empirical level, we gather and attend to the data provided by our senses, memory, and imagination. At the second level, the intellectual level, we are concerned with understanding the data. It is at this intellectual level that we gain insight or an understanding of the data that was previously available but unintelligible. Lonergan (1992, p. 3) illustrates the distinct nature of insight as an act of discovery quite distinct from data gathering by resorting to a common genre of fiction, the detective story.

> "In the ideal detective story the reader is given all the clues yet fails to spot the criminal. He may advert to each clue as it arises. He needs no further clues to solve the mystery. Yet he can remain in the dark for the simple reason that reaching the solution is not the mere apprehension of any clue, not the mere memory of all, but a quite distinct activity of organizing intelligence that places the full set of clues in a unique explanatory perspective."

However, Lonergan notes insights only provide possible explanations. It is at the third or rational level that we reflect upon and pass judgment on our insights in order to decide whether the insights are true, false, or that we are in need of more information before deciding on their veracity. Finally, it is at the fourth or responsible level that we are concerned with applying what we know and coming to a decision on what the results imply for our lives. By (1) actively attending to all relevant facts, (2) intelligently determining the meaningful connections among the facts, (3) validating the discovered meaningful connections via sound reason and reflection, and (4) responsibly reporting the truth, we control for the respective errors of inattentiveness, obtuseness, unreasonableness, and irresponsibility.

Active Attention to All Relevant Data

The relevant data for symptom validity assessment start with a database similar to that used for assessing symptoms. This includes collecting information on veterans' symptoms, symptom development, etiology, and any impact on functioning. In

addition, information that places veterans within their unique developmental, historical, and cultural context helps provide a comprehensive understanding of the current pattern of symptom expression and its impact on functioning. Finally, because accurate assessment relies on honest reporting, results from symptom validity measures should be included in any assessment; this addition is now considered a standard of ethical practice for neuropsychologists (e.g. see Heilbronner et al. 2009) and is becoming increasingly embraced by all assessing psychologists.

While veterans' self-reports are the usual starting point for assessing veteran symptom validity, the growing consensus is to use multiple sources of data (Slick et al. 1999). At a minimum, this would include veterans' self-reports, information in the VHA chart, the Veterans Health Information Systems and Technology Architecture (VISTA) registration information, the DD214s, and the results of symptom validity testing. These data are almost always available.

The reports section of the VHA Computerized Patient Record System (CPRS) yields considerable information including past and future clinic visits, when VBA compensation examinations were or are scheduled, and all current and prior diagnoses and medications provided by VA. Assessments and treatments at other VA facilities may be included. Current and past Department of Defense (DOD) treatments may be included, as well as DOD encounters, diagnoses, medications, and other treatments.

The VISTA imaging display in the tools sections may show signed releases, an important source of information if the veteran is requesting healthcare-related assessments, but the signed releases are to legal counsel. Information veterans present at registration is documented in the VISTA system. This not only includes demographic information but may also contain dates of military service, type of discharge, and dates in combat areas.

Military records may be found in CPRS, but these records are often quite limited. All veterans have copies of their DD214s available for review since these are required for VA registration. Some veterans maintain records that are more comprehensive. In addition, military records are available with the veteran's consent from the National Archives. VBA usually provides disability examiners with the veteran's claims file and relevant medical, psychiatric, and military records. Since Moering (2011) provides detailed information on how to understand military records, this information is not discussed in detail here. Rather, VA psychologists and consultants are advised to review Moering's excellent article.

Information from collateral sources is sometimes available. These range from face-to-face contacts and letters to medical chart entries reporting collateral contact. Note whether the collateral is reporting on something the collateral actually observed, or whether the collateral is simply relaying information the veteran reported.

Repeated self-report screens for alcohol, depression, post traumatic stress disorder, suicide potential, and traumatic brain injury are now routine and provide rough estimates of veterans' self-reported symptoms over time. Caution regarding the accuracy of these screenings should be exercised since, as Cooper et al. (2011) noted, they lack any means of assessing response bias, leaving them vulnerable to manipulation. For example, PTSD screens have few or no validity measures, questionnaires may over estimate PTSD (McNally and Frueh 2013), and structured interviews such as the Clinician Administered PTSD Scale are "ineffective in identifying exaggeration" (Rubenzer 2009, p. 118). Boone (2013, p. 10) warns that symptom checklists "educate patients as to what symptoms might be expected for their condition, and thereby are likely to prime them for reporting symptoms that might not otherwise occur."

Prior comprehensive psychological and neuropsychological assessments may be available. If done at other VA medical centers, these are usually available without consent under the "One VA" rule. Consent for release of confidential information is needed for DOD and non-government assessments, but veterans often retain copies of their assessments.

Psychometric Assessments and Symptom Validity Testing Objective, psychometric methods of assessing symptoms and symptom validity are increasingly recognized as superior to clinical judgment alone (e.g. see Dawes et al. 1989). For example, Rubenzer (2006, p. 499) noted that few clinicians "have sufficient training or tools" to assess feigned symptoms and Morel (2010) noted that research increasingly indicated that psychiatrist could not detect lying at greater than chance levels.

Objective psychological test instruments generally employ strategies to detect invalid responding, and instruments that are more robust employ several. These usually fall into one of three broad types, (a) non-responding, (b) under exaggeration, or (c) over exaggeration. Non-responding represents a class of response styles in which patients are either failing to answer items within their ken or are responding without reference to item content. The latter includes inconsistent responding and responding by repeatedly answering true or false regardless of content. Under exaggeration, sometimes called faking good, describes a response style by which patients portray themselves in an unrealistically favorable light. This can include minimizing symptoms or denying imperfections common to the human condition. Over exaggeration, sometimes called faking bad, describes a response style by which patients portray themselves in an unrealistically unfavorable or pathological light. This can include endorsing a large number of rare or bizarre symptoms, or reporting a large number of dramatic symptoms commonly known to the layperson without also endorsing the less well known, but equally common subtle symptoms that usually coexist with their dramatic counterparts.

Effective psychological test instruments perform two objectives well. They are able to detect those who are members of a certain diagnostic category while eliminating those who are not. The first assesses sensitivity and refers to the percentage of true positives to the total number of patients with the targeted criteria. The second assesses specificity and refers to the percentage of true negatives to the total number of patients lacking the targeted criteria. For example, if one wanted to design a test in order to identify symptom feigning, then a perfectly sensitive test would identify all veterans feigning symptoms while a perfectly specific test would eliminate all veterans accurately and honestly reporting symptoms. Currently, no such test exists. Traditionally, test cutoffs are set at 90 % or better specificity "reflecting the emphasis the field places on protecting credible patients even if this results in some sacrifice in detecting noncredible individuals" (Boone 2013, p. 29). However, as Larrabee (2012) noted, a 90 % specificity rate yields a false positive rate of 10 %; in other words, for every ten veterans, one veteran would be falsely identified as non-credible.

When using psychological tests to assess symptom validity, it is crucial to know the sensitivity and selectivity of the instruments used. This data is provided here for the most common objective psychological measures using Jackson et al.'s (2011) survey of 138 VA psychologists who performed compensation exams across 75 VA facilities. They found that 29 % of practitioners reported using the Minnesota Multiphasic Personality Inventory-2 (MMPI-2), 11 % reported using the Millon Clinical Multiaxial Inventory III (MCMI-III), and 7 % reported using the Personality Assessment Inventory (PAI). The Structured Interview of Reported Symptoms (SIRS) is also included, along with the most recent revision of the MMPI-2, the MMPI-2-RF. The MMPI-2, MMPI-2-RF, MCMI-III, and PAI are tests of psychological functioning with embedded symptom validity scales. The SIRS is included since it is considered the "most well known and most frequently administered" stand alone measure for detecting feigned mental disorders (Green and Rosenfeld 2011, p. 95).

MMPI-2 The MMPI-2 is a 567-item, true-false inventory that assesses pathology via ten clinical scales, nine restructured clinical scales, and numerous supplementary scales. It is the most researched and one of the most commonly used psychological tests (Boone 2013). The MMPI-2 uses three broad types of validity measures, (1) those used to detect non-responding, such as the Cannot Say (CNS), Variable Response Inconsistency (VRIN), and True Response Inconsistency (TRIN) scales; (2) those assessing under exaggeration, such as the Lie (L), Correction (K), and Superlative Self Presentation (S) scales; and (3) those assessing over exaggeration, such as the Infrequency (F), Back F (Fb), F-Psychopathology (Fp), and Symptom Validity (FBS) scales. Because research has shown that the MMPI-2 validity scales related to over exaggeration are minimally related to feigning of symptoms, several other scales were developed to identify a non-credible performance (Boone 2013).

Rogers et al. (2003) conducted a meta-analysis of the MMPI-2 research on symptom exaggeration and malingering using 62 feigning studies and 11 diagnostic studies. They found several scales helpful in the detection of feigned mental illness based on two detection styles, rare symptoms response style and erroneous stereotypes response style. Detection strategies using rare symptoms rest on the tendency of malingerers to endorse "symptoms, characteristics, or associated features of impaired functioning that occur infrequently in genuinely impaired populations" (p. 160). Detection strategies using erroneous stereotypes "rests on the inability of malingerers to differentiate erroneous stereotypes from genuine psychopathology" (p. 161).

For the detection of feigning using the rare symptom strategy, Rogers et al (2003) recommend use of the F-Psychopathology or Fp scale as the "most effective scale in the assessment of feigned illness" (p. 173). They also note that the Infrequency or F scale may be useful even with PTSD clinical groups if a sufficiently high cutoff is used (also see Rubenzer 2009). For the detection of feigning using the erroneous stereotypes strategy, they recommend using Gough's dissimulation or Ds scale. With sufficiently high cutoffs, the Ds scale "appears to be the premier specialized validity scale with its sophisticated strategy and minimal risk of false-positives" (p. 173). In a recent review of MMPI-2 feigning detection scales, Boone (2013) noted that research also supports the use of the Lees-Haley Symptom Validity or FBS Scale, the Meyers Index, and the Response Bias or RBS Scale.

MMPI-2-RF Published in 2008, the MMPI-2-RF is a 338-item version of the MMPI-2. Scale construction was theoretically grounded, hierarchically structured, and based on modern test construction methods not available at the time of the publication of the MMPI. As with the MMPI-2, the MMPI-2-RF continues the use of three broad types of validity measures, (1) those used to detect non-responsiveness, such as the Cannot Say (CNS), Variable Response Inconsistency (VRIN-r), and True Response Inconsistency (TRIN-r) scales; (2) those assessing under reporting, such as the Uncommon Virtues (L-r) and Adjustment Validity (K-r) scales; and (3) those assessing over reporting, such as the Infrequent Responding (F-r), Infrequent Psychopathology Responses (Fp-r), Infrequent Somatic Responses (F-s), Symptom Validity (FBS-r), and Response Bias (RBS) scales (Ben-Porath and Tellegen 2008). As a recent modification of the MMPI-2, the MMPI-2-RF lacks the extensive research support of the MMPI-2. However, several studies show the MMPI-2-RF to be a promising instrument for symptom validity assessment (see for example, Marion et al. 2011; Wygant et al. 2010).

MCMI-III The MCMI-III is a 175-item, true-false inventory that assesses both clinical symptoms and conditions via 10 scales, and personality patterns and disorders via 13 scales. With the 2009 update, the Grossman Facet Scales were included to articulate key personality domains. The MCMI-III assesses validity via five scales to detect (1) random responding, such as the Inconsistency Scale and Invalidity Scale; (2) faking good or presenting oneself in a favorable light, via the Desirability Scale; (3) faking bad or presenting oneself in an unfavorable light, via the Debasement Scale; and (4) defensiveness or the willingness to reveal oneself, via the Disclosure Scale.

In her review of the MCMI-III, Boone (2013) concluded that there was "minimal data" available on the clinical scales or modifying indexes "to identify feigned psychiatric symptoms." Sellbom and Bagby (2008) note a similar shortage of studies supporting the use of the MCMI-III to detect feigning and conclude "under no circumstances should practitioners use this instrument in forensic evaluations to determine response style" (p. 203).

PAI The PAI is a 344-item inventory that uses a four-point Likert type scale with response possibilities ranging from false, slightly true, mainly true to very true. It assesses pathology via 11 clinical scales, supplemented by 5 treatment and 2 interpersonal scales. The PAI uses three broad validity measures to detect (1) non-responding, such as the Inconsistency Scale and Infrequency Scale; (2) under reporting, as in the Positive Impression Management Scale (PIM); and (3) over reporting, as in the Negative Impression Management Scale (NIM). Several scales were developed later to detect over reporting; the two most researched being the Malingering Index (MAL; Morey 1996) and Rogers Discriminant Function (RDF; Rogers et al. 1996).

While not used as widely as the MMPI-2 and not researched as extensively regarding symptom validity issues, several reviews found NIM, MAL, and RDF useful in the detection of symptom exaggeration (Hawes and Boccaccini 2009; Boone 2013; Sellbom and Bagby 2008). Lally's (2003) survey of forensic psychologists found the PAI "acceptable" for use in the detection of malingering.

SIRS The SIRS is a 172-item instrument administered verbally to veterans. The SIRS uses several strategies for detecting feigned symptom reporting; these are scored via eight primary and four supplementary scales. Following Rogers et al. (2009), the primary scales can be grouped into four scales that detect unlikely or atypical symptoms and four other scales that detect amplified symptoms. The former are atypical of mental illness, while the latter include normatively expected symptoms that raise suspicion of feigning when endorsed at a higher than expected rate. Scoring on each of the eight primary scales is based on the number of items endorsed, with the sum for each scale then classified as "honest," "indeterminate," "probable malingering," and "definite malingering."

Green and Rosenfeld (2011) conducted a review and meta-analysis of the SIRS. They found an overall specificity of 89.0 %, and an overall sensitivity was of 73.9 % for both stimulators and suspected malingerers. They concluded that the SIRS appeared to be "highly effective at differentiating feigning from genuinely responding individuals" (p. 103), but added that the results were probably less robust than those observed in meta-analysis of the MMPI-2. The SIRS was revised and published as the SIRS-2 in 2010. As a recent revision, it lacks the research base of the original. For initial reviews of the revised SIRS-2, see DeClue (2011) and Rubenzer (2010).

Intelligently Determining Meaningful Connections Among the Data

While diagnosis consists of establishing a convergence of evidence based on sound clinical principles, symptom validity assessment consists more in recognizing (a) inconsistencies among the data and (b) normative violations based on expectations grounded in sound clinical principles and research. Normative violations include violations based on expectations from that predicted of clinical groups. For example, veterans reporting intact memory during post deployment health assessments following mild traumatic brain but then reporting severely impaired memory years later during VA admission are, in the absence of intervening brain insult, presenting with a "normative violation" or symptom pattern contrary to expectations based on that predicted given the mild traumatic brain injury literature (see Russo 2012).

Inconsistencies and normative violations can be organized thematically as relating to symptoms, functioning, and etiology, as well as evidence of coaching or falsifying information. This extends the guidelines provided by Slick et al. (1999) to include assessing the credibility of existing collateral, clinical, and other data sources. The following questions are a non-exhaustive list of what might be asked.

Symptoms Is there evidence of inconsistency and/or normative violations related to symptom report and expression? Are there inconsistencies between reported and observed symptoms, between reported symptoms and symptoms as reported by collateral sources? Are there inconsistencies between reports of earlier symptom expression and contemporaneous records? For example, is the veteran reporting a history of debilitating symptoms during military service while contemporaneous documentation showing a history of performance excellence and promotion? Are symptoms reported inconsistently over time in ways that violate expected patterns of symptom expression, development, and/or remission? For

example, an increase in symptom intensity as an anniversary reaction might be clinically understandable, while an increase in symptom intensity limited to disability reevaluation periods might be suspect. Is the veteran reporting symptoms commonly known by intelligent laypersons but omitting the less publicized, but equally common associated symptoms? Has the veteran's report of symptom expression changed over time, and is this the result of legitimate intervention such as therapy, or in response to coaching or changes in disability criteria (for example, see Moering 2011)?

Functioning Is there evidence of inconsistency and/or normative violations related to impairments in social, occupational, or other functioning? Are there inconsistencies in reported, observed, and/or documented levels of functioning? Some inconsistencies are obvious, as in the working veteran claiming total unemployability. Some are less obvious, as in the veteran reporting no social contact, but with an ongoing prescription for Levitra. Do claims for total unemployability for military-related issues appear only after retirement and following decades of successful occupational functioning? Is there a denial of expected strengths and capacities?

Etiology Is there evidence of inconsistency and/or normative violations related to veterans' self-report of etiology? Does the veteran deny non-military factors or refuse to provide detailed information other than that pertaining to military service? Are there unexpectedly long gaps between etiology and symptom development? While there is some evidence for distant onset symptom presentation, Ridgway (2011) notes that long gaps between service and symptom onsets may be evidence against the claim. Are there more general discrepancies between self-reported history and documented history or prior self-reports?

Falsification and Coaching Is there evidence of falsified or fabricated information? Is there evidence of coaching? For example, Rosen's (1995) examination of the unusually high rate of PTSD reports among the survivors of the Aleutian Enterprise sinking found attorney coaching a significant factor. Does the veteran show a familiarity with testing in general or with specific symptom validity tests? Did the veteran have access to prior test reports in which symptom validity tests were described in detail or by name, or with cutoffs specified in the report? Does the veteran deny prior assessments despite evidence of prior assessments?

Assessing the Credibility of Collateral, Clinical, and Other Data Sources The credibility of collateral information should be considered, especially when the collateral stands to gain by the veteran's disability. Is the collateral information based on something witnessed or hearsay? Is the collateral making judgments within his/her range of expertise? Boone (2013) notes how in compensation cases, "family members clearly have a vested interest in the outcome…and friends may feel an obligation to provide information helpful to the patient's… case" (p. 14). Is there evidence of malingering by proxy (Chafetz and Prentkowski 2011)? Colleagues report instances in which family members seeking service connection for elderly veterans, encouraged veterans' self-reports of military trauma despite the veteran's obvious dementia and inability to recall that history.

Determine whether clinical assessments are credible. Are the available clinical sources trustworthy? Were the appropriate versions used? For example, at the time of this writing, the VA's CPRS MHA3 testing software did not use the current MCMI-III 2009 normative update, nor the 2009 Inconsistency Scale or Grossman Facet Scales. Is there evidence that the clinical database has been compromised? Poyner (2010) noted how VA evaluations for PTSD were often based on veteran self-report, "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" (p. 131). Is the clinician giving a reasoned formulation based on attention to relevant details or merely repeating the veteran's self-report?

Boone (2013) provides a checklist of errors to consider when judging the adequacy of an assessment report (see also Bow et al. 2010). For example, (1) was the data obtained using several measures of response bias, (2) were appropriate tests with adequate norms used, (3) is the deduced profile consistent with the published literature for the condition, (4) have test results been correctly interpreted, and (5) did the clinician inappropriately explain away obvious evidence of feigned symptoms?

Validating Insight via Sound Reasoning and Reflection

Active attention to relevant details and the discovery of meaningful connections among the inconsistencies and normative violations in the data only provide initial insights. As Lonergan (1972, p. 9) would warn, there is still the rational level on which we "pass judgment on the truth or falsity, certainty or probability, of a statement." For the assessment of symptom validity, this requires passing judgments on three questions related to the existence of exaggeration and feigning, locus of deception and locus of expected gain. Specifically, with what degree of certainty can the clinician judge (1) that symptom exaggeration or feigning exists, (2) that this symptom feigning is based on other versus self deception, and (3) whether expected gains are external versus internal?

How Certain Is the Evidence of Symptom Exaggeration or Feigning Inconsistencies in the data and normative violations

can present without attempts to exaggerate or feign symptoms. Memory is fallible, and faulty report of distant etiological events may not be deliberate. Attribution errors are likely, especially when returning veterans are repeatedly screened or provided lessons in veteran specific pathology. McNally and Frueh (2013) warned that "although this process will identify undiagnosed sufferers of the disorder, it may also encourage veterans to construe transient emotional reactions as symptoms of PTSD. Unwittingly fostering an expectation of permanent disability may be an unexpected consequent of such well-intentioned efforts at outreach" (p. 524).

In addition, individual psychological test results are less than certain. With a common threshold for adequate sensitivity and specificity for symptom validity measures set at 90 %, 10 % of symptom validity failures are false positives. Finally, response styles may affect findings. For example, validity scales with all or mostly true item sets are vulnerable to veterans with acquiescent response styles (McGrath et al. 2010).

On the other hand, some false reports of etiological events are easily judged as intentionally fabricated, as seen, for example, in the purported combat veterans who never served in combat. In addition, while screenings may have the iatrogenic effect of believing that one is impaired, it should not cause impairment. Finally, while individual test result failures are less certain, multiple failures across measures can reduce the false positive rate to zero. As Boone (2013) warned, it is a flaw in judgment to dismiss evidence of symptom validity failure by stating that these are due to physical or emotional factors without evidence that this is, in fact, the case.

How Certain Is the Evidence of Self or Other Deception Factitious disorders and malingering should only be diagnosed when evidence shows that veterans do not believe in their own symptoms, that is, for "those who are engaging in other-deception rather than self deception" (Boone 2013, p. 23). Some patients may be predisposed to experience negative emotions and somatic sensations more intensely than others (Rubenzer 2006). Others may suffer from attribution errors, which are errors in judgment, or from lack of self-knowledge (McGrath et al 2010). Somatoform disorders are sometimes conceptualized as a type of attribution error in which the patient reports physical symptoms that are somatic manifestations of psychological conflict.

On the other hand, self and other deceptions are not mutually exclusive categories, and some suggest that even with conversion phenomena, the patient may be aware of their exaggerations (e.g. Rubenzer 2006). As Iverson (2006) noted, psychiatric problems do not rule out malingering. "That would be tantamount to concluding that people with these conditions are not capable of engaging in goal directed behavior" (p. 78).

How Certain Is the Evidence on Locus of Gain The issue of whether external gain is a primary consideration in veteran symptom feigning is particularly problematic since the potential for financial gain "is potentially ubiquitous in this [VA] system…. Consequently, dividing this population into groups that have and do not have a clear external incentive to appear cognitively compromised may be an impossible task" (Armistead-Jehle 2010, p. 58). The clinical questions though are to what extent hoped for internal and external gains can be identified for this veteran, and with what degree of certainty. Recognition should be given to the fact that within VA, both external and internal incentives often coexist.

The judgment that symptom feigning is a cry for help, or represents a somatic disorder, factitious disorder, or malingering should always be based on a convergence of the evidence, and the degree of certainty the clinician has in that judgment. For example, judging that symptom exaggerations are due to a cry for help should only be proffered when there is evidence that veterans do not believe they will receive proper treatment unless they dramatize their condition (Boone 2013). When symptom exaggeration or feigning is present but questions of locus of deception or locus of gain are less certain, then the clinician should note the finding of symptom exaggeration or feigning and the reasons why further diagnostic certainty is not possible.

It may be helpful to use a more nuanced and expanded understanding of malingering than that provided by the current diagnostic manuals. Resnick (1997) describes three types of malingering: (1) pure malingering, in which a person feigns a disorder that does not exist; (2) partial malingering, in which existing symptoms are consciously exaggerated; and (3) false imputation, in which existing symptoms are knowingly attributed to a false etiological event. The current *Diagnostic and Statistical Manual of Mental Disorders*, *Fifth Edition* (American Psychiatric Association 2013) does not include Resnick's category of false imputation in the malingering designation, yet anyone assessing veterans within the VA system will have come across these cases in their practice.

Responsible Action

Lonergan (1972) writes that "being responsible includes basing one's decisions and choices on an unbiased evaluation of short-term and long-term costs and benefits to oneself, to one's group, to other groups" (p. 53). This has specific import when diagnosing symptom validity failure in veterans. When innocent veterans are reported as malingering, veterans and their families bear the burden. As Bianchini et al. (2001) cautioned, a "false diagnosis of malingering can have important financial, occupational, and personal (emotional, interpersonal) consequences for the patient" (p. 39). When malingering veterans are reported as innocent, the citizenry bears the

burden. The malingering veteran is attempting to steal from the citizenry, including its veteran citizens. When successful, they misappropriate clinical, financial, and other resources that would otherwise be allocated to honest veterans (Morel 2010), and they compromise the integrity of the clinical research database (Rosen and Taylor 2007).

Psychologists should write for the intelligent layperson using clear, unambiguous language that avoids jargon or technical terms. Words and phrases may have different meanings, depending on the audience. For example, the word "reliability" from a psychological viewpoint refers to consistency; from a legal viewpoint, reliability refers to validity. In court, reliable witnesses are considered trustworthy, and their testimony valid.

Given the likelihood that any assessment may be used as evidence within the VBA system, reports should be as clear and comprehensive as possible. Under the current system, psychologists do not present as expert witnesses, and counsel has no opportunity to clarify report statements, or to elicit the data or rationale used in the clinical formulation. Ridgway (2011) states that reports limited to data and conclusions are worthless. At a minimum, assessment reports should include details on the information used, the evidence supporting (a) symptom exaggeration and feigning, (b) self or other deception, and (c) locus of gain, and the degree of certainty for each, as well as the reasons for the clinical opinion.

There are specific practices that should be avoided. It is irresponsible to report the details of symptom validity measures or the cutoffs values. In addition, as Slick et al. (1999) cautioned, "euphemisms or descriptors such as 'poorly motivated' or 'poor effort' should not be used as a synonyms for malingering as persons who malinger may be highly motivated to appear realistically impaired" (p. 557). Finally, clinicians should avoid providing recommendations that are inconsistent with malingering. For example, there is little sense in referring veterans malingering memory impairment for cognitive rehabilitation; this will likely confuse the reader.

The reporting of malingering should be based on a convergence of evidence and a judgment that the level of certainty is at least highly probable or definite. Reasonable doubt should go to the veteran. My practice is to reserve use of the term malingering for when there is near certain evidence of false report, as in the working veteran claiming total unemployability, the non-combat veteran claiming combat related illness, and the veteran caught grossly fabricating symptoms, functioning, and/or etiology.

VA psychologists do well to protect themselves from retaliation by informing veterans via comprehensive informed consent that documents the veterans' signed understanding that they (a) will be treated professionally, with courtesy and respect; and (b) will give their best and most honest effort. Sample consent and post-assessment satisfaction forms are available in Appendix. Since the author created these in 2008 as part of his Federal employment, they are in the public domain. (For a post-feedback version based on these forms, see Carone et al. 2013).

"Given that veterans may show no dissatisfaction with the assessment at the time of the evaluation but file a complaint well after the fact…risk-aversive clinicians do well to document veterans' signed post-assessment acknowledgement that they (a) were treated professionally, with courtesy and respect; and (b) gave their best and most honest effort" (Russo 2013, p. 27). This documentation is best obtained immediately after the assessment to protect the clinician in the event the patient fails to return for a feedback session. A second post-feedback assessment form can also be used. This practice often dramatically reduces patient complaints and leaves exceptions easily managed.

Patient Example Consider the example of a psychologist who assessed a veteran with 80 % service connection and a prior diagnosis of somatization. The assessment supported that diagnosis, which they fully discussed during an audiotaped 90-min feedback session. When asked for feedback, the patient was effusive, stated that this was the first time anyone at the VA explained things in way she could understand, and rated the experience an "A". Three months later, she filed a complaint with the patient representative. Given the glowing praise documented in the audiotaped account and the signed post-session acknowledgment that she had been treated with courtesy and respect, the complaint was quickly dismissed. Nevertheless, the fact remained that the veteran did file a complaint months after praising both the assessment results and the psychologist.

While some might argue that malingering should never be used, others find this irresponsible (e.g. see McNally and Frueh 2013). The citizenry is injured by the malingerer. At times, the injury is directed against innocent veterans and colleagues in a way so grievous that silence or collusion would constitute a grave injustice.

Patient Example Consider the example of the veteran claiming total unemployability due to an inability to sit, secondary to injuries received during his very short military career. A review of his VBA claims file found an initial claim for verbal abuse at the hands of several service members during basic training, but no claim of unemployability. After a year's appeals failed to provide the hoped for benefits, the veteran changed his injury to physical abuse, a charge he had previously and repeatedly denied. The psychologist performing the compensation evaluation correctly diagnosed the veteran as malingering. The VBA denied service connection, citing his compensation evaluation in detail. The veteran came to the psychologist's VA threatening to "splat his brains out," and attempted to destroy the psychologist's reputation by

accusing him of the same verbal abuse he alleged against the service members in his initial claim.

The veteran demanded a new initial evaluation conducted by two female clinicians, which the VBA granted. The two clinicians, colleagues of the psychologist, found for the veteran in a detailed report that focused largely on the veteran's self-report. Missing from the second report was any mention of the first report, the threats to the first evaluator, or the fact that the veteran had falsified his enlistment papers, his VBA applications for benefits, and several VHA reports. These falsifications included but were not limited to (1) falsely reporting his education, (2) falsely reporting his residency, (3) falsely reporting his citizenry, (4) falsely reporting his time in the service, (5) falsely reporting his history of psychiatric hospitalizations, (6) falsely reporting his history of pre-military trauma, (7) falsely reporting his post discharge income, and most significant, (8) falsely reporting his employment. Specifically, during the period in which this veteran pursued unemployability due to his inability to sit, he made several transcontinental and transatlantic flights to continue his career stateside and abroad. This was clearly documented in the veteran's chart, as well as in his several professional resumes and video files available on the internet.

A Lonerganian analysis would see this as more than a difference of opinion regarding veteran-centered advocacy. First, there was clear and undeniable evidence that this veteran had falsely presented himself as unemployable; the videotape evidence of his working was sufficient even without the remaining flood of falsified documents. An opinion supporting the veteran's claimed unemployability could only be maintained by ignoring the facts.

Second, this veteran was willing to hurt several service members and destroy a VA psychologist in order to defraud the citizenry. Regardless of how the psychologist and his colleagues decided to report this, that report would be a moral action with lasting repercussions for the citizenry, the service members accused of injuring this veteran, the psychologist accused of injuring the veteran, and for the three clinicians charged with the moral responsibility of properly assessing this veteran. The first psychologist's silence would indict the service members; his colleagues silence would indict the psychologist, as well as the service members.

The psychologist reported the veteran to the VA inspector general. Based on the second report, VBA awarded this veteran service connection.

In Closing

Assessing veteran symptom validity is part of a trust we hold in relation to our veterans and the citizenry. We are set the task of judging veteran credibility, and in so doing, acting as a witness and guarantor (Marcel 1956). Within VA, the competent assessment and honest reporting of symptom validity is fundamentally a matter of personal integrity since there is no judicial overview and few external consequences for inadequate or unethical work. Our actions, Lonergan (1972) notes, constitute us as conscientious to the degree that we are responsible. We fulfill our responsibility "or fail to do so in the measure that we are attentive or inattentive in experiencing, that we are intelligent or unintelligent in our investigations, that we are reasonable or unreasonable in our judgments" (p. 120); and that we are responsible or irresponsible in our actions.

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Appendix

Informed Consent for Psychological and Neuropsychological Assessment

Welcome. Mr/Ms/Dr. _____ referred you for a (neuro) psychological assessment because of concerns you were having with _____.

A (neuro)psychological assessment consists of an interview and testing. During the interview you will be asked about your symptoms, medical history, medications, and other important factors such as how you did in school, in the military and on the job. I will also ask how you are currently functioning in important areas such as at home, work and in your community. If you are uncomfortable or become upset by any of the questions, please let me know.

Testing involves answering questions, taking paper and pencil tests, and solving problems. Some of the tests are done on the computer. You will find some of these tasks easy, whereas others may be more difficult. Also, most people don't answer every question correctly or finish every item, but please give your best and most honest effort on all of the items.

After the testing is completed, we will schedule a feedback session. At that time, we will go over the results, any questions you have and any recommendations. Also, after the testing is completed, I'll write up a report that will go in your medical chart. That report is confidential. The only people who will be able to see it are people who are treating you, unless you give written permission for someone else to see it. You will also be able to get a copy of your report by going to Correspondence.

The report will include how you were able to solve different types of problems by comparing your results to people who are like you in important ways. The report will also include how you went about solving various problems, how you answered questions and how well you were able to give your best and most honest effort. In addition, the report will include important aspects of your history as they relate to your current problems.

You will be treated professionally, with courtesy and respect. Most veterans find the assessment interesting, and appreciate how the information will contribute to their care. If at any time you feel that you haven't been treated professionally, with courtesy and respect, please let me know and we will stop the assessment.

If you are having any difficulty at any time during this assessment, please let me know. Every hour or so, I'll ask you if you would like a break. If at any time you need a break, please let me know.

We value your time and effort, and want to make sure that the assessment process has been sufficiently explained to you. Do you have any questions?

1. [ ] yes [ ] no Was the assessment process adequately explained to you?
2. [ ] yes [ ] no Were you told why you were being assessed?
3. [ ] yes [ ] no Were you told who would have access to the assessment report?
4. [ ] yes [ ] no Are you able to give your best and most honest effort?

Patient's Signature: _____Date: _____

Feedback Following (Neuro)Psychological Assessment

We would like your feedback both to understand your reaction to the assessment and to identify any areas that we might need to improve. Please complete as much information as you are comfortable providing. We would like to thank you in advance for completing this survey.

1. [ ] yes [ ] no Were you offered a feedback session?
2. [ ] yes [ ] no Were you offered breaks during the assessment?
3. [ ] yes [ ] no Were you able to give you best and most honest effort during this assessment?
4. [ ] yes [ ] no Were you treated professionally, with courtesy and respect?

If anything prevented you from giving your best and most honest effort, please describe.

If you have any comments about your assessment, please write them here.

Patient's Signature: _____Date: _____

References

18 USC § 1001 (2006)
18 USC § 1035 (2006)
18 USC § 115 (2006)
38 CFR § 20.700 (c)
5 CFR § 2635.101 (b) (11)
American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington: American Psychiatric Publishing.
American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. *American Psychologist, 57,* 1060–1073.
Armistead-Jehle, P. (2010). Symptom validity test performance in U.S. veterans referred for evaluation of mild TBI. *Applied Neuropsychology, 17,* 32–59.
Bailey, F. (1991). *The prevalence of deceit*. New York: Cornell University Press.
Ben-Porath, Y., & Tellegen, A. (2008). *Minnesota Multiphasic Personality Inventory-2 restructured form: manual for administration, scoring, and interpretation*. Minnesota: University of Minnesota.
Bianchini, K., Mathias, C., & Greve, K. (2001). Symptom validity testing: a critical review. *The Clinical Neuropsychologist, 15*(1), 19–45.
Boone, K. (2013). *Clinical practice of forensic neuropsychology: an evidence-based approach*. New York: The Guilford.
Bosely, C., & Hennings, B. (2013). A proposed approach to the BVA's clarified hearing duties to explain and suggest pursuant to Bryant v. Shinseki. *Veterans Law Review, 5,* 164–200.
Bow, J., Flens, J., & Gould, J. (2010). MMPI-2 and MCMI-III in forensic evaluations: a survey of psychologists. *Journal of Forensic Psychology Practice, 10,* 37–52.
Carlson, K., Kehle, S., Meis, L., Greer, N., MacDonald, R., Rutks, I., … Wilt, T. (2011). Prevalence, assessment, and treatment of mild traumatic brain injury and posttraumatic stress disorder: a systematic review of the evidence. *Journal of Head Trauma Rehabilitation, 26*(2), 103–115.
Carone, D., Bush, S., & Iverson, G. (2013). Providing feedback on symptom validity, mental health, and treatment in mild traumatic brain injury. In D. A. Carone & S. S. Bush (Eds.), *Mild traumatic brain injury: symptom validity assessment and malingering* (pp. 101–118). New York: Springer.
Chafetz, M. (2011). The psychological consultative examination for social security disability. *Psychological Injury and Law, 4,* 235–887.
Chafetz, M., & Prentkowski, E. (2011). A case of malingering by proxy in a Social Security disability psychological consultative examination. *Applied Neuropsychology, 18*(2), 143–149.
Cooper, D., Nelson, L., Armistead-Jehle, P., & Bowles, A. (2011). Utility of the mild brain injury symptoms scale as a screening measure for symptom over-reporting in operation enduring freedom/operation Iraqi freedom service members with post-concussive complaints. *Archives of Clinical Neuropsychology, 26,* 718–827.
Dawes, R., Faust, D., & Meehl, P. (1989). Clinical versus actuarial judgment. *Science, 243,* 1668–1774.
DeClue, G. (2002). Feigning not equal malingering: a case study. *Behavioral Science and the Law, 20,* 717–726.
DeClue, G. (2011). Harry Potter and the structured interview of reported symptoms? *Open Access Journal of Forensic Psychology, 3,* 1–18.
Department of Veterans Affairs, Office of the Inspector General. (2005). *Review of state variances in VA disability compensation payments: report no. 05-00765-137*. Washington, DC: Department of Veterans Affairs.
Department of Veterans Affairs, Office of the Inspector General. (2012). *Semi-annual report to Congress*. Washington, DC: Department of Veterans Affairs. Issue 68.

Department of Veterans Affairs, Office of the Inspector General. (2013). *March 2013 Highlights*, downloaded May 1, 2013 from http://www.va.gov/oig/publications/other-reports.asp#highlights

Department of Veterans Affairs/Department of Defense. (2010). *VA/DoD clinical practice guideline for management of post traumatic stress disorder (PTSD)*. Washington, DC: Author

Frueh, B., Elhai, J., Gold, P., Monnier, J., Magruder, K., Keane, T., & Arana, G. (2003). Disability compensation seeking among veterans evaluated for posttraumatic stress disorder. *Psychiatric Services, 54,* 84–91.

Green, D., & Rosenfeld, B. (2011). Evaluating the gold standard: a review and meta-analysis of the structured interview of reported symptoms. *Psychological Assessment, 23,* 95–107.

Hanson, R. (2003). Objective decision making in Lonergan and Dworkin. *Boston College Law Review, 44*(3), 825–862.

Hawes, S., & Boccaccini, M. (2009). Detection of over reporting of psychopathology on the personality assessment inventory: a meta-analytic review. *Psychological Assessment, 21,* 112–124.

Heilbronner, R., Sweet, J., Morgan, J., Larrabee, G., Millis, S., & Participants, C. (2009). American Academy of Clinical Neuropsychology Consensus Conference statement on the neuropsychological assessment of effort, response bias, and malingering. *The Clinical Neuropsychologist, 23*(7), 1093–1129.

House Committee on Veterans Affairs. (2012). *Reclaiming the process: Examining the VBA claims transformation plan as a means to effectively serve our veteran: Hearings before the House Committee on Veterans Affairs*. 112th Congress (June 19, 2012) (testimony of Linda A. Halliday). Downloaded August 21, 2013 from http://www.va.gov/oig/publications/statements.asp

Iverson, G. (2006). Ethical issues associated with the assessment of exaggeration, poor effort, and malingering. *Applied Neuropsychology, 13*(2), 77–90.

Jackson, J., Sinnott, P., Marx, B., Murdoch, M., Sayer, N., Alverez, J., … Speroff, T. (2011). Variation in practices and attitudes of clinicians assessing PTSD-related disability among veterans. *Journal of Traumatic Stress, 24*(5), 609–613.

Judicial Review Act of 1988: Pub. L. No. 100-687, 102 Stat. 4105 (1988).

Lally, S. (2003). What tests are acceptable for use in forensic evaluations? A survey of experts. *Professional Psychology: Research and Practice, 4,* 491–498.

Larrabee, G. (2012). Performance validity and symptom validity in neuropsychological assessment. *Journal of the International Neuropsychological Society, 18,* 1–7.

Lonergan, B. (1972). *Method in theology*. New York: Seabury.

Lonergan, B. (1992). Insight: A study of human understanding. In F. Crowe & R. Doran (Eds.), *Collected works of Bernard Lonergan* (Vol. 3). Toronto: University of Toronto.

Marcel, G. (1956). *The philosophy of existentialism*. New Jersey: Citadel.

Marion, B., Sellbom, M., & Bagby, R. (2011). The detection of feigned psychiatric disorders using the MMPI-2-RF overreporting validity scales: an analog investigation. *Psychological Injury and Law, 4,* 1–12.

McGrath, R., Mitchell, M., Kim, B., & Hough, L. (2010). Evidence for response bias as a source of error variance in applied assessment. *Psychological Bulletin, 136*(3), 450–470.

McNally, R., & Frueh, B. (2013). Why are Iraq and Afghanistan war veterans seeking PTSD disability compensation at unprecedented rates? *Journal of Anxiety Disorders, 27,* 520–526.

Moering, R. (2011). Military service records: searching for the truth. *Psychological Injury and Law, 4,* 217–234.

Morel, K. (2010). *Differential diagnosis of malingering versus posttraumatic stress disorder: scientific rationale and objective scientific methods*. New York: Novinka Books.

Morey, L. (1996). *An interpretive guide to the personality assessment inventory*. Odessa: Psychological Assessment Resources.

Poyner, G. (2010). Psychological evaluations of veterans claiming PTSD disability with the Department of Veterans Affairs: a clinician's viewpoint. *Psychological Injury and Law, 3,* 130–132.

Principi, A. (2013, August 29). Wounded veterans deserve better. *The Wall Street Journal*, p. A15. Downloaded February 27, 2014 from http://online.wsj.com/news/articles/SB10001424127887324653004578652600179575338

Resnick, P. (1997). Malingering of posttraumatic stress disorders. In R. Rogers (Ed.), *Clinical assessment of malingering and deception* (2nd ed., pp. 130–152). New York: Guilford.

Ridgeway, J. (2012). Mind reading and the art of drafting medical questions in veterans benefits claims. *Psychological Injury and Law, 5,* 72–87.

Ridgway, J. (2011). The splendid isolation revisited: lessons from the history of veterans' benefits before judicial review. *Veterans Law Review, 3,* 135–219.

Riley, R. (2010). The importance of preserving the pro-claimant policy underlying the Veterans' Benefits Scheme: a comparative analysis of the administrative structure of the Department of Veterans Affairs Disability Benefits system. *Veterans Law Review, 2,* 1–40.

Rogers, R. (Ed.). (2012). *Clinical assessment of malingering and deception* (3rd ed.). New York: Guilford.

Rogers, R., Sewell, K., Morey, L., & Ustad, K. (1996). Detection of feigned mental disorders on the personality assessment inventory: a discriminant analysis. *Journal of Personality Assessment, 67,* 629–640.

Rogers, R., Sewell, K., Martin, M., & Vitacco, M. (2003). Detection of feigned mental disorders: a meta-analysis of the MMPI-2 and malingering. *Assessment, 10*(2), 160–177.

Rogers, R., Payne, J., Berry, D., & Granacher, R. (2009). Use of the SIRS in comparison cases: an examination of its validity and generalizability. *Law and Human Behavior, 33,* 213–224.

Rosen, G. (1995). The Aleutian Enterprise sinking and posttraumatic stress disorder: misdiagnosis in clinical and forensic settings. *Professional Psychology: Research and Practice, 17*(3), 205–222.

Rosen, G., & Taylor, S. (2007). Pseudo-PTSD. *Journal of Anxiety Disorders, 21,* 201–210.

Rubenzer, S. (2006). Malingering of psychiatric problems, brain damage, chronic pain, and controversial syndromes in a personal injury context. *Federation of Defense and Corporate Counsel Quarterly, 56*(4), 499–523.

Rubenzer, S. (2009). Post traumatic stress disorder: assessing response style and malingering. *Psychological Injury and Law, 2,* 114–142.

Rubenzer, S. (2010). Review of the Structured Interview of Reported Symptoms-2 (SIRS-2). *Open Access Journal of Forensic Psychology, 2,* 273–286.

Russo, A. (2012). Consistency of self reported memory functioning and symptom validity test performance of OEF/OIF veterans with positive VA comprehensive TBI evaluations. *Archives of Clinical Psychology, 27*(8), 840–848.

Russo, A. (2013). Ethical, legal and risk management considerations in the neuropsychological assessment of veterans. *Psychological Injury and Law, 6*(1), 21–30.

Sellbom, M., & Bagby, R. (2008). Response style in multiscale inventories. In R. Rogers (Ed.), *Clinical assessment of malingering and deception* (pp. 182–206). New York: Guilford.

Slick, D., Sherman, E., & Iverson, G. (1999). Diagnostic criteria for malingered neurocognitive dysfunction: proposed standards for clinical practice and research. *The Clinical Neuropsychologist, 13,* 545–561.

United States v. Roberts, 534 F.3d 560 (2008).

Veterans Benefits Administration. (2007). *Clinicians guide: compensation and pension*. Washington, DC: Department of Veterans Affairs.

Veterans Claims Assistance Act of 2000: Pub. L. 106–475 (2000).

Watson, P., McFall, M., McBrine, C., Schurr, P., Friedman, M., Keane, T., & Hamblin, J. (2002). *Best practice manual for posttraumatic stress disorder (PTSD) compensation and pension examinations*. Washington, DC: Department of Veterans Affairs.

Wygant, D., Sellbom, M., Gervais, R., Ben-Porath, Y., Stafford, K., Freeman, D., & Heilbronner, R. (2010). Further validation of the MMPI-2 and MMPI-2-RF response bias scale: findings from disability and criminal forensic settings. *Psychological Assessment, 22*(4), 745–756.