

## Post-Traumatic Stress Disorder (Combat)

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### DESCRIPTION OF THE DISORDER

#### *The Clinical Syndrome of PTSD*

In 1980, the American Psychiatric Association's (APA) *Diagnostic and Statistical Manual of Mental Disorder (DSM)* nosologic system formally defined and recognized the cluster of acute, and potentially chronic, symptoms often seen in victims of traumatic events (e.g., combat, sexual, and physical assault), naming this condition post-traumatic stress disorder (PTSD; APA, 1994). Since *DSM-IV* (APA, 1994), the disorder has been classified as an "anxiety" disorder and is defined by six basic criteria: (1) the historical antecedent of a traumatic event that involves both actual or threatened death or serious injury, and an intense response of fear, helplessness, or horror; (2) persistently re-experiencing the traumatic event through intrusive memories, dissociative flashbacks, recurrent distressing dreams, and/or psychological or physiological reactivity upon exposure to associated cues; (3) avoidance of stimuli associated with the event, or a numbing of general responsiveness, including efforts to avoid thoughts and feelings related to the trauma, efforts to avoid activities or situations that arouse recollections of the trauma, loss of interest in significant activities, social detachment, and/or reduced affect; (4) existence of persistent symptoms of increased arousal such as hypervigilance, sleep disturbance, irritability or outbursts of anger, impaired concentration, and/or exaggerated startle response; (5) duration of the disturbance for at least one month; (6) the pervasive effects of the disturbance causing clinically significant distress or impairment in social, occupational, or other important areas of functioning.

There also is emerging evidence of neurobiological markers (e.g., changes in the hypothalamic–pituitary–adrenal axis, noradrenergic, and serotonergic function) that differentiate PTSD from other affective and anxiety disorders (e.g., Bremner et al., 1999; Rasmusson et al., 2000; Southwick et al., 1999; Yehuda, Boissoneau, Lowery, & Giller, 1995); and data from studies examining psychophysiological responding support prominence of autonomic symptoms and heightened reactivity (Keane et al., 1998).

Complicating the syndrome is the fact that PTSD is typically accompanied by multiple comorbid Axis I and II disorders, including major depression, substance abuse, panic attacks, and psychotic symptoms (Hammer et al., 2000; Keane & Wolfe, 1990; Kilpatrick et al., 2000), poor quality of life (Zatzick et al., 1997), medical illness comorbidity (Schnurr, Spiro, & Paris, 2000; Wagner, Wolfe, Rostitsky, Proctor, & Erickson, 2000), and extreme social maladjustment (Frueh, Turner, Beidel, & Cahill, 2001; MacDonald, Chamberlain, Long, Nigdel, & Flett, 1999). In fact, it is notable that a majority (69%) of veterans evaluated within Veterans Affairs (VA) Medical Center PTSD clinics seek disability payments for their debilitating social and occupational impairment (Frueh, Gold, & de Arellano, 1997).

Finally, PTSD is highly prevalent throughout American society, including VA Medical Centers. Epidemiological estimates of PTSD put the current prevalence at 8–14% in the general population (APA, 1994; Kaplan, Sadock, & Greb, 1994; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995), with higher rates of current (up to 15%) and lifetime (up to 31%) prevalence for veterans exposed to war zone trauma (Card, 1987; Center for Disease Control, 1988; Kulka et al., 1990). Preliminary data from a recently funded VA project indicate that prevalence of PTSD among those treated within VA primary care clinics is 9–12% (Magruder et al., 2002). Other studies suggest that prevalence in VA primary care is even higher, at 20% (Hankin, Spiro, Miller, & Kazis, 1999). Among certain disadvantaged groups, history of trauma exposure and PTSD rates may be higher still (Mueser et al., 1998). For example, in an urban mental health center it was found that 94% of patients had a history of trauma exposure and 42% had diagnoses of PTSD (Switzer et al., 1999). In addition, PTSD is often chronic and many combat veterans still suffer severe symptoms from wars fought 30 (e.g., Vietnam) or 50 (World War II) years ago (Gold et al., 2000; Sutker, Winstead, Galina, & Allain, 1990). A striking example of this is that PTSD prevalence among World War II veterans remains high (12%) some 50 years after the combat has ended, with many veterans still suffering in their late 70s (Spiro, Schnurr, & Aldwin, 1994). Thus, it is evident that millions of traumatized Americans (veterans and civilians) suffer PTSD or symptoms characteristic of PTSD. Given that there are over 5 million surviving American veterans of foreign wars, the potential number of veterans currently with PTSD is well above the half million mark. The VA medical system carries the burden of providing mental health, medical, social, and disability services to a large number of persons with severe PTSD and other associated mental illnesses.

Taken together, data indicate that PTSD is a severe, chronic, and prevalent psychiatric disorder resulting in considerable emotional distress and social disruption. The full clinical syndrome of combat-related PTSD often presents as a complex clinical picture and constitutes a significant diagnostic and treatment challenge.

### *The VA Disability Evaluation Process*

Because it is important to consider the context within which diagnostic evaluations are conducted, some discussion of the VA disability evaluation process is germane to this chapter, as many veterans evaluated for PTSD are seeking disability at the time of their evaluation. People who suffer from severe mental illnesses often experience occupational impairment and related financial hardships (Drake et al., 1999; Kouzis & Eaton, 2000). Military veterans may apply for service-connected disability payments for any physical or psychiatric condition, including PTSD, that was initiated during or caused by their military service, and which impairs their ability to earn a living. There is a growing trend in the VA system for veterans to seek these funds. Recent data show that Gulf War veterans draw disability compensation at a much higher rate (16%) than veterans of any previous conflict, and almost twice the current rate (8.6%) of World War II veterans (*Wall Street Journal*, 1999). Furthermore, 69–94% of veterans seeking treatment for PTSD within the VA system apply for psychiatric disability (Fontana & Rosenheck, 1998; Frueh et al., 1997; Frueh, Smith, & Barker, 1996a).

In 1996 total compensation and pension expenditures for the VA were estimated to be just over \$18 billion, with 2.2 million of the surviving 25.4 million veterans (8.9%) receiving some level of service-connected disability benefits (Oboler, 2000). If granted, a rating of disability severity is made on a 0–100% basis. The relationship between disability payments and disability ratings (on 0–100% basis) is curvilinear, and many benefits (e.g., some medical/dental coverage) do not begin until a rating of 100% is awarded. Even veterans who are rated as 90% disabled stand to benefit significantly from an increase to 100%. When claims are denied, or only partially granted, veterans may appeal the decision an indefinite number of times. Such repeat claims outnumber original claims almost three to one and dominate the VA adjudication and appeals system. For veterans who are granted disability compensation there is a continuing disability review, usually every other year, to determine whether they remain eligible for disability payments. For many chronically ill veterans, the process of obtaining and maintaining disability payments is a protracted struggle. However, the financial incentives are significant. For example, in South Carolina, where per capita income is about \$17,000 before taxes (Bureau of Economic Analysis), a single veteran without dependents who was 100% service connected in 1999 received an annual tax-free income of \$23,868, in addition to other benefits. See review by Oboler (2000) for more description of the VA's disability evaluation process.

### *Symptom Reporting Patterns among Veterans*

One difficulty often faced in diagnostic evaluations for PTSD with veterans is that symptom reports often seem grossly unrealistic or inconsistent. Research studies consistently demonstrate that combat veterans evaluated for PTSD within the VA exhibit extreme and diffuse levels of psychopathology across instruments measuring different domains of mental illness, and extreme elevations on the validity scales of the Minnesota Multiphasic Personality Inventory-2 (MMPI-2) in

a "fake-bad" or overreporting direction (Fairbank, Keane, & Malloy, 1983; Frueh, Hammer, Cahill, Gold, & Hamlin, 2000). These validity scales (e.g., the *F-K* index) take advantage of the stereotypes held by many lay people who assume that serious mental illnesses involve a large number of bizarre symptoms, such that high scores indicate endorsement of items rarely endorsed by even the most severely mentally ill persons. Combat veterans also are prone to inflate their reports of combat exposure over time (Southwick, Morgan, Nicolaou, & Charney, 1997). This general reporting pattern significantly complicates accurate diagnostic decision-making and frequently casts doubt on the credibility of symptom reports (Frueh et al., 2000).

### *Compensation-Seeking and Symptom Reporting Patterns*

Some researchers have speculated that the phenomenon of apparent symptom overreporting may reflect motivation of veterans to present as severely disabled in order to obtain disability compensation (Atkinson, Henderson, Sparr, & Deale, 1982; Lees-Haley, 1989). Several studies have examined the influence of compensation-seeking status on symptom reporting patterns using self-report measures of psychopathology. Although results from two early studies were mixed (Jordan, Nunley, & Cook, 1992; Schneider, 1979), conclusions were limited by the manner in which compensation-seeking was defined and in how subjects were grouped for analyses. Two studies (Frueh et al., 1996a, 1997) examined this issue by differentiating veterans on the basis of financial incentive, such that veterans were classified into two groups at the time of evaluation. "Compensation-seeking" veterans were those currently seeking, or planning to seek, VA disability compensation or increases in existing disability payments for PTSD. "Non-compensation-seeking" veterans were those *not* intending to seek VA disability compensation for their symptoms of PTSD. The percentage of veterans classified as "compensation-seeking" in each of these two studies was identical (69%). Compensation-seeking veterans produced significantly more pathological scores on clinical measures and obtained much higher elevations on MMPI-2 validity scales (e.g., *F-K*) associated with symptom exaggeration and malingering than did "non-compensation-seeking" veterans. These results were obtained despite the fact that the two groups did not differ in frequency of PTSD diagnoses. Furthermore, differences on most indices exceeded effect sizes of 1.0, even when the effects of income, global assessment of functioning (GAF), and clinician-rated severity of PTSD were controlled for.

There also is evidence to suggest that the MMPI-2 validity scales can be used as a screening instrument to identify veterans who may be exaggerating their psychopathology in order to gain disability compensation. Specifically, while compensation-seeking was not statistically over-represented among veterans with *F-K* indices of  $\geq 13$  (Smith & Frueh, 1996), veterans with *F-K* indices of  $\geq 22$  were much more likely to be compensation-seeking, and scored much higher on self-report measures of psychopathology, despite having lower rates of PTSD diagnoses and similar rates of other comorbid diagnoses (Gold & Frueh, 1999). These data suggest that availability of disability benefits influences the way in

which veterans present their difficulties. This is consistent with evidence that individuals from other compensation-seeking populations (e.g., injury and pain litigants) also tend to overreport symptoms (Rothke et al., 1994).

### *Implications of Compensation-Seeking and Symptom Reporting Patterns*

The specter of disability payments and symptom overreporting patterns may complicate diagnostic decision-making regarding PTSD criteria and differential diagnosis. Experience suggests that many patients acknowledge using evaluations as a means of documenting, through clinicians' reports, psychiatric difficulties to bolster disability claims. It is important that clinicians in VA practice settings should expect that many veterans will present with unrealistic symptom pictures, but these should not necessarily be taken as evidence of malingering. In fact, in most cases with this population validity scale, elevations are more likely to be due to extreme psychological distress than feigning (Franklin, Repasky, Thompson, Shelton, & Uddo, 2002). If the MMPI-2 is used, traditional validity scale cut points ( $F-K > 12$ ) may not be appropriate. Instead, population specific cut points ( $F-K > 22$ ,  $F(p) > 8$ ) should be considered (Gold & Frueh, 1999). In addition, a new MMPI-2 validity scale offers promise for detecting those veterans who are distorting their symptom reports (Elhai et al., 2002). The Infrequency-Post-Traumatic Stress Disorder scale (*Fptsd*) was created from MMPI-2 items that were infrequently endorsed by nearly 1,000 PTSD-diagnosed male combat veterans presenting for treatment at VA Medical Center PTSD clinics. The validity of *Fptsd* has been preliminarily established, and it appears significantly less related to psychopathology and distress than previously established MMPI-2 validity scales among veterans evaluated for PTSD, while better at discriminating simulated from genuinely reported PTSD. On the other hand, careful follow-up evaluation of overreporting veterans is warranted, including careful examination of military documentation, structured interviews, behavioral assessments, and perhaps even psychophysiological assessment. In the sections that follow we describe the evaluation procedures and instruments in more detail, including case illustrations, information critical to making the diagnosis, and diagnostic assessment "Dos and Don'ts."

### PROCEDURES FOR GATHERING INFORMATION

There are a number of strategies for gathering relevant information in the diagnostic assessment of veterans with symptoms of PTSD. Perhaps more so than for most other psychiatric disorders, broadly based assessment strategies are needed to fully capture the complexity and severity of combat-related PTSD (Frueh et al., 2001). In the section that follows we provide an overview of the assessment modalities that have been used to evaluate combat veterans. In addition to a careful psychosocial history and Mental Status Exam, we recommend the following assessment strategies.

### Structured Interviews

The structured interview is the most frequently used assessment strategy for evaluating veterans. Interviews provide a strategy for assessing for a range of relevant experiences and symptoms. They allow the clinician to query the veteran (and sometimes collateral sources) about functioning across a number of relevant areas and to make clinical ratings based not only on patient report, but also on behavioral observations. They also allow for standardized assessment and generally offer known reliability and validity coefficients. Interviews also have one important limitation with regard to their application in the assessment of combat veterans: they may be vulnerable to the same type of negative reporting bias that affects self-report inventories in this population. This bias may be a result of the inherent retrospective nature of the assessment and the influence of a variety of other economic or systemic forces (e.g., disability compensation incentives). Structured interviews can be used to obtain information regarding lifetime exposure to traumatic experiences, PTSD symptoms, and other psychiatric symptoms. We will discuss structured interviews in more detail in the next section of this chapter.

### Self-Report Inventories

A number of general (e.g., MMPI-2) and specific self-report inventories are widely used in the assessment of combat-related PTSD. Examples of the latter include the *Mississippi Scale for Combat Related PTSD* (Keane, Caddell, & Taylor, 1988), *Impact of Event Scale* (Horowitz, Wilner, & Alvarez, 1979), and the *PTSD Checklist* (PCL; Blanchard, Jones, Buckley, & Forneris, 1996), which provide reliable and valid measures of PTSD symptoms and are highly correlated with diagnostic interviews for PTSD. Several other measures also exist. Objective psychometric inventories have a number of general strengths: they are usually easy to administer; do not require a great deal of time to score or interpret; allow for standardized assessment procedures across multiple patients and sites; allow for comparison of individual veterans to other veteran groups or clinical populations; offer known, and usually adequate, reliability and validity coefficients; and allow veterans to complete the testing procedures at their own pace and represent their affective experience without influence from examiners.

There are also several general drawbacks in the use of self-report inventories with this population. As noted earlier there is the widely demonstrated finding that combat veterans evaluated for PTSD tend to exhibit (1) extreme and diffuse levels of psychopathology across instruments measuring different domains of mental illness, and (2) extreme elevations on the validity scales of the MMPI-2 in a "fake-bad" or unrealistic direction (see Frueh et al., 2000). An additional limitation of self-report measures in general is that the consolidation of a number of items into one scale means that equivalent scores (by two different respondents) may be achieved for very different reasons. Scale scores on self-report inventories may call attention to a general domain, but more specific assessment of actual behaviors, antecedent situations, and the function of the behavior may be more

relevant information. Thus, the global assessment provided by self-report inventories may be helpful in identifying general domains of relative psychopathology, but more specific behavioral assessments are likely required to develop treatment plans aimed at targeting specific areas of concern. This also points toward the importance of examination of "critical items" in making interpretations of general scale scores.

### Psychophysiological Assessment

There is a wide body of literature demonstrating the utility of psychophysiological measures (e.g., heart rate, blood pressure) in the assessment of PTSD (e.g., Blanchard, Kolb, & Prins, 1991), and there is evidence suggesting that reduced physiological reactivity is associated with improvements in both PTSD symptoms and areas of social adjustment (Boudewyns & Hyer, 1990). The prominence of autonomic symptoms in combat veterans with PTSD has been consistently documented via studies of psychophysiological responding, which show clear evidence of heightened reactivity in combat veterans with PTSD (e.g., Keane et al., 1998). In these studies, standardized combat-related cues (e.g., combat sounds and pictures) or individually developed scripts are presented while physiological reactivity is measured via blood pressure, heart rate, forehead electromyogram (EMG), or galvanic skin response (GSR). Combat veterans with PTSD have significantly larger blood pressure and heart rate responses during traumatic cue exposure than do combat veterans without PTSD, although EMG and GSR have proven to be less reliable for purposes of differentiation (e.g., Orr et al., 1990). Sensitivity and specificity for the studies cited above ranged from 0.70 to 0.90 and 0.80 to 1.00, respectively. Furthermore, psychophysiological reactivity may provide relatively good discrimination even when individuals are attempting to evade relatively good discrimination even when individuals are attempting to exaggerate or disguise their responses (Gerardi, Blanchard, & Kolb, 1989). Thus, this assessment modality is less susceptible to the negative reporting bias (conscious or unconscious) potentially found with self-report measures.

### Patient Ratings

Obtaining daily patient ratings of relevant social behaviors, activities, and problems represents a strategy to collect data that is linked to specific and quantifiable behaviors and events. It has an inherent advantage because it is not retrospective in nature, and should not be vulnerable to the same biases that influence responding on more global self-report measures. It also provides data over a specified period of time (e.g., a week or month), rather than providing only cross-sectional data, as do self-report inventories and structured interviews. Patient ratings can also be developed for just about any behavior, and therefore can be tailored to an individual's needs. In other words, assessments are not limited to targets that are represented by nomothetically derived instruments. Furthermore, they can be expanded to include relevant antecedents, cognitions, and consequences of behaviors, so as to provide more information about symptoms and social functioning. Patient ratings have provided valuable information on

treatment outcome in several studies with veterans (e.g., Frueh, Turner, Beidel, Mirabella, & Jones, 1996b).

One limitation of patient ratings is that because of their nature and the period of time involved, they generally do not contribute much toward making initial diagnoses. An additional limitation of patient ratings is that they require patient compliance with a procedure that asks them to spend about 2–5 min a day making relevant ratings. Therefore, they do not provide immediate information, and are subject to the compliance of each individual patient. However, compliance may be encouraged by making sure that patients understand the rationale for the assessment and by establishing regular joint reviews of patient ratings with the clinician. Our experience is that patients are generally likely to comply with such procedures when they see that the results are actually incorporated into the development and implementation of ongoing treatment plans. In this way, the role of the procedure is complicated because it may serve as both an assessment tool and part of an intervention when used during the course of treatment.

### *Behavioral Assessments*

Behavioral assessment can be multifaceted, including a variety of other strategies, and may be used to evaluate both psychiatric symptoms and social functioning along the full range of difficulties associated with the clinical syndrome of combat-related PTSD. One strategy requires patients to respond to a variety of role-played social situations while the clinician makes ratings on the quality of social skills exhibited across a number of potentially problematic situations (e.g., expression of disapproval or criticism, assertiveness, confrontation and anger expression, receiving compliments). Although this does not provide information about how well or how often an individual uses appropriate social behaviors outside of the clinic setting, it does allow for assessment of an individual's repertoire of social behaviors (e.g., skill deficits and strengths). A functional analysis conducted with veterans and/or collateral others can provide valuable information regarding specific symptoms and problem areas. These strategies may require more time and resources than are available for most clinical evaluations, and they do not provide a good diagnostic aid, but they can serve as a valuable basis for the development of behavioral treatment plans to address other specific symptoms and problem areas.

### *Summary*

Given the complexities of assessment with combat veterans evaluated for PTSD (e.g., symptom overreporting, symptom severity), clinicians should not rely only on self-report measures because they may be the most vulnerable to negative reporting biases. Furthermore, because the syndrome of PTSD in veterans comprises a complex set of multidimensional domains, it seems improbable that any single measure will be sufficient to provide a comprehensive evaluation. Thus, an array of different assessment strategies, including behavioral measures, may be necessary. Where resources permit, comprehensive assessment of this population

should consist of a multi-method approach, including structured interviews and self-report measures. Other assessment strategies, such as psychophysiological assessment, patient ratings, and behavioral assessments, may prove helpful to address specific questions. Clinicians might consider relying on the "funnel" metaphor of assessment (see Hawkins, 1979): the global assessment provided by structured interviews and self-report inventories may be helpful in identifying general domains of relative psychopathology and interpersonal maladjustment, but more specific functional (behavioral) assessments and patient ratings are then necessary to identify specific behaviors, antecedents, and functions of the behaviors.

### CASE ILLUSTRATION

"Mr. Smith" is a 52-year-old African-American male, who was referred for evaluation by his primary care physician after the patient revealed during a routine physical examination that he frequently suffered from combat-related nightmares and difficulty sleeping. With no previous psychiatric treatment history, this evaluation was the first time he ever met with a mental health professional. The evaluation procedures included a psychosocial history interview, two trauma interviews (Combat Exposure Scale, Trauma Assessment for Adults), psychiatric interviews (Structured Clinical Interview for DSM-IV [SCID], Clinical-Administered PTSD Scale [CAPS]), and self-report instruments (MMPI-2, Mississippi PTSD Scale, Beck Depression Inventory [BDI]). Also, his VA medical record and military Form DD-214 were reviewed, with additional information elicited from his wife, Mrs. Smith, who accompanied him to this appointment.

At the time of his evaluation, Mr. Smith reported living with his wife and two teenage children in the quiet suburbs of a medium-sized metropolitan city. He reported being married to his wife for the past 20 years. The veteran stated that while he gets along with his wife and children, most of the time "I just want them to leave me alone." When asked about his family of origin, Mr. Smith stated that he was close to his family when growing up, but does not talk to his family members often now.

In terms of education, Mr. Smith reported attaining a college education after serving in the military, majoring in accounting. He has had his own accounting firm for 15 years, where he currently works full-time. He employs several secretaries and additional accountants, with whom he does not associate, preferring to work alone in his office with the door closed. However, he often stares into space in his office, without accomplishing the work he had set out to do. A veteran friend of his talked Mr. Smith into applying for PTSD-related disability compensation. Although Mr. Smith claimed that he does not feel like he needs disability compensation (and does not know enough about PTSD to know if he has it), he reported that sometimes his decreased work productivity makes him think that perhaps he should apply.

Mr. Smith indicated that he received basic training at Ft. Jackson, South Carolina, and later received advanced infantry training. He was shipped to Vietnam in 1968 and served a 1-year tour of duty in the Army, after which he served in the Army reserves in the United States for an additional year. Although much of his Vietnam tour was uneventful, the patient's time there was significant for specific incidents of combat exposure. Serving during a time of numerous enemy attacks in South Vietnam, known as the "Tet Offensive," he reported going on several combat patrols, and receiving incoming enemy fire on a number of occasions. The patient alleged that several men in his platoon were killed in action,

and in one case, one of the men died within 5 feet of the patient. Mr. Smith also reported receiving enemy and sniper fire on a few occasions, and witnessed a truck within his combat convoy hit a land mine, with a man sustaining serious injuries. Mr. Smith further stated that as a result of these traumatic events, he became extremely fearful during his tour of duty in Vietnam. Review of his Form DD214 supported his self-reported military history. He denied other lifetime trauma exposure.

After returning from Vietnam, Mr. Smith started drinking 4–7 cans of beer every night. His alcohol use did not appear to get in the way of his work but seemed to interfere at times with his relationship with his family, with repeated familial attempts to get him to stop drinking. About one year ago, his physician told him that continuing to drink would be detrimental to his health, since he recently developed adult-onset diabetes. It was at this time, when he decreased his alcohol use, that his symptoms of nightmares, sleep disturbance, and social withdrawal became much worse.

Based on the CAPS interview, Mr. Smith appears to suffer from numerous symptoms of PTSD. He reported several reexperiencing symptoms, including experiencing unwanted memories of his traumatic experiences from Vietnam on a weekly basis. On rare occasions, these unwanted memories felt so vivid that to some extent Mr. Smith lost touch with his current surroundings. The veteran's nightmares of Vietnam reportedly happened several nights per week, after which he would not be able to return to bed for 1–2 hr, impairing his sleep schedule and increasing his fatigue during the day. Numerous environmental cues similar to those from Vietnam, including the sounds of helicopters, driving by the beach, and viewing news reports about the U.S. war on terrorism, remind Mr. Smith of his traumatic events and trigger psychological and physical distress several times a month.

Mr. Smith also claimed to suffer from a variety of avoidance/numbing PTSD symptoms. For example, he routinely attempts to avoid thinking about the traumatic events he experienced and often goes out of his way to avoid activities that might remind him of Vietnam (i.e., the beach, the evening TV news, etc.). While he used to enjoy numerous sports and hobbies and spending time with friends and relatives, he now prefers to be alone most of the time, lacking enjoyment in any work or recreational activities. As implied earlier, the patient feels strongly cut off from most people in his life. He also acknowledged feeling emotionally empty, without currently experiencing any intense emotions like love, happiness, or pleasure. For example, he reported feeling unemotional at the recent funeral of a close friend, and reported feeling "flat" at his own birthday party earlier in the year.

Symptoms of hyperarousal were also present for the veteran. He acknowledged spending a large amount of time trying to safeguard his family and home, by routinely inspecting all doors and windows. Most of the time Mr. Smith avoids crowds, and in rare instances when he is forced to be in a crowd, he always positions himself so that he has a good view without blind spots, feeling more protected this way. When a loud noise or something unexpected (i.e., a car backfiring) occurs outside of his home or workplace, he becomes "jumpy" and remains anxious for several hours afterward.

Results from the SCID indicate that Mr. Smith also suffers from Major Depressive Disorder. Specifically, in the past year, he has become more depressed, feeling tired much of the time, with trouble concentrating, decreased appetite, and fleeting thoughts of suicide. Although some of these symptoms conceptually overlap with PTSD, it appears that Mr. Smith meets criteria for both disorders. He also meets criteria for alcohol abuse in partial remission.

Interestingly, a number of Mr. Smith's symptoms may appear to be psychotic in nature. For example, his hypervigilance in crowds may seem like paranoia. His vivid reexperiencing ("flashbacks") resembles visual hallucinations seen in psychotic-disordered individuals. Additionally, his avoidance of people and emotional numbness could be confused with

the negative symptoms of schizophrenia. However, these psychotic-like symptoms are often found in PTSD patients, and it was decided that these symptoms better reflect PTSD symptoms than psychotic experiences. This differential diagnostic decision was based on the qualitative nature of these symptom reports and the finding that he did not display gross impairment in reality testing. For example, his unusual perceptual experiences were virtually all related to combat-related images/sounds, and he easily recognized that they were fleeting "nightmares" or "flashbacks."

Mr. Smith's MMPI-2 was interpreted to be valid and suggested that he is in significant distress. In fact, his *L* and *K* scores were below a *T* score of 45, with an *F* score of about 95. Although an *F* score of that magnitude is often seen in individuals overreporting their psychiatric symptoms, it is quite typical of highly distressed PTSD patients; furthermore, his *F-K* index was well below 22, and neither his *F(p)* or *Fptsd* scales were elevated. Thus, he was considered to be responding in a relatively open and honest manner. His highest clinical scale scores were on scales 2 and 8, with additional elevations on scales 6 and 7, overall indicating significant levels of depression, thinking and concentration problems, as well as suspiciousness and sensitivity, anxiety and rumination. The MMPI-2's PTSD scales were also very elevated. Similarly, his Mississippi PTSD scale score of 115 suggests significant combat-related PTSD symptomatology. His BDI score of 38 is further evidence of his depressive symptoms. Overall, this profile on self-report measures is typical of those seen in combat veterans with severe PTSD.

Mr. Smith's wife corroborated her husband's report of difficulties. She acknowledged that he had appeared to be sad and withdrawn, especially in the past year or so. She has awakened at night several times, to find her husband throwing punches in the air while asleep, not being able to return to sleep afterward. Because Mr. Smith has insisted on avoiding social activities, Mrs. Smith has felt more and more isolated from her friends and family members.

In terms of behavioral observations, Mr. Smith was well groomed and cooperative with the evaluation. He positioned his chair in a corner of the office, reportedly not wanting anyone or anything to surprise him from behind. He made occasional eye contact with the examiner, but slightly less than what would be considered appropriate. At first, he seemed somewhat uncomfortable and reluctant to talk about his emotional problems. Through the course of the evaluation, however, he seemed to warm up to the examiner. Mr. Smith became very anxious and tearful at times when discussing traumatic experiences from the war, seeming to try hard to push back his tears.

In combination, the data described above were used to assign diagnoses of PTSD and Major Depression and to begin appropriate treatment planning with Mr. Smith.

## STANDARDIZED INTERVIEW FORMATS

Relevant standardized interview formats for evaluating veterans for combat-related PTSD fall into three general categories, including interviews that assess for (1) trauma exposure, (2) PTSD symptoms, and (3) other psychiatric conditions. We will address each of these categories, with most emphasis on the first two since the latter is discussed in great detail elsewhere.

### Trauma Exposure

Prior to conducting an assessment of PTSD symptoms per se, it is important to establish that a history of traumatic exposure is present (e.g., Criterion A for a

DSM-based diagnosis of PTSD). In fact, it is worth noting that PTSD is the only psychiatric disorder with a historical antecedent (i.e., trauma) included in the formal diagnostic criteria. We recommend using separate interviews to assess general lifetime traumatic experiences and level of combat exposure. The former is important because research shows that many combat veterans with PTSD also endorse childhood histories of abuse, as well as histories of violent behaviors and victimization after their combat experiences (Smith, Frueh, Sawchuck, & Johnson, 1999); the latter is important for gaining a more thorough understanding of each veteran's combat experiences.

*Trauma Assessment for Adults—Interview Version* (Resnick et al., 1996). This 17-item instrument assesses for lifetime history of traumatic events, including combat experiences, physical abuse and assault, sexual assault, homicide of a close friend or family member, natural disaster, serious accidents, exposure to health threatening chemicals, witnessing someone being seriously injured or killed, and other situations that involved fear of being killed or seriously injured, or in which serious injury did take place. Age of first and most recent occurrence is determined for multiple incidents of a given type, and follow-up questions are included to assess perceived life threat. This instrument has been demonstrated to have strong psychometric properties and has been widely used in clinical practice and research on trauma exposure in adults (Resnick, 1996).

Other reliable and valid measures for assessing lifetime trauma history exist; including the *Trauma History Questionnaire* (Green, 1995) and the *Revised Conflict Tactics Scale* (Straus et al., 1996); and the *Childhood Trauma Questionnaire* (Bernstein et al., 1994) may be administered to adults in order to learn about childhood abuse and neglect (Sher, Stein, Asmundson, McCreary, & Forde, 2001). Each measure uses behaviorally specific language to elicit traumatic experiences and yields other relevant information about traumatic experiences, such as number of events, ages of event occurrence, and physical injuries that may have occurred.

*Combat Exposure Scale* (CES; Keane et al., 1989). The CES is a seven-item self-report questionnaire measuring the extent of exposure to military combat-related traumatic events. The CES takes approximately 5 min to administer, and was developed for use in psychiatric settings. Good internal consistency (0.85), and excellent test-retest reliability (0.97) have been reported for the CES by its authors.

There is evidence that veterans may fabricate their military history or reports of combat exposure with some regularity (Burkett & Whitley, 1998; McGrath & Frueh, 2002), and there is evidence that many veterans' reports of combat exposure become exaggerated over time (Southwick et al., 1997). Therefore, in addition to administering the CES, it is also important to obtain objective documentation of veterans' military service and experiences by reviewing their Form DD214. This form is a one-page summary that all military veterans receive at discharge. Although it is not a comprehensive description of their activities or overseas duty postings, and it may be easily forged, it does provide a starting point for verification of military service, era served, and medals received. Because this is an important document necessary to obtain many veteran benefits, be skeptical of any veteran who claims not to have his/her copy of Form DD214, or who claims that his combat experiences are not evident or cannot be reported because they were

"classified" (Burkett & Whitley, 1998). In the rare instances where this happens or where other doubts persist, additional investigation is warranted before proceeding with evaluation or treatment. Clinicians may request to review the veteran's VA "C-File," and supporting military documentation can be received through the National Personnel Records Center via the Freedom of Information Act by writing National Personnel Records Center, Army (Air Force or Navy) Records Center, 9700 Page Boulevard, St. Louis, MO, 63132, or by visiting <http://www.usdoj.gov/04foia/index.html>.

### *Post-Traumatic Stress Disorder*

*CAPS* (Blake et al., 1990; Weathers & Litz, 1994; Weathers, Ruscio, & Keane, 1999). The CAPS is a 17-item structured interview that assesses both frequency and intensity of PTSD symptoms according to *DSM-IV* (APA, 1994) criteria. It provides both a dichotomous index for PTSD diagnosis and a continuous index of PTSD symptom severity. The scale has been shown to have robust psychometric properties, including strong interrater reliability (0.92–0.99), high internal consistency (0.73–0.85), and high convergent validity (Weathers & Litz, 1994; Weathers, Keane, & Davidson, 2001). It is a highly regarded instrument because it provides information on both symptom intensity and frequency, has clear behavioral anchors, and possesses excellent psychometric properties. An additional strength of the CAPS is that it is widely used throughout VA Medical Centers and Vet Centers across the country, and a VA-sponsored CD-ROM instructional program is available at most VA facilities to help train interviewers. Therefore, it has been the subject of rigorous research and is considered by many to be the gold-standard instrument for making a diagnostic decision regarding PTSD among combat veterans (Weathers et al., 2001).

Although the instrument does not include standardized or objective items for assessing malingering or symptom overreporting, each item does include a space for circling "QV" for "questionable validity." Interviewers are encouraged to probe for detailed descriptions of symptoms, to look for inconsistencies or unlikely descriptions of symptom reports, and to incorporate behavioral observations into their ratings. In other words, interviewers are required to use some degree of clinical judgment in making symptom ratings and to note those instances for which they suspect symptom reports are of questionable validity. Thus, clinicians should look for congruence between symptom reports of exaggerated startle response and behavioral reactions to loud, sudden noises (e.g., do they "jump" when a door slams?); reports of cued reactivity and affective response to discussing traumatic events (e.g., do they appear anxious, distressed, or avoidant when recounting combat experiences?); claims of hypervigilance and comfort with the interview situation (e.g., do they sit easily with their back to the door, or do they reposition the chair?); descriptions of flat affect and observable behavioral evidence (e.g., do they appear animated and interested vs. flat and detached?); and many other possibilities.

While the CAPS is probably the most widely used interview for combat-related PTSD in both clinical settings and research studies, there are other

structured interviews for PTSD. These include: the *Structured Interview for PTSD* (Davidson, Malik, & Travers, 1997), *PTSD Symptom Scale Interview* (Foa, Riggs, Dancu, & Rothbaum, 1993), and the PTSD modules of comprehensive psychiatric interviews such as the SCID (Spitzer, Williams, Gibbon, & First, 1997), *Diagnostic Interview Schedule* (Robins, Helzer, Croughan, & Ratliff, 1981), *Mini-International Neuropsychiatric Interview* (MINI; Sheehan et al., 1998), and *Anxiety Disorders Interview Schedule—Revised* (DiNardo, Moras, Barlow, Rapee, & Brown, 1993) among others. All of these measures have shown reasonably good psychometric properties and have features to recommend their use (see comprehensive review by Newman, Kaloupek, & Keane, 1996).

### Other Psychiatric Conditions

Because virtually all combat veterans with PTSD are expected to have other concurrent psychiatric disorders (Keane & Wolfe, 1990) it is important to conduct a thorough assessment of other psychiatric conditions. A number of reliable and valid structured interviews currently exist for making Axis I psychiatric diagnoses. The most widely used of all these is probably the SCID (Spitzer, Williams, Gibbon, & First, 1997). The SCID is a comprehensive, highly structured psychiatric interview that generally takes between 45 min and 2 hr to administer, depending on the number and nature of symptoms endorsed. It uses decision tree logic to assess the major adult Axis I disorders in *DSM-IV* and ICD-10. It has been demonstrated to have good psychometric properties in the evaluation of persons with serious mental illness. Another psychometrically strong measure is the MINI (Sheehan et al., 1998). Similar in structure and psychometric properties to the SCID, the MINI is an abbreviated interview that takes approximately 10–30 min to complete. It elicits all the symptoms listed in the symptom criteria for *DSM-IV* and ICD-10 for 15 major Axis I categories, and one Axis II disorder. Part of its appeal is that it can be administered in a relatively brief period of time and requires less training than the SCID. Both of these measures have been widely used with combat veterans evaluated for PTSD.

In addition to diagnosing Axis I disorders apart from PTSD, it may be helpful to evaluate a number of other related psychiatric dimensions. The *Structured Clinical Interview for DSM-IV Axis II: Personality Disorders* (First, Gibbon, Spitzer, Williams, & Benjamin, 1997) is a useful, reliable, and valid measure for making diagnostic decisions regarding Axis II personality disorders. To further evaluate symptom severity among relevant identified domains we recommend: the *Hamilton Rating Scales for Anxiety and Depression* (Hamilton, 1959) for assessing severity of anxiety and depressive symptoms, the *Positive and Negative Syndrome Scale* for schizophrenia (PANSS; Kay, Fiszbein, & Opler, 1987) for measuring severity of psychotic features, and the *Addiction Severity Index* (ASI; McLellan, Luborsky, Woody, & O'Brien, 1980) for measuring substance abuse and dependence variables. Additionally, the *Clinical Global Impressions Scale* (CGI; Guy, 1976) provides Severity and Global Improvement Subscales to measure overall severity of psychiatric illness and then improvement over time. These are 7-point scales, which are part of the ECDEU Assessment Manual for Psychopharmacology.

### PTSD (COMBAT)

This is not intended to be a complete list of instruments, and other excellent measures exist for assessing domains of psychopathology relevant to PTSD in combat veterans.

### INFORMATION CRITICAL TO MAKING THE DIAGNOSIS

According to the APA's DSM nosologic system, six categories of experiences or symptom clusters are required in order to make a formal diagnosis of PTSD (APA, 1994). In addition, there are other pieces of clinical information that are critical to making accurate diagnoses among combat veterans. In combination, these are:

1. *Establishing the historical antecedent of a traumatic event (Criterion A).* This is best accomplished through structured trauma interviews and review of military documents (e.g., Form DD214) to verify combat exposure reports.

2. *Evaluating frequency and severity of "reexperiencing" symptoms, such as intrusive memories, dissociative episodes, nightmares, and cued reactivity to trauma cues (Criterion B).* This is best accomplished through structured interviews (e.g., CAPS), with supporting evidence from self-report measures (e.g., Mississippi Scale, PCL). Interviews with collateral others, patients ratings, and behavioral assessments may also provide valuable information.

3. *Evaluating "avoidance" and "numbing" symptoms, including avoidance of stimuli thoughts/feelings/activities associated with the trauma, numbing of general responsiveness, loss of interest in significant activities, social detachment, and/or reduced affect (Criterion C).* This is best accomplished through structured interviews (e.g., CAPS), with supporting evidence from self-report measures (e.g., Mississippi Scale, PCL). Interviews with collateral others, patients ratings, and behavioral assessments may also provide valuable information.

4. *Evaluating the "arousal" symptoms, including hypervigilance, sleep disturbance, irritability or outbursts of anger, impaired concentration, and/or exaggerated startle response (Criterion D).* This is best accomplished through structured interviews (e.g., CAPS), with supporting evidence from self-report measures (e.g., Mississippi Scale, PCL). Psychophysiological assessment, interviews with collateral others, patients ratings, and behavioral assessments may also provide valuable information.

5. *Evaluating whether the duration of the disturbance exceeds one month (Criterion E).* This is best accomplished not only by the patient's self-report but also by the report of collateral others.

6. *Determining whether the trauma-related symptoms cause significant distress or impairment in social, occupational, or other important areas of functioning (Criterion F).* This is best accomplished through structured interviews (e.g., CAPS, SCID, MINI), clinical ratings (e.g., CGI, Hamilton Rating Scales), review of psychosocial history (e.g., employment and marital status, history of legal involvement), and self-report measures that assess other domains (e.g., MMPI-2, BDI). Interviews with collateral others, patients ratings, and behavioral assessments may also provide valuable information.



7. *Determining the nature and severity of psychiatric symptoms for other concurrent Axis I and II disorders.* This is best accomplished through general structured psychiatric interviews (e.g., SCID, MIND), clinical ratings (e.g., CGI, Hamilton Rating Scales, PANSS, ASI), and self-report measures that assess other domains (e.g., MMPI-2, Beck Inventories).

8. *Determining the authenticity of the trauma and symptom reports.* Use of MMPI-2 validity scales can provide a useful screening instrument for detecting exaggerated or feigned symptom reports. Structured interviews, psychophysiological assessment, and review of military and VA records (e.g., Form DD214, VA C-file) should provide information valuable to making this evaluation.

## DOS AND DON'TS

*Do:* Conduct a thorough assessment of each veteran's trauma history, symptoms of PTSD, and symptoms of other concurrent Axis I and II features. Careful diagnostic assessment will be an invaluable guide to treatment planning and will help lay the foundation for building a therapeutic alliance. Veterans are often pleasantly surprised and appreciative when clinicians demonstrate their understanding and expertise by "asking the right questions." Although initially time-consuming, this careful assessment will pay enormous dividends in the long run by helping to target appropriate clinical interventions. It will also help to provide strong documentation, via reports filed in VA medical records, of veterans' difficulties, which may head-off later requests for assessment related to veterans' disability claims.

*Don't:* Do not overwhelm veterans with an assessment process that is so lengthy or tedious that it pushes them away from treatment. We have found it helpful to break the assessment process up into two or three sessions of several hours each. Typically we ask veterans to complete self-report instruments (e.g., MMPI-2) on a separate occasion from the psychiatric interviews. When doing this it is important to schedule all sessions within a fairly short window of time (e.g., 1–3 weeks) so that veterans do not become impatient or frustrated with this process.

*Do:* Provide a careful explanation for the purpose of the evaluation. Many veterans are mistrustful of the VA and/or impatient with regard to receiving clinical services. Therefore, it is important that they understand the need for such careful (and potentially time-consuming) evaluation procedures. If they understand that the assessment is critical to develop the most appropriate treatment plan and to accurately document their psychiatric difficulties in the medical record, they are usually willing to cooperate fully with the assessment procedures. *Don't:* Be apologetic about the assessment procedures or create the impression that they are just part of the VA's bureaucratic "red tape" that must be endured prior to receiving clinical services.

*Do:* Do reassure veterans that they can exercise control of the interview procedures and may stop or pause the interviews whenever they choose.

*Don't:* Allow veterans to bully you or other staff, "bend" clinic rules, or circumvent routine evaluation procedures in such a way that they gain special or

preferential treatment not accorded to other veterans. To maximize the therapeutic alliance it will be important to set firm boundaries with patients from the outset.

*Do:* Inquire about veterans' disability status and disability-seeking plans. This provides important contextual information for interpreting results of evaluation procedures. We recommend that the following questions be asked via a self-report questionnaire: (1) Do you currently have a VA service-connected disability? (2) If so, for what conditions and at what percent? (3) Do you currently have any disability claims or appeals pending with the VA? (4) If so, for what conditions? (5) Do you plan to file any disability claims or appeals in the near future? (6) If so, for what conditions? These questions can be embedded in a self-report instrument that includes other types of relevant questions (e.g., employment and legal status).

*Don't:* Assume that just because a veteran is seeking VA disability compensation for PTSD that s/he is an unreliable historian or prone to exaggerate or feign psychopathology. In fact, most (e.g., approximately 70%) veterans seeking treatment for PTSD also seek disability. Therefore, it is important to use such information cautiously.

*Do:* Exhibit sensitivity during the trauma interview. For persons with PTSD, this may be an extremely difficult, anxiety-provoking aspect of the evaluation. Thus, it is important to conduct element with the utmost sensitivity and care. Be prepared for some veterans to respond with tears, agitation, anger, physiological symptoms, or other signs of extreme anxiety. In some cases it may be necessary to give veterans breaks or pauses to recollect their composure; certainly they should be reassured that they are in control of the interview and can stop it or pause it whenever they choose to.

*Don't:* Do not be apologetic about this aspect of the evaluation or assume that veterans will be unable to tolerate it. In other words, don't send any signals regarding demand characteristics about how you expect a patient to react. It is best to be "matter-of-fact" and straightforward, providing a brief introduction and rationale before proceeding with the interview.

*Do:* Make an effort to obtain all relevant details about each veteran's lifetime trauma history.

*Don't:* Do not pressure or coerce veterans into revealing all details about their trauma history, especially at this early stage of their engagement in treatment. In fact, upon occasion it may be clinically indicated to discontinue a trauma interview altogether once the presence of Criterion A events has been established and move on to other aspects of the evaluation. It is not necessary to obtain all details in order to establish whether an individual meets DSM criteria. Furthermore, inquiring about the specific details, such as thoughts, feelings, and reactions that accompanied traumatic events, that may be important for treatment can be conducted at a later stage when trust and rapport have had a chance to develop.

*Do:* Conduct diagnostic assessments via a multidisciplinary effort. Most specialty PTSD clinics in VA Medical Centers consist of some combination of psychiatrists, psychologists, social workers, and/or nurses. Each of these disciplines has expertise to offer and using a team approach to evaluations offers several benefits, including allowing diagnostic decisions to be made by a consensus of expert opinion and setting the stage for multidisciplinary treatment efforts.

*Don't:* Do not overwhelm veterans with an assessment process that is redundant. It is important to approach each evaluation with a well-coordinated plan about who will do what. Specifically, do not have two interviewers conducting identical or similar interviews on the same content area.

*Do:* Collect, review, and integrate data from sources other than structured psychiatric interviews, such as appropriate self-report questionnaires (e.g., MMPI-2, Mississippi Scale for PTSD, BDI), psychophysiological assessment (e.g., pulse and heart rate reactivity to trauma cues), collateral-other reports, and behavioral assessments. Data from these other sources may prove especially helpful in cases where there is conflicting or ambiguous evidence, or in cases of suspected symptom exaggeration or malingering.

*Don't:* Do not overwhelm veterans with an assessment process that is unnecessarily complicated. We recommend using a relatively concise set of standard evaluation instruments and procedures to be used with all patients, reserving other specific measures for addressing specific questions on a case-by-case basis. For example, psychophysiological assessment is probably not feasible or necessary for all evaluations. However, because it is not susceptible to faking, in cases of suspected malingering, it may prove extremely useful to address the specific question of whether the symptom of cued reactivity is present.

*Do:* Use the MMPI-2 appropriately to provide additional data regarding personality features, symptom acuity, and evaluation response set or style. In particular, the MMPI-2 can serve as a screening measure for symptom exaggeration or malingering, so long as population-specific cutoffs are used, rather than traditional cutoffs. For example, rather than using an  $F-K$  index score of  $\geq 12$ , we recommend a cutoff of  $\geq 22$ ; for the  $F(p)$  scale a score of  $\geq 8$ . When exceeded, this screening cutoff score should indicate the need for additional focused evaluation (e.g., psychophysiological assessment) to rule out malingering.

*Don't:* Do not rely on the MMPI-2 as a diagnostic tool, and do not use the MMPI-2 alone to make diagnoses of malingering. Furthermore, do not rely on traditional MMPI-2 validity scale cutoffs for invalid responding, as these scales have proven to be highly vulnerable to genuine psychological distress in this population.

*Do:* Provide patients with thoughtful feedback regarding the results of their evaluation. It is important to be straightforward and honest with this information. This provides patients important information about themselves, sends the message that the evaluation results have been carefully considered and constitutes an important element of clinical care, helps with treatment planning, and may assist in establishing a therapeutic alliance. If a multidisciplinary team conducted the evaluation, it may prove valuable to provide patient feedback with the entire team present.

*Don't:* Do not provide feedback to veterans using too much technical jargon or professional terminology. While in most cases it is important to provide the specific DSM diagnoses, it is also important to focus on describing these in ways that patients can understand and allowing them to ask questions about anything they do not understand.

*Do:* Write careful and thoughtful reports that integrate all evaluation data. Be sure to remember that these reports are likely to be used by the veteran as supporting documentation in VA disability claims rulings; remember also that

veterans served within the VA system have the right to review documents in their medical record, and most will eventually read their reports.

*Don't:* Do not write anything in your reports that you will not feel comfortable explaining or discussing with the patient concerned.

*Do:* Use diagnostic assessments and all data from the evaluation procedures as a foundation for treatment planning. This information should have clear implications for developing and implementing appropriate interventions. The evaluation and feedback process should serve as a stage of treatment in such a way that patients perceive subsequent interventions as logical extensions of the assessment.

*Don't:* Do not neglect to implement targeted evaluation strategies throughout treatment to help measure therapeutic progress and fine-tune treatment approaches.

## SUMMARY

The clinical syndrome of combat-related PTSD is a severe, chronic, and prevalent psychiatric disorder resulting in considerable emotional distress and social disruption, and often constitutes a significant diagnostic challenge. Studies consistently demonstrate that combat veterans evaluated for PTSD within the VA exhibit extreme and diffuse levels of psychopathology across different domains of mental illness, and extreme elevations on validity scales of the MMPI-2 in a "fake-bad" or overreporting direction. This overreporting response style may be at least partially caused by the specter of disability payments, which many veterans apply for. Furthermore, exaggeration of symptom reports obviously complicates diagnostic decision-making regarding PTSD criteria, differential diagnosis, and development of appropriate treatment plans. There are a number of strategies for gathering relevant information in the diagnostic assessment of veterans with symptoms of PTSD, including structured interviews, self-report measures, psychophysiological assessment, patient ratings, and behavioral assessments. In particular, structured interviews are crucial for making accurate diagnoses, and should include interviews to evaluate lifetime and combat trauma history, PTSD symptoms according to DSM criteria (e.g., CAPS), and symptoms of other psychiatric conditions. Throughout this chapter we discuss a number of assessment strategies for reducing susceptibility to malingering and symptom overreporting. In addition, we present a case illustration, list information critical to making the diagnosis, and address assessment "Dos and Don'ts" to provide a thorough picture of the diagnostic assessment of PTSD among combat veterans.

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