The Military Mental Health Disability System

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Overview of the Mental Health Disability System

The system for determining mental health disability and compensation for service members is termed the Integrated Disability Evaluation System (IDES), combining Department of Defense and Veterans Affairs (VA) processes. The IDES process can vary between service branches but always includes treatment, Medical Evaluation Board (MEB), Physical Evaluation Board (PEB), and, potentially, transitioning out of the military. This process is resource intensive as well as a significant source of stress for service members, in part because it typically takes 6 months or longer. However, that period of time is spent in service, which is the reason the IDES was created (i.e., to address concerns about disabled veterans being separated but then being delayed for long periods of time before receiving VA benefits). For veterans who are no longer serving, disability claims are filed with the Veterans Benefits Administration, which may directly initiate a Separation-Compensation and Pension examination (Worthen and Moering 2011).

The process begins with identification of service members with potentially disqualifying mental health conditions that render them unfit for duty. Fitness for duty is determined by mental health providers evaluating the impact of a condition on occupational functioning (e.g., the ability to deploy overseas). In general, disqualifying conditions are determined by the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) as required by Title 38 of the US Code (38 U.S.C. 4.125). While the *DSM* was not initially intended for determining occupational fitness for duty or disability eligibility, this has become standard in the military, which has led many clinicians to worry about how it will affect access to care and who gets financial benefits (Guina et al. 2016; McFarlane 2014). Some mental disorders are considered unfitting for military duty and can result in medical discharge with disability benefits, while others are considered unsuiting for military duty and can result in administrative separation without benefits or require a waiver to return to certain military duties (AFI 48-123 2014). What is disqualifying may vary between

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service branches and between job duties (e.g., pilots have stricter standards than others). Table 11.1 provides examples of potentially disqualifying conditions based on US Air Force standards (US Air Force 2016). Most disorders are not automatically disqualifying, with disqualification typically depending on impact on functioning, treatment requirements, and risk of recurrence. For example, the US Air Force considers the following unfitting: mental disorders causing impairment beyond 1 year, requiring continuing mental health treatment (e.g., weekly psychotherapy) beyond 1 year in order to perform military duty, requiring psychoactive medications managed by a licensed mental health provider beyond 1 year, requiring mood stabilizers (i.e., lithium, anticonvulsants, antipsychotics), and requiring recurrent psychiatric hospitalizations (US Air Force 2016). Similarly, the US Air Force only considers neurodevelopmental disorders (e.g., learning, communication, attention deficit/hyperactive) disqualifying if they have "ever compromised military duty or training, required treatment, or required special accommodations for job or academic performance" (US Air Force 2016).

Table 11.1 Mental health conditions that are potentially unsuiting or unfitting for military service

Potentially unsuiting conditions	Potentially unfitting conditions
Neurodevelopmental disorders	Schizophrenia
Disruptive, impulse control, and conduct disorders	Bipolar and related disorders
Substance-related and addictive disorders	Depressive disorders
Personality disorders	Anxiety disorders
History of suicide or suicidal behavior	Obsessive-compulsive and related disorders
Nonrecurrent adjustment disorder <60 days	Chronic trauma- and stressor-related disorders
Specific phobia to flying	Dissociative disorders
Schizophrenia in both parents	Somatic symptom and related disorders
Bipolar disorder in both parents	Feeding and eating and elimination disorders
Maladaptive personality traits[a]	Neurocognitive disorders
A pattern of maladaptive behavior[a]	Sexual disorders[b]

[a]Potentially unsuiting for flyers only and only when significantly interfering with safety or mission
[b]Gender nonconforming or transgender is not disqualifying from continued service if there is no duty impact

Service members may be referred to the IDES for a number of reasons, by both commanders and clinicians. Members may be referred for several reasons including, but not limited to, having an automatically disqualifying diagnosis (e.g., psychotic and bipolar disorders), showing continued impairment after receiving optimal medical benefit (i.e., after an adequate trial of treatment), having an unfavorable prognosis, following a suicide attempt, following cancelation of a deployment due to a mental health condition, or requiring significant time away from work or on duty restrictions (e.g., no firearms, no deployments). Once referred, a Medical Evaluation Board (MEB) provider or panel of medical personnel determines if a MEB is required.

If a MEB is deemed appropriate, it requires a mental health evaluation. Service members undergoing MEBs and veterans filing disability claims are evaluated in Separation-Compensation and Pension examinations (Worthen and Moering 2011). These evaluations can be completed by a VA mental health provider or by a trained, private mental health provider. If a service-connected mental health disorder is diagnosed, a rating is assigned. The rating represents the percentage of impairment of the veteran's average earning capacity. The current VA Schedule for Rating Disability is based on a standardized rating for disability that was developed in 1945 (IOM 2007). Veteran disability requires that examiners consider the frequency, severity, and duration of psychiatric symptoms and the veteran's capacity for readjustment during periods of remission (38 U.S.C. 4.125). The examiner must consider the veteran's degree of social and occupational functioning based on all existing evidence and not just the veteran's self-report (38 U.S.C. 4.126). The General Rating Formula for Mental Disorders is based on a 0–100 scale with specific descriptions for ratings of 0%, 10%, 30%, 50%, 70%, and 100% (38 U.S.C. 4.130). For active duty members, a Department of Defense mental health provider also completes a

report including a thorough mental health history, diagnosis, impairment assessment, prognosis, and recommendations and outlines if the condition existed prior to service.

These reports go to the MEB, which must include "at least one psychiatrist or psychologist with a doctorate in psychology"—military or civilian employees—with at least one having "detailed knowledge of the standards pertaining to medical fitness, the disposition of patients, and disability separation processing" (DoDI 1332.18 2014). If requested by the service member, an impartial physician independent of the MEB will review the MEB findings and advise the service member. Service members are permitted to at least one rebuttal of the MEB findings. If the MEB determines that service members cannot perform their duties based on all the required examinations and reports, it refers the case to a Physical Evaluation Board (PEB). The PEB consists of a president who is a military O-6 (i.e., the pay grade of a colonel in the US Army, Air Force, and Marines or a captain in the Navy and Coast Guard) or the civilian equivalent, a medical officer who cannot be the service member's clinician and cannot have served on the service member's MEB examination, and a line officer familiar with duty assignments. PEBs determine fitness for duty and the reason an unfitting condition is or is not compensable (the amount of which is based on the percentage rating of a disability determined by the VA). Determinations may include a medical retirement with compensation, a return to duty with no restrictions, a return to duty with restrictions (e.g., no deployments, must be assigned to bases with mental health providers), a separation with or without severance pay, or a Temporary Disability Retired List (TDRL). A Temporary Disability Retired List provides members temporary retirement including continuing medical benefits for up to 5 years, during which they are reevaluated every 12–24 months by a military mental health provider, and after 5 years or earlier, a permanent determination is made. Whatever the MEB determination, once the rating is assigned, the findings are forwarded to the service member who can choose to accept the determination or appeal. If separation from the military is initiated, the member has a 90–120-day transition period.

Case Study

John Peralta (pseudonym), a 40-year-old male US Air Force Technical Sergeant with a history of post-traumatic stress disorder (PTSD), was referred by his commander for a Medical Evaluation Board (MEB) to determine fitness for duty and medical disability eligibility. He denied any psychiatry history until experiencing combat-related traumas in Afghanistan. He received mental health treatment for the 3 years preceding the MEB, including supportive psychotherapy, sertraline 50 mg daily for mood/anxiety, and hydroxyzine 50 mg daily as needed for anxiety. He had no treatment history other than failing brief trials of trazodone and prazosin. With only minimal improvements from treatment, he continued to have occupational dysfunction, largely due to poor concentration, excessive startle, re-experiencing instances, and irritability. Because he had not received adequate treatment for PTSD, the active duty psychiatrist that evaluated him recommended that he receive a full course of evidence-based trauma-focused psychotherapy and that his sertraline be titrated to a therapeutic dose or changed to another agent if he continued to not respond. His prognosis was deemed to be fair with respect to military service if he received adequate treatment, and it was recommended that he be reassessed in 1 year. An independent VA psychiatric examination concurred with the diagnosis and recommendations. The military placed him on the Temporary Disability Retirement List, medically separating him from the military and awarding him 50% service-connected medical disability for PTSD. Six months later, he started cognitive processing therapy at the VA but dropped out of treatment before completion. One year after the MEB, his sertraline 50 mg was increased to 100 mg. A different active duty psychiatrist reassessed him 18 months after the MEB

and determined there had been little change in symptoms or functioning and repeated the same recommendations for a full course of psychotherapy, maximizing medications and reassessing in 1 year.

Common Concerns

While pensions were given to disabled veterans since the formation of the US, the focus had historically been on physical injuries and diseases like tuberculosis. Although mental health professionals had long recognized the connection between combat and mental health pathology, the *DSM* did not recognize PTSD until 1980—in large part due to lobbying by veterans (Herman 2015). This recognition was partially responsible for the VA increasing resources for the treatment and research of mental disorders since the 1980s (VA 2016). With increased recognition of how combat can impact mental health and increased survival rates from catastrophic injuries—largely due to improved body armor and medical advances—in recent wars (Dunbar 2015; Goldberg 2014), veteran disability compensation for mental health conditions has become more prevalent. In fact, PTSD has become the third most common VA disability, behind tinnitus and hearing loss (McNally and Frueh 2013). The number of veterans receiving PTSD-related disability benefits increased 80% from 1999 to 2004 (Frueh et al. 2007). Among veterans receiving compensation for mental disorders, 58% are for PTSD, and, among Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans, the number rises to 75% (McNally and Frueh 2013). In 2010, the VA implemented the Disability Benefits Questionnaire, a shorter version than previous examination templates to handle the increased load of disability claims following Operation Enduring Freedom/Operation Iraqi Freedom (Worthen and Moering 2011). Beginning in 2011, private mental health providers (in addition to VA providers) were eligible to conduct Separation-Compensation and Pension examinations. Although both changes were intended to streamline the compensation process, concerns regarding accuracy and completeness of the assessments have arisen.

Both over- and underdiagnosis of mental health conditions are fraught with potential occupational/financial consequences for veterans. Since diagnoses can result in service members being limited in their duties or even losing their job—by medical discharge with disability compensation and healthcare benefits, administrative separation without benefits, or dishonorable discharge due to problematic behaviors—proper diagnosis is important for service members' finances, the military's manning, and the VA's budget. Veterans often experience psychological distress and dysfunction but do not meet *DSM* criteria and may be denied VA healthcare services or disability compensation. Conversely, some veterans receive benefits for feigned or exaggerated symptoms or have a true mental health condition but receive benefits despite never attempting or completing treatment. Besides fiscal reasons, accurate diagnosis and proper treatment are important because veterans with service-connected disabilities have lower suicide rates than those without (VA/DoD 2010). Unfortunately, policies such as 50% disability for combat-related mental health conditions have led many to suggest that the military is financially incentivizing individuals to be or remain ill.

Overreporting and Malingering

Detecting malingering is important not only for legal and financial reasons but also clinical and ethical ones. While malingering PTSD for legal and financial gain is common in the civilian setting (Guriel and Fremouw 2003; Kunst et al. 2011), these rates may be even higher in the military, with 37–75% of veterans that report PTSD exaggerating or malingering (McNally 2007; Smith and Frueh 1996). However, these high rates are controversial, and the military has been criticized for overemphasizing malingering, resulting in increased standardization of disability evaluations (Vergun 2012). Nevertheless, overreporting does occur in the military disability

Table 11.2 Possible reasons for over- and underreporting symptoms in military populations

	Overreporting	Underreporting
Help-seeking incentives/ deterrents	Desire for care/pity	Stigma
	Decrease legal responsibility/liability	Lack of mental health knowledge
	Benzodiazepines	Denial of mental health problems
Cultural attitudes	Belonging to a group of sufferers	Overvaluing self-reliance
	Desire to be distinct/important	Stoicism/masculinity
		Perceive mental disorders as weakness
Contextual factors in military	Seeking disability payments	Issues of confidentiality
	Avoid service/deployment	Negative career impacts
		Perceive clinician conflict of interest
Common issues with trauma	Fear of not being believed/understood	Avoidance of trauma discussion
	Excessive blame of military/government	Embarrassment or shame
	Excessive self-blame	Normalization of trauma
	Blaming all life problems on trauma	Belief that nothing can help

From Guina et al. (2016)

system and is important for recommending and monitoring treatment and assuring access to limited treatment resources.

Numerous factors complicate detecting overreporting. With high comorbidity rates among mental disorders, the most scrupulous patients may have difficulty separating trauma-related problems and those from other conditions. Structured interviews found 53% of Vietnam veterans had "clear exaggeration" of PTSD symptoms, but 70% of these had major depressive disorder and 58% alcohol dependence (McNally 2007). Among Vietnam veterans applying for PTSD-related disability in one study, 52% had no documented combat exposure, and 5% either had never been in the military or never deployed (Frueh et al. 2005). Clinicians are generally left with the dilemma of diagnosing mental disorders or malingering without supporting documentation. An alternative to this dichotomous schema is delineating a true mental disorder, "pure malingering," "partial malingering," and "feigning symptoms" (Resnick 1999; Wooley and Rogers 2015). Pure malingering involves fabricating symptoms (and, possibly, trauma). Partial malingering involves exaggerating symptoms (e.g., from an actual trauma). Feigning involves ascribing symptoms to a condition which actually emanate from another source (e.g., ascribing alcohol-induced anxiety to PTSD).

The spectrum of overreporting hints at several causes (Table 11.2), including both primary and secondary gain. Some individuals' desires for disability arise from a sense they are owed recompense, viewing their suffering as the responsibility of a person or system. For others, trauma becomes the single dominant event that precipitated their future distress; all subsequent problems with relationships, substances, and career are blamed on trauma regardless of the real cause (Frueh et al. 2000). For many, overreporting is more like factitious disorder than true malingering. A label like "PTSD" makes them distinct, important, and the object of concern and serves primary gain: receiving care, pity, or the psychosocial benefits of belonging to a self-identified group of sufferers (Ali et al. 2015). Clinicians should consider all of these potentially contributing factors before assuming malingering.

In general, clinicians tend to take everything patients say at face value, but in forensic and occupational settings where motives may exist beyond the desire for treatment, further efforts, tools, and techniques become necessary. Asking open-ended questions, having patients spontaneously report symptoms, inquiring into specific examples of personal manifestations of a

condition, and focusing on evidence of dysfunction rather than symptom self-report are all preferable to allowing patients to recite memorized criteria or affirming symptoms proffered by interviewers. The development of objective measures and screening tools, the standardized evaluation methodology, and the military pushing for more research into biomarkers for PTSD have attempted to improve this, but clinician judgment will always be the most important factor in disability evaluations. However, considering that many veterans seek help from civilian clinicians who are not culturally competent with military patients and policies, there is still a potential for overdiagnosis. Inconsistencies should be explored thoroughly, including within self-report, between what is reported and observed (e.g., inattention, agitation, excessive startle), between self-report and collateral information (e.g., military, police and medical records, and interviews with significant others), and between individual and typical presentations (Ali et al. 2015). Unfortunately, clinicians often do not have access to all military records, or frequently, veterans delay reporting about mental health symptoms or a trauma until years later. The current system is designed to give the benefit of the doubt, as compared to a workman's compensation model requiring the claimant to prove their disability (Worthen and Moering 2011). Diagnosis is improved with structured interviewing techniques such as the Structured Clinical Interview for *DSM* and Clinician-Assessed PTSD Scale (Morgan et al. 2005). Several psychometric tests include subscales for exaggeration: the Minnesota Multiphasic Personality Inventory-2 (MMPI), the Structured Interview of Reported Symptoms, the Miller Forensic Assessment of Symptoms Test (which can be taken and scored in 15 min), and the Traumatic Stress subscale of the Anxiety-Related Disorders Scale of the Personality Assessment Inventory (Smith and Frueh 1996; Freeman et al. 2008). Distinguishing between those who are honestly reporting and inflating symptoms/distress is important for patients, clinicians, the military, and taxpayers.

Underreporting and Reverse Malingering

There are many tangible reasons to underreport (Table 11.2), and minimizing symptoms may be more common in the military than the general population. Service members are probably more likely to "fake good," which is verifiable by the Minnesota Multiphasic Personality Inventory-2 (MMPI) (Elhai et al. 2000), or avoid treatment altogether. A military culture of stoicism and hypermasculinity can lead to underreporting and avoiding and rejecting help (Lollis et al. 2009; Tolin and Foa 2008). Among those with PTSD, it is common to normalize their symptoms or trauma, to feel ashamed about a trauma, or to perceive their symptoms as a failure to cope as well as others they served with, which can further impede help seeking (Nazarov et al. 2015). It is important that military leaders avoid perpetuating mental health stigma, actively support their troops who are suffering (rather than waiting for members to come to leadership for help), and publicly discuss general mental health concerns.

While malingering receives significant attention because of the costs of fraudulent disability compensation (Zarembo 2014), reverse malingering is understudied. Reverse malingering is the intentional underreporting of symptoms or distress (Lurati 2013). Some try to avoid the legal, disciplinary, and social consequences that may result from the revelation of unhealthy behaviors. Others fear negative career impacts, including being prevented from changing to more attractive duty stations, being limited in duties (e.g., leadership, aircrew, medical, police, presidential assignments), and even losing one's career (Lollis et al. 2009). Contrary to popular belief, most service members—unlike Sergeant Klinger from *M*A*S*H*—want to keep their job (including salary and benefits, especially for those nearing 20 years of active duty service when retirement benefits become available), and many want to deploy (whether out of a sense of duty or honor or because it may help their careers). Reverse malingering is most commonly associated with considering work a part of self-worth (military service is

accompanied by a deep sense of purpose and identity) and considering work as therapy or a distraction for problems, having many responsibilities, and income (Lurati 2015). Clinicians have a responsibility to determine with reasonable certainty fitness for duty because failure to recognize limitations in unfit service members can increase their risk to themselves, others, and even national security. For these reasons, the military needs to be careful about over-incentivizing or disincentivizing self-disclosure of mental health concerns.

Stigmatizing and over-punishing mental health problems can be a major deterrent for service members seeking mental health care. Because there are more exceptions for confidentiality in military than civilian medicine, including being deemed unfit for duty to perform a mission, violation of military standards and laws, and substance use (DoDI 6025.18-R 2003), concerns about clinician conflicts of interest can be particularly off-putting. Even if members are comfortable seeking mental health treatment, they are often concerned how leadership will respond. It is important that military leaders find a balance between lenient (even those with a mental health condition should be held responsible for their criminal or insubordinate behaviors) and punitive actions (which can exacerbate mental health conditions and deter honest self-disclosure of problems), because both ignoring and castigating mental health problems are harmful.

Disability Without Adequate Treatment

Veterans seeking compensation for mental disorders without completing treatment (i.e., being deemed permanently disabled without knowing if recovery is possible) is a pervasive problem for the military, complex in its causes, and an ethical and clinical conundrum for those evaluating disability. Most veterans receiving PTSD-related disability payments report increasing symptoms until given 100% disability ratings after which mental health visits precipitously decrease implying that compensation—not treatment—was the primary focus (Frueh et al. 2007). However, avoidance (of treatment and discussing problems) is common in many mental disorders—especially PTSD—and may partially explain why many receive disability compensation without adequate treatment.

Many clinicians and researchers implicate dropouts in the volume of veterans not receiving adequate treatment. A systematic review of psychotherapies for Operation Enduring Freedom/Operation Iraqi Freedom-related PTSD reported a 36% dropout rate (Goetter et al. 2015). Most dropouts occur within three sessions, prior to starting exposure (Najavits 2013), leading many to theorize that fears of revisiting trauma lead to dropouts. However, the most robust correlate of dropouts is younger age, with no significant correlations to exposure, symptom severity, comorbidity, or disability status (Goetter et al. 2015). Most studies define adequate treatment as attending 8 PTSD-related sessions within 12 months (Hoge et al. 2014), but most standard treatment courses are longer, such as cognitive processing therapy (CPT) (12 sessions) and prolonged exposure (PE) (8–15) (Najavits 2013). Despite this low bar, only one-third of Operation Enduring Freedom/Operation Iraqi Freedom veterans with PTSD obtain "adequate care" (Hoge et al. 2014), and that is likely an overestimate as number of visits provides little information about treatment quality and patient engagement.

Another concern is whether veterans receive evidence-based PTSD treatments, including cognitive processing therapy, prolonged exposure, eye movement desensitization and reprocessing (EMDR), cognitive restructuring therapy, trauma-focused cognitive behavioral therapy, brief eclectic psychotherapy, narrative therapy, stress inoculation training, and serotonergic antidepressants (Haagan et al. 2015; VA/DoD 2010). Although the VA and Department of Defense have invested substantially into training clinicians in prolonged exposure and cognitive processing therapy (Karlin et al. 2010; Eftekhari et al. 2013), less than 10% of veterans with PTSD have completed either cognitive processing therapy or prolonged exposure (Seal et al. 2010; Shiner et al. 2013; Mott et al. 2014),

and supportive therapy continues to be the most common treatment (Najavits 2013). Clinician barriers include low confidence in effectiveness, fear of dropout or symptom exacerbation, and lack of training (Najavits 2013). Additionally, many clinicians modify treatment protocols, homework, and number or structure of sessions—changes which have unknown efficacy (Najavits 2013).

Of veterans who engage in treatment, recovery rates are 70–80% for evidence-based treatment completers but decrease to 40% after accounting for dropouts (Hoge et al. 2014). Some speculate that real-world conditions further limit effectiveness since studies often exclude suicidal, homicidal, substance-using, and cognitively impaired patients (Najavits 2013). Nevertheless, number of sessions and focus on traumatic content are most predictive of improvement (Haagan et al. 2015).

Treatment dropout and lack of evidence-based treatment commonly contribute to veterans making claims for mental health disabilities without adequate treatment. How should the VA/Department of Defense respond? Is it ethical to withhold or delay compensation until treatment is completed? Is it ethical to declare someone disabled without adequate treatment? Even with treatment, how often will secondary gain deter recovery? If veterans drop one treatment, it is reasonable to recommend further treatment with a different provider and/or modality. The system should work to incentivize getting healthy, but many argue the current system disincentivizes recovery. Increased training and consultation with senior clinicians to discuss cases may help address clinicians who opt for nonevidence-based approaches, alter treatment protocols, or are limited in the modalities they provide (e.g., only cognitive processing therapy or prolonged exposure for PTSD). Implementing these proposals is almost certainly cost-effective because if recovery rates improve, so will disability rates.

Implications for the Future

While most clinicians are trained to diagnose in clinical settings, many are unfamiliar with occupational and forensic settings (Morgan et al. 2005), where evaluees have motivations for dishonesty and under- and overreporting. Although it is easy to give examples when most clinicians are appropriately skeptical of a patient's intent (e.g., doctor shopping, efforts to obtain controlled substances, etc.), it could be argued that clinicians should take a trusting stance and accept the information given by patients. All the while assessing for historical reliability, some have argued that reciprocal trust is an important aspect of the healthcare relationship (Thorne and Robinson 1988). It has even been said that trusting patients is a "moral duty" (Rogers 2002). This notion has face validity—who wants to see a provider who does not believe him/her? Yet, clinicians have good reason to be skeptical of many subjective reports, especially those of behaviors related to eating, substance use, and medication adherence (Gadkari and McHorney 2012; Mertz 1984; Morgan et al. 2005; Palamar et al. 2015). Indeed, even in settings where malingering is more common, it can be difficult to stave cynicism and preserve empathy. A middle ground is possible, where individuals are trained to respect, empathize, and trust their patients but also are trained to be aware of possible secondary gain and the signs of malingering. As always, the differential diagnoses must be broad, and all possibilities must be systematically ruled in or ruled out. Clinicians need to be able to identify typical vs. atypical symptoms and should avoid leading, coaching, or suggesting. Administration must insist that professionals are thorough and a culture of immediate suspicion or dismissal of patients must not be tolerated. On the other hand, they must ensure that clinicians are provided with ongoing training and support about the issues of feigning and malingering. Support for obtaining an access to necessary sources of collateral data (e.g., VA *and* Department of Defense's medical *and* personnel records) is crucial, and cli-

nicians should be more familiar with validated instruments and structured interviews.

The VA/Department of Defense (and others treating service members) should expand their treatment armamentarium (e.g., currently the military only provides cognitive processing therapy and prolonged exposure trainings for PTSD) and address the needs of those who do not respond to first-line treatments or do not fit in the current procrustean *DSM* bed. Treatment model fidelity and adherence to protocol are notoriously difficult to achieve, but efforts should be made to ensure members receive the correct treatment for the correct duration. Currently, disability benefits are not tied to treatment adherence. This begs the question: is it just to provide benefits for individuals who never attempt a valid course of treatment? Perhaps this is an uncomfortable question, but clinicians should not shy away from discussions about the need for evidence-based treatment and efforts to ensure veterans and service members have the opportunities to receive the treatment they deserve. As assessments and biomarkers become available, they should be utilized as appropriate. Clearer policies for treatment requirements may improve outcomes and retention. The disability system must not be structured to discourage individuals from improving their health.

While clearer policies for fitness requirements can make evaluations easier for clinicians (especially civilians), they may also make feigning symptoms easier. Clinical judgment and case-by-case determinations are essential as absolutist policies can be exploited for secondary gain. The structure of the disability system must be carefully designed as not to over-incentivize or disincentivize fitness/compensation evaluations.

Finally, in keeping with the Institute of Medicine's recommendation that healthcare workers have better education in social determinants of health, it would be wise to ensure the healthcare workforce understands social determinants as risk factors for future mental illness and other health burdens (Institute of Medicine 2016). This is a component of resiliency training but should be considered as practitioners assess individuals with symptoms. Better knowledge of these factors may help leadership target preventative interventions, help clinicians focus treatment, and may help with selection and retention.

Conclusions

Treating active duty and veteran military personnel can involve complex clinical and occupational decisions. It can be difficult to determine when what is reported is true (or feigned, overreported, or minimized), when adequate levels and the right types of treatment have been utilized, and when there is sufficient distress/dysfunction to warrant changes in diagnosis, treatment, and occupational status. More research is needed to best understand and care for service members with psychiatric disorders, both their mental health and their careers.

Key Concepts

1. The Integrated Disability Evaluation System may vary between service branches but always includes treatment, occupational evaluations, and Department of Defense/Veterans Affairs' determinations of fitness for duty, medical disability eligibility, and compensation.
2. The military disability process is time and resource intensive and can be stressful for service members.
3. Some mental health conditions are considered potentially unfitting and may result in medical retirement with disability compensation, while others are considered potentially unsuiting and may result in administrative separation without benefits.
4. Overreporting, misattribution of symptoms, and malingering can result in overdiagnosis and misappropriation of limited resources (e.g., compensation, treatment).
5. Minimization and reverse malingering can result in underdiagnosis and are common in the military, where a culture of stoicism and self-reliance, and fear of negative career impacts, often deters forthrightness.
6. Thorough reviews of records and collateral information, structured interviews, psychometric testing, and training evaluators in occu-

pational/forensic issues can help ensure the validity of diagnoses, though the current system is designed to give the benefit of the doubt to service members and veterans.

7. Symptomatic avoidance, stigma, treatment dropouts, and limited evidence-based treatment resources often lead to service members qualifying for medical disability without adequate treatment (i.e., deeming someone is permanently disabled without determining if recovery is possible with treatment).
8. Expanding and providing regular evidence-based treatment trainings and ensuring veterans are not disincentivized from recovering may improve outcomes, increase rates of returning service members to duty, and make available limited resources.

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