Drs Gilbertson and Pitman Reply

To the Editor: Dr Elliot criticizes our finding that "the majority of psychiatric symptoms reported by combat veterans with PTSD [posttraumatic stress disorder] would not have been present were it not for their exposure to traumatic events"[1(p1324)] on the grounds that "an important factor contributing to reported psychopathology in veterans is compensation status." This criticism is without merit. Our objective was to explore whether psychopathological symptoms are "acquired" in individuals with PTSD or, alternatively, whether such symptoms reflect general psychiatric psychopathology that would have existed even in the absence of traumatic exposure. The twin methodology employed in our model can show that a certain abnormality observed in PTSD was acquired, but it has limited ability to identify the mechanisms by which it was acquired. Dr Elliot's argument addresses the latter issue and not the former, and therefore in no way conceptually invalidates our conclusion that the majority of symptoms reported by combat veterans would not have existed absent trauma exposure. Trivially stated, even if we were to grant his suggestion that compensation-seeking substantially influenced the Symptom Checklist 90-Revised scores in our study, the combat veterans with PTSD could not have become compensation-seekers had they not experienced traumatic events in the military! Hence, there is no flaw in our original inference. Rather, the appropriate question is, What proportion of the variance in acquired psychiatric symptoms in PTSD versus non-PTSD veterans is accounted for by symptom exaggeration induced by the former's motivation to obtain, or maintain, disability payments? Certainly if the variance attributable to compensation-seeking were substantial, this would influence the meaning of the "acquired" symptomatology. However, the writer's concern is not unique to our study but applies equally to the hundreds of singleton (non-twin) studies that have shown greater psychopathology in veterans with versus without PTSD.

Dr Elliot's assertion that we "dismissed the possibility" of the impact of compensation status is unfounded. As he noted himself, our article explicitly *acknowledged* "the possibility that increased SCL-90-R scores to some degree represent compensation-seeking or general symptom overreporting in the PTSD group."[1(p1328)] Even so, in our view, the current literature far from establishes compensation status as a major, delegitimizing factor in PTSD and, consequently, one that must routinely be accounted for in all studies. To date, this interpretation rests upon an assumption that the relationship observed between compensation-seeking and some measure of symptom exaggeration, eg, the F-K index of the Minnesota Multiphasic Personality Inventory,[2] is causally unidirectional, ie, greater symptoms are reported because individuals are seeking compensation. It appears, however, that the average F-K scores for compensation-seeking veterans, though elevated, fall short of the typically accepted cutoff for symptom "exaggeration" per se.[2] Moreover, an equally viable interpretation of this correlation is that individuals seek compensation because they have more severe and disabling symptoms. For this reason, even if we had data available that assessed compensation status in our PTSD veteran sample as hoped for by the writer (which we do not), these data would not provide a basis for resolving the issue of compensation seeking. Were we to find significant differences in symptom severity between compensation-seeking and non–compensation-seeking PTSD veterans, we still would have no mechanism within the scope of our study for determining the causality of the association.

References

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2. Frueh BC, Elhai JD, Gold PB, et al. Disability compensation seeking among veterans evaluated for posttraumatic stress disorder. *Psychiatr Serv*. 2003;54(1):84–91.

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