

MENTAL HEALTH PROFILES AND SYMPTOM VALIDITY CONCERNS AMONG
JUSTICE-INVOLVED VETERANS

A Dissertation

Presented to

The Faculty of the Department of Psychology & Philosophy
Sam Houston State University

In Partial Fulfillment

of the Requirements for the Degree of
Doctor of Philosophy

by

Brittany E. Ridge

December, 2019

MENTAL HEALTH PROFILES AND SYMPTOM VALIDITY CONCERNS AMONG
JUSTICE-INVOLVED VETERANS

by

Brittany E. Ridge

APPROVED:

Jorge G. Varela, PhD
Dissertation Director

Marcus T. Boccaccini, PhD
Committee Member

Jaime L. Anderson, PhD
Committee Member

Adam T. Schmidt, PhD
Committee Member

Abbey Zink, PhD
Dean, College of Humanities and Social
Sciences

ABSTRACT

Ridge, Brittany E., *Mental health profiles and symptom validity concerns among justice-involved veterans*. Doctor of Philosophy (Clinical Psychology), December, 2019, Sam Houston State University, Huntsville, Texas.

Mental health concerns and criminal justice involvement are two undeniably prevalent issues amongst military service members in the United States. Veterans Treatment Courts (VTCs) have been established in growing numbers across the country in an effort to rehabilitate justice-involved veterans (JIVs) with mental health problems; however, research pertaining to the specific characteristics and needs of this subgroup is sparse. This study sought to clarify the nature of JIV mental health concerns and the accuracy of reported symptomatology in order to better inform identification, assessment, and rehabilitation of those who are most in need. Although limited in sample size, the results of this study suggest that the mental health profiles of JIVs are not vastly different from other incarcerated individuals. Further, JIVs are no more likely to inaccurately represent their distress/symptoms, as compared to other forensic populations. Results also indicate that veterans may exhibit lower levels of boldness than their incarcerated civilian counterparts. This may reflect the characteristics that drew individuals to the military in the first place, and were reinforced throughout their time in service. These preliminary findings suggest that JIVs would benefit from rehabilitation models similar to those developed for the general population, such as mental health courts, drug courts, and specific programming within incarcerated settings. Incorporating military values, customs, and courtesies into the culture of these programs would likely enhance veterans' commitment to treatment and ultimately contribute to more lasting positive outcomes.

KEY WORDS: Veterans, Veterans Treatment Court, justice-involved, mental health, symptom validity, psychopathy, forensic assessment

TABLE OF CONTENTS

	Page
ABSTRACT.....	iii
TABLE OF CONTENTS.....	iv
LIST OF TABLES.....	vi
LIST OF FIGURES.....	vii
CHAPTER	
I INTRODUCTION.....	1
Veterans and Mental Health Concerns.....	2
Veterans and Criminal Justice Involvement.....	3
Veterans Treatment Courts.....	4
Forensic Evaluation in VTCs.....	5
Symptom Validity Concerns.....	7
II CURRENT STUDY.....	10
Hypotheses.....	11
III METHOD.....	13
Overview.....	13
Participants.....	13
Measures.....	15
Procedure.....	18
IV RESULTS.....	19
Cognitive Impairment.....	19
PTSD Symptoms.....	19

Mental Health Profiles	19
Validity Profiles	22
Psychopathic Traits.....	25
V DISCUSSION.....	27
Implications.....	28
Limitations	30
Conclusion	31
REFERENCES	33
APPENDIX A.....	42
APPENDIX B.....	44
APPENDIX C	46
APPENDIX D.....	50
VITA.....	52

LIST OF TABLES

Table		Page
1	Means, Standard Deviations, and One-Way ANOVA Results for MMPI-2-RF Clinical Scales.....	20
2	Means, Standard Deviations, and t-test Results for MMPI-2-RF Clinical Scales	22
3	Means, Standard Deviations, and One-Way ANOVA Results for MMPI-2-RF Validity Scales	23
4	Means, Standard Deviations, and t-test Results for MMPI-2-RF Validity Scales	24
5	Means, Standard Deviations, and One-Way ANOVA Results for Triarchic Psychopathy Measure Scales	26
6	Means, Standard Deviations, and t-test Results for Triarchic Psychopathy Measure Scales.....	26

LIST OF FIGURES

Figure		Page
1	Comparison of Veteran vs. Non-Veteran MMPI-2-RF Clinical Scale Profiles....	21
2	Comparison of Veteran vs. Non-Veteran MMPI-2-RF Validity Scale Profiles. ..	24

CHAPTER I

Introduction

The problems faced by veterans as a result of combat exposure represent a significant public health concern in the United States. The Institute of Medicine (2010) outlines an array of negative outcomes associated with combat exposure including depression, PTSD, panic disorder, generalized anxiety disorder, substance use disorder, suicide, TBI and other blast injuries, homelessness, and criminal justice involvement, to name a few. These problems frequently co-occur and likely operate in an exacerbating fashion: research has indicated that mental health problems in veterans are associated with increased risk of violence, arrest, and incarceration (e.g., Elbogen et al., 2012; Greenberg & Rosenheck, 2009; Taft et al., 2007). Recognizing the nexus between service-connected mental health disorders and criminal behavior, recent efforts have been made to establish rehabilitative, rather than punitive, practices to improve the trajectories of justice-involved veterans. Based on the success of community-based alternatives such as problem-solving courts in reducing recidivism among the mentally ill (DeMatteo, LaDuke, Locklair & Heilbrun, 2013), Veterans Treatment Courts (VTCs) have been established throughout the U.S. to cater to the specific needs of justice-involved veterans with mental health problems (Russell, 2009).

VTCs are a relatively new development in the justice system; thus, research examining this unique veteran population is sparse. Further, the identification and assessment of VTC participants in forensic evaluations has yet to be systematically researched, and procedures vary by jurisdiction (Russell, 2009). A major concern within this veteran-forensic interface (Pinals, 2010) is parsing out those who are suffering with

mental illness and are in need of treatment from those who may be inaccurately reporting symptoms for some secondary gain (Sreenivasan et al., 2013). Despite symptom over-reporting among compensation-seeking veterans being problematic in civil forensic contexts (Frueh et al., 2003), no study has directly investigated whether seeking VTC qualification has an effect on the validity of veterans' reported mental health symptoms. The accurate assessment and diagnosis of justice-involved veterans is paramount in ensuring that VTCs are allocating resources to those who are most in need of, and amenable to, rehabilitation.

Veterans and Mental Health Concerns

The pervasiveness of mental health problems among veterans returning from deployment is an issue that cannot be overstated. Studies of soldiers returning from Iraq have reported prevalence rates of mental health concerns as high as 42.4%, of which Posttraumatic Stress Disorder (PTSD), major depression, alcohol misuse, and interpersonal conflict were the most common (e.g., Milliken, Auchterlonie & Hoge, 2007). According to the Department of Defense, Health Related Behavior Surveys collected in 2008 from 28,546 active duty military personnel indicated that prescription drug misuse, heavy alcohol use, stress, PTSD, and suicide attempt rates showed a marked increase from rates reported in 2005 (Bray, Pemberton, Lane, Hourani, Mattiko, & Babeu, 2010). The presence of this distress not only undermines quality of life, but also is associated with fatal outcomes. According to the Veterans Health Administration, suicide rates among veterans exceed that of the general population, with veterans comprising 20% of suicides nation-wide and an alarming approximation of 22 veterans committing suicide every day (Kemp & Bossarte, 2013).

A contributing factor to this predicament is the under-utilization of mental health services. The VA has made significant efforts to prioritize veterans' mental health through dedicated suicide prevention, PTSD treatment, and substance use disorder treatment programs, with the number of veterans receiving mental health treatment rising from 900,000 in 2006 to over 1.6 million in 2015 (U.S. Department of Veterans Affairs, 2016). Despite additional dedicated resources and increased mental health treatment utilization among veteran populations, treatment adherence remains an obstacle. For example, a study of 49,425 veterans with a PTSD diagnosis indicated that only 9.5% attended nine or more treatment sessions offered by the Department of Veterans Affairs (VA) (Seal, et al., 2010). This stark discrepancy between high mental health problems and low treatment engagement, hypothesized to extend from stigma and beliefs about mental health care (DeViva, Sheerin, Southwick, Roy, Pietrzak & Harpaz-Rotem, 2016), highlights an area of need for better identification and treatment of post-deployment veterans with psychopathology.

Veterans and Criminal Justice Involvement

Of further concern is the significant involvement of veterans in the criminal justice system (Institute of Medicine, 2010). Mental health problems have been identified as a risk factor for veteran incarceration (Greenberg & Rosenheck, 2009), hypothesized to extend from the relationship between hyperarousal symptoms and greater violence risk (Taft et al., 2007). Indeed, Elbogen et al. (2012) reported veterans with PTSD and concomitant higher levels of anger and irritability were at increased risk of arrest. Findings also indicated that substance use was a contributing factor to this relationship. Importantly, the provision of behavioral health services through the Veterans Health

Administration has been demonstrated to reduce rates of criminal charges by 33% in veterans with co-occurring psychological and substance use disorders (Pandiani, Ochs, & Pomerantz, 2010). Clearly, increased criminal justice involvement among veterans has been linked to mental health problems, and the treatment of these disorders has demonstrated an improvement in outcomes for justice-involved veterans (JIVs).

Veterans Treatment Courts

Given the high prevalence of mental illness and substance use disorders in incarcerated individuals, efforts to reduce recidivism have included the introduction of community-based alternatives such as problem-solving courts to rehabilitate these offenders (DeMatteo, LaDuke, Locklair, & Heilbrun, 2012). These courts are distinct from criminal courts in that they have a separate docket for mentally ill or substance-abusing defendants, a dedicated judge, prosecution, and defense counsel, a collaborative rather than adversarial approach, voluntary participation for defendants who adhere to treatment, supervision by the court, and dismissal or reduction of charges in exchange for treatment compliance (Moore & Hiday, 2006). Modeled after these specialty courts, the first Veterans Treatment Court (VTC) was established in 2008 to address the specific needs presented by justice-involved veterans with mental health issues (Russell, 2009). Since that time, VTCs have proliferated across the nation, with approximately 260 courts established as of January 2016 (Edelman, Berger, & Crawford, 2016).

Veterans eligible for VTC are those with a mental health and/or substance abuse disorder diagnosis who are charged with committing nonviolent felony or misdemeanor offenses, typically. VTC programming varies by jurisdiction, but generally involves the provision of a number of services such as financial assistance, housing, vocational

training, and mental health treatment. Additionally, court participants are paired with a veteran mentor who provides support and accountability throughout the VTC program. Finally, regular status hearings are held to ensure adherence to treatment and court conditions with reinforcement in the form of rewards or sanctions handed down by the judge (Russell, 2009).

Given that VTCs are relatively new, research on outcomes after program completion is sparse; however, preliminary evidence suggests that recidivism rates are low. For example, in a survey of 14 VTCs, the recidivism rate was under 2% for the 59 reported graduates (Holbrook & Anderson, 2011). By way of comparison, meta-analytic research has revealed a recidivism rate of 38% among drug court participants, which compared favorably to the overall rate of recidivism of 50% among non-drug court offenders (Wilson, Mitchell & MacKenzie, 2006). Given the abundance of studies demonstrating the effectiveness of drug and mental health courts in reducing recidivism (Heilbrun et al., 2012), the favorable outcomes observed thus far in VTCs are likely to persist. As VTCs become more widespread, the need for both efficient and accurate identification of mentally ill, justice-involved veterans is paramount.

Forensic Evaluation in VTCs

Evaluating the presence of psychopathology within a forensic context (i.e., for establishing eligibility for participation in VTC) requires specialized training in both mental health and legal domains. Additionally, Pinals (2010) brings attention to the critical need for forensic mental health professionals to develop knowledge and skills specific to working with veterans in this context, aptly referred to as the veteran-forensic interface. She emphasizes the importance of veteran-specific forensic practice, stating:

Especially at this time, there is a growing recognition of the unique clinical challenges of veterans, the likelihood and risk of veterans' involvement in the criminal justice system, and the need for forensic assessment and treatment that show a better understanding of veterans' needs. (p. 166)

Sreenivasan et al. (2013) elaborate on this specific domain of forensic evaluation of justice-involved veterans, highlighting the importance of context in understanding the behaviors of veterans that make them more susceptible to engaging in criminal behavior. For instance, the concept of "battlemind" has been used to encompass the mindset and abilities of a soldier that were adaptive in a combat environment, but after transitioning to civilian life become maladaptive and potentially illegal (Walter Reed Army Institute of Research, 2006). In addition to contextual considerations, Sreenivasan et al. (2013) identify various complicating factors to be cognizant of when establishing the link between military service and criminal behavior, including the overlapping manifestations of PTSD and TBI, as well as concerns about malingered or fabricated mental health symptoms and/or combat exposure. Further, pre-existing psychopathology such as antisocial personality disorder may express similarly to PTSD in terms of hyperarousal and thrill-seeking tendencies (Miller, 2012). Given the complexity of veteran-specific forensic evaluations in terms of establishing a nexus between military service, psychopathology, and criminal behavior, the need for accurate assessment tools is clear. The inaccurate reporting of symptoms is problematic in the forensic domain in general, but becomes especially difficult to identify considering individual differences and variable reactions to combat exposure among veterans.

Symptom Validity Concerns

When considering symptom validity, forensic evaluators are trained to attend to various response styles that may be indicative of inaccurate symptom presentation. The detection of symptom validity through response styles is a well-researched phenomenon and a detailed discussion of the various patterns of responding is beyond the scope of this article; however, relevant terms will be reviewed briefly to set the stage for veteran-specific validity concerns. One such response style is symptom underreporting, in which an individual is characterized as more well-adjusted than they actually are, whether through minimizing symptomatology or denying symptoms altogether. Symptom overreporting is a response style that characterizes individuals as having more pathology than they actually do. This can be unintentional, due to poor insight, or intentional whether by exaggerating symptoms as a “cry for help” or fabricating symptoms entirely (Ben-Porath, 2003). Malingering, a form of symptom overreporting, is the fraudulent exaggeration or fabrication of symptoms for secondary gain and is differentiated by the overt intent to deceive (American Psychological Association, 2000). Malingering can be further differentiated into three subtypes. Pure malingering is the feigning of a disorder that does not exist. Partial malingering involves exaggerating symptoms that do not exist. Finally, false imputation is the attribution of symptoms that do exist to an unrelated origin; for example, attributing real PTSD symptoms to an event that was not the true source of the traumatic symptomatology (Collie, 1917).

When applying these concepts to forensic evaluations of veterans, a number of contextual factors must be considered. Symptom underreporting may be of most significant concern pre-deployment, when service members may be motivated to

appear more well-adjusted than they are to avoid being disqualified for mental health reasons. Indeed, a retrospective study of U.S. military personnel who had completed the Pre-Deployment Health Assessment (PreDHA) indicated that more than half of the subjects who had mental health diagnoses denied such a history, suggesting that these self-reports have low validity in the context of pre-deployment (Nevin, 2009).

Symptom overreporting may be most problematic in the civil forensic context due to motivation to seek compensation for service-connected disabilities. In a study of combat veterans evaluated for PTSD, Frueh et al. (2003) reported that compensation-seeking veterans were more likely to overreport symptoms of psychopathology than were veterans who were not seeking compensation. In a later review of psychometric studies, Frueh, Hamner, Cahill, Gold, and Hamlin (2000) identify a general presentation style among combat veterans characterized by “extreme and diffuse levels of psychopathology” as well as elevated validity scales indicating symptom overreporting. This finding is hypothesized to result from the nature of the PTSD disorder, a more general representation of negative affect, and/or intentional exaggeration for secondary gain. As a cautionary note, Marx et al. (2012) argue that insufficient evidence exists to estimate rates of malingered PTSD and that further research is needed before making unsubstantiated assumptions about the prevalence of symptom exaggeration for secondary gain among veterans.

Personality features may also be of importance when assessing symptom validity. For instance, antisocial personality traits include failure to follow social and legal norms, deceitfulness, impulsivity, aggressiveness, irresponsibility, and lack of remorse. Indeed, the Diagnostic and Statistical Manual of Mental Disorders-Fifth Edition

[(DSM-5); American Psychiatric Association, 2013] identifies Antisocial Personality Disorder as a risk factor for malingering. Despite the face validity of this purported relationship, research identifying an association between antisocial traits and malingering is sparse and generally not well supported. For example, individuals diagnosed with Antisocial Personality Disorder were not significantly better than other prison inmates at feigning mental disorders (Rogers, Kropp, Bagby, & Dickens, 1992). Rogers (2008) argues that the idea of antisocial traits being predictive of malingering in forensic contexts is confounded by the adversarial nature of the proceedings, suggesting that any individual in that setting would be more likely to feign symptoms for personal gain. Although personality traits may not be directly predictive of symptom exaggeration, they represent an additional contextual factor to be aware of when assessing the veracity of veterans' reports in forensic evaluations.

CHAPTER II

Current Study

The current study was exploratory in nature and sought to contribute to the limited literature pertaining to offenders in VTCs. Little empirical data exists that captures the specific mental health profiles of this unique population, and no studies to date have assessed symptom validity concerns in this particular context. A better understanding of the mental health needs of JIVs will be advantageous in refining the rehabilitation goals set forth by VTCs. Whether these needs vary from other frequently studied populations such as substance-abusing or incarcerated individuals can inform how rehabilitation models might be reformed to address the specific needs of VTC members.

Participants in this study were screened for PTSD and cognitive impairment secondary to TBI, given the frequency with which these problems are endorsed in veteran populations. The Triarchic Psychopathy Measure [(TriPM); Patrick, 2010], a self-report measure of psychopathy which encompasses domains of Boldness, Meanness, and Disinhibition, was also administered to assess whether group differences in antisocial behavior existed.

Given the inherent benefits of participating in VTCs (i.e., avoiding incarceration, sentence dismissal, etc.) that hinge on the presence of a service-connected mental health disorder, evaluators must also be aware of the potential for inaccurate symptom reporting. Gathering collateral data is one way to corroborate a veteran's reported history. An additional technique for verifying accuracy is the use of assessment measures developed to evaluate symptom validity. The Minnesota Multiphasic Personality Inventory, Second

Edition – Restructured Form [(MMPI-2-RF); Ben-Porath & Tellegen, 2008] is one such tool commonly used in forensic settings to evaluate personality, psychopathology, and symptom validity. An abundance of studies have demonstrated the efficacy of the MMPI-2-RF's Validity Scales in detecting response patterns suggestive of inaccurate responding in forensic settings. For example, these indexes were used to effectively discriminate a known-group of symptom over-reporters in a civil forensic setting (Wygant, Ben-Porath, Arbisi, Berry, Freeman & Heilbronner, 2009), and have demonstrated efficacy for detecting feigned PTSD (Mason et al., 2013; Marion, Sellbom & Bagby, 2011). With veterans specifically, the MMPI-2 (an earlier version of the MMPI-2-RF) was used to differentiate between compensation-seeking veterans instructed to exaggerate symptoms, and compensation-seeking veterans instructed to respond honestly (Arbisi, Ben-Porath & McNulty, 2006). Despite strong support for the use of the MMPI-2-RF Validity Scales with veterans and in forensic contexts, no studies to date have applied this method of symptom validity testing within the context of VTCs. If effective in this setting, the MMPI-2-RF could augment existing forensic evaluation practices and contribute to more effective identification, assessment, and treatment of JIVs in VTC.

Hypotheses

This study was exploratory in nature and thus utilized three major research questions to outline the objectives of this research project.

Research question 1. Will VTC participants' mental health profiles differ significantly in comparison to incarcerated veterans or non-veteran offenders? This will inform whether rehabilitation methods need to be tailored specifically for VTC populations.

Research question 2. Will VTC participants' validity profiles represent differing patterns of invalid responding when compared to other forensic populations? If participating in VTC motivates symptom overreporting for the purpose of secondary gain, more parsimonious forensic evaluation methods may be warranted.

Research question 3. Will antisocial/psychopathic personality traits distinguish VTC participants from other forensic populations? Ultimately, veterans who may be overreporting symptoms as a "cry for help" ought to be distinguished from those who are inaccurately portraying their symptoms as a function of antisocial tendencies.

CHAPTER III

Method

Overview

Data collection occurred across a number of sites in order to obtain a more representative sample of justice-involved veterans and sufficient comparison groups. The VTCs in Harris County and Montgomery County provided access to populations of JIVs in treatment court, and the Montgomery County and Brazos County Jails allowed access to incarcerated JIVs (both within designated veteran units and in general population) as well as incarcerated non-veteran offenders. The data for this project was a subset of the variables collected as part of a larger study investigating both the mental health and criminogenic needs of JIVs. Overall, the larger study involved an individual interview with each participant, followed by the administration of questionnaires in a group format. The current project was limited to data collected from the questionnaires administered in a group format and focused primarily on mental health factors among JIVs.

Participants

Participants included 4 veterans attending VTC in Harris County and 4 veterans attending VTC in Montgomery County. Participants also included 47 veterans housed in a designated veteran-only unit and 15 general population veterans at the Montgomery County Jail, with 38 non-veteran general population offenders at this site acting as the comparison group. The majority of participants ($n = 108$) were male (68.3%, $n = 86$) and between the ages of 25-34 (35.9%, $n = 38$). The remaining participants fell within the age ranges of 19-24 (7.5%, $n = 8$), 35-44 (24.5%, $n = 26$), 45-54 (19.8%, $n = 21$), and 55 and older (12.3%, $n = 13$). With respect to race, 81 identified as Caucasian, 9 reported being

Hispanic or Latino, 9 identified as Black or African American, while the remaining 7 participants reported being of another racial background (e.g., Native American, Pacific Islander). Two participants declined to report their age or race. In terms of veteran status, 54.8% of the sample reported being veterans ($n = 69$). Of those veterans, the majority served in the Army (55.1%, $n = 38$), followed by the Navy (21.8%, $n = 15$), Marine Corps (14.5%, $n = 10$), Air Force (7.2%, $n = 5$), or multiple service branches (1.4%, $n = 1$). The majority reported a history of at least one deployment (59.7%, $n = 37$), with 45.9% of those endorsing a history of combat exposure ($n = 22$). 49.3% of veterans reported a history of punishment within the military ($n = 33$).

Participants were screened for invalid responding based on MMPI-2-RF Validity Scale scores. T-scores above 80 on VRIN-r and TRIN-r, above 120 on F-r, and above 100 on Fp-r were excluded from analyses involving MMPI-2-RF Clinical Scales, the TriPM, and the PCL-5. In total, 1 VTC participant, 11 incarcerated veteran participants, and 11 general offender participants were removed from these analyses because of invalid responding; however, these profiles were included in analyses related to symptom validity to assess the full range of reporting styles.

Four graduate-level clinical psychology students (two male and two female) served as evaluators who conducted both the individual interviews and group testing sessions. Each of these evaluators was prior military or entering active duty. All evaluators received training on the proper administration and scoring of the measures used in this study.

Measures

Minnesota Multiphasic Personality Inventory-2-Restructured Form (MMPI-2-RF; Ben-Porath & Tellegen, 2008). The MMPI-2-RF is a self-report inventory of adult personality and psychopathology consisting of 338 True-False items, designed to assess psychological variables in terms of a more dimensional conceptualization of psychopathology and personality through the Higher-Order (H-O) and Restructured Clinical (RC) Scales. It was developed as a much shorter version of the MMPI-2, with items on this measure being drawn from the original item pool of the MMPI-2 and utilizing the same normative sample with some adjustments (Ben-Porath & Tellegen, 2008). The instrument's technical manual reports reliability coefficients across the major scales ranging from ($\alpha = .63$ to $.95$). A more extensive overview of the reliability and validity data for this instrument can be found in the MMPI-2-RF technical manual (Tellegen & Ben-Porath, 2008). Of specific interest to the aims of this study, the MMPI-2-RF consists of Validity Scales created to detect various response styles that may be indicative of inaccurate or biased responding. The Variable Response Inconsistency-Revised (VRIN-r) and the True Response Inconsistency-Revised (TRIN-r) scales assess random responding and fixed responding, respectively. The instrument's technical manual reports reliability coefficients for each scale, by gender, within the normative sample (with VRIN-r α ranging from $.20$ to $.39$, and TRIN-r α ranging from $.23$ to $.37$). The F scales include Infrequent Responses (F-r) which indicates general overreporting ($\alpha = .69$ to $.71$), Infrequent Psychopathology Responses (Fp-r) which assesses overreported symptoms of severe psychopathology ($\alpha = .41$), Fs which identifies overreported somatic complaints ($\alpha = .40$ to $.45$), and Symptom Validity (FBS-r) which measures infrequent

somatic and neurocognitive complaints ($\alpha = .50$ to $.56$). The Response Bias Scale (RBS) indicates possible over-reporting of memory complaints. Finally, Uncommon Virtues (L-r) indicates uncommon moral virtues ($\alpha = .60$ to $.61$) and Adjustment Validity (K-r) is a measure of psychological adjustment ($\alpha = .67$ to $.68$).

Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5; Weathers, Litz, Keane, Palmieri, Mark, & Schnurr, 2013). The PCL-5 is a 20-item self-report measure of PTSD symptoms that corresponds to the symptom criteria for PTSD in the DSM-5 (See Appendix A). Respondents are asked to rate the presence and severity of these symptoms using a five point Likert-type scale, ranging from 0 (Not at All) to 4 (Extremely). A total symptom severity score is obtained by summing the item scores, with higher scores indicating more severe PTSD symptoms. DSM-5 symptom cluster severity scores can be obtained by summing the item scores within a particular cluster. PCL-5 scores demonstrated strong internal consistency values ($\alpha = .91$ to $.95$) in both civilian and war veteran samples (Armour et al., 2015; Pietrzak et al., 2015; Wortmann et al., 2016). Due to an error in reproducing the measure, the last item (“In the past month, how much were you bothered by trouble falling or staying asleep?”) was omitted for 108 participants. As this omission was nonsystematic, the mean value across all items of the measure for each participant was substituted.

Symbol Digit Modalities Test (SDMT; Smith, 1982). The SDMT is a neuropsychological test used to detect cognitive impairment (See Appendix B). It was developed as a brief screener for organic cerebral dysfunction in adults and children over the age of eight. The SDMT involves a substitution task in which the examinee is given 90 seconds to substitute a number for randomized presentations of geometric shapes, in

either an oral or written format. The test-retest reliability coefficient for the oral response version of the measure is 0.76 in a healthy population (Smith, 1982).

Triarchic Psychopathy Measure (TriPM; Patrick, 2010). The TriPM is a 58-item self-report measure of psychopathic traits encompassing three dispositional domains – meanness, boldness, and disinhibition (See Appendix C). This triarchic theory of psychopathy was developed to unify previous theoretical approaches, including those introduced by Cleckley (1941/1988) and measured by the Psychopathy Checklist, Revised (Hare, 2003), in a way that aligned with broader, dimensional conceptualizations of personality and psychopathology (Patrick & Drislane, 2015). The Meanness domain is characterized by callousness, interpersonal aggression, and cruelty. Boldness encompasses high social dominance, low anxiousness, and general fearlessness. The Disinhibition domain is defined as high impulsivity, irresponsibility, and anger (Patrick, Fowles, & Krueger, 2009). According to prior studies, internal consistency values for each subscale of the TriPM have ranged from ($\alpha = .88$ to $.90$) for Meanness, ($\alpha = .82$ to $.89$) for Boldness, and ($\alpha = .84$ to $.89$) for Disinhibition (Sellbom & Phillips, 2013).

Demographics Form. The researcher-developed demographics form was used to gather relevant background information from participants as well as details specific to military service (e.g., branch, status, rank, time served, deployment history, combat exposure, disciplinary history; see Appendix D). The same form was provided to all participants, regardless of military history; civilian participants did not respond to military-specific questions.

Procedure

Recruitment. Researchers recruited VTC participants in-person prior to their court sessions in the Harris County and Montgomery County courthouses. Incarcerated participants were identified through jail records by jail administrators and recruited in-person by graduate research assistants. Participants were informed that they were being asked to participate in a study about factors associated with rehabilitation and success post-release, specifically in terms of mental health and criminogenic needs.

Test administration. Group data collection occurred in an isolated room reserved by court or jail staff at each site. Group size was determined by the size of the room and appropriate spacing between participants; generally, four to six individuals were evaluated per session. In order to maintain confidentiality, participants were spaced no less than three feet apart from each other. Upon arrival to the site, the evaluator provided a brief overview of the study's purpose and procedures before obtaining informed consent. Administration took approximately two to three hours; in some instances, participants expressed a desire to complete the MMPI-2-RF or interview portion of the study at a later date, and were allowed to do so by research assistants. The written version of the SDMT was administered first because of the timed element. Subsequently, the participants were asked to complete the battery of self-report questionnaires including the MMPI-2-RF, the PCL-5, and the Tri-PM.

CHAPTER IV

Results

Cognitive Impairment

SDMT scores were compared across veteran and non-veteran groups, to determine whether groups differed on their degree of cognitive impairment. There is no one cut score specified in the manual; rather, studies have suggested that a score approximately 1.5 standard deviations below the mean for a particular age group can suggest dysfunction (Smith, 1982). As a reference point, the mean score for adults 25-34 years old with 12 years or less of education is 54.40 (SD = 8.31). The mean SDMT score was 50.06 (SD = 12.17) for the veteran group and 48.49 (SD = 8.70) for the non-veteran group, indicating that, on average, respondent scores were not suggestive of cognitive impairment. Further, SDMT scores did not vary significantly by veteran or non-veteran status ($t(102) = .694, p = .489$).

PTSD Symptoms

Total scores on the PCL-5 were compared across veteran and non-veteran groups, to determine whether the groups differed on the reported presence and severity of PTSD symptoms. PCL-5 scores did not vary significantly by veteran status ($t(71) = .747, p = .458$). Although mean scores for non-veterans (M = 30.60, SD = 17.74) did not rise to a level of clinical significance (indicated by a score of 33 or higher), veteran mean scores fell just above this cutoff (M = 34.00, SD = 17.20).

Mental Health Profiles

Table 1 provides descriptive statistics for participants' scores on the clinical scales of the MMPI-2-RF, reflecting sample totals as well as average scores within each subgroup

(VTC participants, incarcerated veterans, incarcerated non-veterans). A one-way ANOVA was performed to compare the average scores across groups; however, there were no statistically significant differences among the three groups across the MMPI-2-RF clinical scales. Given the relatively small size of the VTC participant group, the two veteran subgroups were combined in order to compare veteran and non-veteran clinical profiles. Average clinical scale scores of each of the two groups were used to create a clinical profile for comparison. Figure 1 illustrates the MMPI-2-RF clinical profiles for veteran and non-veteran participants. Consistent with the lack of statistically significant differences, the two profiles reflect a similar pattern of reported psychopathology across groups, with most scale averages falling shy of clinically significant elevations. An independent samples t-test was then conducted in order to compare MMPI-2-RF clinical scale scores between the two groups. Similarly, there were no statistically significant differences between veterans and non-veterans (see Table 2).

Table 1

Means, Standard Deviations, and One-Way ANOVA Results for MMPI-2-RF Clinical Scales

MMPI-2-RF Scales	Veterans Treatment Court (n = 6)	Incarcerated Veterans (n = 49)	Incarcerated Nonveterans (n = 22)	Total	<i>F</i> (df = 2, 76)	<i>p</i>	η^2
RCd	51.67 (7.87)	55.88 (10.35)	54.82 (11.01)	55.25 (10.32)	.465	.630	.012
RC1	56.17 (10.87)	59.61 (10.67)	58.64 (10.97)	59.07 (10.67)	.298	.743	.008
RC2	47.33 (8.64)	48.22 (9.54)	49.64 (8.40)	48.56 (9.08)	.238	.789	.006

(continued)

MMPI-2-RF Scales	Veterans Treatment Court (n = 6)	Incarcerated Veterans (n = 49)	Incarcerated Nonveterans (n = 22)	Total	<i>F</i> (df = 2, 76)	<i>p</i>	η^2
RC3	53.83 (9.93)	54.78 (9.91)	53.18 (8.03)	54.25 (9.32)	.224	.800	.006
RC4	61.67 (7.89)	67.06 (11.95)	69.73 (11.69)	67.40 (11.67)	1.188	.311	.031
RC6	59.50 (12.42)	61.86 (12.97)	63.41 (14.79)	62.12 (13.34)	.223	.800	.006
RC7	56.17 (13.98)	53.08 (9.99)	54.14 (11.98)	53.62 (10.78)	.249	.781	.007
RC8	54.17 (15.22)	58.90 (12.01)	57.77 (10.05)	58.21 (11.66)	.455	.636	.012
RC9	55.83 (13.54)	55.61 (11.74)	56.41 (11.70)	55.86 (11.71)	.034	.966	.001

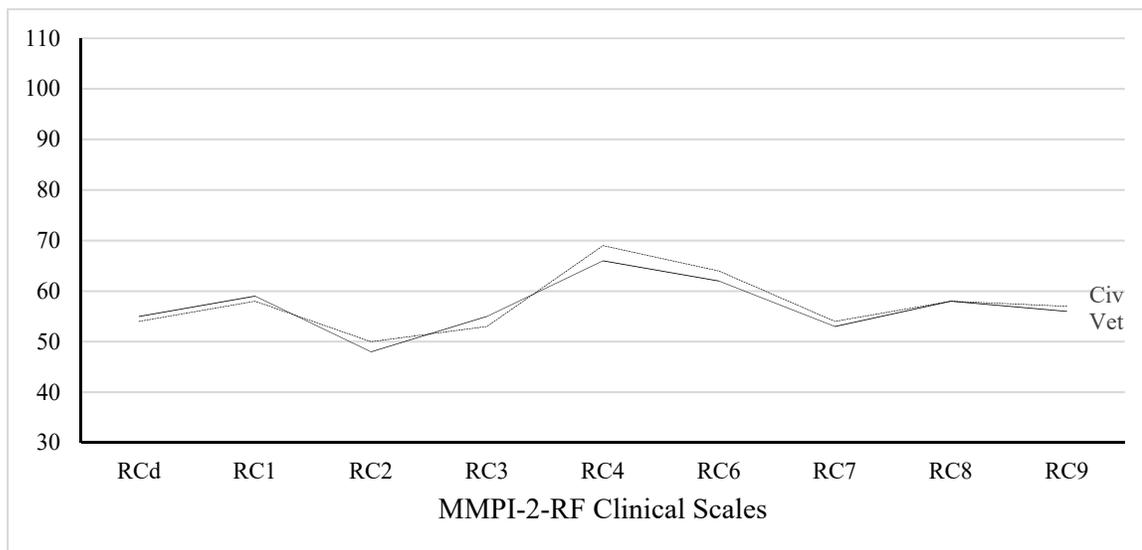


Figure 1. Comparison of Veteran vs. Non-Veteran MMPI-2-RF Clinical Scale Profiles.

Table 2

Means, Standard Deviations, and t-test Results for MMPI-2-RF Clinical Scales

MMPI -2-RF Scales	Veterans (n = 54)	Nonveterans (n = 21)	<i>t</i> (<i>df</i> = 73)	<i>p</i>	<i>d</i>	95% C.I. (Lower)	95% C.I. (Upper)
RCd	55.33 (10.21)	54.14 (10.80)	.446	.657	.1147	-.3902	.6187
RC1	59.20 (10.74)	57.76 (10.43)	.526	.600	.1353	-.3699	.6394
RC2	48.02 (9.43)	49.62 (8.61)	-.676	.501	.1738	-.3314	.6781
RC3	54.63 (9.91)	53.48 (8.10)	.475	.637	.1222	-.3827	.6262
RC4	66.35 (11.71)	69.00 (11.45)	-.884	.379	.2273	-.2788	.7320
RC6	61.70 (12.91)	63.76 (15.06)	-.591	.556	.1520	-.3533	.6561
RC7	53.20 (10.35)	53.76 (12.14)	-.200	.842	.0514	-.4529	.5554
RC8	58.43 (12.43)	57.71 (10.30)	.233	.817	.0599	-.4443	.5639
RC9	55.78 (11.88)	56.67 (11.92)	-.291	.772	.0748	-.4297	.5788

Validity Profiles

Table 3 provides descriptive statistics for participants' scores on the validity scales of the MMPI-2-RF, both in terms of the total sample and within each subgroup. There were no statistically significant differences between VTC participants, incarcerated veterans, and incarcerated non-veterans in terms of reporting style. Figure 2 illustrates the MMPI-2-RF validity profiles based on average validity scale scores of veteran and non-veteran group membership. As with the clinical profiles, the validity of participants' reporting generally reflected a similar pattern of responding across groups, with average scale scores falling within interpretable range. An independent samples t-test was conducted in order to compare MMPI-2-RF validity scale scores between the two groups.

Similarly, there were no statistically significant differences between veterans and non-veterans (see Table 4).

Table 3

Means, Standard Deviations, and One-Way ANOVA Results for MMPI-2-RF Validity

Scales

MMPI-2-RF Scales	Veterans Treatment Court (n = 7)	Incarcerated Veterans (n = 60)	Incarcerated Nonveterans (n = 33)	Total	<i>F</i> (df = 2, 97)	<i>p</i>	η^2
VRIN-r	57.29 (16.90)	56.27 (13.31)	55.97 (14.62)	56.24 (13.86)	.026	.975	.001
TRIN-r	61.71 (16.79)	60.20 (11.03)	62.03 (14.20)	60.91 (12.47)	.241	.786	.005
F-r	65.14 (27.05)	71.93 (23.67)	76.67 (24.37)	73.02 (24.08)	.811	.447	.016
Fp-r	66.86 (23.00)	68.68 (22.74)	69.79 (23.03)	68.92 (22.63)	.056	.946	.001
Fs	64.57 (26.80)	67.50 (19.34)	69.15 (21.81)	67.84 (20.53)	.161	.851	.003
FBS-r	59.86 (11.05)	59.33 (14.20)	57.00 (14.12)	58.60 (13.91)	.326	.723	.007
RBS	65.71 (20.74)	63.13 (17.56)	63.52 (16.04)	63.44 (17.13)	.070	.932	.001
L-r	59.43 (12.39)	56.88 (10.72)	54.70 (8.37)	56.34 (10.11)	.847	.432	.017
K-r	49.71 (10.36)	44.72 (9.81)	41.49 (11.13)	44.00 (10.42)	2.208	.115	.044

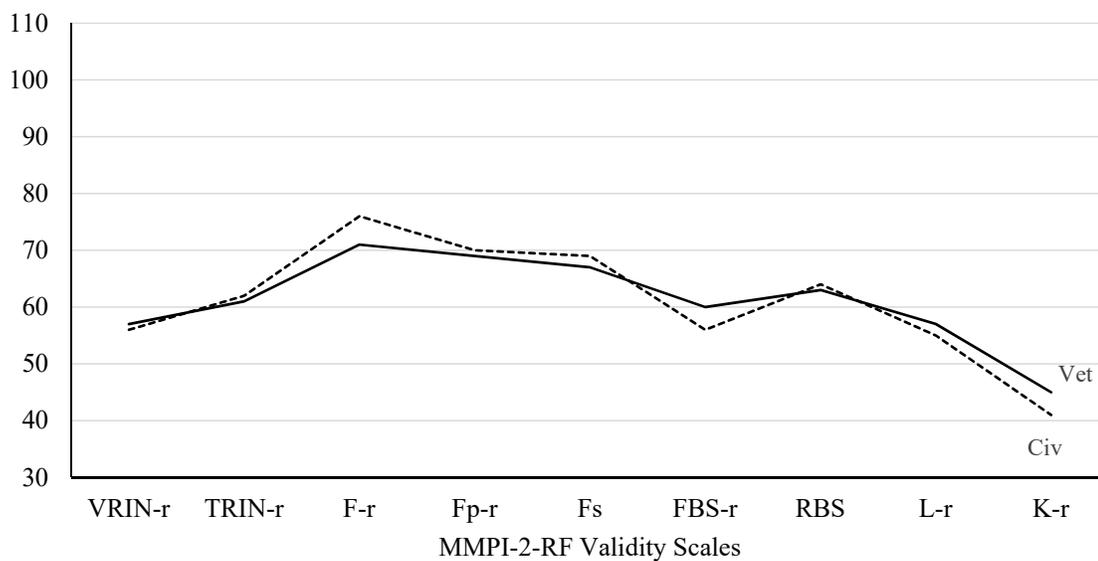


Figure 2. Comparison of Veteran vs. Non-Veteran MMPI-2-RF Validity Scale Profiles.

Table 4

Means, Standard Deviations, and t-test Results for MMPI-2-RF Validity Scales

MMPI-2-RF Scales	Veterans (n = 66)	Nonveterans (n = 32)	<i>t</i> (df = 96)	<i>p</i>	<i>d</i>	95% C.I. (Lower)	95% C.I. (Upper)
VRIN-r	56.50 (13.65)	56.38 (14.66)	.041	.967	.0088	-.3621	.3709
TRIN-r	60.52 (11.61)	61.94 (14.42)	-.525	.601	.1131	-.3097	.5353
F-r	71.11 (24.07)	76.47 (24.74)	-1.025	.308	.2208	-.2030	.6436
Fp-r	68.76 (22.67)	70.38 (23.15)	-.329	.743	.0709	-.3516	.4930
Fs	67.21 (20.16)	69.00 (22.14)	-.399	.691	.0859	-.3367	.5081
FBS-r	59.70 (13.71)	56.28 (13.72)	1.156	.250	.2490	-.1753	.6720
RBS	63.47 (17.88)	63.53 (16.29)	-.016	.987	.0034	-.1413	.1448
L-r	57.30 (10.84)	54.94 (8.39)	1.086	.280	.2339	-.1901	.6568
K-r	45.29 (9.97)	41.38 (11.29)	1.744	.084	.3757	-.0507	.8002

Psychopathic Traits

Table 5 provides descriptive statistics for participants' scores on the TriPM, including Total score and subscale scores for Boldness, Meanness, and Disinhibition. Disinhibition scores varied significantly across groups ($F(2, 74) = 5.079, p = .009, \eta^2 = .172$). VTC participants reported significantly higher rates of Disinhibition ($M = 41.83, SD = 7.63$) as compared to both incarcerated non-veterans ($M = 30.13, SD = 11.56$) and incarcerated veterans ($M = 25.99, SD = 1.05$). Boldness scores also varied significantly across groups ($F(2, 74) = 4.228, p = .018, \eta^2 = .172$), with incarcerated non-veterans reporting higher rates of Boldness ($M = 20.37, SD = 7.92$) than incarcerated veterans ($M = 15.69, SD = 6.38$) or VTC participants ($M = 13.81, SD = 5.37$). There were no statistically significant differences between groups on Meanness or Total scores.

VTC and incarcerated veteran subgroups were then combined, in order to compare more broadly between all veteran participants and non-veteran participants. An independent samples t-test was conducted in order to compare the TriPM scores between the two groups. There was a significant difference in Boldness for veteran ($M = 15.48, SD = 6.25$) and non-veteran ($M = 20.25, SD = 8.09$) groups ($t(72) = -2.715, p = .008$), with veterans endorsing comparatively less bold traits than civilians (see Table 6).

Table 5

Means, Standard Deviations, and One-Way ANOVA Results for Triarchic Psychopathy

Measure Scales

TriPM Scales	Veterans Treatment Court (n = 6)	Incarcerated Veterans (n = 47)	Incarcerated Nonveterans (n = 22)	Total	<i>F</i> (<i>df</i> = 2, 74)	<i>p</i>	η^2
Disinhibition	41.83 (7.63) _a	30.13 (11.56) _b	25.99 (9.82) _c	29.85 (11.42)	5.079	.009	.172
Boldness	13.81 (5.37)	15.69 (6.38)	20.37 (7.92)	16.91 (7.09)	4.228	.018	.105
Meanness	38.17 (6.79)	36.28 (8.27)	38.05 (8.11)	36.95 (8.07)	.427	.654	.012
Total	93.98 (16.00)	82.12 (18.96)	84.40 (16.86)	83.74 (18.21)	1.153	.321	.031

Note. Row values with different subscripts have statistically significant differences, $p \leq .05$.

Table 6

Means, Standard Deviations, and t-test Results for Triarchic Psychopathy Measure

Scales

TriPM Scales	Veterans (n = 53)	Nonveterans (n = 21)	<i>t</i> (<i>df</i> = 72)	<i>p</i>	<i>d</i>	95% C.I. (Lower)	95% C.I. (Upper)
Disinhibition	31.45 (11.74)	25.79 (10.02)	1.944	.056	.5013	-.0122	1.0115
Boldness	15.48 (6.25)	20.24 (8.09)	-2.715	.008	.7001	.1798	1.2159
Meanness	36.50 (8.08)	37.91 (8.29)	-.675	.502	.1740	-.3328	.6796
Total	83.46 (18.90)	83.94 (17.14)	-.100	.920	.0258	-.4798	.5311

CHAPTER V

Discussion

Research pertaining to justice-involved veterans is limited when it comes to delineating specific mental health and rehabilitation needs. This study sought to clarify the nature of JIV mental health concerns and the accuracy of reported symptomatology in order to inform the rising utilization of VTCs across the country. Although limited in sample size, the results of this study suggest that the mental health profiles of JIVs are not vastly different from other incarcerated individuals. Further, JIVs were no more likely to inaccurately represent their distress/symptoms, as compared to other forensic populations; however, this may be attributable to the lack of motivation for response bias in this study. These preliminary findings would suggest that JIVs would benefit from rehabilitation models similar to those developed for the general population, such as mental health courts, drug courts, and specific programming within incarcerated settings.

Of note is the variation in levels of psychopathic traits across comparison groups. Veterans were more disinhibited than their non-veteran counterparts, and this difference was most pronounced among VTC participants. This difference between veterans and non-veterans may be explained in part by the nature of military service and the types of individuals who are drawn to more action-oriented, dangerous jobs. Some questions on the TriPM are likely to load more heavily on military experience and values, and may represent a level of disinhibition that was functional and necessary for optimal performance. Within the military context, the qualities associated with disinhibition may be viewed as valuing personal courage, rather than seen as impulsive or thrill seeking.

Furthermore, disinhibited individuals may have been drawn to military service in the first place, given the inherent risks of such an occupation.

Comparatively, boldness was more characteristic of non-veterans. This pattern may reflect a difference attributable to military service, with veterans demonstrating a learned tendency to value teamwork, respect, and dutifulness. Social dominance, an aspect of boldness, would be discouraged in a military setting, where rank structure and strict personal bearing are heavily emphasized. A bold, individualistic approach likely would not integrate easily into a culture of selfless service and respect, which are key aspects of military values.

Implications

Though these data do not speak specifically to the effectiveness of VTCs, certain characteristics and observations can be gleaned from this study to inform the development of such rehabilitative programs. Given that some antisocial features distinguish veterans from non-veterans, special attention is warranted to address those clear differences in behavior. Because JIVs are lower on boldness and have a history of military service, appealing to this aspect of their backgrounds may contribute to the eventual success of veterans involved in various rehabilitation programs. For example, JIVs housed in a designated veterans' pod at the Montgomery County Jail were given additional duties (e.g., raising and lowering the flag daily, washing their own laundry, etc.) and held to higher, military-like standards (e.g., making their beds every morning, keeping common areas clean and quiet). The veterans given this opportunity embraced these duties and standards, and generally demonstrated an exceptional level of respect and professionalism toward the researchers. This bearing was vastly different from

offenders housed in general population. These alterations in the environment appeared to encourage JIVs rise to a higher standard of behavior because of the additional emphasis on military values and customs, and may warrant attention in future studies.

Although the overall profiles of mental health concerns did not indicate significant pathology, there were a number of participants who indicated clinically significant concerns. Mental health treatment is accessible within both jail and VTC settings, but it may not be openly advertised or viewed in a positive light. JIVs may not be aware of all resources available to them, both within their current setting and more broadly as a function of their military service. For example, several participants housed within the veterans' pod at the Montgomery County Jail expressed that, after their time in service, they were unaware of the possibility of filing a claim with the Veterans' Administration in order to receive medical care and other forms of assistance. Others requested a referral to the jail psychologist after participating in this study. Increasing education and awareness about available resources amongst incarcerated veterans, as well as providing assistance with accessing those resources, would be of great benefit to those individuals.

Symptom reporting across groups showed an overall valid pattern of responding that did not vary significantly across groups. While this does not suggest a need for more specialized assessment of veterans' symptom validity, assessing the accuracy of reported pathology should be an integral aspect of assessment nonetheless. Within the context of VTCs, there is inherent motivation to endorse a service-connected mental disorder in order to have access to the benefits and resources provided by the court. Embedding a measure with built-in validity indicators (such as the MMPI-2-RF)

into the pre-admission evaluation process would help to identify individuals with mental health problems and assess their response style. Those qualified individuals who are most in need of treatment will reap the most benefit from such programs; restricting access from those individuals who may be misrepresenting their mental health concerns for secondary gain will ensure that resources and interventions are not directed away from those who are truly in need.

Limitations

The conclusions drawn from this study are limited by several unforeseen methodological factors. Most significant is the small sample of VTC participants. Recruiting these individuals proved challenging primarily because of time limitations. These participants attended VTC for approximately two hours biweekly, during which time the researchers would recruit, consent, and administer assessments. Typically, administration could not be completed within one session of VTC, and participants were not amenable to remaining beyond those hours because of work, probation, and family obligations. Thus, data collection for one participant frequently took two to three sessions, over the course of several weeks. Unfortunately, these time limitations severely restricted the number of VTC participants included in this study. Given that the primary focus of the research was this particular population, the conclusions drawn from this study are limited in their applicability. Without strong support from judges and court administrators, future studies within VTCs likely will face similar challenges. Providing incentives for participation within the VTC system (i.e., community service hours) could possibly increase participation. Additionally, securing funding sources from veteran

organizations or research institutions to incentivize participation (i.e., gift cards) would both benefit participants and bolster numbers.

Time limitations were less problematic among jail participants; however, some individuals would request to complete longer tasks (i.e., the MMPI-2-RF) over multiple encounters or at a later date. Depending on researcher availability, some participants were released from custody before all test materials could be administered. Other participants partially completed the test battery, but dropped out before all measures could be administered. A shorter battery of assessment measures likely would have resulted in increased participant numbers and fewer instances of dropout.

Relatedly, the frequency of extended administrations led to some measures, such as the MMPI-2-RF, being given over multiple encounters, often weeks apart. This certainly raises concerns over the validity of the results; however, given the situational limitations (i.e., working within a jail system) and the voluntary nature of the study, researchers were limited in what could feasibly be done to resolve this issue. Despite the limitations of this study's methodology, these findings contribute an important foundation and direction for future studies within the limited body of research investigating specific mental health and symptom validity concerns among JIVs.

Conclusion

This study provides preliminary evidence that JIVs are not experiencing differing patterns of pathology and are not more or less likely to report those symptoms accurately, as compared to incarcerated civilian populations. However, some differences in externalizing behavior indicate that military values and customs continue to play a role in behavior and interpersonal interaction. Is the general lack of differences among groups

truly representative of similarity in mental health concerns among justice-involved individuals, regardless of veteran status? Or does this indicate a need for more specific assessment tools designed specifically for the veteran-forensic interface? Future studies with more robust samples, and perhaps different methods of assessment, may indicate that small differences do exist that warrant further attention. Additionally, dedicating more attention to criminogenic needs and other traits, such as sensation-seeking, may provide a better understanding of the externalizing behaviors (or lack thereof) that characterize this population. Regardless, the results of this study would suggest that veteran-specific specialty courts and jail programming modeled after civilian rehabilitation programs would show similar patterns of success in treating the mental health concerns of their participants. Incorporating military values, customs, and courtesies into the culture of these programs may further enhance veterans' commitment to, and benefits gained from, such programs.

REFERENCES

- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders, text revision (4th ed.)*. Washington, DC: American Psychiatric Association.
- Appelbaum, P. S., Jick, R. Z., Grisso, T., Givelber, D., Silver, E., & Steadman, H. J. (1993). Use of posttraumatic stress disorder to support an insanity defense. *The American Journal of Psychiatry*, 150, 229-234.
<https://doi.org/10.1176/ajp.150.2.229>
- Arbisi, P. A., Ben-Porath, Y. S., & McNulty, J. (2006). The ability of the MMPI-2 to detect feigned PTSD within the context of compensation seeking. *Psychological Services*, 3, 249. <http://psycnet.apa.org/doi/10.1037/1541-1559.3.4.249>
- Armour, C., Tsai, J., Durham, T. A., Charak, R., Biehn, T. L., Elhai, J. D., & Pietrzak, R. H. (2015). Dimensional structure of DSM-5 posttraumatic stress symptoms: Support for a hybrid Anhedonia and Externalizing Behaviors model. *Journal of Psychiatric Research*, 61, 106-113.
<https://doi.org/10.1016/j.jpsychires.2014.10.012>
- Ben-Porath, Y. S. (2003). Assessing personality and psychopathology with self-report inventories. In J.R. Graham & J.A. Naglierie (Eds.), *Handbook of psychology: Assessment methods* (pp. 553-578). New York, NY: Wiley.
[doi:10.1002/0471264385.wei1024](https://doi.org/10.1002/0471264385.wei1024)
- Ben-Porath, Y. S., & Tellegen, A. (2008). *MMPI-2-RF: Manual for administration, scoring and interpretation*. Minneapolis, MN: University of Minnesota Press.

- Blevins, C. A., Weathers, F. W., Davis, M. T., Witte, T. K., & Domino, J. L. (2015). The posttraumatic stress disorder checklist for DSM-5 (PCL-5): Development and initial psychometric evaluation. *Journal of Traumatic Stress, 28*, 489-498. doi:10.1002/jts.22059
- Bray, R. M., Pemberton, M. R., Lane, M. E., Hourani, L. L., Mattiko, M. J., & Babeu, L. A. (2010). Substance use and mental health trends among US military active duty personnel: key findings from the 2008 DoD Health Behavior Survey. *Military Medicine, 175*, 390-399. doi:10.7205/MILMED-D-09-00132
- Cleckley, H. (1941). *The mask of sanity; an attempt to reinterpret the so-called psychopathic personality*. Oxford, England: Mosby.
- Cleckley, H. (1988). *The mask of sanity* (5th ed.). Augusta, GA: Emily S. Cleckley.
- Collie, J. (1917). *Malingering and feigned sickness* (2nd ed.). London, England: Edward Arnold.
- DeMatteo, D., LaDuke, C., Locklair, B. R., & Heilbrun, K. (2013). Community-based alternatives for justice-involved individuals with severe mental illness: Diversion, problem-solving courts, and reentry. *Journal of Criminal Justice, 41*, 64-71. <https://doi.org/10.1016/j.jcrimjus.2012.09.002>
- DeViva, J. C., Sheerin, C. M., Southwick, S. M., Roy, A. M., Pietrzak, R. H., & Harpaz-Rotem, I. (2016). Correlates of VA mental health treatment utilization among OEF/OIF/OND veterans: Resilience, stigma, social support, personality, and beliefs about treatment. *Psychological Trauma: Theory, Research, Practice, and Policy, 8*, 310. <http://psycnet.apa.org/doi/10.1037/tra0000075>

- Edelman, B., Berger, T.J., & Crawford, G. (2016). *Veterans Treatment Courts: A second chance for vets who have lost their way*. Washington, DC: U.S. Department of Justice National Institute of Corrections.
- Elbogen, E. B., Johnson, S. C., Newton, V. M., Straits-Troster, K., Vasterling, J. J., Wagner, H. R., & Beckham, J. C. (2012). Criminal justice involvement, trauma, and negative affect in Iraq and Afghanistan war era veterans. *Journal of Consulting and Clinical Psychology, 80*, 1097-1102.
<http://psycnet.apa.org/doi/10.1037/a0029967>
- Frueh, B. C., Elhai, J. D., Gold, P. B., Monnier, J., Magruder, K. M., Keane, T. M., & Arana, G. W. (2003). Disability compensation seeking among veterans evaluated for posttraumatic stress disorder. *Psychiatric Services, 54*, 84-91.
<https://doi.org/10.1176/appi.ps.54.1.84>
- Frueh, B. C., Hamner, M. B., Cahill, S. P., Gold, P. B., & Hamlin, K. L. (2000). Apparent symptom overreporting in combat veterans evaluated for PTSD. *Clinical Psychology Review, 20*, 853-885. [https://doi.org/10.1016/S0272-7358\(99\)00015-X](https://doi.org/10.1016/S0272-7358(99)00015-X)
- Greenberg, G. A., & Rosenheck, R. A. (2009). Mental health and other risk factors for jail incarceration among male veterans. *Psychiatric Quarterly, 80*, 41-53.
[doi:10.1007/s11126-009-9092-8](https://doi.org/10.1007/s11126-009-9092-8)
- Hare, R. D. (2003). *Hare Psychopathy Checklist-Revised (2nd Ed.) technical manual*. Multi-Health Systems: Toronto.
- Hawkins, M. D. (2009). Coming home: Accommodating the special needs of military veterans to the criminal justice system. *Ohio State Journal of Criminal Law, 7*,

563. Retrieved from http://www.ncdsv.org/images/OSJCL_Coming-Home-Accommodating-the-Special-Needs-of-Military-Veterans-to-the-CJS_2010.pdf
- Heilbrun, K., DeMatteo, D., Yasuhara, K., Brooks-Holliday, S., Shah, S., King, C., ... & Laduke, C. (2012). Community-based alternatives for justice-involved individuals with severe mental illness: Review of the relevant research. *Criminal Justice and Behavior*, 39, 351-419. <https://doi.org/10.1177/0093854811432421>
- Holbrook, J. G., & Anderson, S. (2011). Veterans courts: Early outcomes and key indicators for success. Widener Law School Legal Studies Research Paper Series No. 11-25. Retrieved from <https://ssrn.com/abstract=1912655>
- Institute of Medicine. (2010). *Returning home from Iraq and Afghanistan: Preliminary assessment of readjustment needs of veterans, service members, and their families*. Washington, DC: The National Academies Press.
- Kemp, J., & Bossarte, R. (2013). *Suicide data report: 2012*. Washington, DC: Department of Veterans Affairs, Mental Health Services, Suicide Prevention Program. Retrieved from <http://wiiwarrior.org/downloads/suicide-data-report-2012-final.pdf>
- Marion, B. E., Sellbom, M., & Bagby, R. M. (2011). The detection of feigned psychiatric disorders using the MMPI-2-RF overreporting validity scales: An analog investigation. *Psychological Injury and Law*, 4, 1-12. doi:10.1007/s12207-011-9097-0
- Marx, B. P., Jackson, J. C., Schnurr, P. P., Murdoch, M., Sayer, N. A., Keane, T. M., ... & Speroff, T. (2012). The reality of malingered PTSD among veterans: Reply to

McNally and Frueh (2012). *Journal of Traumatic Stress*, 25, 457-460.

doi:10.1002/jts.21714

Mason, L. H., Shandera-Ochsner, A. L., Williamson, K. D., Harp, J. P., Edmundson, M., Berry, D. T., & High Jr, W. M. (2013). Accuracy of MMPI-2-RF validity scales for identifying feigned PTSD symptoms, random responding, and genuine PTSD. *Journal of Personality Assessment*, 95, 585-593.

<http://dx.doi.org/10.1080/00223891.2013.819512>

Miller, L. (2012). Posttraumatic stress disorder and criminal violence: Basic concepts and clinical-forensic applications. *Aggression and Violent Behavior*, 17, 354-364.

<https://doi.org/10.1016/j.avb.2012.03.007>

Milliken, C. S., Auchterlonie, J. L., & Hoge, C. W. (2007). Longitudinal assessment of mental health problems among active and reserve component soldiers returning from the Iraq war. *Journal of the American Medical Association*, 298, 2141-2148.

doi:10.1001/jama.298.18.2141

Moore, M. E., & Hiday, V. A. (2006). Mental health court outcomes: a comparison of re-arrest and re-arrest severity between mental health court and traditional court participants. *Law and Human Behavior*, 30, 659-674.

<https://doi.org/10.1007/s10979-006-9061-9>

Nevin, R. L. (2009). Low validity of self-report in identifying recent mental health diagnosis among US service members completing Pre-Deployment Health Assessment (PreDHA) and deployed to Afghanistan, 2007: a retrospective cohort study. *BMC Public Health*, 9, 376-386. <https://doi.org/10.1186/1471-2458-9-376>

- Pandiani, J. A., Ochs, W. R., & Pomerantz, A. S. (2010). Criminal justice involvement of armed forces veterans in two systems of care. *Psychiatric Services, 61*, 835-837.
<https://doi.org/10.1176/ps.2010.61.8.835>
- Patrick, C. J., Fowles, D. C., & Krueger, R. F. (2009). Triarchic conceptualization of psychopathy: Developmental origins of disinhibition, boldness, and meanness. *Development and Psychopathology, 21*, 913-938.
[doi:10.1017/S0954579409000492](https://doi.org/10.1017/S0954579409000492)
- Patrick, C.J. (2010). Operationalizing the triarchic conceptualization of psychopathy: preliminary description of brief scales for assessment of boldness, meanness, and disinhibition. Unpublished manual, Department of Psychology, Florida State University, Tallahassee, FL. Retrieved from <https://www.phenxtoolkit.org>
- Patrick, C. J., & Drislane, L. E. (2015). Triarchic model of psychopathy: Origins, operationalizations, and observed linkages with personality and general psychopathology. *Journal of Personality, 83*, 627-643. [doi:10.1111/jopy.12119](https://doi.org/10.1111/jopy.12119)
- Pietrzak, R. H., Tsai, J., Armour, C., Mota, N., Harpaz-Rotem, I., & Southwick, S. M. (2015). Functional significance of a novel 7-factor model of DSM-5 PTSD symptoms: Results from the National Health and Resilience in Veterans Study. *Journal of Affective Disorders, 174*, 522-526.
<https://doi.org/10.1016/j.jad.2014.12.007>
- Pinals, D. A. (2010). Veterans and the justice system: The next forensic frontier. *Journal of the American Academy of Psychiatry and the Law, 38*, 163-167. Retrieved from <http://jaapl.org/content/jaapl/38/2/163.full.pdf>

- Pitman, R. K., & Sparr, L. F. (1998). PTSD and the law. *PTSD Research Quarterly*, 9, 1-6. Retrieved from <https://www.hsdl.org/?view&did=13631>
- Rogers, R. (Ed.). (2008). *Clinical assessment of malingering and deception* (3rd ed.). New York, NY: Guilford Press.
- Rogers, R., Kropp, P. R., Bagby, R. M., & Dickens, S. E. (1992). Faking specific disorders: A study of the Structured Interview of Reported Symptoms (SIRS). *Journal of Clinical Psychology*, 48, 643-648. doi:10.1002/1097-4679(199209)48:53.0.CO
- Russell, H. R. (2009). Veterans treatment courts developing throughout the nation. In Flango, C. R., McDowell A. M., Campbell, C. F., & Kauder, N. B. (Eds.), *Future trends in state courts 2009* (pp. 130-133). Williamsburg, VA: National Center for State Courts.
- Seal, K. H., Maguen, S., Cohen, B., Gima, K. S., Metzler, T. J., Ren, L., Bertenthal, D. & Marmar, C. R. (2010). VA mental health services utilization in Iraq and Afghanistan veterans in the first year of receiving new mental health diagnoses. *Journal of Traumatic Stress*, 23, 5-16. doi:10.1002/jts.20493
- Sellbom, M., & Phillips, T. R. (2013). An examination of the triarchic conceptualization of psychopathy in incarcerated and nonincarcerated samples. *Journal Of Abnormal Psychology*, 122, 208-214. doi:10.1037/a0029306
- Sellbom, M., Wygant, D. B., & Drislane, L. E. (2015). Elucidating the construct validity of the psychopathic personality inventory triarchic scales. *Journal of Personality Assessment*, 97, 374-381. doi:10.1080/00223891.2014.962654

Smee, D. E., McGuire, J., Garrick, T., Sreenivasan, S., Dow, D., & Woehl, D. (2013).

Critical concerns in Iraq/Afghanistan war veteran-forensic interface: Veterans treatment court as diversion in rural communities. *Journal of the American Academy of Psychiatry and the Law Online*, 41, 256-262. Retrieved from <http://jaapl.org/content/41/2/256>

Smith, A. (1982). *Symbol digit modalities test: Manual*. Los Angeles, CA: Western Psychological Services.

Sreenivasan, S., Garrick, T., McGuire, J., Smee, D. E., Dow, D., & Woehl, D. (2013).

Critical concerns in Iraq/Afghanistan war veteran-forensic interface: Combat-related postdeployment criminal violence. *Journal of the American Academy of Psychiatry and the Law Online*, 41, 263-273. Retrieved from <http://jaapl.org/>

Taft C.T., Kaloupek D.G., Schumm J.A., Marshall A.D., Panuzio J., King D.W., &

Keane, T.M. (2007). Posttraumatic stress disorder symptoms, physiological reactivity, alcohol problems, and aggression among military veterans. *Journal of Abnormal Psychology*, 116, 498–507. doi:10.1037/0021-843X.116.3.498

Tellegen, A., & Ben-Porath, Y. S. (2008). *MMPI-2-RF: Technical Manual*. Minneapolis, MN: University of Minnesota Press.

U.S. Department of Veterans Affairs. (2016). *Fact sheet: VA mental health care*.

Washington, DC: Office of Public Affairs. Retrieved from

<https://www.va.gov/opa/publications/factsheets/April-2016-Mental-Health-Fact-Sheet.pdf>

- Walter Reed Army Institute of Research (WRAIR). (2006, February 15). Battlemind training I: Transition from combat to home. Retrieved from <http://www.ptsd.ne.gov/pdfs/WRAIR-battlemind-training-Brochure.pdf>
- Weathers, F.W., Litz, B.T., Keane, T.M., Palmieri, P.A., Marx, B.P., & Schnurr, P.P. (2013). The PTSD Checklist for DSM-5 (PCL-5). Retrieved from the National Center for PTSD at www.ptsd.va.gov
- Wilson, D. B., Mitchell, O., & MacKenzie, D. L. (2006). A systematic review of drug court effects on recidivism. *Journal of Experimental Criminology*, 2, 459-487. doi:10.1007/s11292-006-9019-4
- Wortmann, J. H., Jordan, A. H., Weathers, F. W., Resick, P. A., Dondanville, K. A., Hall-Clark, B., Foa, E. B., Young-McCaughan, S., Yarvis, J. S., Hembree, E. A., Mintz, J., Peterson, A. L., & Litz, B.T. (2016). Psychometric analysis of the PTSD Checklist-5 (PCL-5) among treatment-seeking military service members. *Psychological Assessment*, 28, 1392. <http://psycnet.apa.org/doi/10.1037/pas0000260>
- Wygant, D. B., Ben-Porath, Y. S., Arbisi, P. A., Berry, D. T., Freeman, D. B., & Heilbronner, R. L. (2009). Examination of the MMPI-2 Restructured Form (MMPI-2-RF) validity scales in civil forensic settings: Findings from simulation and known group samples. *Archives of Clinical Neuropsychology*, 24, 671-680. <https://doi.org/10.1093/arclin/acp073>

APPENDIX A

Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5)

Instructions: The table below lists problems that people sometimes have in response to extremely stressful experiences. Keeping your worst event in mind, please read each problem carefully and then circle one of the numbers to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	<i>Not at All</i>	<i>A Little Bit</i>	<i>Moderately</i>	<i>Quite a Bit</i>	<i>Extremely</i>
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (e.g., heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (e.g., people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (e.g., having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (e.g., being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4

16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being “super-alert” or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

APPENDIX B**Symbol Digit Modalities Test (SDMT), Written Version:**

Verbal Instructions:

Please look at these boxes at the top of the page. You can see that each box in the upper row has a little mark in it. Now look at the boxes in the row just underneath the marks. Each of the boxes under the marks has a number. Each of the marks in the top row is different, and under each mark in the bottom row is a different number.

Now look at the next line of boxes (*examiner points to line of boxes*) just under the top two rows. Notice that the boxes on the top have marks, but the boxes underneath are empty. You are to fill each empty box with the number that should go there according to the way they are paired in the key at the top of the page. For example, if you look at the first mark, and then look up at the key, you will see that the number 1 goes in the first empty box. So write the number 1 in the first box. Now, what number should you put in the second box? (*Number 5*) That's right. So write the number 5 in the second box. What number goes in the third box? (*Number 2*) Two, right, that is the idea. You are to fill each of the empty boxes with the numbers that should go in them according to the key. Now for practice, fill in the rest of the boxes until you come to the double line. When you come to the double line, stop.

Now when I say "Go!" write in the numbers just like you have been doing as fast as you can until I say "Stop!" When you come to the end of the first line, go quickly to the next line without stopping, and so on. If you make a mistake, do not erase, just write the correct answer over your mistake. I repeat, DO NOT ERASE as you will waste time. Just write the correct answer over your mistake. Do not skip any boxes and work as quickly as you can. Ready? Go!

Exactly 90 seconds from starting, the examiner says: Stop!

KEY

(÷	┌	Γ	└	>	+)	÷
1	2	3	4	5	6	7	8	9

(└ ÷ (┌ > ÷ Γ (> ÷ (> (÷

Γ > (÷ └ > ┌ Γ (÷ > ÷ Γ ┌)

Γ └ +) (┌ + Γ) └ ÷ ┌ Γ +

÷ Γ └ (> Γ (└ > + ÷) ┌ > Γ

÷ └) ┌ > + Γ └ ÷ ┌ + ÷ ÷) (

> ÷ + ÷ ┌ > Γ ÷ (+ ÷ └ >) Γ

÷) + ÷ ┌ +) └ (÷ ÷ (Γ ┌ >

└ ÷ (> Γ ÷ (> ÷ + ┌ └ Γ) ÷

APPENDIX C

Triarchic Psychopathy Measure (TriPM):

Instructions: This questionnaire contains statements that different people might use to describe themselves. Each statement is followed by four options:

True Somewhat true Somewhat false False

For each statement, mark "X" on the option that describes you best. There are no right or wrong answers; just choose the option that best describes you.	<i>True</i>	<i>Somewhat True</i>	<i>Somewhat False</i>	<i>False</i>
1. I'm optimistic more often than not.	0	1	2	3
2. How other people feel is important to me.	0	1	2	3
3. I often act on immediate needs.	0	1	2	3
4. I have no strong desire to parachute out of an airplane.	0	1	2	3
5. I've often missed things I promised to attend.	0	1	2	3
6. I would enjoy being in a high-speed chase.	0	1	2	3
7. I am well-equipped to deal with stress.	0	1	2	3
8. I don't mind if someone I dislike gets hurt.	0	1	2	3
9. My impulsive decisions have caused problems with loved ones.	0	1	2	3
10. I get scared easily.	0	1	2	3
11. I sympathize with others' problems.	0	1	2	3
12. I have missed work without bothering to call in.	0	1	2	3
13. I'm a born leader.	0	1	2	3
14. I enjoy a good physical fight.	0	1	2	3
15. I jump into things without thinking.	0	1	2	3

For each statement, mark "X" on the option that describes you best. There are no right or wrong answers; just choose the option that best describes you.	<i>True</i>	<i>Somewhat True</i>	<i>Somewhat False</i>	<i>False</i>
16. I have a hard time making things turn out the way I want.	0	1	2	3
17. I return insults.	0	1	2	3
18. I've gotten in trouble because I missed too much school.	0	1	2	3
19. I have a knack for influencing people.	0	1	2	3
20. It doesn't bother me to see someone else in pain.	0	1	2	3
21. I have good control over myself.	0	1	2	3
22. I function well in new situations, even when unprepared.	0	1	2	3
23. I enjoy pushing people around sometimes.	0	1	2	3
24. I have taken money from someone's purse or wallet without asking.	0	1	2	3
25. I don't think of myself as talented.	0	1	2	3
26. I taunt people just to stir things up.	0	1	2	3
27. People often abuse my trust.	0	1	2	3
28. I'm afraid of far fewer things than most people.	0	1	2	3
29. I don't see any point in worrying if what I do hurts someone else.	0	1	2	3
30. I keep appointments I make.	0	1	2	3
31. I often get bored quickly and lose interest.	0	1	2	3
32. I can get over things that would traumatize others.	0	1	2	3
33. I am sensitive to the feelings of others.	0	1	2	3
34. I have conned people to get money from them.	0	1	2	3

For each statement, mark "X" on the option that describes you best. There are no right or wrong answers; just choose the option that best describes you.	<i>True</i>	<i>Somewhat True</i>	<i>Somewhat False</i>	<i>False</i>
35. It worries me to go into an unfamiliar situation without knowing all the details.	0	1	2	3
36. I don't have much sympathy for people.	0	1	2	3
37. I get in trouble for not considering the consequences of my actions.	0	1	2	3
38. I can convince people to do what I want.	0	1	2	3
39. For me, honesty really is the best policy.	0	1	2	3
40. I've injured people to see them in pain.	0	1	2	3
41. I don't like to take the lead in groups.	0	1	2	3
42. I sometimes insult people on purpose to get a reaction from them.	0	1	2	3
43. I have taken items from a store without paying for them.	0	1	2	3
44. It's easy to embarrass me.	0	1	2	3
45. Things are more fun if a little danger is involved.	0	1	2	3
46. I have a hard time waiting patiently for things I want.	0	1	2	3
47. I stay away from physical danger as much as I can.	0	1	2	3
48. I don't care much if what I do hurts others.	0	1	2	3
49. I have lost a friend because of irresponsible things I've done.	0	1	2	3
50. I don't stack up well against most others.	0	1	2	3
51. Others have told me they are concerned about my lack of self-control.	0	1	2	3
52. It's easy for me to relate to other people's emotions.	0	1	2	3

For each statement, mark "X" on the option that describes you best. There are no right or wrong answers; just choose the option that best describes you.	<i>True</i>	<i>Somewhat True</i>	<i>Somewhat False</i>	<i>False</i>
53. I have robbed someone.	0	1	2	3
54. I never worry about making a fool of myself with others.	0	1	2	3
55. It doesn't bother me when people around me are hurting.	0	1	2	3
56. I have had problems at work because I was irresponsible.	0	1	2	3
57. I'm not very good at influencing people.	0	1	2	3
58. I have stolen something out of a vehicle.	0	1	2	3

APPENDIX D

Participant Demographic Information

Gender:	Male	Female	Non-Binary	Prefer Not to Say	Age: _____				
Ethnicity:	Asian or P.I.	A- A/Black	Caucasian/White	Marital Status:	Single	Married	Widow		
	Hispanic/Latino- a	Native Am.	Other: _____		Divorced	Co-Habitating			
Highest Level of Education:		Did Not Graduate	H.S. Grad or GED	Some College	Bachelor's Degree	Graduate Degree			
Employed at time of arrest?	Yes	No	Occupation: _____						
Employment after release?	Yes	No	Unsure	Occupation: _____					
Mental health treatment?	Yes	NO	Setting:	Outpatient	Inpatient				
How long? _____			Type of treatment:	Counseling/Therapy	Medication	Substance Abuse			
Have you ever suffered a head injury or head trauma?	Yes	No			If YES, how many times?	_____			
Military Veteran:	Yes	No	<i>If NO, please skip to next page. If YES, please continue to questions below.</i>						
Dates of Service:	_____		_____		Highest Pay Grade (e.g., E-3, W-3, O-3)				
	<i>From (Month/Year)</i>		<i>To (Month/Year)</i>						
Service Branch:	Air Force	Army	Coast Guard	Marines	Navy	Component:	Active Duty	Reserve	National Guard
Article 15 / NJP / Captain's Mast?	Yes	No	How many times? _____						
Court-Martial?	Yes	No	Convicted?	Yes	No	Offense: _____			

Number of deployments:	Total months deployed:			Combat exposure: Yes No		
	_____			_____		
Conflict/Era:	Vietnam	Gulf War	OEF/OIF	Other: _____		
Mental health treatment in military?	Yes	NO	Setting:	Outpatient	Inpatient	
How long?	_____		Type of treatment:	Counseling/Therapy	Medication	Substance Abuse
Discharge Status:	Honorable	General	Other than Honorable	Dishonorable	Bad Conduct	Entry-Level Separation
Medical discharge?	Yes	No	Service-Connected Disability?	Yes	No	Percent: _____
Reason for Medical Discharge: (Circle all that apply)	Combat Medical/Injury	Combat Mental Health	Non-Combat Medical/Injury	Non-Combat Mental Health		

VITA

Brittany E. Ridge, M.A.

EDUCATION

- Candidate** **Doctor of Philosophy (Clinical Psychology, Forensic Emphasis)**
 Sam Houston State University
Dissertation: Mental Health Profiles and Symptom Validity Among
 Justice-Involved Veterans
Advisor: Jorge G. Varela, Ph.D.
- 2015** **Master of Arts (Clinical Psychology, Forensic Emphasis)**
 Sam Houston State University
Thesis: Exploring the Role of Executive Dysfunction Within the
 Externalizing Spectrum
Advisor: Adam Schmidt, Ph.D.
- 2013** **Bachelor of Arts**
 Psychology & Sociology, *Magna Cum Laude*
 University of North Carolina at Chapel Hill

CLINICAL EXPERIENCE

- October 2018 - Present** **Clinical Psychology Intern**
Brooke Army Medical Center
 San Antonio, Texas
- Responsibilities:*
- Provide individual and group evidence-based interventions to adult active duty service members including Cognitive Processing Therapy (CPT), Prolonged Exposure (PE), Acceptance & Commitment Therapy (ACT), Cognitive Behavioral Therapy (CBT), and components of Dialectical Behavioral Therapy (DBT)
 - Conduct suicide risk assessments
 - Conduct, and author reports for, military-specific evaluations (including command-directed evaluations, positions of significant trust and authority, fitness for duty, and chapter separations)

- Conduct psychodiagnostic and neuropsychological assessments
- Deliver psychoeducational briefs to service members
- Communicate information to Commanders regarding the mental health and fitness for duty of service members

Supervisor: Raymond Beckman, Ph.D.

**June 2017 –
June 2018** **Practicum Student- Individual Therapist**
Texas A&M Telehealth Counseling Clinic
College Station, Texas

- Responsibilities:*
- Provide individual evidence-based interventions to adults including Cognitive Behavioral Therapy (CBT), components of Dialectical Behavioral Therapy (DBT), and Cognitive Processing Therapy (CPT)
 - Conduct intake evaluations and authored intake reports
 - Conduct suicide risk assessments
 - Provide individual psychotherapy as needed
 - Attend collaborative care community meetings
 - Participate in community outreach efforts

Population: A diverse, low-income, multi-ethnic population of adults seeking outpatient services

Supervisors: Carly McCord, Ph.D. & Kevin Tarlow, Ph.D.

**August 2014 – June
2018** **Assistant Forensic Evaluator**
Psychological Services Center
Sam Houston State University
Huntsville, Texas

- Responsibilities:*
- Conduct court-ordered evaluations consisting primarily of a comprehensive clinical interview and symptom responses assessments
 - Discuss assessment and case formulation with supervisor
 - Co-author reports for adult forensic evaluations, including evaluations of competence to stand trial, criminal responsibility
 - Conduct psychodiagnostic evaluations, and provide treatment recommendations

Population: Justice-involved adults

Supervisor: Mary Alice Conroy, Ph.D., ABPP

May 2014 – June 2018 **Practicum Student-Individual Therapist & Evaluator**
Psychological Services Center
 Sam Houston State University
 Huntsville, Texas

- Responsibilities:*
- Individual psychotherapy with adult and child clients
 - Conducted intake evaluations and authored intake reports
 - Formulated detailed treatment plans and closely monitored treatment goals
 - Applied evidence-based interventions, including Cognitive Behavioral Therapy (CBT), components of Dialectical Behavior Therapy (DBT), Skills Training in Affective and Interpersonal Regulation/Narrative Story-Telling (STAIR-NST)
 - Engaged in suicide risk assessment and prevention
 - Comprehensive psychological evaluations
 - Clinical and collateral interviews
 - Intelligence and achievement testing
 - Personality and psychopathology testing
 - Neuropsychological testing
 - Authored comprehensive, integrated reports
 - Communicated assessment results and recommendations to clients

Population: A diverse, low-income, multi-ethnic population of children, adolescents, and adults seeking outpatient services

Supervisors: Adam Schmidt, Ph.D., Melissa Magyar, Ph.D., & Darryl Johnson, Ph.D., Jorge G. Varela, Ph.D.

August 2016 – May 2017 **Practicum Student-Individual Therapist**
Office of Rebecca Hamlin, private practice
 Spring, Texas

- Responsibilities:*
- Co-facilitated individual evidence-based therapy to children, adolescents, and adults, including Cognitive Behavioral Therapy (CBT) and components of Dialectical Behavior Therapy (DBT)
 - Assisted in formulating detailed treatment plans and closely monitoring treatment goals
 - Administered and scored assessment materials, including cognitive, achievement, adaptive behavior, personality, neuropsychological, and behavioral measures
 - Assessments included, but were not limited to, ADHD, learning disabilities, memory impairments, and comprehensive psychological evaluations
 - Engaged in integrative report writing for ethnically diverse college students and child, adolescent, and adult populations
 - Communicated assessment results and recommendations to clients
 - Conducted ex-parte forensic evaluations consisting primarily of a comprehensive clinical interview and neuropsychological, intelligence, and psychodiagnostic testing
 - Co-authored reports for adult forensic evaluations, including evaluations of competence to stand trial and criminal responsibility

Population: Children, adolescent, and adult populations; justice-involved adults

Supervisor: Rebecca Hamlin, Ph.D.

**October 2015 –
July 2016** **Practicum Student- Individual and Group Therapist**
Federal Prison Camp Bryan
Bryan, Texas

- Responsibilities:*
- Co-facilitated therapeutic groups within the Residential Drug Abuse Program (RDAP) and Non-Residential Drug Treatment Program, with a particular focus on psychoeducation and cognitive skills building
 - Conducted intake screening interviews and co-authored intake reports for Non-Residential Drug Treatment Program participants
 - Participated in weekly multidisciplinary treatment team meetings
 - Attended weekly community meetings
 - Observed and conducted brief crisis interventions for inmates seeking immediate services

- Developed and delivered a presentation discussing research-based risk and protective factors for recidivism to inmates and prison staff
- Administered intelligence assessment measures to male inmates at FCI Bastrop
 - Co-authored integrative reports of intelligence and achievement testing results; provided recommendations for accommodations

Population: Ethnically diverse, adult female offenders incarcerated in a minimum security federal prison camp

Supervisors: Ashley Noble, Psy.D., Leana Talbot, Ph.D., & Deanna Vokes Berg, Psy.D.

August 2015 – September 2015 **Practicum Student-Individual Evaluator**
Montgomery County Juvenile Probation Department
 Conroe, Texas

- Responsibilities:*
- Conducted a psychodiagnostic evaluation on a juvenile as ordered by the court or probation department
 - Assessments included use of intelligence, achievement, and adaptive behavior measures
 - Authored an integrated report, and provided treatment and placement recommendations

Population: Ethnically diverse, justice-involved youth

Supervisor: Darryl Johnson, Ph.D.

TEACHING EXPERIENCE

August 2017 – May 2018 **Instructor**
Psychology and The Law (PSYC 3383)
 Department of Psychology & Philosophy
 Sam Houston State University
 Huntsville, Texas

- Responsibilities:*
- Developed online course curriculum to address key learning objectives
 - Create assignments and exams to evaluate students' performance
 - Grade coursework and provide ongoing feedback for students

Supervisor: Christopher Wilson, Ph.D.

**August 2016 –
May 2017** **Graduate Teaching Assistant**
Assessment of Intelligence and Achievement (PSYC 5395)
Department of Psychology & Philosophy
Sam Houston State University
Huntsville, Texas

- Responsibilities:*
- Instructed students regarding standardized administration of various intelligence and achievement measures
 - Supervised administration and scoring of numerous intelligence, achievement, and adaptive behavior measures to ensure student competence upon course completion in preparation for further clinical training

Supervisor: Amanda Venta, Ph.D.

**May 2016 –
August 2016** **Graduate Teaching Assistant**
Human Neuropsychology (PSYC 7374)
Department of Psychology & Philosophy
Sam Houston State University
Huntsville, Texas

- Responsibilities:*
- Instructed students regarding standardized administration of various neuropsychological measures
 - Supervised administration and scoring of numerous neuropsychological measures to ensure student competence upon course completion in preparation for further clinical training

Supervisor: David Nelson, Ph.D.

SUPERVISORY EXPERIENCE

**August 2016 –
March 2017** **Undergraduate Research Supervisor**
Department of Psychology & Philosophy
Sam Houston State University
Huntsville, Texas

- Responsibilities:*
- Supervised an undergraduate honors student in designing and executing a research project involving a case law review

- Co-authored a data presentation presented at a national conference

Supervisor: Adam Schmidt, Ph.D.

**August 2015 –
December 2015**

Peer Supervisor

Capstone Practicum (PSYC 8381)
Department of Psychology & Philosophy
Sam Houston State University
Huntsville, Texas

- Responsibilities:*
- Supervised second-year doctoral students on their psychological assessment cases
 - Verified scoring of various testing protocols
 - Edited clinical documentation as needed
 - Reviewed and provided feedback for case presentations

Supervisor: David Nelson, Ph.D.

RESEARCH EXPERIENCE

**January 2017 –
Present**

Principal Investigator

Mental Health Profiles and Symptom Validity Concerns of Justice-Involved Veterans
Department of Psychology and Philosophy
Sam Houston State University
Huntsville, Texas

- Responsibilities:*
- Design and execute study of mental health and criminogenic needs of veteran and non-veteran offenders involved in problem solving and specialty courts

Supervisor: Jorge G. Varela, Ph.D.

**July 2016 –
December 2016**

Co-Investigator

Evaluator Empathy in Psychopathy Interviews
Department of Psychology and Philosophy
Sam Houston State University
Huntsville, Texas

- Responsibilities:*
- Interviewed and administered measures to undergraduate research participants as part of an experimental study exploring the influence of evaluator empathy on reports of defendant psychopathy and normative personality traits
 - Co-authored data presentations at multiple national conferences

Supervisor: Marcus Boccaccini, Ph.D.

**July 2016 –
December 2016**

Contract Researcher

The Lone Star Project: Study of Offender Trajectories, Associations, and Reentry
College of Criminal Justice
Sam Houston State University
Huntsville, Texas

- Responsibilities:*
- Interviewed Texas Department of Criminal Justice offenders as part of an NIJ-funded study exploring the implications of gang membership for prison group affiliation, recidivism, and reentry
 - Coded and transcribed data collected from in-person interviews

Supervisors: Erin Orrick, Ph.D.

**August 2015 –
March 2016**

Graduate Research Assistant

Pilot Testing Approaches to Suicide Risk Assessment Training: Preliminary Efficacy and an Extension to Violence Risk
Department of Psychology and Philosophy
Sam Houston State University
Huntsville, Texas

- Responsibilities:*
- Pilot study examining the efficacy of a suicide risk assessment training workshop
 - Coded data gathered from training participants regarding their suicide risk assessment competency pre- and post-training
 - Co-authored publications and a data presentation at a national conference

Supervisor: Rob Cramer, Ph.D.

**August 2014 –
August 2016**

Graduate Research Assistant

A Case Law Review of the Million Clinical Multiaxial Inventory (MCMI)

Department of Psychology and Philosophy
 Sam Houston State University
 Huntsville, Texas

- Responsibilities:*
- Conducted detailed reviews of case law in order to identify, extract, and code information relevant to the MCMI and its use in the legal arena
 - Assisted in developing and refining coding categories for the purpose of data analysis

Supervisor: Melissa Magyar, Ph.D.

**August 2014 –
 May 2016**

Co-Investigator

A Four-Factor Model of Executive Functioning: The Relationship Between Personality, Intelligence, and Executive Functioning
 Department of Psychology and Philosophy
 Sam Houston State University
 Huntsville, Texas

- Responsibilities:*
- Study exploring the relationship between personality, intelligence, impulsivity, and neuropsychological functioning
 - Administered intelligence, personality, neuropsychological, and behavioral measures to undergraduate research participants
 - Co-authored data presentations at multiple national conferences

Supervisor: Adam Schmidt, Ph.D.

**August 2014 –
 May 2016**

Principal Investigator

An Investigation of a Psychopathology/Personality-Based Typology Among Juvenile Male Offenders Utilizing the Personality Assessment Inventory-Adolescent (PAI-A)
 Department of Psychology and Philosophy
 Sam Houston State University
 Huntsville, Texas

- Responsibilities:*
- Utilized latent class analyses to develop a typology based on personality and psychopathology profiles obtained from juvenile male offenders
 - Authored a data presentation at a national conference

Supervisor: Melissa Magyar, Ph.D.

February 2014 – August 2014 Co-Investigator
The Influence of Context on Personality Reports
 Department of Psychology and Philosophy
 Sam Houston State University
 Huntsville, Texas

- Responsibilities:*
- Recruited and administered a multi-instrument survey to 150 undergraduate participants for a study examining differences in personality assessment scores between private and public administration contexts
 - Co-authored data presentations at multiple national conferences

Supervisor: Rowland Miller, Ph.D.

August 2013 – May 2014 **Graduate Research Assistant**
Hate Crime Victimization and Internalized Stigma Among Minority Groups
 Department of Psychology and Philosophy
 Sam Houston State University
 Huntsville, Texas

- Responsibilities:*
- Conducted an extensive literature review of the physical, mental, and legal repercussions of hate crimes
 - Co-authored a manuscript detailing the existing literature on hate crime victimization and the effects of internalized stigma on both individual victims and minority groups in general, as well as a review of existing hate crime legislation

Supervisor: Rob Cramer, Ph.D.

PUBLICATIONS

Vera, L. M., Boccaccini, M.T., Laxton, K., Bryson, C., Pennington, C., **Ridge, B.**, & Murrie, D. C. (2018, November 5). How does evaluator empathy impact a forensic interview?. *Law and Human Behavior*. Advance online publication. <http://dx.doi.org/10.1037/lhb0000310>.

Cramer, R. J., Bryson, C. N., Eichorst, M. K., Keyes, L. N., & **Ridge, B. E.** (2017). Conceptualization and pilot testing of a core competency-based training workshop

in suicide risk assessment and management. *Journal of Clinical Psychology*, 73, 233-238.

Cramer, R. J., Bryson, C. N., Stroud, C. H., & **Ridge, B. E.** (2016). A pilot test of a graduate course in suicide theory, risk assessment and management. *Teaching of Psychology*, 43, 238-242.

Schmidt, A., **Ridge, B. E.**, & Pennington, C. (2015). An overview of facial affect recognition deficits following traumatic brain injury in children and adults. In A. Freitas-Magalhães (Ed.), *Emotional Expression: The brain and face* (Vol. 6, pp. 307-350). Porto, Portugal: FEELab Science Books.

PROFESSIONAL RESEARCH PRESENTATIONS

Camins, J. S., Brooks, C. L., Francis, J., & **Ridge, B.E.** (February, 2019). *Service members among us: Military culture in & out of the classroom*. Presentation given at the annual convention of the Sam Houston State University Diversity Leadership Conference, Huntsville, TX.

Pennington, C. R., Henderson, C. E., **Ridge, B. E.**, Bryson, C. N., McCallum, K. E., Marshall, K. K., & Schmidt, A. T. (February, 2018). *Exploratory factor analysis of neuropsychological test data suggests a four factor model of executive functioning in an undergraduate sample*. Poster presentation accepted for the Annual Meeting of the International Neuropsychological Society, Washington, D.C.

Vera, L., Boccaccini, M., Laxton, K., Bryson, C. N., Pennington, C. R., & **Ridge, B. E.** (August, 2017). *Evaluator empathy in psychopathy interviews*. Poster presented at the annual convention of the American Psychological Association, Washington, D.C.

Camins, J. S., Henderson, C. E., Magyar, M. S., Schmidt, A. T., Crosby, J., **Ridge, B. E.**, & Kurus, S. (March 2017). *Predicting adolescent delinquency from a behavior typing model: The role of exposure to community violence*. Paper presented at the annual convention of the American Psychology-Law Society, Seattle, WA.

Vera, L., Boccaccini, M., Laxton, K., Bryson, C. N., Pennington, C. R., & **Ridge, B. E.** (March, 2017). *Evaluator empathy in psychopathy interviews*. Poster presented at the annual convention of the American Psychology-Law Society, Seattle, WA.

Stallard, C. E., Schmidt, A. T., & **Ridge, B. E.** (March, 2017). *The role and admissibility of neuroimaging evidence in U.S. criminal law: A case law review*. Poster presented at the annual convention of the American Psychology-Law Society, Seattle, WA.

- Cramer, R. J., Bryson, C. N., Stroud, C. H., Eichorst, M. K., Keyes, L. N., and **Ridge, B. E.** (March, 2016). *Pilot testing approaches to suicide risk assessment training: Preliminary efficacy and an extension to violence risk*. Paper presented at the annual convention of the American Psychology-Law Society, Atlanta, GA.
- Hart, J. R., Magyar, M. S., Ball, E. M., Camins, J., & **Ridge, B. E.** (March, 2016). *Using the Personality Assessment Inventory-Adolescent to predict high-risk behaviors among juvenile male offenders*. Paper presented at the annual convention of the American Psychology-Law Society, Atlanta, GA.
- Ridge, B. E.**, Pennington, C. R., Bryson, C. N., McCallum, K. E., Marshall, K. K., & Schmidt, A. T. (February, 2016). *Connecting the dots: Relating executive dysfunction to the externalizing spectrum of psychopathology*. Poster presented at the annual convention of the International Neuropsychological Society, Boston, MA.
- Pennington, C. R., Marshall, K. K., Bryson, C. N., McCallum, K. E., **Ridge, B. E.**, Cheiffetz, R. T., Stanford-Galloway, P., & Schmidt, A. T. (February, 2016). *The role of executive functions in externally-valid decision-making processes*. Poster presented at the annual convention of the International Neuropsychological Society, Boston, MA.
- Ridge, B. E.**, Magyar, M. S., & Bitting, B. S. (March, 2015). *An investigation of a psychopathology/personality-based typology among juvenile male offenders utilizing the Personality Assessment Inventory-Adolescent (PAI-A)*. Poster presented at the annual convention of the American Psychology-Law Society, San Diego, CA.
- Gardner, B. O., Miller, R. S., & **Ridge, B. E.** (March, 2015). *Cognitive capacity and its effect on lie detection ability*. Paper presented at the annual convention of the American Psychology-Law Society, San Diego, CA.
- Gardner, B. O., Vera, L., **Ridge, B. E.**, Bitting, B. S., & Miller, R. S. (February, 2015). *Place and personality: Need for cognition scores vary across settings*. Poster presented at the annual convention of the Society for Personality and Social Psychology, Long Beach, CA.
- Pennington, C. R., Schmidt, A. T., **Ridge, B. E.**, McCallum, K. E., Bryson, C. N., Marshall, K. K., & Cheiffetz, R. T. (February, 2015). *Personality traits influence processing speed performance in a neurologically intact population*. Poster presented at the annual convention of the International Neuropsychological Society, Denver, CO.
- Gardner, B. O., Vera, L., Bitting, B., **Ridge, B. E.**, & Miller, R. (August, 2014). *The influence of context on personality reports*. Poster presented at the annual convention of the American Psychological Association, Washington, DC.

PROFESSIONAL MEMBERSHIPS

- American Psychological Association of Graduate Students
- American Psychology-Law Society (APA Division 41)
- American Psychological Association
- Society for Military Psychology (APA Division 19)