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HIGHLIGHTS OF THE INSTITUTE OF MEDICINE AND NATIONAL RESEARCH COUNCIL REPORT
PTSD COMPENSATION AND MILITARY SERVICE

Statement of

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Good morning, Mr. Chairman and members of the Committee. My name is Dean Kilpatrick and I am Distinguished University Professor in the Department of Psychiatry and Behavioral Sciences and Director of the National Crime Victims Research and Treatment Center at the Medical University of South Carolina. Thank you for the opportunity to testify on behalf of the members of the Committee on Veterans' Compensation for Posttraumatic Stress Disorder. This committee was convened under the auspices of the National Research Council and the Institute of Medicine. Our committee's work was requested by the Department of Veterans Affairs, which provided funding for the effort. Its work was also presented to and used by the congressionally-constituted Veterans Disability Benefits Commission.

Last June, our committee completed its report-entitled PTSD Compensation and Military Service-which addresses potential revisions to the Schedule for Rating Disabilities in the context of a larger review of how VA administers its PTSD compensation program. I am pleased to be here today to share with you the content of that report, the knowledge I've gained as a clinical psychologist and researcher on traumatic stress, and my experience as someone who previously served as a clinician at the VA.

I will begin with some background information on posttraumatic stress disorder. Briefly described, PTSD is a psychiatric disorder that can develop in a person after a traumatic

experience. Someone is diagnosed with PTSD if, in response to that traumatic experience, he or she develops a cluster of symptoms that include:

- reexperiencing the traumatic event as reflected by distressing recollections, memories, nightmares, or flashbacks;
- avoidance of anything that reminds them of the traumatic event;
- emotional numbing or feeling detached from other people;
- hyperarousal as reflected by trouble sleeping, trouble concentrating, outbursts of anger, and having to always be vigilant for potential threats in the environment; and

• impairment in social or occupational functioning, or clinically significant distress.

PTSD is one of an interrelated and overlapping set of possible mental health responses to combat exposures and other traumas encountered in military service. It has been described as one of the signature wounds of the most recent Iraq conflicts. Although PTSD has only been an official diagnosis since the 1980's, the symptoms associated with it have been reported for centuries. In the U.S., expressions including shell shock, combat fatigue, and gross stress reaction have been used to label what is now called PTSD.

Our committee's review of the scientific literature regarding PTSD led it to draw some conclusions that are relevant to this hearing. It found abundant evidence indicating that PTSD can develop at any time after exposure to a traumatic stressor, including cases where there is a long time interval between the stressor and the recognition of symptoms. Some of these cases may involve the initial onset of symptoms after many years of symptom-free life, while others may involve the manifestation of explicit symptoms in persons with previously undiagnosed PTSD. The determinants of delayed-onset PTSD are not well understood. The scientific literature does not identify any differences material to the consideration of compensation between these delayed-onset or delayed-identification cases and those chronic PTSD cases where there is a shorter time interval between the stressor and the recognition of symptoms.

Our review also identified several areas where changes to VA's current practices might result in more consistent and accurate ratings for disability associated with PTSD.

There are two primary steps in the disability compensation process for veterans. The first of these is a compensation and pension, or C&P, examination. These examinations are conducted by VA mental health professionals or outside professionals who meet certain education and licensing requirements. Testimony presented to our committee indicated that clinicians often feel pressured to severely constrain the time that they devote to conducting a PTSD C&P examination-sometimes to as little as 20 minutes-even though the protocol suggested in a best practice manual developed by the VA National Center for PTSD can take three hours or more to properly complete. The committee believes that the key to proper administration of VA's PTSD compensation program is a thorough C&P clinical examination conducted by an experienced mental health professional. Many of the problems and issues with the current process can be addressed by consistently allocating and applying the time and resources needed for a thorough examination. The committee also recommended that a system-wide training program be implemented for the clinicians who conduct these exams in order to promote uniform and consistent evaluations.

The second primary step in the compensation process for veterans is a rating of the level of disability associated with service-connected disorders identified in the clinical examination. This rating is performed by a VA employee using the information gathered in the C&P exam and criteria set forward in the Schedule for Rating Disabilities. Currently, the same set of criteria are used for rating all mental disorders. They focus on symptoms from schizophrenia, mood, and anxiety disorders. The committee found that the criteria are at best a crude and overly general instrument for the assessment of PTSD disability. We recommended that new criteria be developed and applied that specifically address PTSD symptoms and that are firmly grounded in the standards set out in the Diagnostic and Statistical Manual of Mental Disorders used by mental health professionals.

Our committee also suggested that VA take a broader and more comprehensive view of what constitutes PTSD disability. In the current scheme, occupational impairment drives the determination of the rating level. Under the committee's recommended framework, the psychosocial and occupational aspects of functional impairment would be separately evaluated, and the claimant would be rated on the dimension on which he or she is more affected. We believe that the special emphasis on occupational impairment in the current criteria unduly penalizes veterans who may be capable of working, but significantly symptomatic or impaired in other dimensions, and thus it may serve as a disincentive to both work and recovery. This recommendation is consistent with the Dole-Shalala Commission's suggestion to add quality of life payments to compensation.

Research reviewed by the committee indicates that disability compensation does not in general serve as a disincentive to seeking treatment. While some beneficiaries will undoubtedly understate their improvement in the course of pursuing compensation, the scientific literature suggests that such patients are in the minority, and there is some evidence that disability payments may actually contribute to better treatment outcomes in some programs. The literature on recovery indicates that it is influenced by several factors, and the independent effect of compensation on recovery is difficult to disentangle from these.

Determining ratings for mental disabilities in general and for PTSD specifically is more difficult than for many other disorders because of the inherently subjective nature of symptom reporting. In order to promote more accurate, consistent, and uniform PTSD disability ratings, the committee recommended that VA establish a specific certification program for raters who deal with PTSD claims, with the training to support it, as well as periodic recertification. Rater certification should foster greater confidence in ratings decisions and in the decision-making process.

At VA's request, the committee addressed whether it would be advisable to establish a set schedule for re-examining veterans receiving compensation for PTSD. We concluded that it is not appropriate to require across-the-board periodic reexaminations for veterans with PTSD service-connected disability. The committee instead recommended that reexamination be done only on a case-by-case basis when there are sound reasons to expect that major changes in disability status might occur. These conclusions were based on two considerations. First, there are finite resources-both funds and personnel-to conduct C&P examinations and determine disability ratings. The committee believes that resources should be focused on the performance

of uniformly high-quality C&P clinical examinations. It believes that allocating resources to such examinations-in particular, to initial C&P evaluations-is a better use of resources than periodic, across-the-board reexaminations. Second, as the committee understands it, across-the-board periodic reexaminations are not required for other mental disorders or medical conditions. The committee's review of the literature on misreporting or exaggeration of symptoms by PTSD claimants yielded no justification for singling out PTSD disability for special action and thereby potentially stigmatizing veterans with the disability by implying that their condition requires extra scrutiny.

I understand that the Veterans Disability Benefits Commission subsequently recommended that VA should conduct PTSD reevaluations every 2-3 years to gauge treatment effectiveness and encourage wellness. Since the Commission report was released after the end of our work, my committee did not address the disparity in our recommendations. I know that our committee and the Commission both want veterans to receive fair treatment and the finest care, and I consider this to be an honest difference of opinion on how to best achieve those goals. There are advantages and disadvantages to the approaches that our two groups put forward, and the important thing is for VA to give these careful consideration when they formulate their policy. I believe that-if periodic reexaminations are implemented-this should not be done until there are sufficient resources to insure that every veteran gets a first-rate initial C&P exam in a timely fashion.

To summarize, the committee identified three major changes that are needed to improve the compensation evaluation process for veterans with PTSD:

- First, the C&P exam should be done by mental health professionals who are adequately trained in PTSD and who are allotted adequate time to conduct the exams.
- Second, the current VA disability rating system should be substantially changed to focus on a more comprehensive measure of the degree of impairment, disability, and clinically significant distress caused by PTSD. The current focus on occupational impairment serves as a disincentive for both work and recovery.
- Third, the VA should establish a certification program for raters who deal with PTSD clams.

Our committee also reached a series of other recommendations regarding the conduct of VA's compensation and pension system for PTSD that are detailed in the body of our report. I have provided copies of this report as part of my submitted testimony.

Thank you for your attention. I will be happy to answer your questions.