

**THE NEXUS BETWEEN ENGAGED IN COMBAT
WITH THE ENEMY AND POST-TRAUMATIC
STRESS DISORDER IN AN ERA OF
CHANGING WARFARE TACTICS**

HEARING

BEFORE THE

SUBCOMMITTEE ON DISABILITY ASSISTANCE
AND MEMORIAL AFFAIRS

OF THE

COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

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TUESDAY, MARCH 24, 2009

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON DISABILITY ASSISTANCE
AND MEMORIAL AFFAIRS,
Washington, DC.

The Subcommittee met, pursuant to notice, at 2:13 p.m., in Room 334, Cannon House Office Building, Hon. John J. Hall [Chairman of the Subcommittee] presiding.

Present: Representatives Hall, Donnelly, and Lamborn.

OPENING STATEMENT OF CHAIRMAN HALL

Mr. HALL. Good afternoon, ladies and gentlemen. The Veterans' Affairs Disability Assistance and Memorial Affairs Subcommittee hearing on the topic of "The Nexus Between Engaged in Combat with the Enemy and Post-Traumatic Stress Disorder (PTSD) in an Era of Changing Warfare Tactics" will now come to order.

I would ask everyone to rise for the Pledge of Allegiance. Flags are located at both ends of the room.

[Pledge of Allegiance.]

The task of today's hearing will prove to be both retrospective and prospective in order to understand Title 38, section 1154. We must look both backward to the original intent of Congress and forward to defining it in an era of modern warfare tactics and counterinsurgency.

I ask that the full text of title 38 U.S. Code, section 1154, be entered into the record.

[The information follows:]

Title 38 U.S.C., Section 1154

Consideration to be accorded time, place, and circumstances of service

(a) The Secretary shall include in the regulations pertaining to service-connection of disabilities (1) additional provisions in effect requiring that in each case where a veteran is seeking service-connection for any disability due consideration shall be given to the places, types, and circumstances of such veteran's service as shown by such veteran's service record, the official history of each organization in which such veteran served, such veteran's medical records, and all pertinent medical and lay evidence, and (2) the provisions required by section 5 of the Veterans' Dioxin and Radiation Exposure Compensation Standards Act (Public Law 98-542; 98 Stat. 2727).

(b) In the case of any veteran who engaged in combat with the enemy in active service with a military, naval, or air organization of the United States during a period of war, campaign, or expedition, the Secretary shall accept as sufficient proof of service-connection of any disease or injury alleged to have been incurred in or aggravated by such service satisfactory lay or other evidence of service incurrence or aggravation of such injury or disease, if consistent with the circumstances, conditions, or hardships of such service, notwithstanding the fact that there is no official record of such incurrence or aggravation in such service, and, to that end, shall resolve every reasonable doubt in favor of the veteran. Service-connection of such injury or disease may be rebutted by clear and convincing evidence to the contrary. The reasons for granting or denying service-connection in each case shall be recorded in full.

Mr. HALL. So what does it mean to have been “engaged in combat with the enemy” to a sufficient enough degree to prove a stressor that in turn, warrants service connection for post-traumatic stress disorder, or PTSD, by the Department of Veterans Affairs (VA)? And what has been the intent of Congress?

Congress’ commitment originated with the Military Pension Law of 1776. By the end of the Civil War, Congress recognized, “every soldier who was disabled while in service of the Republic, either by wounds, broken limbs, accidental injuries, or was broken down in the service by the exposure and hardships incident to camp life and field duty is entitled to an invalid pension.”

It was believed that those exposures and hardships led to a malaise at the time known as, “Soldier’s Heart,” which we now know as PTSD. I find Soldier’s Heart to be more poetic myself.

Shortly after the 65th Congress declared war on Germany, it passed the War Risk Insurance Act of 1917, which outlined benefits to World War I veterans. In 2 years, it was amended 22 times. These amendments included the first VA Schedule for Rating Disabilities and established wartime versus peacetime rates for pension. The 1933 rating schedule included instructions to notate the phrase, “incurred in service and combat with an enemy of the United States,” and to list the period of wartime service. This practice indicated that the enemy was a foreign government or a hostile force of a nation and not an individual combatant.

On December 12, 1941, days after the attack on Pearl Harbor, Congress expressed its desire to, “overcome the adverse effect of a lack of an official record,” and “the difficulties encountered in assembling records of combat veterans.”

Congress further instituted, “more liberal service pension laws by extending full cooperation to the veteran.” The 1945 rating schedule required that wartime service be noted by including the phrase, “disability resulted from injury received in actual combat in an expedition or occupation.” Importantly, this prerequisite refined the broader 1933 required statement.

Additionally, the 1945 schedule described the onset of “War Psychosis” as the result of “incident in battle or enemy action or following bombing, shipwreck, imprisonment, exhaustion or prolonged operational fatigue.” This diagnosis was removed when the rating schedule for mental disorders was revised in 1976, 1988 and 1996.

Some would say that our service men and women are experiencing prolonged operational fatigue today. But at any rate, the current rating schedule for PTSD has been described as vague and subjective. Furthermore, the adjudication process does not solely

accept, as the law prescribes, lay evidence as sufficient proof as long as it is consistent with the circumstances, conditions, or hardships of such service, notwithstanding that there is no official record.

This law should seem self-evident as to the intent of Congress. So why isn't it? The controversy seems to exist because of numerous interpretations of Congressional intent. Leading decision-makers at VA General Counsel have issued opinions and court decisions that concluded that if it were the intent of Congress to specify a combat zone or theater of combat operations, Congress would have done so as it has in other provisions of the law under Title 38, but omitted in section 1154.

So our intention today is to reopen this dialog. The nature of wartime services changed, as many can agree. Warfare encompasses acts of terrorism, insurgency, and guerilla tactics. No place is safe and the enemy may not be readily identifiable.

Psychiatry has changed also. PTSD is a relatively new diagnosis, first having appeared in the Diagnostic and Statistical Manual in 1980, 5 years after the end of the Vietnam War. Since then, an array of mental health research has been conducted and assessment techniques have been developed.

Since the world is not the same place it was in 1941, I have introduced H.R. 952, the "COMBAT PTSD Act," to redefine section 1154 to include a theater of combat operations during a period of war or in combat against a hostile force. There should be a better way for VA, to assist veterans suffering from PTSD, to adjudicate those claims without it being burdensome, stressful and adversarial. Veterans still face issues with stigma, gender and racial disparities in rating decisions, poorly conducted disability exams, and inadequate military histories. So, I am eager to hear from the witnesses today about their experiences with denials, inequities and variances.

In the last few years, the Institute of Medicine (IOM) comprehensively reviewed the research on PTSD diagnosis, assessment and compensation. In 2008, the RAND report on the "Invisible Wounds of War" gave us a new perspective on the costs of war when soldiers are left without treatment or support. I look forward to hearing more of its witnesses' analyses.

Finally, the U.S. Department of Defense (DoD) and VA will share their insights into how they determine combat versus noncombat and how they have chosen to evaluate PTSD disability.

So I welcome you all. I look forward to all of the witnesses' testimony and now will yield to Ranking Member Lamborn for his opening statement.

[The prepared statement of Chairman Hall appears on p. 36.]

OPENING STATEMENT OF HON. DOUG LAMBORN

Mr. LAMBORN. Thank you, Mr. Chairman, for yielding. I am pleased to have the opportunity to discuss the important issue before us today. I hope that through the collective efforts and knowledge of the individuals gathered here this afternoon, we can help ensure that every veteran who has service-related PTSD is able to access the benefits to which they are entitled.

Chairman Hall, I would also like to commend you for your compassion toward our veterans. I know it has been a longstanding issue for you to ensure that no one falls through the cracks due to unintended consequences of the laws and regulations pertaining to compensation for PTSD.

You have reintroduced in the 111th Congress a bill to clarify the meaning of “combat with the enemy” for purposes of service connection. As you and our witnesses are aware, section 1154(b) of Title 38 already provides special consideration for veterans attempting to establish service connection for PTSD or other medical conditions incurred or aggravated in combat. In short, this means that the VA must accept a combat veteran’s lay testimony as sufficient proof of service connection for any disease or injury incurred in combat, even if there is no official record of such incident.

Congress established this broad threshold in recognition of the chaotic nature of battle and the appropriateness of resolving every reasonable doubt in favor of the veteran. Unfortunately, circumstances can conceivably arise in which an individual who is not a combat veteran under the existing definition is exposed to an overwhelming stressor but he or she is unable to prove evidence of the occurrence. This is especially true for veterans of Vietnam and earlier wars. And this is the problem we are trying to resolve.

Chairman Hall’s proposed solution is the bill which would essentially redefine “combat with the enemy” to include service on active duty in a theater of combat operations.

As I have stated previously, I am concerned that too broad of a presumptive threshold would damage the integrity of the system. I also believe that too loose a definition of “combat” would diminish the immeasurable sacrifice and service of those who actually did engage in battle with the enemy.

While I understand and appreciate the effort to address problems regarding the VA claims backlog, I believe that they generally result from procedural issues and we can and should address those problems accordingly. In addition to the policy concerns I have stated, I would also point out that the mandatory offsets that would be necessary to pass this bill under existing PAYGO rules would be difficult to find.

Mr. Chairman, as you know it is always a challenge to identify offsets within our jurisdiction, and the Congressional Budget Office estimated cost of this measure last year exceeded \$4 billion. I certainly would not be in favor of reducing existing veterans benefits elsewhere in the VA budget in order to establish an overly broad definition of “combat with the enemy.”

Mr. Chairman, I extend my thanks to you for holding this hearing and I look forward to hearing the testimony of our colleagues and witnesses on our panel today. And I yield back.

[The prepared statement of Congressman Lamborn appears on p. 37.]

Mr. HALL. Thank you, Congressman Lamborn. I would like to welcome all of our panelists today and other Members of the Subcommittee as they arrive. Congressman Donnelly.

I will remind all panelists that your complete written statements have been made a part of the hearing record, so you can limit your

remarks so that we can have sufficient time to follow up with questions once everyone has had the opportunity to testify.

On our first panel is Mr. Ian De Planque, Assistant Director of Veterans Affairs and Rehabilitation Commission at the American Legion; Dr. Thomas J. Berger, Senior Analyst for Veterans' Benefits and Mental Health Issues at Vietnam Veterans of America (VVA); and Ms. Carolyn Schapper, a member of the Iraq and Afghanistan Veterans of America (IAVA).

Welcome to our first panelists. You may come join us at the witness table, please.

Mr. De Planque, your statement is entered into the record. You are now recognized for 5 minutes.

STATEMENTS OF IAN C. DE PLANQUE, ASSISTANT DIRECTOR, VETERANS AFFAIRS AND REHABILITATION COMMISSION, AMERICAN LEGION; THOMAS J. BERGER, PH.D., SENIOR ANALYST FOR VETERANS' BENEFITS AND MENTAL HEALTH ISSUES, VIETNAM VETERANS OF AMERICA; AND CAROLYN SCHAPPER, REPRESENTATIVE, IRAQ AND AFGHANISTAN VETERANS OF AMERICA

STATEMENT OF IAN C. DE PLANQUE

Mr. DE PLANQUE. Thank you. Good afternoon Mr. Chairman, Members of the Subcommittee. On behalf of the American Legion, I would like to thank you for allowing me the opportunity to present this testimony today.

We are basically here to clarify the concept of engaged in combat with the enemy in a manner that is consistent with the realities of warfare in today's world. I think it is important to note that this is not creating any sort of new benefit. What is really at issue today is an attempt to clarify the meaning and intent of the existing statute in section 1154(b). What we are looking at is something that hopefully fulfills the original intent of the statute, while at the same time streamlining some of the red tape involved with one small part of the claims process.

These provisions were created in recognition of the recordkeeping abnormalities and difficulties experienced in the thick of war fighting. They were created to recognize that in war we don't always have the time to write meticulously detailed reports. However, these statutes were originally created in 1941 and the distinctions between being in a combat zone and being on the frontline were perhaps more cut and dry than what we are seeing in the age of modern warfare.

As with all things in life, the world changes and we must evaluate these changes and make sure we adapt to them. In today's non-linear battlefield, the frontline is not so clear. Simply drawing a line on a map and stating that this unit was present here does not always adequately reflect the extent of combat situations where servicemembers are in harm's way.

I would like to present an example of two soldiers. Both soldiers witnessed the exact same event, an event clearly consistent with the hardships and circumstances of combat as presented in 1154(b). However, because of the differences in military occupational speciality (MOS) of the two soldiers, one faces much more difficult bat-

tle when he returns home. Imagine a convoy traveling through southeastern Afghanistan. An improvised explosive device (IED) detonates ahead of them on the road. Fortunately, no American soldiers are injured. No vehicles are damaged in the blast. However, by the side of the road, a family of Afghans are struck by the blast and killed instantly. In the convoy, the soldiers traveling by witness the aftermath of the explosion.

Subsequent to this event, two soldiers in the convoy develop post-traumatic stress disorder as a result of what they have seen. The first veteran is an infantryman, a veteran of several combat operations prior to this convoy and a recipient of the Combat Infantryman Badge (CIB). The second veteran is a mechanic pulled along on the convoy as part of a temporary assignment and has no decorations of combat.

When they file a claim with the VA, both veterans must prove and do prove that they have the present condition of PTSD and that a doctor links the PTSD to the event described above.

Now they must prove the third element of the claim. They must prove that the alleged incident occurred. Here is where the two soldiers are then treated differently. The first veteran, the infantryman, has a combat infantry badge. As long as his story is consistent with the hardships and circumstances of combat, which we can all agree that it is, the VA cedes the existence of the event and a claim is granted.

The second veteran has no combat decoration. In his job he was fortunate enough to not have been injured or merited a Purple Heart. His story is the same story, exactly consistent with the circumstances of war, but he lacks a decoration to say that he was in combat. This veteran must now prove several things happened. He must prove that he was on the convoy. This can be difficult, if not impossible. Temporary details are assigned in the military all the time, other duties as assigned. You piece together troops because you have one overriding goal: Get the job done.

If the veteran is fortunate, morning reports or patrol reports not only exist for the routine convoy, but they actually are detailed enough to list all the personnel who went on it. This is not always the case. Assuming that the veteran can prove that he was on this particular convoy on this particular day, he must now prove that this convoy experienced the incident described above. This is not as easy as it sounds. Does every incident get recorded? What if no Americans were hurt? What if no equipment was damaged?

The provisions of 1154(b) were intended to reflect the often thin recordkeeping in combat. Detailed notes aren't always there. Now, keep in mind, all of this sifting through the records has to be done by VA and the veteran. This is a colossal amount of effort. Requests must be sent back and forth to various repositories of records. This problem is compounded by the fact that Guard and Reserve units often keep their own records separate from those of active duty, and that the records don't always mesh up the way that they should. If a veteran can't find all of these separate pieces in writing, then the VA must deny the claim because they can't verify the alleged incident.

Ultimately we have to ask ourselves why we are holding two soldiers serving in the same military to different standards when the

hardships and circumstances faced by them are so vastly similar. 1154(b) was never intended nor should it be used as a means of handing out benefits carte blanche. It only exists as a means to help sort through the fog of war and establish the existence of events that might not otherwise be meticulously documented. It is a means to fill in the last piece of the puzzle for veterans who have already proved that they are deserving of a benefit otherwise.

A great deal of things have changed in our understanding of the realities of modern warfare. This does not mean, however, that our Nation's duties to aid and assist the brave men and women who go forth to defend it on the fields of battle should change. In the modern combat zone the battlefield is everywhere, and we need to treat all the veterans who serve with the same hand. Thank you very much.

[The prepared statement of Mr. De Planque appears on p. 38.]

Mr. HALL. Thank you, Mr. De Planque. Mr. Berger, you are now recognized for 5 minutes.

STATEMENT OF THOMAS J. BERGER, PH.D.

Dr. BERGER. Mr. Chairman, Ranking Member Lamborn, and other distinguished Members of the House Veterans' Affairs Committee, Subcommittee on Disability Assistance and Memorial Affairs, Vietnam Veterans of America thanks you for the opportunity to present our views on the record surrounding the Department of Veterans Affairs' application of the provisions found in Title 38 U.S.C. 1154, the definition of "engaged in combat with the enemy" and its effect on processing claims for veterans suffering from post-traumatic stress disorder.

Despite the promises of change from this Administration, for those most in need of renewed attention are veterans of our military who have come home from war seeking disability benefits for post-traumatic stress disorder. While the dysfunctional state of the VA claims adjudication system has become a matter of growing public concern, the rhetoric surrounding our obligation to returning troops still falls short of actual legislative priorities. Meanwhile, recent efforts to reform the VA benefits system through litigation have only affirmed the need for legislative action with courts repeatedly dismissing the issue as a Congressional matter.

The resulting inertia makes the passage of Congressman Hall's proposed change to 38 U.S.C. especially vital, particularly when viewed in conjunction with his proposed COMBAT PTSD Act. Under current VA policy, disability claims are effectively presumed fraudulent until proven otherwise. Beyond establishing their medical condition, claimants must prove, through elaborate documentation, that their disability stems from the military service while a veteran was "engaged in combat." While the disability claims process imposes a toll on all veterans seeking benefits, this burden falls with particular weight on those with PTSD who must identify the specific stressor that triggered their condition, even if they have already been diagnosed and referred to treatment.

A personal story: A very good friend of mine who served as a combat medic with the 25th Light Infantry Division in Vietnam just passed away recently. He suffered hepatitis, had a liver transplant. All of that he had to fight for, for years with the VA, because

as a combat medic, he did not receive the Combat Infantryman's Badge. This man died without ever receiving all the benefits and compensation that was due him.

Under the existing system the VA Clinicians Guide warns examiners that PTSD symptoms are "relatively easy to fabricate" directing them to supplement treatment records with elaborate documentation from claimants' family and friends concerning changes from pre- to post-service status. Despite the fact that one of the diagnostic criteria for PTSD is an inability to recall important aspects of a trauma, reviewers routinely deny or remand claims due to incomplete information.

At the same time, the VA continues to measure employee productivity by number of cases processed, offering reviewers an incentive to take any shortcut necessary to clear their desks of pending claims. The resulting combination of too much work and too little time ultimately gives rise to premature and inaccurate determinations, setting in motion years of appeals.

Claimants seeking compensation for military sexual trauma, for example, are inevitably obstructed by the military's policy of retaining harassment complaint files for only 2 years, eliminating critical evidence of the stressor that gave rise to their condition. Even in the best of circumstances, the retrieval of military records is a bureaucratic nightmare requiring protracted negotiation with a central archive in Missouri, other National Archives facilities, and/or DoD agencies.

In spite of these inequities, the VA defends its current system as a precaution against claimant fraud. And even according to VA spokesperson Kerri Childress, eliminating the proof requirement, quote, would be a travesty for veterans, an assault to the pride of honest soldiers when other vets are scammed by the system.

Establishing service in combat as the presumptive stressor for the incurrence of PTSD would be a long overdue first step toward fixing a notoriously broken system. VVA can support the proposed legislative change because we believe the proposed change to be well intended and most considerate for those of our veterans suffering from PTSD and who face interminable delays and denials in their compensation claims from the VA under the current claims processes and procedures.

VVA thanks this Committee for the opportunity to submit its views and testimony on this important veterans issue. Thank you, sir.

[The prepared statement of Dr. Berger appears on p. 41.]

Mr. HALL. Thank you, Dr. Berger. Ms. Schapper, you are now recognized for 5 minutes.

STATEMENT OF CAROLYN SCHAPPER

Ms. SCHAPPER. Mr. Chairman and Members of the Subcommittee, thank you for inviting me to testify today on behalf of Iraq and Afghanistan Veterans of America, the Nation's first and largest nonpartisan organization for veterans of the current conflicts. I would like to thank you all for your unwavering commitment to our Nation's veterans.

My name is Carolyn Schapper and I am a combat veteran. While serving as a member of the military intelligence unit in Iraq from

October 2005 to September 2006 with the Georgia National Guard, I participated in approximately 200 combat patrols. While many of these patrols included positive interactions with the local population, I did encounter direct fire, improvised explosive devices and other threats during some of my missions. Overall, I valued the opportunity to learn about the Iraqi people, my country and myself.

However, when I came home from Iraq, I dealt with a wide range of adjustment issues and symptoms including rage, anger, withdrawal and depression, high anxiety, agitation, nightmares and hypervigilance. When you are in this state of mind, it is difficult to traverse the VA's maze. I might still be lost if I had not had the good luck of running into another veteran who had already gotten help and who had pointed out that a Vet Center could help me start navigating the VA system.

While I was able to receive the appropriate help and rating from the VA due to the existence of proper paperwork for my adjustment issues, many of my sisters-in-arms have not been so lucky. Part of the problem is that because females are excluded from official combat roles in the military, women veterans have a greater burden of proof when it comes to establishing combat-related PTSD. But the reality on the ground in Iraq and Afghanistan is that there is no clear frontline, and female servicemembers are seeing combat. Modern warfare makes it impossible to delineate between combat, combat support, and combat service support roles. You do not even need to leave the forward operating base to be exposed to the continual threat of mortars and rockets. Military personnel are often required to walk around in, or sleep in, body armor. As one female veteran told me, life in Iraq and Afghanistan is combat.

Moreover, many female troops in Iraq and Afghanistan have been exposed to direct fire while serving in support roles such as military police, helicopter pilots and truck drivers. All of our troops, whether or not they serve in the combat arms, must exhibit constant vigilance. And this can take an extreme psychological toll on all servicemembers.

The traditional understanding of female servicemembers' military duties has been the biggest hurdle to getting them adequate compensation for their injury. The nature of PTSD and other psychological injuries makes it difficult to identify the exact stressor, and therefore, disability may be determined based on the claims processor's perception of exposure to combat.

While service connection for PTSD would seem obvious for a male infantryman, it can easily come under more scrutiny for a female intelligence soldier despite how much actual combat either of them have seen.

Another obstacle that female servicemembers face when trying to establish presumption of service-connected PTSD involves collecting the proper paperwork, especially in instances of military sexual trauma. Some women forgo documenting their injury, whether combat or sexual trauma, rather than get official military documentation from a male commander or doctor. If you are suffering from a mental health injury, the possibility of having someone question, deride or expose such a personal and painful experience is often overwhelming and can lead many female servicemembers to avoid the process altogether.

H.R. 952, introduced by the Chairman, solves this problem. It changes Title 38 to presume service connection for PTSD based solely on a servicemember's presence in the combat zone. IAVA wholeheartedly endorses this legislation and looks forward to working with the Subcommittee to see this bill become law.

While this legislation will aid veterans once they have become diagnosed with a psychological injury and are seeking disability compensation, we know not every servicemember or veteran is getting the care they need. To better identify troops suffering from psychological injuries and help them receive the appropriate treatment, IAVA recommends mandatory face-to-face and confidential screenings by a licensed medical professional for all servicemembers both before and after combat tour. This is one of the organization's top legislative priorities for 2009.

To help ensure that veterans seeking access to care and benefits, particularly those in need of treatment for their psychological injuries, get the support they need, IAVA has partnered with the Ad Council to conduct a multiyear public service announcement (PSA) campaign. The IAVA-Ad Council Veteran Support PSAs are currently running on television, radio, print, outdoors and online. The companion campaign, engaging the family and friends of new veterans will, be launching later this year.

I will leave you with this final thought. More and more women are being called upon to serve a more active role in the combat zone and all too often find themselves in harm's way. There is no better way to honor the service and sacrifices of these brave women than to ensure that when they are injured, they receive the care and compensation they deserve.

Thank you again for the opportunity to testify on this critical issue. And I think we would all be pleased to take your questions at this time.

[The prepared statement of Ms. Schapper appears on p. 43.]

Mr. HALL. Thank you Ms. Schapper.

First, Mr. De Planque, in your statement you noted that if Congress were to change section 1154 it would not be creating a new benefit, but providing a clarification to the original law since the veterans' entitlement already existed. Can you expand upon this contention and how entitlement is already established?

Mr. DE PLANQUE. Yes. Essentially what I am trying to address with this is that it is not in any sense trying to give out a golden ticket to PTSD or anything. The problem, what 1154 was created to address, is the problem of establishing incidents that happen in combat, in the combat area.

I will give a very quick example from my personal experience. In Afghanistan, my platoon came under fire and engaged in combat with the enemy. We were an infantry platoon so we all got CIBs out of the deal and we all—what we said happened happened. But I compiled all of the reports because every soldier had to file a contact report and everything. And I compiled all of those for our platoon and pushed them on. We had over 20 people involved in that. There were over 20 different stories of what happened. Everybody experiences things a little bit differently. And when you look at all of those things, you realize just how hard it is to get an accurate record of exactly what happened.

I think that that is what 1154(b) was about, is that it is very, very hard to document and to really capture everything that is happening in combat, which is a zone-wide exposure when you look at it in modern warfare. So what 1154(b) is about is establishing that those things happened.

With the VA claim, it is not just that you establish that something happened, you still have to have a present diagnosis. You still have to have a linkage opinion between the two of those. These aspects of the claims process are not changing at all, and they haven't changed and they are not affected by 1154(b); 1154(b) is establishing the incident in service. And that is the difficult part and that is the thing that—when I talk about what this is doing and clarifying it, it is trying to create a sense of equity between infantry soldiers, for example, who have that ticket, that CIB that says, you know, what you said happened happened, and other soldiers who are going through exactly the same things and exactly the same conditions are having their word—they are having a much more difficult time proving their word because it is not being taken for granted unless they can say, this combat occurred.

And so in terms of not establishing the benefit, it is more attempting to deal with the existing facet of benefits, the sort of nebulous area of confirming something that happened in combat or in a combat zone.

Mr. HALL. Thank you.

Dr. Berger, at what point would you support VA accepting a veteran's lay statement as proof of a stressor, instead of requiring VA to continue to develop a claim by searching for records and documents that may or may not exist at any of the centers you mentioned in your statement?

Dr. BERGER. Certainly what we call buddy records would seem very appropriate. As I mentioned, my colleague was a combat medic with the 25th, had to rely heavily on people that he served with in order to document his service. And that particular unit that he served with, the time period took place in the Michelin rubber plantation area in the Republic of South Vietnam at the time. A lot of enemy action down there. But as I said, he did not receive a CIB, so it was very difficult for him to prove that he had actually been in combat. So certainly the supporting statements of colleagues who are with you at the time would help.

I know that in my own personal case, I was in a field hospital up north, and there weren't many of us Navy corpsmen there present. In fact, there is only one alive today who could document my presence there. I would have to go through the Marines that I served with in order to prove that I was even there.

Mr. HALL. How accurate would you say veterans are when they self-report their stressors? In your observations, have you seen many cases where stressors are exaggerated?

Dr. BERGER. I think Bruce Dohrenwend, a Professor at Columbia University who reevaluated the National Vietnam Veterans' Readjustment Study (NVVRS) a couple of years ago, stated it clearly when they looked at the NVVRS data, the PTSD data from Vietnam veterans, and found very few, very few instances of fraud, lying in the process that they used to document their combat service.

Mr. HALL. Thank you, sir.

And, Ms. Schapper, are there situations that the IAVA is aware of where veterans who served in Iraq or Afghanistan were not considered to be combat veterans and therefore had their PTSD claims denied?

Ms. SCHAPPER. I don't have specific instances from IAVA. But I do have instances of fellow female servicewomen who have had difficulty. I did not have difficulty supplying the "burden of proof" because I was lucky enough that I was either a convoy commander or a team sergeant and I wrote up all the reports for the incidents that occurred. But as Mr. DePlanque was saying earlier, that if you don't happen to have your name on that report, that you were in that instance, that combat, that IED, you will be denied. And I do know several female servicemembers who have been denied because their name was not on the proper paperwork.

Mr. HALL. I am over my time. But before I turn it over to the Ranking Member, I wanted to ask one more question, if I could. What would you suggest the VA do to improve its assistance to female veterans in order to help develop their claims?

Ms. SCHAPPER. Personally I would like to see stronger women's centers in the VA and women's PTSD groups for combat and/or military sexual trauma. Right now a lot of the PTSD groups are mixed groups. And although some women do feel open to speaking in those groups, I do believe most of them hold back a lot of experiences just because men are in there as well.

Mr. HALL. Okay. Thank you very much.

Mr. Lamborn.

Mr. LAMBORN. Thank you. And Ms. Schapper, I have a question for you also. If I heard you correctly during your testimony, you talked about how this bill, if passed, would help in the case of a woman who has suffered sexual assault or rape. Did I hear you correctly? And if so, what would the connection be?

Ms. SCHAPPER. This bill wouldn't specifically address military sexual trauma. I was using that as an instance of how women often feel more exposed and that people generally question them more. Whether it is sexual trauma or combat, that is often more difficult for them to prove they have any sort of PTSD symptoms at all.

Mr. LAMBORN. Okay. Thank you for that clarification. Mr. Chairman, I would yield back.

Mr. HALL. Thank you. Well first of all, thank you all for your service to our country. And thank you for your service to our veterans and for being here to testify today.

We will now excuse you and move on to our second panel, which consists of Dean G. Kilpatrick, Ph.D., member of the Committee on Veterans Compensation for Post-Traumatic Stress Disorder, Institute of Medicine of the National Academies; Terry Tanielian, Co-Study Director of the "Invisible Wounds of War Study" by the RAND Center for Military Health Policy Research, accompanied by Christine Eibner, also a Ph.D. and Economist with the RAND Corporation.

As usual, your full written statement is entered into the record, so feel free to abridge it if you wish. Mr. Kilpatrick, you are recognized for 5 minutes.

STATEMENTS OF DEAN G. KILPATRICK, PH.D., DISTINGUISHED UNIVERSITY PROFESSOR, AND DIRECTOR, NATIONAL CRIME VICTIMS RESEARCH AND TREATMENT CENTER, MEDICAL UNIVERSITY OF SOUTH CAROLINA, CHARLESTON, SC, AND MEMBER, COMMITTEE ON VETERANS' COMPENSATION FOR POSTTRAUMATIC STRESS DISORDER, INSTITUTE OF MEDICINE AND NATIONAL RESEARCH COUNCIL, THE NATIONAL ACADEMIES; AND TERRI TANELIAN, MA, STUDY CO-DIRECTOR, "INVISIBLE WOUNDS OF WAR" STUDY TEAM, RAND CORPORATION, ACCOMPANIED BY CHRISTINE EIBNER, PH.D., ECONOMIST, RAND CORPORATION

STATEMENT OF DEAN G. KILPATRICK, PH.D.

Dr. KILPATRICK. Thank you very much, Mr. Chairman, Mr. Ranking Member, and Members of the Committee. I appreciate the opportunity of being able to testify on behalf of the National Academy of Sciences' Committee on Veterans Compensation For Post-Traumatic Stress Disorder.

In June 2007, our Committee completed its report entitled, "PTSD Compensation and Military Service." I am here today to share with you some of the contents of that report and will briefly address four issues: the evaluation of traumatic exposures for VA compensation and pension purposes; the reliability and completeness of military records for evaluation of exposure to stressors; what studies say about malingering in the veteran population; and the means that mental health professionals use to detect malingering.

In terms of the first issue, VA Compensation and Pension (C&P) examinations for PTSD consist of a review of medical history, evaluations of mental status and of social and occupational functioning, a diagnostic examination and an assessment of exposure to traumatic events occurred during military service. To help focus the examination, the VA Veterans Benefits Administration (VBA) provides examiners with worksheets that set forth what an assessment should cover. The PTSD worksheet indicates the elements of a claimant's military history that should be documented, or it indicates that that should include military occupational specialty, combat wounds sustained, citations or medals received, and a clear description of "the specific stressor event the veteran considered to be particularly traumatic, particularly if the stressor is the type of personal assault including sexual assault, providing information with examples, if possible."

It notes that a diagnoses of PTSD cannot be made or adequately documented or ruled out without obtaining detailed military history and reviewing the claims folder. This means that the initial review of the folder conducted prior to examination, the history and the examination itself, and the dictation for an examination initially establishing PTSD will often require more time than for examinations of other disorders. They recommend that 90 minutes to 2 hours on an initial exam is normal.

There was also a Best Practices Manual developed by VA that stated that the initial PTSD compensation basically requires up to 3 hours. Notwithstanding this guidance, our Committee, and testimony reported to our Committee, indicated that some people are so

pressured that they spend as little as 20 minutes on these exams. And we concluded that that was an unacceptably short period of time.

Military records, with respect to the second issue, are prized because they are thought to be a description or an unbiased source of evidence to support or refute claims. However, specifically the conclusion that this is so was really not supported by our Committee. And in fact, the National Archives and Research Administration warns that, "Detailed information about the veteran's participation in military battles and engagements is not contained in military service records and personnel files." Studies indicate, instead, that broad-based research into other indicators of the likelihood of having experienced traumatic stressors has value. And in fact, someone just mentioned Dr. Dohrenwend's NVVRS reexamination study in which they looked at news accounts and a variety of other things to augment the official records.

Our Committee concluded that the most effective strategy for dealing with problems with self-reports of traumatic exposure is to ensure that a comprehensive, consistent and rigorous process is used throughout the VA to verify veteran-reported evidence.

What studies say about malingering in veterans populations: The Committee noted that assessment of malingering—and, I would add, accusing someone of malingering—is a high-stakes issue, because it is as devastating to falsely accuse a veteran of malingering as it is unfair to other veterans to miss malingered cases.

Our Committee concluded that while misrepresentation of combat involvement and traumatic exposure undoubtedly does occur, the evidence is insufficient to establish how prevalent this is. And in fact, there is not a lot of evidence that it is prevalent, or how much effect malingering has on the ultimate outcome of disability claims. The preponderance of evidence does not support the notion that receiving compensation for PTSD makes veterans less likely to make treatment gains or acknowledge improvement from treatment.

Finally, the means that mental health professionals use to detect malingering, although there is a need for a reliable valid way to detect malingering, experts agree that there is no magic bullet or gold standard for doing so. It would be really nice if we had a means for determining whether someone is telling the truth or not or if they are malingering or not. But, unfortunately, no way exists to do that in a simple manner.

While some investigators use psychological tests to indirectly infer the possibility of malingering, these measures have clear limitations and should not be used as the sole basis for determining whether a veteran is malingering.

The Committee concluded that in the absence of a definitive measure, the most effective way to detect inappropriate PTSD claims is to require a consistent and comprehensive state-of-the-art examination and assessment that allows the time to conduct appropriate testing and assessment in these specific circumstances where it would inform the assessment.

Thank you very much. And I will be happy to take questions.

[The prepared statement of Dr. Kilpatrick appears on p. 44.]

Mr. HALL. Thank you, Mr. Kilpatrick.

Ms. Tanielian, you are now recognized for 5 minutes.

STATEMENT OF TERRI TANELIAN, MA

Ms. TANELIAN. Chairman Hall, Representative Lamborn, and distinguished Members of the Subcommittee, thank you for inviting me to testify today. It is an honor and a pleasure to be here.

Last April, my colleagues and I released findings from a 1-year project entitled "Invisible Wounds of War." This independent study focused on three major conditions: post-traumatic stress disorder, major depression and traumatic brain injury among Iraq and Afghanistan veterans.

My comments today will focus on our findings about servicemembers' exposure to trauma during deployment, prevalence of mental health conditions post deployment and their associated costs to society as they bear directly on the issue you are considering today.

First, how is exposure to combat trauma assessed? In research studies, combat experience has been assessed in a variety of ways. These include documenting deployment to a combat zone based on receipt of hostile-fire pay, or assessing specific experiences during deployment based on self-report.

In our study, combat trauma exposure was assessed using questions from recent Army studies and included both direct and vicarious trauma exposure. Rates of reported exposure to specific types of combat trauma range from 5 to 50 percent in our study, with close to one-third reporting exposure to two or more traumatic events. Vicariously experienced traumas, such as having a friend who was seriously wounded or killed, were the most frequently reported.

Despite these exposures, most military servicemembers who have deployed to date will return home from war without problems and readjust successfully. But many have already returned or will return with significant mental health problems.

Among Iraq and Afghanistan veterans, our study found rates of PTSD and major depression to be relatively high, particularly when compared with the general population. In late 2007, we conducted a telephone study of about 2,000 previously deployed individuals. Using well-accepted screening tools, we estimated substantial rates of mental health problems in the past 30 days, with 14 percent reporting current symptoms consistent with a diagnoses of PTSD and 14 percent reporting current symptoms consistent with a diagnoses of depression; 9 percent of veterans reported symptoms consistent with a diagnoses of both.

We found that some specific groups previously underrepresented in studies, including the Reserves and those who had left military service, may be at higher risk of suffering from these conditions. We also found that the single best predictor of reporting current mental health problems was the number of reported combat traumas while deployed.

From the literature, we know that socioeconomic status, access to post-deployment social support and transition services, as well as treatment can mitigate the immediate consequences of these post-combat mental health problems.

In our study, however, only about half of those with current PTSD or major depression have sought help from a physician or other provider in the past year. And of those, just over half received minimally adequate treatment.

The number who received proven effective care would be expected to be even smaller. Survey respondents identified many barriers to getting treatment for their mental health problem. In particular, they were concerned that treatment would not be kept confidential and would constrain future job assignments.

The costs of these invisible wounds go beyond the immediate costs of mental health treatment. Adverse consequences that may arise from post-deployment mental problems include suicide, engagement in unhealthy behaviors, substance abuse, unemployment, homelessness, marital strain and domestic violence. The costs stemming from these problems are substantial and include costs related to lost productivity, reduced quality of life, treatment and premature mortality.

To quantify these costs, RAND used a microsimulation model to estimate 2-year post-deployment costs associated with PTSD and depression for military servicemembers returning from Iraq and Afghanistan. Our analyses used a societal cost perspective which considers costs that accrue to all members of U.S. society, including the Government, servicemembers, their families, employers, private health insurers, taxpayers and others.

We found that, unless treated, PTSD and depression exact a high economic toll to society. Our model predicted that the 2-year post-deployment cost to society for 1.6 million deployed servicemembers ranged from \$4 to \$6.2 billion. The majority of these costs were due to lost productivity; and for a variety of reasons, the model underestimates the total future costs to society.

While these costs are high, we also found that providing evidence-based treatment for PTSD and depression can reduce societal costs. We estimate that evidence-based treatment for PTSD and major depression would pay for itself within 2 years, even without including the many known costs.

Investing in evidence-based care for all those in need can reduce costs to society by \$1.7 billion in just 2 years. However, ensuring that all veterans with these conditions get quality care will require addressing the significant gaps that exist in access to and quality of care for our Nation's veterans.

Thank you again for the opportunity to testify today and to share the results of our research. I am joined by my colleague Christine Eibner, the Health Economist who led these cost analyses. And together we are happy to answer your questions. Thank you.

[The prepared statement of Ms. Tanielian appears on p. 47.]

Mr. HALL. Thank you.

So, Ms. Eibner, you have no statement of your own. You are in a support role?

Ms. EIBNER. Right. Exactly.

Mr. HALL. Thank you, Ms. Tanielian. Thank you for your study. It is an impressive piece of work.

Dr. Kilpatrick, generally speaking, how well can a mental health provider validate a veteran's self-reported history of trauma? Do you rule out other diagnoses during the evaluation period, including malingering?

Dr. KILPATRICK. Well, I think if a mental health professional is well trained, understands about post-traumatic stress disorder, understands specifically about not just combat but war zone exposure,

including military sexual trauma, and looks at the entire picture including the self-report of the veteran, what we do is we really see how well everything hangs together.

And, frankly, in terms of post-traumatic stress disorder, there are things that people write books about it theoretically, in terms of how to malingering it. And I am not suggesting that you cannot fool a clinician, because you probably can fool anybody a little bit. But I do think that for the most part, by looking at how well the symptoms hang together and the types of experiences, including things that many people don't know about and wouldn't know to think of in order to make something up, that we can tell pretty much whether people are telling the truth.

The other thing that I would say—and I think our Committee felt this way, too—is that it is really the stance of people doing these examinations is important. And if the stance is that we are going to assume that everybody is lying until they prove to me that they are not, that we felt was really unfair and unsupported by the data on how much malingering there really is.

On the other hand, you can be somewhat skeptical but at the same time saying, I am going to assume that this person is telling me the truth until my antenna goes up and I find some reason to believe that they are not.

Mr. HALL. Along that line of thinking, there has been a great deal of concern regarding false positives for PTSD. What about false negatives? Are veterans being denied post-traumatic stress disorder compensation, in your opinion, who maybe should not have been?

Dr. KILPATRICK. Well, I think if you look at the whole picture and you say, all right, how many people—and I think your study is—the study that we just heard about is very good. Like how many veterans would we estimate have had, had PTSD, and then we look at how many of those come forward to the VA, there is going to be a lot of attrition there for various reasons.

And then you look at—there is a C&P examination, and how many of those are denied? I think the group that—one could make the case that there are a lot of unserved veterans with PTSD who are unserved and uncompensated. And that would be a much larger number than a very small number of veterans who maybe have malingered or exaggerated something and have gotten a treatment or compensation.

Mr. HALL. Thank you.

Ms. Tanielian, in the model of consequences for post-combat mental health and cognitive conditions, figure 5.1 in the RAND report, one of the categories listed as a resource or vulnerability is social, which includes support, transition, socioeconomic status and treatment availability. Would you agree that VA service connection can impact each of those and transform vulnerabilities into resources?

Ms. Tanielian. Based on the literature, we understand that an individual has certain resources or vulnerabilities to whether or not they will actually develop a disorder and then how they cope and whether or not those consequences can be mitigated. Access to social support, socioeconomic status and transition services are associated with being able to mitigate those consequences. And so to

the extent that the eligibility requirements in place to gain those services make it so that those services are more available, then they have the opportunity to promote better outcomes for individuals.

Mr. HALL. Right. You didn't address this directly because your report was done for the DoD, but as I understand, they are not in the compensation business.

Ms. TANIELIAN. Actually, our report was independent of both the DoD and the VA. We looked specifically at trying to identify the size and scope of the problem associated with PTSD, depression and traumatic brain injury among returning troops.

Mr. HALL. Okay. But it is nonetheless your opinion, as I understand, that you just stated that compensation would mitigate some of the negative outcomes from detrimental impact on social support, life or identity transitions and socioeconomic status.

Ms. TANIELIAN. Our study identified several barriers to getting help for mental concerns reasons and problems. To the extent that eligibility requirements and structural barriers are diminished, more veterans would have access to appropriate care, and thus lower the cost to society associated with PTSD.

Mr. HALL. Thank you. Last I wanted to ask you, RAND suggested the societal cost of untreated PTSD could run from \$4 to \$6 billion over a 2-year period just for Iraq and Afghanistan veterans. I understand that these figures only somewhat include the cost to VA. If you adjusted for the cost of disability compensation, do you think the cost to society would be more or less? And why?

Ms. TANIELIAN. Sure. I am going to actually ask Dr. Eibner to address that question.

Ms. EIBNER. Sir, we believe this does incorporate the cost to the VA in terms of disability compensation. And the reason is, we account for lost productivity in our estimates. So the lost productivity cost is really what the VA payments are designed to replace. So it is included in that category.

Mr. HALL. Okay. Thank you very much. Mr. Lamborn.

Mr. LAMBORN. Thank you, Mr. Chairman.

Ms. Tanielian, how did you diagnose PTSD among the people you interviewed? Was there a physician with you? Or what were the mechanics of that?

Ms. TANIELIAN. As I mentioned, we conducted a telephone survey of 2,000 individuals who had been previously deployed. We used well-accepted screening measures that are used in conducting epidemiological studies for detecting need for various different health reasons. Using these screening tools, we identified current symptoms of PTSD and depression that were consistent with a diagnosis using DSM-IV scoring criteria for these screening tools. And so we report the number who were at the level of consistent symptoms of a diagnosis with PTSD and depression using these validated screening measures.

Mr. LAMBORN. Thank you. And Mr. Chairman, they have done a good job of explaining themselves. I don't have any further questions.

Mr. HALL. They sure have. Thank you very much.

We still have—well, this diagram of the immediate consequences and emergent outcomes and the experience of the post-combat dis-

order and what resources and vulnerabilities there are, that is enough to keep me working for a while. And it comes in a book. If you haven't seen it, all of you here in the audience, it is definitely worth reading. It is a serious contribution and an important contribution to our country's attempt to help our veterans through this difficult problem. So I thank you all on this panel for your testimony. You are now excused.

Moving at breakneck speed, thanks to the fact that there are no votes being called, and the fact that most of our Members are not here using their 5 minutes—we will call our third panel. Rear Admiral David J. Smith, a Joint Staff Surgeon for the United States Department of Defense; Colonel Robert Ireland, Program Director of Mental Health Policy for the Office of the Assistant Secretary of Defense for Health Affairs, U.S. Department of Defense; Bradley G. Mayes, Director of the Compensation and Pension Service for the Veterans Benefits Administration, U.S. Department of Veterans Affairs, accompanied by Richard Hipolit, General Counsel for the Department of Veterans Affairs; Antonette Zeiss, Ph.D., Deputy Chief Consultant, Office of Mental Health Services for the Veterans Health Administration (VHA); and Maureen Murdoch, M.D., Core Investigator, Center for Chronic Disease Outcomes Research of the Minneapolis Veterans Affairs Medical Center, Veterans Health Administration, U.S. Department of Veterans Affairs.

As always, your statement is entered into the record as written. You can feel free to deviate from it.

Mr. HALL. Starting with Rear Admiral Smith, you are recognized for 5 minutes.

STATEMENTS OF REAR ADMIRAL DAVID J. SMITH, M.D., SHCE, USN, JOINT STAFF SURGEON, OFFICE OF THE CHAIRMAN OF THE JOINT CHIEFS OF STAFF, WOUNDED AND SURVIVOR CARE TASK FORCE, U.S. DEPARTMENT OF DEFENSE; COLONEL ROBERT IRELAND, PROGRAM DIRECTOR, MENTAL HEALTH POLICY, OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS, U.S. DEPARTMENT OF DEFENSE; BRADLEY G. MAYES, DIRECTOR, COMPENSATION AND PENSION SERVICE, VETERANS BENEFITS ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY RICHARD HIPOLIT, GENERAL COUNSEL, OFFICE OF GENERAL COUNSEL, U.S. DEPARTMENT OF VETERANS AFFAIRS; ANTONETTE ZEISS, PH.D., DEPUTY CHIEF CONSULTANT, OFFICE OF MENTAL HEALTH SERVICES, OFFICE OF PATIENT CARE SERVICES, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND MAUREEN MURDOCH, M.D., MPH, CORE INVESTIGATOR, CENTER FOR CHRONIC DISEASE OUTCOMES RESEARCH, MINNEAPOLIS VETERANS AFFAIRS MEDICAL CENTER, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

**STATEMENT OF
REAR ADMIRAL DAVID J. SMITH, M.D., SHCE, USN**

Admiral SMITH. Mr. Chairman, distinguished Members of the Subcommittee, I am privileged to appear before you today and report on wounded-warrior issues and specifically those associated with post-traumatic stress disorder.

In my capacity as the Joint Staff Surgeon, I serve as the Chief Medical Advisor to the Chairman of the Joint Chiefs of Staff and as a Senior Member of the Chairman's Warrior and Survivor Care Task Force.

On behalf of the Chairman, let me emphasize to you that wounded warrior issues, particularly including post-traumatic stress, continue to be a top priority for the Chairman and the Department of Defense as a whole.

Working in concert with the respective services, we continue to focus on revitalizing and reconstituting the force, actively identifying the needs of and giving support to our servicemembers' families and removing the stigma associated with post-traumatic stress within the DoD.

I make the statement of revitalizing and reconstituting the force, because those are the terms the Chairman uses when speaking of the top issues and, specifically, his imperative concern.

I, along with the task force, continuously focus on improving current programs, while inviting the creation of new ones. And we are strongly focused on teaming with the Veterans Affairs and non-governmental organizations to ensure our veterans and their families receive care that they so aptly deserve after they leave active duty.

In regards to doctrine definitions and terminology associated with post-traumatic stress, let me say that the Department evaluates definitions for their use in doctrine, but we do not evaluate definitions for the potential implications on benefit determination.

DoD's definitions and terminologies may be used, but are not replacements for policy and law in determination matters.

The doctrine and definitions are tools we use to provide a common starting point across the Department, but compensation will continue to be dictated by policy and law rather than terms of reference for post-traumatic stress.

The DoD and the VA use the Diagnostic and Statistical Manual for Mental Disorders, 4th edition, frequently referred to as the DSM-IV, for the diagnosis of post-traumatic stress disorder, and CFR 38 outlines the necessary prerequisites for eligibility.

With these rule sets, the medical community then applies professional judgment to interpret and diagnose individual cases, and the DoD continuously monitors changes within the medical community of terms of reference, research findings, and new treatment modalities and improvements to ensure we stay in touch with changes that do occur.

Now, let me take a moment of your time to identify one area of concern related to the treatment of post-traumatic stress and other issues related to the care of our servicemembers and veterans. The disability evaluation and compensation system, in its current state, is clearly too complex and burdensome for even the most tolerant of our servicemembers and veterans.

The time associated with working through the system has been identified as a significant additional stressor to our servicemembers and their families that we want to fix. And in contrast to the stop-gap efforts, which have been employed in the past, I believe that the disability evaluation and compensation system requires revolutionary, systemic overhaul.

DoD is working closely with our representatives from the Veterans Affairs counterparts to begin this process. Both Secretary Gates and Admiral Mullen have identified this issue as an important focus area for DoD and VA.

I identified this issue to the Committee and its Members to let you know we are keenly aware of the problem, and at some time in the future DoD and VA may ask for assistance from the Legislative Branch to help streamline and correct deficiencies that may require adjustments to current law.

DoD will continue to keep your Committee and the Congress at whole apprised of the situation as we work through the nuances to help fix the disability evaluation system.

Now, I would like to reemphasize the point to you: Congress and the DoD have committed hundreds of millions of dollars to improve our understanding of combat and operational stress, psychological health, the resilience of our personnel, as well as to diagnose and treat post-traumatic stress and related conditions, including mild traumatic brain injury.

We continue to face many challenges and are working closely with the Veterans Affairs, the National Institute of Mental Health, and academic centers across the country to better improve our services for veterans and their families. We will continue to focus on post-traumatic stress until we feel every servicemember is optimally prepared to cope with combat stress and, when needed, is receiving the treatment he or she has earned through their service.

Mr. Chairman, thank you again for the invitation to appear here this afternoon, and I am pleased to respond to any questions you or the Subcommittee Members may have.

[The prepared statement of Admiral Smith appears on p. 53.]

Mr. HALL. Thank you, Admiral. I am pleased to hear you talk, as does Secretary Shinseki, about his ongoing and evolving work with Secretary Gates and the two Departments working together, because there is so much of this that is a continuum that starts with entry into active duty and continues on into one's later years as a veteran. Many of these problems can best be solved if the two Departments work together.

And when you talk about, I think you said, revolutionary and systematic overhaul of the disability evaluation system, you may be aware that last year we passed a bill that was passed by the Senate also and signed into law to do just that. So it will take a while to do it, but we have started the ball rolling and hopefully that revolutionary and systematic overhaul will happen. Colonel Ireland, you now have the floor for 5 minutes.

STATEMENT OF COLONEL ROBERT IRELAND

Colonel IRELAND. Chairman Hall, Ranking Member Lamborn, and distinguished Members of the Subcommittee, thank you for this opportunity to discuss the Department of Defense approach to diagnosing PTSD and defining related stressors and the use of the servicemember's record.

In many ways, due to the complexities we have heard earlier today, it may seem quite simple on the DoD clinical side. When servicemembers' medical conditions do require further medical evaluation in order to assess whether they are retainable in their

service to perform their duties, military treatment facility clinicians perform an evaluation, write a summary and submit it for review by a medical evaluation board, or MEB.

This consists simply of two or three clinicians in the treatment—medical treatment facility. And when it is a mental health issue it should include—must include—a psychiatrist. So if there is an MEB review of the psychiatric condition, there should be a sign-off by a psychiatrist on that report.

The report is to confirm the diagnosis and document thoroughly the medical condition of the member and to review each case based on relevant facts. The local MEB simply determines whether the servicemember meets the retention standards and can be returned to duty, or whether the member fails to meet those standards and would require either a waiver to continue in service or has to go to a Physical Evaluation Board (PEB) for further consideration to look at whether they should be retained with that waiver, separated with or without severance pay, or retired.

All of these fall outside of the clinical processes at the local level and are a service matter with the Personnel Physical Evaluation Board system.

With respect to PTSD, military providers do use the same criteria as their civilian counterparts to diagnose PTSD, using the American Psychiatric Association's (APA's) DSM-IV criteria. And I will skip going through those criteria to avoid duplication and save some time.

With regard to comments on stressors, there is a long history of how that word is used and the development of theory related to it. But to simply to refer to well, that was an appropriate stressor, is probably an oversimplification in assessing what someone has experienced, what they have witnessed. And then we also need to consider how that caused a physiologic reaction within them and an emotional reaction—and then for human beings, usually there is some form of self-assessment of that experience or that event and one's own perception of one's own reaction to it, and one's sense of whether they can meet the demand. And when they can't, that is usually when they show up to mental health. So a stressor is a complex thing to speak about, and simply checking off the stressors of what would cause PTSD may be an oversimplification.

To conclude, the importance of such records of these evaluations and PEB recommendations and conclusions to transitioning servicemembers cannot be overemphasized. We do encourage servicemembers to request copies of their medical and mental health records upon separation from the military to assure continuity of care, irrespective of where they receive their care in the future.

Those utilizing the VA have the added advantage of VA provider visibility of their medical and their mental health records through the use of the Bidirectional Health Information Exchange, which is functional and is receiving military medical records.

Thank you, again, for allowing the opportunity to appear before you and to discuss these issues.

[The prepared statement of Colonel Ireland appears on p. 53.]

Mr. HALL. Thank you, Colonel.

Mr. Mayes, welcome back. It is always good to see you. You are now recognized for 5 minutes.

STATEMENT OF BRADLEY G. MAYES

Mr. MAYES. Thank you.

Mr. Chairman, Ranking Member Lamborn, I would like to thank you for the opportunity to testify on this important topic of post-traumatic stress disorder. Mr. Dick Hipolit, from the Department of Veterans Affairs, Office of General Counsel, accompanies me today.

The number of veterans receiving service-connected compensation for PTSD from VA has grown dramatically. From fiscal year 1999 through fiscal year 2008, the number increased from 120,000 to more than 345,000.

We all share the goals of preventing this disability, minimizing its impact on our veterans, and providing those who suffer from it with just compensation for their service to our country. Consequently, VA has expanded its efforts to assist veterans with the claims process and keep pace with the increased number of claims.

Today, I will briefly describe the PTSD claims process and explain how VA applies the statutory requirements of 38 U.S.C., section 1154, to the processing of these claims. Section 1154, which, as we heard earlier, was enacted by Congress in 1941, requires that VA consider the time, place and circumstances of a veteran's service in deciding a claim for service connection.

Section 1154(b) provides for reliance on certain evidence as a basis for service connection of disabilities that result from a veteran's engagement in combat with the enemy. As a result, veterans who engaged in combat with the enemy and filed claims for service-connected disability related to that combat are not subject to the same evidentiary requirements as noncombat veterans. Their lay statements alone may provide the basis for a service-connected disability without additional factual or credible supporting evidence.

In PTSD claims, a combat veteran's personal stressor statement can serve to establish the occurrence of the stressor.

The processing of PTSD claims is governed by our regulations at 3.304(f). Specifically this regulation states that in order for service connection for PTSD to be granted, there must be, first of all, medical evidence diagnosing the condition.

Second of all, medical evidence establishing a link between current symptoms and an in-service stressor.

And then, third, credible supporting evidence that the claimed in-service stressor occurred.

As I said, the first two requirements involve medical assessments, while the third requirement may be satisfied by nonmedical evidence.

PTSD is defined as a mental disorder that results from a stressor. That third requirement of the regulation emphasizes the importance of the stressor and the obligation of the Department of Veterans Affairs to seek credible evidence supporting the occurrence of that stressor.

In PTSD claims where the stressor is not combat related, VBA personnel conduct research and develop for credible evidence to support the claimed stressor.

However, we have incorporated into our regulations the 1154(b) provisions, so that when there is evidence of combat participation and the stressors related to that combat, no stressor corroboration

is required. The veteran's lay statement alone, as stated, is sufficient to establish the occurrence of the stressor.

Through the years, VA has made changes to our regulations at 3.304(f) based on the requirement at section 1154 of the statute that mandates us to consider the time, place and circumstance of a veteran's service. The definition and diagnostic criteria for PTSD evolved to a great extent from the psychiatric community's attempt during the seventies to explain the psychological problems of some Vietnam War veterans. Once the medical community recognized this mental disorder, VA added it as a disability to the schedule. VA then moved to incorporate PTSD diagnostic criteria from the APA's DSM-IV into the PTSD claim evaluation process.

Given the delay that may occur between the occurrence of that stressor and the onset of PTSD, and the subjective nature of a person's response to an event, VA concluded when it first promulgated the regs in 1993, that it was reasonable to require corroboration of the in-service stressor.

However, as the military incorporated more female members into its ranks, VA recognized that PTSD could result from personal assault and sexual trauma.

To meet this evolving situation, VA added a section at 3.304(f), which provides for acceptance of evidence for stressor corroboration in such cases from multiple sources other than the veteran's service records. The evidence may include local law enforcement records, hospital or rape crisis center records, or testimony from family, friends or clergy members.

Although the combat participation provisions of section 1154 have been in effect for many years, the VA has recently provided a regulatory change that further extends the intent of that statute and recognizes the changing conditions of modern warfare.

A new section, 3.304(f)(1), now provides for service connection of PTSD when there is an in-service diagnosis of the disability. In such cases, the veteran's lay stressor statement and the medical examiner's association of PTSD with a stressor is sufficient to establish service connection where PTSD is diagnosed.

This liberalization of regulatory requirements is due to the recognition by VA of the heightened awareness of PTSD among military medical personnel, resulting in the increasing numbers and reliability of PTSD diagnoses for personnel that are still on active duty.

These descriptions of PTSD-related initiatives make it clear that VA is committed to following the mandate of the provisions of section 1154, and adjusting the PTSD claims process as necessary to serve our veterans.

This concludes my testimony, and I would be happy to answer any questions that the Members may have.

[The prepared statement of Mr. Mayes appears on p. 54.]

Mr. HALL. Thank you, Mr. Mayes.

Dr. Zeiss.

STATEMENT OF ANTONETTE ZEISS, PH.D.

Dr. ZEISS. Good afternoon, Chairman Hall and Members of the Subcommittee.

Thank you for the opportunity to discuss the diagnosis of PTSD by Veterans Health Administration health clinicians, particularly in the context of a compensation and pension claim.

The Department of Veterans Affairs is recognized for its outstanding PTSD treatment and research programs, the quality of VA health care in this area is outstanding, and we improve as we learn more. All VA clinicians, including those responsible for completing compensation and pension evaluations, adhere to the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, Text Revision, DSM-IV-TR of the American Psychiatric Association.

According to these clinical criteria, PTSD can follow exposure to a severely traumatic stressor that involves personal experience of an event involving actual or threatened death or serious injury. It also can be triggered by witnessing an event that involves death, injury or a threat to the physical integrity of another. This would meet criterion A in the DSM-IV criteria for PTSD.

The person's response to the event, also to meet criterion A, must involve intense fear, helplessness or horror. If criterion A is met, then symptoms characteristic of PTSD to fully establish the diagnosis would be explored, including persistent reexperiencing of the traumatic event, persistent avoidance of stimuli associated with the trauma, along with numbing of general responsiveness and persistent symptoms of increased arousal.

No single individual would display all these symptoms, and a diagnosis requires a combination of a sufficient number of symptoms, while recognizing that individual patterns will vary.

PTSD also can be experienced in many ways. Symptoms must last for more than 1 month to receive the diagnosis, and the disturbance must cause clinically different distress or impairment in social, occupational or other important areas of functioning.

Military combat certainly creates situations that fit the DSM-IV-TR description of a severe stressor event that could result in PTSD. The likelihood of developing PTSD is known to increase as the proximity to, intensity of, and number of exposures to such stressors increase.

PTSD is associated with increased rates of other mental health conditions and can directly or indirectly contribute to other medical conditions. Symptoms may be brief or persistent. The course of PTSD may ebb and return over time, and PTSD can have delayed onset. Clinicians use these criteria in discussions with patients to identify cases of PTSD.

VA seeks to ensure that we offer the right diagnosis in all clinical settings, whether for C&P examinations or part of the standard mental health assessment. In the C&P context, only psychiatrists and psychologists may conduct an initial C&P examination in which a diagnosis of PTSD is being considered in response to a claim by a veteran.

In addition, any psychiatrist or psychologist who will conduct a PTSD C&P exam must complete specific training on that process and receive certification in conducting C&P examinations in relation to diagnostic criteria of PTSD.

We recognize that many individuals with symptoms of combat stress or PTSD may find it difficult to discuss the details of those

experiences. Without the patient disclosing the source of the stress, it is impossible for a clinician to diagnose PTSD according to the clinical criteria of DSM-IV-TR. This is part of why only doctoral-level providers are allowed to conduct initial exams and to have the sensitivity and expertise to enable a full description of the concerns being presented.

VHA clinicians who conduct the clinical interview for the diagnosis of PTSD in the context of a claim do not ask for external corroborating evidence for the described stressful event. That would be really determined by the clinician's experience of the description of the veteran of their stressful experience, and how that led to the symptoms that they also would describe.

Apart from issues of determining diagnosis in the C&P context, identifying and treating patients with PTSD and other mental health conditions is, of course, of paramount concern for Veterans Health Administration, and we provide mental health care in many different environments, including Vet Centers.

And I might add that while the RAND study showed about 14 percent returning with possible PTSD, in VA we are serving over 20 percent of those veterans who have returned and sought care from VA, and have been diagnosed with possible PTSD. So we are very much trying to identify cases and ensure delivery of care as well as, in the appropriate context, support for claims.

So I have submitted my written statement, and just convey that any veteran with a mental health condition we hope will seek care from VA, will receive treatment and counseling for mental health conditions, and we are ready to help.

Thank you for the opportunity to speak, and I am prepared to answer questions.

[The prepared statement of Dr. Zeiss appears on p. 56.]

Mr. HALL. Thank you, Dr. Zeiss.

Dr. Murdoch, you are now recognized for 5 minutes.

STATEMENT OF MAUREEN MURDOCH. M.D., MPH

Dr. MURDOCH. Thank you. Mr. Chair and Members of the Subcommittee, thank you for the opportunity to appear before you today to present findings from my team's research on post-traumatic stress disorder disability awards.

I must note that the views presented here are mine and don't necessarily represent the view of the Department of Veterans Affairs; and they reflect the results of my studies, not necessarily other studies that have been done. And I must emphasize that this research was done more than 10 years ago and may not reflect experiences of new cohorts of veterans.

So I am sure you know that PTSD is the most common psychiatric condition for which veterans seek VA disability benefits. Between 1998 and 2000, my colleagues and I conducted three studies looking at differences in PTSD disability awards.

The first study was a historical administrative database evaluation of all 180,039 veterans who applied for disability benefits between 1980 and 1998. The second was a mailed survey of about 5,000 veterans who applied for disability benefits between 1994 and 1998. And then, finally, we did a claims audit of about 345 veterans who also responded to the survey.

These studies had several objectives, but the most relevant to today's proceedings included identifying the role of combat experience on receiving disability benefits for PTSD and understanding how claiming combat versus military sexual trauma influenced gender differences in receiving PTSD service connection.

From the historical database study, we learned that rates of service connection increased over time between 1980 and 1998. And across all time periods, men and women who were documented as being combat-injured in the database had a rate of service connection of greater than 90 percent.

By 1998, the observed rate of service connection for men without combat injuries was 64 percent, and the rate for women without combat injuries was 57 percent. From the survey's study which, again, covered the time period between 1994 and 1998, we again saw that more than 90 percent of men and women who had documented combat injury in the database received service connection for PTSD.

Of those who did not, who were not identified as being combat injured, 52 percent of women and 64 percent of men received PTSD service connection. However, this gender difference was almost completely explained by the men and women's different rate of combat experience. Regardless of gender, veterans with more combat experiences were more likely to receive service connection than veterans with fewer or no combat experiences.

Since men were more likely to report combat experiences, they were also more likely to be service connected for PTSD. I would also like to point out that in this study, 30 percent of the women reported some kind of combat experience.

In our claims audit of 345 veterans who participated in the mailed survey, we found that 85 percent of men received a diagnosis of PTSD from a qualified clinician, compared to 76 percent of women.

Veterans who were selected for chart audits did not get service connection for PTSD unless his or her examining clinician made a diagnosis of PTSD. About a third of veterans with PTSD diagnosis did not receive service connection.

Veterans diagnosed with PTSD at the time of their clinical examination reported an average of two more combat experiences at the time of survey, compared to men who were not diagnosed with PTSD.

Women who were diagnosed with PTSD were as likely to report a military sexual assault on the survey as were those not diagnosed. So, put another way, reporting more combat experiences was associated with greater odds of PTSD diagnosis, but reporting sexual assault was not.

The factor most strongly associated with veterans receiving a diagnosis of PTSD was having a stressor documented in their claims file.

Mr. Chairman, Subcommittee Members, this concludes my statement, and I am pleased to respond to any questions you may have. Thank you.

[The prepared statement of Dr. Murdoch appears on p. 58.]

Mr. HALL. Thank you, Doctor.

I will begin my questioning with Admiral Smith. In its testimony in an earlier panel, the IAVA referred to “combat support” and “combat service support.” Can you describe these terms and how they function in a combat zone or combat theater of operations?

Admiral SMITH. I am not sure that I am the expert that can answer that but—and I said in my testimony—the doctrine that we set up is primarily based on needs of what we need within the military.

For example, in doctrine we don’t have a definition for “combat,” because it is clear from Webster’s Dictionary what that is. There is a DoD Instruction that talks about benefits, that actually does define, based on CFR, various aspects of combat, and that is DoD-I 1332.38 that I have with me.

Mr. HALL. Okay, and this question would be to you and Colonel Ireland both. Given the circumstances in Iraq and Afghanistan, would you say that it is distinguishable in terms of who is engaged in combat with the enemy and who is not?

Let me elaborate? As one Member of Congress who went and slept in the Green Zone for one night and was told, if you hear a siren in the middle of the night, jump out of bed and run over to that bunker because last week we lost two soldiers to incoming mortar rounds; now if that was my one-night experience in the Green Zone, the safest place in the country, then presumably supply sergeants, nurses, cooks, servicemembers who are there on a break from being out in the countryside working at their regular duties, are all subject to a nightly possibility of incoming rounds impacting close to them and injuring or killing members of our forces.

Obviously, there are different degrees of combat. You can’t compare that to being attacked or ambushed on the road and hit with an IED and so on or so forth. But nonetheless, it is the kind of thing that repeated experience might cause—in some people—might cause symptoms.

Admiral SMITH. Yes, sir. As far as combat, clearly that is where the history becomes so important; because as you aptly pointed out, it varies dramatically by the location you are in, the particular jobs that you are assigned and what your experiences are there.

Over the course of the last 10 years, a number of combat badges have actually been developed and the definitions of those are defined by each one of the services. And then it is dependent on the particular commander of the units as to who gets allocated that designation.

Mr. HALL. Colonel Ireland, do you care to add to that?

Colonel IRELAND. From the clinical perspective, it doesn’t matter much whether we were involved in offensive or defensive or no operations whatsoever at the time of attack. So that is not part of my expertise to comment, sir.

Mr. HALL. Does the Post-Deployment Health Reassessment (PDHRA) program screen for PTSD, Colonel Ireland, and what happens with those PDHRA results?

Colonel IRELAND. The results of the assessment are made available to the VA, and then clinicians can pull them up off their screen and look at them when they see a patient.

From our standpoint, the servicemember is evaluated by a designated health care member to review their physical and mental health concerns on the health assessment, and discuss with them the nature of them—to determine how badly they are bothered by them—to make a brief functional assessment, but not a formal one, and make a determination as to whether further evaluation or treatment may be necessary, and then discuss with the member various options they may have, both clinical and preclinical, and help them influence the direction, dependent on the number of endorsements, the severity of what they are perceiving and the member's willingness to engage in care.

So the member may go to a chaplain but not necessarily go—but refuses to go to a clinic for evaluation, we start there with pre-clinical care.

If they don't want to see anyone, we might refer them to <http://afterdeployment.org>—our Web site, so we will try to work with a member based on the severity of their condition and what they are willing to do.

Mr. HALL. Can you tell us more about the DoD BATTLEMIND program and how it identifies potentially traumatic events. And is BATTLEMIND mandatory for all servicemembers before and after deployments?

Colonel IRELAND. BATTLEMIND is a unique Army program, sir, and it is using mostly Army contexts to display its messages. Those types of messages are included in other types of programs.

For example, the Air Force is utilizing LANDING GEAR, a similar-type program, but using more of the experiences familiar to Air Force members. It is my understanding, though, that other services are using BATTLEMIND for certain situations and are certainly free to do so. As in suicide prevention, we encourage the sharing and stealing of good ideas wherever they are found.

Mr. HALL. Thank you.

Mr. Mayes, as you have acknowledged, the language in section 1154 that was enacted by Congress in 1941—and VA, of course, has to base its rulemaking on it—if Congress broadened the definition, would VA change its requirements?

Mr. MAYES. Well, certainly, if Congress passed legislation that changed the language, for example, that is in section 1154 right now, then we would engage in rulemaking to comport with the law.

Mr. HALL. Thank you. I am going to turn it over to Ranking Member Lamborn.

Mr. LAMBORN. I thank the Chairman.

Admiral Smith, what type of recourse does a non-combat veteran have if the traumatic event he or she experienced is not expressly written down in their service record?

Admiral SMITH. I am not sure that I can answer from a DoD perspective. Within the DoD, it would be reliant on their history and in trying to document it by talking to members of their unit, et cetera. But we primarily are relying on the medical information that we received during the encounter.

I think I am going to have to defer to the VA relative to how one would document that or how they would deal with that from a benefits point of view.

Mr. LAMBORN. Okay, let's turn that over—if someone wants to address that.

Mr. MAYES. Ranking Member, could you repeat the question? I am sorry; you caught me there.

Mr. LAMBORN. What type of recourse would a noncombat veteran have if the traumatic event they experienced is not expressly written down in their service record?

Mr. MAYES. Well, as I said in my testimony, we will go ahead and develop for that stressor, that would then substantiate or could be used to support a diagnosis of post-traumatic stress disorder. So we are required by statute, as stipulated in section 5107, to go out and secure any evidence that the veteran might have available or presented to us or indicated that they have in their possession.

We would go out and look at service records. Potentially we would ask for buddy statements. And so we would begin to assemble a picture that would begin to try and corroborate the stressor that is asserted by the claimant. And with that evidence that we had collected—if it was sufficient, if there was sufficient corroboration and there was an indication that the veteran was suffering from symptoms related to PTSD—then we would send that documentation along with a request to our colleagues in VHA for a C&P exam so that they could then provide the other two elements—and that is the diagnosis and the medical link between that diagnosis and the stressor that is asserted by the claimant.

Mr. LAMBORN. Okay. Thank you.

Admiral Smith, back to you. How would a servicemember's record reflect their temporary assignments while in theater? For example, would a record show that a helicopter mechanic was temporarily assigned to a convoy, and would their records show that they saw potentially traumatic events while part of the convoy?

Admiral SMITH. I think I am going to have to take that for record, sir. Sorry.

Mr. LAMBORN. Okay. Well, we could maybe get a written response at another time.

Admiral SMITH. Sure.

[The DoD subsequently provided the following information:]

Currently there is no uniform recording of the exposure to traumatic events within a service member's records when they are assigned to temporary duties described by Congressman Lamborn such as convoy duty or patrol.

This is a problem identified recently by a task force formed by the Chief of the Army National Guard Bureau as well as by a team of investigators sent by the Chairman of the Joint Chiefs of Staff to Iraq and Afghanistan in February. Currently, these combat events are recorded in CIDNE (Combined Information Data Network Exchange) and SIGACT (Significant Activity) Reports. CIDNE and SIGACT reporting are used for battlefield intelligence. There are no direct linkages, however, of personnel data to these reports. In some cases, these exposures to traumatic events are recorded in the service member's medical record if they report for medical evaluation or treatment. In other cases, the service member may report the exposure in their Post Deployment Health Assessment or Post Deployment Re-assessment (PDHA and PDHRA) long after the event. The Office of the Surgeon General of the Army is working in conjunction with the Chief of the National Guard Bureau in the development of a joint application for associating service member identification numbers with CIDNE and SIGACT reporting. The Chairman of the Joint Chiefs of Staff has formally listed this tracking program as one of his top wounded warrior priorities.

Mr. LAMBORN. Mr. Mayes, can the definition of combat under section 1154 be improved on, short of making everyone in the combat theater fall under the definition?

Mr. MAYES. My sense is—let me back up and say, first of all, any veteran can be service-connected for PTSD. They don't have to be a combat veteran. So let's start from that premise.

I believe, and we have looked to the legislative history on section 1154, regarding section 1154, that the intent of Congress was to reduce the evidentiary burden on those veterans who engaged in combat with the enemy. And they were very specific. Congress was very specific in selecting that language when you look at the bills that were being contemplated at the time.

If the intent is to address the evidentiary burden to prove the stressor for a noncombat veteran, I believe you can get at that by looking at section 1154, but you can also get there possibly by looking at the regulations that we have codified at 3.304(f), 38 CFR, 3.304(f).

And we have done that over the years. That is what I was saying. We have reduced the evidentiary burden for female veterans suffering from post-traumatic stress disorder due to personal assault.

We have reduced the evidentiary burden for American ex-POWs. We have reduced the evidentiary burden for veterans diagnosed with post-traumatic stress disorder when they are diagnosed while still on active duty.

And we would certainly be willing to work with the Committee to explore avenues for achieving what I think it is that is being attempted here, as I understand it. However, it is not a legislative hearing. We didn't come over to talk about the proposed bill, but I extend my offer to work with the Committee.

Mr. LAMBORN. May I have one followup question, Mr. Chairman?

Mr. HALL. Yes.

Mr. LAMBORN. My time has expired, but as a followup to this important line of reasoning that we are all discussing here, you maybe were able to hear the example earlier from the American Legion representative about two people in the same convoy but they had differing burdens of proof afterward.

Do you have any reflections on that particular scenario based on what you just said?

Mr. MAYES. Well, I do, Mr. Lamborn. As a matter of fact, I made a note of it. Mr. De Planque, I thought, did an outstanding job of laying out the issue.

And the truth is that if we could place the servicemember—or the veteran who was not in the combat MOS—if we could place them in that area at the time that those events were occurring, then our procedures, where we are today, would allow us to grant service connection in that case as long as the evidence that corroborated the stressor was used by the clinician as the stressor that supported the diagnosis of post-traumatic stress.

So that was my point. There is a way to reach the noncombat veteran right now in our existing procedures, and I would say that on its face, we have seen a dramatic increase in the number of veterans that are on the rolls for PTSD. It is a 188 percent increase

in the last 10 years, as opposed to a 10-percent increase on the rolls for all disabilities.

So the things that we have done along the line to reduce that evidentiary burden, I believe, are part of the reason, not all of the reason, but part of the reason that we are seeing that dramatic increase in veterans receiving compensation for PTSD.

Mr. LAMBORN. Okay. Thank you all for your answers and for being here today.

Mr. HALL. Thank you, Mr. Lamborn.

I would like to follow up, if I may, by noting, Mr. Mayes, that you testified there are 345,520 veterans who are service-connected for PTSD. Dr. Zeiss testified that she is treating 442,862 veterans, which is an almost 100,000 different number. What do you attribute that difference to? Or I could ask Dr. Zeiss the same thing.

Mr. MAYES. Well, I can't definitively say why every veteran—I mean, there is no way for me to know why a veteran might be treated for PTSD, yet not file a claim for post-traumatic stress disorder. I mean, I can only offer you conjecture.

But, certainly, it is possible that some veterans are seeking counseling and treatment to get healthy, and aren't interested in proceeding to VBA to file a claim for disability compensation.

Mr. HALL. Dr. Zeiss?

Dr. ZEISS. I would say the same, and say that we are very grateful to Congress that you have offered the 5-year window where all veterans returning from the current conflicts can come to VA and have eligibility to receive care. So it is not necessary to establish a service-connected diagnosis of PTSD for these returning veterans in order to be diagnosed and receive care on the VHA side of the house.

Clearly there are many veterans who are receiving care with the diagnosis of PTSD. And what their individual reasons for perhaps not submitting a claim, or what the data is about how many of them have submitted a claim that has not been accepted, we don't have that data on the VHA side of the house.

Mr. HALL. Or maybe the treatment is so successful that they don't feel that they are in need of assistance.

In your testimony, Dr. Zeiss, you noted that safety and trust are important issues when discussing these traumatic events. Patients need to be comfortable, examiners need to be sensitive.

The IOM recommends exams take at least 90 minutes and perhaps up to 3 hours, but noted that VA exams frequently can take as little as 20 minutes. How can you achieve safety, trust and comfort in that short a time to elicit a complete military history and develop an understanding of the patient stressors?

Dr. ZEISS. Our guidelines and part of the training for those who are going to conduct C&P exams would support what has been said by IOM. And the recommendation is that the exams should take at least 2 hours, I believe, was the final decision.

It is certainly the case that for some repeat exams, where the only question is what the current level of disability is, and there is not a diagnosis being established, a much shorter interview might be very appropriate.

But for a diagnostic exam, we have been at pains to stress and to try to set up a system in which full interviews would be done

in a timeframe that supports the recommendation of IOM and our own VHA recommendations, and we continue to follow up to try to ensure that that is the standard.

Mr. HALL. How good are you, do you think, at detecting veterans who might claim to have PTSD who don't actually have it?

Dr. ZEISS. Well, I thought that Dr. Kilpatrick covered that beautifully, and so I will simply echo some of the things that he said. Everyone would love it if we had a simple test that could establish malingering or a simple blood test that established PTSD, and many of these issues would be moot. We don't. This is a much more complex and experiential kind of decision and clinical process.

And so clinicians need to be sensitive, as Dr. Kilpatrick said. We should start with the assumption that people are telling us the truth. But if there are red flags in what they are saying, if there are different stories at different points, or contradictory things being said, the clinician may want to slow down and take additional time.

We actually have in the established practices for doing a C&P exam for PTSD, and in the training, the idea that if there is such a concern, the clinician has the option of setting up a second interview or an opportunity for psychological testing. No psychological testing, as Dr. Kilpatrick said, could give a definitive answer, but it might inform whether or not there is some malingering.

It also might inform whether the appropriate diagnosis is not PTSD but some other mental health problem.

So we have tried to build into the process clinically sensitive ways to ensure that the clinician is really attending to all the information they are getting and making staged decisions about how much additional evaluation should occur prior to making the diagnosis.

Mr. HALL. And you are using the Best Practices Manual for PTSD and C&P exams?

Dr. ZEISS. That is part of the training evaluation, and there is also a study going on looking at the CAPS process, the Best Practices Manual, to see whether or not in fact it does lead to superior quality of diagnosis.

Mr. HALL. Are worksheets for the PTSD C&P exams mandated?

Dr. ZEISS. Yes. We have developed those in collaboration with the VBA. All clinicians who are doing the C&P interview would complete that information to provide to VBA. And if they don't, it comes back from VBA, and they will not make a decision until they have that complete information.

Mr. HALL. A couple more quick ones. When the Compensation Pension Examine Program (CPEP) has reviewed VHA records for PTSD, how accurate have those records been?

Dr. ZEISS. I am sorry, I couldn't hear.

Mr. HALL. When the CPEP has reviewed VHA records for PTSD, how accurate have those exams been?

Dr. ZEISS. I would defer the answer to that to Mr. Mayes. CPEP is a part of VBA, and that data would be evaluated internally within the VBA side.

Mr. MAYES. I don't have that data with me today, but we can certainly take that back and provide it for the record. Just so I am

clear, you are looking for the accuracy of only PTSD exams; is that correct, Mr. Chairman?

Mr. HALL. Yes, please.

Mr. MAYES. Okay.

[The VA provided the information in response to Question #5 of the post-hearing questions and responses for the record, which appears on p. 91.]

Mr. HALL. I understand that primary care providers have been instructed to screen Iraq and Afghanistan veterans for traumatic brain injury and PTSD. I guess this could go to Mr. Mayes and Dr. Zeiss.

Why not screen all combat veterans for both?

Dr. ZEISS. We are mandated to screen all veterans, not just the currently returning veterans. And in addition, there is mandatory screening for depression, military sexual trauma and problem drinking.

Mr. HALL. Let me just close by posing a—we heard a couple of hypotheticals before when one of the earlier panels was here.

This is an actual case that we are aware of that a veterans service organization (VSO) representative is working on for a Vietnam veteran who was trained as a cook and—deployed to a forward base in Vietnam.

When he arrived there, according to the veteran, the commander looked at his papers and said, “I don’t know what you were sent here for. We don’t have a mess hall. Here is a rifle, you are doing perimeter duty.”

And so he spent his tour in Vietnam doing perimeter guard duty, taking incoming fire at night, and finished his tour and came back to the United States and was discharged and has, I understand, the classic symptoms of PTSD. Let’s assume for the sake of argument that is true. Now, obviously, none of you have seen him. This is not a case where we have examined the person in question. But the VSO rep who is working with him is himself a veteran, obviously, a Vietnam veteran. Because of the fact, so far, that this veteran’s record says he was a cook, he is so far being denied PTSD classification, which would accord him a disability compensation.

Does a change such as that, which we are considering to provide a presumed stressor, once there is a diagnosis—you have to have the diagnosis from a doctoral-level person—but once you have that service in uniform in a combat zone, would provide this stressor to allow disability assistance?

Does that sound like that would solve that kind of problem, Admiral, starting with you? Or would it be necessary? Is it necessary to solve that problem?

Admiral SMITH. Well, from the testimony that I have heard and looking over what the CFR actually says, it would appear that it could be documented that he was not doing mess work. If there is no documentation for that, that is where the conundrum comes in.

Mr. HALL. Colonel?

Colonel IRELAND. It sounds like what you are proposing may apply and be helpful to that person.

Mr. HALL. Mr. Mayes?

Mr. MAYES. Two comments. The first comment is, I believe, that if we could gather sufficient corroborating evidence that we could

service-connect that veteran—for example, evidence that he participated in hostile activities, the types of activities that would support a diagnosis of PTSD. And then we would need, as I said, the diagnosis and the medical evidence establishing the link between that stressor and that diagnosis. That is my first comment.

So I think we are reaching veterans with similar fact patterns.

My second comment is if, hypothetically, you relaxed the evidentiary burden for that veteran, then their lay testimony alone would serve as sufficient evidence for the stressor. It would also, if they claimed a low-back condition, their lay testimony alone would establish the injury to the lower back or any disability, because changing their evidentiary threshold at 1154 is going to apply across the board, not just to neuropsychiatric disabilities.

Those are the two comments that I would offer.

Mr. HALL. Dr. Zeiss?

Dr. ZEISS. I don't think that from the VHA examiner's perspective, a change in the law would change our approach, because we are not looking at the evidentiary burden.

Mr. HALL. Right.

Dr. ZEISS. The person would have the same kind of evaluation and that information would be evaluated by VBA.

Mr. HALL. Dr. Murdoch?

Dr. MURDOCH. I don't think I have anything to add.

Mr. HALL. Okay. Well, there are many more variations on that theme.

I commend you all for the work that you are doing and your service to our veterans.

And just the fact that the numbers, as Mr. Mayes among others have noted, numbers are going up of the veterans who are being treated for PTSD is a sign that at the very least the outreach is working better, and that hopefully some of the stigma is being removed. Veterans are realizing that help is available, and that asking for it doesn't place them in some kind of dubious category that will make it harder for them as they continue. On the contrary, it should make the rest of their lives more successful and easier.

So we are looking at some success already that I think is good, and our aim here is to try to make that—to maximize that success, if we can, if it is helpful to provide this presumed stressor.

I thank you all for your testimony. If we have any further questions, we will send them to you in writing. Admiral Smith, Colonel Ireland, Mr. Mayes, Mr. Hipolit—sorry I didn't ask you a question directly, I am sure you will get over it.

Mr. HIPOLIT. Maybe next time.

Mr. HALL. Right. We will think of one. Dr. Zeiss and Dr. Murdoch, thank you all. This hearing is now adjourned.

[Whereupon, at 4:08 p.m., the Subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of Hon. John J. Hall, Chairman, Subcommittee on Disability Assistance and Memorial Affairs

Good Morning Ladies and Gentleman:

The task of today's hearing will prove to be both retrospective and prospective; for in order to understand title 38 section 1154, we must look both backward to the original intent of Congress, and forward to defining it in an era of modern warfare tactics and counterinsurgency. I ask that the full text of title 38 United States Code section 1154 be entered into the record.

So, what does it mean to have been "Engaged in Combat with the Enemy" to a sufficient enough degree to prove a stressor that in turn warrants service connection for Post-Traumatic Stress Disorder—or PTSD—by the Department of Veterans Affairs and what has been the intent of Congress?

Congress' commitment originated with the Military Pension Law of 1776 and by the end of the Civil War, Congress recognized that "every soldier who was disabled while in service of the Republic, either by wounds, broken limbs, accidental injuries, . . . or was broken down in the service by the exposure and hardships incident to camp life and field duty . . . is entitled to an invalid pension." It was believed that those exposures and hardships led to a malaise known as "Soldier's Heart"—what we now know as PTSD.

Shortly after the 65th Congress declared war on Germany, it passed the War Risk Insurance Act of 1917, which outlined benefits to WWI veterans. In 2 years, it was amended 22 times. These amendments included the first VA Schedule for Rating Disabilities and established wartime versus peacetime rates for pension.

The 1933 Rating Schedule included instructions to notate the phrase "incurred in service in combat with an enemy of the United States" and to list the period of wartime service. This practice indicated that the enemy was a foreign government or a hostile force of a nation, and not an individual combatant.

On December 12, 1941, days after the attack on Pearl Harbor, Congress expressed its desire to "overcome the adverse effect of a lack of an official record . . ." and "the difficulties encountered in assembling records of combat veterans." Congress further instituted "more liberal service pension laws . . . by extending full cooperation to the veteran."

The 1945 Rating Schedule required that wartime service be noted by including the phrase "disability resulted from injury received in actual combat in an expedition or occupation." Importantly, this prerequisite refined the broader 1933 required statement. Additionally, the 1945 schedule described the onset of "War Psychosis" as the result of an "incident in battle or enemy action, or following bombing, shipwreck, imprisonment, exhaustion, or prolonged operational fatigue." This diagnosis was removed when the Rating Schedule for mental disorders was revised in 1976, 1988, and 1996.

The current Rating Schedule for PTSD has been described as vague and subjective. Furthermore, the adjudication process does not solely accept, as the law prescribes, *lay evidence as sufficient proof as long as it is consistent with the circumstances, conditions, or hardships of such service, notwithstanding that there is no official record.* This law should seem self-evident as to the intent of Congress! So why isn't it? The controversy seems to exist because of numerous interpretations of Congressional intent. Leading decisionmakers at VA General Counsel have issued opinions and Court decisions concluded that if it were the intent of Congress to specify a combat zone or a theater of combat operations, Congress would have done so as it has in other provisions of the law under title 38, but omitted in section 1154.

My intention today is to re-open this dialog. The nature of wartime service has changed as many can agree. Warfare encompasses acts of terrorism, insurgency, and guerilla tactics. No place is safe and the enemy may not be readily identifiable.

Psychiatry has changed too. PTSD is a relatively new diagnosis; first having appeared in the Diagnostic and Statistical Manual in 1980—5 years after the end of the Vietnam War. An array of mental health research has been conducted and assessment techniques have been developed. Since the world is not the same place it was in 1941, I have introduced H.R. 952, the Combat PTSD Act to redefine section 1154 to include a theater of combat operations during a period of war or in combat against a hostile force.

There should be a better way for VA to assist veterans suffering from PTSD adjudicate those claims without it being burdensome, stressful and adversarial. Veterans still face issues with stigma, gender and racial disparities in rating decisions, poorly conducted disability exams, and inadequate military histories. So, I am eager to hear from the witnesses today about their experiences with denials, inequities, and variances. In the last few years, the IOM comprehensively reviewed the research on PTSD diagnosis, assessment, and compensation. In 2008, the RAND Report on the *Invisible Wounds of War* gave us a new perspective on the costs of war when soldiers are left without treatment or support and I look forward to hearing more of its witness' analysis. Finally, DoD and VA will share their insights into how they determine combat vs. noncombat and how they have chosen to evaluate PTSD disability.

**Prepared Statement of Hon. Doug Lamborn, Ranking Republican Member,
Subcommittee on Disability Assistance and Memorial Affairs**

Thank you, Chairman Hall for yielding.

I am pleased to have the opportunity to discuss the important issue before us today.

I hope that through the collective efforts and knowledge of the individuals gathered here this afternoon, we can help ensure that every veteran who has service-related PTSD is able to access the benefits to which they are entitled.

Chairman Hall, I would also like to commend you for your compassion toward our veterans.

I know it has been a longstanding issue for you to ensure no one falls through the cracks due to unintended consequences of the laws and regulations pertaining to compensation for PTSD.

You've reintroduced in the 111th Congress, a bill to clarify the meaning of "combat with the enemy" for purposes of service-connection.

As you and our witnesses are aware, section 1154(b) of title 38, United States Code, already provides special consideration for veterans attempting to establish service-connection for PTSD or other medical conditions incurred or aggravated in combat.

In short, this means that the VA must accept a combat veteran's lay testimony as sufficient proof of service-connection for any disease or injury incurred in combat, even if there is no official record of such incident.

Congress established this broad threshold in recognition of the chaotic nature of battle, and the appropriateness of resolving every reasonable doubt in favor of the veteran.

Unfortunately, circumstances could conceivably arise in which an individual, who is not a combat veteran under the existing definition, is exposed to an overwhelming stressor, but he or she is unable to provide evidence of the occurrence.

This is especially true for veterans of Vietnam and earlier wars.

This is the problem we are trying to resolve.

Chairman Hall's proposed solution is his bill, which would essentially redefine "combat with the enemy" to include service on active duty in a theater of combat operations.

As I've stated previously, I am concerned that too broad of a presumptive threshold would damage the integrity of the system.

I also believe that too loose of a definition of combat would diminish the immeasurable sacrifice and service of those who actually did engage in battle with the enemy.

While I understand and appreciate the effort to address problems regarding the VA claims backlog, I believe that they generally result from procedural issues and we should address those problems accordingly.

In addition to the policy concerns I have stated, I would also point out that the mandatory offsets that would be necessary to pass this bill under existing PAYGO rules, would be difficult to find.

Mr. Chairman as you know, it is always a challenge to identify offsets within our jurisdiction, and the CBO estimated cost of this measure last year exceeded \$4 billion.

I would not be in favor of reducing existing veterans' benefits in order to establish an overly broad definition of combat with the enemy.

Mr. Chairman I extend my thanks to you for holding this hearing and I look forward to hearing the testimony of our colleagues and the witnesses on our panel today. I yield back.

**Prepared Statement of Ian C. De Planque Assistant Director,
Veterans Affairs and Rehabilitation Commission, American Legion**

Mr. Chairman and Members of the Subcommittee:

Thank you for this opportunity to present the American Legion's views on "The Nexus between Engaged in Combat with the Enemy and Post-Traumatic Stress Disorder (PTSD) in an Era of Changing Warfare Tactics." The progression of modern warfare through the end of the 20th century and the beginning of the 21st century has seen fundamental changes in how we must view the battlefield. We must give recognition to the unique exigencies of the modern battlefield. As we examine the modern day state of war fighting, it becomes clear that old models of clear cut boundaries have given way to nonlinear battlefields, where simply defined lines of battle are no longer present. In recognition of this state of asymmetrical warfare, we must look at assumptions of how combat operations are defined and recorded by the Nation's military. The American Legion commends the Subcommittee for holding a hearing to discuss this extremely important and topical issue.

Combat veterans have a huge advantage when attempting to establish service-connection for PTSD or other medical conditions incurred or aggravated in combat. Claims for service-connection of a combat-related condition receive special treatment under law and regulation administered by Department of Veterans Affairs (VA). They receive favorable treatment because war is, and has always been, a chaotic endeavor. It can be difficult to record every detail of operations in the heat of battle. There are so many unrecorded nuances to the activity of military forces that Congress has specifically directed that the special circumstance of combat merit special circumstances in the establishment of incidents during military service in the conditions of war. Therefore, if a combat veteran states that he or she suffered a disease, injury, or stressor event during combat, VA must generally accept that statement as fact. This is true even if there are no service records that support the statement.

Specifically, section 1154(b) of title 38, United States Code (USC), provides:

In the case of any veteran who engaged in combat with the enemy in active service with a military, naval, or air organization of the United States during a period of war, campaign, or expedition, the Secretary shall accept as sufficient proof of service-connection of any disease or injury alleged to have been incurred in or aggravated by such service satisfactory lay or other evidence of service incurrence or aggravation of such injury or disease, if consistent with the circumstances, conditions, or hardships of such service, notwithstanding the fact that there is no official record of such incurrence or aggravation in such service, and, to that end, shall resolve every reasonable doubt in favor of the veteran. Service-connection of such injury or disease may be rebutted by clear and convincing evidence to the contrary. The reasons for granting or denying service-connection in each case shall be recorded in full.

As a point of clarification, the special provisions in section 1154(b) lower the burden on the veteran to show that the injury, disease or event during service, which the veteran claims led to the current medical condition, in fact happened. Section 1154(b) does not, however, remove the need to prove the other two requirements for service-connection: medical evidence of current disability and medical evidence of a relationship between the current medical condition and the in-service precipitating injury, disease or event. Medical evidence, not lay evidence, is nearly always needed to satisfy those two requirements for a grant of service-connection. For example, if a combat veteran seeking service-connection for a shoulder disability states that "he landed with great force on the shoulder after being knocked to the ground by a shell blast," then under section 1154(b), his statement is likely to be sufficient proof that the incident happened. For service-connection to be granted, however, the veteran will also need to present medical evidence of a current shoulder disability and medical evidence of an etiological link between the current shoulder problem and the

combat injury. Section 1154(b) does not help the veteran meet those two requirements. It should also be noted that the relaxed evidentiary standards in section 1154(b) only apply to incidents that are combat-related. They do not apply to veterans who did not engage in combat and they do not apply when combat veterans are trying to prove the occurrence of noncombat incidents.

Unfortunately for many veterans, the most difficult burden is establishing themselves as a combat veteran in order to benefit from the advantages afforded by statute. In order to determine whether VA is required to accept a particular veteran's "satisfactory lay or other evidence" as sufficient proof of service incurrence under section 1154(b), an initial determination must be made as to whether the veteran "engaged in combat with the enemy." The United States Court of Appeals for Veterans Claims (CAVC) has held that this determination is not governed by the specific evidentiary standards and procedures in section 1154(b), which only apply once combat service has been established. See *Cohen v. Brown*, 10 *Vet. App.* 128, 146 (1997).

The Veterans Benefits Administration's (VBA) Adjudication Procedures Manual M21-1MR PART III, SUBPART 4, CHAPTER 4, section H, Par., 29b states that "**Engaging in combat with the enemy** means personal participation in events constituting an actual fight or encounter with a military foe or hostile unit or instrumentality. It includes presence during such events either as a combatant, or servicemember performing duty in support of combatants, such as providing medical care to the wounded" (emphasis added). In *Sizemore v. Principi*, 18 *Vet. App.* 264, 272 (2004), the CAVC concluded that a determination whether a veteran was in combat must be made on a case-by-case basis, and the definition of "engaged in combat with the enemy," as used in section 1154(b) of title 38, USC, requires that the veteran has "personally participated in events constituting an actual fight or encounter with a military foe or hostile unit or instrumentality."

Unless a veteran was wounded or received a specific combat decoration or badge (such as the Combat Infantryman Badge or Combat Action Ribbon) or award for valor, it is often very difficult to establish that a veteran engaged in combat with the enemy in order to trigger the combat presumptions under section 1154(b). Despite the various narrow, and in our opinion outdated, interpretations of combat as discussed above, we must recognize, however, that the very meaning of the term "engaged in combat with the enemy" has taken on a whole new meaning as the nature of warfare in today's world has changed. This is especially true of service in the combat zones of Iraq and Afghanistan.

Due to the fluidity of the modern battlefield and the nature of the enemy's tactics, there is no defined frontline or rear (safe) area. It is simply a reality of today's warfare that servicemembers in traditional non-combat occupations and support roles are subjected to enemy attacks such as mortar fire, sniper fire, and improvised explosive devices (IED) just as their counterparts in combat arms-related occupational fields. Unfortunately, such incidents are rarely documented making it extremely difficult, if not impossible in some instances, for many veterans to verify in order to prove that they "engaged in combat with the enemy," to the satisfaction of VA, to trigger the combat presumptions of section 1154(b).

Servicemembers, who received a combat-related badge or award for valor, trigger the combat-related presumptions of section 1154(b), but a clerk riding in a Humvee, who witnessed the carnage of an IED attack on a convoy, and later develops PTSD, does not automatically trigger such a presumption. Proving that the incident happened or that clerk was involved in the incident, in order to benefit from the presumption afforded under section 1154(b), can be extremely time consuming and difficult. In some instances, it may even be impossible to submit official documentation or records of the incident because such records do not exist. A good example of this is a soldier stationed in the Green Zone in Iraq who falls and injures his or her knee while running for cover during a mortar attack and later develops a chronic knee condition, but never received treatment after the initial injury. Since the soldier didn't think he or she was hurt that bad and never sought treatment for the knee, the only proof the soldier has to offer that he or she injured his or her knee during an enemy attack on his or her base is his or her word. Since the soldier was stationed in a "safe" area and did not receive a combat decoration or award or participate in any combat operations, establishing that he or she "engaged in combat with the enemy" in order to satisfy the current narrow interpretation of the phrase just to trigger the provisions of section 1154(b) will be extremely difficult, if not impossible. Adding to this already difficult burden is the VA General Counsel decision ruling that "the absence from a veteran's service records of any ordinary indicators of combat service may, in appropriate cases, support a reasonable inference that the veteran did not engage in combat." This means that, according to the General Counsel, records supporting such an inference may be considered as negative evidence

even though they do not affirmatively show that the veteran did not engage in combat. See *VAOPGCPREC 12-99, dated October 18, 1999*.

In addressing the definition of “engaged in combat with the enemy,” the VA General Counsel noted that the phrase is not defined by any applicable statute or regulation. In offering its interpretation, the General Counsel examined the legislative history surrounding the 1941 enactment of the provisions now provided in section 1154(b). The General Counsel noted that there had been several bills considered in the House of Representatives that contained varying criteria for invoking the special evidentiary requirements now contained in section 1154(b). These bills used phrases such as “in a combat area” (H.R. 4737, 77th Cong., 1st Sess. 1941; H.R.2652, 77th Cong., 1st Sess. 1941) and “within the zone of advance” (H.R. 1587, 77th Cong., 1st Sess. 1941; H.R. 9953, 76th Cong., 3d Sess. 1940). Language addressing veterans who were subjected to “arduous conditions of military or naval service” in a war, campaign, or expedition was also used (H.R. 6450, 76th Cong., 3d Sess. 1940). The General Counsel surmised that, in light of these various proposed standards, Congress’ choice of the language “engaged in combat with the enemy” must be “viewed as purposeful.” The General Counsel concluded that, “[c]onsistent with the ordinary meaning of that phrase, therefore, section 1154(b) requires that the veteran have actually participated in combat with the enemy and would not apply to veterans who served in a general “combat area” or “combat zone” but did not themselves engage in combat with the enemy.” See *VAOPGCPREC 12-99, dated October 18, 1999*. It is important to point out that even if VA’s view of Congress’ intent in 1941 is correct, today’s battles, as has been emphasized throughout this statement, no longer take place on a linear battlefield. Defined lines of battle are no longer present and “general” combat areas or combat zones no longer exist. Therefore, it is essential that a statute based in a forties reality of combat adapt to the realities of combat in the 21st century.

Given the evolving nature of modern warfare, as reflected in the enemy’s unconventional tactics on today’s battlefields, and the outdated and overly restrictive interpretations of combat by both the courts and VA, it not only makes sense to clarify the definition of “engaged in combat with the enemy” under section 1154(b) in a manner consistent with the new realities of modern warfare, it is essential that we do so, not just for those serving now, but for those who have served in the past and those who will serve in the future. Such a clarification would also benefit the VA by negating extensive development, and in some cases overdevelopment, of the combat-related stressor verification portion of a PTSD claim or the incident in service requirement of claims for other combat-related conditions and, in doing so, reduce the length of time it takes to adjudicate such claims. To this end, Congress must examine the manner in which combat is defined for the purposes of the statute. It is not a matter of drastically changing the existing law or creating a new benefit, but simply clarifying how it must be construed. Under the provisions of section 1154(b) soldiers, sailors and airmen are still required to detail alleged incidents. The only question that arises is when do the provisions of this subsection apply and how is combat to be judged on this modern, nonlinear battlefield?

The American Legion is well aware that these alleged incidents must still be consistent with the conditions and actions of a combat situation, indeed that combat or combat conditions must be alleged. Furthermore, we are aware that simply accepting the occurrence of these occurrences in combat is not a magic wand to grant service-connection for any condition, as a veteran must still show evidence of a present condition and of a medical linkage between the incident and present condition.

Mr. Chairman, the American Legion reinforces the belief that we as a Nation must reexamine how we view many aspects of war and war fighting. While many things have changed, there are and will always be some consistencies. This Nation has a long tradition of extending its hand to those who have sacrificed to protect and serve. We have never, nor should we ever, veered from the promises to “. . . care for him who shall have borne the battle and for his widow and his orphan . . .” as was ably stated by President Abraham Lincoln.

It is our hope that the information we have presented on what is at issue here will provide some insight into this challenging topic. The American Legion stands ready to assist this Subcommittee and VA in the examination of the criteria which must be met to trigger the provisions of section 1154(b) of title 38, USC. Thank you again for this opportunity to provide testimony on behalf of the members of the American Legion.

**Prepared Statement of Thomas J. Berger, Ph.D., Senior Analyst for
Veterans' Benefits and Mental Health Issues, Vietnam Veterans of America**

Mr. Chairman, Ranking Member Lamborn, Distinguished Members of the House Veterans' Affairs Committee's Subcommittee on Disability Assistance & Memorial Affairs, and honored guests, Vietnam Veterans of America (VVA) thanks you for the opportunity to present our statement for the record surrounding the Department of Veterans Affairs (VA) application of the provisions found in Title 38 United States Code 1154, the definition of "engaged in combat with the enemy" and its effect on processing claims for veterans suffering from Post-Traumatic Stress Disorder (PTSD).

Background: VVA reminds the Chairman and the distinguished Members of this Subcommittee that the Veterans Claims Assistance Act (VCAA) became effective in November 2000. Designed to codify VA's longstanding practice of assisting veterans (at least in theory) in developing their claims for benefits, Congress promulgated this statute "to reaffirm and clarify the duty of the Secretary of Veterans Affairs to assist claimants for benefits under laws administered by the Secretary . . ." In other words, the enactment of the VCAA in November 2000, in conjunction with its implementing regulations, was supposed to render mandatory assistance to all veteran-claimants upon submission of a claim, and in this way, it "defined VA's obligation to fully develop the record. . . ." And while the VCAA imposes a substantial duty on the VA to assist the veteran-claimant in obtaining evidence in support of a claim, it also obliges the claimant to aid in this process by providing "enough information to identify and locate the existing records including the custodian or agency holding the records; and the approximate timeframe covered by the records. . . ."

VA fought proper implementation of the VCAA for several years, and only after losing in court did they move to at least in theory implement the VCAA according to the Congressional intent and eliminate the usually misapplied requirement to present a "well-grounded" claim before the VA would assist a veteran with his or her claim. Prior to passage of the VCAA, 38 U.S.C.S. 5107(a) stated:

Except when otherwise provided by the Secretary in accordance with the provisions of this title, a person who submits a claim for benefits under a law administered by the Secretary shall have the burden of submitting evidence sufficient to justify a belief by a fair and impartial individual that the claim is well grounded. The Secretary shall assist such a claimant in developing the facts pertinent to the claim. Section 5107 as revised by the VCAA eliminates the words well-grounded and simply states: CLAIMANT RESPONSIBILITY Except as otherwise provided by law, a claimant has the responsibility to present and support a claim for benefits under laws administered by the Secretary.

Enactment of the VCAA ended the confusion, unnecessary expenses, premature denials and improper adjudications caused by the interpretation of the words "well-grounded claim." Essentially, 10 years of CAVC and U.S. Court of Appeals for the Federal Circuit case law dealing with the well-grounded claim requirement no longer has relevance because that requirement has been eliminated by the 2000 VCAA law.

It is clear now that the intent of the Congress is for the VA to assist almost every claimant with the development of their claim, except for those who have no reasonable possibility of obtaining benefits. (In effect, the well-grounded claim requirement has been replaced with the no reasonable possibility standard.) It is also clear that the VA is obligated to explain to all claimants just what evidence is necessary to substantiate their claims before a final adjudication can be promulgated.

The VCAA does not however change any of the rules governing what a claimant needs to prove to be granted a VA benefit. Nor does the VCAA change the burden of proof or the standard of proof that the VA must apply to a claim. The burden of proof is generally on the claimant and the rule in existence both before and after the VCAA requires the VA to grant a claim if either (1) a preponderance of the evidence supports the claim or (2) the weight of the evidence in support of the claim is approximately equal to the weight of the evidence against the claim.

In filing a PTSD claim the veteran is required to have proof that he or she experienced a "stressor" event in service; that is, a traumatic event that involves experiencing, witnessing, or confronting an event or events that involve actual or threatened death and/or serious injury, or encountering a threat to the physical integrity of others, and responding with intense fear, helplessness or horror. Subsequently, the medical evidence must reflect a diagnosis of PTSD at any time during or after service and a link between the current diagnosis and the in-service stressor event, which may involve combat or non-combat-related events.

While the veteran need not prove that s/he incurred an in-service disease or physical injury, the record must nevertheless contain "credible supporting evidence" to establish the existence of the claimed stressor event, with the only exceptions being if the veteran engaged in combat or was a prisoner of war and the claimed stressor was related to that combat or captivity. Combat exposure verification is based on the receipt of certain military decorations verified within service personnel records, and the VA has recognized that a "number of citations appear to be awarded primarily or exclusively for circumstances related to combat," including for example, the Medal of Honor, Navy Cross, and Combat Infantryman's Badge. In addition, the United States Court of Appeals for Veterans Claims (CAVC) has also eased the burden on veterans by finding that personal participation in combat need not be established.

Therefore, although the veteran with verified combat service has no burden to verify his or her claimed stressor (having instead only the burden to verify that s/he participated in combat), the veteran for whom combat participation is not established in the record is not so fortunate. His or her claim must have "credible supporting evidence" or face denial. Non-combat stressors typically include, but are not limited to, exposure to or involvement in aircraft crashes, vehicle crashes, ship wrecks, explosions, rape or assault, witnessing a death, duty on a burn ward, and/or service with a graves registration unit. The non-combat stressor may be experienced alone or with a group of people and is not necessarily limited to just one single episode. In addition, in personal trauma cases such as in-service sexual assault, alternative sources may be used to verify the stressful event and can include documents from rape crisis centers, counselors, clergy, health clinics, civilian police reports, medical records immediately following the incident, and/or diaries or journals, or other credible evidence. Herein lies a major problem in our view, because the VA does not necessarily accept or apply these criteria uniformly and consistently.

In addition, if the veteran provides sufficient detail, the VA can submit a referral to the U.S. Army and Joint Services Records Research Center (JSRRC) to conduct a records search to verify the in-service stressor. These requests are supposed to be sent through the VA's Personnel Information Exchange System (PIES) using codes. Once the request is submitted through PIES, there is an interface process from the Defense Personnel Records Information Retrieval System to the appropriate military service records information management system (which may utilize a completely different coding system) whereupon it is then sent to the JSRRC electronically.

The JSRRC does not search through records in an attempt to identify an in-service stressor, but rather to verify the stressor. Some of the difficulties with the JSRRC include the fact that not every event that occurred during the course of the veteran's service is recorded, and service records do not typically chronicle the specific experiences of individual servicemembers. In addition, most of the records searched by the JSRRC are not stored electronically and must be searched manually. Typically, the staff will bring out one to a dozen boxes of written material, and the JSRRC staff member has 30 minutes to go through this mass of material. Obviously, more often than not, the majority of the data available is not combed, even in a cursory manner, because there is not time to so. The Committee should be aware that reportedly there are only 13 staff members to do this work, and they are more than 4,000 requests in arrears. Moreover, there is no master index of subjects or names, and military records are often incomplete. The JSRRC is under the control of DoD, as are all the unit and individual records. Therefore the VA cannot control this essential step in the current process.

If the Congress is looking for very useful ways to stimulate the economy, and to accomplish much needed work at the same time, then working with your colleagues on the Armed Services Committee to start the long needed process of computerizing and indexing these key military records would be a most useful thing to do. The DoD can utilize the Temporary (up to 1 year) Schedule A hiring authority issued by the President earlier this month to hire disabled young veterans to start this work immediately. We would note that the latest Bureau of Labor Statistics (BLS) reported that the unemployment figure for our youngest veterans is 11.2%, which in and of itself cries out for immediate meaningful action by the Congress.

In summary, an appropriate process already exists for VA PTSD claims processing as mandated by the Congress back in 2000. However, it doesn't work, because the VA has again failed to provide for the consistency, uniformity and efficiency that are necessary to ensure that this process works in a timely fashion for all veteran-claimants. Further, DoD has been dilatory in doing its part to supply needed information in a complete, thorough, and timely manner.

Obviously, something needs to be done to render what has become an intolerable chronic problem for veterans who are legitimately seeking service connection com-

pensation and access to quality medical services for their very real neuro-psychiatric wounds.

VVA Position on H.R. 952

VVA can support the proposed legislative change as outlined in H.R. 952 if the intent is that it be applied to veterans with a valid diagnosis (i.e., in the manner called for as noted in the 2006 I.O.M. report at <http://iom.edu/CMS/3793/32410.aspx>) of PTSD, and if the intent is that any veteran who served in a combat zone be taken at their word that the event or incident which occurred in service gave rise to their disability. The criteria recommended by the Institute of Medicine or the National Academies of Sciences should be taken as the definitive methodology. Incidentally, that methodology, which includes testing and intense analysis largely mirrors that contained in the "Best Practices" PTSD manual. The problem, of course, is that VA does not do it, despite the 3,800 new clinicians they have hired ostensibly to better treat PTSD. VVA has come to learn that a similar legislative change has been proposed on the Senate side by Senator Charles Schumer of New York.

It would of course be useful if VA used their own "Best Practices" manual in the adjudication of PTSD claims . . . but they do not. In fact, the only place that one can get a copy of that 2002 manual, produced at great expense, is from VVA. So the VA does not properly train their physicians nor do they properly train the folks who are adjudicators.

If need be, VVA offers its assistance in developing clearer language in the proposed legislative change because we believe the proposed H.R. 952 to be well-intended and most considerate for those of our veterans suffering from PTSD and who face interminable delays and denials in their VA compensation claims under the current claims process and procedures. VVA thanks this Committee for the opportunity to submit its views and testimony on this important veterans' issue.

**Prepared Statement of Carolyn Schapper, Representative
Iraq and Afghanistan Veterans of America**

Mr. Chairman and Members of the Subcommittee, thank you for inviting me to testify today. On behalf of Iraq and Afghanistan Veterans of America, the Nation's first and largest non-partisan organization for veterans of the current conflicts, I would like to thank you all for your unwavering commitment to our Nation's veterans.

My name is Carolyn Schapper, and I am a combat veteran. While serving as a member of a Military Intelligence unit in Iraq from October 2005 to September 2006 with the Georgia National Guard, I participated in approximately 200 combat patrols. Whether it was interacting with the local population or extracting injured personnel, I encountered direct fire, Improvised Explosive Devices (IEDs), and the constant threat from insurgents.

When I came home from Iraq, I dealt with a wide range of adjustment issues/ Post-Traumatic Stress Disorder (PTSD) symptoms; rage, anger, revenge-seeking, increased alcohol use, withdrawal from friends and family, depression, high anxiety, agitation, nightmares and hyper-vigilance. I could barely stay focused at work, let alone traverse the VA maze. I might still be lost if I had not had the dumb luck of running into another veteran who already had gotten help, and who pointed out that a Vet Center could help me start navigating the VA system. While I was able to find help and receive the appropriate disability compensation for my psychological injury, many of my sisters-in-arms have not been so lucky.

Part of the problem is that, because females are excluded from official "combat roles" in the military, women veterans have a greater burden of proof when it comes to establishing combat-related PTSD. But the reality on the ground in Iraq and Afghanistan is that there is no clear front line, and female servicemembers are seeing combat.

Modern warfare makes it impossible to delineate between combat, combat-support, and combat service support roles. You do not even need to leave the Forward Operating Base to be exposed to the continual threat of mortars and rockets. Military personnel are often required to walk around in or sleep in body armor. As one female veteran told me, "Life in Iraq and Afghanistan is combat." Moreover, many female troops in Iraq and Afghanistan have been exposed to direct fire while serving in support roles, such as military police, helicopter pilots, and truckdrivers. All of our troops, whether or not they serve in the combat arms, must exhibit constant vigilance, and this can take an extreme psychological toll on our servicemembers.

The traditional understanding of female servicemembers' military duties has been the biggest hurdle to getting them adequate compensation for their injury. The nature of PTSD and other psychological injuries makes it difficult to identify the exact stressor, and therefore, disability may be determined based on the claims processor's perception of exposure to combat. While a service-connection for PTSD would seem obvious for a male infantryman, it could easily come under more scrutiny for a female intelligence soldier despite how much actual contact either of us had with enemy forces.

Another issue that female servicemembers face when trying to establish presumption of service-connected PTSD involves collecting the proper paperwork. Especially in instances of Military Sexual Trauma, some women would rather forgo documenting their injury, rather than get official military documentation from a male commander or doctor. If you are suffering from a mental health injury, the possibility of having someone question, deride or expose such a personal and painful experience is often overwhelming, and can lead many female servicemembers to avoid the process altogether.

H.R. 952, introduced by the Chairman, solves this problem by changing Title 38 to presume service-connection for PTSD based solely on a servicemember's presence in a combat zone. IAVA wholeheartedly endorses this bill, and looks forward to working with the Subcommittee to see this legislation become law.

While this legislation will aid veterans once they have been diagnosed with a psychological injury and are seeking disability compensation, we know that not every servicemember or veteran is getting the care they need. This is why IAVA has partnered with the Ad Council to conduct a multiyear Public Service Announcement campaign to help ease the transition and readjustment challenges facing Iraq and Afghanistan veterans when they return home. The campaign also helps ensure that veterans seeking access to care and benefits, and particularly those who need treatment for their psychological injuries, get the support they need. Ad Council is responsible for many of the Nation's most iconic and successful PSA campaigns in history, including "Only You Can Prevent Forest Fires," "A Mind is a Terrible Thing to Waste," and "Friends Don't Let Friends Drive Drunk." The IAVA-Ad Council Veteran Support PSAs are currently running on television, radio, in print, outdoors and online. A companion campaign engaging the family and friends of new veterans will be launching later this year.

I will leave you with this final thought. More and more, women are being called upon to serve a more active role in the combat zone, and all too often find themselves in harm's way. There is no better way to honor their service and sacrifices than to ensure that when they are injured, they receive the care and compensation they deserve. Thank you again for the opportunity to testify on this critical issue, and I would be pleased to take your questions at this time.

Respectfully,

Carolyn Schapper

**Prepared Statement of Dean G. Kilpatrick, Ph.D.,
Distinguished University Professor, and Director,
National Crime Victims Research and Treatment Center,
Medical University of South Carolina, Charleston, SC, and
Member, Committee on Veterans' Compensation for Posttraumatic
Stress Disorder, Institute of Medicine and National Research Council,
The National Academies**

***The Institute of Medicine and National Research Council Report
"PTSD Compensation and Military Service" Findings Regarding the
Evaluation of Traumatic Exposures and Malingering in
Veterans Seeking PTSD Compensation***

Good afternoon, Mr. Chairman, Mr. Ranking Member, 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 Post-Traumatic Stress Disorder. This Committee was convened under the auspices of the National Research Council and the Institute of Medicine of the National Academy of Sciences. Our Committee's

work—which was conducted between March 2006 and July 2007—was requested by the Department of Veterans Affairs, which provided funding for the effort.

In June 2007, our Committee completed its report, entitled *PTSD Compensation and Military Service*. I am pleased to be here today to share with you some of 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 briefly address four issues in this testimony:

- The evaluation of traumatic exposures for VA compensation and pension purposes,
- The reliability and completeness of military records for evaluation of exposure to stressors,
- What studies say about malingering in the veterans population, and
- The means that mental health professionals use to detect malingering.

Evaluation of traumatic exposures for VA compensation and pension purposes

VA compensation and pension (C&P) examinations for PTSD consist of a review of medical history; evaluations of mental status and of social and occupational function; a diagnostic examination, which may include psychological testing; and an assessment of the exposure to traumatic events that occurred during military service.

To help focus the examination, the Veterans Benefits Administration (VBA) provides examiners with worksheets that set forth what an assessment should cover. These worksheets are designed to ensure that a rating specialist receives all the information necessary to rate a claim.

The PTSD worksheet provides guidance on the elements of a claimant’s military history that should be documented. These include Military Occupational Specialty (MOS), combat wounds sustained, citations or medals received, and a clear description of the “specific stressor event(s) the veteran considered to be particularly traumatic, particularly if the stressor is a type of personal assault, including sexual assault, [providing] information, with examples, if possible.” The worksheet notes:

. . . Service connection for post-traumatic stress disorder (PTSD) requires medical evidence establishing a diagnosis of the condition that conforms to the diagnostic criteria of DSM–IV, credible supporting evidence that the claimed in-service stressor actually occurred, and a link, established by medical evidence, between current symptomatology and the claimed in-service stressor. It is the responsibility of the examiner to indicate the traumatic stressor leading to PTSD, if he or she makes the diagnosis of PTSD.

A diagnosis of PTSD cannot be adequately documented or ruled out without obtaining a detailed military history and reviewing the claims folder. This means that initial review of the folder prior to examination, the history and examination itself, and the dictation for an examination initially establishing PTSD will often require more time than for examinations of other disorders. **Ninety minutes to 2 hours on an initial exam is normal.** (emphasis added)

A *Best Practice Manual* developed by VA practitioners also offers guidance on assessing trauma exposure, and recommends tests that can be administered to help elicit information. The Manual states that “[i]nitial PTSD compensation and pension evaluations typically require up to 3 hours to complete, but complex cases may demand additional time.” It estimates that 30 minutes of that time would be used for records review and an additional 20 minutes for orientation to the interview, review of the military history, and conduct of the trauma assessment.

Notwithstanding this guidance, testimony presented to the 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.

The reliability and completeness of military records for evaluation of exposure to stressors

VA’s statutory “duty to assist” includes helping veterans gather evidence to support their claims, including the provision of VA records and facilitation of requests for information from the Department of Defense (DoD) and other sources. Military personnel records—which document duty stations and assignments, MOS, citations, medals, and related administrative information—are valued in this regard because they are perceived as unbiased evidence that can corroborate or refute claimants’ accounts. One study reviewed by the Committee found that less than half of treatment-seeking Vietnam veterans reporting combat involvement had objective evi-

dence of combat exposure documented in their publicly available military personnel records. It concluded that a “meaningful” number of treatment-seekers “may be exaggerating or misrepresenting their involvement [and combat exposure] in Vietnam and, by inference, they attributed this to “the disability benefit incentive” and compensation-seeking.

However, this conclusion is not supported by other research that the Committee examined, calling into question whether the information available in the military personnel files is always adequate to evaluate trauma exposure. The National Archives and Research Administration, the Nation’s conservator of the military personnel records, offers the following caveat for users of these data: “Detailed information about the veteran’s participation in military battles and engagements is NOT contained in the record”. Studies indicate, instead, that broad-based research into other indicators of the likelihood of having experienced traumatic stressors has value. This may be especially important in cases of PTSD related to sexual assault. Available information suggests that female veterans are less likely to receive service connection for PTSD and that this is a consequence of the relative difficulty of substantiating exposure to noncombat traumatic stressors like military sexual assault.

The Committee concluded that the most effective strategy for dealing with problems with self-reports of traumatic exposure is to ensure that a comprehensive, consistent, and rigorous process is used throughout the VA to verify veteran-reported evidence.

What studies say about malingering in the veterans population

The Committee noted that assessment of malingering is a high stakes issue because it is as devastating to falsely accuse a veteran of malingering as it is unfair to other veterans to miss malingered cases. The most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)* defines malingering as “the intentional production of false or grossly exaggerated physical or psychological symptoms motivated by external incentives . . . such as obtaining financial compensation”.

Combat veterans who are evaluated for PTSD frequently exhibit elevations across various assessment measures, including elevations on tests used to detect symptom overreporting. Concerns have thus been raised regarding the accuracy of veterans’ accounts of their psychological functioning, which in turn poses significant challenges for diagnostic assessment and treatment. While some research and commentary suggests that this pattern may reflect, at least in part, symptom overreporting by a subset of veterans who are motivated by possible receipt of financial compensation, access to treatment, and other incentives, the Committee found that literature examining the relationship between compensation seeking and reported levels of psychopathology has in fact yielded mixed results.

The Committee’s review of the literature concluded that, while misrepresentation of combat involvement and trauma exposure undoubtedly does happen among veterans seeking treatment and compensation for PTSD, the evidence currently available is insufficient to establish how prevalent such misrepresentations are and how much effect they have on the ultimate outcome of disability claims. Further, while some veterans do drop out of mental-health treatment once they obtain service-connected disability compensation for PTSD, the currently available data suggest that this concern may not apply to the majority of veterans who seek and obtain such awards. Although more research is needed, the Committee concluded that the preponderance of evidence does not support the notion that receiving compensation for PTSD makes veterans less likely to make treatment gains or acknowledge improvement from treatment.

The means that mental health professionals use to detect malingering

Although there is a need for a reliable, valid way to detect malingering, experts agree that there is no magic bullet or gold standard for doing so. Several investigators have used scales from such tests as the Minnesota Multiphasic Personality Inventory (MMPI) and MMPI-2 to indirectly infer the possibility of malingering, and the *Best Practice Manual* notes that they are useful in identifying the test-taking style of veterans and in assessing service-connected PTSD status. However, these measures have clear limitations and should not be used as the sole basis for assessing whether a veteran is malingering with respect to PTSD status. The Committee concluded that, in the absence of a definitive measure, the most effective way to detect inappropriate PTSD claims is to require a consistent and comprehensive state-of-the-art examination and assessment that allows the time to conduct appropriate testing in those specific circumstances where the examining clinician believes it would inform the assessment.

Our Committee also reached a series of other findings and recommendations regarding the conduct of VA's compensation and pension system for PTSD that are detailed in the body of our report. The National Academies previously provided the Subcommittee with copies of this report and would be happy to fulfill any additional requests for it.

Thank you for your attention. I'm happy to answer your questions.

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Prepared Statement of Terri Tanielian,* MA, Study Co-Director, Invisible Wounds of War Study Team, RAND Corporation

Assessing Combat Exposure and Post-Traumatic Stress Disorder in Troops and Estimating the Costs to Society Implications from the RAND Invisible Wounds of War Study¹

Chairman Hall, Representative Lamborn, and distinguished Members of the Subcommittee, thank you for inviting me to testify today. It is an honor and pleasure to be here. I will discuss the findings from our study "Invisible Wounds of War" as they relate to the topic of your hearing today. More specifically, my testimony will briefly review the findings from our study related to assessing exposure to combat and prevalence of post-traumatic stress disorder and depression among servicemembers returning from Operations Enduring Freedom and Iraqi Freedom; as well as the societal costs associated with these conditions. The full findings and recommendations from our study were also presented in the testimony to the full House Committee on Veterans Affairs on June 11, 2009.

Background

Since October 2001, approximately 1.7 million U.S. troops have deployed as part of Operation Enduring Freedom (OEF; Afghanistan) and Operation Iraqi Freedom (OIF; Iraq). The pace of the deployments in these current conflicts is unprecedented in the history of the all-volunteer force (Belasco, 2007; Bruner, 2006). Not only are a higher proportion of the armed forces being deployed, but deployments have been longer, redeployment to combat has been common, and breaks between deployments have been infrequent (Hosek, Kavanagh, and Miller, 2006). At the same time, episodes of intense combat notwithstanding, these operations have employed smaller forces and have produced casualty rates of killed or wounded that are historically lower than in earlier prolonged wars, such as Vietnam and Korea. Advances in both medical technology and body armor mean that more servicemembers are surviving experiences that would have led to death in prior wars (Regan, 2004; Warden,

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¹This testimony is available for free download at <http://www.rand.org/pubs/testimonies/CT321/>.

2006). However, casualties of a different kind have emerged in large numbers—invisible wounds, such as post traumatic stress disorder.

As with safeguarding physical health, safeguarding mental health is an integral component of the United States' national responsibilities to recruit, prepare, and sustain a military force and to address service-connected injuries and disabilities. But safeguarding mental health is also critical for compensating and honoring those who have served our Nation.

In April 2008, my colleagues and I released the findings from a 1-year project entitled "Invisible Wounds of War." This independent study focused on three major conditions—post-traumatic stress disorder (PTSD), major depressive disorder, and traumatic brain injury (TBI). Unlike the physical wounds of war that maim or disfigure, these conditions remain invisible to other servicemembers, to family members, and to society in general. All three conditions affect mood, thoughts, and behavior; yet these wounds often go unrecognized and unacknowledged. Our study was guided by a series of overarching questions about the prevalence of mental health conditions, costs associated with these conditions, and the care system available to meet the needs of servicemembers afflicted with these conditions. In my comments today, I will focus on our findings about servicemembers' exposure to trauma during deployment, prevalence of mental health conditions post deployment among OEF/OIF veterans, and the costs to society associated with these conditions among veterans, as they bear directly on the issue you are considering today. Specifically, I will address several related questions:

Deployment Related Experiences and Exposure to Trauma: How is exposure to combat trauma assessed among OEF/OIF troops in research studies?

Prevalence of PTSD and Depression: What is the scope of mental health conditions that troops experience when returning from deployment to Afghanistan and Iraq?

Societal Costs of PTSD and Depression Among Veterans: What are the costs of these conditions, including treatment costs and costs stemming from lost productivity and other consequences? What are the costs and potential savings associated with different levels of medical care—including proven, evidence-based care; usual care; and no care?

How is exposure to combat trauma assessed among OEF/OIF troops in research studies?

In research studies, combat experience has been assessed using a variety of different means, including documenting deployment to a combat zone based on receipt of hostile-fire pay or assessing specific experiences during deployment based on self-report. Most of the prior research has evaluated the relationship between these exposures and the development of post-combat adjustment difficulties such as post-traumatic stress disorder. Scholarly interest in exposure to combat-related traumas emerged following the official designation of PTSD as a psychiatric disorder by the American Psychiatric Association in 1980 (APA, 1980). The PTSD diagnosis replaced earlier terms such as "battle fatigue" and "war neurosis." Among other changes, the PTSD diagnosis required a "catastrophic stressor that was outside the range of usual human experience", and this requirement spurred the need to assess such experiences. The definition of what constitutes a trauma has changed over time, but the requirement that PTSD be linked to specific experiences remains. Researchers studying veteran populations since that time have used different scales to assess (using mainly self-report) specific details about a variety of exposures that military personnel may experience when deployed to a war zone.

In our study, combat trauma exposure was assessed using 24 questions that were adapted from Hoge et al. (2004) and includes both direct and vicarious trauma exposure (e.g., witnessing a traumatic event that occurred to others). However, we found that many questions were empirically redundant with one another, and thus used only a subset of exposures (11 questions) to form a combat exposure measure that formed two indices: (1) a one-question measure that assessed whether the servicemember had ever experienced an injury or wound that required hospitalization while deployed (this may or may not have required medical evacuation from theater), and (2) a scale derived by counting the number of ten specific trauma exposures that occurred during any of the servicemember's OEF/OIF deployments.

Rates of reported trauma exposures on these 11 items are presented in Table 1. As shown, rates of exposure to specific types of combat trauma ranged from 5 to 50 percent, with high reporting levels for many traumatic events. Vicariously experienced traumas (e.g., having a friend who was seriously wounded or killed) were the most frequently reported. About 10–15 percent of OEF/OIF veterans reported NO trauma exposures, and about 15–20 percent reported exposure to just ONE event

(largely death or injury of a friend), so most (close to 75 percent) reported multiple exposures.

Table 1. Rates of Trauma Exposure in OEF/OIF (N=1965)

	Weighted Percentage	95% CI LL	95% CI UL
Having a friend who was seriously wounded or killed	49.6	45.7	53.6
Seeing dead or seriously injured non-combatants	45.2	41.3	49.1
Witnessing an accident resulting in serious injury or death	45.0	41.1	48.9
Smelling decomposing bodies	37.0	33.3	40.7
Being physically moved or knocked over by an explosion	22.9	19.6	26.1
Being injured, not requiring hospitalization	22.8	19.2	26.3
Having a blow to the head from any accident or injury	18.1	15.1	21.1
Being injured, requiring hospitalization	10.7	8.2	13.1
Engaging in hand-to-hand combat	9.5	7.3	11.6
Witnessing brutality toward detainees/prisoners	5.3	3.3	7.3
Being responsible for the death of a civilian	5.2	3.0	7.4

Source: Schell and Marshall, 2008, in Tanielian and Jaycox (eds). *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery*. RAND Corporation, MG-720CCF.
 Note: CI = Confidence Interval; LL = Lower Limit; UL = Upper Limit. Percentages are weighted to reflect the full population of 1.64 million servicemembers who had deployed to OEF/OIF as of October 31, 2007.

What is the scope of mental health issues faced by OEF/OIF troops returning from deployment?

Most of the military servicemembers who have deployed to date in support of OIF or OEF will return home from war without problems and readjust successfully, but many have already returned or will return with significant mental health conditions. Among OEF/OIF veterans, our study found rates of PTSD and major depression to be relatively high, particularly when compared with the general U.S. civilian population. In late fall 2007, we conducted a telephone study of 1,965 previously deployed individuals sampled from 24 geographic areas. Using well-accepted screening tools for conducting epidemiological studies, we estimated substantial rates of mental health problems in the past 30 days among OEF/OIF veterans, with 14 percent reporting current symptoms consistent with a diagnosis of PTSD and 14 percent reporting symptoms consistent with a diagnosis of major depression (9 percent of veterans reported symptoms consistent with a diagnosis of both PTSD and major depression). Major depression is often not considered a combat-related injury; however, our analyses suggest that it is highly associated with combat exposure and should be considered in the spectrum of post-deployment mental health consequences.

Assuming that the prevalence found in this study is representative of the 1.64 million servicemembers who had been deployed for OEF/OIF as of October 2007, we estimate that as of April 2008 approximately 303,000 OEF/OIF veterans were suffering from PTSD or major depression. We also found that some specific groups, previously underrepresented in studies—including the Reserve Components and those who have left military service—may be at higher risk of suffering from these conditions. But the single best predictor of reporting current mental health problems consistent with a diagnosis of PTSD or depression was the number of combat traumas reported while deployed. It is important to note that these data were cross-sectional in nature, that is, they provide a snapshot of the scope of mental health need among OEF/OIF veterans. These estimates may change as more individuals return from deployments or more individuals begin to suffer post-combat related difficulties that rise to a level of meeting diagnostic criteria.

Seeking and Receiving Treatment. Military servicemembers with probable PTSD or major depression seek care at about the same rate as the civilian population, and, just as in the civilian population, many of the afflicted individuals were not receiving treatment. About half (53 percent) of those who met the criteria for current PTSD or major depression had sought help from a physician or mental health provider for a mental health problem in the past year. Even when individuals receive care for their mental health condition, too few receive quality care. Of those who

have a mental disorder and also sought medical care for that problem, just over half received a minimally adequate treatment. The number who received *quality* care (i.e., a treatment that has been demonstrated to be effective) would be expected to be even smaller. Focused efforts are needed to significantly improve both accessibility to care and quality of care for these groups. The prevalence of PTSD and major depression will likely remain high unless greater efforts are made to enhance systems of care for these individuals. Survey respondents identified many barriers to getting treatment for their mental health problems. In general, respondents were concerned that treatment would not be kept confidential and would constrain future job assignments and military-career advancement. About 45 percent were concerned that drug therapies for mental health problems may have unpleasant side effects, and about one-quarter thought that even good mental health care was not very effective. These barriers suggest the need for increased access to confidential, evidence-based psychotherapy, to maintain high levels of readiness and functioning among previously deployed servicemembers and veterans.

What are the costs of these mental health and cognitive conditions to the individual and to society?

The costs of these invisible wounds go beyond the immediate costs of mental health treatment. Adverse consequences that may arise from post-deployment mental and cognitive impairments include suicide, reduced physical health, increased engagement in unhealthy behaviors, substance abuse, unemployment, poor performance while at work, homelessness, marital strain, domestic violence, and poor parent-child relationships. The costs stemming from these consequences are substantial, and may include costs related to lost productivity, reduced quality of life, substance abuse treatment, and premature mortality.

To quantify these costs, RAND undertook an extensive review of the literature on the costs and consequences of post-traumatic stress disorder (PTSD) and depression. Our analysis included the development and use of a micro-simulation model to estimate 2-year post-deployment costs associated with PTSD and depression for military servicemembers returning from OEF and OIF. Our analyses use a societal cost perspective, which considers costs that accrue to all members of U.S. society including Government agencies (e.g., DoD and VA), servicemembers, their families, employers, private health insurers, taxpayers, and others. In conducting the micro-simulation analysis for PTSD and depression, we also estimated the costs and potential savings associated with different levels of medical care, including proven, evidence-based care, usual care, and no care.

We found that unless treated, PTSD and depression have wide-ranging and negative implications for those afflicted and exact a high economic toll to society. The presence of any one of these conditions can impair future health, work productivity, and family and social relationships. Individuals afflicted with any of these conditions are more likely to have other psychiatric diagnoses (e.g., substance use) and are at increased risk for attempting suicide. They have higher rates of unhealthy behaviors (e.g., smoking, overeating, unsafe sex) and higher rates of physical health problems and mortality. Individuals with any of these conditions also tend to miss more days of work or report being less productive. There is also a possible connection between having one of these conditions and being homeless. Suffering from these conditions can also impair relationships, disrupt marriages, aggravate the difficulties of parenting, and cause problems in children that may extend the consequences of combat experiences across generations. Below, we summarize some of the key negative outcomes that have been linked to PTSD and depression in prior studies. For a more thorough discussion of these issues, please see Tanielian and Jaycox [Eds.], 2008, Chapter Five.

Suicide: Depression and PTSD both increase the risk for suicide, as shown by evidence from studies of both military and civilian populations. Psychological autopsy studies of civilian suicides have consistently shown that a large number of civilians who committed suicide had a probable depressive disorder. One study showed that approximately 30 percent of veterans committing suicide within 1-year had a mental health disorder such as depression, as did approximately 40 percent of veterans attempting suicide. Although not as strongly associated with suicide as depression, PTSD is more strongly associated with suicidal thoughts and attempts than any other anxiety disorder and has also been linked to elevated rates of suicide among Vietnam veterans.

Physical Health: Depression and PTSD have been linked to increased morbidity. With respect to physical health, cardiovascular diseases are the most frequently studied morbidity outcome among persons with psychiatric disorders. Both PTSD and depression have been linked to higher rates of heart disease in military and civilian populations. Depression also affects conditions associated with aging, includ-

ing osteoporosis, arthritis, Type 2 diabetes, certain cancers, periodontal disease, and frailty.

Health-compromising Behaviors: The link between depression and PTSD and negative physical health outcomes may be partly explained by increases in health-risk behaviors that influence health outcomes. For example, research on civilian populations has shown a clear link between PTSD and depression and smoking, as well as a link between symptoms of depression and PTSD and sexual risk taking.

Substance Abuse: Rates of co-occurring substance use disorders with PTSD and depression, are common and are often associated with more-severe diagnostic symptoms and poorer treatment outcomes. Several studies have examined the relationship between mental disorders and alcohol and drug abuse. The results have varied, depending on the specific condition studied. Studies of Vietnam veterans showed that PTSD increases the risk of alcohol and substance abuse, while other studies of civilian populations have found that depression tends to be a consequence of substance abuse rather than a cause.

Labor Market Outcomes: PTSD and depression influence labor-market outcomes as well. Specifically, there is compelling evidence indicating that these conditions will affect servicemembers' return to employment, their productivity at work, and their future job prospects. Studies of Vietnam veterans have also found that those with a diagnosis of depression or PTSD had lower hourly wages than Vietnam veterans without a diagnosis.

Homelessness: Few studies have examined the rates of homelessness among individuals with PTSD or depression; rather, most studies have studied the prevalence of mental disorders among homeless individuals. Compared with non-homeless persons in the general population, homeless people have higher rates of mental disorder and are more likely to experience a severe mental disorder. One study found that 75 percent of homeless individuals with PTSD had developed the condition prior to becoming homeless. However, evidence in this area is not strong, and the prevalence of mental disorders among homeless people may be overstated, possibly the consequence of studies relying on poor sampling methods or flawed assumptions.

Marriage and Intimate Relationships: The effects of post-combat mental and cognitive conditions inevitably extend beyond the afflicted servicemember. As servicemembers go through life, their impairments cannot fail to wear on those with whom they interact, and those closest to the servicemember are likely to be the most severely affected. Studies of Vietnam veterans, whose results parallel those among civilian populations, have linked PTSD and depression to difficulties maintaining intimate relationships, and these deficits account for a greatly increased risk of distressed relationships, intimate-partner violence, and divorce among those afflicted.

Child Outcomes: In addition, the interpersonal deficits that interfere with emotional intimacy in the romantic relationships of servicemembers with these PTSD and depression may interfere with their interactions with their children. In particular, interviews with spouses of veterans from several conflicts (World War II, Korea, and Vietnam) have all revealed a higher rate of problems among children of veterans with symptoms of PTSD. Rates of academic problems, as well as rates of psychiatric treatment, were also higher in children of veterans with PTSD compared to children of veterans without PTSD. The implications of a parent's depression on children's outcomes has not been studied directly in military populations, but numerous studies of civilian populations have shown that the children of depressed parents are at far greater risk of behavioral problems and psychiatric diagnoses than children of non-depressed parents.

A limitation of the research summarized above is that virtually none of the studies we reviewed were randomized controlled trials, and thus may not be able to detect causal relationships between these disorders and subsequent adverse consequences such as homelessness, substance abuse, or relationship problems. Further, the majority of studies reviewed drew from data on Vietnam-era veterans or from data on civilians. Nevertheless, these studies are important for understanding the range of co-morbidities and behavioral outcomes likely to be associated with PTSD and depression, and this information is relevant for determining the required resources for treating veterans with these conditions. Effective treatments for PTSD and depression exist (Tanielian and Jaycox [Eds.], 2008, Chapter 7), and can greatly improve functioning. With adequate treatment and support, some veterans may avoid negative outcomes altogether.

What are the associated economic costs to society?

To understand the consequences of these conditions in economic terms, we developed a microsimulation model. Using data from the literature (which had limited information on specific populations and costs), we estimated the costs associated

with mental health conditions (PTSD and major depression) for a hypothetical cohort of military personnel deployed to Afghanistan and Iraq.

We defined costs in terms of lost productivity, treatment, and suicide attempts and completions, and we estimated costs over a 2-year period (see Tanielian and Jaycox [Eds.], 2008, Chapter Six). For this analysis, we focus specifically on the costs of PTSD and depression, and we considered the costs associated with different types of treatment and different patterns of comorbidity, allowing for remission and relapse rates to be influenced by treatment type. The data available to conduct this type of detailed analysis for specific mental health conditions, however, did not support projecting costs beyond a 2 year time horizon.

For each condition, we generated two estimates—one that included the medical costs and the value of lives lost due to suicide, and one that excluded such costs. We were unable to estimate the costs associated with homelessness, domestic violence, family strain, and substance abuse because reliable data are not available to create credible dollar figures for these outcomes. If figures for these consequences were available, the costs of having these conditions would be higher. Our estimates represent costs incurred within the first 2 years after returning home from deployment, so they accrue at different times for different personnel. For servicemembers who returned more than 2 years ago and have not redeployed, these costs have already been incurred. However, these calculations omit costs for servicemembers who may deploy in the future, and they do not include costs associated with chronic or recurring cases that linger beyond 2 years. (Details of our model assumptions and parameters can be found in Tanielian and Jaycox [Eds.], 2008, Chapter Six).

Our microsimulation model predicts that 2-year post-deployment costs to society resulting from PTSD and major depression for 1.64 million deployed servicemembers (as of October 2007) could range from \$4.0 to \$6.2 billion (in 2007 dollars), depending on how we account for the costs of lives lost to suicide. For PTSD, average costs per case over 2 years range from \$5,904 to \$10,298; for depression, costs range from \$15,461 to \$25,757; and for PTSD and major depression together, costs range from \$12,427 to \$16,884. The majority of the costs were due to lost productivity. Because these numbers do not account for future costs that may be incurred if additional personnel deploy and because they are limited to 2 years following deployment, they underestimate total future costs to society.

Providing Evidence-Based Treatment for PTSD and Depression Can Reduce Societal Costs. Certain treatments have been shown to be effective for both PTSD and major depression, but these evidence-based treatments are not yet available in all treatment settings. We estimate that evidence-based treatment for PTSD and major depression would pay for itself within 2 years, even without considering costs related to substance abuse, homelessness, family strain, and other indirect consequences of mental health conditions. Evidence-based care for PTSD and major depression could save as much as \$1.7 billion, or \$1,063 per returning veteran; the savings come from increases in productivity, as well as from reductions in the expected number of suicides. Given these numbers, investments in evidence-based treatment would make sense, not only because of higher remission and recovery rates but also because such treatment would increase the productivity of servicemembers. The benefits to increased productivity would outweigh the higher costs of providing evidence-based care. These benefits would likely be even higher had we been able to capture the full spectrum of costs associated with mental health conditions. However, a caveat is that we did not consider additional implementation and outreach costs (over and above the day-to-day costs of care) that might be incurred if DoD and the VA attempted to expand evidence-based treatment beyond current capacity.

Summary

Our study found high rates of exposures to combat trauma during deployment and revealed serious prevalence (18.5 percent) of current PTSD and depression among servicemembers who had returned from OEF or OIF. In our analyses (not presented in this testimony), we also found significant gaps in access to and the quality of care provided to this population. Too few of those with PTSD and depression were getting help, and among those that were getting help too few were getting even minimally adequate care. If left untreated or under-treated, these conditions can have negative cascading consequences and result in a high economic toll. Investing in evidence based care for all of those in need can reduce the costs to society in just 2 years. Ensuring all veterans afflicted with these conditions will require addressing the significant gaps that exist in access to and quality of care for our Nation's veterans.

Thank you again for the opportunity to testify today and to share the results of our research. Additional information about our study findings and recommendations can be found at: <http://veterans.rand.org>.

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Prepared Statement of Rear Admiral David J. Smith, M.D., SHCE, USN, Joint Staff Surgeon, Office of the Chairman of the Joint Chiefs of Staff, Wounded and Survivor Care Task Force, U.S. Department of Defense

Mr. Chairman and Members of the Subcommittee, thank you for the opportunity to appear before you today. In my capacity as the Joint Staff Surgeon, I serve as the medical advisor to the Chairman of the Joint Chiefs of Staff, the Joint Staff and Combatant Commanders and coordinate operational medicine, force health protection and readiness issues among the Combatant Commands, the Office of the Secretary of Defense and the services. I am a board-certified Occupational Medicine physician with 27 years of service and additional background in medical management and undersea medicine.

I serve as the senior ranking member of the Chairman's Wounded and Survivor Care Task Force. Under the direction of the Chairman, the Task Force has been actively engaged in focused efforts to implement necessary change and reinforce successful efforts to improve the health of the force and to ensure the appropriate care and support is provided for our wounded servicemembers, their families, and the families of those killed in action so they can effectively manage the physical and mental challenges incurred during military service.

Mr. Chairman, thank you again for the invitation to appear here this afternoon. I am pleased to respond to any questions you or the Subcommittee Members may have.

Prepared Statement of Colonel Robert Ireland, Program Director, Mental Health Policy, Office of the Assistant Secretary of Defense for Health Affairs, U.S. Department of Defense

Chairman Hall, Ranking Member Lamborn, and distinguished Members of the Subcommittee, thank you for the opportunity to discuss the Department of Veterans Affairs (VA), Title 38, United States Code, section 1154, and how these provisions align with the Department of Defense's (DoD) approach to diagnosing Post-Traumatic Stress Disorder (PTSD), defining related stressors, and the use of the servicemember's medical record.

PTSD, Stressors, and Military Mental Health

When servicemembers' medical condition(s) requires further medical evaluation to ensure they meet Service-specific medical retention standards, military clinicians

will write a summary and submit it for review by a military Medical Evaluation Board (MEB). The MEB typically consists of two to three providers at a local installation medical treatment facility. Any MEB review of a psychiatric diagnosis must contain a thorough psychiatric evaluation and include the signature of at least one psychiatrist. The MEB is required to:

1. Confirm the medical diagnosis(es).
2. Document the servicemember's current medical condition to include treatment status and potential for medical recovery.
3. Review each case based on relevant facts.

The MEB determines whether the servicemember meets Service-specific medical retention standards and is medically qualified to return to duty, or whether the servicemember fails to meet Service-specific medical retention standards, in which case the MEB recommends the case be forwarded to a Physical Evaluation Board (PEB) that has the authority to determine retention, separation with or without severance pay, or retirement. Decisions related to continued military service, separation, or retirement due to a disability are part of the DoD personnel process.

With respect to PTSD, military providers use the same criteria as their civilian counterparts to diagnose PTSD (a common disorder in both settings), as defined by the American Psychiatric Association's Diagnostic and Statistical Manual for Mental Disorders, 4th Edition-TR (DSM-IV TR). The first criterion, "A", requires:

*The person has been exposed to a traumatic event in which **both** of the following have been present:*

1. *The person experienced, witnessed, or was confronted with an event or events that **involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.***
2. *The person's response involved **intense fear, helplessness, or horror.***

In a medical record, at least one such event should be documented by a provider in order to show how it met both components of Criterion A: a traumatic event and specific intense responses to it. It is not enough to simply list "stressors," which, in reality, involve perception of a threat, one's emotional and physical responses to it, and a perception about whether or not one can manage one's reactions.

Documentation of re-experiencing, avoidance, and hyper-arousal symptoms should connect to corresponding traumatic events. Veterans should be encouraged to provide copies of their military medical and mental health records to ensure continuity of care and assist in confirmation of their entitlements.

Thank you again for allowing me the opportunity to appear before you to discuss Military Mental Health and for your continued support. I look forward to working together to improve mental health care for our beneficiaries.

**Prepared Statement of Bradley G. Mayes, Director,
Compensation and Pension Service, Veterans Benefits Administration,
U.S. Department of Veterans Affairs**

The evolving PTSD claims process and the application of 38 U.S.C. § 1154

Mr. Chairman and Members of the Committee:

I would like to thank the Chairman for this opportunity to testify on the important topic of post-traumatic stress disorder (PTSD). Mr. Richard Hipolit of the Department of Veterans Affairs (VA) Office of General Counsel accompanies me today. The number of veterans receiving service-connected compensation for PTSD from VA has grown dramatically. From fiscal year 1999 through fiscal year 2008, the number increased from 120,000 to 345,520. We all share the goals of preventing this disability, minimizing its impact on our veterans, and providing those who suffer from it with just compensation for their service to our country. Consequently, VA has expanded its efforts to assist veterans with the claims process and keep pace with the increased number of claims. Today I will describe the PTSD claims process and explain how VA applies the statutory requirements of 38 U.S.C. § 1154 to the processing of these claims. I will also describe the challenges met by VA through the years as PTSD claims and warfare tactics have evolved.

38 U.S.C. § 1154

Section 1154, which was enacted by Congress in 1941, requires that VA consider the time, place, and circumstances of a veteran's service in deciding a claim for service connection. Section 1154(b) provides for a reliance on certain evidence as a basis for service connection of disabilities that result from a veteran's engagement in com-

bat with the enemy. As a result, veterans who “engaged in combat with the enemy” and file claims for service-connected disability related to that combat are not subject to the same evidentiary requirements as non-combat veterans. Their lay statements alone may provide the basis for service connecting a disability, without additional factual or credible supporting evidence. In PTSD claims, a combat veteran’s personal stressor statement can serve to establish the occurrence of the stressor.

The PTSD Claims Process

The processing of PTSD claims is governed by 38 C.F.R. § 3.304(f). This regulation states that, in order for service connection for PTSD to be granted, there must be: (a) medical evidence diagnosing the condition, (b) medical evidence establishing a link between current symptoms and an in-service stressor, and (c) credible supporting evidence that the claimed in-service stressor occurred. The first two requirements involve medical assessments, while the third requirement may be satisfied by non-medical evidence. PTSD is defined as a mental disorder that results from a stressor. The third requirement of the regulation emphasizes the importance of the stressor and the obligation of the Veterans Benefits Administration (VBA) to seek credible evidence supporting the occurrence of that stressor.

In PTSD claims where the stressor is not combat-related, VBA personnel will conduct research and develop credible evidence to support the claimed stressor. However, the statutory directives of § 1154(b) have been incorporated into PTSD regulations at § 3.304(f)(2), so that when there is evidence of combat participation, and the stressor is related to that combat, no stressor corroboration is required. The veteran’s lay statement alone is sufficient to establish the occurrence of the stressor. In *Moran v. Peake*, 525 F.3d 1157, 1159 (Fed. Cir. 2008), the United States Court of Appeals for the Federal Circuit held “the term ‘engaged in combat with the enemy’ in § 1154(b) requires that the veteran have personally participated in events constituting an actual fight or encounter with a military foe or hostile unit or instrumentality, as determined on a case-by-case basis.” The Court said that “[a] showing of no more than service in a general ‘combat area’ or ‘combat zone’ is not sufficient to trigger the evidentiary benefit of § 1154(b).” When no combat award has been received, VBA relies on the circumstances of the individual case, as determined from the veteran’s service records and other sources, to evaluate whether the veteran engaged in combat.

VBA responses to the changing circumstances of PTSD and warfare tactics

Through the years VA has made changes to § 3.304(f) based on the § 1154 mandate to consider the time, place, and circumstances of a veteran’s service.

The definition and diagnostic criteria for PTSD evolved to a great extent from the psychiatric community’s attempt during the seventies to explain the psychological problems of some Vietnam War Veterans. Once the medical community recognized this mental disorder, VA added it as a disability to the VA rating schedule. VA then moved to incorporate PTSD diagnostic criteria from the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders (DSM)* into the PTSD claims evaluation process. According to DSM-IV, the symptoms of PTSD “usually begin within the first 3 months after the trauma, although there may be a delay of months, or even years, before symptoms appear.” Given the delay that may occur between the occurrence of a stressor and the onset of PTSD and the subjective nature of a person’s response to an event, VA concluded, when it first promulgated § 3.304(f) in 1993, that it is reasonable to require corroboration of the in-service stressor, a conclusion with which the Federal Circuit agreed in *Nat’l Org. of Veterans’ Advocates, Inc. v. Sec’y of Veterans Affairs*, 330 F.3d 1345, 1351–52 (Fed. Cir. 2003). Work is currently underway to update the disability rating schedule to compensate more effectively for disability due to PTSD.

As the military incorporated more female members into its ranks, VBA recognized that PTSD could result from personal assault and sexual trauma. These types of claims were increasing in numbers and are difficult to document. To meet this evolving situation, VA added § 3.304(f)(4), which provides for acceptance of evidence for stressor corroboration in such cases from multiple sources other than the veteran’s service records. This evidence may include local law enforcement records, hospital or rape crisis center records, or testimony from family, friends, or clergy members. In addition, this evidence may be submitted to an appropriate medical or mental health professional for an opinion regarding the occurrence of the stressor. This expanded concept of potential evidence to corroborate the stressor in personal assault PTSD claims shows a positive and sensitive responsiveness on the part of VA to the changing demographics of the veteran population.

For the evaluation of PTSD claims where the stressor is not combat-related or the claimed stressor is related to combat but there is no initial evidence of combat par-

ticipation, VBA has provided claims processing personnel with special tools to research veterans' stressor statements. A website was developed that contains a database of thousands of declassified military unit histories and combat action reports from all periods of military conflict. In many cases, evidence is found in these documents to support the veteran's stressor statement or confirm combat participation. Nationwide training was conducted to explain the use of this database and other official Web sites that can aid with stressor corroboration. This initiative illustrates the VBA commitment to assisting veterans with PTSD claims.

Although the combat participation provisions of § 1154 have been in effect for many years, VA has recently provided a PTSD regulatory change that further carries out the intent of that statute and recognizes the changing conditions of modern warfare. Section 3.304(f)(1) now provides for service connection of PTSD when there is an in-service diagnosis of the disability. In such cases, the veteran's lay stressor statement and the medical examiner's association of PTSD with that stressor is sufficient to establish service connection when PTSD is diagnosed. This liberalization of regulatory requirements is due to the recognition by VA of the heightened awareness of PTSD among military medical personnel, resulting in increasing numbers and reliability of PTSD diagnoses for personnel still on active duty. This regulation also facilitates the timely resolution of PTSD claims and provides expedited payment of needed benefits to veterans.

These descriptions of PTSD-related initiatives make it clear that VA is committed to following the mandate of § 1154 and adjusting the PTSD claims process as necessary to better serve veterans. This concludes my testimony and I would be happy to answer any questions the Committee Members may have.

**Prepared Statement of Antonette Zeiss, Ph.D., Deputy Chief Consultant,
Office of Mental Health Services, Office of Patient Care Services,
Veterans Health Administration, U.S. Department of Veterans Affairs**

Good afternoon, Mr. Chairman and Members of the Subcommittee. Thank you for the opportunity to discuss "The Nexus between 'Engaged in Combat with the Enemy' and PTSD in an Era of Changing Warfare Tactics." I am here to discuss the diagnosis of post-traumatic stress disorder (PTSD) by Veterans Health Administration (VHA) clinicians.

VA is nationally recognized for its outstanding PTSD treatment and research programs, and the quality of VA health care in this area is outstanding, with continual enhancements as more is learned. For example, VA's National Center for PTSD advances the clinical care and social welfare of Veterans through research, education and training on PTSD and stress-related disorders. Those advances are used to guide clinical program development in collaboration with the Office of Mental Health Services.

All VA clinicians, including those responsible for completing Compensation and Pension (C&P) evaluations, adhere to the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, Text Revision (DSM-IV-TR), recognized as the authoritative source for mental health conditions. According to the DSM-IV-TR clinical criteria, PTSD can follow exposure to a severely traumatic stressor that involves personal experience of an event involving actual or threatened death or serious injury. It can also be triggered by witnessing an event that involves death, injury, or a threat to the physical integrity of another. The person's response to the event must involve intense fear, helplessness or horror. The symptoms characteristic of PTSD include persistent re-experiencing of the traumatic event, persistent avoidance of stimuli associated with the trauma, numbing of general responsiveness, and persistent symptoms of increased arousal. No single individual displays all these symptoms, and a diagnosis requires a combination of a sufficient number of symptoms, while recognizing that individual patterns will vary. PTSD can be experienced in many ways. Symptoms must last for more than 1 month and the disturbance must cause clinically significant distress or impairment in social, occupational or other important areas of functioning. Military combat certainly creates situations that fit the DSM-IV TR description of a severe stressor event that can result in PTSD. The likelihood of developing PTSD is known to increase as the proximity to, intensity of, and number of exposures to such stressors increase.

PTSD is associated with increased rates of other mental health conditions, including Major Depressive Disorder, Substance-Related Disorders, Generalized Anxiety Disorder, and others. PTSD can directly or indirectly contribute to other medical conditions. Duration and intensity of symptoms can vary across individuals and within individuals over time. Symptoms may be brief or persistent; the course of

PTSD may ebb and return over time, and PTSD can have delayed onset. Clinicians use these criteria and discussions with patients to identify cases of PTSD, sometimes in combination with additional psychological testing. VA adheres to the guidance of the DSM-IV-TR when it states, "Specific assessments of the traumatic experience and concomitant symptoms are needed for such individuals." VA seeks to ensure we offer the right diagnosis in all clinical settings, whether for C&P examinations or as part of a standard mental health assessment.

Because personal experience in combat can be such a significant source of trauma, our mental health professionals have been trained to solicit this information from patients. Only Psychiatrists and Psychologists may conduct initial C&P examinations in which a diagnosis of PTSD is being considered in response to a claim by a Veteran. In addition, any Psychiatrist or Psychologist who will conduct a PTSD C&P examination must complete training and receive certification in the process of conducting C&P examinations in relation to the diagnostic criteria of PTSD. We recognize that many individuals with symptoms of combat stress or PTSD find it difficult to discuss the details of their experiences, although they can more easily describe their symptoms and level of distress. However, without the patient disclosing the source of the stress, it is impossible for a clinician to diagnose PTSD according to the clinical criteria of the DSM-IV-TR. Clinicians must develop a sense of safety and trust with some patients in order to make them feel comfortable enough to share their trauma in the clinical interview. The expertise and sensitivity required for such clinical evaluation are two reasons why only doctoral level Psychiatry and Psychology providers are allowed to conduct initial exams. VHA clinicians conducting the clinical interview for the diagnosis of PTSD in the context of a Veteran's claim do not ask for external corroborating evidence for the described stressful event. VBA requires this evidence to make a determination of service-connection for C&P.

Apart from issues of determining diagnoses in the C&P context, identifying and treating patients with PTSD and other mental health conditions are paramount for VHA. VA's efforts to facilitate treatment while removing the stigma associated with seeking mental health care are yielding valuable results. VA screens any patient seen in our facilities for depression, post-traumatic stress disorder (PTSD), problem drinking, and military sexual trauma. We have incorporated this screening and treatment into primary care settings. We also offer a full continuum of care, including inpatient, residential rehabilitation, and outpatient services for Veterans with one or more of the following conditions (this list is illustrative, not exhaustive): PTSD, alcohol and substance abuse disorders, depression, anxiety, and other serious mental illnesses. We further offer programs for Veterans at risk of suicide, Veterans who are homeless, and Veterans who have experienced military sexual trauma with resulting development or exacerbation of mental health problems.

In Fiscal Year 2008, VA treated 442,862 unique Veterans for PTSD in VA medical centers, clinics, inpatient settings, and residential rehabilitation programs. Given the increasing numbers of Veterans seeking VA care for PTSD, VA is monitoring the promptness and efficiency of services provided them, such as "time to first appointment" for Veterans of all service eras who present with new mental health problems. Nationally, we are meeting our new standard of care, which is to see all new patients seeking a mental health care appointment within 14 days of their requested date, 95 percent of the time. Almost all VISNs meet this standard, and focused efforts continue to bring all VISNs and facilities up to this standard. We conduct an initial evaluation of all patients with potential mental health issues within 24 hours of contact and we provide urgent care immediately. VA has extended hours of operation, expanded points of access, and increased our core staff to date by 5,000 positions. We plan again this year to continue increasing the number of mental health professionals and support staff in the field to ensure sustained operations of this vital service line.

We also believe it is essential that our mental health professionals across the system be able to provide the most effective treatment for PTSD once it has been identified. In addition to use of effective psychoactive medications, VA is conducting national training initiatives to educate therapists in two particular evidence-based psychotherapies (EBPs) for PTSD. A number of studies have supported the use of these exposure-based treatments for PTSD. The first of these therapies is Cognitive Processing Therapy (CPT); training for CPT began in 2006, and to date, VA has trained over 1,100 VA clinicians in the use of CPT. The second national initiative is an education and training module on Prolonged Exposure (PE) for treatment of PTSD; this training began in 2008, and to date, OMHS has trained over 350 clinicians in the use of PE. For both of these psychotherapies, following didactic training, clinicians participate in clinical consultations to attain full competency in the therapy. VA is also using new CPT and PE treatment manuals, developed for VA

with inclusion of material on the treatment of issues arising from combat trauma during military service.

VA provides mental health care in several different environments, including Vet Centers. There are strong, mutual interactions between Vet Centers and our clinical programs. Vet Centers provide a wide range of services that help Veterans cope with and transcend readjustment issues related to their military experiences in war. Services include counseling for Veterans, marital & family counseling for military related issues, bereavement counseling, military sexual trauma counseling and referral, demobilization outreach/services, substance abuse assessment and referral, employment assistance, referral to VA medical centers, VBA referral and Veterans community outreach and education. Vet Centers provide a non-traditional therapeutic environment where Veterans and their families can receive counseling for readjustment needs and learn more about VA's services and benefits. By the end of FY 2009, 271 Vet Centers with 1,526 employees will be operational to address the needs of Veterans. Additionally, VA is deploying a fleet of 50 new Mobile Vet Centers this year that will provide outreach to returning Veterans at demobilization activities across the country and in remote areas. Vet Centers facilitate referrals to either Veterans Benefits Administration offices or VHA facilities to ensure Veterans have multiple avenues available for receiving the care and benefits they have earned through service to the country.

Thank you again for this opportunity to speak about VA's diagnosis and treatment of PTSD in Veterans and its relevance to the determination of whether a diagnosis of PTSD is warranted when Veterans submit claims to VBA. I am prepared to answer any questions you may have.

**Prepared Statement of Maureen Murdoch, M.D., MPH, Core Investigator,
Center for Chronic Disease Outcomes Research,
Minneapolis Veterans Affairs Medical Center,
Veterans Health Administration, U.S. Department of Veterans Affairs**

Mr. Chairman and Members of the Subcommittee, thank you for the opportunity to appear before you today to present findings from my team's research on post-traumatic stress disorder (PTSD) disability awards. I must note the views presented today are mine and do not necessarily represent the views of the Department of Veterans Affairs (VA) and reflect the results of my studies and not necessarily the findings of other research. It is also important to note that these data were collected almost 10 years ago and may not reflect experiences of a new cohort of Veterans from Operation Enduring Freedom or Operation Iraqi Freedom.

Background

PTSD is the most common psychiatric condition for which Veterans seek VA disability benefits. Between 1998 and 2000, my colleagues and I conducted three studies looking at differences in PTSD disability awards.

The first study was a historical, administrative database evaluation of all 180,039 Veterans who applied for PTSD disability benefits between 1980 and 1998. The second was a mailed survey of almost 5,000 men and women Veterans who applied for PTSD disability benefits between 1994 and 1998. Surveys were collected from 1998 to 2000, and responses were supplemented with VA administrative data. The third study involved conducting a claims audit of 345 Veterans who also participated in the survey.

Although these studies had several objectives, those most relevant to today's proceedings include: (1) Identifying the role of combat experience on receiving PTSD service-connection; and (2) Understanding how claiming combat versus military sexual trauma influenced gender differences in receiving PTSD service connection.

Results of the Studies

From the historical database study, we learned that rates of service-connection increased over time. Across all time periods, men and women who had been identified as being "combat injured" in the database were twice as likely to receive service-connection for PTSD compared to men and women who were not combat injured.

By 1998, the observed rate of service-connection for PTSD was 94 percent among combat-injured men and 92 percent among combat-injured women.

For men without combat injuries, the rate of PTSD service-connection in 1998 was 64 percent, and the rate for women without combat injuries was 57 percent.

From the survey study, which covered the time period from 1994 to 1998, we learned that 94 percent of men and 29 percent of women reported some type of combat experience. Twenty-four percent of men and 2 percent of women were identified

as being “combat-injured” in VA databases. “Combat injury” probably anchors the extreme end of a broad range of combat-associated experiences for these Veterans. Four percent of men and 71 percent of women reported sexual assault. As with the historical study, we again saw that more than 90 percent of men and women identified as “combat-injured” received PTSD service-connection. Among those who were not identified as combat-injured, 52 percent of women and 64 percent of men received PTSD service-connection. However, this gender difference was almost entirely explained by men and women’s different rates of combat experience. Regardless of gender, Veterans with more combat experiences were more likely to receive a service-connection for PTSD than Veterans with fewer or no combat experience. Since men were more likely to report combat experiences, they were also more likely to receive service-connection for PTSD.

In our claims audits of 345 Veterans who participated in the mail survey, we found that 85 percent of men received a diagnosis of PTSD from a qualified clinician compared to 76 percent of women. No Veteran selected for chart audit received a service-connection for PTSD unless his or her examining clinician made a diagnosis of PTSD. About a third of Veterans diagnosed with PTSD did not receive service-connection. Veterans diagnosed with PTSD at the time of their clinical examination reported an average of two more combat experiences at the time of the survey compared to men who were not diagnosed with PTSD. Women who were diagnosed with PTSD were as likely to report a military sexual assault on the survey as were women not diagnosed with PTSD. The factor most strongly associated with Veterans receiving a diagnosis of PTSD was having a stressor documented in their claims file.

Mr. Chairman, this concludes my statement. I am pleased to respond to any questions you or the Subcommittee Members may have. Thank you.

Statement of John R. Vaughn, Chairperson, National Council on Disability

National Council on Disability
Washington, DC.
April 2, 2009

The Honorable John Hall
The Honorable Doug Lamborn
House Committee on Veterans’ Affairs
337 Cannon House Office Building
Washington, DC 20515

Dear Chairman Hall and Ranking Member Lamborn:

I am pleased to write to you on behalf of the National Council on Disability (NCD), an independent Federal agency, to submit for the record the executive summary of our most recent report entitled “Invisible Wounds: Serving Servicemembers and Veterans with PTSD and TBI.” We are making this submission in order for it to be considered part of the record for the March 24, 2009 hearing of the House Veterans’ Affairs Subcommittee on Disability Assistance and Memorial Affairs entitled “The Nexus between Engaged in Combat with the Enemy and PTSD in an Era of Changing Warfare Tactics.”

In light of last Tuesday’s hearing on Post-Traumatic Stress Disorder (PTSD), we have chosen to submit a summary of our most recent report, which addresses the military health care systems which are serving servicemembers and veterans with PTSD and Traumatic Brain Injury (TBI). The Council addressed both PTSD and TBI together, as they are often experienced together and because the symptoms of each are often difficult to distinguish.

In its full report, NCD outlines a reality that many studies and commissions have presented in greater detail—that while many evidence-based practices exist to address PTSD and TBI, servicemembers and veterans face numerous barriers in accessing these vital interventions and services. The summary that follows offers ten policy recommendations for the Committee’s consideration.

NCD is composed of 15 members, appointed by the President with the consent of the U.S. Senate. The purpose of NCD is to promote policies, programs, practices, and procedures that guarantee equal opportunity for all individuals with disabilities, and that empower individuals with disabilities to achieve economic self-sufficiency, independent living, and integration into all aspects of society. To accomplish this, we gather stakeholder input, review Federal programs and legislation, and provide advice to the President, Congress and governmental agencies. Much of this ad-

vice comes in the form of timely reports and papers NCD releases throughout each year.

If you have any questions about this submission or any matter related to disability policy, please contact NCD Executive Director Michael Collins by phone at (202) 272-2004, or email at mcollins@ncd.gov. On behalf of NCD, thank you for your leadership in focusing attention on this important topic. I also thank you for the opportunity to submit this statement for the record.

Sincerely,

John R. Vaughn
Chairperson

Invisible Wounds: Serving Service Members and Veterans With PTSD and TBI
National Council on Disability
March 4, 2009

National Council on Disability
1331 F Street, NW, Suite 850
Washington, DC 20004

Read the full report at: <http://www.ncd.gov/newsroom/publications/2009/veterans.doc>

Executive Summary

More than 1.6 million American servicemembers have deployed to Iraq and Afghanistan in Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF). As of December 2008, more than 4,000 troops have been killed and over 30,000 have returned from a combat zone with visible wounds and a range of permanent disabilities. In addition, an estimated 25–40 percent have less visible wounds—psychological and neurological injuries associated with post traumatic stress disorder (PTSD) or traumatic brain injury (TBI), which have been dubbed “signature injuries” of the Iraq War.

Although the Department of Defense (DoD) and the Veterans Administration (VA) have dedicated unprecedented attention and resources to address PTSD and TBI in recent years, and evidence suggests that these policies and strategies have had a positive impact, work still needs to be done. In 2007, the Department of Defense Task Force on Mental Health concluded that

Despite the progressive recognition of the burden of mental illnesses and substance abuse and the development of many new and promising programs for their prevention and treatment, current efforts are inadequate to ensure the psychological health of our fighting forces. Repeated deployments of mental health providers to support operations have revealed and exacerbated pre-existing staffing inadequacies for providing services to military members and their families. New strategies to effectively provide services to members of the Reserve Components are required. Insufficient attention has been paid to the vital task of prevention.

PTSD and TBI can be quite debilitating, but the effects can be mitigated by early intervention and prompt effective treatment. Although medical and scientific research on how to prevent, screen for, and treat these injuries is incomplete, evidence-based practices have been identified. A number of panels and commissions have identified gaps between evidence-based practices and the current care provided by DoD and VA and have recommended strategies to address these gaps. The window of opportunity to assist the servicemembers and veterans who have sacrificed for the country is quickly closing. It is incumbent upon the country to promptly implement the recommendations of previous panels and commissions and fill the remaining gaps in the mental health service systems.

In terms of prevention, emphasis must be placed on minimizing combat stress reactions, and preventing normal stress reactions from developing into PTSD when they do occur. When PTSD or TBI does occur, the goal of treatment must be to help the servicemember regain the capacity to lead a complete life, to work, to partake in leisure and civic activities, and to form and maintain healthy relationships.

PTSD and TBI are often addressed together because they often occur together and because the symptoms are at times difficult to distinguish.

PTSD is an anxiety disorder arising from “exposure to a traumatic event that involved actual or threatened death or serious injury.” It is associated with a host of chemical changes in the body’s hormonal system, and autonomic nervous system. Symptoms vary considerably but the essential features of PTSD include:

- *Re-experiencing*: Such as flashbacks, nightmares and intrusive memories;
- *Avoidance/Numbing*: Including a feeling of estrangement from others; and,
- *Hyperarousal/Hypervigilance*: Including feelings of being constantly in danger.

The challenge for both professionals and veterans is to recognize the difference between “a normal response to abnormal circumstances” and PTSD. Some will develop symptoms of PTSD while they are deployed, but for others it will emerge later, after several years in many cases.

According to current estimates, between 10 and 30 percent of servicemembers will develop PTSD within a year of leaving combat. When we consider a range of mental health issues including depression, generalized anxiety disorder, and substance abuse, the number increases to between 16 and 49 percent.

Traumatic brain injury (TBI), also called acquired brain injury or simply head injury, occurs when a sudden trauma causes damage to the brain. TBI can result when the head suddenly and violently hits an object, or when an object pierces the skull and enters brain tissue. Victims may have a wide range of symptoms such as difficulty thinking, memory problems, attention deficits, mood swings, frustrations, headaches, or fatigue. Between 11 and 20 percent of servicemembers may have acquired a traumatic injury in Iraq and Afghanistan.

Evidence-based practices to prevent PTSD include teaching skills to enhance cognitive fitness and psychological resilience that can reduce the detrimental impact of trauma. In terms of screening, evidence suggests that identifying PTSD and TBI early and quickly referring people to treatment can shorten their suffering and lessen the severity of their functional impairment. Several types of rehabilitative and cognitive therapies, counseling, and medications have shown promise in treating both injuries.

Servicemembers and veterans may access care through the Department of Defense, the Veterans Health Administration, or the private sector. Each health care system has a number of strengths and weaknesses in delivering evidence-based care. For example:

Department of Defense: DoD has developed a number of evidence-based programs designed to (1) maintain the psychological readiness of the forces in order to reduce the incidence of stress reactions; (2) embed psychological services in deployed settings to ensure early intervention when stress reactions occur; and (3) deliver evidence based rehabilitative therapies on base and through TRICARE, a managed care system that uses a network of civilian providers. However, the military, not unlike the civilian health care setting, has a shortage of mental health providers who must be spread about military bases and deployed settings.

Servicemembers who rely on the TRICARE network may have limited access to services. Because of the low reimbursement rates, many of TRICARE’s providers are not accepting new TRICARE patients and because of the shortage of available mental health providers in some areas, enrollees may wait weeks or months for an available appointment.

Veterans Health Administration: VA has undergone significant changes in the past 10–15 years that has transformed it into an integrated system that generally provides high quality care. In response to the increased demand for services to treat OEF/OIF veterans with PTSD, the system has invested resources in expanding outreach activities enhancing the availability and timeliness of specialized PTSD services. Nevertheless, access to care is still unacceptably variable across the VA system.

Some servicemembers continue to face barriers to seeking care. These barriers include stigma and limited access.

Stigma: Servicemembers are affected by three types of stigma:

- **Public stigma:** The notion that a veteran would be perceived as weak, treated differently, or blamed for their problem if he or she sought help.
- **Self Stigma:** The individual may feel weak, ashamed and embarrassed.
- **Structural Stigma:** Many servicemembers believe their military careers will suffer if they seek psychological services. Although the level of fear may be out of proportion to the risk, the military has institutional policies and practices that restrict opportunities for servicemembers who reveal that they have a psychological health issue by seeking mental health services.

Limited Access: Even when servicemembers or veterans decide to seek care, they need to find the “right” provider at the “right” time. Long waiting lists, lack of information about where to find treatment, long distances to providers, and limited clinic hours create barriers to getting care. When care is not readily available, the “window of opportunity” may be lost.

Culturally diverse populations and women face additional barriers. Despite high rates of PTSD, African American, Latino, Asian, and Native American veterans are less likely to use mental health services. This is due, in part, to increased stigma, absence of culturally competent mental health providers, and lack of linguistically accessible information for family members with limited English proficiency who are

providing support for the veteran. Women have an increased risk of PTSD because of the prevalence of Military Sexual Trauma.

Family and Peer Support: Family support is a key component to the veteran's recovery. However, because of the stress of providing care, the veteran's PTSD puts the family at increased risk of developing mental health issues as well. The current system provides inadequate support for the family in its caregiving role and inadequate access to mental health services that directly address the psychological well-being of the spouse, children, or parents.

Support from peers who have shared a similar experience is also important. Peers can provide information, offer support and encouragement, provide assistance with skill building, and provide a social network to lessen isolation. Peer support may come in the form of naturally occurring mutual support groups; consumer-run services; formal peer counseling services. In addition, consumers need to be involved in the development and deployment of services for patients with PTSD and TBI.

Recommendations and Conclusion

The wars in Iraq and Afghanistan are resulting in injuries that are currently disabling for many, and potentially disabling for still more. They are also putting unprecedented strain on families and relationships, which can contribute to the severity of the servicemember's disability over the course of time. NCD concurs with the recommendations of previous Commissions, Task Forces and national organizations that:

1. A comprehensive continuum of care for mental disorders, including PTSD, and for TBI should be readily accessible by all servicemembers and veterans. This requires adequate staffing and adequate funding of VA and DoD health systems.
2. Mechanisms for screening servicemembers for PTSD and TBI should be continuously improved to include baseline testing for all servicemembers pre-deployment and followup testing for individuals that are placed in situations where head trauma may occur.
3. The current array of mental health and substance abuse services covered by TRICARE should be expanded and brought in line with other similar health plans.

It is particularly critical that prevention and early intervention services be robust. Effective early intervention can limit the degree of long term disability and is to the benefit of the servicemember or veteran, his or her family and society. Therefore, NCD recommends that:

4. Early intervention services such as marital relationship counseling and short term interventions for early hazardous use of alcohol and other substances should be strengthened and universally accessible in VA and TRICARE.

Consumers play a critical role in improving the rehabilitation process. There are many opportunities for consumers to enhance the services offered to servicemembers and veterans and their families. NCD recommends that:

5. DoD and VA should maximize the use of OIF/OEF veterans in rehabilitative roles for which they are qualified including as outreach workers, peer counselors and as members of the professional staff.
6. Consumers should be integrally involved in the development and dissemination of training materials for professionals working with OIF/OEF veterans and servicemembers.
7. Current and potential users of VA, TRICARE and other DoD mental health and TBI services should be periodically surveyed by a competent independent body to assess their perceptions of: a) the barriers to receiving care, including distance, cost, stigma, and availability of information about services offered; and b) the quality, appropriateness to their presenting problems and user-friendliness of the services offered.
8. VA should mandate that an active mental health consumer council be established at every VA medical center, rather than have this be a local option as is currently the case.
9. Congress should mandate a Secretarial level VA Mental Health Advisory Committee and a Secretarial level TBI Advisory Committee with strong representation from consumers and veterans organizations, with a mandate to evaluate and critique VA's efforts to upgrade mental health and TBI services and report their findings to both the Secretary of Veterans Affairs and Congress.

DoD and VA have initiated a number of improvements, but as noted by earlier Commissions and Task Forces, gaps continue to exist.

It is imperative that these gaps be filled in a timely manner. Early intervention and treatment is critical to the long-term adjustment and recovery of servicemembers and veterans with PTSD and TBI. NCD recommends that:

10. Congress and the agencies responsible for the care of OEF/OIF veterans must redouble the sense of urgency to develop and deploy a complete array of prevention, early intervention and rehabilitation services to meet their needs now.

As this report indicates, the medical and scientific knowledge needed to comprehensively address PTSD and TBI is incomplete. However, many evidence-based practices do exist. Unfortunately, servicemembers and veterans face a number of barriers in accessing these practices including stigma; inadequate information; insufficient services to support families; limited access to available services, and a shortage of services in some areas. Many studies and commissions have presented detailed recommendations to address these needs. There is an urgent need to implement these recommendations.

Statement of Paul Sullivan, Executive Director, Veterans for Common Sense

Veterans for Common Sense (VCS) thanks Subcommittee Chairman John Hall, Ranking Member Doug Lamborn, and Members of the Subcommittee for allowing us to submit a written statement for the record about today's hearing on "The Nexus Between Engaged in Combat with the Enemy and Post-Traumatic Stress Disorder in an Era of Changing Warfare Tactics."

VCS applauds your attention to the issue of post traumatic stress disorder (PTSD) among deployed veterans. Left untreated, PTSD is a significant factor that increases the risk of broken homes, unemployment, drug and alcohol abuse, crime, homelessness, and suicide. According to the Institute of Medicine (IOM), deployment is associated with increased risk of PTSD, suicide, and other significant health problems.

In order to mitigate the long-term adverse consequences of PTSD, VCS advocates improving the quality and timeliness of how the Department of Veterans Affairs (VA) processes PTSD disability compensation benefit claims.

The situation is most acute for the 1.83 million U.S. servicemembers deployed to the Iraq and Afghanistan wars, especially since nearly 40 percent have deployed to combat twice or more.¹

We are disappointed VA failed to take advantage of five opportunities to address this issue since 2007. Less than 2 years ago, VA ignored an important PTSD disability claim ruling, *Castle v. Mansfield*. In 2008, VA ignored the IOM report linking PTSD to deployment to a war zone. The same year, VA ignored the growing disability backlog and the escalating surge of PTSD claims filed by Iraq and Afghanistan war veterans. In 2009, VA ignored a request by VCS to issue new regulations to streamline the adjudication of PTSD claims.

In light of VA's intentional inaction on this issue, VCS strongly urges Congress to quickly pass H.R. 952, the "COMBAT PTSD Act," introduced by Chairman Hall last month.

VA Ignored Three Important Cases: *Daye*, *Suozzi*, and *Pentecost*

VA missed an important opportunity to streamline PTSD claims after the United States Court of Appeals for Veterans Claims ("the Court") issued its recent decision in the case of *Daye v. Nicholson* 20 Vet. App. 512 (2006) concerning the amount of evidence needed for a veteran to corroborate a stressor occurred. The Court held that:

When a claim for PTSD is based on a noncombat stressor, 'the noncombat veteran's testimony alone is insufficient proof of a stressor.' Corroboration does not require, however, 'that there be corroboration of every detail including the appellant's personal participation in the [activity].'

The *Daye* decision relied upon two prior decisions by the Court: *Suozzi v. Brown* 10 Vet. App. 307 (1997), and *Pentecost v. Principi* 16 Vet. App. 124 (2002). Clearly, a veteran does not need to "verify" personal involvement in a stressful event. The veteran need only provide corroborating evidence they were deployed in the war zone along with credible evidence of an event.

Yet, even though the Court has provided clear guidance as to how VA should assess in-service stressor-related evidence submitted in support of PTSD claims, VA consistently fails to develop and adjudicate these claims correctly.²

These three Court decisions are equally important because the military does not document every combat incident, especially the deaths of civilians.

¹Department of Defense, "Contingency Tracking System," through Oct. 31, 2008.

²VA, "No Across-the-Board Review of PTSD Cases—Secretary Nicholson," press release quoting then Secretary James Nicholson, Nov. 11, 2005. <http://www1.va.gov/opa/pressrel/pressrelease.cfm?id=1042>.

In 2004, a landmark Army study confirmed nearly universal involvement in combat among U.S. servicemembers deployed to Iraq and Afghanistan. In one critical finding, the study found that nearly all Marines and soldiers deployed to Iraq reported they were “attacked or ambushed.”³

This table prepared by Army Colonel Charles Hoge demonstrates the need for the VA to make a whole-sale change in its mindset; that is, simply because a veteran’s service records do not include notations of combat, it does not mean they were not exposed to combat-related events or incidents, and the stresses to those incidents.

Too often, the VA is quick to assume that when a veteran’s service record is void of combat notations, their PTSD-related claim for VA benefits is fraudulent or not valid.

Table 1. Combat Experiences Reported by Members of the U.S. Army and Marine Corps after Deployment to Iraq or Afghanistan*

Experience	Army Groups		Marine Groups
	<i>Afghanistan (N=1062)</i>	<i>Iraq (N=894)</i>	<i>Iraq (N=815)</i>
	<i>number/total number (percent)</i>		
Being attacked or ambushed	1139/1961 (58)	798/883 (89)	764/805 (95)
Receiving incoming artillery, rocket, or mortar fire	1648/1960 (84)	753/872 (86)	740/802 (92)
Being shot at or receiving small-arms fire	1302/1962 (66)	826/886 (93)	779/802 (97)
Shooting or directing fire at the enemy	534/1961 (27)	672/879 (77)	692/800 (87)
Being responsible for the death of an enemy combatant	229/1961 (12)	414/871 (48)	511/789 (65)
Being responsible for the death of a noncombatant	17/1961 (1)	116/861 (14)	219/794 (28)
Seeing dead bodies or human remains	771/1958 (39)	832/879 (95)	759/805 (94)
Handling or uncovering human remains	229/1961 (12)	443/881 (50)	445/800 (57)
Seeing dead or seriously injured or killed	591/1961 (30)	572/882 (65)	604/803 (83)
Knowing someone seriously injured or killed	850/1962 (43)	751/878 (86)	693/797 (87)
Participating in demining operations	314/1962 (16)	329/867 (38)	270/787 (34)
Seeing ill or injured women or children whom you were unable to help	907/1961 (5)	604/878 (69)	665/805 (83)
Being wounded or injured	90/1961 (5)	119/870 (14)	75/803 (9)
Had a close call, was shot or hit, but protective gear saved you	— †	67/870 (8)	77/805 (10)
Had a buddy shot or hit who was near you	— †	192/880 (22)	208/797 (26)
Clearing or searching homes or building	1108/1961 (57)	705/884 (80)	695/805 (86)
Engaging in hand-to-hand combat	51/1961 (3)	189/876 (22)	75/800 (9)
Saved the life of a soldier or civilian	125/1961 (6)	183/859 (21)	150/789 (19)

*Data exclude missing values, because not all respondents answered every question. Combat experiences are worded as in the survey.

†The question was not included in the survey.

³Hoge, Charles, *et. al.*, “Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care,” *New England Journal of Medicine*, 2004. <http://content.nejm.org/cgi/content/full/351/1/13>.

VA Ignored 2008 IOM Study Linking Deployment to PTSD and Suicide

VA missed their second opportunity to issue new regulations streamlining PTSD claims when an IOM review of peer-reviewed scientific research concluded that PTSD and suicide are associated with deployment to a war zone:

The epidemiologic literature on deployed vs. nondeployed veterans yielded sufficient evidence of an association between deployment to a war zone and psychiatric disorders, including *post traumatic stress disorder (PTSD), other anxiety disorders, and depression; alcohol abuse; accidental death and suicide* in the first few years after return from deployment; and marital and family conflict, including interpersonal violence (*emphasis added*).⁴

Similarly, VA ignored two prior IOM reports on PTSD. In 2006, IOM validated the diagnosis of PTSD and listed war zone exposures not directly associated with combat:

A war environment is rife with opportunities for exposure to traumatic events of many types. Types of traumatic stressors related to war include serving in dangerous military roles, such as driving a truck at risk for encountering roadside bombs, patrolling the streets, and searching homes for enemy combatants, suicide attacks, sexual assaults or severe sexual harassment, physical assault, duties involving graves registration, accidents causing serious injuries or death, friendly fire, serving in medical units, killing or injuring someone, seeing someone being killed, injured, or tortured, and being taken hostage.⁵

In 2007, a third IOM report addressed VA's concerns regarding the steep increase in disability payments made to veterans service-connected for PTSD. During the period from 1999 to 2004, the amount of money VA paid rose from \$1.72 billion to \$4.28 billion.⁶ To explain the rise in PTSD benefit payments, the IOM concluded that:

PTSD can develop at any time after exposure to a traumatic stressor. The scientific literature does not identify any differences material to the consideration of compensation between 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.⁷

VA leaders could and should have promptly issued regulations to streamline PTSD claims based on the best available current scientific literature, including three separate IOM reports.

VA Ignored Growing Disability Claims Backlog, Now Nearly 900,000

VA missed their third opportunity to issue improved PTSD regulations when the claim backlog ballooned over the past few years. The disability claims backlog has soared, from just over 600,000 in January 2004 to nearly 900,000 in March 2009.⁸

VA's current claims backlog nightmare includes more than 60,000 pending claims from Iraq and Afghanistan war veterans for any type of medical condition. To date, more than 370,000 Iraq and Afghanistan war veterans have filed a disability claim against VA for any type of condition, overwhelming evidence that the two current wars are creating a sustained and significant hardship on VA's already broken claims system.⁹

VA could and should have issued new regulations to expedite PTSD claims in order to break the bottleneck of 900,000 claims awaiting adjudication.

VA Ignored PTSD Claims Filed by Iraq and Afghanistan War Veterans

VA missed their fourth opportunity for new regulations when the Department learned that only half of the Iraq and Afghanistan war veterans diagnosed with PTSD received PTSD disability compensation benefits from VA.

⁴IOM, *Gulf War and Health: Volume 6. Physiologic, Psychologic, and Psychosocial Effects of Deployment-Related Stress*, 2008, page 319, http://www.nap.edu/catalog.php?record_id=11922.

⁵IOM, Subcommittee on Post-Traumatic Stress Disorder of the Committee on Gulf War and Health: *Physiologic, Psychologic, and Psychosocial Effects of Deployment-Related Stress, "Post-Traumatic Stress Disorder: Diagnosis and Assessment"* 2006, <http://www.nap.edu/catalog/11674.html>.

⁶IOM, "PTSD Compensation and Military Service" 2007, http://www.nap.edu/catalog.php?record_id=11870.

⁷Ibid.

⁸VA, "Monday Morning Workload Report," Mar. 14, 2009, indicates 697,000 claims of all types pending at VA regional offices plus another 190,000 claims pending at VA's Board of Veterans Appeals.

⁹VA, "VA Benefits Activity: Veterans Deployed to the Global War on Terror," Mar. 2009.

According to the most recent VA reports obtained exclusively by VCS using the Freedom of Information Act (FOIA), more than 105,000 Iraq and Afghanistan war veterans were diagnosed by VA with PTSD.¹⁰ However, only 51,000 Iraq and Afghanistan war veterans were granted disability benefits by VA for PTSD.¹¹

More than 338,000 Iraq and Afghanistan war veterans are at risk of developing PTSD. According to a 2008 report by RAND, 18.5 percent of the 1.83 million service-members deployed to the Iraq and Afghanistan war zones are expected to return home and develop PTSD.¹²

PTSD among deployed veterans may be further exacerbated by the high rates of military sexual trauma (MST) among Iraq and Afghanistan war veterans.¹³

According to VA's National Center for PTSD, MST is a very serious problem among both female and male Iraq and Afghanistan war veterans:

Among [Iraq and Afghanistan war] veterans, nearly one in seven women, about 15 percent, who accessed care through VA screened positive for MST and 0.7 percent of males also reported having experienced MST. Both males and female [Iraq and Afghanistan war] veterans who reported a history of MST also were more likely to be diagnosed with a mental health condition than patients who did not report an experience of MST in their history.¹⁴

Based on VA's estimate of 15 percent, more than 30,000 of our female service-members experienced MST while deployed to the Iraq and Afghanistan wars. Similarly, based on an estimate of 0.7 percent, more than 11,000 of our male service-members experienced MST while deployed to the two current wars. The grand total could be as high as 41,000 MST cases from the Iraq and Afghanistan war zones.

VA could and should have issued new rules based on the tidal wave of Iraq and Afghanistan war veterans diagnosed by VA with PTSD who are filing disability claims against VA for PTSD, including those who experienced MST while deployed to war.

VA Rejected VCS Request for Streamlined PTSD Regulations

VA missed their fifth opportunity to write new PTSD regulations when VCS wrote a letter to VA requesting the Department use their rule-making authority to address the growing crisis.

On January 26, 2009, VCS wrote VA Secretary Eric Shinseki asking VA to issue streamlined PTSD regulations based on the IOM report and the failure of VA to approve PTSD claims filed by Iraq and Afghanistan war veterans.

The rule change VCS sought was simple and straightforward: we clearly demonstrated how science supported the rule and how veterans are being harmed by on-going VA failures. VCS provides a copy of our letter to VA for the Subcommittee's records.

On February 27, 2009, VA's Chief of Staff, John Gingrich, wrote to VCS and rejected our request for streamlined PTSD claim regulation. Tragically and inexplicably, VA ignored the overwhelming scientific evidence, ignored the growing claims backlog, and ignored the pressing needs of our Iraq and Afghanistan war veterans. VCS provides a copy of VA's incomprehensible and outrageous rejection letter for your records.

VA could and should have issued new rules based on our letter and the new scientific evidence.

VA Confirmed PTSD Claim Fraud is Not a Problem

During 2005, as the number of PTSD claims filed by veterans continued to increase, VA leaders tasked VA's Office of the Inspector General to review PTSD claims that were already approved. According to a VA statement issued in 2005:

The problems with these files appear to be administrative in nature, such as missing documents, and not fraud. . . . In the absence of evidence of fraud, we're not going to put our veterans through the anxiety of a widespread review of their [approved PTSD] disability claims. . . . Instead,

¹⁰VA Facility Specific OIF/OEF Veterans Coded with Potential PTSD, 4th Qt FY 2008, Dec. 23, 2008.

¹¹VA, "VA Benefits Activity: Veterans Deployed to the Global War on Terror," Mar. 2009.

¹²RAND, "Invisible Wounds: Mental Health and Cognitive Care Needs of America's Returning Veterans," Apr. 17, 2008.

¹³Blumenthal, Les, "VA Struggles to Gear Up to Care for Female Veterans," McClatchy News, May 18, 2009, <http://www.mcclatchydc.com/reports/veterans/story/37409.html>.

¹⁴VA, National Center for PTSD, Fact Sheet, "Female OIF/OEF Veterans Report Military Sexual Trauma—Associated with Higher Rates of Mental Health Problems—October 2008."

we're going to improve our training for VA personnel who handle disability claims and toughen administrative oversight.¹⁵

VA confirmed fraud is not a problem. Rather, poor documentation, poor training, and poor administrative oversight by VA were the actual culprits. VA could and should have instituted better documentation, better training, and better administrative oversight.

VA Should Launch Campaign to De-Stigmatize PTSD

VA, Congress, and veterans groups should do more to end discrimination against veterans with mental health conditions. In our view, passage of H.R. 952 may further assist veterans by reducing the stigma that two medical research studies found often prevents veterans from seeking medical care.¹⁶

VCS encourages veterans with mental health conditions to reach out to VA for assistance. We also urge VA to be ready, willing, and able to assist veterans by providing both prompt mental health care and disability benefits when veterans seek help—especially for PTSD.

Urgent Unmet Need: Congress Should Act Now to Assist Veterans

The scientific evidence is overwhelming: engaging in combat with the enemy can and does cause PTSD among some veterans. In addition, the scientific evidence concludes that deployment itself, without combat, is also linked to PTSD and suicide. Due to VA's cumbersome, complex, and adversarial rules for veterans diagnosed with PTSD to prove the existence of a combat stressor incident, VA takes longer than 6 months to process PTSD claims. As a result, VA's claim system becomes further mired in a growing backlog of benefit requests.

VCS believes a fair and reasonable way to resolve this situation, keeping with VA's stated objective of putting veterans first, would be to define combat under the law (38 USC § 1154) as deployment to any nation or body of water declared a war zone by the Department of Defense. *Deployment itself, not combat with the enemy, should be considered the stressor for PTSD claims, as the IOM study concluded.*

In an effort to resolve VA's claim crisis, VCS urges Congress to pass H.R. 952 as soon as possible because of VA's continued adversarial policies against veterans and because VA has utterly failed to address the PTSD claim disaster. VA's crisis is expected to worsen significantly as the two current wars continue and multiple deployments increase.¹⁷ Based on VA's health care use reports indicating 10,000 new, first-time Iraq and Afghanistan war veterans flooding into VA each month, VCS estimates VA may diagnose and treat total of 450,000 mental health patients by the end of 2013, including as many as 250,000 diagnosed with PTSD.

Now is the time to fix the problem of unreasonable claim delays for veterans with PTSD so they can receive the disability benefits needed and earned in a timely manner. With a new law, VA should be able to quickly approve tens of thousands of PTSD claims filed by Iraq and Afghanistan war veterans that remain mired in VA red tape. Veterans of other conflicts may also find justice with the passage of H.R. 952.

VA should and could be putting disability benefits into the hands of deserving veterans during the current economic crisis when their need is most acute. A timely and proper adjudication of claims may make the difference between staying in a home or living on the streets for veterans, especially veterans deployed to a war zone with PTSD.

Although enactment of H.R. 952 may cost billions of dollars in the short-term, these are entitlement payments VA will eventually pay to veterans and survivors. This is true because VA confirms fraudulent claims are nearly non-existent. VA may actually realize a cost savings and improved efficiency when VA employees now working on complex and time-consuming PTSD claims are freed up to process other disability compensation claims of equally deserving veterans.

¹⁵VA, "No Across-the-Board Review of PTSD Cases—Secretary Nicholson," press release quoting then Secretary James Nicholson, Nov. 11, 2005. <http://www1.va.gov/opa/pressrel/pressrelease.cfm?id=1042>.

¹⁶RAND, "Invisible Wounds: Mental Health and Cognitive Care Needs of America's Returning Veterans," Apr. 17, 2008; Hoge, Charles, *et al.*, "Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care," *New England Journal of Medicine*, 2004.

¹⁷Tyson, Ann Scott, "Repeat Tours Raise Risk of PTSD, Army Finds," *Washington Post*, Dec. 20, 2006, <http://www.washingtonpost.com/wp-dyn/content/article/2006/12/19/AR2006121901659.html>.

MATERIAL SUBMITTED FOR THE RECORD

Committee on Veterans' Affairs
Subcommittee on Disability Assistance and Memorial Affairs
Washington, DC.
April 7, 2009

Ian De Planque
Assistant Director, Veterans Affairs and Rehabilitation Commission
The American Legion
1608 K Street, NW
Washington, DC 20006

Dear Mr. De Planque:

Thank you for testifying at the House Committee on Veterans' Affairs' Subcommittee on Disability Assistance and Memorial Affairs hearing on "The Nexus between Engaged in Combat with the Enemy and PTSD in an Era of Changing Warfare Tactics," held on March 24, 2009. I would greatly appreciate if you would provide answers to the enclosed followup hearing questions by Monday, May 4, 2009.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for material for all Full Committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively on letter size paper, single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your responses to Ms. Megan Williams by fax at (202) 225-2034. If you have any questions, please call (202) 225-3608.

Sincerely,

John J. Hall
Chairman

The American Legion
Washington, DC.
May 4, 2009

Honorable John J. Hall, Chairman
Subcommittee on Disability Assistance and Memorial Affairs
Committee on Veterans' Affairs
U.S. House of Representatives
337 Cannon House Office Building
Washington, DC 20515

Dear Chairman Hall:

Thank you for allowing The American Legion to participate in the Subcommittee hearing on March 24, 2009, entitled "The Nexus between Engaged in Combat with the Enemy and PTSD in an Era of Changing Warfare Tactics." I respectfully submit the following response to your Post-Hearing Question:

Question 1: What is the American Legion's position on the VA rule-making process that promulgated regulations for defining combat?

Response:

- a. During the process of the implementation of the Congressional action which resulted in the creation of 38 USC § 1154 VA conducted an examination to determine whether the phrasing used by Congress in passage of the Bill was significant. What VA determined was that Congress had, in other legislation, distinguished Combat Zone, but here, in this legislation, specifically described "combat with the enemy," therefore indicating that the intent was there to differentiate.
- b. The American Legion disagrees with this interpretation for a number of reasons, not least of which is the profound recognition that the conditions and expectations of warfare in 1941 were very different than what soldiers in later conflicts would face.
- c. In 1941, with Europe and mainland Asia erupting into combat, but no direct experience of U.S. servicemembers involved, the primary experience of warfare to consider was World War I and the emerging details of World War II. World War I, as any student of basic history will be cognizant of, was marked by uniformed combatants, defined trenches of battle lines, clearly drawn across the fields of

Europe in mud and barbed wire. Even in the emerging battlefields of World War II, it would become clear that the distinction between lines of battle and the rear echelons was widely apparent. Artillery fire did indeed bring the fighting to some in the rear, but the vast majority of action seen was by combat arms soldiers on the pointy front end of combat.

- d. Flash forward several years and we began to see changes. Vietnam was marked by stealthy guerilla warfare “behind the lines” as well as what would be considered today terrorist bombings on the streets of Saigon. Remote forward operating bases sometimes required servicemembers to take up arms in activities not normally considered part of their military specialty. When the numbers of Infantrymen grow short, you must still defend your perimeter utilizing clerks, cooks, whoever can hold a rifle and remember their Basic Training.
- e. As we watch the events of the modern warfare conducted by the United States and its allies in the Global War on Terror, nobody can doubt that the expectations and face of the battlefield have substantially changed over the last 70 years. Regularly stories are shown of supply clerks, of mechanics, or communications specialists and other servicemembers not traditionally thought of as combat soldiers engaging in activity against the enemies. We see IEDs detonated in the streets as a commonplace event. We see journalists cringe from incoming rocket fire, and Members of Congress and the USO wearing protective vests and helmets as they visit troops even in locations in the heart of the so called “Green Zone” of safety in Iraq or at Bagram Air Base in Afghanistan. We know that the danger is all around the brave men and women who fight for this country.
- f. The American Legion believes strongly that the legislative intent of section 1154 (b) is to recognize the difficulties inherent in record keeping in combat, and to provide a means to assist the men and women of this country in proving the occurrence of events under these difficult conditions. What we have seen time and time again in the advocacy for veterans is that the very same conditions which make the proving of individual events difficult further make the proving of an individual’s participation in the combat a great difficulty. Yet we know these servicemembers face these conditions day in and day out. Therefore it is the belief of The American Legion that the legislative intent, which must be recognized, or amended to specifically state such, is to recognize the word of these servicemembers under combat conditions to be true and honorable as long as they are consistent with the conditions and hardships of battle in the combat zone.

Question 2: What would you suggest be the standard for combat related stressors and who should make that determination?

Response:

- a. This could potentially be seen as two questions. Decisions revolving around the adequacy of stressors to trigger PTSD are specifically stated in the Diagnostic and Statistical Manual of Mental Disorders (4th Edition, 1994. The 5th Edition is current under revision for estimated distribution in 2012). A medical opinion is necessary to determine the adequacy of a stressor event in triggering PTSD. Therefore, the determination as to whether a combat event “meets the standard” for PTSD in terms of severity of experience should be made by a medical expert.
- b. If however, this question is interpreted to mean-what is the standard for determining if an incident is combat related and should fall under the criteria of 38 USC §1154 with regard to confirmation of the occurrence of the event through lay testimony alone, then one must examine the standard already existing to measure if claimed events described by a servicemember are acceptable under 1154 where combat has been confirmed.
 - i. Such actions as are consistent with the circumstances, conditions or hardships of combat.
- c. It is the position of The American Legion that the interpretation of 1154(b) should be recognized for all soldiers serving in a combat zone (to be adequately determined by conference with the Secretaries of Defense and of the Department of Veterans Affairs) when describing the occurrence of events “consistent with the conditions and hardships of combat.” This provision was meant to reduce the heavy burden of proof required in recognition of the exigencies of record keeping on the battlefield. It is the position of The American Legion that the dispersed nature of the modern non-linear battlefield has rendered the battlefield less clear, and thus a more broad net must be cast to capture the conditions the provision was intended to remedy.

Question 3: In your testimony, you stated that VA overdevelops claims. Can you explain this contention further and give examples of how this occurs?

Response:

- a. VA is often presented with evidence, anecdotal or non-traditional in the sense of concrete military records, which would tend to confirm the veteran's statements and allow them to move on with their adjudication. However, they continue to ignore this information and continually send out for records which may or may not even exist, further lengthening the process through exhaustive record searches.
- b. Furthermore, VA tends to get locked in on proving "combat" and overlook that they may have already proved the existence of an event specific to the veteran. Once they determine that a veteran was in a convoy they then have to go back to the beginning of the process and start tracking the events of the convoy. They continue to find more and more questions that need to be answered as each new piece of evidence is uncovered.
- c. When VA discovers each new piece of evidence, they must then contact the veteran, let the veteran know they are in receipt of such evidence, and then seek to confirm the next piece in the puzzle rather than taking a holistic approach which could drastically simplify things.
- d. A veteran could be sent for an exam in which the doctor confirms the veteran has PTSD and links it to the experiences described by the veteran. VA denies this claim because they don't find evidence of the stressor. Later, through Herculean efforts the veteran manages to prove that not only were they stationed at a firebase in the middle of the heart of the Tet Offensive. However, VA determines that they must still confirm that this firebase . . . in the heart of the fighting of the Tet Offensive, actually took fire. Eventually this is proven. Now VA decides to send the veteran BACK for another examination because "now they can confirm the incident." This is obviously a needlessly lengthy and convoluted process for something that should be conducted more smoothly.
- e. Something further to consider, which could greatly reduce the number of bounce back examinations described above, would be to either wait to conduct the examinations until the events are proven, or to direct the examining physicians to *assume* for the purposes of the examination, that all statements regarding stressors or incidents described by the veteran are true when considering their diagnosis.
 - i. In the second part of the above example, if VA finds clear and convincing evidence later that the events did not occur, then that knowledge could be applied to assess the validity of the diagnosis. However, should VA determine that the events described occurred, they would be in possession of enough evidence to grant the claim and reduce the backlog by not keeping claims around needlessly in endless development.

Question 4: When The American Legion conducts its quality reviews with NVLSP, does it evaluate the accuracy and completeness of PTSD C&P examinations being used by the adjudicators? What issues, if any, has the organization been able to identify during these site visits regarding PTSD claims?

Response:

- a. In conducting the quality reviews, The American Legion and NVLSP review all aspects of accuracy in the claims processed through the Regional Offices (RO's). A common theme throughout many RO's is the inadequacy of the exams being conducted. One of the most consistent problems noted in PTSD exams is that examiners are being asked to examine the veterans without evidence of a stressor event—leading them to state they cannot confirm a diagnosis without a confirmed stressor. Also, very often medical examiners will review the medical aspects of a claims file, but not the personnel portions of the file from the military record. In some cases, subsequent exams when an advocate has directed the examiner to note the patterns of behavior before and after the claimed stressors (for a servicemember with exemplary service before a stressor event and extremely derelict service afterwards) the examiner will note that the changes in behavior are consistent with the behavioral changes associated with PTSD type disorders.
- b. However, it is also important to point out that many types of examinations are inadequately performed at the RO level, and end up being remanded by the Board of Veterans' Appeals (BVA) for the performance of an adequate examination. Although it is beyond the PTSD oriented purview of this question, an over-

all effort to get the examinations right the first time would go a long way to reducing the backlog by removing a lot of the cases clogging the system that could be removed from consideration if they were adjudicated properly the first time.

Question 5: In PTSD cases where the veteran does not have the required medals or awards, what does a service officer do to develop the claim?

Response:

- a. To assist a veteran in developing claims of this nature, service officers will try to seek some additional types of information which may confirm the claimed stressor or incident in service.
 - i. By combing the veteran's military files, hopefully the personnel records can confirm which units the veteran was assigned to for which dates. Then, sometimes, unit records can be obtained which would help establish events for non-combat servicemembers such as mechanics or other non-Infantry soldiers who may not have decorations indicating combat.
 - ii. In the above examples, advocates often will try to track down information from independent research regarding which units were stationed where (which firebases in Vietnam for example) and then see if they can establish any incidents which affected the LOCATION. If a unit can be placed at a location when an incident occurred, the veteran is assumed, in the absence of clear evidence to the contrary, to have been present with their unit.
 - iii. Also, sometimes a search of back issues of hometown or national newspapers document the occurrence of some of these issues. These newspaper articles would require a good deal of research to track down.
 - iv. By asking the veterans to try to dig up old photos and old letters home which could confirm any of the claimed events. Sometimes, such as in the case of communications soldiers who are seconded out to other units to provide support in the field, a diligent service officer can associate the veteran with a unit they were temporarily assigned to by identifying the unit patches on soldiers in a photograph. Keep in mind such activities are very time consuming and difficult.
 - v. As a last resort, the veteran can submit their own lay testimony, which VA is usually reluctant to accept, and/or the testimony of other witnesses who were present for the events described. This is a lesser course of action because 1) it can be difficult to find old members of the unit, especially after many, many years; and 2) VA must "weigh" the lay testimony against the balance of the case and generally does not accept it if there is no independent military records confirming the lay testimony.

Question 6: In the experiences of The American Legion Service Officers, does VA accept the lay statement of a veteran when he/she has not already met the criteria in 38 USC § 1154(b) by establishing that they had engaged in combat with the enemy? Or, does the veteran have to first prove combat before VA uses the lay statement to identify the specific stressor?

Response:

- a. Although this is largely anecdotal and we have no exact figures on this, the overwhelmingly prevalent situation is that without proving combat, the VA is very reluctant to accept lay evidence to confirm a stressor. This occurs even in situations when a veteran has presented stressor descriptions in detail relating stressor events which mirror those expressed by the veteran as a part of an examination by a psychiatrist. Even in cases where the psychiatrist clearly diagnoses PTSD and relates it to a described stressor by the veteran, unless the veteran can provide military records to document a combat event, VA is reluctant to acknowledge the stressor and grant the service connection for PTSD.
- b. Sometimes a veteran will also supply supporting statements from other veterans who served with them in their unit. Again, the VA frequently does not accept these statements without independent confirmation in military records, citing to their requirements to weigh the validity of lay testimony.
- c. The one area where there has been some success is in situations where the veteran may have a postmarked letter from the dates described, say a 1968 letter to their parents from Vietnam, which describes the circumstances claimed, and/or if the veteran can provide verifying photographs as detailed above. There have been more successes in establishing the credibility of this lay evidence, although even this is not always foolproof.

- d. Ultimately, one of the largest difficulties in this area is that recognition of these types of evidence is widely inconsistent between not only Regional Office to Regional Office, but even Rater to Rater within certain RP's.

Thank you for your continued commitment to America's veterans and their families.

Sincerely,

Ian De Planque, Assistant Director
National Veterans Affairs and Rehabilitation

Committee on Veterans' Affairs
Subcommittee on Disability Assistance and Memorial Affairs
Washington, DC.
April 7, 2009

Thomas Berger, Ph.D.
Senior Analyst for Veterans' Benefits and Mental Health Issues
Vietnam Veterans of America
8605 Cameron Street, Suite 400
Silver Spring, MD 20910

Dear Mr. Berger:

Thank you for testifying at the House Committee on Veterans' Affairs' Subcommittee on Disability Assistance and Memorial Affairs hearing on "The Nexus between Engaged in Combat with the Enemy and PTSD in an Era of Changing Warfare Tactics," held on March 24, 2009. I would greatly appreciate if you would provide answers to the enclosed followup hearing questions by Monday, May 4, 2009.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for material for all Full Committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively on letter size paper, single-spaced. In addition, please restate the question in its entirety before the answer.

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Sincerely,

John J. Hall
Chairman

**Questions from the House Committee on Veterans' Affairs
Subcommittee on Disability Assistance and Memorial Affairs
Hearing on "The Nexus Between Engaged in Combat With the Enemy
and PTSD in an Era of Changing Warfare Tactics"
March 24, 2009**

Question 1: In your testimony you cited the findings of the National Vietnam Veterans Readjustment Study regarding PTSD in Vietnam veterans. How can this study further inform Congress to better help future generations of veterans while still meeting the needs of Vietnam veterans who enter the VA disability claims processing system?

Response: The National Vietnam Veterans Readjustment Study (NVVRS) is the largest nationwide psychiatric study of veterans ever conducted to date. Results of the NVVRS demonstrated that some 15.2 percent of all male and 8.5 percent of all female Vietnam theater veterans were current PTSD cases (i.e., at some time during 6 months prior to interview). Rates for those exposed to high levels of war zone stress were dramatically higher (i.e., a fourfold difference for men and sevenfold difference for women) than rates for those with low-moderate stress exposure. Rates of lifetime prevalence of PTSD (i.e., at any time in the past, including the previous 6 months) were 30.9 percent among male and 26.9 among female Vietnam theater veterans. Comparisons of current and lifetime prevalence rates indicate that 49.2 percent of male and 31.6 percent of female theater veterans, who ever had PTSD,

still had it at the time of their interview. The NVVRS also found that African American veterans and Latino veterans not only had a higher rate of PTSD, but also were much less likely to seek assistance. Thus the NVVRS was a landmark investigation in which a national random sample of all Vietnam Theater and era veterans, who served between August 1964 and May 1975, provided definitive information about the prevalence and etiology of PTSD and other mental health readjustment problems in comparison with a random sample of those who had never served in the military. The study over-sampled African-Americans, Latinos, as well as women, enabling conclusions to be drawn about each subset of the veterans' population.

Subsequently in August 2006, the preeminent research journal, *Science*, published a study by Dr. Bruce Dohrenwend and colleagues that included a re-analysis of the NVVRS data. After application of a particularly rigorous method for validating combat exposure was applied to the data, their re-analysis concluded that nearly one out of every five (18.7 percent) Vietnam veterans had experienced post-traumatic stress disorder (PTSD) and that nearly one out every ten (9.1 percent) Vietnam veterans was **still** suffering from chronic and disabling PTSD, more than 10 years after the war had ended. In VVA's opinion, this study only underscores our belief that the Congressionally mandated NVVRS followup study be conducted so that there can truly be a longitudinal study of Vietnam veterans that will be useful both for us and for the veterans who follow us.

COMPARISONS WITH OTHER STUDIES

There are two other studies under consideration by the VA for establishing prevalence rates, course, and physical health outcomes associated with PTSD. The "Vietnam Veteran Twin Registry" was assembled some 15 years ago to conduct behavioral genetics studies. The goal was to determine if a wide range of psychological, neurological, and behavioral conditions could be related to a common genetic pattern. The Twin Registry was established by recruiting male-male twin pairs using a wide variety of approaches to identifying the pairs. However, VVA's concerns about this registry for establishing prevalence of PTSD and related problems are:

- The study is too simple to be substituted for the NVVRS.
- Twins are inherently not representative of the population who served in the war.
- Recruitment strategies didn't focus on random selection nor representativeness.
- The registry doesn't include women; only male twins are included.
- The registry doesn't reflect the racial and ethnic diversity of those who served in Vietnam. It is a registry that is largely and disproportionately Caucasian.
- The vast majority of the early work on the sample was conducted through the mail with only recent studies employing state of the art measurement of PTSD.

A second ongoing study that is supported by the VA is a risk and resiliency study of Persian Gulf War 2 active duty military soldiers. This "Deployment Health Study" by J. Vasterling and S. Proctor is examining risk factors for health, mental health and cognitive functioning prior to and at intervals following deployment. The samples included in this study are also not representative of all military serving in OIF-OEF as they were selected based upon the willingness of commanders of several military bases to participate. The sample, thus, isn't able to answer or address questions about prevalence of PTSD or any condition among individuals in service in Afghanistan or Iraq. The sampling again is very selective and may possess significant biases from which erroneous conclusions could be drawn about the prevalence of PTSD, its nature and its course. Obviously, this study tells us nothing about the long-term course of PTSD in Vietnam veterans, nor the long-term physical health implications of being afflicted with PTSD for decades.

Through the initial NVVRS the American public and medical community has become aware of the high rates of current and lifetime PTSD, and of the long-term consequences of high stress war zone combat exposure, enabling better policies and services available to military personnel returning from deployments today. Because of its unique scope, the NVVRS has had a large effect on VA and Department of Defense (DoD) policies, and direct health care delivery and services planning.

Question 1(a): Does VVA have additional recommendations for research to improve the disability claims process for veterans with PTSD?

Response: Another noteworthy NVVRS finding was the unusually high number of health problems reported by veterans who served in the Vietnam theater of operations. This finding is consistent with a steadily growing body of research evidence suggesting a link between PTSD and physical health conditions, such as cardiovascular disorders, for example, as well as related mental health problems such as

chronic depression. Therefore, in VVA's opinion, only completion of the NVVRS followup could best establish the bases for any additional research needed to improve the disability claims process for veterans suffering with PTSD.

Question 2: What has been the impact to Vietnam veterans suffering from PTSD who have been denied compensation?

Response: Generally the impact has been devastating, including for some the risk of homelessness, substance abuse, unemployment, and suicide. However, the most obvious impact is the loss of hope in achieving any meaningful quality of life, followed closely by an ever-increasing sense of abandonment by the nation they so proudly served.

Lastly, language for the NVVRS follow up has been included in the past two Congressional budget proposals, but not acted upon. More importantly, however, despite the law requiring it and the recommendation of the Institute of Medicine of the National Academies of Science in July 2007 that the VA move forward to complete the NVVRS follow up study, the VA remains obdurate in its refusal to adhere to the law and good sense, and complete the study as directed by the Congress. Therefore, the need is for Congress to obtain accountability from the VA in this matter, as VVA's presumption is that the current VA Secretary will follow the letter of the law.

Thank you for the opportunity to provide this information, and please let me know if there are any additional questions.

Thomas J. Berger, Ph.D.
Senior Analyst for Veterans' Benefits and Mental Health Issues
Vietnam Veterans of America

Committee on Veterans' Affairs
Subcommittee on Disability Assistance and Memorial Affairs
Washington, DC.
April 7, 2009

Carolyn Schapper
Member
Iraq and Afghanistan Veterans of America
308 Massachusetts Ave., NW
Washington, DC 20002

Dear Ms. Schapper:

Thank you for testifying at the House Committee on Veterans' Affairs' Subcommittee on Disability Assistance and Memorial Affairs hearing on "The Nexus between Engaged in Combat with the Enemy and PTSD in an Era of Changing Warfare Tactics," held on March 24, 2009. I would greatly appreciate if you would provide answers to the enclosed followup hearing questions by Monday, May 4, 2009.

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Sincerely,

John J. Hall
Chairman

**Answers to Additional Questions From the March 23rd Hearing on
“The Nexus Between Engaged in Combat With the Enemy and
PTSD in an Era of Changing Warfare Tactics”**

Carolyn Schapper, IAVA Veteran Spokeswoman

Question 1: In your statement you noted that life in Iraq and Afghanistan is combat. Can you describe other types of stressful events besides rocket attacks, IED, or weapons fire that might also cause a servicemember to develop PTSD?

Question 1(a): In the experiences of Iraq or Afghanistan veterans would you say that a stressor might be one event or could it be multiple events or hardships?

Response: In my statement I stated that some of my fellow female servicemembers consider life in Iraq and Afghanistan as combat, and this statement was to imply that life on a base, for even those who do not leave, can be considered combat because of the constant threat of mortars and rocket fire, which is a very real threat. I, personally, did leave base and had exposure to IEDs and sniper-fire in addition to mortars and rockets while on base. So, there is no way that I can quantify what is real for people who did not have my experience.

Regarding whether it takes one incident or several incidents to create a stressor significant enough to lead to PTSD it is unfortunately not an easy answer. I have no doubt that a person that was involved in one significant event that caused injury or death can have PTSD. Again, I cannot answer for others and how they process their experiences. Personally, I experienced seven significant events involving vehicle damage and/or enemy contact within 100 yards, which all factor into my PTSD. There is no way for me to remove myself from six of these events to determine if one of them would have led to adjustment issues.

Question 2: At the hearing on March 24, 2009, you urged a stronger presence of women veterans' centers. How could these centers better assist female veterans file claims for PTSD when they have been in combat or experienced a sexual trauma?

Response: Women Veterans' Centers can assist female veterans primarily through addressing comfort levels. It is not an understatement that women who have been traumatized by combat or MST can feel intimidated in relaying their experiences to males. We feel like we will be judged in a more skeptical manner than our male counterparts would be. Therefore, these centers would assist females just through their very existence. If women knew they had the opportunity to go to a VA center that routinely deals with females I believe more women would be likely to seek help and counseling. This would include having all-female PTSD groups.

Personally I feel very uncomfortable going to the VA because of the predominance of males at the VA. I am the obvious “other” which leads to uncomfortable looks and questions. If I knew there would be more women seeking services at the VA I would not feel as uncomfortable going there as I do now.

However, all this being said, I would like to point out that the VA does have some very significant women's services, such as a state of the art breast cancer research center. The VA has reached out to women and the issues that affect them, but there is certainly more that can be done to make women more willing to get the help they deserve.

Committee on Veterans' Affairs
Subcommittee on Disability Assistance and Memorial Affairs
Washington, DC.
April 7, 2009

Dean G. Kilpatrick, Ph.D.
Member, Committee on Veterans' Compensation for
Posttraumatic Stress Disorder
Institute of Medicine
500 Fifth Street, NW
Washington, DC 20001

Dear Mr. Kilpatrick:

Thank you for testifying at the House Committee on Veterans' Affairs' Subcommittee on Disability Assistance and Memorial Affairs hearing on “The Nexus between Engaged in Combat with the Enemy and PTSD in an Era of Changing Warfare Tactics,” held on March 24, 2009. I would greatly appreciate if you would provide answers to the enclosed follow-up hearing questions by Monday, May 4, 2009.

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Due to the delay in receiving mail, please provide your responses to Ms. Megan Williams by fax at (202) 225-2034. If you have any questions, please call (202) 225-3608.

Sincerely,

John J. Hall
Chairman

**Dr. Dean Kilpatrick's Response to Questions Posed by
The Honorable John J. Hall, Chairman, Subcommittee on Disability
Assistance and Memorial Affairs, House Committee on Veterans' Affairs
Pursuant to the Hearing on "The Nexus Between Engaged in Combat With
the Enemy and PTSD in an Era of Changing Warfare Tactics"**

March 24, 2009

Question 1: What does the IOM mean by a comprehensive, consistent and rigorous PTSD evaluation process? Does VA have such a process?

Response: Our IOM committee (the Committee on Veterans' Compensation for Post-Traumatic Stress Disorder) concluded the following in its report *PTSD Compensation and Military Service* (IOM, 2006):

The most effective strategy for dealing with problems with self-reports of traumatic exposure is to ensure that a comprehensive, consistent, and rigorous process is used throughout the VA to verify veteran-reported evidence. (p. 194)

The committee's report did not detail the elements of such a process but did cite examples:

One approach to achieving this objective is routine and consistent use of the full range and battery of methods implemented and tested by Dohrenwend and colleagues (2006). The best-practice manual for C&P examinations, written by VA clinicians, already recognizes the value of careful and in-depth review of records (Watson et al., 2002). (p. 174)

Although our committee did not recommend mandating use of the *Best Practice Manual*, this manual offers guidelines for assessing traumatic exposure that represent the type of comprehensive, consistent, and rigorous evaluation process that the committee recommended.

Question 1(a): How well does VA use its own Best Practice Manual for PTSD C&P Exams?

Response: Our committee did not conduct a systematic assessment of the content of, nor of the average length of time taken to complete, VA PTSD compensation and pension (C&P) examinations; and it did not collect data on the frequency with which the procedures contained in the *Best Practice Manual* (Watson et al., 2002) were used. However, it did obtain anecdotal information on the process. Testimony presented to the committee indicated that clinicians often feel pressured to severely constrain the time that they devote to conducting a PTSD C&P examination—to as little as 20 minutes (Arbisi, 2006)—even though the examination protocol suggested in the *Best Practice Manual* requires up to 3 hours to complete, with additional time needed for complex cases.

In my opinion, this information suggests that use of the *Best Practices Manual* was not universal when the Committee conducted its review. In fairness to the VA, it is possible that the agency may have subsequently implemented some of the Committee's recommendations concerning C&P exams, so the best way to answer this question would be to ask the VA to provide current data.

Question 2: Is the VA's regulation requiring certain awards and medals to document a stressor for PTSD consistent with the DSM-IV criteria for the diagnosis?

Response: According to the *DSM-IV* criteria for the PTSD diagnosis, a characteristic set of symptoms must develop following exposure to an extreme traumatic stressor (APA, 2000). The text describing the types of traumatic stressors that qualify includes events that are directly experienced, witnessed, or learned about (IOM,

2006; p. 72). Many of these traumatic stressors are relevant to and can occur during military service (e.g., military combat; sexual assault; being kidnapped or taken hostage; torture; incarceration as a prisoner of war or in a concentration camp; severe motor vehicle accidents; observing serious injuries or deaths of others due to assaults, accidents or war; learning about serious injury or deaths of friends). Veterans who have experienced some of these types of traumatic stressors might receive awards or medals documenting their exposure, but it is unlikely that exposure to many of these traumatic stressors would result in awards or medals. In any case, the *DSM-IV* diagnostic criteria for PTSD do not require having received an award, medal, or other independent recognition of exposure to a traumatic stressor for that stressor to count as a traumatic stressor.

The committee was not aware of an explicit VA regulation requiring certain awards or medals to document a stressor. It was aware that VA values such devices and other documentation found in military personnel records—duty stations and assignments, military occupational specialties (MOS), and related administrative information—because they are perceived as unbiased evidence that can corroborate or refute claimants' accounts. The committee noted and commented—on page 193 of its report—on a student guide produced by the Veterans Benefits Administration (VBA) for use in the training of examiners (VBA, 2005), stating:

. . . a great deal of guidance is given on various service medals and devices that can be used to support PTSD claims and on how to use DoD resources to corroborate possible combat-related traumatic exposures.

The Student Guide delineates a number of decorations that “may serve as evidence that the veteran engaged in combat” but indicates that the evaluation needed to support an assertion that a claimant served in the area in which the incident stressful event is reported to have occurred is to be “made on an individual case basis following analysis of all the evidence of record, particularly the veteran’s description of the events” (p. 8).

As my testimony indicated, much of the research that the committee examined calls into question whether the information available in the military personnel files is always adequate to evaluate trauma exposure and notes circumstances—notably, cases of military sexual assault—where veterans are less likely to receive service connection for PTSD as a consequence of the relative difficulty of substantiating exposure to noncombat traumatic stressors.

The VA’s disability examination workshop for an initial evaluation of PTSD states that:

[s]ervice connection for post-traumatic stress disorder (PTSD) requires medical evidence establishing a diagnosis of the condition that conforms to the diagnostic criteria of *DSM-IV*, credible supporting evidence that the claimed in-service stressor actually occurred, and a link, established by medical evidence, between current symptomatology and the claimed in-service stressor (IOM, 2006; p. 224; quoting the workshop contained at the following Web address: <http://www.vba.va.gov/bln/21/Benefits/exams/disexm43.htm>).

The committee’s report indicates that C&P examinations “. . . differ in both scope and purpose from standard clinical examinations, as their core function is to provide VBA staff with the evidentiary foundation with which a claim for a service-connected disability can be rated or denied” (IOM, 2006; p. 89). It goes on to discuss the ways in which C&P exams deviate from examinations that clinicians administer in diagnostic and treatment settings. Quoting Greenberg and Shuman (1997), the report notes on page 89:

In most instances, it is not realistic, nor is it typically the standard of care, to expect a therapist to be an investigator to validate the historical truth of what a patient discusses in therapy. . . . In contrast, the role of a forensic examiner is, among other things, to offer opinions regarding historical truth and the validity of the psychological aspects of . . . claims. The accuracy of this assessment is almost always more critical in a forensic context than it is in psychotherapy (Greenberg and Shuman, p. 53).

The requirements for documentation of a stressor for service connection of PTSD thus go beyond the diagnostic criteria set out in the *DSM-IV* (APA, 2000), but it must be remembered that the C&P exam has a different intent than the diagnostic evaluation set forth in the *DSM*.

Question 3: If Congress were to redefine the criteria for determining combat engagement to include a theater of combat operations do you think it would improve the claims process or harm it?

Response: Our IOM Committee did not address this question directly and did not make recommendations regarding it. Therefore, this response reflects my own opinion and not necessarily that of the Committee.

In my opinion, there are two advantages to clarifying the meaning of “combat with the enemy” to include service in a theater of combat operations. First, this change would highlight the fact that exposure to the types of traumatic stressors that can cause PTSD is no longer limited to those with particular Military Occupational Specialties or who are serving at the “front lines.” The distinction between serving at the front line in a combat role and at the rear in a supporting role is certainly less pronounced than it was in World War II, and anyone serving anywhere in a theater of combat operations is at risk of experiencing a wide variety of stressor events capable of producing PTSD. Second, establishing service connection for PTSD would still require an examiner to gather information about the actual traumatic events that the veteran reported they experienced within the theater of combat operations and to determine if these events were causally related to their PTSD symptoms. It would therefore be impossible for an examiner to diagnose PTSD and to establish that it is service-connected without obtaining information about specific traumatic events that happened to the veteran and determining that exposure to these events were causally related to the PTSD and/or had aggravated preexisting PTSD.

For these reasons, it is my opinion that this change would improve the claims process—not harm it.

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Committee on Veterans' Affairs
Subcommittee on Disability Assistance and Memorial Affairs
Washington, DC
April 7, 2009

Terri Tanielian
Study Co-Director, Invisible Wounds of War
RAND Center for Military Health Policy Research
1776 Main Street P.O. Box 2138
Santa Monica, CA 90407–2138

Dear Ms. Tanielian:

Thank you for testifying at the House Committee on Veterans' Affairs' Subcommittee on Disability Assistance and Memorial Affairs hearing on “The Nexus between Engaged in Combat with the Enemy and PTSD in an Era of Changing Warfare Tactics,” held on March 24, 2009. I would greatly appreciate if you would provide answers to the enclosed follow-up hearing questions by Monday, May 4, 2009.

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Due to the delay in receiving mail, please provide your responses to Ms. Megan Williams by fax at (202) 225-2034. If you have any questions, please call (202) 225-3608.

Sincerely,

John J. Hall
Chairman

**Responses of Terri Tanielian and Christine Eibner,¹ Study Co-Director
Invisible Wounds of War Study Team, The RAND Corporation
In Response to Questions From the House Committee on Veterans' Affairs
Subcommittee on Disability Assistance and Memorial Affairs**

**Hearing on "The Nexus Between Engaged in Combat With the Enemy and
PTSD in an Era of Changing Warfare Tactics"**

March 24, 2009

Chairman Hall, thank you for requesting answers to your followup hearing questions. My responses appear below, following each of your questions which are repeated here.

Question 1: The information contained in the *Invisible Wounds of War* Report is very impressive; however it seems there are still some unanswered questions. If you were going to recommend further study, what would you suggest that the VA or DoD study in order to better assist veterans with PTSD? What other data would we need to further develop the cost estimate model used by RAND?

Response: We will answer each of these sub-questions in turn. First, our recommendations for further study:

In many respects, the *Invisible Wounds of War* study raises more research questions than it provides answers. Better understanding is needed of the full range of problems (emotional, economic, social, health, and other quality-of-life deficits) that confront individuals with post-combat post traumatic stress disorder (PTSD). This knowledge is required both to enable the health care system to respond effectively and to calibrate how disability benefits are ultimately determined. Greater knowledge is needed to understand who is at risk for developing mental health problems and who is most vulnerable to relapse, and how to target treatments for these individuals. We also need to be able to accurately measure the costs and benefits of different treatment options so that fiscally responsible investments in care can be made. We need sustained research into the effectiveness of treatments, particularly treatments that can improve the functioning of individuals who do not improve from the current evidence-based therapies. Finally, we need research that evaluates the effects of policy changes implemented to address the injuries of veterans who served in Operations Enduring and Iraqi Freedom (OEF/OIF), including how such changes affect the health and well-being of the veterans, the costs to society, and the state of military readiness and effectiveness.

Addressing these vital questions will require a substantial, coordinated, and strategic research effort. We see the need for several types of studies to address these information gaps. A coordinated Federal research agenda on these issues within the veterans' population is needed. Further, to adequately address knowledge gaps will require funding mechanisms that encourage longer term research that examines a broader set of issues than can be financed within the mandated priorities of an existing funder or agency. Such a research program would likely require funding in excess of that currently devoted to PTSD research through DoD and the VA, and

¹The opinions and conclusions expressed in this testimony are the authors' alone and should not be interpreted as representing RAND or any of the sponsors of its research. This product is part of the RAND Corporation testimony series. RAND testimonies record testimony presented by RAND associates to Federal, State, or local legislative Committees; Government-appointed commissions and panels; and private review and oversight bodies. The RAND Corporation is a nonprofit research organization providing objective analysis and effective solutions that address the challenges facing the public and private sectors around the world. RAND's publications do not necessarily reflect the opinions of its research clients and sponsors.

would extend to the National Institutes of Health, the Substance Abuse and Mental Health Services Administration, the Centers for Disease Control and Prevention, and the Agency for Health Care Research and Quality. These agencies have limited research activities relevant to military and veteran populations, but these populations have not always been prioritized within their programs. Initial strategies for implementing this national research agenda include the following:

- A large, longitudinal study on the natural course of these mental health and cognitive conditions among OEF/OIF veterans, including predictors of relapse and recovery. Ideally, such a study would gather data pre-deployment, during deployment, and at multiple time points post-deployment. The study should be designed so that its findings can be generalized to all deployed servicemembers while still facilitating identification of those at highest risk, and it should focus on the causal associations between deployment and mental health conditions. A longitudinal approach would also make it possible to evaluate how use of health care services affects symptoms, functioning, and outcomes over time; how TBI and mental health conditions affect physical health, economic productivity, and social functioning; and how these problems affect the spouses and children of servicemembers and veterans. These data would greatly inform how services are arrayed to meet evolving needs within this population of veterans. They would also afford a better understanding of the costs of these conditions and the benefits of treatment so that the nation can make fiscally responsible investments in treatment and prevention programs. Some ongoing studies are examining these issues (Smith et al., 2008; Vasterling et al., 2006); however, they are primarily designed for different purposes and thus can provide only partial answers.
- Aggressive support for research to identify the most effective treatments and approaches, especially for TBI care and rehabilitation. Although many studies are already under way or under review (as a result of the recent congressional mandate for more research on Post traumatic stress disorder (PTSD) and traumatic brain injury (TBI), an analysis that identifies priority-research needs within each area could add value to the current programs by informing the overall research agenda and creating new program opportunities in areas in which research may be lacking or needed. More research is also needed to evaluate innovative treatment methods, since not all individuals benefit from the currently available treatments.
- Evaluations of new initiatives, policies, and programs. Many new initiatives and programs designed to address psychological and cognitive injuries have been put into place, ranging from screening programs and resiliency training, to use of care managers and recovery coordinators, to implementation of new therapies. Each of these initiatives and programs should be carefully evaluated to ensure that it is effective and is improving over time. Only programs that demonstrate effectiveness should be maintained and disseminated.

Second, with respect to the data that would be needed to further develop our cost estimates. As we highlighted in our earlier testimony, based on limitations in the existing literature, our model only considers costs incurred within the first 1 to 2 years following deployment. We know the consequences of PTSD, depression, and TBI can extend beyond 2 years; however, estimating long-term costs is difficult because we have limited information on the long term course of illness for these conditions under different treatment regimes. Longitudinal data on servicemembers that tracked treatment use, remission, and relapse would be necessary to fully understand costs.

Another limitation of our current model is that, because we did not have data from either DoD or the VA, we had to estimate costs based on TRICARE reimbursement rates, Medicare reimbursement rates, published literature, and civilian sources. More detailed cost and workload data from DoD and VA would allow us to estimate more accurate costs figures overall, and for these systems in particular.

Finally, there are many potential consequences of PTSD, TBI, and depression that require further study before they can be definitively linked to the illnesses. For example, we know that veterans with PTSD and depression are more likely to be homeless than other veterans. However, it is unclear whether PTSD and depression caused this homelessness. It's possible that homelessness causes depression. A better understanding of the causal relationship between homelessness and mental illness would be needed in order to confidently ascertain costs. A similar argument could be made for other potential consequences of PTSD, TBI, and depression, including family strain, drug and alcohol abuse, and violent behavior. A longitudinal study of service personnel could be used to better understand the causal relationship between mental health and cognitive conditions and downstream consequences.

Question 2: Based on your microsimulation model, could you estimate the cost to Congress, if veterans who have been deployed to a theater of combat operations were able to enter the disability compensation system within months of filing a claim rather than if they are denied?

Response: Currently, our model is not designed to answer this type of question. In order to understand costs to Congress, we'd need better information on costs to DoD and the VA, as well as any costs incurred by SSA (e.g. through disability payments) as well as through CMS (Medicaid). We'd also need a better understanding of how disability payments and access to VA health systems improve outcomes. Access to cost information from DoD and VA would enable us to partially answer this question. However, longitudinal data would be required to fully understand how veteran's benefits mitigate against the negative consequences of PTSD, TBI, and depression.

Committee on Veterans' Affairs
Subcommittee on Disability Assistance and Memorial Affairs
Washington, DC.
April 7, 2009

Rear Admiral David Smith, M.D., SHCE, USN
Joint Staff Surgeon, Office of the Chairman of the Joint Chiefs of Staff
Wounded and Survivor Care Task Force
U.S. Department of Defense
1400 Defense Pentagon
Washington, DC 20301

Dear Rear Admiral Smith:

Thank you for testifying at the House Committee on Veterans' Affairs' Subcommittee on Disability Assistance and Memorial Affairs hearing on "The Nexus between Engaged in Combat with the Enemy and PTSD in an Era of Changing Warfare Tactics," held on March 24, 2009. I would greatly appreciate if you would provide answers to the enclosed followup hearing questions by Monday, May 4, 2009.

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Due to the delay in receiving mail, please provide your responses to Ms. Megan Williams by fax at (202) 225-2034. If you have any questions, please call (202) 225-3608.

Sincerely,

John J. Hall
Chairman

Response From Rear Admiral David Smith, M.D., SHCE, USN
U.S. Department of Defense
To the House Committee on Veterans' Affairs
Subcommittee on Disability Assistance and Memorial Affairs
Hearing on "The Nexus Between Engaged in Combat With the Enemy and PTSD in an Era of Changing Warfare Tactics"
March 24, 2009

Question 1: I understand that the Defense Department has a process for agreeing on terms, which it publishes in a Dictionary of Military and Associated Terms. Can you describe how DoD develops an agreed upon understanding for the terms that are entered into the Dictionary, and are they applied consistently throughout the branches?

Response: Joint Publication (JP) 1-02, The Department of Defense Dictionary of Military and Associated Terms, (aka "the DoD Dictionary") contains terms and definitions that are commonly used throughout the DoD, but not adequately defined for DoD purposes in standard English-language dictionaries. These terms broadly underpin joint operations, education and training; as such, JP 1-02 definitions are best defined and introduced in a descriptive context that facilitates understanding.

Terms in JP 1-02 come from four sources, as follows:

- a. *Joint Doctrine*. The 77-volume Joint Doctrine¹ hierarchy issued under CJCS Title 10 authority consists of the principles that guide the employment of U.S. military forces in coordinated action toward a common objective. It represents what is taught, believed and advocated as what is right (i.e., what works best). Its purpose is to enhance the operational effectiveness of U.S. forces. Joint Doctrine is neither policy nor strategy; it is authoritative guidance that is implemented by a commander exercising judgment regarding a specific circumstance. Terminology routinely emanates from recording these principals; certain terms are therefore both defined and described in context. This is the preferred method as the narrative text of the doctrine provides contextual meaning.
- b. *Policy Issuances*. Policy issuances from the Secretary of Defense and the CJCS (specifically DoD Directives, DoD Instructions, and CJCS Instructions) have the authority of orders (vice the authoritative advice of Joint Doctrine). Certain terms are defined and then briefly described in context of these issuances. (Policy issuances do not normally have the space to provide full contextual meaning.)
- c. *NATO Agreed*. The North Atlantic Treaty Organization issues Allied joint doctrine and policy. Terms that emanate from those issuances, when agreed to by the U.S., may be entered in JP 1-02 to delineate their usage in a NATO context. (This is germane when a NATO definition may be different than a U.S. definition. Inclusion in JP 1-02 cues U.S. users to the differences.)
- d. *Specifically Directed*. Certain terms will be incorporated in JP 1-02 when specifically directed by either the Secretary of Defense or the CJCS. This normally occurs when development efforts regarding the other paths to inclusion requires a specific decision in order to progress.

It should be noted that *not* all terms defined in Joint Doctrine, in DoD or CJCS policy issuances, or agreed to in NATO are entered into JP 1-02. In the staffing relative to producing these items, terms proposed for inclusion in JP 1-02 are specifically so marked so that they may be considered in a DoD-wide context. Terms having specific, vice general application (e.g. limited applicability), such as those used in medical diagnosis or administrative determinations, are not considered appropriate for inclusion in the DoD dictionary.

The administrative process regarding the inclusion of terms in JP 1-02 involves DoD-wide² staffing. During the staffing process, any DoD component may comment on a proposal recommending approval, disapproval, or modification. The CJCS, through the Joint Staff J-7, is responsible for resolving any contentious issues that arise during staffing.

Question 2: Thank you for your observations on the problems with the DoD Disability Evaluation System. How would you suggest that DoD and VA work to streamline the process and correct deficits? a. What legislative fixes are you anticipating from Congress?

Response: Since the passing of the Career Compensation Act of 1949, DoD and VA have operated parallel systems to examine, rate and compensate disabled veterans. DoD's responsibility is to make fit versus unfit determinations; our disability ratings and compensation are based solely on the unfitting conditions. In contrast, VA examines, rates and compensates veterans based upon all service-related disabling conditions. There are different ground-rules and evidentiary standards for each, and as a result, the parallel processes produce different results. This duplicative system is confusing and frustrating to servicemembers and veterans alike. Disability compensation rules further compound the problem, frequently resulting in DoD benefits paid to servicemembers which must then be repaid before VA benefits may begin.

Prior to and since the aftermath of the Walter Reed articles in early 2007, multiple commissions and review groups have been chartered to evaluate and make recommendations on the treatment, rehabilitation and compensation of our wounded warriors and veterans. The Dole-Shalala, Scott and Nicholson reports, in particular,

¹The current Joint Doctrine library can be found at: http://www.dtic.mil/doctrine/nipr_index.html.

²DoD components which review Terminology proposals are the Office of the Secretary of Defense, the Military Departments, the CJCS and the Joint Staff, the Office of the Inspector General of the DoD, the combatant commands, the DoD agencies, field activities, and all other organizational entities in the DoD.

recommended significant reform of the Disability Evaluation and Compensation Systems. The DoD, VA and Military Departments established a DES pilot program that has streamlined within the constraints of existing statutes, moving to a single physical exam (done by VA for both DoD and VA rating purposes) and reducing the timeline for some portions of the process.

However, even with the DES pilot, the DoD and VA Disability and Compensation Systems are still frustrating and complex, and two separate ratings are still required by statute. It is our belief that the time has come for a more revolutionary, systematic overhaul of DoD and VA disability evaluation and compensation policy and procedures. Our vision is a disability and compensation system that simultaneously promotes ability—with the goal of returning all servicemembers or veterans to either continued service in the military or transition to productive lives in their community while the system appropriately compensates service-related disability. The path to this vision is not yet fully mapped, but we feel it is a journey worth taking, and we ask for your support.

Some of the possible elements of the transformed system were outlined by the Dole-Shalala and Scott commissions to include: (a) elimination of parallel activities, e.g., DoD to only determine fitness and provide annuity benefits based on longevity and rank if found unfit and VA to provide all disability ratings and associated benefits; (b) restructuring disability payments in to three components: transition, earning loss, and quality of life payments (transition payments to provide a solid base for the return of injured veterans to productive lives and to improve vocational, rehabilitation, and education completion rates. The proposed system must be transparent, relatively simple and understandable by the patients and beneficiaries it affects.

This issue has been identified by the Secretary of Defense (Sec. Gates) and Chairman of the Joint Chiefs of Staff as an important focus area for DoD and VA. To achieve this vision, continuing emphasis at the highest levels in both departments will be key components to successful analysis, determination of the specific components and enabling actions required for implementation, and ultimate achievement of the vision.

In addition, the VA and DoD need to continue to evaluate and implement “best practices” from the civilian medical community for incorporation into DES as well. Electronic records and system interfaces which support sharing of medical and personnel information between DoD, the Military Health System and VA will go a long way toward correcting inefficiencies and expediting processes. President Obama³ has identified this as a key focus area for his administration. DoD and VA are moving toward solving this part of the problem, although we are in the very early stages of resolution.

We do not have specific legislative fixes identified for the DES or Joint Virtual Lifetime Electronic Record issues to support the outlined vision at this point.

Question 3: In reviewing the single VA/DoD exam pilot program, what issues still need to be addressed in order to fully institute the program?

Response: The DES pilot program was established as a test-bed for streamlined DES processes within present statutory constructs and includes, but is not limited to, the single physical exam done by VA for both DoD and VA rating purposes. Significant, positive steps have occurred as a result of this test program, but frustration persists with a complex system which still produces ratings which are used for two separate purposes (DoD—unfitting condition only and VA—total disability rating) and often results in DoD benefits which must be repaid before VA benefits may begin.

The DES pilot program is being continually refined, and expansion to sites outside the National Capital Regions’ resource-rich environment is moving forward. Differing levels of resources at outlying locations may necessitate significant modification of procedures or changes altogether.

The 2007 Dole-Shalala report made the recommendation to “completely restructure the disability and compensation systems” to “update and simplify the disability determination and compensation system, eliminate parallel activities, reduce inequities, and provide a solid base for the return of injured veterans to productive lives.”⁴ The report also recommended that DoD and VA create individualized recovery plans for wounded servicemembers, help them navigate the complex systems through im-

³09 April 2009, The White House Briefing Room Press Release, “President Obama announces the Creation of a Joint Virtual Lifetime Electronic Record.”

⁴July 2007 “Serve, Support, Simplify”; *Report of the President’s Commission on Care for America’s Returning Wounded Warriors*, pg 6.

proved IT infrastructure and simplified underlying constructs, and improve the transfer of patient information across systems.⁵ The DoD and VA Recovery Coordination Programs provide Recovery Coordinators for seriously and severely injured servicemembers. Standard, uniform Comprehensive Recovery Plans are created for each recovering servicemember by their Recovery Coordinator and the Recovery Team. DoD and the Services are in the process of improving current IT systems to incorporate these plans. We would contend that all of these issues require more work to institute an improved program.

Question 4: Does the DoD Disability Advisory Committee that VA participates on provide any guidance on how to adjudicate PTSD claims?

Response: The DoD Disability Advisory Council (DAC) operates under the policy coordinating guidance of the Office of the Under Secretary of Defense (Transition Policy and Care Coordination) (TPCC). Its permanent membership includes Office of the Assistant Secretary of Defense (Health Affairs), Office of the Assistant Secretary of Defense (Reserve Affairs), Office of the Deputy General Counsel (Personnel and Health Policy), and Office of the Deputy Under Secretary of Defense (Military Community and Family Policy) (Casualty Affairs). Each Military Department appoints knowledgeable representatives and the Secretary of the Department of Veterans Affairs is also asked to provide representatives from the Office of the Under Secretary of Benefits and the Under Secretary for Health Affairs.

The primary objectives of the DAC are to ensure fair and equitable determination of servicemember fitness for continued duty; ensure the disability determinations are uniform across the Services; ensure servicemembers move through the DES process expeditiously and are knowledgeable about the process and kept informed of the status of their respective cases, and that due process rules are strictly followed; provide oversight and advice to the Director, TPCC and USD (P&R) regarding the efficient and effective management of the DES, and provide information for accession policy review.

The DoD is required to rate disabilities using the Veterans Affairs Schedule of Rating Disabilities (VASRD). The DoD Disability Advisory Council is the chartered venue to discuss recommendations for changes in the VASRD with the VA. In January 2009, the VBA reported that they were convening a panel of subject matter experts to evaluate the degree to which the VASRD adequately provides appropriate considerations for rating those impaired by PTSD. The VBA has stated DoD experts will be invited to participate with their experts to update this section of the VASRD; with the next meeting scheduled for May 2009.

Committee on Veterans' Affairs
Subcommittee on Disability Assistance and Memorial Affairs
Washington, DC.
April 7, 2009

Colonel Robert Ireland
Program Director, Mental Health Policy
Office of the Assistant Secretary of Defense for Health Affairs
U.S. Department of Defense
1400 Defense Pentagon
Washington, DC 20301

Dear Colonel Ireland:

Thank you for testifying at the House Committee on Veterans' Affairs' Subcommittee on Disability Assistance and Memorial Affairs hearing on "The Nexus between Engaged in Combat with the Enemy and PTSD in an Era of Changing Warfare Tactics," held on March 24, 2009. I would greatly appreciate if you would provide answers to the enclosed followup hearing questions by Monday, May 4, 2009.

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⁵ July 2007 "Serve, Support, Simplify"; *Report of the President's Commission on Care for America's Returning Wounded Warriors*, pg 6, 25-28.

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Sincerely,

John J. Hall
Chairman

**Response from Colonel Robert Ireland, U.S. Department of Defense,
To the House Committee on Veterans' Affairs,
Subcommittee on Disability Assistance and Memorial Affairs,
Hearing on "The Nexus Between Engaged in Combat With the Enemy and
PTSD in an Era of Changing Warfare Tactics"
March 24, 2009**

Question 1: In your testimony you described the diagnostic process using the DSM-IV criteria for PTSD. Does DoD require further stressor documentation for diagnosis and a disability award? What if the servicemember's record does not indicate a specific event?

Question 1(a): Does DoD determine if a servicemember has been engaged in combat with an enemy?

Response: Our Military Health System clinicians focus on the clinical aspects of diagnosis and treatment of post-traumatic stress disorder (PTSD), including therapeutic management of those who experience traumatic stress. Those who suffer psychological stress from a motor vehicle accident who have no significant physical injuries are not required to produce a police report of the mishap. In the same fashion, treating clinicians do not initiate investigations to confirm traumatic combat or deployment related exposures. Rather, if a mental disorder is diagnosed, medical records should document how the patient meets the criteria for that disorder. If specific criteria required to make a particular diagnosis are not documented, then it cannot be established by such medical records that an individual has the disorder.

When PTSD is diagnosed and treated by clinicians in the military (to include any identified stressors), it is for treatment and clinical management and not for consideration of disability award. When a member's medical condition(s) calls into question his/her ability to perform military duties, a medical evaluation board reviews the member's case. The member's case is referred to the Service's Physical Evaluation Boards (PEB) if the member fails to meet Service medical retention standards. While the member is being evaluated in the Disability Evaluation System for continued military service, his/her treatment and clinical management of medical condition(s) continue.

The Service's PEB determine the member's fitness for continued service and, if found unfit, determine the rating percentage for compensation and pension, according to applicable code and regulations.

Question 2: Does DoD have Combat Stress Teams that evaluate all servicemembers who have been on a deployment?

Response: It is DoD policy that all servicemembers receive assessments through Post-Deployment Health Assessments (PDHA) and Post-Deployment Health Reassessments (PDHRA). Questions on these assessments do evaluate servicemembers' stress-related issues. Referrals for further evaluations or treatment are made for the servicemember, if indicated.

In addition, DoD has taken a proactive stance in addressing combat and other military life stressors of servicemembers. Combat and Operational Stress teams take on essential and integral roles in the continuous monitoring, prevention, and mitigation of stress injuries in servicemembers and units throughout the deployment cycle. Based on DoD Instruction 6490.5, "Combat and Operational Stress Control (COSC) Programs," policies and programs are "implemented throughout the Department of Defense to enhance readiness, contribute to combat effectiveness, enhance the physical and behavioral health of military personnel, and to prevent or minimize adverse effects that may be associated with Combat and Operational Stress Reactions and Injuries (COSR/Is)."

The Services develop and coordinate their programs and teams, engage line leadership throughout the development and implementation of programs, and maintain common principles of combat and operational stress management of COSRs. Examples of these ongoing efforts include the Army's "Battlemind Warrior Resiliency" COSC Detachments and embedded behavioral health assets within Brigade Combat

Teams; the Air Force's "Landing Gear" program; and the Marine Corps Operational Stress Control and Readiness (OSCAR) programs. The Services COSC programs share common objectives for their members and include:

1. Preparing servicemembers for military operations;
2. Providing support during transitions;
3. Building resiliency through education and awareness;
4. Promoting family participation;
5. Reducing stigma associated with behavioral health and to promote psychological health; and
6. Assuring peer and line responsibility to ensure psychological health and readiness and to assure programs are socialized.

Question 3: Does the Post Deployment Health Reassessment Program specifically screen for PTSD? If a servicemember is exhibiting symptoms of PTSD, what is the referral process?

Response: The Post-Deployment Health Reassessment Program (PDHRA) is a clinical process designed to enhance the deployment-related continuum of care. Targeted at 3 to 6 months after returning from a contingency operation, the PDHRA provides education and a global health assessment to identify and facilitate access to care for deployment-related physical health, mental health, and re-adjustment concerns. This is just one part of the DoD Health Assessment Cycle that includes Baseline Assessment (soon after accession), Periodic Health Assessment (annually), Pre-deployment Health assessment (no earlier than 60 days before deploying), Post-Deployment Health Assessment (within 30 days of return from deployment), and Separation-Retirement.

Standardized questions covering symptoms of post-traumatic stress disorder (PTSD) are on the PDHRA. A primary care provider reviews the questions with each individual, interviews the servicemember and recommends additional specialty evaluation or treatment if clinically indicated. Quality assurance and program evaluation to assess program success is ongoing.

Treatment and followup are arranged on a continuum of care model, building on DoD and Department of Veterans Affairs partnerships. The continuum ranges from the community-based support and preclinical counseling to referral for treatment in primary care, specialty care, or community-based education or counseling services, as warranted. In addition, the military health system added behavioral health providers to the staff of many primary care settings to facilitate access to low-stigma care and support, specifically to provide referral care related to deployments.

Question 4: In your testimony, you stated that DoD providers who administer the PDHRA will refer servicemembers to the VA Web site www.afterdeployment.org if they feel they would benefit from additional information on PTSD. Can they contact a clinician through the site or find peer support through blogging?

Response: This is actually a DoD Web site that the Defense Centers of Excellence (DCoE) for Psychological Health and Traumatic Brain Injury has been collaborating on with subject matter experts from the Department of Veterans Affairs (VA). Beginning later this year, afterdeployment.org's Phase 3 development will be to provide users and senior leadership with interactive forums and features. Site enhancements will focus on incorporating innovative Web-based technologies, such as collaborative networking, podcasting, and blogging. Site design also will aim to provide users with up-to-date and user-friendly content-search and navigational systems. These features will be coordinated with the DCoE Outreach Center (866-966-1020) to provide the user a coordinated experience in receiving information and resources. The DCoE Outreach Center affords 24/7 availability of health resource consultants, although not in a direct clinical care role. Customers can engage one of our consultants via phone, email, and private chat (which will be accessible via the soon-to-be-launched dcoeoutreach.org and realwarriors.net Web sites). Peer support will be available at both of these Web sites, but clinician care will not.

Question 5: How does DoD identify Potentially Traumatic Events? Is combat stress debriefing attendance mandatory for all servicemembers after deployments and is participation documented in their service medical records?

Response: Every servicemember can report a potentially traumatic event at any point of contact with the medical system. The report will become part of the permanent medical record. They also are prompted to report combat-related exposures and head injuries during the Post-Deployment Health Assessment (PDHA) and Post-Deployment Health Reassessment (PDHRA) processes.

Critical incident stress debriefing is not endorsed by DoD policy. Research has proven this type of intervention ineffective and potentially harmful. Commanders and small group leaders do conduct operational debriefings after combat operations, which has been found helpful for members to process the experience as well as to learn valuable operational lessons. Following deployments, all Services are required to provide education and a medical threat debriefing to returning servicemembers. These educational products are tailored to the specific culture and experiences of the different Services to improve their effectiveness. The Army uses BATTLEMIND, the Marines use Marine Operational Stress Training and Marine Corps Operational Stress Control and Readiness team training, and the Air Force uses Landing Gear. These programs provide information that will assist in processing possible trauma experienced during operational deployments, identify potential signs and symptoms to watch for during the reintegration period and beyond, and provide information about the many resources available for assistance. Medical threat debriefing is mandatory during the PDHA and education is mandated as part of the PDHRA process.

Question 6: Has there been any concern that servicemembers returning from Iraq or Afghanistan are over or under reporting PTSD symptoms?

Response: Two sources of data are used to estimate the prevalence of Post-Traumatic Stress Disorder (PTSD) among U.S. military deployers. These include clinically diagnosed cases of PTSD and self-reported symptoms of PTSD on a survey.

Diagnosed Cases of PTSD

Between October 1, 2001, and December 31, 2008, there were 42,600 servicemembers who were diagnosed with PTSD at some point following the start of a deployment in support of Operations Enduring Freedom or Iraqi Freedom (OEF or OIF). A case of PTSD is defined as having at least two outpatient visits or one or more hospitalizations at which PTSD was diagnosed. The threshold of two or more outpatient visits is used to increase the likelihood that the individual actually had PTSD. A single visit on record commonly reflects someone who was evaluated for possible PTSD, but did not meet the established criteria for the diagnosis.

This number (42,600) represents 2.4 percent of the total number (1,769,116) of Active Duty, National Guard, and Reserve servicemembers who deployed for at least 30 days to OEF/OIF prior to January 1, 2009, according to the Defense Manpower Data Center deployment rosters.

The number of diagnosed cases of PTSD reported above comes from the DoD electronic medical record system and only reflects conditions that are coded by the provider as PTSD. This does not include the treatment of PTSD symptoms that are coded as something other than PTSD.

There are other important caveats to consider when interpreting these numbers. The analysis did not exclude servicemembers that had mental health encounters (including PTSD) prior to the first deployment. The analysis includes PTSD cases that occurred after a qualifying deployment regardless of how long after return the servicemember was first diagnosed—cases are not necessarily a result of an in-theater event. Results do not consider followup time for servicemembers (e.g., a servicemember who separates immediately after return from deployment carries the same weight as one who remained in service years after deployment). Identified cases only represent individuals who were diagnosed in a military medical treatment facility or where DoD was billed for medical care (e.g., TRICARE). Thus, OEF/OIF servicemembers who are not seeking treatment are not represented in the 2.4 percent figure. Finally, information from Military OneSource, VA facilities, non-DoD insurance, and non-medical providers (clergy, etc) was not available. This analysis therefore likely underestimates the actual total number of PTSD cases.

Self-Reported Symptoms of PTSD on a Survey

1. The Millennium Cohort study is a longitudinal stratified random sample of the military population followed for 20 years. Results from a recent study using these data indicated that 7.6 percent of cohort members who deployed and reported some sort of exposure to combat developed *new onset* of PTSD symptoms, compared with 1.4 percent of cohort members who were deployed and did not report combat exposures. These numbers exclude anyone with self-reported prior cases of PTSD, which means that servicemembers who had prior PTSD symptoms exacerbated by deployment would not be counted in these numbers. Furthermore, the cohort includes Air Force and Navy personnel, as well as Army personnel in a variety of support roles, many of whom would have had limited exposure to sustained ground combat experiences.

2. Studies of Brigade and Regimental Combat Teams (BCTs and RCTs), which represent about 40 percent of the total deployed force and are known have greater

exposure to sustained ground combat, have been surveyed using the same measures and scoring criteria as was used in the Millennium Cohort study. Investigators at the Walter Reed Army Institute of Research in a series of studies focused on BCTs and RCTs have shown that self-reported prevalence of PTSD symptoms during deployment and 3–12 months post-deployment ranges from 10–15 percent.

Summary

The prevalence of clinically diagnosed cases of PTSD following a deployment to OEF/OIF is 2.4 percent, subject to the limitations noted above. Prevalence of PTSD symptoms based on self-reported surveys ranges from 1.4 percent (not exposed to combat) to 15 percent (populations exposed to sustained ground combat). As a comparison from previous conflicts, Dohrenwend et al.'s (2006) reanalysis of the National Vietnam Veteran's Readjustment Study found between 9.1 percent and 12.2 percent of combat-veterans met criteria for PTSD at the time of the evaluation, which is similar to the findings of BCTs and RCTs. The true prevalence of PTSD among OEF/OIF deployers is unknown but likely underestimated, primarily as a result of the well-documented presence of stigma surrounding the reporting of mental health symptoms. Efforts are underway to reduce the stigma of seeking mental health care in the military, including the launching of the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury's "Real Warriors. Real Battles. Real Strength" public awareness campaign in May of 2009. Until our efforts to change the culture related to seeking mental health care are more successful, our reported total cases of PTSD will likely continue to be somewhat of an underestimate.

Question 7: DoD is using the VA Schedule for Rating Disabilities (VASRD) when determining fitness for duty and retirement for PTSD. Does the VASRD effectively reflect PTSD symptoms and level of impairment? What changes, if any, would you suggest be made to the VASRD so that it could be a more consistent, precise and standardized instrument for evaluating and rating PTSD?

Response: The DoD is required to rate disabilities using the Veterans Administration Schedule for Rating Disabilities (VASRD). The DoD Disability Advisory Council (DAC) now includes members from the Department of Veterans Affairs (VA) and is the chartered venue to discuss recommendations for changes in the VASRD with the VA. The DAC recommended to the Veterans Benefits Administration (VBA) a formal review of the adequacy of the VASRD to effectively reflect PTSD symptoms and impairment. The VBA reported that they are convening a panel of subject matter experts for this purpose and has confirmed that DoD experts will be invited to participate with VA experts in updating this section of the VASRD; with the next meeting scheduled for May 2009.

Committee on Veterans' Affairs
Subcommittee on Disability Assistance and Memorial Affairs
Washington, DC.
April 7, 2009

Bradley Mayes
Director, Compensation and Pension Service
Veterans Benefits Administration
U.S. Department of Veterans Affairs
810 Vermont Ave., NW
Washington, DC 20420

Dear Mr. Mayes:

Thank you for testifying at the House Committee on Veterans' Affairs' Subcommittee on Disability Assistance and Memorial Affairs hearing on "The Nexus between Engaged in Combat with the Enemy and PTSD in an Era of Changing Warfare Tactics," held on March 24, 2009. I would greatly appreciate if you would provide answers to the enclosed followup hearing questions by Monday, May 4, 2009.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for material for all Full Committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively on letter size paper, single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your responses to Ms. Megan Williams by fax at (202) 225-2034. If you have any questions, please call (202) 225-3608.

Sincerely,

John J. Hall
Chairman

Questions for the Record

**The Honorable John J. Hall, Chairman,
Subcommittee on Disability Assistance and Memorial Affairs,
House Committee on Veterans' Affairs,**

**Nexus Between Engaged in Combat With the Enemy and PTSD in an Era
of Changing Warfare Tactics**

March 24, 2009

Questions for Bradley G. Mayes

Question 1: As you acknowledged in your testimony, the language in section 1154 was enacted by Congress in 1941, and VA has had to base its rule making on it. Would you agree that 1941 language and the paradigm it represents is outdated and should be addressed by Congress to reflect a more modern era of warfare?

Response: The purpose of section 1154 is to recognize that recordkeeping during combat activity is not first priority and particular combat events, as well as the resulting harm to the individuals involved, may not be documented. Therefore, Veterans who engaged in combat have a lowered evidentiary standard for service-connecting disabilities incurred or aggravated during combat. We do not believe that this concept is outdated.

Although the technology, tactics, circumstances, and nature of warfare have evolved since section 1154 was enacted, much remains the same. Combat military personnel continue to experience events that are not recorded and receive injuries that may not be treated in Theater. Even if a combat injury is treated in Theater, some documentation consists of single paper reports and servicemembers may be treated by more than one medical support unit. In such circumstances, there is significant potential for missing or late-flowing documentation that would support a Veteran's claim.

Question 2: How is VA applying the benefit of the doubt rule in relation to section 1154(b) where it specifically states that VA shall accept lay evidence when there is no official record? Why does VA continue to develop those claims beyond the statement from the veteran? What constitutes sufficient evidence of combat participation?

Response: The Department of Veterans Affairs (VA) provides Veterans with the benefit of the doubt in any claim-related decision where the evidence for and against an issue is evenly distributed. In such circumstances, VA regulations require that the decision be made in favor of the Veteran.

With respect to section 1154(b), the Veteran's lay statement will establish the in-service incurrence or aggravation of a disease or injury if the available evidence shows engagement in combat; the Veteran alleges that the disease or injury was incurred in or aggravated in such service; and the allegations are consistent with the place, type, and circumstances of service. If the evidence for and against engagement in combat is in approximate equipoise, the Veteran will be given the benefit of doubt regarding any issue material to that determination. Awards or medals indicating combat participation, such as a Combat Infantryman Badge, Combat Action Ribbon, or Purple Heart Medal, will automatically establish combat status. When the Veteran claims combat participation, but there is no apparent evidence for this in the military records, VA will develop for evidence of combat participation. This involves researching the activities of the Veteran's unit at the time of reported combat participation. VA will request assistance from the Department of Defense (DoD) and the Joint Services Records Research Center if it is unable to find evidence of combat participation. When combat status is established, the lowered evidentiary standard established by section 1154(b) applies.

Question 3: In a hearing last April, the Disabled American Veterans testified that VA has circumvented the law by conducting improper rulemaking through its Office of General Counsel and the adjudication procedures in the M21-1MR by re-

quiring proof of combat in official military records. On what grounds does VA purport that it had the authority to redefine the intent of section 1154, which specifically states that no official records need be available?

Response: VA has not circumvented the law, conducted improper rulemaking, or redefined the intent of section 1154(b). The statute provides a lowered evidentiary standard permitting use of satisfactory lay evidence as proof of service connection for a disease or injury alleged to have been incurred or aggravated if a Veteran “engaged in combat with the enemy.” This lowered evidentiary standard establishes sufficient “proof” that a claimed disease or injury was incurred or aggravated in active service; it is not a way for a Veteran to establish “proof” of combat participation when there is no other evidence of record showing combat participation. It is clear from the language of section 1154(b) that the phrase “notwithstanding the fact that there is no official record” is linked to the “incurrence or aggravation in such service” of a disability. It is the incurrence or aggravation of a disability during active service that does not require an official record. This is distinctly different from stating that there is no need for an official record or other credible evidence showing combat participation. With respect to M21-1MR, the procedural manual does not state that proof of combat must come from official military records. To the contrary, it is much more expansive. It states: “There are no limitations as to the type of evidence that may be accepted to confirm engagement in combat. Any evidence that is probative of (serves to establish the fact at issue) combat participation may be used to support a determination that a veteran engaged in combat.”

Question 4: Can you provide the Committee a breakdown of how many Veterans’ claims were denied for PTSD by period of service, gender, and race for the last 5 years? How many are on appeal?

Response: We are unable to provide the number of claims denied for post traumatic stress disorder (PTSD) for the last 5 years. The Veterans Benefit Administration (VBA) is converting all disability claims records from our legacy system benefit delivery network (BDN) to VETSNET. In cases where the rating is not currently in VBA’s corporate database, the conversion creates a new “rating” with data from BDN. The “rating” date shows as the date of conversion, not the date the condition was granted or denied. Therefore, we cannot say with certainty when VA determined a condition to be service-connected or not. We also are unable to provide data concerning claims denied by period of service, race, or gender. Our corporate database shows that 233,265 Veterans who filed claims for PTSD at anytime in the past were denied service connection for PTSD. As of September 30, 2008, there were 344,533 Veterans service-connected for PTSD. There are currently over 25,000 appeals involving PTSD.

Question 5: What are the CPEP results on the overall quality of C&P exams when comparing exams conducted using templates to those conducted without using templates, and, specifically the results for veterans claiming PTSD? Please provide information on the use and frequency of the templates nationwide and by VISN and VAMC. What are VA’s intentions regarding mandating the use of templates?

Response: The compensation and pension examination program (CPEP) does not routinely identify the examination protocol used to prepare a report selected for quality review. Consequently, there is no current comparison data of the relative quality of template and dictated exam reports. However, a special study was conducted by CPEP during calendar 2005 comparing the quality of reports prepared under the two protocols for PTSD examinations. The table below provides the results.

Examination Protocol (CY 2005 data)

Average Scores

<i>Examination Type</i>	<i>Template</i>	<i>Dictated</i>	<i>p-value</i>
<i>Initial PTSD</i>	95%	87%	0.0628
<i>Review PTSD</i>	96%	85%	0.0154

The p-value represents the probability that an equal or greater difference in average scores would be found in a repeated test if the difference observed in this test

could be ascribed to chance alone. The low p-values signify that it is unlikely the differences seen in this test are attributable to chance alone.

Since CPEP does not routinely track template use, the latest available data is from October 2007. At that time, approximately 28,000 templates were used per month. For context, the total number of examinations the Veterans Health Administration (VHA) conducts per month ranges from about 40,000 to about 70,000.

VA recognizes the value of exam reports that are reliably thorough and that use language designed to directly support consistent application of the rating schedule. VA is also aware, however, that the template application, while useful in its current form, is not yet a fully mature application. Certain practical matters must be resolved before any systemwide mandate can be considered. Ideally, the template application and output will soon be sufficiently superior to the traditional exam worksheet/dictation approach that no mandate of template use would be necessary. Clinicians would simply choose templates because they are more efficient and assure all exam issues are addressed. Rating Veterans service representatives (RVSR) and other users would prefer template-generated reports because they are more thorough, uniformly constructed, and easier to navigate than worksheets. Mandating the use of templates is still under discussion in VA, with careful consideration being accorded to issues of user acceptance.

Question 6: What are the requirements for using templates for C&P exams by the VBA contractor? What are the results of analysis of the quality of exams in general and specifically for PTSD claims conducted by contract in comparison with exams conducted by VHA?

Response: Two companies, QTC Management, Inc. (QTC), and MES Solutions (MES), conduct compensation and pension (C&P) exams. QTC uses a proprietary exam-reporting format that corresponds to the C&P exam worksheet protocol. MES also uses a proprietary exam-reporting format that corresponds very closely with the C&P exam worksheet protocol. VA does not currently anticipate any change in this arrangement. Both contractors post completed reports to a secure Web site for retrieval by the requesting regional office.

C&P Service reviews the quality of contracted exam reports by quarter while CPEP reviews VHA quality. The following is the latest data on PTSD exam quality:

CPEP (VHA) FY08 sample size – 1,764 Initial PTSD; 1,764 Review PTSD

VHA Performance	FY2008	FY2009 (Sep–Dec)
Initial PTSD	94%	95%
Review PTSD	91%	86%

QTC and MES fiscal years run from May through April. C&P Service review yielded the following results. [QTC results shown cover May 2008–January 2009; MES results cover August 2008–January 2009].

QTC sample size: 79 Initial PTSD; 15 Review PTSD
MES sample size: 14 Initial PTSD; 7 Review PTSD

Contractor Performance	QTC	MES
Initial PTSD	98.9%	100%
Review PTSD	100%	100%

Question 7: Can you tell the Committee more about the work that is underway to update the Rating Schedule criteria for PTSD? How is that work going to impact section 1154?

Response: VBA and VHA are working together to conduct a mental health summit to be held sometime during the fourth quarter of fiscal year (FY) 2009 or first quarter of FY 2010. The summit will include a diverse representation of medical professionals from the Government and civilian sectors. The summit will focus on determining the most up-to-date rating criteria for all mental disorders, including PTSD. This work will not impact section 1154.

Committee on Veterans' Affairs
Subcommittee on Disability Assistance and Memorial Affairs
Washington, DC.
April 7, 2009

Antonette Zeiss, Ph.D.
Deputy Chief Consultant, Office of Mental Health Services
Office of Patient Care Services
Veterans Health Administration
U.S. Department of Veterans Affairs
810 Vermont Ave., NW
Washington, DC 20420

Dear Ms. Zeiss:

Thank you for testifying at the House Committee on Veterans' Affairs' Subcommittee on Disability Assistance and Memorial Affairs hearing on "The Nexus between Engaged in Combat with the Enemy and PTSD in an Era of Changing Warfare Tactics," held on March 24, 2009. I would greatly appreciate if you would provide answers to the enclosed followup hearing questions by Monday, May 4, 2009.

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Due to the delay in receiving mail, please provide your responses to Ms. Megan Williams by fax at (202) 225-2034. If you have any questions, please call (202) 225-3608.

Sincerely,

John J. Hall
Chairman

Questions for the Record

**The Honorable John J. Hall, Chairman,
Subcommittee on Disability Assistance and Memorial Affairs,
House Committee on Veterans' Affairs,**

**Nexus Between Engaged in Combat With the Enemy and PTSD in an Era
of Changing Warfare Tactics**

March 24, 2009

Questions for Antonette Zeiss, Ph.D.

Question 1: What is different about how the VHA conducts C&P exams and how it conducts standard mental health assessments as referenced in your testimony? What is the process for each?

Response: A standard mental health exam is performed for treatment purposes, and is comprised of a clinical interview with a progress note and a treatment plan. Both types of exams would use the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) to reach a medical conclusion. A C&P exam, however, is a disability exam performed for medical-legal purposes, not for treatment, and is governed by relevant statutes and regulations. The exam report is used as evidence by the Ratings Board to make service-connection determinations and to determine the average loss of earning capacity due to service-connected conditions. The C&P exam is documented by following the approved C&P worksheets or by using the compensation and pension records interchange (CAPRI) templates. A treatment plan is not provided as part of a C&P exam report.

Question 2: In your testimony, you noted that the VHA has implemented the IOM recommendation that approximately 2 hours be allocated for PTSD C&P exams. What is the current VHA average time to complete these exams?

Response: CPEP does not currently collect this data, and we do not have a database with this information. Anecdotally, 2 hours is the average time in which most providers can complete a mental health C&P exam, allowing 1 hour for the interview and 1 hour for documentation. More complex cases could take longer, up to 3 or 4 hours, but rarely would one be completed in less than 2 hours.

Question 3: In your testimony you mentioned that VHA is addressing quality and accuracy of C&P exams for PTSD through training and certification. Please provide the Committee the syllabus for this training and the process by which certification takes place. Who is the certifying agency and is competency being certified?

Response: The certifying agency is the employee education system (EES) in cooperation with CPEP. Courses are completed and recorded in the learning management system (LMS). There are six C&P certification modules with an online test associated with each one. The courses are: (1) general C&P certification, (2) musculoskeletal, (3) initial PTSD, (4) review PTSD, (5) initial mental diseases, and (6) review mental Diseases. The certification process ensures that the examiner has completed the training module and has passed a test certifying their knowledge and competency in understanding the requirements of a C&P exam. CPEP also maintains a separate list of certified C&P providers. A copy of the syllabus is attached. [The copies of the syllabus are being retained in the Committee files.]

Question 4: What is the status of the Best Practices Manual for PTSD C&P Exams? Is it mandated for all PTSD C&P exams? Are there any plans to continuously update the manual?

Response: The Best Practices Manual for PTSD C&P Exams is not currently mandated for all PTSD C&P exams. The manual is dated June 5, 2002, and VA does not currently plan to revise it. VA does however plan to update the Mental Disorders section of the VA Schedule for Rating Disabilities (VASRD). VA exam protocols and guidance will be modified consistently with any future VASRD revisions as appropriate.

Question 5: Are the electronic templates for PTSD C&P exams mandated? Are they available and used consistently throughout the VISNs?

Response: CAPRI templates are not mandated. VA is aware that the current template application is not yet a fully mature application and is known to present some problems in data input for providers.

Question 6: Does VHA have designated C&P examiners for mental health or is it a collateral duty?

Response: Both methods are used. This is a local decision; it is made on a facility basis and varies from one examining site to another. Some exams are completed by contract providers.

Question 7: Do you have access to Vet Center files when reviewing the patient treatment record before a C&P exam?

Response: Vet Center counseling files are completely confidential and are not electronic. If the Veteran chooses to share this information, they can request that it be sent to the regional office and incorporated into their claims file (C-File), thus giving the examiner access to the information in those cases only.

Question 8: What feedback, if any, does VHA get from the CPEP office?

Response: CPEP provides monthly and quarterly quality scores, assessed by using quality indicator specific findings (which allows facilities to target improvement efforts). In addition, CPEP provides narrative explanations of our decisions in cases where the facility disagrees with a CPEP "unmet" score. CPEP provides detailed explanations on an individual basis to providers' questions regarding quality indicators in order to improve exam quality.

Question 8(a): What does VHA do with those results?

Response: Quality scores are a performance measure for Veterans Integrated Service Network (VISN) directors. Practices vary, but many C&P facilities use the feedback for instructional purposes for their examiners.

Question 8(b): Are examiners held accountable for inaccurate or incomplete exams?

Response: CPEP does not hold individual examiners accountable for inaccurate or incomplete exams. We review and score the exam reports for quality indicators and for timeliness. We do not track the accuracy of C&P exam reports. Incomplete exams would likely be identified as they would score poorly on our quality review. Given the sampling strategy (statistically significant at the VISN level based on a full fiscal quarter of data), CPEP review findings are not statistically significant for individual examiners.

Question 9: Are primary care providers taking a complete military history when a Veteran first enrolls at a VA Medical Center?

Response: Primary care providers perform a complete history and physical (H&P) when a Veteran is first assigned to the provider. A portion of the H&P is seeking information about military service to ensure proper screening for identified Veteran-specific concerns such as traumatic brain injury (TBI), Agent Orange, and PTSD.

Question 10: In an era of changing warfare and tactics, is it safe to say that a stressor can be the result of individual perception? For instance, can the hardships of war, such as witnessing extreme poverty and destruction also be traumatic?

Response: The definition of a stressor as it occurs in the Diagnostic and Statistical Manual of the American Psychiatric Association, DSM-IV-TR, includes the concept that events are stressors because of the perception of the individual who experiences them. No explicit list of stressors is given. Rather, the stressor must meet two criteria:

1. "The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others;
2. The person's response involved intense fear, helplessness, or horror."

The two examples in this question, extreme poverty and destruction, could meet this definition, if they involve "threatened death or serious injury, or a threat to the physical integrity of self or others," if the individual who perceives such situations responds with "intense fear, helplessness, or horror." For example, seeing destruction in which there was clear loss of life or that created new threats to physical safety, for example after an earthquake while aftershocks continue, might be considered such a stressor. Extreme poverty that resulted in the death or potential death of others also could create such an experience. The question suggests that these might be considered stressors because of "changing warfare and tactics"; again, the identification of such events as potential stressors has always been a component of the DSM-IV-TR definition of PTSD. Poverty and destruction are characteristics of many wars, throughout human history, not just a consequence of "changing warfare and tactics." The crucial issue is whether the experiences fit the parameters thoughtfully laid out in DSM-IV-TR in defining stressors that meet Diagnostic Criterion A in the overall diagnostic criteria for PTSD.

Question 11: In its testimony, the Vietnam Veterans of America noted the significant contributions of the National Vietnam Veterans Readjustment Study to inform our understanding of disabilities related to service in Vietnam. Public Law 106-419 required VA to conduct the National Vietnam Veterans Longitudinal Study and report by October 1, 2004, which it has not done. Please provide VA's plan and timeline for implementing this study to bring the Department into compliance with the law.

Response: When initially completed back in 1988, the National Vietnam Veterans Readjustment Study (NVVRS) did make a contribution to better understanding disabilities, including PTSD, in Vietnam Veterans. Many other research studies conducted since that time have even further improved our knowledge of the health care needs of Vietnam Veterans.

VA is committed to answering the questions in Public Law (P.L.) 106-419; however, there are serious scientific concerns about using the National Vietnam Veterans Longitudinal Study (NVVLS) approach to adequately answer the questions. The concerns include:

- The NVVLS has not undergone independent scientific peer review to evaluate methodology, assess merit or ascertain feasibility.
- The NVVRS used a complex and unconventional method to diagnose PTSD that has not been used in other studies. Since the NVVRS serves as the basis for the NVVLS according to P.L. 106-419, this is a serious constraint.
- The NVVRS was not designed as a longitudinal cohort study, causing possible bias in followup. The feasibility of re-connecting with the original participants of the NVVRS is unknown, but likely to be low as longitudinal studies plan ways to keep cohorts intact through continuous contacts over time to ensure high participation rates.

Because of these concerns, VA has alternatively supported a broad portfolio of rigorous scientific studies dedicated to addressing the needs of the Vietnam Veteran population. Notably, the Department has funded major research efforts, including the Vietnam Era Twins Registry (VET-R) longitudinal followup study entitled, *A Twin Study of the Course and Consequences of Post-Traumatic Stress Disorder*

(PTSD) in Vietnam Era Veterans and is planning a study entitled, *Determining the Physical and Mental Health Status of Women Vietnam Veterans*. In addition to ongoing research, these two studies will provide answers to the questions posed in P.L. 106–419, for both male and female Vietnam Veterans. Detailed study overviews and timelines are attached.

On January 16, 2009, the Secretary of Veterans Affairs, wrote to the House and Senate Committees on Veterans' Affairs and Subcommittees on Military Construction, Veterans Affairs and Related Agencies, Committees on Appropriations, requesting that the studies proposed as alternatives to a followup on NVVLS be accepted in lieu of the proposed followup in P. L. 106–419.

Attached are overviews and timelines for the Vietnam Era Twins Registry and the Long-term Health Outcomes of Women Veterans' Service in Vietnam:

Attachments to Question 11
VA Cooperative Studies Program 569
A Twin Study of the Course and Consequences of
PTSD in Vietnam Era Veterans
Study Overview and Timeline

Study Overview

The purpose of this study is to describe and characterize the long-term course and consequences of Post-Traumatic Stress Disorder (PTSD) in Vietnam era Veterans. CSP #569 will estimate the impact of the longitudinal course of PTSD on medical and psychiatric conditions and on functioning and disability. CSP #569 is a followup of a national sample of 7,172 male Vietnam era Veteran twins who were enrolled in the Vietnam Era Twin (VET) Registry in 1987. These Veterans were diagnostically assessed for PTSD in 1992 and are known to be alive in 2007. The study will collect new data using a structured psychiatric assessment to assess current PTSD and, when combined with PTSD data from 1992, will be used to describe the long-term course of PTSD. A questionnaire will be used to collect information on physical health such as cardiovascular disease (validated by medical record review) and diabetes. Assessments of mental health outcomes, including depression, generalized anxiety disorder and substance use disorders, will also be conducted. Factors that may be related to the course and consequences of PTSD, such as physical health, health habits, psycho-social measures, and health services utilization will be collected. New data will be combined with extensive archival data (spanning over 20 years of studies from the VET Registry), and analyzed using epidemiologic and biometrical genetic methods. It is expected that results from this 4.5-year study will have broad implications for the health and health care delivered to Vietnam era Veterans as well as Veterans of recent wars. In addition to this specific study, many efforts have been directed toward updating the entire VET Registry, including seeking IRB approval to re-consent the entire cohort.

Study Timeline

April 2006	Planning request approved.
May 2006	Planning Committee membership approved.
October 2006	Planning Committee meeting #1.
October 2006	Co-principal proponents appointed; VAMC approval.
January 2007	Planning Committee meeting #2.
February 2007	Planning Committee meeting #3.
April 2007	Proposal submitted for peer review.
June 2007	Peer review; funding approval.
October 2007	Human rights committee approval.
February 2008	Revision to VET Registry recommended by ORO.
March 2008	Contractor selected.
May 2008	Protocol submitted to IRB.
July 2008	Executive committee meeting.
August 2008	Registry newsletter mailing with study information.
August 2008	Protocol submitted for Seattle R&D Committee approval.
Sept 2008	Final submission of VET Registry protocol to IRB.
October 2008	Study protocol submitted to VA Central IRB.
January 2009	Central IRB approval (with minor modification).
March 2009	VET-Registry consent begins.
May 2009	Recruitment/enrollment begins (tentative).
Mar 2009–Jun 2011	Data collection via mail survey & telephone interview.
Through 2011	Data and safety monitoring continues.
December 2011	Study closeout; publish findings.

**VA Cooperative Studies Program 579
Long-term Health Outcomes of Women Veterans' Service in Vietnam
Study Overview and Timeline**

Background

The VA Office of Research and Development (ORD) has aggressively pursued an understanding of the causes and consequences of PTSD in women Veterans. For example, the recently completed "Clinical Trial of Cognitive Behavioral Treatment for Post-Traumatic Stress Disorder in Women Veterans" was a large, multi-site randomized clinical trial focusing exclusively on female Veterans and active duty personnel. It is important because of its focus on treatment exclusively for women Veterans as well as the evaluation of a psychotherapy. Results were published JAMA February 2007 and directly impact VA PTSD treatment. In addition, CSP566, "Neuropsychological and Mental Health Outcomes of OIF: A Longitudinal Cohort Study" was approved for funding in 2007. CSP566 will use scientifically validated methods to assess the risk factors, prevalence, course, and consequences of PTSD, anxiety and depression, and traumatic brain injury (TBI) following deployment to Iraq, and is the first study ever that captured baseline performance data prior to military service for long-term follow up. VA Central IRB approval was obtained on February 19, 2009. In Spring 2008, VA senior leadership determined that these activities were not sufficient to meet the demands of fully understanding the course and consequences of PTSD in Vietnam era women, thus, CSP579 was approved for planning and is described below.

CSP579 Overview

ORD is planning a large-scale, cross-sectional study to assess general and mental health status and health service utilization in the population of women Vietnam Veterans. Many studies have examined the effects of combat or military service in male Veterans; less is known however about the consequences of military service for women, especially those who served during the Vietnam era. CSP579 will focus on determining prevalence of physical and mental disorders, including PTSD, and the possible relationship with Vietnam war-time and war-zone experience in women Veterans. The prevalence of medical conditions, including cardiovascular disease, diabetes, neurologic disease, and gender specific cancers, will be determined, and the relationship between PTSD and functional status. This information will be valuable in understanding the current mental and physical health care status of women who served in the military during the Vietnam era and determining their health care needs. The study planning Committee is comprised of scientific experts in epidemiology, women's health, health services, and psychological health, and is informed by women Vietnam Veterans including representatives on the planning Committee. Prior to the formal planning process, multiple discussions and meetings have taken place: to solicit stakeholder input and potential interest, to meet with Women in Military Service to America Foundation, to identify questions of interest, and to define the population parameters.

In addition to the women's study described here, ORD recommends pursuit of multiple scientific approaches to meet the intent of the legislation to "help the VA to better understand the long-term mental health and social needs of Vietnam Veterans" and to "prepare the VA for the long-term needs of Iraq and Afghanistan Veterans who are returning in record numbers with PTSD." Meeting these comprehensive goals require multiple, peer-reviewed studies. ORD has long been studying the Vietnam Veteran population and their needs, and more recently has aggressively supported studies to evaluate the newest generation of Veterans. All told, these studies will help VA clearly understand the needs of the Veteran population, and also provide the best treatment our health care system can provide. The following provides the timelines for CSP566 and CSP579:

CSP566 Study Timeline

Prior to 2006	Initial baseline, cohort development and data collection managed under DoD administration.
2005	Letter of intent approved for planning longitudinal data collection under VA administration.
2006	Planning Committee meetings and protocol development. Study publication <i>JAMA</i> , pre and post deployment Time 1 findings.
2007	Approved for funding.

2008	Kick-off meeting. Executive committee approved and EC meetings convened. Submission to VA Central IRB (approved on 2/19/2009).
2009	Subject enrollment begins.
2009–2011	Data collection continues; data and safety monitoring.
2012	Study closeout; results published.

CSP579, Long-term Health Outcomes of Women Veterans' Service in Vietnam Study Timeline (Draft)

May and June 2008 VA conducted individual phone calls with senior representatives of stakeholder groups.

July 2008	VA convened conference call with stakeholders.
August 2008	VA CSP coordinating center (CSPCC) began planning.
October 2008	Co-principal proponents appointed.
October 2008	Planning committee membership developed.
October 2008	Weekly telephone conference calls begin with study team.
November 2008	Plan to develop cohort, including validation and recruitment strategy.
December 2008	First planning committee meeting to define specific aims, sampling strategy, and methodology.
Dec 2008–Apr 2009	Planning committee develops study proposal.
February 2009	Second planning committee meeting to finalize protocol and proposed budget.
April 2009	Proposal submission for scientific peer review.
June 2009	Scientific panel to review proposal and consider recommendation for funding.

After proposal is approved for funding:

Summer 2009	Administrative startup; solicit bids for survey contract.
September 2009	Finalize protocol and survey contract. Submit protocol to human rights committee.
October 2009	Protocol submission to VA Central IRB. Protocol submission to R&D committee.
November 2009	Appoint executive committee. Incorporate IRB suggestions (plan for resubmission if needed).
December 2009	Hold Kick-off meeting.
January 2010–2011	Recruitment/enrollment data collection/Data and safety monitoring.
2012	Study closeout; publish findings.

Question 12: At the hearing, you testified that primary care providers have been instructed to screen all generations of Veterans for a Traumatic Brain Injury (TBI), PTSD, and Substance Abuse. Please provide a breakdown of those screened who have TBI, PTSD, or Substance Abuse by period of service, gender, and race.

Response: Data are available to address some, but not all of the information requested. The standard is that all Veterans should receive initial screening for TBI, PTSD and substance use disorder (SUD).

PTSD and SUD. The following tables provide information on the percent of all Veterans screened by gender and race for PTSD and SUD in FY 2008. Empty cells denote no users of VA services who needed a screen completed in the timeframe covered. Overall, VA screened 86 percent of all Veteran patients due for PTSD screening and 91 percent of all Veteran patients due for SUD screening. Since Veterans have the right to refuse to participate in screening, this represents a likely upper limit on the level of screening that can be obtained:

Percent of Veterans Screened for PTSD, by Age group, Gender, and Race/Ethnicity, in FY 2008									
		Amer. Indian	Asian	Black	Hispanic Black	Hispanic White	White	Unknown	TOTAL
under 30	female	*	*	*	*	*	100%	77%	78.3%
under 30	male	*	*	100%	*	*	100%	82%	83.1%
31-55	female	100%	100%	82%	*	50%	68%	84%	81.4%
31-55	male	100%	75%	84%	62%	56%	81%	84%	82.9%
31-55	Unknown	*	*	*	*	*	*	94%	94.4%
over 55	female	*	*	80%	*	75%	85%	81%	82.7%
over 55	male	88%	83%	86%	61%	52%	86%	87%	86.7%
over 55	Unknown	*	*	*	*	*	*	94%	94.3%
Grand Total—PTSD									85.6%

Percent of Veterans Screened for SUD, by Age group, Gender, and Race/Ethnicity, in FY 2008									
		Amer. Indian	Asian	Black	Hispanic Black	Hispanic White	Unknown	White	TOTAL
under 30	female	*	*	100%	*		89%	100%	90.0%
under 30	male	*	*	100%	*	100%	87%	88%	86.9%
under 30	Unknown	*	*	*	*	*	66%	*	66.7%
31-55	female	100%	100%	86%	100%	93%	88%	83%	87.2%
31-55	male	90%	86%	84%	92%	82%	89%	86%	88.0%
31-55	Unknown	*	*	*	*	*	96%	*	95.5%
over 55	female	100%	100%	83%	100%	90%	91%	92%	91.4%
over 55	male	93%	89%	88%	86%	86%	91%	91%	91.4%
over 55	Unknown	*	*	100%	*	*	91%	*	91.1%
Grand Total—SUD									90.6%

The second part of the question involves how many of those screened received a diagnosis of PTSD or SUD. By use of a randomized sample of all patients seen in primary care, the Office of Quality and Performance is currently tracking the results of the screen of Veterans for PTSD. To be “eligible” for the screen, the Veteran must not have a diagnosis of PTSD as a focus for care in the past 12 months; plus for those who separate from service, the screen is performed annually for the first 5 years after separation and then every 5 years thereafter. The sample does not distinguish between “new” to VHA or Veterans in ongoing care. The sample also does not record gender, race/ethnicity, or era of service.

A FY 2008 sample included chart reviews of approximately 116,000 Veterans who met the above criteria. Of those, 97 percent were screened for PTSD and 6.5 percent screened positive. Of those with a positive screen, results indicate that 39 percent received a complete evaluation by the time of the chart review (i.e., the others were in the process of a full evaluation but were not yet completed). Of those with a completed evaluation, 11.7 percent had a new diagnosis of PTSD, 12.5 percent were found to have had a diagnosis of PTSD greater than 1 year ago and had apparently recurred, and 75.7 percent were not found to have PTSD and were false positives.

There must be caution in the interpretation of this data. It cannot be used to estimate the prevalence of PTSD in the full population, as the full population of Veterans is not seen within VHA. In addition, the screen process does not account for those patients in whom the clinician determines a diagnosis based on presentation of symptoms by the patient outside the screening process. These data do provide information that the screen is a worthwhile process to assist in the identification of patients with PTSD.

A comparable chart review process is underway in the Office of Quality and Performance for Substance Use Disorder, but data are not available at this time.

TBI. Reported diagnostic data are only applicable to the VA patients—a population actively seeking health care—and do not represent Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) or other Veterans not enrolled for VHA health care. Further, VA does not screen all generations of Veterans for TBI, but does screen all Veterans from OEF/OIF. Compliance with TBI screening for OEF/OIF Veterans is a VA measure of performance. From April 2007–January 31, 2009, VA has screened 270,022 OEF/OIF Veterans for possible TBI, of which 17,179 have been confirmed with a diagnosis of mild TBI. Demographic information is as follows:

	Screened for TBI	Definitive TBI Diagnosis*
Total	270,022	17,179
American Indian or Alaska Native	2,389	218
	0.9%	1.3%
Asian	5,106	238
	1.9%	1.4%
Black or African American	38,196	1,907
	14.1%	11.1%
Native Hawaiian or Other Pacific Islander	2,851	198
	1.1%	1.2%
White	155,492	10,999
	57.6%	64.0%
Declined to Answer	3,945	318
	1.5%	1.9%
Unknown	2,372	195
	0.9%	1.1%
Missing	59,671	3,106
	22.1%	18.1%
Total		
Total	270,022	17,179
Female	33,560	912
	12.4%	5.3%
Male	236,345	16,260
	87.5%	94.7%
Unknown	117	7

* Attachment to Question #11.

Committee on Veterans' Affairs
Subcommittee on Disability Assistance and Memorial Affairs
Washington, DC.
April 7, 2009

Maureen Murdoch, M.D., MPH
Core Investigator, Center for Chronic Disease Outcomes Research
Minneapolis Veterans Affairs Medical Center
Veterans Health Administration
U.S. Department of Veterans Affairs
810 Vermont Ave., NW
Washington, DC 20420

Dear Ms. Murdoch:

Thank you for testifying at the House Committee on Veterans' Affairs' Subcommittee on Disability Assistance and Memorial Affairs hearing on "The Nexus between Engaged in Combat with the Enemy and PTSD in an Era of Changing Warfare Tactics," held on March 24, 2009. I would greatly appreciate if you would provide answers to the enclosed followup hearing questions by Monday, May 4, 2009.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for material for all full committee and subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively on letter size paper, single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your responses to Ms. Megan Williams by fax at (202) 225-2034. If you have any questions, please call (202) 225-3608.

Sincerely,

John J. Hall
Chairman

Questions for the Record

**The Honorable John J. Hall, Chairman
Subcommittee on Disability Assistance and Memorial Affairs
House Committee on Veterans' Affairs**

**Nexus Between Engaged in Combat With the Enemy and PTSD in an Era
of Changing Warfare Tactics**

March 24, 2009

Questions for Maureen Murdoch, M.D., MPH

Question 1: The studies you have conducted raised great concern over how fairly VA evaluates and compensates Veterans for PTSD. Other studies since yours seem to replicate your findings. So, in regard to women Veterans, how can VA do a better job of meeting their needs in the compensation process?

Response: Since my data were collected almost 10 years ago, it is unclear whether those findings still pertain. In addition, the discrepancy in rates of service connection between men and women that I described seemed to be less an issue of gender and more one of combat exposure versus sexual assault. For example, men who reported sexual assault were as unlikely as sexually assaulted women to be service connected for PTSD. Rates of service connection for combat-exposed men and women were roughly the same. Near the time of my research, VBA liberalized the evidentiary standard for service connecting PTSD related to sexual assault, and it launched several training initiatives to train claims processors on how to process claims related to personal assault. VBA also has a women's advisory group whose job is to alert leadership about emerging issues related to women Veterans, and women Veterans coordinators at all regional offices to assist women Veterans in developing their claims. Before making additional recommendations for changing the way VBA processes sexual assault claims, I would suggest that my research be updated and replicated. Of course, eradicating military sexual assault would be the very best strategy for dealing with these issues.

Question 2: Does VA need to do additional research and track female Veterans during the claims process, especially in cases of military sexual trauma?

Response: VA tracks granted claims for post-traumatic stress disorder (PTSD) due to personal trauma, but does not capture information about the nature of the verified in-service stressor(s) when a Veteran is awarded service-connected disability compensation for PTSD. VA defines personal trauma as events of human design that threaten or inflict harm that have lingering physical, emotional, or psychological symptoms. Military sexual trauma (MST) is one of the potential causes for PTSD. However, MST may also be a factor in the development of other service-related conditions, such as physical injury or depression.

Question 2(a): What else might you suggest for research?

Response: The VA disability system is second only to Social Security Disability Insurance in terms of scope and size, and I believe there are a great number of fruitful questions related to VA's disability system that researchers could explore. Replicating my earlier study to see if gender and race disparities in rates of PTSD service connection still exist might be one obvious avenue of research. I believe the most innovative, vibrant, and helpful research tends to come through specific calls to the field, e.g., in the form of requests for proposals (RFP). RFPs tend to attract very bright and creative researchers while emphasizing the importance of the topic. Any submitted proposals also benefit by being subjected to scientific peer-review, thus ensuring rigor.

Question 3: You also noted a finding of racial disparities among Veterans and PTSD awards, but did not draw a conclusion as to what was causing those disparities. Can you provide any further insights in these areas? Has there been any follow-up to that finding or are there plans to study these rating imbalances by race?

Response: Again, keep in mind that the data is 10 years old and I was unable to draw a conclusion as to what caused the racial disparity. The difference did not seem to be related to racial differences in PTSD symptoms, levels of self-reporting functioning, or combat exposures. I am currently examining the long-term impact of receiving or not receiving PTSD service connection on outcomes such as PTSD symptom severity and work, role, and social functioning. I plan to see if race interacts with PTSD service connection to affect outcomes. However, I am not aware of any follow-up findings or plans by others to examine race imbalances.

