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SWEET DREAMS AREN'T MADE OF THESE: HOW THE VA'S DISABILITY COMPENSATION PROGRAM LEAVES VETERANS ALONE IN THE NIGHTMARE OF POSTTRAUMATIC STRESS DISORDER

“Walkin’ tall, machine gun man,
They spit on me in my homeland.
Gloria sent me pictures of my boy.
Got my pills ’gainst mosquito death,
My buddy’s breathin’ his dyin’ breath.
Oh God, please, won’t you help me make it through.”¹

I. INTRODUCTION

Posttraumatic stress disorder (PTSD) already afflicts a large number of veterans,² and these numbers are only rising with the wars in Iraq and

1. ALICE IN CHAINS, *Rooster*, on *DIRT* (Sony Music 1992).

2. The National Research Council Committee on Youth Population and Military Recruitment predicted that out of 10,000 active-duty personnel, 3000–3500 “will experience some form of mental illness or psychiatric symptoms during their military career, with roughly similar short-term risk in the period following deployment to combat duty.” NAT’L RESEARCH COUNCIL, *ASSESSING FITNESS FOR MILITARY ENLISTMENT: PHYSICAL, MEDICAL & MENTAL HEALTH STANDARDS* 142 (Paul R. Sackett & Anne S. Mavor eds., 2006), *available at* http://books.nap.edu/openbook.php?record_id=11511&page=R1. The Committee also predicted that out of that 3000, “perhaps only 750 to 1,400 will seek care for their mental illness.” *Id.* Accordingly, one study of active-duty military personnel in the 1990s reported that mental disorders represented 13% of all hospitalizations. Charles W. Hoge et al., *Mental Disorders Among U.S. Military Personnel in the 1990s: Association with High Levels of Health Care Utilization and Early Military Attrition*, 159 *AM. J. PSYCHIATRY* 1576, 1578–79 (2002); *see also* Lizette Alvarez, *Nearly a Fifth of War Veterans Report Mental Disorder, a Private Study Finds*, N.Y. TIMES, Apr. 18, 2008, at A20, *available at* http://www.nytimes.com/2008/04/18/us/18vets.html?r=1&ref=posttraumatic_stress_disorder (reporting results from various surveys finding that 19% of service members exhibited symptoms of both PTSD and major depression, with 17% of active-duty troops and 25% of reservists screening positive for PTSD); Charles W. Hoge et al., *Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care*, 351 *NEW ENG. J. MED.* 13, 17–20 (2004) [hereinafter Hoge et al., *Combat Duty*] (discussing results demonstrating that “as many as 11 to 17 percent [of soldiers] may be at risk for [mental] disorders three to four months after their return from combat deployment”). One study surveying veterans of Vietnam found that 15% of male veterans suffer from PTSD. Matthew J. Friedman et al., *Post-Traumatic Stress Disorder in the Military Veteran*, 17 *PSYCHIATRIC CLINICS N. AM.* 265, 266 (1994). Similarly, more recent studies demonstrate that the same percentage of Iraq and Afghanistan veterans are diagnosed with PTSD. *Invisible Casualties: The Incidence and Treatment of Mental Health Problems by the U.S. Military*, *Hearing Before the H. Comm. on Oversight and Gov’t Reform*, 110th Cong. 7 (2007) (prepared statement of Rep. Henry A. Waxman, Chairman, Comm. on Oversight and Gov’t Reform) [hereinafter *Invisible Casualties Hearing*] (stating that 15–17% of veterans exhibit PTSD after four months and 21% after

Afghanistan.³ The daunting psychological effects of war have been acknowledged since the World War II era, albeit under the names of shell shock, traumatic war neurosis, and combat exhaustion.⁴ With the Global War on Terror, servicemen and servicewomen have deployed and redeployed to remote areas,⁵ and officials in the Department of Veterans Affairs (VA) and the Department of Defense (DOD) are struggling to meet the psychological needs of present and future veterans who suffer from PTSD.⁶ From 1999 to 2006, PTSD diagnoses in veterans *increased* by 126%, while diagnoses of other anxiety disorders *decreased* by 34%.⁷

twelve months); Charles W. Hoge et al., *Association of Posttraumatic Stress Disorder with Somatic Symptoms, Health Care Visits, and Absenteeism Among Iraq War Veterans*, 164 AM. J. PSYCHIATRY 150, 151 (2007) [hereinafter Hoge et al., *Association*] (stating that 16.6% of the nearly 3,000 veterans involved in the study met screening criteria for PTSD); *1 in 8 Returning Soldiers Suffers From PTSD*, MSNBC, June 30, 2004, <http://www.msnbc.msn.com/id/5334479/> [hereinafter *Returning Soldiers*]. In contrast, approximately 27% of civilians suffer from at least one mental disorder, and 3.6% suffer from PTSD. See generally Ronald C. Kessler et al., *The Prevalence and Correlates of Serious Mental Illness (SMI) in the National Comorbidity Survey Replication (NCS-R)*, in U.S. DEP'T OF HEALTH & HUMAN SERVS., PUB. NO. (SMA)-06-4195, MENTAL HEALTH, UNITED STATES, 2004, at 134, 135–36 (Ronald W. Manderscheid & Joyce T. Berry eds., 2004), available at <http://store.samhsa.gov/shin/content/SMA06-4195/SMA06-4195.pdf>. This means that compared with average individuals, military personnel are twice as likely to suffer from any mental disorder, and five times more likely to suffer from PTSD.

3. See Friedman et al., *supra* note 2. According to one study, for example, PTSD affects between 10% and 20% of all veterans returning from Iraq and Afghanistan. Karen H. Seal et al., *Bringing the War Back Home: Mental Health Disorders Among 103,788 US Veterans Returning from Iraq and Afghanistan Seen at Department of Veterans Affairs Facilities*, 167 ARCHIVES INTERNAL MED. 476, 478 (2007) (listing PTSD as affecting 52% of veterans suffering from a mental disorder and 13% of all veterans). According to another study, however, 40% of veterans returning from Iraq and Afghanistan will suffer from PTSD at some point in their lives. Nathan J. Comp, *War Without End*, ISTHMUS, THE DAILY PAGE, Dec. 7, 2006, <http://www.thedailypage.com/isthmus/article.php?article=5023>.

4. Friedman et al., *supra* note 2.

5. See, e.g., Elisabeth Bumiller, *Bush to Back Pentagon Plan to Redeploy 70,000 Troops*, N.Y. TIMES, Aug. 15, 2004, at N6, available at <http://www.nytimes.com/2004/08/15/world/bush-to-back-pentagon-plan-to-redeploy-70000-troops.html> (reporting then President Bush's intent to support "the most significant rearrangement of the American military since the end of the cold war"); Karen DeYoung, *Five Years in Iraq: Iraqis and Americans Offer Perspective on the War*, WASH. POST, Mar. 19, 2008, at A1, available at <http://www.washingtonpost.com/wp-dyn/content/article/2008/03/18/AR2008031803199.html> ("[E]ven U.S. officials acknowledge that the surge [in troops] has not led to the political reconciliation the administration had hoped for." (internal quotations omitted)).

6. James Dao & Thom Shanker, *No Longer a Soldier, Shinseki Has a New Mission*, N.Y. TIMES, Nov. 11, 2009, at A21, available at <http://www.nytimes.com/2009/11/11/us/politics/11vets.html>; Friedman et al., *supra* note 2, at 265; see also Comp, *supra* note 3 (acknowledging projections that 40% of veterans from Iraq and Afghanistan will acquire PTSD, as opposed to the 30% rate in Vietnam veterans). The large numbers of veterans with PTSD may be due to "longer, more frequent combat tours and to the nearly 96% survival rate of seriously injured combatants due to advances in battlefield medicine." *Id.*

7. INST. OF MED. & NAT'L RESEARCH COUNCIL, PTSD COMPENSATION AND MILITARY SERVICE 145 (2007), available at http://www.nap.edu/openbook.php?record_id=11870. This could

Even more troubling, these numbers may underrepresent the actual impact of PTSD on the Armed Forces, as soldiers fear the stigma of weakness associated with having a psychological disorder,⁸ and VA clinicians can easily confuse PTSD with other disorders such as depression or brain injury.⁹ In light of all these difficulties, it is important to focus specifically on compensation rules regarding PTSD.

Over the past few years, the media has begun to bring the veteran's story to the public. In 2007, reporters exposed the deplorable conditions at the Walter Reed Army Medical Center¹⁰ and other VA facilities.¹¹

represent veterans' willingness to bring PTSD claims or raters' willingness to recognize PTSD. *Id.* at 147.

8. *Invisible Casualties Hearing*, *supra* note 2, at 41 (testimony of Army Specialist Michael Bloodworth); see also *Returning Soldiers*, *supra* note 2 (stating that "less than half of those with [psychological] problems sought help, mostly out of fear of being stigmatized or hurting their [military] careers"); Thom Shanker, *Combating the Stigma of Psychological Injuries*, N.Y. TIMES AT WAR BLOG (Oct. 26, 2009, 17:28 EST), <http://atwar.blogs.nytimes.com/2009/10/26/combating-the-stigma-of-psychological-injuries/>.

9. Often, "[t]here are no reliable means to differentiate between symptoms involving impaired awareness that are caused by severe stress or mild traumatic brain injury, so differential diagnosis is problematic." Richard A. Bryant, *Disentangling Mild Traumatic Brain Injury and Stress Reactions*, 358 NEW ENG. J. MED. 525, 526 (2008) (footnote omitted). Moreover, several studies have shown that physical head trauma is correlated with PTSD and depression. See Hoge et al., *Association*, *supra* note 2, at 152 (finding that veterans with PTSD suffered from limb pain, hyperarousal, disturbed sleep physiology, and fatigue); Charles W. Hoge et al., *Mild Traumatic Brain Injury in U.S. Soldiers Returning from Iraq*, 358 NEW ENG. J. MED. 453, 461 (2008) (finding that "the high rates of physical health problems reported by soldiers with mild traumatic brain injury 3 to 4 months after deployment are mediated largely by PTSD or depression"); Yvonne Lee, *Study: PTSD, Not Brain Injury, May Cause Vets' Symptoms*, CNN, Jan. 30, 2008, <http://www.cnn.com/2008/HEALTH/01/30/brain.injury/index.html#cnnSTCText> (stating that "soldiers who suffered concussions in Iraq were not only at higher risk of developing post-traumatic stress disorder and depression, but also that depression and PTSD, not the head injuries, may be the cause of ongoing physical [postconcussive] symptoms"). Without screening for PTSD and depression, clinicians can erroneously diagnose—and prescribe treatment for—physical neurological injuries instead of psychological disorders. Bryant, *supra*, at 525. The combination of PTSD and depression can be particularly deadly, as such a diagnosis is associated with an increased risk of suicide. Several studies involving Vietnam veterans found that a diagnosis of PTSD and depression correlates with suicidal thinking and with a risk for suicide that is nearly double the risk for those with only PTSD. See Tim A. Bullman & Han K. Kang, *Posttraumatic Stress Disorder and the Risk of Traumatic Deaths Among Vietnam Veterans*, 182 J. NERVOUS & MENTAL DISEASE 604 (1994), available at http://journals.lww.com/jonmd/Abstract/1994/11000/Posttraumatic_Stress_Disorder_and_the_Risk_of.2.aspx; Teresa L. Kramer et al., *The Comorbidity of Post-traumatic Stress Disorder and Suicidality in Vietnam Veterans*, 24 SUICIDE & LIFE-THREATENING BEHAV. 58 (1994). More recent research projects indicate that veterans who have PTSD and two or more other mental disorders are more than five times more likely to report suicidal ideation than veterans with only PTSD. Matthew Jakupcak et al., *Posttraumatic Stress Disorder as a Risk Factor for Suicidal Ideation in Iraq and Afghanistan War Veterans*, 22 J. TRAUMATIC STRESS 303, 305–06 (2009), available at <http://onlinelibrary.wiley.com/doi/10.1002/jts.20423/pdf>.

10. The infamous Building 18 was in stark contrast with the public perception of Walter Reed as "a surgical hospital that shines as the crown jewel of military medicine." Dana Priest & Anne Hull, *Soldiers Face Neglect, Frustration At Army's Top Medical Facility*, WASH. POST, Feb. 18, 2007, at A1, available at <http://www.washingtonpost.com/wp-dyn/content/article/2007/02/17/AR20070217>

Included on the list of deteriorating facilities were many psychiatric wards,¹² where veterans were forced to tolerate not only “mouse droppings, belly-up cockroaches, stained carpets, [and] cheap mattresses”¹³ but also PTSD and other disorders.¹⁴ Then, in 2009, the shootings at Fort Hood shocked the nation,¹⁵ and regardless of the shooter’s actual reasons,¹⁶ the tragedy forced the public to look at the immense stress experienced by mental health professionals at VA

01172.html [hereinafter Priest & Hull, *Soldiers Face Neglect*]. Even with a \$30,000 grant to improve the building, decision-making bodies were more worried about a possible audit from spending increases than about improvements to holes in the walls and mold in the ceilings. *Id.*

11. See generally Anne Hull & Dana Priest, ‘*It Is Not Just Walter Reed*,’ WASH. POST, Mar. 5, 2007, at A1, available at <http://www.washingtonpost.com/wp-dyn/content/article/2007/03/04/AR2007030401394.html> [hereinafter Hull & Priest, *Walter Reed*]; *Some Veterans’ Hospitals in Shocking Shape*, ABCNEWS, Apr. 8, 2010, <http://abcnews.go.com/Primetime/story?id=132383&page=1> (recounting a hidden-camera investigation finding, among other things, “bathrooms filthy with what appeared to be human excrement” and “examining tables [that] had dried blood and medications still on them”).

12. See, e.g., Scott Farwell, *Veteran Recalls Nightmarish Conditions in Dallas VA Medical Center’s Psych Ward*, DALLAS MORNING NEWS, Apr. 15, 2008, <http://www.txcn.com/sharedcontent/dws/news/localnews/stories/041608dnmetva.3cf3820.html>; Priest & Hull, *Soldiers Face Neglect*, *supra* note 10 (stating that “[s]oldiers discharged from the psychiatric ward [at Walter Reed] are often assigned to Building 18”).

13. Priest & Hull, *Soldiers Face Neglect*, *supra* note 10.

14. See Hull & Priest, *Walter Reed*, *supra* note 11 (stating that “[n]early 64,000 of the more than 184,000 Iraq and Afghanistan war veterans who have sought VA health care have been diagnosed with potential symptoms of post-traumatic stress, drug abuse or other mental disorders as of the end of June [2007]”). The VA has reportedly taken steps to review the quality of its facilities. See *Veterans Affairs to Review Quality of 1,400 Hospitals, Clinics*, FOXNEWS.COM, Mar. 12, 2007, <http://www.foxnews.com/story/0,2933,258347,00.html>; Press Release, Dep’t of Veteran Affairs, VA Reviews Maintenance Needs for All Facilities (Mar. 21, 2007), available at <http://www1.va.gov/opa/pressrel/pressrelease.cfm?id=1314>. Still, the system is, according to some, “in shambles.” Joseph Abrams, *VA Medical System in Shambles, Veterans Groups Say*, FOXNEWS.COM, June 24, 2009, <http://www.foxnews.com/politics/2009/06/24/va-medical-shambles-veterans-groups-say/>. Not only are some veterans being denied treatment, but the ones who are treated risk exposure to infections like HIV. See, e.g., *Video: Vet Denied Screening Has Cancer*, CNN.com (Dec. 7, 2009), <http://www.cnn.com/video/#/video/health/2009/12/07/cohen.vet.denied.colonoscopy.cnn?iref=allsearch> (discussing denial of treatment); see also Bill Poovey, *Doctor: More VA Facilities Report ‘Incorrect Techniques’*, USA TODAY, May 15, 2009, http://www.usatoday.com/news/health/2009-05-15-veterans-colonoscopies_N.htm (describing HIV contamination in VA medical facilities).

15. See *Gunman Kills 12, Wounds 31 at Fort Hood*, NBC, Nov. 5, 2009, http://www.msnbc.msn.com/id/33678801/ns/us_news-crime_and_courts/; Robert D. McFadden, *Army Doctor Held in Ft. Hood Rampage*, N.Y. TIMES, Nov. 5, 2009, at A1, available at <http://www.nytimes.com/2009/11/06/us/06forthood.html>; *Officials: Fort Hood Shootings Suspect Alive; 12 Dead*, CNN, Nov. 7, 2009, <http://www.cnn.com/2009/US/11/05/texas.fort.hood.shootings/index.html>.

16. Various sources have stated that a plausible explanation for the shooter’s actions was his constant contact with PTSD. See, e.g., Press Release, PRNewswire, Secondary PTSD a Possible Factor for Fort Hood Shooter (Nov. 6, 2009), available at <http://www.prnewswire.com/news-releases/secondary-ptsd-a-possible-factor-for-fort-hood-shooter-69396797.html>. But see Jonah Goldberg, Op-Ed., *Sometimes, an Extremist Really Is an Extremist*, L.A. TIMES, Nov. 10, 2009, at A23, available at <http://articles.latimes.com/2009/nov/10/opinion/oe-goldberg10>.

facilities.¹⁷ With PTSD at the forefront of many Americans' minds, the time is ripe for us to explore what is being done to treat veterans with this disorder.

After providing a basic overview of the VA's disability compensation program, this Note will examine the ways in which the regulations would and do apply to veterans who seek treatment for PTSD. Specifically, this Note explores the scientific underpinnings—or lack thereof—of the medical aspects of the regulations. This Note will also look at the particular training deficiencies that affect a clinician's ability to accurately diagnose a veteran with PTSD, as well as the unique effects of VA procedures on veterans. In concluding that the current system is grossly insufficient, this Note will provide several specific suggestions as to how the compensation program can be revised to better treat veterans who suffer from PTSD.

II. THE DEPARTMENT OF VETERANS AFFAIRS' DISABILITY COMPENSATION PROGRAM

Over the past four decades, the Department of Veterans Affairs¹⁸ has developed and expanded regulations in the U.S. Code of Federal Regulations (C.F.R.)¹⁹ so that those who serve in the Armed Forces²⁰ may receive disability compensation after their return home. To receive such compensation, a veteran must submit an application that describes evidence of a disability and explains why the veteran believes it is connected to military service.²¹ A connection between service and the

17. Benedict Carey et al., *For Therapists in the Military, Painful Stories*, N.Y. TIMES, Nov. 7, 2009, at A1, available at <http://www.nytimes.com/2009/11/08/us/08stress.html>.

18. Two other programs are the Disability Evaluation System (DES) and the Transition Assistance Program (TAP). INST. OF MED. & NAT'L RESEARCH COUNCIL, *supra* note 7, at 114–16. The DES was designed by the DOD to compensate veterans for “military careers . . . cut short by illness or injury before they meet time-in-service requirements for retirement benefits eligibility.” *Id.* at 113. The program uses the criteria promulgated by the VA, albeit in a nonexclusive manner, and DES compensation may be granted concurrently with VA compensation. *Id.* at 115. TAP, administered jointly by the DOD, VA, and Department of Labor, was designed to help veterans make the initial transition from military service to civilian employment. *Id.* at 116.

19. See generally 38 C.F.R. pts. 3, 4.

20. See 38 C.F.R. § 3.1(a) (2006) (defining “Armed Forces” as “the United States Army, Navy, Marine Corps, Air Force, and Coast Guard, including their Reserve components”).

21. 38 C.F.R. § 3.151(a) (1989) (stating that “[a] specific claim in the form prescribed by the Secretary must be filed in order for benefits to be paid to any individual”); 38 U.S.C. § 5101(a) (2006) (stating same); INST. OF MED. & NAT'L RESEARCH COUNCIL, *supra* note 7, at 85. The veteran must file VA form 21-526 with the appropriate VA Regional Office or through the VA website. *Id.* at 118. The application then goes through several teams that review the evidence and determine whether compensation may be granted. *Id.* at 120–21.

disability, called a service connection, is established if the claimant can demonstrate that the “injury or disease resulting in disability was incurred coincident with service in the Armed Forces, or if preexisting such service, was aggravated therein.”²²

The C.F.R. includes specific criteria for various diagnoses,²³ and VA publications lay out formalized diagnostic procedures.²⁴ The VA may provide a medical examination, called a compensation and pension examination (“C & P exam”), to determine whether the disability is in fact service connected.²⁵ These exams were designed specifically for disability rating purposes,²⁶ and their results²⁷ are included in veterans’ medical records so that raters may make informed decisions.²⁸

22. 38 C.F.R. § 3.303(a) (1961); *see* 38 U.S.C. § 1131 (1998) (stating that an injury suffered while serving during a time of peace may still be compensable). A presumptive service connection for a particular disability may also be established by law. 38 U.S.C. §§ 1112, 1133 (2006); 38 C.F.R. §§ 3.306–3.309 (2006) (listing tropical diseases, diseases from exposure to herbicidal agents, and diseases after having been a prisoner of war as disabilities entitled to a presumptive service connection). However, such a presumption may be rebutted by the government if there is “affirmative evidence” that the onset of the disability occurred after service or that the disability was the result of “the veteran’s own willful misconduct.” 38 U.S.C. § 1113(a) (2006).

23. *See* 38 C.F.R. §§ 4.40–4.124(a), 4.150 (1996) (listing criteria for disabilities involving the musculoskeletal, respiratory, cardiovascular, digestive, immune, genitourinary, lymphatic, and endocrine systems, and specifying procedures for rating conditions of specific organs such as the eyes, ears, skin, and mouth); *see also* 38 C.F.R. pt. 4, app. B (2008) (listing over 700 physical disorders with which a veteran may be diagnosed during a VA examination).

24. *See* VETERANS BENEFITS ADMIN., ADJUDICATION PROCEDURES MANUAL M21-1MR, pt. III, subpt. IV, ch. 3, § D.18.f, 3-D-5 (2010), *available at* http://www.warms.vba.va.gov/admin21/m21_1/mr/part3/subptiv/ch03/ch03_sec2.doc [hereinafter MANUAL M21-1MR] (requiring that the report from a C & P exam include medical history, a record of all the veteran’s complaints, objective findings, answers and opinions specifically requested, a diagnosis, and “the clinical findings required by the rating schedule for the evaluation of the specific disability being claimed”). *See generally* DEP’T OF VETERANS AFFAIRS, CLINICIAN’S GUIDE (Lewis R. Coulson ed., 3d ed. 2002), *available at* <http://www.vetsforjustice.com/C&P%20Service%20Clinician%E%80%99s%20Guide.htm> [hereinafter DEP’T OF VETERANS AFFAIRS, CLINICIAN’S GUIDE]; MANUAL M21-1MR, *supra*, at pt. I, ch. 4.

25. 38 C.F.R. § 3.159(c)(4) (2008) (stating that a C & P exam “is necessary if the information and evidence of record does not contain sufficient competent medical evidence to decide the claim” but still contains some evidence of the disability); *see* DEP’T OF VETERANS AFFAIRS, COMPENSATION & PENSION (C&P) EXAMINATIONS, VHA HANDBOOK 1601E.01, at 1 (2009), *available at* http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2094 [hereinafter DEP’T OF VETERANS AFFAIRS, C&P EXAMINATIONS]. The veteran may also request a hearing under 38 C.F.R. 3.103(c) in order to present testimony. MANUAL M21-1MR, *supra* note 24, at pt. I, ch. 4, 4-1.

26. DEP’T OF VETERANS AFFAIRS, C&P EXAMINATIONS, *supra* note 25, at 1.

27. In recording the results of a C & P examination, a clinician is required to give an opinion as to whether there was a nexus between service and the disability. The guidelines promulgated by the VA include the relative language and relative belief in a nexus: (1) “is due to” (100% sure [that there is a nexus]), (2) “more likely than not” (greater than 50%), (3) “at least as likely as not” (equal to or greater than 50%), (4) “not at least as likely as not” (less than 50%), (5) “is not due to” (0%). DEP’T OF VETERANS AFFAIRS, CLINICIAN’S GUIDE, *supra* note 24, at 14.

28. DEP’T OF VETERANS AFFAIRS, C&P EXAMINATIONS, *supra* note 25, at 9. In rating a veteran’s disability, a rater must consider medical records, lay evidence, medical opinions, and medical treatises.

If a rater deems an injury service connected, a veteran is entitled to monthly disability compensation.²⁹ The amount of compensation depends on the degree (zero percent to one hundred percent, with one hundred percent being the most disabled) to which the veteran is disabled.³⁰ If a rater deems an injury not service connected,³¹ a dissatisfied veteran may file a Notice of Disagreement with the regional VA office³² and has the right to have a reviewer reconsider the decision.³³ A veteran who files a Notice of Disagreement must receive a Statement of the Case from the regional office that provided the rating.³⁴ Upon filing a Notice of Disagreement and receiving a Statement of the Case, a veteran may file a Substantive Appeal³⁵ with the Board of Veterans Appeals (BVA).³⁶ Further appeals may be taken to the Court of Appeals for Veterans Claims (CAVC),³⁷ then to the Court of Appeals for the Federal Circuit,³⁸ and ultimately to the Supreme Court.

MANUAL M21-1MR, *supra* note 24, at pt. III, subpt. iv, ch. 5, 5-3.

29. 38 U.S.C. §§ 1110, 1113 (2006); 38 C.F.R. § 3.4 (1979).

30. 38 C.F.R. § 4.1 (1976) (stating that percentages should be representative of “the average impairment in earning capacity resulting from such diseases and injuries [caused by military service] and their residual conditions in civil occupations”); *see* 38 C.F.R. § 1114 (2008) (delineating monthly compensation amounts from \$123 up to \$2,673 for disability ratings from 10% to 100%).

31. Every veteran is entitled to written notification of decisions “affecting the payment of benefits or granting relief.” 38 C.F.R. § 3.103(f) (2001). These notifications must include the VA’s reasons underlying its decision, the effective date of the decision, the right to an evidentiary hearing if the veteran wishes to present further evidence he considers material, and the right to appeal. *Id.*

32. While there is no time limit to file an initial compensation claim, a veteran has 120 days to file an appeal of a decision. DEP’T OF VETERANS AFFAIRS, VA PAMPHLET NO. 21-00-1, A SUMMARY OF VA BENEFITS (2009), available at <http://www.vba.va.gov/vba/benefits/factsheets/general/21-00-1.pdf>. The Notice need not include particular language but “must be in terms which can be reasonably construed as disagreement with that determination and a desire for appellate review.” 38 C.F.R. § 20.201 (1999).

33. 38 C.F.R. § 3.2600(a) (2009). The reviewer will be from the agency of original jurisdiction and may be a Veterans Service Center Manager, a Pension Management Center Manager, or a Decision Review Officer. *Id.* Upon the filing of a timely Notice of Disagreement, a review will be conducted with “no deference [given] to the decision being reviewed.” *Id.* A reviewer has the authority to “grant a benefit sought in the claim . . . but . . . may not revise the decision in a manner that is less advantageous to the claimant.” 38 C.F.R. § 3.2600(d). However, “the reviewer may reverse or revise (even if disadvantageous to the claimant) . . . on the grounds of clear and unmistakable error.” 38 C.F.R. § 3.2600(e).

34. 38 C.F.R. § 3.103(f) (2001).

35. A Substantive Appeal must include “specific arguments relating to errors of fact or law made by the agency of original jurisdiction in reaching the determination, or determinations, being appealed.” 38 C.F.R. § 20.202 (1999). Filing a proper Substantive Appeal perfects a veteran’s appeal to the Board. *Id.*

36. 38 C.F.R. § 20.200 (1999); *see also* DEP’T OF VETERANS AFFAIRS, CLINICIAN’S GUIDE, *supra* note 24, at 10. Although bound by statutes and regulations, the Board “is not bound by Department [of Veterans Affairs] manuals, circulars, or similar administrative issues.” 38 C.F.R. § 19.5 (1992).

37. Veterans’ Judicial Review Act, 38 U.S.C. §§ 7251–7299 (1988) (establishing the Court of

III. PTSD-SPECIFIC COMPENSATION REGULATIONS: SHORTCOMINGS ON PAPER AND IN PRACTICE

To comport with the regulations regarding the specific diagnosis of PTSD, a diagnosis must include (1) “medical evidence diagnosing the condition,” (2) a link between service and the disability, and (3) credible evidence to support a finding of an in-service stressor.³⁹ Although the VA has a statutory duty to assist a veteran in substantiating a claim,⁴⁰ the regulations create an initial bias against a veteran claiming disability—particularly disability that was aggravated during service—by creating the presumption that “every veteran shall be taken to have been in sound condition when examined, accepted, and enrolled in service.”⁴¹ Assuming that a veteran is able to move his claim past this initial barrier, the veteran must then battle the “crude and overly general”⁴² PTSD regulations. This Note looks first at the difficulty veterans have demonstrating symptoms of PTSD that fall within the regulations as “medical evidence,”⁴³ and then at the practical problems that additionally burden veterans with PTSD.

Veterans Appeals to review the decisions of the Board of Veterans Appeals); Veterans Programs Enhancement Act of 1998, H.R. 4110, 105th Cong. § 511(a) (1998) (renaming the Court of Veterans Appeals as the Court of Appeals for Veterans Claims). For more information on the CAVC, see *USCAVC History*, U.S. CT. OF APPEALS FOR VETERANS CLAIMS, <http://www.uscourts.cavc.gov/about/History.cfm> (last visited Feb. 12, 2011).

38. 38 U.S.C. § 7292 (2002).

39. 38 C.F.R. § 3.304(f) (2010); MANUAL M21-1MR, *supra* note 24, at pt. III, subpt. iv, ch. 4, § H, 4-H-6; see *Golz v. Shinseki*, 590 F.3d 1317, 1321–22 (Fed. Cir. 2010) (stating same).

40. 38 U.S.C. § 5103A (2006) (stating that “[t]he Secretary shall make reasonable efforts to assist a claimant in obtaining evidence necessary to substantiate the claimant’s claim for a benefit under a law administered by the Secretary”); see also 38 C.F.R. § 3.159 (2008) (stating same).

41. 38 U.S.C. §§ 1111, 1132 (2006). The military prescreen form has a vague mental illness screen that relies mostly on self-report. The initial interview asks the individual to report whether he has “seen a psychiatrist, psychologist, counselor or other professional for any reason (inpatient or outpatient) including counseling or treatment for school, adjustment, family, marriage, or any other problem to include depression, or treatment for alcohol, drug, or substance abuse.” NAT’L RESEARCH COUNCIL, *ASSESSING FITNESS*, *supra* note 2, at 143 (internal quotations omitted). The prescreening process involves “no formal psychiatric assessment” and therefore relies exclusively on self-report. *Id.* First, the person reporting is a candidate for the military and therefore has the incentive to answer “no.” Furthermore, he is also probably not an expert on mental health and therefore may not be able to detect the early signs of a mental disorder.

42. INST. OF MED. & NAT’L RESEARCH COUNCIL, *supra* note 7, at 156; see *id.* at 118–62 (examining how the rating system for mental disorders, which lists a hodgepodge of symptoms from a range of disorders, compares with the more precise system for physical disabilities).

43. On July 13, 2010, the C.F.R. was amended so that

[i]f a stressor claimed by a veteran is related to the veteran’s fear of hostile military or terrorist activity and a VA psychiatrist or psychologist . . . confirms that the claimed stressor is adequate to support a diagnosis of posttraumatic stress disorder and that the veteran’s symptoms are related to the claimed stressor, . . . the veteran’s lay testimony alone may establish the occurrence of the claimed in-service stressor.

A. The Medical Evidence Requirement Ignores Established Psychological Research, Thereby Failing to Control for Inaccurate Diagnoses

To be diagnosed with any disability in accordance with the C.F.R., “the disability [must] be symptomatic at the time service-connection is sought or awarded.”⁴⁴ In other words, the veteran must exhibit current symptomatology, or have “a current medical diagnosis,” of PTSD.⁴⁵

A psychological diagnosis is supposed to be based on C & P exam results⁴⁶ and on a clinician’s observances during a psychiatric interview.⁴⁷ However, the psychiatric interviews are optional,⁴⁸ and the veteran

Stressor Determinations for Posttraumatic Stress Disorder, 75 Fed. Reg. 39,843, 39,852 (July 13, 2010) (to be codified at 3 C.F.R. § 3.304(f)). Because this new regulation is designed to lessen the burdens of demonstrating the “nexus” and “credible evidence” elements of a PTSD claim, this Note will look only at the problems remaining with the first element.

44. *Gilpin v. West*, 155 F.3d 1353, 1355 (Fed. Cir. 1998).

45. *Golz v. Shinseki*, 590 F.3d 1317, 1321–22 (Fed. Cir. 2010).

46. The guidelines for clinicians state that a C & P examination report should include military and occupational history, a description of symptoms, and an opinion on mental and social functioning. DEP’T OF VETERANS AFFAIRS, CLINICIAN’S GUIDE, *supra* note 24, at 180.

47. *Id.* at 184–85. Compare this to the regulations for physical disabilities, injuries that are discretely observable and can be uniformly measured. *See, e.g.*, 38 C.F.R. § 4.46 (2009) (mandating “[a]ccurate measurement of the length of stumps, excursion of joints, dimensions and location of scars with respect to landmarks,” as well as “use of a goniometer in the measurement of limitation of motion” to determine functional impairment of the musculoskeletal system). Even instructions on measuring pain are described in terms of physical manifestations. *See, e.g.*, 38 C.F.R. § 4.40 (2009) (stating that “functional loss [within the musculoskeletal system] may be due to . . . pain, supported by adequate pathology and evidenced by the visible behavior of the claimant undertaking the motion” (emphasis added)); *see also* DEP’T OF VETERANS AFFAIRS, CLINICIAN’S GUIDE, *supra* note 24, at 12 (prohibiting clinicians from “us[ing] symptoms (pain) or signs (tenderness) for a diagnosis if a more exact diagnosis is known”).

48. The psychiatric interview is offered by the guidelines “as a suggestion only,” but no alternative methods are discussed. DEP’T OF VETERANS AFFAIRS, CLINICIAN’S GUIDE, *supra* note 24, at 184–86. The rationale behind this is that “most examiners have their own methods of eliciting information to be used as a basis for classification and evaluation.” *Id.* at 186. However, the VA allows a wide variety of clinicians to perform a mental health C & P examination. DEP’T OF VETERANS AFFAIRS, VHA DIRECTIVE 2006-013, QUALIFICATIONS FOR EXAMINERS PERFORMING COMPENSATION AND PENSION (C&P) MENTAL DISORDER EXAMINATIONS (2006), *available at* http://www1.va.gov/VHAPUBLICATIONS/ViewPublication.asp?pub_ID=1391 [hereinafter DEP’T OF VETERANS AFFAIRS, QUALIFICATIONS] (listing the mental health professionals who may perform a VA C & P examination). A board-eligible or board-certified psychiatrist may have developed his or her own methods of examining patients, but a doctorate-level psychology student may not have. Further, different methods necessarily have different strengths and weaknesses, and neither the guidelines nor the regulations takes this into account or offers a preference on any of the wide variety of examinations. Rather, the examining clinician is granted much deference, which loosely translates into errors being overlooked. *See, e.g.*, Office of the Inspector Gen., *Major Management Challenges*, in DEP’T OF VETERANS AFFAIRS, II FY 2008 PERFORMANCE AND ACCOUNTABILITY REPORT 276 (2008), *available at* http://www4.va.gov/budget/docs/report/archive/FY-2008_VA-PerformanceAccountabilityReport.zip [hereinafter Office of the Inspector Gen., *Major Management Challenges* 2008] (stating that the VA has been maintaining an “unacceptably high” error rate of 13% for its disability ratings); Office of the Inspector Gen., *Major Management Challenges*, in DEP’T OF VETERANS AFFAIRS, II FY

generally is not allowed to present the medical opinion of his or her own private psychiatrist.⁴⁹

The *Diagnostic and Statistical Manual of Mental Disorders IV—Text Revision*,⁵⁰ the most up-to-date compilation of mental disorders used by mental health professionals,⁵¹ lists six diagnostic criteria for PTSD.⁵² An individual (1) experiences a traumatic event.⁵³ Then, this person (2) reexperiences that event through dreams or hallucinations, (3) purposefully avoids trauma-related stimuli, and (4) experiences numbing of general responsiveness and increased alertness.⁵⁴ These altered

2009 PERFORMANCE AND ACCOUNTABILITY REPORT 182 (2009), available at http://www4.va.gov/budget/docs/report/archive/FY-2009_VA-PerformanceAccountabilityReport.zip [hereinafter Office of the Inspector Gen., *Major Management Challenges* 2009] (comparing the VA's target error rate of 10% or less with its actual error rate of 12–16% between 2004 and 2008); Office of the Inspector Gen., *Major Management Challenges*, in DEP'T OF VETERANS AFFAIRS, II FY 2010 PERFORMANCE AND ACCOUNTABILITY REPORT 165 (2010), available at http://www4.va.gov/budget/docs/report/PartII/FY2010-VAPAR_PartII_MajorManagementChallenges.pdf [hereinafter Office of the Inspector Gen., *Major Management Challenges* 2010] (stating that although the VA has begun to identify and determine root causes of error trends, 14% of errors were falsely reported to have been corrected, and over 25% of claims were incorrectly processed).

49. The regulations create a narrow exception for situations where “the issue under consideration poses a medical problem of such obscurity or complexity, or has generated such controversy in the medical community at large, as to justify solicitation of” such an opinion. 38 C.F.R. 3.328(c) (1990); see *White v. Principi*, 243 F.3d 1378, 1381 (Fed. Cir. 2001) (holding that treating physicians would be unable to consider all evidence of record, which is required under 38 C.F.R. § 3.303(a)); see also MANUAL M21-1MR, *supra* note 24, at pt. III, subpt. IV, ch. 4, § H, 4-H-19 (stating that “[w]hen requesting a PTSD examination, [a clinician should] specify that if possible, the veteran’s treating mental health professional should not perform the examination”). But see *Gardin v. Shinseki*, 613 F.3d 1374, 1377 (Fed. Cir. 2010) (stating that the opinion of a veteran’s private physician may not be discounted “solely because the physician . . . did not review the veteran’s service medical records”).

50. For simplicity, and because the manual is constantly under revision, this Note will use the general term “DSM” instead of referring to specific editions.

51. An alternative diagnostic resource is the International Classification of Diseases, developed by the World Health Organization. See *International Classification of Diseases, Ninth Revision*, code 309.81 (1996), available at ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Publications/ICD9-CM/1996/DISEASES/TABULAR/chap05.rtf. This Note will refer exclusively to the DSM because it is directly referenced in the regulations, 38 C.F.R. § 3.304(f) (2009), and it reflects input from the American Psychiatric Association and other organizations. See *DSM-IV-TR: The Current Manual*, AM. PSYCHIATRIC ASS’N, <http://www.psych.org/mainmenu/research/dsmiv/dsmivtr.aspx>. The *DSM-IV-TR*, the fourth edition’s text revision, was published in 2000. It reflects the empirical research since the publication of the *DSM-IV*, the fourth edition, in 1992, as well as the most recent updates of the federal government’s *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM). The next edition of the DSM is scheduled for publication in 2012. *Id.* For more information, see *DSM-V: The Future Manual*, AM. PSYCHIATRIC ASS’N, <http://www.psych.org/MainMenu/Research/DSMIV/DSMV.aspx>.

52. AM. PSYCHIATRIC ASS’N, *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS*, 4TH EDITION, TEXT REVISION 463–64, 467–68 (2000).

53. *Id.* at 467.

54. *Id.* at 468.

behaviors (5) endure for more than one month and (6) result in clinically significant distress.⁵⁵

Despite the fact that the regulations mandate that ratings must coincide with *DSM* criteria,⁵⁶ the courts have adhered to the view that “the symptoms listed in the *DSM*[] do not replace, but rather *supplement* the criteria listed in the general rating formula as the basis for rating PTSD claims.”⁵⁷ In fact, the courts have limited the use of the *DSM* so that the BVA may use it “only as the basis for a return of the examination report to the RO [regional office] for clarification or further examination.”⁵⁸ The courts have thereby relaxed the requirements so that the *DSM* need not be used during the initial examination, any future examinations, or any reviews of such examinations.⁵⁹

Because the regulations are silent on exactly how to diagnose PTSD, and *DSM* criteria are only “auxiliary,”⁶⁰ the obvious solution for the rater is to turn to the general rating formula for mental disorders.⁶¹ Indeed, raters are encouraged to *prefer* the general rating schedule over resources like the *DSM* because the rating schedule was designed with the VA compensation system in mind.⁶² Although the rating schedule purports to be “based upon” the *DSM*,⁶³ it deviates substantially from the manual. For example, personality disorders, which the *DSM* lists as diagnosable psychological disorders, are specifically excluded from compensation consideration.⁶⁴ The rating system is based on a sixty-year-old model

55. *Id.*; INST. OF MED. & NAT'L RESEARCH COUNCIL, *supra* note 7, at 72.

56. 38 C.F.R. § 3.304(f) (2009); 38 C.F.R. § 4.125 (2009); DEP'T OF VETERANS AFFAIRS, CLINICIAN'S GUIDE, *supra* note 24, at 180.

57. *Sellers v. Principi*, 372 F.3d 1318, 1327 (Fed. Cir. 2004) (emphasis added) (quoting *Sellers v. Principi*, 18 Vet. App. 165 (2002)) (internal quotation marks omitted).

58. *Cohen v. Brown*, 10 Vet. App. 128, 140 (1997) (emphasis added).

59. The court in *Sellers* stated that “[t]here is nothing in the plain language of the regulation that supports the argument . . . that, in rating a mental disorder, the VA must be bound by the symptoms set forth in the *DSM-IV*.” *Sellers*, 372 F.3d at 1327.

60. *Cohen*, 10 Vet. App. at 140.

61. The general rating schedule for mental disorders is located at 38 C.F.R. § 4.130 (2009).

62. See *Sellers*, 372 F.3d at 1327 (stating that “the *DSM-IV* is not directed to assigning disability ratings for mental disorders,” but “[t]hat task is accomplished in the general rating formula of section 4.130”).

63. 38 C.F.R. § 4.130 (2009).

64. Compare 38 C.F.R. § 4.127 (1996) (stating that personality disorders “are not diseases or injuries for compensation purposes”), and *Carpenter v. Brown*, 8 Vet. App. 240, 244–45 (1995) (holding that if multiple disorders are found, personality disorder must be excluded from rating except if the other disorder is a service-connected psychotic disorder (citing 38 C.F.R. § 4.127)), with AM. PSYCHIATRIC ASS'N, *supra* note 52, at 685 (defining a personality disorder as “an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual’s culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment”).

focusing on schizophrenia⁶⁵ and lists a hodgepodge of symptoms, from memory loss to obsessional rituals to disorganized speech,⁶⁶ none of which are symptoms of PTSD.⁶⁷ Plus, the primary factors in rating decisions are earnings capacity and employment compensation,⁶⁸ which ignore the fact that mental disorders can occur in episodes (e.g., anxiety disorders that manifest themselves in panic attacks)⁶⁹ and therefore may not affect the majority of one's time at work.⁷⁰ In addition, clinicians are not instructed

65. See 38 C.F.R. § 4.130 (2009). Schizophrenia is usually characterized by both positive and negative symptoms that reflect dysfunctions of "perception, inferential thinking, language and communication, behavioral monitoring, affect, fluency and productivity of thought and speech, hedonic capacity, volition and drive, and attention." AM. PSYCHIATRIC ASS'N, *supra* note 52, at 299. In schizophrenic individuals, delusions and hallucinations are often ungrounded in any real life experience; a person may suffer from delusions that he or she is being persecuted by strangers (the most common kind of delusion), or from hallucinations of voices conversing or maintaining a running commentary. *Id.* at 299–302. Although individuals who suffer from PTSD may indeed experience illusions and hallucinations, these symptoms are a means of *reexperiencing a specific traumatic event*. See *id.* at 468 (listing illusions and hallucinations as means of "acting or feeling as if the traumatic event were reoccurring"). The VA rating formula fails to take into account the specific nature of PTSD symptoms *as independent from schizophrenia symptoms*. See 38 C.F.R. § 4.130 (2009). The schedule simply states that "persistent delusions or hallucinations" may entitle a veteran to a 100% disability rating if it indicates "[t]otal occupational and social impairment." *Id.*

66. *Id.*

67. AM. PSYCHIATRIC ASS'N, *supra* note 52, at 467–68 (listing symptoms of PTSD). Memory loss is a symptom of dementia, Alzheimer's (dementia of the Alzheimer's type), stroke (vascular dementia), amnesic disorders, and various dissociative disorders like dissociative amnesia and dissociative fugue. *Id.* at 148 (stating that "[m]emory impairment is required to make the diagnosis of a dementia," including dementia of the Alzheimer's type and vascular dementia); *id.* at 172 (stating that "[i]ndividuals with an amnesic disorder are impaired in their ability to learn new information or are unable to recall previously learned information or past events"); *id.* at 520 (stating that dissociative amnesia is characterized by "an inability to recall important personal information, usually of a traumatic or stressful nature, that is too extensive to be explained by normal forgetfulness"); *id.* at 523 (stating that dissociative fugue has the essential feature of "sudden, unexpected travel away from home or one's customary place of daily activities, with inability to recall some or all of one's past"). Obsessional rituals are most commonly symptoms of obsessive-compulsive disorder and obsessive-compulsive personality disorder. *Id.* at 456 (stating that obsessive-compulsive disorder has the essential features of "recurrent obsessions or compulsions"); *id.* at 725 (stating that obsessive-compulsive personality disorder is characterized by "a preoccupation with orderliness, perfectionism, and mental and interpersonal control"). Disorganized speech is a symptom of schizophrenia, delirium disorders, and various types of dementia. *Id.* at 300 (stating that "the concept of disorganized speech . . . has been emphasized in the definition for Schizophrenia"); see also *id.* at 136 (stating that language disturbance may occur during a delirium); *id.* at 148 (stating that dementia may produce "[d]eterioration of language function").

68. See DEP'T OF VETERANS AFFAIRS, CLINICIAN'S GUIDE, *supra* note 24, at 182; INST. OF MED. & NAT'L RESEARCH COUNCIL, *supra* note 7, at 138.

69. AM. PSYCHIATRIC ASS'N, *supra* note 52, at 429 (describing a panic disorder as "a discrete period in which there is the sudden onset of intense apprehension, fearfulness, or terror, . . . [with] symptoms such as shortness of breath, palpitations, chest pain or discomfort, choking or smothering sensations, and fear of 'going crazy' or losing control").

70. For example, one study found that although nearly half of veterans with PTSD rated their health as fair to poor, less than twelve percent had missed two or more workdays in the last month because of illness. Hoge et al., *Association*, *supra* note 2, at 151.

on how to identify and measure such amorphous characteristics as social functioning and mental competency,⁷¹ and they are therefore prone to “subjective decision making.”⁷² Although the clinician guidelines lay out the (optional) *DSM* criteria for PTSD,⁷³ they give no instruction as to how these criteria are to be measured. The scales referred to in the guidelines, such as the Clinician Administered PTSD Scale, are mentioned but not substantiated,⁷⁴ and the clinician is expected to assess whether the veteran was actually exposed to trauma based only on a C & P exam and an (optional) interview.⁷⁵

Even if symptoms of PTSD are detected, they may be misattributed as symptoms of other disorders. Because “the [examination] system was designed to avoid multiple diagnoses,” clinicians are encouraged to categorize a symptom under one, and only one, diagnosis.⁷⁶ The possibility of a veteran’s having multiple psychological disorders is not taken into account,⁷⁷ even though comorbidity between PTSD and other mental disorders, particularly psychotic and anxiety disorders, is significant.⁷⁸ In addition, the guidelines for physicians conducting PTSD examinations are completely void of references to physical symptoms of PTSD,⁷⁹ even though research indicates that individuals who suffer from PTSD frequently exhibit symptoms such as limb pain, back pain, headaches, and indigestion.⁸⁰

71. DEP’T OF VETERANS AFFAIRS, CLINICIAN’S GUIDE, *supra* note 24, at 181. The guidelines list several factors of social and occupational functioning, such as “the ability to hold employment continuously; the showing of efforts to advance one’s self; satisfactory adjustment to superiors and fellow workers; conformance to social standards of the environment; the absence of eccentricities of behavior or gross errors in judgment; and freedom from the necessity of supervision.” *Id.*

72. INST. OF MED. & NAT’L RESEARCH COUNCIL, *supra* note 7, at 123.

73. DEP’T OF VETERANS AFFAIRS, CLINICIAN’S GUIDE, *supra* note 24, at 198–200.

74. *Id.* at 197–200, 201.

75. *Id.* at 196–98.

76. INST. OF MED. & NAT’L RESEARCH COUNCIL, *supra* note 7, at 94–97.

77. *Id.*

78. See generally AM. PSYCHIATRIC ASS’N, *supra* note 52; Mark W. Miller et al., *The Internalizing and Externalizing Structure of Psychiatric Comorbidity in Combat Veterans*, 21 J. TRAUMATIC STRESS 58 (2008) (developing a three-factor model to explain why PTSD is often comorbid with depression, panic disorders, antisocial personality disorder, and substance abuse disorders).

79. DEP’T OF VETERANS AFFAIRS, CLINICIAN’S GUIDE, *supra* note 24; MANUAL M21-1MR, *supra* note 24, at pt. III, subpt. iv, ch. 4, § H; *id.* at pt. IV, subpt. ii, ch. 1, § D.

80. Hoge et al., *Association*, *supra* note 2, at 151. Out of the nearly 3000 Army infantrymen surveyed, those who screened positive for PTSD reported “significantly more” somatic symptoms than those who screened negative for PTSD. *Id.* These findings “indicate[] that veterans who have served in combat and are seen with significant physical symptoms should be evaluated for PTSD and vice versa.” *Id.* at 152; see also Friedman et al., *supra* note 2, at 273–74.

B. Inadequate Training of Clinicians Directly Affects the Amounts of Compensation Received by Veterans Claiming PTSD

The manuals published by the VA specify that only clinicians with “doctoral-level training in psychopathology, diagnostic methods, and clinical interview methods” are qualified to perform PTSD examinations.⁸¹ With such a high level of education, one would expect a clinician to have the requisite training to accurately diagnose veterans.⁸² However, the Office of the Inspector General has recently reported that many clinicians are not screened for such qualifications before being employed to perform examinations.⁸³

Furthermore, very few employees, new and experienced, are provided with any training at all,⁸⁴ despite the VA’s regimented training program

81. DEP’T OF VETERANS AFFAIRS, CLINICIAN’S GUIDE, *supra* note 24, at 200–01. In 2006, the VA further specified that only five types of persons may perform such exams: board-eligible or board-certified psychiatrists; licensed doctorate-level psychologists; doctorate-level mental health providers under close supervision; psychiatry residents under close supervision; and clinical or counseling psychologists completing a one-year internship or residency under close supervision. DEP’T OF VETERANS AFFAIRS, QUALIFICATIONS, *supra* note 48, at 2. The phrase “under close supervision” requires that the relative mental health professional be supervised by a board-certified or board-eligible psychiatrist, or a licensed doctorate-level psychologist. *Id.* Such a supervisor must “[meet] with the veteran and confer[] with the examining mental health professional in providing the diagnosis and the final assessment” as well as sign the examination report. *Id.*

82. This may explain the general posture taken by the CAVC that “[m]ental health professionals are experts and are presumed to know the *DSM* requirements applicable to the practice and to have taken them into account in providing a PTSD diagnosis.” *Cohen v. Brown*, 10 Vet. App. 128, 140 (1997).

83. Office of the Inspector Gen., *Major Management Challenges* 2008, *supra* note 48, at 257 (finding that “providers’ [clinicians’] previously undisclosed medical licenses create significant problems due to their unmonitored status” and that “[p]roviders’ privileging for diagnostic and therapeutic interventions is not always appropriate to the capabilities of the medical staff and facilities”). In addition, VA Manual M21-1M states that “Veterans Service Center (VSC) employees are not expected to routinely review the credentials of clinical personnel to determine the acceptability of their reports.” MANUAL M21-1MR, *supra* note 24, at pt. III, subpt. iv, ch. 3, § D.

84. The VA “(1) does not provide new hires with ‘comprehensive training and a consistent foundation in claims processing principles;’ (2) does not assure that incumbent employees follow a ‘national standardized training curriculum’ that is made equally and fully available to all . . . and (3) does not assure that all employees receive the full cycle of training and complete an 80-hour curriculum each year.” *Examining the Effectiveness of the Veterans Benefits Administration’s Training, Performance Management, and Accountability: Hearing Before the Subcomm. on Disability Assistance and Memorial Affairs of the H. Comm. on Veterans’ Affairs*, 110th Cong. 33-38, 55 (2008) [hereinafter *Examining the Effectiveness Hearing*] (Letter from Local 2823 of American Federation of Government Employees to Dep’t of Veteran Affairs (Aug. 29, 2008)). Compare Office of the Inspector Gen., *Major Management Challenges* 2009, *supra* note 48, at 169 (listing the “develop[ment of] a credentialing and privileging assessment tool” as a planned 2010 milestone), with Office of the Inspector Gen., *Major Management Challenges* 2010, *supra* note 48, at 145–46 (not listing the development of such a tool as a completed 2010 milestone or a planned 2011 milestone).

and eighty-hour annual training requirement.⁸⁵ Out of the 150,000 VA employees who provide medical services,⁸⁶ only about 3,000 (or two percent) are trained in the most effective PTSD therapy methods to date.⁸⁷ Even for those who do receive training, individual progress is not tracked, and there are no consequences for failing to meet any certification requirements.⁸⁸ Staff has reported to the U.S. Government Accountability Office that lectures are inconsistent and that computer-based training supplements are outdated, overly theoretical, and difficult to use.⁸⁹ Even experienced staff members have expressed difficulty in meeting the eighty-hour training requirements due to heavy production workloads.⁹⁰ Because of these shortcomings, “[l]ess than 50 percent of [clinicians] passed the certification exam, even though it was an open-book test.”⁹¹ This results in “significant inconsistencies in ratings between VA’s 57 ROs [regional offices] and a high rate of remanded cases.”⁹²

85. U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-08-561, VETERANS' BENEFITS: INCREASED FOCUS ON EVALUATION AND ACCOUNTABILITY WOULD ENHANCE TRAINING AND PERFORMANCE MANAGEMENT FOR CLAIMS PROCESSORS 7–12 (2008), available at <http://www.gao.gov/new.items/d08561.pdf>.

86. DEP'T OF VETERANS AFFAIRS, 1 FY 2008 BUDGET SUBMISSION 2-1 (2007), available at http://www4.va.gov/budget/docs/summary/archive/FY-2008_VA-BudgetSubmission.zip (stating the number of employees providing medical services in 2006 and 2007 as 135,186 and 137,648, respectively); DEP'T OF VETERANS AFFAIRS, 2 FY 2011 BUDGET SUBMISSION 1B-1 (2010), available at http://www4.va.gov/budget/docs/summary/Fy2011_Volume_2-Medical_Programs_and_Information_Technology.pdf (stating the number of employees providing medical services in 2009 and 2010 as 172,338 and 178,581, respectively).

87. Office of the Inspector Gen., *Major Management Challenges* 2009, *supra* note 48, at 171; see *id.* at 175 (listing the implementation of “the latest evidence-based training modules for cognitive-behavioral treatment (CBT) for PTSD” as a planned 2010 milestone); Office of the Inspector Gen., *Major Management Challenges* 2010, *supra* note 48, at 152 (listing same as a planned 2011 milestone). For general discussion of cognitive processing therapy and prolonged exposure therapy, see NAT'L CENTER FOR POST-TRAUMATIC STRESS DISORDER, IRAQ WAR CLINICIAN GUIDE 37–39 (2d ed. 2004); Sheila A. M. Rauch et al., *Prolonged Exposure for PTSD in a Veterans Health Administration PTSD Clinic*, 22 J. TRAUMATIC STRESS 60 (2009); David J. Ready et al., *A Field Test of Group Based Exposure Therapy With 102 Veterans With War-Related Posttraumatic Stress Disorder*, 21 J. TRAUMATIC STRESS 150 (2008).

88. U.S. GOV'T ACCOUNTABILITY OFFICE, *supra* note 85, at 14–15; see *Examining the Effectiveness Hearing*, *supra* note 84, at 32 (statement of Daniel Bertoni, Dir. of Educ., Workforce & Income Sec. Issues, U.S. Gov't Accountability Office); see also *id.* at 31 (prepared statement of Hon. John J. Hall, Chairman, Subcomm. on Disability Assistance & Mem'l Affairs); Office of the Inspector Gen., *Major Management Challenges* 2008, *supra* note 48, at 278 (noting that the VA “faces a major challenge in training, reviewing the work of employees at developmental stages, and in controlling the quality of work” done by employees); Office of Inspector Gen., *Major Management Challenges* 2009, *supra* note 48, at 185 (noting same).

89. U.S. GOV'T ACCOUNTABILITY OFFICE, *supra* note 85, at 19–20.

90. *Id.* at 21.

91. *Examining the Effectiveness Hearing*, *supra* note 84, at 31 (prepared statement of Hon. John J. Hall, Chairman, Subcomm. on Disability Assistance & Mem'l Affairs).

92. *Id.*

Clinicians are also ordered to meet steep production demands regarding how many patients must be diagnosed over a particular period of time.⁹³ Clinicians race through appointments to meet these quotas⁹⁴ and are given “no meaningful feedback”⁹⁵ from their superiors regarding the quality of their work. The House Committee on Veterans’ Compensation for Posttraumatic Stress Disorder, which assessed the VA system in 2006, found no evidence of calibration or communication between rating experts.⁹⁶ This has naturally resulted in inconsistent ratings across different disorders and different VA offices.⁹⁷ However, it is the veterans—the ones who are filing for disability compensation in the first place, the ones for whom the Department of Veterans Affairs was created—who ultimately feel the brunt of these pressures. Indeed, even for those veterans who meet the diagnostic requirements of the rating system, at least one out of every ten veterans still receives an inaccurate rating.⁹⁸

93. See *id.* at 41 (prepared statement of Michael Ratajczak, Decision Review Officer, Cleveland Veterans Affairs Regional Office, Veterans Benefits Administration, U.S. Department of Veterans Affairs, on Behalf of American Federation of Government Employees, AFL-CIO) (explaining that clinicians “are often met with a choice between meeting their productivity requirements and ensuring that decisions are rendered in accordance with all applicable duty to assist requirements”); see also *id.* at 66 (prepared statement of Nicholas T. Bartzis, Veteran and Employee of the Veterans Benefits Administration) (“With the exception of productivity, I have seldom seen numerical values assigned to any of the other measures for RVSRs. As such, neither the employee nor any person who reviews their accomplishments after the fact has an accurate description of how much work the employee really did. In general, RVSRs do not obtain work credit for work such as: deferring the rating for additional development by other VA employees, instructional time for the VSR, or sufficient time for reviewing a claims file and ordering a VA exam or reordering the VA exam if it is insufficient.”); Office of Inspector Gen., *Major Management Challenges* 2010, *supra* note 48, at 156 (noting that “[t]he claims workload is expected to further increase based upon new eligibility guidelines related to PTSD”).

94. See *Examining the Effectiveness Hearing*, *supra* note 84, at 48–61 (Letter from Local 2823 of American Federation of Government Employees to Department of Veterans Affairs (Aug. 29, 2008)).

95. See *id.* at 41. Although clinicians are rated according to a scale of performance levels, the differences between those levels are extremely vague such that different levels do not really represent any significant distinctions between individual clinicians. See U.S. GOV’T ACCOUNTABILITY OFFICE, *supra* note 84; see also Office of the Inspector Gen., *Major Management Challenges* 2010, *supra* note 48, at 168 (stating that “VBA officials reported challenges maintaining productivity while also ensuring reviews of the work completed by new employees”).

96. INST. OF MED. & NAT’L RESEARCH COUNCIL, *supra* note 7, at 125–37.

97. *Id.*

98. Office of the Inspector Gen., *Major Management Challenges* 2009, *supra* note 48, at 182 (noting error rate of 12–16% between 2004 and 2008); Office of the Inspector Gen., *Major Management Challenges* 2010, *supra* note 48, at 165 (noting error rate of approximately 15%).

C. Extensive Procedural Rules Form a Bureaucratic Barrier Between a Veteran and the Receipt of Timely Compensation

Many times, even if a veteran displays symptoms of PTSD and a qualified clinician is available, overly complicated procedural rules form a barrier to treatment. A veteran claiming disability is required to file more than twenty administrative forms, and even then there is no guarantee that records of military service will make it to the VA's medical centers.⁹⁹ Assuming that all forms and records make it into the hands of appropriate medical personnel, many veterans are forced to wait in VA medical centers "for weeks with no appointments and no help from the staff to arrange them."¹⁰⁰ Even when veterans are able to meet with psychiatrists, the only things close to treatment they get are "complex cocktails of medications that raise[] concerns about accidental overdoses, addiction and side effects from interactions."¹⁰¹ Further, any decision is difficult to track because a single veteran's application can float from region to region due to understaffing, and VA regulations do not specify exactly what responsibilities each person in this process has.¹⁰² Even Defense Secretary

99. "The typical soldier is required to file 22 documents with eight different commands"—and this is just to gain access to medical facilities. Priest & Hull, *Soldiers Face Neglect*, *supra* note 10. Even then, "[t]he disappearance of necessary forms is the most common reason soldiers languish at [medical centers] longer than they should." *Id.* Some soldiers have to present letters and photos from their tours in other countries to prove that they served. *Id.*

100. Office of the Inspector Gen., *Major Management Challenges* 2009, *supra* note 48, at 180 (discussing one audit finding that out of all claims pending for more than one year, 90% were delayed for an average of more than six months, and another audit statistically projecting that about 296,000 out of 4.2 million claims folders are inaccurately tracked); Priest & Hull, *Soldiers Face Neglect*, *supra* note 10; see Office of the Inspector Gen., *Major Management Challenges* 2010, *supra* note 48, at 152–53 (discussing a July 2010 audit that "identified claims processing inefficiencies estimated to cost \$36.6 million, or \$183 million over [a] 5-year period"). Some patients become so frustrated that they leave to go home; apparently this is a common practice, as these individuals are called "call-in patients" because they sometimes check in by phone. Priest & Hull, *Soldiers Face Neglect*, *supra* note 10. Other patients, such as Master Sergeant James C. Coons, a veteran who had been positively diagnosed with PTSD, do not even have a chance to go home at all. *Invisible Casualties Hearing*, *supra* note 2, at 18–20 (statement of Richard and Carol Coons, parents of Army Master Sergeant Coons). It took Coons's parents ten days to learn how their son had died; they did not disclose the cause of death at the hearing. *Id.* at 20–21.

101. James Dao & Dan Frosch, *Feeling Warehoused in Army Trauma Care Units*, N.Y. TIMES, Apr. 24, 2010, at A1, available at <http://www.nytimes.com/2010/04/25/health/25warrior.html>.

102. INST. OF MED. & NAT'L RESEARCH COUNCIL, *supra* note 7, at 120–21. The VBA does not retain the results of the initial triage team's evaluation, and the titles and pay grades of the triage team members are the same as those of the predetermination team's members. *Id.* Therefore, finding exactly who made what decision is nearly impossible, which makes the appeal process especially difficult for veterans whose claims reach the U.S. Court of Veterans' Appeals. *Id.* at 122.

Robert Gates has acknowledged that the road to medical assistance is “frustrating, adversarial, and unnecessarily complex.”¹⁰³

After the initial rating process is completed, the BVA and CAVC are responsible for reviewing decisions of VA rating agencies for any errors.¹⁰⁴ The BVA receives approximately 40,000 appeals per year¹⁰⁵ and decides 150 or more cases per workday.¹⁰⁶ More than half of all cases decided are either allowed (granted despite the regional office’s initial denial) or remanded back to the regional offices from which they came.¹⁰⁷ However, a remand alone necessarily means a “significant[] increase [in] the time it takes for a Veteran to receive a final decision.”¹⁰⁸ Furthermore, about seventy-five percent of the remanded cases are appealed again to the Board, resulting in even more waiting time for the veteran and more time wading through a backlog of appeals for the BVA.¹⁰⁹

If a veteran’s claim is ultimately denied by the BVA, he or she may appeal to the CAVC, which has historically set aside over three-fourths of the Board decisions it reviews on the merits.¹¹⁰ The first step, however, is getting the court to even hear the case. In cases involving mental disabilities, the CAVC has adhered to the rule that the VA’s factual findings must reach the level of “clear and unmistakable error” to warrant court review.¹¹¹ Indeed, the regulations mandate that “decisions of service

103. Thom Shanker, *Combating the Stigma of Psychological Injuries*, N.Y. TIMES AT WAR BLOG, (Oct. 26, 2009, 5:28 PM), <http://atwar.blogs.nytimes.com/2009/10/26/combating-the-stigma-of-psychological-injuries/> (internal quotations omitted).

104. 38 U.S.C. § 7252 (2006) (granting the CAVC “exclusive jurisdiction to review decisions of the Board of Veterans’ Appeals”); 38 C.F.R. § 19.4 (1992) (stating the principal functions of the Board of Veterans’ Appeals).

105. CHAIRMAN, BOARD OF VETERANS’ APPEALS, DEP’T OF VETERANS AFFAIRS FISCAL YEAR 2008 REPORT TO CONGRESS 18 (2009), available at http://www.bva.va.gov/BVA/docs/Chairmans_Annual_Rpts/BVA2008AR.pdf (listing the number of cases received by the BVA from 2005 through 2008 as, respectively: 41,816; 41,802; 39,817; 40,916).

106. *Id.* at 20.

107. *Id.* at 23 (breaking down the decisions from 2005 through 2008). For these four years, about 20% of claims were allowed, and about 35% were remanded. *Id.* This is a significant decrease from prior years, as the BVA’s remand rate in 2004 was 56.8%. *Id.* at 6.

108. *Id.* at 5.

109. *Id.* at 5–6.

110. UNITED STATES COURT OF APPEALS FOR VETERANS CLAIMS, ANNUAL REPORTS 2000–2009, available at http://www.uscourts.cavc.gov/documents/Annual_Report_FY_2009_October_1_2008_to_September_30_2009.pdf; see also *Examining the Effectiveness Hearing*, *supra* note 84, at 48 (prepared statement of Ronald B. Abrams, Joint Executive Director, National Veterans Legal Services Program).

111.

It is *not* the function of this Court to decide whether a veteran was injured or whether any such injury occurred in or was aggravated during military service; rather, it is the function of this Court to decide whether such factual determinations made by the BVA in a particular case constituted clear error. . . . [U]nder the ‘clearly erroneous’ rule this Court is not

connection . . . will be accepted as correct in the absence of clear and unmistakable error.”¹¹² Furthermore, an appeal to the Federal Circuit is consistently a dead end, as the court has held it does not have jurisdiction over decisions made by the CAVC because they qualify as factual determinations.¹¹³

IV. PROGRESS AND PROPOSED CHANGES

In 2009 alone, more than ten bills relating to veterans and mental health were introduced to the House of Representatives.¹¹⁴ Although all of

permitted to substitute its judgment for that of the BVA on issues of material fact; if there is a ‘plausible’ basis in the record for the factual determination[s] of the BVA, even if this Court might not have reached the same factual determinations, we cannot overturn them.

Soyini v. Derwinski, 1 Vet. App. 540, 545–46 (1991) (citing *Gilbert v. Derwinski*, 1 Vet. App. 49, 53 (1990) (amended 1991)); see also *Moody v. Principi*, 360 F.3d 1306, 1310 (Fed. Cir. 2004) (stating that “absent a constitutional issue, [the courts] are without jurisdiction to review a factual determination or an application of law to the particular facts in an appeal from the Court of Appeals of Veterans Claims”).

112. 38 C.F.R. § 3.105(a) (2002).

113. *Bastien v. Shinseki*, 599 F.3d 1301, 1305 (Fed. Cir. 2010); *Newhouse v. Nicholson*, 497 F.3d 1298, 1302 (Fed. Cir. 2007); *Buchanan v. Nicholson*, 451 F.3d 1331, 1334 (Fed. Cir. 2006). However, the Federal Circuit has entertained claims that the CAVC misinterpreted or misapplied statutes or regulations regarding types of evidence that may be considered by a clinician. *Buchanan*, 451 F.3d at 1335 (citing 38 U.S.C. § 7292(c)).

114. H.R. 3368, 111th Cong. (2009) (Honor Act of 2009, “[t]o enhance benefits for survivors of certain former members of the Armed Forces with a history of post-traumatic stress disorder or traumatic brain injury, to enhance availability and access to mental health counseling for members of the Armed Forces and veterans, and for other purposes”); H.R. 2699, 111th Cong. (2009) (Armed Forces Behavioral Awareness Act, “[t]o improve the mental health care benefits available to members of the Armed Forces, to enhance counseling available to family members of members of the Armed Forces, and for other purposes”); H.R. 2698, 111th Cong. (2009) (Veterans and Survivors Behavioral Health Awareness Act, “[t]o improve and enhance the mental health care benefits available to veterans, to enhance counseling and other benefits available to survivors of veterans, and for other purposes”); H.R. Res. 443, 111th Cong. (2009) (expressing the support of the House of Representatives for members of the Armed Forces and veterans with post-traumatic stress disorder and their families and urging the Secretary of Veterans Affairs and the Secretary of Defense to improve the services and support available to such members, veterans, and families); H.R. Res. 261, 111th Cong. (2009) (expressing the sense of the House of Representatives that the Department of Veterans Affairs should not retreat from its responsibility to support those veterans with combat wounds or service-connected disabilities); H.R. Res. 249, 111th Cong. (2009) (expressing the sense of the House of Representatives that the Department of Veterans Affairs should take full responsibility for financing the health-care benefits earned by veterans with service-connected disabilities); H.R. 1544, 111th Cong. (2009) (“to provide for unlimited eligibility for health care for mental illnesses for veterans of combat service during certain periods of hostilities and war”); H.R. 1308, 111th Cong. (2009) (Veterans Mental Health Screening and Assessment Act, “[t]o direct the Secretary of Defense to adopt a program of professional and confidential screenings to detect mental health injuries acquired during deployment in support of a contingency operation and ultimately to reduce the incidence of suicide among veterans”); H.R. 785, 111th Cong. (2009) (“to direct the Secretary of Veterans Affairs to carry out a pilot program to provide outreach and training to certain college and university mental health centers relating to the mental health of veterans of Operation Iraqi Freedom and Operation Enduring

these bills died in committee, the individuals sponsoring these acts represent a growing consort of governmental officials who advocate better health benefits for veterans. At the recent mental health summit, Defense Secretary Robert Gates and VA Secretary Eric Shinseki expressed their commitment to interdepartmental collaboration¹¹⁵ and noted some of the specific effects of mental disabilities, including homelessness, substance abuse, family problems, and suicide.¹¹⁶ They both encouraged the VA to become an advocate for veterans instead of an adversarial barrier to health care.¹¹⁷ The VA has also announced new programs designed to specifically research¹¹⁸ and treat PTSD.¹¹⁹ In the judicial arena, the CAVC has developed an extraschedular consideration, which may be included in a diagnosis if the evidence is severe and schedular evaluations for that disability are inadequate.¹²⁰ With this development, the CAVC has adopted the position that “it is not the symptoms, but their *effects* that determine the level of impairment.”¹²¹ With various arms of the

Freedom, and for other purposes”); H.R. 784, 111th Cong. (2009) (“to direct the Secretary of Veterans Affairs to submit to Congress quarterly reports on vacancies in mental health professional positions in Department of Veterans Affairs medical facilities”).

115. Michael J. Carden, *Shinseki Cites Collaboration in Mental Health Care*, AIR FORCE PRINT NEWS TODAY, Oct. 27 2009, <http://www.af.mil/news/story.asp?id=123174629>; John DuBois, *Gates And Shinseki Speak Out Against Post-Traumatic Stress Disorder*, TALK RADIO NEWS SERVICE, Oct. 26, 2009, <http://talkradionews.com/2009/10/26/gates-and-shinseki-speak-out-against-ptsd/>; Ed Lamb, *DoD, VA Commit to Expediting, Improving Care for Veterans*, NORFOLK HEALTH CARE EXAMINER, Oct. 26, 2009, <http://www.examiner.com/x-15966-Norfolk-Health-Care-Examiner~y2009m10d26-DoD-VA-commit-to-expediting-improving-care-for-veterans>; see also *Obama Announces New Record System for Vets*, MSNBC, Apr. 9, 2009, <http://www.msnbc.msn.com/id/30137931/> (encouraging the VA and Department of Defense to adopt an electronic record-keeping system).

116. Carden, *supra* note 115.

117. Kimberly Hefling, *Gates: Injured Troops Face Too Much Bureaucracy*, ABCNEWS, Oct. 26, 2009, <http://abcnews.go.com/Politics/wireStory?id=8918320>.

118. Press Release, Dep’t of Veterans Affairs, Secretary Shinseki Announces New Efforts to Explore Health Consequences of Service in Vietnam (Sept. 14, 2009), *available at* <http://www1.va.gov/opa/pressrel/pressrelease.cfm?id=1766> (a research project expected to run from 2011 through 2013 that will continue and expand PTSD research that ended in the late 1980s); see also Press Release, Dep’t of Veterans Affairs, Registration Opens for VA Forum on Women Veterans: VA to Help Blind Women Veterans Communities and Networks (Nov. 19, 2009), *available at* <http://www1.va.gov/opa/pressrel/pressrelease.cfm?id=1821> (one part of the PTSD-focused study that will assess the post-war effects of deployment on women).

119. Press Release, Dep’t of Veterans Affairs, VA Secretary Helps Launch The Red Sox Foundation-Massachusetts General Hospital Home Base Program (Sept. 17, 2009), *available at* <http://www1.va.gov/opa/pressrel/pressrelease.cfm?id=1768> (a program expressing four main goals: diagnosing and caring for veterans, family support, research, and community education).

120. Thun v. Peake, 22 Vet. App. 111, 115 (2008). After reviewing the full diagnosis, the VA Board “must determine whether the claimant’s exceptional disability picture exhibits other related factors.” *Id.* at 116. Based on this decision, the Under Secretary for Benefits or the Director of the Compensation and Pension Service must make “a determination of whether, to accord justice, the claimant’s disability picture requires the assignment of an extraschedular rating.” *Id.*

121. *Id.* at 118 (emphasis added) (internal quotations omitted) (citing *Mauerhan v. Principi*, 16

government moving to support veterans with PTSD, the prospect of improvement is closer than ever.

The rating system as it stands now is full of confusing medical jargon. As the VA has begun to acknowledge, these regulations must be revised so that veterans with PTSD may have their claims properly reviewed and receive appropriate treatment.¹²² The VA has recently promulgated a new regulation that would change the evidentiary burdens on veterans claiming PTSD by allowing a veteran's testimony of "fear of hostile military or terrorist activity" to establish a service connection.¹²³ Still, even though subjective fear of war-related stimuli may be one element of PTSD, it is not the only stressor that can be incorporated into the regulations.¹²⁴ A first step in improving the rating system—and possibly toward securing the approval of medical organizations¹²⁵—would be to make use of the *DSM* mandatory, not merely a suggestion. Although the federal regulations require a rating to comply with the *DSM*,¹²⁶ the relevant case law makes use of the *DSM* completely optional at all stages of compensation.¹²⁷ If the CAVC were to make the *DSM* criteria mandatory, the prospect of a standardized test for PTSD would be more realistic, and diagnoses across medical centers would most likely become more calibrated with further instruction. This may also lessen the VA's one-out-of-ten error rate, about which the Office of the Inspector General has expressed concern.¹²⁸

Vet. App. 436, 443 (2002)); *see also* *Barringer v. Peake*, 22 Vet. App. 242, 245 (2008) (pointing out that the extraschedular rating is difficult and still uses employment performance as a key component).

122. Press Release, Dep't of Veterans Affairs, Secretary Shinseki Moves to Simplify PTSD Compensation Rules (Aug. 24, 2009), *available at* <http://www1.va.gov/opa/pressrel/pressrelease.cfm?id=1751>.

123. Stressor Determinations for Posttraumatic Stress Disorder, 75 Fed. Reg. 39,843, 39,852 (proposed July 13, 2010) (to be codified at 38 C.F.R. § 3.304(f)).

124. *See, e.g.,* Zahava Solomon et al., *The Contribution of Stressful Life Events Throughout the Life Cycle to Combat-Induced Psychopathology*, 21 J. TRAUMATIC STRESS 318, 320–24 (2008) (finding that negative childhood events such as death of family member and negative postwar events such as divorce or termination from work are positively correlated with PTSD, although wartime stress remained a very high indicator); Marcus K. Taylor et al., *Behavioral Predictors of Acute Stress Symptoms During Intense Military Training*, 22 J. TRAUMATIC STRESS 212, 216 (2009) (citations omitted) (finding that soldiers with emotion-oriented and avoidant coping styles are more at risk for PTSD than those with other styles).

125. Currently, both the American Psychiatric Association and American Medical Association decline to approve of rating systems for mental disorders. INST. OF MED. & NAT'L RESEARCH COUNCIL, *supra* note 7, at 151–53.

126. 38 C.F.R. § 4.125 (1996).

127. *See* *Sellers v. Principi*, 372 F.3d 1318, 1327 (Fed. Cir. 2004); *Cohen v. Brown*, 10 Vet. App. 128, 140 (1997).

128. Office of the Inspector Gen., *Major Management Challenges* 2008, *supra* note 48, at 276; Office of the Inspector Gen., *Major Management Challenges* 2009, *supra* note 48, at 182; Office of the Inspector Gen., *Major Management Challenges* 2010, *supra* note 48, at 156–60 (stating the VA's goal of processing claims with 98% accuracy by the year 2015).

In addition, better methods may be implemented to target the high prevalence of PTSD in the military. Instead of general psychological screenings, tests that specifically target PTSD and incorporate self-reports should be used in light of their comparative reliability.¹²⁹ The most modern, most effective treatment methods, like prolonged exposure therapy and cognitive processing therapy, should be at least offered to veterans who demonstrate a risk of PTSD.¹³⁰ The VA seems to be receptive to changes in methodology,¹³¹ which means that the only step remaining is implementation.

The VA has recently used nearly \$17 million from federal stimulus funds¹³² to create new jobs and hire approximately 500 permanent and 2000 temporary employees.¹³³ However, more individuals who are specifically *mental health* professionals, not just *health* professionals with general training, should be hired.¹³⁴ Although production numbers have remained high, training has been suffering.¹³⁵ To help cure this deficiency, training programs for current VA employees, as well as for incoming clinicians, should be undertaken and perfected before production requirements are raised any higher. The recently enacted Caregivers and

129. INST. OF MED. & NAT'L RESEARCH COUNCIL, *supra* note 7, at 97–101 (advocating for use of the Minnesota Multiphasic Personality Inventory (MMPI) and Symptom Checklist-90 (SCL-90), as opposed to the global assessment of functioning test (GAF)).

130. Recent studies show that prolonged exposure therapy, in which patients are repeatedly exposed to stressful stimuli in an effort to decrease their sensitivity, is quite effective. After such therapy, participants' scores on the Posttraumatic Diagnostic Scale decreased by approximately 20 points, from a range of 34.2–38.3 to a range of 16.0–19.0. To put this in perspective, a score of 15.0 indicates that an individual no longer meets the criteria for PTSD. Rauch et al., *supra* note 87, at 61–62. In addition, brain scans are effective at measuring the neurological effects of PTSD therapy. Luran Neergaard, *Scanning Invisible Damage of PTSD, Brain Blasts*, ABCNEWS, Nov. 10, 2009, <http://abcnews.go.com/Health/wireStory?id=9040133>.

131. Press Release, Dep't of Veterans Affairs, VA Agrees with Key Points about PTSD Treatment in New Institute of Medicine Report (Oct. 17, 2007), *available at* <http://www1.va.gov/opa/pressrel/pressrelease.cfm?id=1397>.

132. DEP'T OF VETERANS AFFAIRS, *Part 1—The Recovery Act of 2009*, in FY 2009 PERFORMANCE AND ACCOUNTABILITY REPORT 76, 77 (2009), *available at* http://www4.va.gov/BUDGET/docs/report/PartI/FY2009-VAPAR_PartI_Recovery_Act.pdf.

133. DEP'T OF VETERANS AFFAIRS, *Executive Summary*, in FY 2009 PERFORMANCE AND ACCOUNTABILITY REPORT 1–2 (2009), *available at* http://www4.va.gov/budget/docs/report/FY2009-VAPAR_Executive_Summary.pdf. For a more detailed report of VA programs funded by the American Recovery and Reinvestment Act of 2009, enacted on February 17, 2009, see *Agency Plans and Reports*, U.S. Dep't of Veterans Affairs, http://www.va.gov/recovery/Agency_Plans_and_Reports.asp (last updated June 22, 2010). For more information on the Act, in general, see RECOVERY.GOV, <http://www.recovery.gov/Pages/home.aspx?q=content/act> (last visited Feb. 12, 2011).

134. Hefling, *supra* note 117.

135. Office of the Inspector Gen., *Major Management Challenges* 2008, *supra* note 48, at 278; Office of the Inspector Gen., *Major Management Challenges* 2009, *supra* note 48, at 185–86; Office of the Inspector Gen., *Major Management Challenges* 2010, *supra* note 48, at 168.

Veterans Omnibus Health Services Act of 2010 mandates that all mental health professionals providing nursing home care must participate in an ongoing education program that focuses, in part, on PTSD, but the act still leaves open exactly what such a program should entail.¹³⁶ The training instrumentalities are largely already in existence; the VA has a regimented training program,¹³⁷ and the National Center for PTSD has made detailed guidelines available to clinicians over the internet.¹³⁸

In order to effectively make such changes, the VA could amend the existing federal regulations as it did in 2010.¹³⁹ As this Note has shown, however, much of the problem is not in the formal requirements mandated by the VA but in the enforcement of those requirements. Although the regulations require use of the *DSM*, the manual is optional. Although the clinician guidelines require extensive training, no (or at least very few) education programs are used. The VA must be overseen to ensure that any proposed changes are in fact implemented. This responsibility may be given to an independent third party or may be delegated to an existing arm of the VA, perhaps to the VA Office of the Inspector General. Even with this, there must be some kind of credible enforcement ability if the VA regional offices are to meet any new (or newly enforced) requirements. If each VA regional office were to report the extent to which it meets the rating accuracy and training requirements, and perhaps even if a new VA office were in charge of supplementing enforcement, then veterans with PTSD might not face the same amount of difficulty in receiving disability compensation.

V. CONCLUSION

As it stands now, the VA's disability compensation program does not adequately address posttraumatic stress disorder, even though the disorder is one of the most prevalent in the military. Although the rating regulations

136. S. 1963, 111th Cong. § 202 (2010).

137. U.S. GOV'T ACCOUNTABILITY OFFICE, *supra* note 85, at 7–12.

138. See Nat'l Center for PTSD, *Clinician's Trauma Update*, U.S. DEP'T OF VETERANS AFFAIRS, <http://www.ptsd.va.gov/professional/newsletters/ctu-online.asp> (last updated Dec. 23, 2010) (offering an online newsletter published six times per year); Nat'l Center for PTSD, *PTSD 101 Courses*, U.S. DEP'T OF VETERANS AFFAIRS, <http://www.ptsd.va.gov/professional/ptsd101/ptsd-101.asp> (last updated Jan. 28, 2011) (providing online courses on PTSD for which clinicians may earn continuing education credit); see also Nat'l Center for PTSD, *Dissemination and Education Within the VA*, U.S. DEP'T OF VETERANS AFFAIRS, http://www.ptsd.va.gov/about/major-initiatives/education/dissemination_education_within_the_va.asp (last updated Mar. 23, 2010) (providing details about the Clinical Training Program, offered through workshops designed specifically for VA employees).

139. See *supra* note 43.

require use of the *DSM*, the Court of Appeals of Veterans Claims has made that mandate largely ineffective. A veteran must also present evidence that his or her disability is linked to service and evidence that there was an in-service stressor that would have caused the disability. Presuming that a veteran can meet these burdens, he must then face inadequately trained clinicians and a time-consuming appeals system that forces veterans to wade through a mass of procedural rules. Despite such shortcomings, the system can be revised by implementing requirements that have recently been ignored and by formulating an enforcement policy for offices that do not meet such requirements. Then, and only then, can the system do what it was originally designed to do—compensate men and women who have risked their lives for their country.

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