I have kept all information in this manual. The Table of Contents page numbers are not valid for this version since I have eliminated all of them. They interfered in the actual information for this version. I have also altered some paragraphs to make them easier to read. Some tables have also been remade since I could not make the actual tables. If you are wishing to quote, be aware. You might want to find the link and quote direct from the document. If the link disappears, this will, hopefully, still be here.

Department of Veterans Affairs

Best Practice Manual for Posttraumatic Stress Disorder (PTSD)

Post-Traumatic Stress Disorder

Compensation and Pension Examinations

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Compensation and Pension Examinations
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Executive Summary

This document provides information on Posttraumatic Stress Disorder and current recommendations regarding what is known about "best practice" procedures for assessing PTSD among veteran populations. A Veterans Benefits Administration (VBA) review of 143 initial claims for PTSD revealed that PTSD was diagnosed in 77% of the cases, that the exam was not adequate for rating in at least 8%, but that inadequate exams were not routinely returned for correction. A common problem was that the examiner did not describe how Diagnostic and Statistical Manual for Mental Disorders-IV (DSM-IV) diagnostic criteria were met. Good exams delineated how the PTSD diagnostic criteria were met by giving specific examples. Other noted problems were the examiner using DSM-III rather than DSM-IV criteria, and the examiner sometimes failing to discuss whether other mental disorders that were diagnosed are due to or part of PTSD. The

VBA and Veterans Health Administration (VHA) are committed to improving these services to veterans, and improving the quality of compensation and pension examinations for PTSD.

Included in this manual are an assessment protocol based on best practices for assessing PTSD, and disability examination worksheets which correlate with the protocol. Included in the protocol are guidelines on:

I. Trauma Exposure Assessment

• The objective of trauma assessment

• DSM-IV Stressor Criterion

• Sources of information used in trauma assessment

• Guidelines for interview assessment of trauma exposure

• Orienting the claimant to trauma assessment

• Documentation of trauma-related information.

• Suggested interview queries

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• Administration of the Clinician-Administered PTSD Scale (CAPS) Life Event Checklist

• Recommended Instruments for Trauma Assessment.

II. Assessment of PTSD

• Four objectives which should be addressed:

a. Establishing the presence or absence of a diagnosis of PTSD

b. Determining the severity of PTSD symptoms

c. Establishing a logical relationship between exposure to military stressors and current PTSD symptomatology

d. Describing how PTSD symptoms impair social and occupational functioning and quality of life.

• DSM-IV Diagnostic Criteria for PTSD

• Diagnostic interview assessment of PTSD.

• Psychometric assessment of PTSD

III. Recommended Time Allotment for Completing Examination

• Initial PTSD compensation and pension evaluations typically require about three hours, but complex cases may demand additional time.

• Follow-up evaluations usually require an hour to an hour and a half.

IV. Professionals Qualified to Conduct Compensation and Pension Examinations for PTSD

The VHA encourages use of this protocol when examining veterans for compensation purposes to ensure that a detailed history is obtained from the veteran and a comprehensive evaluation is performed and documented.

Comprehensive report templates have also been included as guides when writing reports.

Also included in this manual as reference material are:

• The VBA training letter based on a PTSD case review

• The governing regulation from 38 CFR, Part 3 for Service Connection for PTSD

• Excerpts from VBA's Adjudication Procedures manual concerning the adjudication of claims for PTSD

• Background research on PTSD and the Global Assessment of Functioning (GAF)

• The GAF Scale

• Scoring rules for Mississippi and PTSD checklist

• Examples of trauma history and PTSD symptom narratives

• A social history questionnaire.

It is anticipated that this document will raise the quality and standards of PTSD Compensation and Pension (C&P) examinations. This increased quality will require increased time and expense allotted to the evaluation process. Under current VA standards, with local and regional variations in time mandated for exams, clinical expertise, and resources, the examiners must use their discretion in selecting the most relevant information for completing a competent, comprehensive examination for PTSD.

The examination protocol can be accessed electronically through VA's Veterans Health Information Systems and Technology Architecture (VISTA) computer system – formerly the Decentralized Hospital Computer System (DHCP).

Clinicians may receive assistance in accessing this protocol from C&P clerks, information Resources Management (IRM) staff, chiefs of Health Administration Services (HAS), or other staff members, depending on the facility's local organization.

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I. Background Information: PTSD Initial Claims Review

A review of 143 initial claims for PTSD under a special protocol was conducted during the week of June 19, 2000, by three field reviewers and one member of the Star Review Staff under the supervision of Dr. Caroll McBrine. The statistics reported are based on the 143 files formally reviewed, but an additional 77 cases were informally reviewed. The review was not statistically valid but was sufficient to point out problem areas that call for additional training.

Examination findings

• PTSD was diagnosed in 77% (75/97 exams).

• The exam was not adequate for rating in at least 8% (8), but only 3 were returned.

• The examiner reconciled multiple psychiatric diagnoses in all but 3 or 35% (34) where they were present."

• The examiner had the claims folder in 44% (43).

• The examiner considered and discussed documentary evidence in 36% (35).

• The examiner identified the stressor and commented on the nexus in 68% (51/75).

• A common problem (in at least 5 exams) was that the examiner did not describe how DSM-IV diagnostic criteria were met. All exams were accepted by regional office (RO), but should have been returned. Good exams delineated how the PTSD diagnostic criteria were met by giving specific examples.

• The examiner clearly used DSM-III rather than DSM-IV criteria in many cases.

• The examiner sometimes failed to discuss whether other mental disorders that were diagnosed are due to or part of PTSD.

II. Background Information: Assessment of Posttraumatic Stress Disorder

PTSD is a prevalent mental disorder among veterans exposed to traumatic stress during military service. The VA's commitment to providing thorough and accurate assessment and care of veterans raises a need for a more standardized approach to assessment and documentation of PTSD and resulting impairment in psychosocial functioning. This background information reports on the current standards for PTSD assessment. Further information on the research associated with PTSD is included in Appendix E.

Assessment of PTSD

PTSD is assessed by a variety of methods, including questionnaires, interviews, and biological tests. Chapter 2 gives a summary of the recommended instruments and format for PTSD assessment. Under optimal circumstances, assessment of PTSD and associated disorders is based on multiple sources of information, derived from clinical interview, psychometric testing, review of military and medical records, reports from collaterals who know the veteran, and

studies of psychophysiological reactivity. A multi-method approach is especially helpful to address concerns about either denying or overreporting symptoms.

Many clinicians find the addition of the Minnesota Multiphasic Personality Inventory (MMPI) and Minnesota Multiphasic Personality Inventory-2 (MMPI- 2 helpful, particularly in very complex or difficult cases. The MMPI and MMPI- 2 include scales that assess overreporting; they have what are known as “validity scales” that are elevated in people who are trying to exaggerate their symptoms. There has been evidence to suggest that compensation-seeking veterans endorse higher levels of psychopathology across measures and produce elevated validity indices on the MMPI and MMPI-2 as compared to non-compensation-seeking veterans (Smith & Frueh, 1996; Frueh & Kinder, 1994). Sample sizes in these studies, however, are small, and clinicians were not correlating scores on the MMPI with collateral sources of data suggestive of overreporting. Even in non-compensation-seeking settings, the preponderance of evidence suggests that people with PTSD report significantly higher subjective distress than those without PTSD. Several studies suggest that Vietnam combat veterans and child abuse survivors may have elevated scores as a result of chronic post traumatic difficulties or comorbid affective symptoms, as opposed to motivated symptom overendorsement (Elliott, 1993; Jordan, Nunley, & Cook, 1992; Smith & Frueh, 1996).

The Infrequency-Psychopathology Scale F(p), was designed by Arbisi and Ben-Porath (1995), for the MMPI-2 as an additional validity measure for use with patient populations where a high rate of endorsement of psychological disturbance is expected. The scale’s validity has been tested in with inpatient veterans, with results indicating that the F(p) scale may be used as an adjunct to the F in settings characterized by relatively high base rates of psychopathology and psychological distress. Arbisi and Ben-Porath suggest that when the F(p) scale is elevated along with the F Scale, the clinician can more confidently attribute the high scores to a patient’s attempt to overreport psychopathology if other validity measures are not elevated significantly. The F(p) Scale is less influenced by diagnostic group and distress/psychopathology than the F Scale in distinguishing groups with genuine psychopathology from those asked to feign psychiatric impairment (Arbisi and Ben-Porath, 1997; 1998). In patients likely to be encountered in both clinical and forensic settings, elevations on the F(p) Scale are much more common when malingering or exaggeration of psychopathology is expected (Rothke et. al, 2000). Hit rates (Rothke et. al. 2000) and cutoff scores (Strong et. al., 2000) have been reported across a number of settings (see disability examination worksheets for cutoff scores). Nonetheless, it is critical that clinicians understand the nature of their population with regard to frequency and type of psychopathology before interpreting the F(p) Scale. Independent verification that patients are overreporting is needed. With this caveat in mind,

use of the MMPI and MMPI-2 may help the evaluator in determining test-taking style of the veteran (i.e., defensive, overendorsing, underendorsing).

In using the MMPI-2 to assess for PTSD, cutoff scores for utilizing the MMPI-2 to assess validity of PTSD diagnosis have been reported in a number of studies (Lyons, 1999; Wetter et al., 1993). In addition, MMPI-2 cutoff scores for specific PTSD scales (i.e., PK, PS) have been shown to be effective at assessing PTSD (Lyons & Keane, 1992). (See disability examination worksheets for cutoff scores). A Cochrane review of Effectiveness report (September, 2000) indicated that six of 21 studies reviewed (29%) reported that the mean 8-2 profile pattern significantly differentiated PTSD from non-PTSD patients. Seven (33%) of the studies demonstrated either no significant mean two-point profile pattern differences, or differences that were attributable to scale elevations, but not mean code type patterns. In five of these seven studies, mean 8-2 profile patterns were produced by both the PTSD and comparison samples, although the PTSD groups were significantly more elevated than the comparison groups. Of seven inpatient veteran studies, all reported an 8-2 mean profile pattern, although four of these reported non-significant differences. When five outpatient veteran studies were grouped together, 50% demonstrated the mean 8-2 profile pattern. The three POW studies were consistent in generating an averaged 1-2 profile pattern. Of the eight studies that reported many profile patterns other than the 8-2, the most frequent mean two-point profile patterns were 1-2 (four, 19%), 4-8 (three, 14%), 4-2 (three, 14%), and 8-7 (three, 14%).

At this time, the current findings call for careful and accurate, multimodal assessment, and a conservative approach in our ability to interpret symptom overendorsement in the context of psychometric testing alone. Comprehensive assessments based on multiple sources of information that yield consistent results tend to create greater confidence in the veracity of diagnostic judgments.

Biological measures such as measures of heart rate, blood pressure, skin conductance, and EKG muscle tension have been found to yield valuable information for corroborating a PTSD diagnosis (Keane et. al, 1998). Veterans more prone to psychophysiological response to war-zone cues tended to be more impaired on both clinician and self-report measures of PTSD, have poorer functioning, and endorse patterns of guilt and depression. However, it is important to keep in mind that some psychophysiological responses can be fabricated, and almost one third of veterans with PTSD *do not* show a psychophysiological response to war-zone cues. Therefore, biological data can best be framed as corroborative of other data, rather than as a determining factor in making a diagnosis.

Assessment of Functioning Using the GAF Scale

In 1997, the Department of Veterans Affairs mandated (VHA Directive # 97- 059) that a GAF score be assigned at regular intervals for veterans receiving mental health care in the VHA system. According to this directive, the GAF scores were to be used to define who is seriously mentally ill (SMI), and to calculate a GAF index for the SMI population in 1998.

On occasion, the GAF score has been employed by disability rating boards as an index of a claimant's functional status as part of the process of determining eligibility for benefits. The GAF scale was included as the fifth axis in a DSM profile beginning as a 7-point format with the DSM-III. It was changed from a 7-point scale in DSM-III to a 0-90 point scale in DSM-III-R, and to a 0-100 point scale in DSM-IV. The current version of the GAF is based on the Global Assessment Scale (GAS) developed by Endicott and colleagues. The GAF and the GAS are almost identical to each other in content, with the exception of some re-arrangement of rating descriptions and examples for the categories. While no information on the reliability and validity of the GAF is included in the DSM-IV, these psychometric features of the GAS were formally examined and published by the GAS authors (Enidcott, Spitzer, Fleiss & Cohen, 1976; see Appendix F of this manual for more details on the GAS).

GAF Rating Issues

1. **GAF Reliability and Training.**

The existing GAF literature shows that in the absence of systematic training with the GAF, reliability is generally poor. Evidence suggests that without training some raters may base their ratings on average symptom occurrence or functionality over time, while others will rate the most recent episode or lowest level of these two components. In disorders like PTSD, where symptom severity and functionality can fluctuate, these two approaches will yield very different GAF scores. Therefore, training in using the GAF with PTSD is essential.

2. **GAF Accuracy and Clinician-Rater Biases.**

While training is important for obtaining reliable ratings; high accuracy should be given equal consideration. Outcome data from GAF trainings have shown that raters show a bias against assigning low GAF scores for PTSD vignettes. For PTSD cases used as part of organized GAF trainings, it was typically true that the GAF ratings made before training were too high. This reflected various biases

and beliefs of the clinician raters regarding what defined a functional problem, and equally important, their personal perspective on what qualified as a “mild,” “moderate,” and “serious” levels of severity. These biases affect the accuracy of the GAF rating assigned.

3. **GAF Accuracy with PTSD and Comorbidity.**

DSM-IV GAF symptom examples in the text do not represent PTSD symptoms directly, although they capture associate features and general level of functioning . The clinician must decide what should be considered as either a symptom or functional problem that is then rated for its severity (e.g., avoidance can be an individual PTSD symptom and part of more broad social and interpersonal dysfunction). Additionally, the presence of other comorbid diagnoses is common in cases of chronic PTSD. To assess PTSD symptom severity in the context of comorbidity, the clinician must somehow weigh the combined impact of all coexisting diagnoses, but without directions or examples.

4. **Resolution of the GAF Scale.**

The GAF scale is organized into 10 decile (10- point) bands that yield 100 possible points. Available GAF instructions recommend first finding the decile band that seems to best describe either the degree of symptomatology or functional severity. Then, parenthetically, the DSM-IV adds a note advising that the rater “use intermediate codes when appropriate (e.g., 45, 68, 72)”, but gives no guidance on exactly how to arrive at these intermediate values. Practically speaking, the larger deciles may have greater reliability because they are more clearly specified in the DSM-IV and thus easier to select. Consequently, if GAFs are based only on decile values (30, 40, 50, 60, etc.), then the difference between raters assigning GAFs for the same patient could easily vary by 20 points. This could occur, for example, if one rater considered the symptoms to be Mild and the other judged them to be Moderate - Severe in nature. This discussion highlights the problem of using GAF cutoff scores that set strict thresholds for disability (e.g., 40 and higher is not disabled / below 40 is disabled). This is unwise and unsupported by both the inherent resolution of the GAF scale (3 – 5 points) and the data from standardization studies of the GAS (see Appendix F) showing that raters normally vary by as much as +/- 5 to 8 points.

5. **Assigning Separate GAFs by Condition.**

No published information associated with the DSM-IV instructs users in a valid method for partitioning the GAF score (Partial Assessmemt of Functioning [PAF]) by comorbid clinical conditions for the areas of Social and Occupational / School functioning. While the same is also true for Psychological functioning, it might appear from reading the descriptors in DSM-IV (i.e., mild, moderate, serious) that separate ratings by diagnosis could be made (e.g., only for depression symptoms, only for anxiety symptoms, only for substance abuse symptoms). However, the separate ratings that would result have no validated relationship to each other, and no established process for integrating them into a value that truly considers the combined effect of having them all concurrently. Second, if PAFs are requested for a disability determination, it is likely that multiple conditions exist comorbidly, and having separate ratings of severity of dysfunction would fit with a process of assigning a percentage of service connection to each particular disorder. In PTSD, depression and substance abuse frequently coexist and attempting to attribute a portion of the functional problems to depression and another to substance use and another to PTSD, as if they were independent of each other, is beyond the intended purpose and capability of the GAF scale. This is an instance of incompatibility between the capabilities of the GAF scale and the compensation review process. While the logic of separate ratings by disorder may make sense from an adjudication perspective, it is not clinically validated, and PAFs assigned in this manner should be seriously questioned for their validity as evidence in the disability determination proceedings.

Some Considerations for Making GAF Ratings:

Given the GAF considerations described above, clinicians who assign GAF ratings should: a) attend available trainings, b) study available GAF materials carefully, c) try to assign scores as accurately as possible by adhering to the definitions provided, and d) strive to become consistent in choosing their GAF ratings.

It is important to gather through multiple means (i.e., structured interview, social history, self-report measures), an assessment of the individual's level of functioning across the time periods prior to, during, and subsequent to military service. Areas of functioning to assess include: developmental, social, familial, educational, vocational, cognitive, interpersonal, behavioral, and emotional domains. The clinician is then responsible for assigning a GAF score, but more importantly *including sufficient narrative which supports the rationale behind the score assigned.*

At the current time, existing Disability Examination worksheets (as included in this publication) reflect VBA's policy of sometimes requesting that the examiner

partition out GAF scores for comorbid disorders. While this information may be requested, if the clinician feels that to do so would be impossible or clinically invalid, he or she is not required to do so, and should state specifically why he or she feels that this is not possible.

Finally, in making ratings, clinicians should be cognizant of the presence of violence toward self and others in the veteran's history. While these events may be episodes of aggression vs. continuous aggression or a general aggressive demeanor, they are significant features that drop the GAF into the lower decile ranges. If these features are present clinically, they should not be overlooked or minimized by the clinician when making GAF ratings, even if it appears that the veteran has higher functionality in other areas.

III. Recommended Guidelines for Assessing Trauma Exposure and PTSD

A. Trauma Exposure Assessment

A.1. ***Objective.***

Compensation and pension examinations routinely address PTSD resulting from combat exposure. However, many other forms of military-related stress are sufficient to induce PTSD and should be reviewed among veterans applying for service-connected disability benefits. Non-combat forms of military-related trauma that are not uncommon include sexual assault or severe harassment; non-sexual physical assault; duties involved in graves registration or morgue assignment; accidents involving injury, death, or near death experiences; and actions associated with peace-keeping deployments that meet the DSM-IV stressor criterion.

The objective of trauma assessment is to document whether the veteran was exposed to a traumatic event, during military service, of sufficient magnitude to meet the DSM-IV stressor criterion, described below.

DSM-IV Stressor Criterion

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.

Note. *Adverse psychological reactions are often associated with stressful events that have the quality of being unpredictable and uncontrollable. Additionally, stressors that result in bodily injury, threat to life, tragic loss of a significant other, or involvement with brutality or the grotesque heighten risk for subsequent PTSD. Exposure to assaultive violence, particularly of a criminal nature, is more likely to induce PTSD than are random "acts of God." It is known that severity of the stressor, in terms of intensity, frequency, and duration, is the most important trauma characteristic associated with subsequent development of PTSD. Factors surrounding the trauma incident, such as absence of social support for the victim, may also influence the degree to which a stressful event is experienced as psychologically traumatic and may contribute to its potential for inducing psychiatric symptoms.*

A.2. ***Sources of information used in trauma assessment.***

Multiple sources of information should be used to assess history of exposure to traumatic stress, as well as its nature and severity. These sources include:

(a) VA Claims File,

(b) DD- 214,

(c) medical records from the VA, Department of Defense, and non-VA health care facilities,

(d) statements from others who have information about the veteran's trauma exposure and its behavioral sequela,

(e) evidence of behavior changes that occurred shortly after the trauma incident, and

(f) statements derived from interview of the claimant.

The occurrence of some forms of trauma (e.g., combat exposure) are usually substantiated by official military records, while support for other stressors (e.g., sexual assault) may depend on sources other than military records. (See Section VII for further information about supporting evidence regarding traumatic stressors.)

A.3. ***Guidelines for interview assessment of trauma exposure.***

Initial examinations conducted for purposes of establishing a diagnosis of PTSD require clinician assessment of trauma exposure and documentation of findings. Provided below are guidelines for (a) orienting the claimant to the interview assessment process, (b) gathering and documenting information about the trauma, (c) eliciting information about the stressor from the claimant, and (d) assessing trauma using structured questionnaire and interview methods.

A.3.a. ***Orienting the claimant to trauma assessment.***

For initial examinations, it is important to explain to the claimant that it is necessary to obtain a detailed description of one or more traumatic events related to military service, in order to complete the examination. Further, it is helpful to alert him or her to the fact that trauma assessment, though brief (about 15-20 minutes), may cause some distress. The veteran should be advised that trauma assessment is a mutual and collaborative process, and that he or she is not required to provide unnecessarily detailed answers to all questions, if it is too distressing to do so.

A.3.b. ***Documentation of trauma-related information.***

For initial examinations, a detailed narrative description of the traumatic episode must be recorded in the report. This description, as appropriate and feasible, should include information about:

(1) the objective features of the traumatic event;

(2) date and location of the stressor(s);

(3) names of individuals who witnessed or were involved in the traumatic incident;

(4) individual decorations or medals received;

(5) the veteran's subjective emotional reaction and behavioral response during and after the trauma;

(6) the veteran's view of perceived consequences of the traumatic event, including abrupt changes in behavior, adjustment, and well-being; and

(7) names of health care facilities where trauma-related injuries were treated.

A.3.c. ***Suggested interview queries.***

Assessment of one or more personally relevant traumas proceeds after sufficient rapport has developed and some cursory details regarding the context of the trauma situation(s) have been gathered (e.g., branch of the military served in; events leading up to the traumatic situation). Provided below are suggested questions, strategies, and tools that mayassist in trauma assessment, as appropriate to the nature and context of the veteran's stressful military experiences:

Stem or lead inquiry:

The Clinician Administered PTSD Scale (CAPS) (Blake et al., 1995) strategy for assessing the stressor criterion is recommended for the initial inquiry about trauma exposure. This strategy involves the following orienting procedures and questions:

Orienting statement:

"I'm going to be asking you about some difficult or stressful things that sometimes happen to people. Some examples of this are being in some type of serious accident; being in a fire, a hurricane, or an earthquake; being mugged or beaten up or attacked with a weapon; or being intensely sexually harassed or forced to have sex when you didn't want to. I'll start by asking you to look over a list of experiences like this and check any that apply to you. Then, if any of them do apply to you, I'll ask you to briefly describe what happened and how you felt at the time.

"Some of these experiences may be hard to remember or may bring back uncomfortable memories or feelings. People often find that talking about them can be helpful, but it's up to you to decide how much you want to tell me. As we go along, if you find yourself becoming upset, let me know and we can slow down and talk about it. Do you have any questions before we start?"

Administration of the CAPS Life Event Checklist:

The CAPS 17-item Life Event Checklist may be administered as a preliminary means of identifying exposure to different traumatic events. Detailed inquiry should follow positive endorsement of traumatic events, in order to clarify objective features of the stressor, using questions suggested below as appropriate:

• Were you wounded or injured?

• Did you witness others being killed, injured or wounded?

• Were you exposed to bodies that had been dismembered?

• About how many times were you exposed to [the traumatic event]?

• During the trauma, did the perpetrator coerce (i.e., threaten, demand, push, trick) you into doing something against your will? (sexual assault)

• During the trauma, did the perpetrator threaten to injure you or kill you if you did not comply with his or her wishes? Did you believe there would be any other negative consequences to you if you did not comply with the perpetrator's intentions (i.e., do what was demanded)? (sexual assault)

• Was somebody important to you killed or seriously hurt during this situation?

• What did other people notice about your emotional response?

• What were the consequences or outcomes of this event?

• Did you receive any help, or talk to anyone, after this event occurred?

Suggested Questions for Screening Sexual Assault Experiences:

"Have you ever had any unwanted or uncomfortable sexual experiences, either as a child or an adult?"

The Life Events Checklist has 2 questions that offer the opportunity for the assessor to ask follow-up questions. It is suggested that you change the listed follow-up questions referring to sexual assault experiences to questions such as:

a) During this event, did the other person pressure you verbally or physically to do something against your will?

b) During this event, did the other person threaten to hurt or kill you if you didn't do what he or she wanted?

c) Did you think that there would be something else that would happen if you didn't do what he or she wanted?

Questions assessing subjective response to the stressor:

Suggested inquiries for assessing subjective reactions to trauma exposure (DSM-IV criterion A.2) include:

a) At the time the trauma was occurring, did you believe your life was threatened? Did you think you could be physically injured in this situation?

b) At the time this occurred, how did you feel emotionally (fearful, horrified, helpless)?

c) Were you stunned or in shock so that you didn't feel anything at all?

d) Did you disconnect from the situation, like feeling that things weren't real or feeling like you were in a daze?

e) Can you recall any bodily sensations you may have had at the time?

Suggested inquiries if no events are endorsed on the CAPS trauma exposure checklist:

If no events were identified on the CAPS trauma exposure checklist or during other parts of the interview, consider the following additional inquiries:

a) Has there ever been a time in the military when your life was in danger or you were seriously injured or harmed?

b) What about a time when you were threatened with death or serious injury, even if you weren't actually injured or harmed?

c) What about witnessing something like this happen to someone else or finding out that it happened to someone close to you?

d) What would you say are some of the most stressful experiences you had during the military, which still upset you today?

A.3.d. ***Recommended Instruments for Trauma Assessment.***

The following instruments are useful in assessing objective features of trauma exposure. These instruments should be administered only to claimants who represent the appropriate criterion group that the instruments were developed for. Clinicians may use items from these instruments as prompts for interview questions, and responses to items may provide a focus for more detailed interview inquiry. Some instruments (e.g., the Combat Exposure Scale) provide sufficient information to make gross assessments of whether the individual was exposed to a "high," "moderate," or "low" degree of trauma. While helpful, use of these instruments is never sufficient, and must be accompanied by a narrative description of unique details of the veteran's traumatic experience. Many of the self-report measures noted in this document have means and cut-off scores that were validated on combat veterans. Other traumatized populations (i.e., sexual assault) may look differently on these measures.

Infantryman and other ground troop personnel

• Combat Exposure Scale (Keane et al., 1989)

Females serving in a war zone

• Women's Wartime Stressor Scale (Wolfe, Brown, Furey, & Levin, 1993)

• Trauma Questionnaire (McIntyre et al., 1999).

Persian Gulf War Veterans

• Desert Storm Trauma Exposure Questionnaire (Southwick et al., 1993)

Veterans Exposed to Sexual Assault (both male and female)

• Sexual Experiences Survey (SES, Koss & Oros, 1982).

Veterans Exposed to Sexual Harassment (both male and female)

• Sexual Experiences Questionnaire (SEQ-DOD, Fitzgerald, Gelfand, & Drasgow, 1995). There is a version specifically asking about sexual harassment in the military.

B. Assessment of PTSD

B.1. ***Objective.***

Assessment of PTSD for compensation and pension purposes should address four objectives:

(a) establish the presence or absence of a diagnosis of PTSD;

(b) determine the severity of PTSD symptoms;

(c) establish a logical relationship between exposure to military stressors and current PTSD symptomatology; and

(d) describe how PTSD symptoms impair social and occupational functioning and quality of life.

Assessment of PTSD requires inquiry into the presence/absence of all 17 symptoms of the disorder, but consideration should also be given to associated features articulated in DSM-IV.

Assessment of PTSD using a structured interview constitutes the recommended minimum or "core" diagnostic procedure in compensation and pension settings. Structured diagnostic interview assessment has the advantage of enhancing the objectivity, standardization, and consistency of evaluations across settings and examiners.

Routine use of psychometric tests and questionnaires for assessing PTSD and psychopathology may not be feasible in all settings, though many practitioners regularly use these instruments to enhance the comprehensiveness and quality of their evaluation. The clinician's reliance on psychometric assessment is at the discretion of clinician, and may depend on the professional background of the examiner and availability of personnel trained in use of the relevant methods. *However, psychometric assessment is strongly suggested as a supplement to interview methods in complex examination situations*. These situations may include but are not limited to (a) claimants who are appealing a rating decision, (b) cases where interview findings are of questionable validity, and (c) veterans

having complicated clinical pictures involving multiple and confusing comorbid mental disorders.

Many instruments are available for assessing PTSD. Provided below is a menu of suggested instruments to be used in compensation and pension settings, based on their established reliability and validity, ease of administration, and the fact that no fee is charged for their use. Selection of particular assessment instruments will likely depend on the examiner's professional background, preferences, and allotted time to complete the assessment. The instruments suggested here are designed to assist the examiner in assessing the presence and severity of PTSD diagnostic criteria (listed below) in a manner that is systematic, objective, and standardized.

DSM-IV Diagnostic Criteria for PTSD

A. The person has been exposed to a traumatic event .

B. The traumatic event is persistently re-experienced in one (or more) of the following ways:

1. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions.

2. Recurrent distressing dreams of the event.

3. Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated).

4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

5. Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma.

2. Efforts to avoid activities, places, or people that arouse recollections of the trauma.

3. Inability to recall an important aspect of the trauma.

4. Markedly diminished interest or participation in significant activities.

5. Feeling of detachment or estrangement from others.

6. Restricted range of affect (e.g., unable to have loving feelings).

7. Sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span).

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

1. Difficulty falling or staying asleep.

2. Irritability or outbursts of anger.

3. Difficulty concentrating.

4. Hypervigilance.

5. Exaggerated startle response.

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:
Acute: if duration of symptoms is less than 3 months
Chronic: if duration of symptoms is 3 months or more

Specify if:

With Delayed Onset: if onset of symptoms is at least 6 months after the stressor.

B.2. ***Diagnostic interview assessment of PTSD.***

The Clinician Administered PTSD Scale (CAPS) (Blake et al., 1995) is recommended as the interview method of choice, for conducting compensation and pension examinations for PTSD. The CAPS is a structured clinical interview designed to assess symptoms of PTSD corresponding to DSM-IV criteria.

The CAPS has a number of advantages over other diagnostic interview methods for PTSD, including

(a) the use of explicit behavioral anchors as the basis for clinician ratings,

(b) separate scoring of frequency and intensity dimensions for each PTSD symptom,

(c) measurement of associated clinical features,

(d) assessment of the impact of PTSD symptoms on social and occupational functioning, and

(e) ratings of the validity of information obtained. The CAPS provides dichotomous information about the presence/absence of the PTSD diagnosis as well as overall severity of the disorder. An additional advantage of the CAPS is its sound psychometric structure, with high inter-rater agreement, very high diagnostic sensitivity and specificity, and convergent validity with other measures of PTSD.

The CAPS requires approximately one hour to administer, though it can be customized and abbreviated by eliminating less relevant components. However, other interview-based diagnostic instruments for PTSD are also suitable for use in conducting compensation and pension examinations and require less time to administer. These instruments include the PTSD Symptom Scale (Foa, Riggs, Dancu, & Rothbaum, 1993); Structured Interview for PTSD (Davidson, Malik, & Travers, 1997); Structured Clinical Interview for DSM-IV (First, Spitzer, Gibbon, & Williams, 1995); Anxiety Disorders Interview—Revised (DiNardo & Barlow, 1988); and the PTSD Interview (Watson, Juba, Manifold, Kucala, & Anderson, 1991). Although a modest time savings may result from using these alternative

instruments, the information gleaned from them is typically not as comprehensive and, unlike the CAPS, there may be a charge associated with their use.

B.3. ***Psychometric assessment of PTSD***.

Psychometric assessment of PTSD provides quantitative assessment of the degree of PTSD symptom severity. Judgments about symptom severity can be made by comparing an individual's scores against norms established on reference samples of individuals who are known to have or not have PTSD. Cutting scores have been established for the psychometric measures of PTSD recommended here, based on their high sensitivity and specificity in discriminating individuals with PTSD from those without PTSD. Data from psychometric tests never serve as a "stand alone" means for diagnosing PTSD. Rather, the psychometric measures suggested here should be used to supplement and substantiate findings gleaned from interview assessment and other sources of data, particularly when there is a need to reconcile multiple diagnoses. Use of at least one of the following psychometric instruments is recommended for inclusion in disability evaluations for PTSD, on a routine basis or in cases where testing is selectively administered:

a) Mississippi Scale for Combat-Related PTSD (Keane, Caddell, & Taylor, 1988) (for combat-exposed populations)

b) PTSD Checklist (Blanchard, Jones-Alexander, Buckley, & Forneris, 1996; Weathers, Litz, Herman, Huska, & Keane, 1993) (for individuals exposed to both combat and non-combat forms of trauma)

A number of other psychometric instruments are acceptable alternative methods for assessing PTSD. These include, but are not limited to, the MMPI PTSD subscales (Lyons & Keane, 1992), Impact of Event Scale—Revised (Weiss & Marmar, 1997), Penn Inventory (Hammarberg, 1992), PTSD Stress Diagnostic Scale (Foa, 1995), and Trauma Symptom Inventory (Briere, 1995). Additionally, many instruments that provide comprehensive assessment of psychopathology and personality functioning that may supplement PTSD-specific symptom assessment (e.g., MMPI, MCMI, Personality Assessment Inventory). These instruments are useful in quantifying severity of symptoms of other disorders that often co-occur with PTSD and may provide information about possible overstatement of symptoms and test-taking attitude (e.g., defensiveness).

C. Recommended Time Allotment for Completing Examination

This guideline is designed to enhance the objectivity, reliability, and overall quality of PTSD C&P examinations. It is recognized that implementing these recommendations may require more clinician time and institutional resources than is currently devoted to the PTSD assessment. The time required for the conduct of initial PTSD examinations may vary widely, depending on a number of factors. These factors include, but are not limited to, the availability and quantity of records to be reviewed, the existence of objective evidence of clearcut stressors, the veteran's degree of emotional distress exhibited during trauma assessment, the amount and complexity of comorbid psychopathology, and a number of other veteran-specific factors that may impact the pace of the assessment process.

C&P examinations for PTSD extend far beyond the scope of simply rendering a diagnosis of PTSD, similar to that occurring in a clinical assessment situation. Specific complexities of PTSD assessment in the compensation and pension situation include:

(a) implicit examiner requirements to make complex judgments about potential malingering in the context of an administrative evaluation with obvious financial implications;

(b) VBA requests of examiners to comprehensively diagnose *all* comorbid mental disorders and partition disability to different disorders in an increasingly chronic veteran population, where co-occurring mental disorders are inextricably related to PTSD; and

(c) requirements of examiners to render an informed opinion about the effects of PTSD on social and occupational functioning. Since examiners are not able to observe the work performance of claimants and they typically do not have access to such observational information, a careful and often time-consuming walk-through of the histories of our aging veteran claimants is required as the foundation for an opinion regarding functional disability.

Initial PTSD compensation and pension evaluations typically require up to three hours to complete, but complex cases may demand additional time. Time estimates for accomplishing components of the examination are as follows:

• Records review (30 minutes)

• Orientation to interview, review military history, and conduct trauma assessment (20 minutes)

• PTSD symptom assessment and diagnosis (40 minutes)

• Mental status examination and multiaxial DSM-IV diagnoses (20 minutes)

• Psychosocial history and assessment of change in social and occupational functioning (30 minutes)

• Report preparation (50 minutes)

• Psychometric assessment (additional time required, if administered)

Follow-up evaluations for PTSD do not require a trauma exposure assessment, military history, or comprehensive psychosocial history, and the records review burden is usually less than for an initial examination. These evaluations can typically be completed in about half the time required for an initial PTSD examination. (See Examination Worksheet I [p. 23-29] and Examination Worksheet II [p. 30-34] for a distinction between *initial* and *follow-up* examination content.)

D. Professionals Qualified to Conduct Compensation and Pension Examinations for PTSD

Professionals qualified to perform PTSD examinations should have doctoral-level training in psychopathology, diagnostic methods, and clinical interview methods. They should have a working knowledge of DSM-IV, as well as extensive clinical experience in diagnosing and treating veterans with PTSD. Ideally, examiners should be proficient in the use of structured clinical interview schedules for assessing PTSD and other disorders, as well as psychometric methods for assessing PTSD. Board certified psychiatrists and licensed psychologists have the requisite professional qualifications to conduct compensation and pension examinations for PTSD. Psychiatric residents and psychology interns are also qualified to perform these examinations, under close supervision of attending psychiatrists or psychologists.

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IV. Compensation and Pension PTSD Disability Examination Worksheets

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INITIAL EVALUATION FOR
POSTTRAUMATIC STRESS DISORDER (PTSD)

Name:
SSN:
Date of Exam:
C-number:
Place of Exam:

A. Identifying Information

• age

• ethnic background

• era of military service

• reason for referral (original exam to establish PTSD diagnosis and related psychosocial impairment; re-evaluation of status of existing serviceconnected PTSD condition)

B. Sources of Information

• records reviewed (C-file, DD-214, medical records, other documentation)

• review of social-industrial survey completed by social worker

• statements from collaterals

• administration of psychometric tests and questionnaires (identify here)

C. Review of Medical Records:

1. Past Medical History:

a. Previous hospitalizations and outpatient care.

b. Complete medical history is required, including history since discharge from military service.

c. Review of Claims Folder is required on initial exams to establish or rule out the diagnosis.

2. Present Medical History - over the past one year.

a. Frequency, severity and duration of medical and psychiatric symptoms.

b. Length of remissions, to include capacity for adjustment during periods of remissions.

D. Examination (Objective Findings):

Address each of the following and fully describe:

History (Subjective Complaints):

Comment on:

Premilitary History (refer to social-industrial survey if completed)

• describe family structure and environment where raised (identify constellation of family members and quality of relationships)

• quality of peer relationships and social adjustment (e.g., activities, achievements, athletic and/or extracurricular involvement, sexual involvements, etc.)

• education obtained and performance in school

• employment

• legal infractions

• delinquency or behavior conduct disturbances

• substance use patterns

• significant medical problems and treatments obtained

• family psychiatric history

• exposure to traumatic stressors (see CAPS trauma assessment checklist)

• summary assessment of psychosocial adjustment, progression through developmental milestones (performance in employment or schooling, routine responsibilities of self-care, family role functioning, physical health, social/ interpersonal relationships, recreation/leisure pursuits), and level of overall functioning.

Military History

• branch of service (enlisted or drafted)

• dates of service

• dates and location of war zone duty and number of months stationed in war zone

• Military Occupational Specialty (describe nature and duration of job(s) in war zone

• highest rank obtained during service (rank at discharge if different)

• type of discharge from military

• describe routine combat stressors veterans was exposed to (refer to Combat Scale)

• combat wounds sustained (describe)

• clearly describe specific stressor event(s) veteran considered particularly traumatic. Clearly describe the stressor. Particularly if the stressor is a type of personal assault, including sexual assault, provide information, with examples, if possible.

• indicate overall level of traumatic stress exposure (high, moderate, low) based on frequency and severity of incident exposure (refer to trauma assessment scale scores described in Appendix B).

• citations or medals received

• disciplinary infractions or other adjustment problems during military

NOTE: Service connection for 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. *Crucial in this description are specific details of the stressor, with names, dates, and places linked to the stressor, so that the rating specialist can confirm that the cited stressor occurred during active duty.* 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 two hours on an initial exam is normal.

Post-Military Trauma History (refer to social-industrial survey if completed)

• describe post-military traumatic events (see CAPS trauma assessment checklist)

• describe psychosocial consequences of post-military trauma exposure(s) (treatment received, disruption to work, adverse health consequences)

Post-Military Psychosocial Adjustment (refer to social-industrial survey if completed)

• legal history (DWIs, arrests, time spent in jail)

• educational accomplishment

• employment history (describe periods of employment and reasons)

• marital and family relationships (including quality of relationships with children)

• degree and quality of social relationships

• activities and leisure pursuits

• problematic substance abuse (lifetime and current)

• significant medical disorders (resulting pain or disability; current medications)

• treatment history for significant medical conditions, including hospitalizations

• history of inpatient and/or outpatient psychiatric care (dates and conditions treated)

• history of assaultiveness

• history of suicide attempts

• summary statement of current psychosocial functional status (performance in employment or schooling, routine responsibilities of self care, family role functioning, physical health, social/interpersonal relationships, recreation/leisure pursuits)

E. Mental Status Examination

Conduct a *brief* mental status examination aimed at screening for DSM-IV mental disorders. Describe and fully explain the existence, frequency and extent of the following signs and symptoms, or any others present, and relate how they interfere with employment and social functioning:

• Impairment of thought process or communication.

• Delusions, hallucinations and their persistence.

• Eye contact, interaction in session, and inappropriate behavior cited with examples.

• Suicidal or homicidal thoughts, ideations or plans or intent.

• Ability to maintain minimal personal hygiene and other basic activities of daily living.

• Orientation to person, place and time.

• Memory loss, or impairment (both short and long-term).

• Obsessive or ritualistic behavior which interferes with routine activities and describe any found.

• Rate and flow of speech and note any irrelevant, illogical, or obscure speech patterns and whether constant or intermittent.

• Panic attacks noting the severity, duration, frequency and effect on independent functioning and whether clinically observed or good evidence of prior clinical or equivalent observation is shown.

• Depression, depressed mood or anxiety.

• Impaired impulse control and its effect on motivation or mood.

• Sleep impairment and describe extent it interferes with daytime activities.

• Other disorders or symptoms and the extent they interfere with activities, particularly:

- mood disorders (especially major depression and dysthymia)

- substance use disorders (especially alcohol use disorders)

- anxiety disorders (especially panic disorder, obsessive-compulsive disorder, generalized anxiety disorder)

- somatoform disorders

- personality disorders (especially antisocial personality disorder and borderline personality disorder)

Specify onset and duration of symptoms as acute, chronic, or with delayed onset.

F. Assessment of PTSD

• state whether or not the veteran meets the DSM-IV stressor criterion

• identify behavioral, cognitive, social, affective, or somatic change veteran attributes to stress exposure

• describe specific PTSD symptoms present (symptoms of trauma re-experiencing, avoidance/numbing, heightened physiological arousal, and associated features [e.g., disillusionment and demoralization])

• specify onset, duration, typical frequency, and severity of symptoms

G. Psychometric Testing Results

• provide psychological testing if deemed necessary

• provide specific evaluation information required by the rating board or on a Bureau of Veterans' Affairs (BVA) Remand

• comment on validity of psychological test results. Arbisi and Ben-Porath (1995) recommend that the following sequence be used when interpreting an elevated F Scale:

a). rule out random responding and acquiescence by eliminating profiles with elevated VRIN (t>100) or TRIN (t>80) scores,

b). Rule our malingering or exaggeration by considering whether the F(p) Scale is elevated, and

c). if Steps a and b are negative, then a high F Scale can be considered consistent with psychopathology.

A hit rate of 97% or greater for F(p) at a cut score of T = 100 was found for both clinical and forensic samples, and taxometric analysis revealed that F(p) cutting cores are stable across non-VA and VA clinical settings and that F(p) raw scores greater than 6 could be classified as overreported (Strong et. al., 2000).

Nonetheless, it is critical that clinicians understand the nature of their population with regard to frequency and type of psychopathology before interpreting the F(p) Scale.

Independent verification that patients are overreporting is needed.

• provide scores for PTSD psychometric assessments administered

• state whether PTSD psychometric measures are consistent or inconsistent with a diagnosis of PTSD, based on normative data and established "cutting scores" (cutting scores that are consistent with or supportive of a PTSD diagnosis are as follows: PCL ≥ 50; Mississippi Scale ≥ 107; MMPI PTSD subscale a score > 28; MMPI code type: 2-8 or 2-7-8)

• state degree of severity of PTSD symptoms based on psychometric data (mild, moderate, or severe)

• describe findings from psychological tests measuring problems other than PTSD (MMPI, etc.)

H. Diagnosis:

1. The Diagnosis must conform to DSM-IV and be supported by the findings on the examination report.

2. If there are multiple mental disorders, delineate to the extent possible the symptoms associated with each and a discussion of relationship.

3. Evaluation is based on the effects of the signs and symptoms on occupational and social functioning.

NOTE: VA is prohibited by statute, 38 U.S.C. § 1110, from paying compensation for a disability that is a result of the veteran's own alcohol and drug abuse. However, when a veteran's alcohol or drug abuse disability is secondary to or is caused or aggravated by a primary service-connected disorder, the veteran may be entitled to compensation. See Allen v. Principi, 237 F.3d 1368, 1381 (Fed. Cir. 2001). Therefore, it is important to determine the relationship, if any, between a service-connected disorder and a disability resulting from the veteran's alcohol or drug abuse. Unless alcohol or drug abuse is secondary to or is caused or aggravated another mental disorder, you should separate, to the extent possible, the effects of the alcohol or drug abuse from the effects of the other mental disorder(s). If it is not possible to separate the effects in such cases, please explain why.

I. Diagnostic Status

Axis I disorders
Axis II disorders
Axis III disorders
Axis IV (psychosocial and environmental problems)
Axis V (GAF score - current)

[Preference is for current level of functioning for C&P purposes, although rating should take into consideration all evidence of functioning, over past year or since previous exam.]

J. GAF

NOTE: The complete multi-axial format as specified by DSM-IV may be required by BVA REMAND or specifically requested by the rating specialist. If so, include the GAF score and note whether it refers to current functioning. A BVA REMAND may also request, in addition to an overall GAF score, that a separate GAF score be provided for each mental disorder present when there are multiple Axis I or Axis II diagnoses and not all are service-connected. If separate GAF scores can be given, an explanation and discussion of the rationale is needed. If it is not possible, an explanation as to why not is needed. (See the above note pertaining to alcohol or drug abuse.)

K. Capacity to Manage Financial Affairs

Mental competency, for VA benefits purposes, refers only to the ability of the veteran to manage VA benefit payments in his or her own best interest, and not to any other subject. Mental incompetency, for VA benefits purposes, means that the veteran, because of injury or disease, is not capable of managing benefit payments in his or her best interest.

In order to assist raters in making a legal determination as to competency, please address the following:

What is the impact of injury or disease on the veteran's ability to manage his or her financial affairs, including consideration of such things as knowing the amount of his or her VA benefit payment, knowing the amounts and types of bills owed monthly, and handling the payment prudently?

Does the veteran handle the money and pay the bills himself or herself?

Based on your examination, do you believe that the veteran is capable of managing his or her financial affairs? Please provide examples to support your conclusion.

If you believe a Social Work Service assessment is needed before you can give your opinion on the veteran's ability to manage his or her financial affairs, please explain why.

L. Other Opinion

Furnish any other specific opinion requested by the rating board or BVA remand (furnish the complete rationale and citation of medical texts or treatise supporting opinion, if medical literature review was undertaken).

If the requested opinion is medically not ascertainable on exam or testing, please state *why.*

If the requested opinion can not be expressed without resorting to speculation or making improbable assumptions, say so, and explain why.

If the opinion asks " ... is it at least as likely as not ... ", fully explain the clinical findings and rationale for the opinion.

M. Integrated Summary and Conclusions

• Describe changes in *psychosocial functional status* and *quality of life* following trauma exposure (performance in employment or schooling, routine responsibilities of self care, family role functioning, physical health, social/ interpersonal relationships, recreation/leisure pursuits)

• Describe linkage between PTSD symptoms and aforementioned changes in impairment in functional status and quality of life. *Particularly in cases where a veteran is unemployed, specific details about the effects of PTSD and its symptoms on employment are especially important.*

• If possible, describe extent to which disorders other than PTSD (e.g., substance use disorders) are independently responsible for impairment in psychosocial adjustment and quality of life. If this is not possible, explain why (e.g., substance use had onset after PTSD and clearly is a means of coping with PTSD symptoms).

• If possible, describe pre-trauma risk factors or characteristics that may have rendered the veteran vulnerable to developing PTSD subsequent to trauma exposure.

• If possible, state prognosis for improvement of psychiatric condition and impairments in functional status.

• Comment on whether veteran should be rated as competent for VA purposes in terms of being capable of managing his/her benefit payments in his/her own best interest.

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REVIEW EXAMINATION FOR POSTTRAUMATIC STRESS DISORDER

Name:
SSN:
Date of Exam:
C-number:
Place of Exam:

A: Review of Medical Records.

B. Medical History since last exam:

Comment on:

1. Hospitalizations and outpatient care from the time between last rating examination to the present, UNLESS the purpose of this examination is to ESTABLISH service connection, then the complete medical history since discharge from military service is required.

2. Frequency, severity and duration of psychiatric symptoms.

3. Length of remissions from psychiatric symptoms, to include capacity for adjustment during periods of remissions.

4. Treatments including statement on effectiveness and side effects experienced.

5. *Subjective Complaints*: Describe fully.

C. Psychosocial Adjustment since the last exam

• legal history (DWIs, arrests, time spent in jail)

• educational accomplishment

• extent of time lost from work over the past 12 month period and social impairment. If employed, identify current occupation and length of time at this job. *If unemployed, note in complaints whether veteran contends it is due to the*

effects of a mental disorder. Further indicate following diagnosis, what factors, and objective findings support or rebut that contention.

• marital and family relationships (including quality of relationships with spouse and children)

• degree and quality of social relationships

• activities and leisure pursuits

• problematic substance abuse

• significant medical disorders (resulting pain or disability; current medications)

• history of violence/assaultiveness

• history of suicide attempts

• summary statement of current psychosocial functional status (performance in employment or schooling, routine responsibilities of self care, family role functioning, physical health, social/interpersonal relationships, recreation/leisure pursuits)

D. Mental Status Examination

Conduct a *brief* mental status examination aimed at screening for DSM-IV mental disorders. Describe and fully explain the existence, frequency and extent of the following signs and symptoms, or any others present, and relate how they interfere with employment and social functioning:

• Impairment of thought process or communication.

• Delusions, hallucinations and their persistence.

• Eye contact, interaction in session, and inappropriate behavior cited with examples.

• Suicidal or homicidal thoughts, ideations or plans or intent.

• Ability to maintain minimal personal hygiene and other basic activities of daily living.

• Orientation to person, place and time.

• Memory loss, or impairment (both short and long-term).

• Obsessive or ritualistic behavior which interferes with routine activities and describe any found.

• Rate and flow of speech and note any irrelevant, illogical, or obscure speech patterns and whether constant or intermittent.

• Panic attacks noting the severity, duration, frequency and effect on independent functioning and whether clinically observed or good evidence of prior clinical or equivalent observation is shown.

• Depression, depressed mood or anxiety.

• Impaired impulse control and its effect on motivation or mood.

• Sleep impairment and describe extent it interferes with daytime activities.

• Other disorders or symptoms and the extent they interfere with activities, particularly:

- mood disorders (especially major depression and dysthymia)

- substance use disorders (especially alcohol use disorders)

- anxiety disorders (especially panic disorder, obsessive-compulsive disorder, generalized anxiety disorder)

- somatoform disorders

- personality disorders (especially antisocial personality disorder and borderline personality disorder)

E. Assessment of PTSD

• state whether the veteran currently meets the DSM-IV stressor criterion

• identify behavioral, cognitive, social, affective, or somatic symptoms veteran attributes to PTSD

• describe specific PTSD symptoms present (symptoms of trauma re-experiencing, avoidance/numbing, heightened physiological arousal, and associated features [e.g., disillusionment and demoralization])

• specify typical frequency and severity of symptoms

F. Psychometric Testing Results

• provide psychological testing if deemed necessary

• provide specific evaluation information required by the rating board or on a BVA Remand**.**

• comment on validity of psychological test results

• provide scores for PTSD psychometric assessments administered

• state whether PTSD psychometric measures are consistent or inconsistent with a diagnosis of PTSD, based on normative data and established “cutting scores” (cutting scores that are consistent with or supportive of a PTSD diagnosis are as follows: PCL ≥ 50; Mississippi Scale ≥ 107; MMPI PTSD subscale a score > 28; MMPI code type: 2-8 or 2-7-8)

• state degree of severity of PTSD symptoms based on psychometric data (mild, moderate, or severe)

• describe findings from psychological tests measuring problems other than PTSD (MMPI, etc.)

G. Diagnosis:

1. The Diagnosis must conform to DSM-IV and be supported by the findings on the examination report.

2. If there are multiple mental disorders, delineate to the extent possible the symptoms associated with each and a discussion of relationship.

3. Evaluation is based on the effects of the signs and symptoms on occupational and social functioning.

NOTE: VA is prohibited by statute, 38 U.S.C. § 1110, from paying compensation for a disability that is a result of the veteran's own alcohol or drug abuse. However, when a veteran's alcohol or drug abuse disability is secondary to or is caused or aggravated by a primary service-connected disorder, the veteran may be entitled to compensation. See Allen v. Principi, 237 F.3d 1368, 1381 (Fed. Cir. 2001). Therefore, it is important to determine the relationship, if any, between a service-connected disorder and a disability resulting from the veteran's alcohol or drug abuse. Unless alcohol or drug abuse is secondary to or is caused or aggravated another mental disorder, you should separate, to the extent possible, the effects of the alcohol or drug abuse from the effects of the other mental disorder(s). If it is not possible to separate the effects in such cases, please explain why.

H. Diagnostic Status

Axis I disorders
Axis II disorders
Axis III disorders
Axis IV (psychosocial and environmental problems)
Axis V (GAF score: current)

I. Global Assessment of Functioning (GAF):

NOTE: The complete multi-axial format as specified by DSM-IV may be required by BVA REMAND or specifically requested by the rating specialist. If so, include the GAF score and note whether it refers to current functioning. A BVA REMAND may also request, in addition to an overall GAF score, that a separate GAF score be provided for each mental disorder present when there are multiple Axis I or Axis II diagnoses and not all are service-connected. If separate GAF scores can be given, an explanation and discussion of the rationale is needed. If it is not possible, an explanation as to why not is needed. (See the above note pertaining to alcohol or drug abuse.)

J. Competency:

Competency, for benefits purposes, has a special meaning, and refers *only* to veterans' ability to manage benefit payments in their own best interests without restriction, and not to any other subject. State whether the veteran is capable of managing his/her or her benefit payments in the individual's own best interests (a physical disability which prevents the veteran from attending to financial matters in person is not a proper basis for a finding of incompetency unless the veteran

is, by reason of that disability, incapable of directing someone else in handling the individual's financial affairs).

K. Capacity to Manage Financial Affairs

Mental competency, for VA benefits purposes, refers only to the ability of the veteran to manage VA benefit payments in his or her own best interest, and not to any other subject. Mental incompetency, for VA benefits purposes, means that the veteran, because of injury or disease, is not capable of managing benefit payments in his or her best interest.

In order to assist raters in making a legal determination as to competency, please address the following:

What is the impact of injury or disease on the veteran's ability to manage his or her financial affairs, including consideration of such things as knowing the amount of his or her VA benefit payment, knowing the amounts and types of bills owed monthly, and handling the payment prudently?

Does the veteran handle the money and pay the bills himself or herself?

Based on your examination, do you believe that the veteran is capable of managing his or her financial affairs? Please provide examples to support your conclusion.

If you believe a Social Work Service assessment is needed before you can give your opinion on the veteran's ability to manage his or her financial affairs, please explain why.

L. Integrated Summary and Conclusions

1. Describe changes in *psychosocial functional status* and *quality of life* since the last exam (performance in employment or schooling, routine responsibilities of self care, family role functioning, physical health, social/interpersonal relationships, recreation/leisure pursuits).

2. Describe linkage between PTSD symptoms and aforementioned changes in impairment in functional status and quality of life. *Particularly in cases where a veteran is unemployed, specific details about the effects of PTSD and its symptoms on employment are especially important.*

3. If possible, describe extent to which disorders other than PTSD (e.g., substance use disorders) are independently responsible for impairment in psychosocial adjustment and quality of life. If this is not possible, explain why (e.g., substance use had onset after PTSD and clearly is a means of coping with PTSD symptoms).

4. If possible, state prognosis for improvement of psychiatric condition and impairments in functional status.

5. Comment on whether veteran should be rated as competent for VA purposes in terms of being capable of managing his/her benefit payments in his/her own best interest.

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V. Suggested Report Template For Initial PTSD Compensation and Pension Exam

The following template includes examples of all information listed in the Initial Disability Examination worksheet, and is intended as an aid to organizing information gained during the examination. Taking into account the individual differences in patients, clinician specialty, writing style, and resources and time available, it is recommended that the examiner utilize clinical judgment in choosing which template options are particularly relevant to documenting a thorough assessment and diagnosis of the veteran.

Name:
Date:
Address:
Clinician:
DOB:
Supervisor:
SS#:

1. Identifying information & Referral Question
The veteran is a __ year old, ____ (race), _____ war era veteran , living with _____ for the past _____, referred to the C&P program, _____ division for a comprehensive evaluation for the diagnosis of PTSD. General remarks on the 2507 form request _____.

2. Sources of Information

The veteran was interviewed for approximately ___ hour(s) on (date) _____. In addition, a review was made of his/her C-file / DD-214, / medical records from VA, Department of Defense, and other health care facilities. In addition, the veteran saw (social worker) _____ on (date) _____ who conducted a comprehensive psychosocial history. Additionally, the veteran saw Dr. _____ on (date) _____ who diagnosed the veteran with _____, _____. Other sources of information include statements
from collaterals or others who have information about the veteran's trauma exposure and its behavioral sequelae, evidence of behavior changes that occurred shortly after the trauma incident, and statements derived from interview of the claimant. These will be cited where appropriate as sources of information below.

The veteran was administered a battery of psychometric tests to assess psychopathology
and specific symptoms of PTSD. Instruments utilized included
the following (choose): Mississippi Scale for Combat Related PTSD, the Combat Exposure Scale, the PCL, a modified version of the Structured Clinical Interview for DSM-IV PTSD module, the Women's Wartime Stressor Scale, the Desert Storm Trauma Exposure Questionnaire, the Sexual Experiences Survey, the Childhood Trauma Questionnaire, the MMPI PTSD subscales, the Impact of Event Scale—Revised, the Penn Inventory , the PTSD Stress Diagnostic Scale, and the Trauma Symptom Inventory. The assessments were administered at the time of this interview. Results will be reported below.

1. Premilitary History and Functioning

The veteran was raised by his/her biological / adoptive / step parents until the age of ____, at which time he/she enlisted in the (military branch) _____. His/her father was described as (type of work, personality):
_____, and his/her mother as (type of work, personality)
_____. He/she has (#) _____ siblings who currently are ages _____, and living in _____.
He/she maintains that he/she has(type of relationship; contact)
_____ with parents and (type of relationship; contact)
_____ with his/her siblings.
Prior to entering the service, the veteran completed _____ years of schooling and earned / did not earn a high school diploma. He describes him/herself during this time as being " _____, " and his/her pre-military adjustment as being / very good / good / average / marginal / poor. His/her performance in school, grades, suspensions, general behavior, sports participation, dating were _____. Legal history included: _____.

He/she had _____ history of trouble as a youth which he/she described as _____. His/her college history is _____.
His/her substance usage was reported to be _____ and
included the use of (types) _____ with (no) associated problems including:
_____. He/she had health-related problems which included (include history of injury, including head injury) _____.
According to the veteran's reports, his/her pre-military stressors included: _____, at ages _____, resulting in (academic problems, hospital, jail, mental symptoms, treatment, etc). _____. Medications taken regularly prior to military included _____.
Family history of psychiatric problems included: _____.
Overall assessment of psychosocial adjustment, progression through developmental
milestones, and general level of functioning is: _____
_____.

2. Military History
According to military records and self-report, the veteran _____ was enlisted / was drafted / commissioned in (branch _____) from _____ to _____. He/she was stationed for (months/years) ____ in (location/s) _____, from (dates) _____ to _____. His/her primary
duty was _____.
In addition, other duties included _____.
He/she served _____ tours in (war) _____ with the (unit) _____ as (MOS & Duties) _____ in the areas of (location) _____ from (dates) _____ to _____. He/she attained the rank of _____ while in (war) _____. He/she was /honorably / dishonorably / generally / discharged. The veteran's duty in (war) _____ could be classified as mainly combat / combat support / support. The veteran was awarded _____ medals. The veteran reported the following general war experiences: (see: Combat Scale): _____.
Specific Trauma's will be discussed below in Section VIII.

3. Post-Military History

Education and Employment History:
The veteran received _____ education following active duty, with a _____ certificate / degree(s) achieved. His/her employment history

includes _____ jobs from _____ to _____. He/she is currently
unemployed / employed. His/her current occupation is _____ and length of time at this job has been _____.

Social Functioning:
The veteran is currently Married/Divorced (onset and length of time for each, reason for divorce): _____. He/she has _____ contact
(with spouse & children). His/her children are (ages) _____.
He/she describes his/her current relationships as:
_____.
His/her attitude towards social interactions, and how he/she feels others view him/her appears to be: _____.
His/her social support & hobbies include: _____.

Post Military Stressors:
According to the veteran's reports, his/her post-military stressors and significant losses have included: _____, at ages _____.

Legal History:
The veteran's legal history includes the following incidents (reckless driving, DWI, assault, etc.) _____ on (dates for each)
_____,
which resulted in _____.

Substance Abuse/Alcohol History & Treatment:
The veteran reports the following use of alcohol and drug (s): (age of onset): _____, (types): _____, (amounts): _____ (last usage): _____, periods of exacerbation and remission): _____, (related psychosocial problems (marital, occupational,)): _____, (withdrawal problems): _____, (related health problems): _____, (treatments): _____.

Medical History:
The veteran's medical history includes the following significant illnesses and injuries: _____.
Hospitalizations: _____.
Current medications: _____.
Review of Claims Folder (for initial exams) revealed: _____.
Current disability rating is: _____.

Subjective Complaints:
The veteran _____ reports the following current subjective complaints: _____ _____. Suicidal / homicidal ideation: _____.
During and following his/her active duty, the veteran reported the following psychiatric symptoms (onset, frequency, severity and duration, suicide attempts) _____ . His/her most troublesome / frequent / disruptive symptoms appear to be _____.

History of Psychiatric care:
The Veteran's history of psychiatric care began on _____, and has included (medications, inpatient treatment, outpatient care, groups, etc). _____. The veteran is currently receiving (type and frequency of treatment) _____.
History and length of remissions, have been _____. His/her capacity for adjustment during periods of remissions appeared to be _____.

Social Impairment:
The extent of social impairment and work impairment (time lost, problems with supervisors/coworkers, loss of productivity, etc.) over the past 12 month period was _____. (If unemployed), The veteran does not contend
/ contends it is due to the effects of a mental disorder. (Further discuss in DIAGNOSIS, if possible, what factors and objective findings support or rebut that contention).

4. Mental Status Exam and Observations

Appearance:
Dress: (casual) (formal) (other: _____)
Eye contact: (excellent) (good) (fair) (poor) (variable) (other: _____)
Grooming: (excellent) (good) (fair) (poor) (other: _____)
Hygiene: (excellent) (good) (fair) (poor) (other: _____)
Posture: (excellent) (good) (fair) (poor) (variable) (impaired) (abnormal) (other: _____)
Appearance: (healthy) (excellent) (good) (fair) (poor) (sickly) (muscular) (atrophied) (other: _____)

Psychomotor:
Gait: _____
Level of Activity: (hyperactive) (combative) (normal) (restless) (lethargic)

(fatigued) (tense) (other: _____)

Manner: (cooperative) (angry) (defensive) (apathetic) (interested) (guarded) (attentive) (achievement orientated) (rigid conscience) (other: _____)

Speech: (normal rate & rhythm)(rapid) (slow) (pressured) (hesitant) (loud) (whispered) (slurred) (mumbled) (echolalia) (spontaneous) (irrelevant answers) (loosening of answers) (muddled) (other: _____)

Mood {**pt. Report**}: (dysphoric) (euthymic) (depressed) (elated) (expansive) (anxious) (frightened) (angry) (labile) (inappropriate) (appropriate) (guilty) (other: _____)
{**examiner's evaluation of affect**} (broad) (restricted) (depressed) (blunted) (flat) (anxious) (mood congruent) (mood incongruent) (other: _____)

Thought Processes: (overabundance of ideas) (paucity of ideas) (flight of ideas) (slow thinking) (perseverations) (goal directed answers to questions) (loose associations to questions) (tangential) (rambling) (evasive) (blocking) (other: _____)

Thought Content: (obsessions) (compulsions) (phobias) (intrusive memories)
[**delusions**] (bizarre) (somatic) (grandeur) (persecution) (reference)
(selfaccusation)
(control) (paranoid) (other): _____)
[**hallucinations]** (auditory) (visual) (olfactory) (gustatory) (tactile)
(other: _____) (SUICIDAL IDEATION) (PLAN) (INTENT)
(HISTORY) [No evidence of SI]
(HOMICIDAL IDEATION) (PLAN) (INTENT) (HISTORY)
[No evidence of HI]

Orientation: person _____ place _____ date _____

Abstract Thinking "A Rolling Stone Gathers No Moss" (concept formation problems) (appropriate answer) (Result: _____)

Information and Intelligence: (relative to education level: _____)

Concentration: SERIAL 7's: 100, 93, 86, 79, 72, 65, 58, 51, 44, 37, 30, 23, 16, 9, 2, (report number of integers): _____)

Remote memory (memory for childhood information) (intact) (deficits) (other: _____)

Recent memory: (past few months) (intact) (deficits)
(other: _____)

Immediate retention: (pen, clothespin, car, dog)

Delayed recall: (pen, clothespin, car, dog)

Judgment: Social Judgment: understand outcome of behavior? (YES NO)

Insight: (awareness of problems) (other: _____)

7. Testing Results
The veteran was administered measures specifically designed to assess PTSD.

OPTION 1:
In summary, the psychometric findings are consistent with information gathered during the diagnostic and social history interviews for the presence and level of symptomatology. On all measures he or she scored in a manner similar to normative
patient samples known to have PTSD. **(**Scores are suggestive of an individual with Mild / Moderate / Severe PTSD.) *OR* The veteran scored in a
range that is characteristic of patient samples that do not carry the diagnosis of PTSD. The pattern among the psychometric findings supports / does not support a diagnosis of PTSD.

OPTION 2:
In summary, the psychometric findings are inconsistent with information gathered during the diagnostic and social history interviews for presence and level of symptomatology. The level of reporting on the battery of psychometrics is greater than / less than / more variable than interview information. The discrepancy
may be due to (discuss reasons why the two sources do not agree): _____. Given this inconsistency, conclusions about a PTSD diagnosis based on the psychometric findings cannot be advanced.
Mississippi: _____ PCL: _____ Combat Exposure Scale: _____ Women's Wartime Stressor Scale: _____ Sexual Experiences Survey: _____ Brief Questionnaire for Sexual Assault: _____ Desert Storm Trauma Exposure Questionnaire: _____ Childhood Trauma Questionnaire: _____ MMPI PTSD subscales: _____ Impact of Event Scale—Revised: _____

Penn Inventory: _____ PTSD Stress Diagnostic Scale: _____
Trauma Symptom Inventory: _____ *Other:*_____

5. Other Symptoms
This veteran also meets criteria for: (Diagnostic and Statistical Manual for Mental Disorders-IV DSM-IV diagnosis, brief description of symptoms) _____.

6. PTSD Assessment

Military Stressor(s)
(To follow from Combat Exposure Questionnaire and interview):
The veteran's military-related stressors have included injury / captivity / torture / witnessing atrocities / personal assault / sexual assault / other. Because there is a history of multiple stressors, the veteran considers the most severe to have been _____. The impact of each is believed to have been:
a: _____ b: _____ c:_____
d: _____. Other stressful life events during this period included (noncombat
events such as death in family, etc): _____.

Symptoms and impairment in functioning:
(To follow from SCID/CAPS):
Behavioral, cognitive, social, or affective changes linked to the veteran's military stressor(s) have included: _____. Related somatic symptoms have included: _____. One of his/her most bothersome
symptoms seems to be _____.

PTSD Symptoms include:

A. The veteran has been exposed to a traumatic event in which both of the following were present:

• The veteran 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

• The veteran's response involved intense fear, helplessness, or horror.

B. The traumatic event is persistently re-experienced in one or more of the following ways:

• Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions.

• Recurrent distressing dreams of the event.

• Acting or feeling as if the traumatic event were recurring includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those which occur on awakening or when intoxicated).

• Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

• Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three or more of the following:

• Efforts to avoid thoughts, feelings, or conversations associated with the trauma

• Efforts to avoid activities, places, or people that arouse recollections of the trauma

• Inability to recall an important aspect of the trauma

• Markedly diminished interest or participation in significant activities

• Feelings of detachment or estrangement from others

• Restricted range of affect (e.g., unable to have loving feelings)

• Sense of foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two or more of the following:

• difficulty falling or staying asleep

• irritability or outbursts of anger

• difficulty concentrating

• hypervigilance

• exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, D) is more than 1 month

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:
Acute: if duration is less than 3 months
Chronic: if duration is 3 months or more

Specify if:
With Delayed Onset: if onset of symptoms is at least 6 months after the stressor.

7. Impression:

The overall picture is one of an individual who had made a / satisfactory / poor / adjustment prior to entering military service to the extent that there were / no / many / gross indications of behavior control problems, subjective unhappiness or family dysfunction. The veteran did struggle in (date, age) _____, and he/she did / did not / appear to come from a deprived or abusive background or exhibit early life disturbances of conduct that would predict his/her psychiatric and psychosocial adjustment problems as an adult. Prior to entering the military, the veteran did / did not appear to suffer from symptoms of PTSD / other.

In summary, this veteran meets the DSM-IV criteria for (PTSD, etc) _____. He/she maintains that he/she has (summarize symptoms) _____. In the interview, he/she exhibited (any behavioral

observations noted from interview which are consistent with reported symptoms) _____, and reports from collaterals / records / previous evaluations confirm his/her interview responses and observed behaviors.

The veteran maintains that these symptoms have been present over for (duration of time) _____. The symptoms seem to be intensified during (anniversary dates) _____.

Changes in functioning from pre to post military service were noted in the areas of: affect / mental health / cognition / sleep / health / social / employment / housing / finances / litigation / acculturation / academic. Changes in psychosocial functional status and quality of life following trauma exposure were noted in employment or schooling / routine responsibilities of self care / family role functioning / physical health / social/interpersonal relationships / and recreation/ leisure pursuits (describe changes in all areas).

The veteran's PTSD symptoms /appear to be/do not appear to be/ related to changes in impairment in functional status and quality of life (describe) _____.

OPTION 1: Disorders other than PTSD (e.g., substance use disorders) are independently responsible for impairment in psychosocial adjustment and quality of life (describe) _____.

OPTION 2: At this time, it is not possible, to separate the effects of PTSD and co-occurring disorders on the veteran's functioning because _____ (e.g., substance use had onset after PTSD and clearly is a means of coping with PTSD symptoms).

Pre-trauma risk factors or characteristics than may have rendered the veteran vulnerable to developing PTSD subsequent to trauma exposure are _____. Prognosis for improvement of psychiatric condition and impairments in functional status is _____.

11. Other Psychiatric Symptoms:

12. Diagnoses:

Axis I:

Axis II:

Axis III:

Axis IV: health problems, death of family member, separation or divorce, exposure
to combat, inadequate social support, living alone, unemployment, discord at work, inadequate housing, inadequate finances, litigation, difficulty with acculturation, academic problems, other.

Axis V: GAF= (current level of functioning. Use descriptor phrases - link functioning to diagnoses via behavioral / concrete anchors and descriptions)

13. Competency:
It is recommended that this veteran be rated as competent for VA purposes. The veteran is capable of managing his/her or her benefit payments in his/her own best interests.

****

VI. Suggested Report Template For Follow-up PTSD Compensation and Pension Exam

****The following template includes examples of all information listed in the Follow-up Disability Examination worksheet, and is intended as an aid to organizing information gained during the examination. Taking into account the individual differences in patients, clinician specialty, writing style, and resources and time available, it is recommended that the examiner utilize clinical judgement in choosing which template options are particularly relevant to documenting a thorough assessment and diagnosis of the veteran.****

Name:
Date:
Address:
Clinician:
DOB:
Supervisor:
SS#:

1. Identifying Information & Referral Question
The veteran is a __year old, ____ (race), _____war era veteran, living with _____ for the past _____, referred to the C&P program, _____ division for

a follow-up evaluation for compensation and pension for PTSD.

2. Sources of Information
The veteran was interviewed for approximately ___ hour(s) on (date) _____.

In addition, a review was made of his/her C-file / DD-214, / medical records from VA, Department of Defense, and other health care facilities. In addition, the veteran saw (social worker) _____ on (date) _____ who conducted a comprehensive psychosocial history. Additionally, the veteran saw Dr. _____ on (date) _____ who diagnosed the veteran with _____, _____. Other sources of information include statements
from collaterals or others who have information about the veteran's trauma exposure and its behavioral sequelae, evidence of behavior changes that occurred shortly after the trauma incident, and statements derived from interview of the claimant. These will be cited where appropriate as sources of information below.

The veteran was administered a battery of psychometric tests to assess psychopathology
and specific symptoms of PTSD. Instruments utilized included
the following (choose): Mississippi Scale for Combat Related PTSD, the Combat Exposure Scale, the PCL, a modified version of the Structured Clinical Interview for DSM-IV PTSD module, the Women's Wartime Stressor Scale, the Desert Storm Trauma Exposure Questionnaire, the Sexual Experiences Survey, the Childhood Trauma Questionnaire, the MMPI PTSD subscales, the Impact of Event Scale—Revised, the Penn Inventory , the PTSD Stress Diagnostic Scale, and the Trauma Symptom Inventory. The assessments were administered at the time of this interview. Results will be reported below.

3. History Since Last C & P Exam

Education and Employment History:
The veteran received _____ education, with a _____ certificate /
degree(s) achieved. His/her employment history includes _____ jobs from _____ to _____. He/she is currently unemployed / employed. His/her current occupation is _____ and length of time at this job has been _____.

Social Functioning:
The veteran is currently Married/Divorced (onset and length of time for each,

reason for divorce): _____. He/she has _____ contact
(with spouse & children). His/her children are (ages) _____.
He/she describes his/her current relationships as:
_____.
His/her attitude towards social interactions, and how he/she feels others view him/her appears to be: _____.
His/her social support & hobbies include: _____.

Stressors:
According to the veteran's reports, his/her stressors and significant losses since the last C & P exam have included: _____.

Legal History:
The veteran's legal history includes the following incidents (reckless driving, DWI, DV etc.) _____ on (dates for each) _____, which resulted in _____.

Substance Abuse/Alcohol History & Treatment:
The veteran reports the following use of alcohol and drug (types): _____, (amounts): _____ (last usage): _____,
periods of exacerbation and remission): _____, (related psychosocial
problems (marital, occupational,)): _____,
(withdrawal problems): _____, (related health problems): _____, (treatments): _____.

Medical History:
The veteran's medical history since the last C & P exam includes the following significant illnesses and injuries: _____.
Hospitalizations: _____.
Current medications: _____.
Review of Claims Folder (for initial exams) revealed: _____.
Current disability rating is: _____.

Subjective Complaints:
The veteran _____reports the following current subjective complaints: _____ _____. Suicidal / homicidal ideation: _____.

History of Psychiatric care:
Since his/her last C & P exam, the veteran reported the following psychiatric

symptoms (onset, frequency, severity and duration, suicide attempts) _____ . His/her most troublesome / frequent / disruptive symptoms appear to be _____. His/her history of psychiatric care has included (medications,
inpatient treatment, outpatient care, groups, etc). _____.
The veteran is currently receiving (type and frequency of treatment) _____.
History and length of remissions, have been _____. His/her capacity for adjustment during periods of remissions appeared to be _____.

Social Impairment:
The extent of social impairment and work impairment (time lost, problems with supervisors/coworkers, loss of productivity, etc.) since the last C & P examination was _____. (If unemployed), The veteran does not contend / contends it is due to the effects of a mental disorder. (Further discuss in DIAGNOSIS, if possible, what factors and objective findings support or rebut that contention).

4. Mental Status Exam and Observations

Appearance:
Dress: (casual) (formal) (other: _____)
Eye contact: (excellent) (good) (fair) (poor) (variable) (other: _____)
Grooming: (excellent) (good) (fair) (poor) (other: _____)
Hygiene: (excellent) (good) (fair) (poor) (other: _____)
Posture: (excellent) (good) (fair) (poor) (variable) (impaired) (abnormal) (other: _____)
Appearance: (healthy) (excellent) (good) (fair) (poor) (sickly) (muscular) (atrophied) (other: _____)

Psychomotor:
Gait: _____
Level of Activity: (hyperactive) (combative) (normal) (restless) (lethargic) (fatigued) (tense) (other: _____)

Manner: (cooperative) (angry) (defensive) (apathetic) (interested) (guarded) (attentive) (achievement orientated) (rigid conscience) (other: _____)

Speech: (normal rate & rhythm)(rapid) (slow) (pressured) (hesitant) (loud)

(whispered) (slurred) (mumbled) (echolalia) (spontaneous) (irrelevant answers) (loosening of answers) (muddled) (other: _____)

Mood {pt. Report}: (dysphoric) (euthymic) (depressed) (elated) (expansive) (anxious) (frightened) (angry) (labile) (inappropriate) (appropriate) (guilty) (other: _____)
{examiner's evaluation of affect} (broad) (restricted) (depressed) (blunted) (flat) (anxious) (mood congruent) (mood incongruent) (other: _____)

Thought Processes: (overabundance of ideas) (paucity of ideas) (flight of ideas) (slow thinking) (perseverations) (goal directed answers to questions) (loose associations to questions) (tangential) (rambling) (evasive) (blocking) (other: _____)

Thought Content: (obsessions) (compulsions) (phobias) (intrusive memories) [**delusions**] (bizarre) (somatic) (grandeur) (persecution) (reference) (selfaccusation)
(control) (paranoid) (other: _____)
[**hallucinations]** (auditory) (visual) (olfactory) (gustatory) (tactile) (other: _____) (SUICIDAL IDEATION) (PLAN) (INTENT)
(HISTORY) [No evidence of SI]
(HOMICIDAL IDEATION) (PLAN) (INTENT) (HISTORY)
[No evidence of HI]

Orientation: person _____ place _____ date _____

Abstract Thinking "A Rolling Stone Gathers No Moss" (concept formation problems) (appropriate answer) (Result: _____)

Information and Intelligence: (relative to education level: _____)

Concentration: SERIAL 7's: 100, 93, 86, 79, 72, 65, 58, 51, 44, 37, 30, 23, 16, 9, 2, (report number of integers: _____)

Remote memory (memory for childhood information) (intact) (deficits) (other: _____)

Recent memory: (past few months) (intact) (deficits) (other: _____)

Immediate retention: (pen, clothespin, car, dog)

Delayed recall: (pen, clothespin, car, dog)

Judgment: Social Judgment: understand outcome of behavior? (YES NO)

Insight: (awareness of problems) (other: _____)

5. Testing Results
The veteran was administered measures specifically designed to assess PTSD.

OPTION 1:
In summary, the psychometric findings are consistent with information gathered during the veteran's initial C & P examination for PTSD. On all measures he/she scored in a manner similar to normative patient samples known to have PTSD. (Scores are suggestive of an individual with Mild / Moderate / Severe PTSD.) *OR* The veteran scored in a range that is characteristic of patient samples that do not carry the diagnosis of PTSD. The pattern among the psychometric
findings supports / does not support a diagnosis of PTSD.

OPTION 2:
In summary, the psychometric findings are inconsistent with information from the veteran's initial C & P evaluation for PTSD. The level of reporting on the battery of psychometrics is greater than / less than / more variable than interview information. The discrepancy may be due to (discuss reasons why the two sources do not agree): _____. Given this inconsistency, conclusions about a PTSD diagnosis based on the psychometric findings cannot
be advanced.
Mississippi: _____ PCL: _____ Combat Exposure Scale: _____ Women's Wartime Stressor Scale: _____ Sexual Experiences Survey: _____ Desert Storm Trauma Exposure Questionnaire: _____ Childhood Trauma Questionnaire: _____ MMPI PTSD subscales: _____ Impact of Event Scale—Revised: _____ Penn Inventory: _____ PTSD Stress Diagnostic Scale: _____Trauma Symptom Inventory: _____ *Other:* _____

6. Other Symptoms
This veteran also meets criteria for: (DSM-IV diagnosis, brief description of symptoms) _____.

7. PTSD Assessment

Symptoms and impairment in functioning:
(To follow from SCID/CAPS):
Behavioral, cognitive, social, or affective changes linked to the veteran's military stressor(s) have included: _____. Related somatic symptoms have included: _____. One of his/her most bothersome
symptoms seems to be _____.

PTSD Symptoms include:

A. The veteran has been exposed to a traumatic event in which both of the following were present:

1. The veteran 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 veteran's response involved intense fear, helplessness, or horror.

B. The traumatic event is persistently re-experienced in one or more of the following ways:

- Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions.

- Recurrent distressing dreams of the event.

- Acting or feeling as if the traumatic event were recurring includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those which occur on awakening or when intoxicated).

- Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

- Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three or more of the following:

- Efforts to avoid thoughts, feelings, or conversations associated with the trauma

- Efforts to avoid activities, places, or people that arouse recollections of the trauma

- Inability to recall an important aspect of the trauma

- Markedly diminished interest or participation in significant activities

- Feelings of detachment or estrangement from others

- Restricted range of affect (e.g., unable to have loving feelings)

- Sense of foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two or more of the following:

- difficulty falling or staying asleep

- irritability or outbursts of anger

- difficulty concentrating

- hypervigilance

- exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, D) is more than 1 month

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:
Acute: if duration is less than 3 months
Chronic: if duration is 3 months or more

Specify if:

With Delayed Onset: if onset of symptoms is at least 6 months after the stressor.

8. Impression:

The overall picture is one of an individual who had made a / satisfactory / poor / adjustment since his/her last C & P examination for PTSD, to the extent that there were / no / many / gross indications of behavior control problems, subjective
unhappiness or family dysfunction

In summary, this veteran meets the DSM-IV criteria for (PTSD, etc.,) _____. He/she maintains that he/she has (summarize symptoms) _____. In the interview, he/she exhibited (any behavioral
observations noted from interview which are consistent with reported symptoms) _____, and reports from collaterals / records / previous evaluations confirm his/her interview responses and observed behaviors.

The veteran maintains that these symptoms have been present over for (duration of time) _____. The symptoms seem to be intensified during (anniversary dates) _____.

Changes in functioning were noted in the areas of: affect / mental health / cognition
/ sleep / health / social / employment / housing / finances / litigation / acculturation / academic. Changes in psychosocial functional status and quality of life were noted in employment or schooling / routine responsibilities of self care / family role functioning / physical health / social/interpersonal relationships / and recreation/leisure pursuits (describe changes in all areas).

The veteran's PTSD symptoms /appear to be/do not appear to be/ related to changes in impairment in functional status and quality of life (describe) _____.

OPTION 1: Disorders other than PTSD (e.g., substance use disorders) are independently responsible for impairment in psychosocial adjustment and quality of life (describe) _____.

OPTION 2: At this time, it is not possible, to separate the effects of PTSD and co-occurring disorders on the veteran's functioning because _____ (e.g., substance use had onset after PTSD and clearly is a means of coping with

PTSD symptoms).

Prognosis for improvement of psychiatric condition and impairments in functional status is _____.

9. Other Psychiatric Symptoms:

10. Diagnoses:

Axis I:

Axis II:

Axis III:

Axis IV: health problems, death of family member, separation or divorce, exposure to combat, inadequate social support, living alone, unemployment, discord at work, inadequate housing, inadequate finances, litigation, difficulty with acculturation, academic problems, other.

Axis V: GAF= (current level of functioning. Use descriptor phrases - link functioning to diagnoses via behavioral / concrete anchors and descriptions)

11. Competency:

It is recommended that this veteran be rated as competent for VA purposes. The veteran is capable of managing his/her or her benefit payments in his/her own best interests.

****

Appendix A: Training Letter Based On PTSD Case Review

January 8, 2001

All VBA Regional Offices and Centers TL 01-01

SUBJECT: PTSD Case Review

We recently completed a review of 143 initial claims for PTSD, with the assistance of reviewers from the field, under a special protocol. An additional 77 cases were informally reviewed.

The attached training letter addresses some of our general findings as well as problems revealed by the review. The 10 important rating points about PTSD emphasize major areas of concern. They are followed by more detailed information on our findings.

Additional and broader training on PTSD will be conducted in the near future. This letter is not intended to make policy but to restate and clarify existing policy.

If you have any questions or comments about the content of this letter, or note any errors, please contact the person listed at http://vbaw.vba.va.gov/bl/21/publicat/letters/trngltrs.htm.

/s/
Robert J. Epley, Director
Compensation and Pension Service

Enclosure

10 important rating points about PTSD

1. You are obligated (per 4.125) to assure that the diagnosis of PTSD is well-supported by the findings and is based on DSM-IV diagnostic criteria. Return examination reports that do not meet this requirement.

2. You must rate PTSD based on its overall effects on social and occupational functioning. Return examination reports that do not describe these effects in detail.

3. A veteran does *not* need to have any or all of the specific examples of signs and symptoms listed in the general rating formula for mental disorders in order for a particular evaluation level of PTSD to be assigned.

4. Evaluate PTSD on the core requirements at each evaluation level, i.e., the language that refers to the *effects* of a mental disorder *on social and occupational functioning.*

5. Make sure you have made reasonable efforts to obtain all pertinent evidence (consistent with the new duty to assist requirements), including private medical records the veteran may have referred to, before you make an unfavorable decision.

6. Don't go through the I.U. process if there is clear evidence on the examination that the veteran is unable to work because of PTSD. A 100% evaluation would be more appropriate in such cases, and a future exam can be requested when indicated.

7. Do not base a rating solely or mainly on the GAF score. The GAF score does not translate directly to the rating schedule criteria.

8. Do not ignore additional mental disorders that are diagnosed in someone with PTSD. Ask the examiner about the relationship to PTSD if not already addressed in the examination report.

9. Explain the *reasons* for all of your rating decisions.

10. You must notify the veteran in clear terms of the rating decisions and fully inform him or her of any action necessary to further or complete the claim for PTSD.

What were our general findings in the review?

• 127 of the 143 decisions reviewed (89%) correctly disposed of the basic issue of service connection.

• 11% (16 decisions) contained a mistake.

- 10 decisions incorrectly established service connection.

- 6 decisions incorrectly denied service connection.

• 84% (63 decisions) correctly assigned the appropriate evaluation.

• 16% (12 decisions) assigned incorrect evaluations.

- 10 decisions underevaluated the degree of disability, particularly at the higher levels, e.g., 70%.

- 2 decisions overevaluated the degree of disability.

• 53% of the claims were granted.

• 65% of the claims cited combat as the stressor; 10% cited sexual trauma.

• When C&P examinations were conducted, 77% diagnosed PTSD.

• Very few decisions contained any real analysis.

What are some of the evaluation problems found?

1. Difficulty understanding why a particular evaluation was assigned.

Most reviewed cases were correctly evaluated, but of those that were not, most were underevaluated. Granted that evaluating any mental disorder is difficult, the reason these cases were underevaluated is unclear because of the failure to analyze evidence and explain the rating decision in the reasons and bases. As a rule, ratings laid out the evidence and gave the conclusion, but did not address how the rater reached the decision. The rating redesign initiative directly addresses this issue, as well as our organizational expectations concerning the fix.

2. Problem in applying rating schedule criteria

One reason for erroneous evaluations may be confusion about the criteria in the general rating formula for mental disorders. The signs and symptoms named at each level are **examples** of what might be seen at each level. However, the absence of those specific findings in an individual does not exclude a rating at any given level.

It is the **described effects on social and occupational functioning at each level** of whatever signs and symptoms the veteran has that should determine the rating. In particular, the examples of signs and symptoms given do not encompass the common diagnostic findings specific to PTSD, but apply to any mental disorder. Therefore, you must look beyond the generic signs and symptoms in the rating schedule and look at the **effects** of PTSD in that

individual. As with other disabilities, there is often a difference between the findings that establish the diagnosis of PTSD and those that indicate its level of severity.

Example: Vietnam combat veteran reported or showed:

• sleep disturbances to point of getting only 3-4 hours of sleep a night

• avoidance of most people and social events, distant and estranged from others

• restricted range of affect

• aggressive outbursts at work indicating impaired judgment in thinking (almost threw a man off a building, drove a vehicle into something else and caused damage)

• withdrawn, decreased concentration, hypervigilance

• mood depressed and hopeless, suicidal ideation

• fatigued and irritable

• hallucinatory flashbacks

• impairment in reality testing

Some of these are examples (in the general rating formula for mental disorders) of signs and symptoms at the 70-percent evaluation level, and others are more akin to the 100-percent level. Some of his significant problems are not in either list of examples. Taking into account all of the findings, it is clear he is at least severely, if not totally, impaired in both social and occupational functioning. He was given a 70% evaluation. Others might judge a 100% evaluation as more appropriate, particularly in view of the episodes of violence.

The National PTSD Center points out to examiners in soon-to-be-released guidelines for PTSD examiners that the presence of violence toward self and others in the veteran's history is a significant feature that should drop the GAF score into the lower ranges, even if functioning in other areas appears better. This indicates the Center's belief that violence should be regarded as an indication of very serious disease.

3. Reluctance to grant 100%

Many cases of PTSD were rated at 70% even when there were clear indications on the examination that the veteran had severe symptoms and had total occupational impairment because of PTSD symptoms.

Examples: One veteran had not been working for 2 years because of PTSD symptoms; one was reported as unable to work and getting progressively worse; one had not worked for 7 or 8 months since seeing “Saving Private Ryan”; one was complying with his treatment plan but was said not to be sufficiently stable (e.g., had suicidal ideation) to maintain competitive employment; one was said to have an inability to function in almost all areas; and one had impairment of reality testing, active flashbacks, depression, hopeless mood, etc.

Each of these was rated at 70% but could have been rated at 100%. GAF scores in these cases ranged from 30 to 45. (30 was the lowest GAF score given for any case in this review.) Most were eventually given I.U., but there seemed to be great reluctance to grant a schedular 100-percent evaluation even when there was ample medical evidence of severe disability due to PTSD, and a clear indication of impaired functioning sufficient for a schedular 100-percent evaluation.

The old Physician’s Guide stated in the chapter on mental disorders: “In the case of anxiety disorders, except for severe phobias, it is unusual for a person to be completely incapacitated.” However, VA’s National Center for PTSD states that anxiety disorders, severe phobias, PTSD, OCD (obsessive-compulsive disorder), panic disorder (esp. with agoraphobia), and social phobia all can be debilitating, sometimes to the point of complete incapacitation. Currently, over 29,000 veterans with PTSD are rated at 100% and over 6000 with generalized anxiety disorder are rated at 100%. Therefore, it is no longer correct to say that total incapacitation for anxiety disorders is unusual.

What problem was found on notification letters?

A common problem noted in the review was the failure to provide correct and adequate notification letters. A letter notifying a claimant about a rating should not simply refer to an attached copy of a rating for all information, only for a more detailed explanation of what is summarized in the notification letter itself *(See* M21-1, Part III, 11.09a and FL 00-58.)

What are the examination-related problems?

1. Availability of claims file

The examiner had the claims file for review in less than half the cases. Since these were all initial PTSD claims, this was a significant omission. We are addressing this issue with VHA and will also discuss it on the satellite broadcast.

2. Inadequacy of exams

Examinations were largely adequate, but of those that were not adequate, few were returned for correction or completion.

Example: One examiner said the veteran seemed to have some minor PTSD symptoms—but did not name them. This was the only reference to PTSD in the examination, and the veteran was SC and evaluated for PTSD based on this exam. The examination should have been returned to get more specific information.

3. Failure to apply DSM-IV criteria

In good exams, the examiner listed the DSM-IV criteria and supplied examples of the veteran's own signs and symptoms that met those criteria. When this procedure is followed, the rater should have few reservations about the validity of the diagnosis.

In several cases, the examiner clearly used DSM-III-R criteria, and they were accepted as adequate for rating, contrary to regulations (38 CFR 4.125). If you read the DSM-III-R and DSM-IV diagnostic criteria, the differences will be obvious. The language used by the examiner will usually make it clear which version is the basis of the diagnosis.

Example: Examiner began explanation of PTSD diagnosis by stating that the veteran has experienced an event that is outside the range of usual human experience and would have been markedly distressing to almost anyone. These are DSM-III-R, but not DSM-IV, criteria and are a clear indication that the diagnosis is not based on DSM-IV criteria.

What are some problems related to the use of GAF Scores?

1. Failure to explain how GAF score was used.

The GAF score was always reported in ratings when it was available, but how it was used or taken into account, if it was, was rarely explained. In some cases, however, the GAF score was the only apparent justification for the evaluation.

Example: Rating stated GAF of 60 is indicative of moderate symptoms, and therefore 30% is assigned.

The GAF scale is generally acknowledged to be an unreliable tool for assessment, although it may have value for treatment and prognostic purposes. No rating should be based primarily or even substantially on the GAF score.

2. Timeframe of GAF score.

The GAF is simply an indicator of an examiner's assessment of overall functioning, and the period of time it represents differs with different examiners. Common timeframes are either current level of functioning or best level of functioning during the past year. Which is intended is not always explained in the examination report.

While current functioning is the more useful of the two for our purposes, it is really only of interest if the veteran has been relatively stable over the past year or since the last examination. Remember that we are to consider all evidence of record, including any periods of remission, to attain a comprehensive picture of functioning. Taking this into account might lead you to an evaluation that is not consistent with the examiner's GAF score but which is more appropriate to rating requirements.

How should the GAF score be used?

You might want to look upon the GAF score as a finding that you could use as a crosscheck against your own evaluation based on the reported signs and symptoms. The GAF score, your evaluation based on the rating schedule, and the reported signs and symptoms should theoretically all correlate with one another. If they do not, you should carefully reexamine the evidence, and perhaps explain in the rating why your evaluation is at substantial variance with the GAF score, when it is, perhaps, for example, because of different timeframes. If the GAF score is not supported by other information in the examination report, it has little or no value.

However, there is no reason to change an evaluation because a GAF score differs in the assessed level of functioning from your evaluation, because your assessment may be based on more complete information than the examiner has.

Example: One examiner reported that the criteria that best describe the veteran are mild impairment with occasional decrease in efficiency due to such symptoms as depressed mood, anxiety, chronic sleep impairment, and mild memory loss (part of the 30% criteria from the general rating formula for mental disorders), which reflects a GAF score of 55. In essence, he was making a rating schedule determination and correlating the GAF to it, rather than linking the GAF score to the clinical findings.

What are the problems in duty to assist?

In some cases where it seemed indicated, all private medical records were not requested, the SMRs were not requested, there was no U.S. Armed Services Center for Unit Records Research (CURR) request, pertinent service personnel records were not requested, or all VA medical records were not requested. You should not deny a claim until you are sure that all requested evidence has been received (or the reason why it could not be obtained noted), the claimant has been afforded the opportunity to obtain and submit evidence, and you have sought relevant evidence from available sources.

How often was CURR used for stressor verification?

CURR stressor verification was used in 4 of the 6 cases where it was required.

CURR verified the stressor in one of these 4 cases.

How should other diagnosed mental disorders be handled?

When comorbid (co-existing) mental disorders were present, the examiner did not always comment on their relationship to PTSD. Ratings often failed to address co-existing disorders in any way or to ask the examiner to determine whether they were related to or part of PTSD. Since depression, for example, and substance abuse are both common accompaniments to PTSD and are sometimes due to or part of PTSD, mental disorders diagnosed in addition to PTSD cannot be ignored in ratings. If the examiner doesn't make it clear whether they are distinct and unrelated entities, the examination should be returned to clarify that.

A related problem is the need to reconcile varying diagnoses. Clarification is necessary if the examination upon which you are basing a rating makes a

different diagnosis from a diagnosis or diagnoses in other evidence of record. This is required by 38 CFR 4.25(b), which states: ” the rating agency shall determine whether the new diagnosis represents progression of the prior diagnosis, correction of an error in the prior diagnosis, or development of a new and separate condition. If it is not clear from the available records what the change of diagnosis represents, the rating agency shall return the report to the examiner for a determination.” This was not routinely done.

What are examples of erroneous grants and denials?

1. Premature grants

PTSD may occur as an acute condition that resolves after a severely stressful experience. Therefore, it cannot always be assumed to be a chronic disease.

Example: SC at 50% granted. Had PTSD in svc. Has no current diagnosis. Veteran did not appear for exam. Reason for separation was personality disorder.

Example: SC at 10% granted. Had PTSD in service related to Lebanon embassy bombing. Exam is inadequate—gives history of PTSD—but it is unclear whether he now has PTSD.

2. SC grants but with failure to reconcile diagnoses

Example: SC at 10% granted in Vietnam combat veteran. Treatment records showed PTSD. VAE showed anxiety disorder. Diagnoses should have been reconciled.

Example: SC at 50% granted. WWII Navy veteran. Had multiple diagnoses on different exams—PTSD, substance abuse, depression, etc.— not reconciled. Stressor not confirmed.

Example: SC at 50% granted for PTSD with major depression. Stressors were explosion on ship and abandonment by wife. Rating does not discuss SMRs (had a medical board) or VA examination, does not state why PTSD is SC, and does not indicate the basis of the evaluation.

3. SC grant based on inadequate exams

Example: 2 cases where SC at 10% was granted where the diagnosis was made only by the VHA POW exam coordinator (who is not a mental health professional). One did have an examination by a mental health professional. While inadequate, it did not diagnose PTSD.

Example: SC at 10% granted. Record of hospitalization for depression, and VAE showed bipolar disorder and PTSD. Criteria for PTSD were not laid out and psychological tests did not support a PTSD diagnosis. Report should have been returned for clarification and
explanation.

Examples of incorrect or questionable evaluations

Underevaluations

Example: SC 30% in WWII combat veteran. Examiner said PTSD has severe impact on functioning. Evaluation of at least 50% seems warranted.

Example: SC 70%. Vietnam combat veteran. Examiner says there is inability to function in almost all areas. GAF 30, the lowest GAF given in this group of reviewed cases. To consider I.U. Should have been given 100%.

Overevaluation

Example: SC 70% in 86 year old WWII veteran with Purple Heart. GAF 62. Barely meets PTSD criteria. Has mild dementia. Grossly overevaluated because there is no indication he is severely disabled, even taking into account his mild dementia.

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Appendix B: Governing Regulation For Service Connection For PTSD (From 38 CFR Part 3).

3.304 Direct service connection; wartime and peacetime.

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Posttraumatic stress disorder. Service connection for posttraumatic stress disorder requires medical evidence diagnosing the condition in accordance with

4.125(a) of this chapter; a link, established by medical evidence, between current symptoms and an in-service stressor; and credible supporting evidence that the claimed in-service stressor occurred. If the evidence establishes that the veteran engaged in combat with the enemy and the claimed stressor is related to that combat, in the absence of clear and convincing evidence to the contrary, and provided that the claimed stressor is consistent with the circumstances, conditions, or hardships of the veteran's service, the veteran's lay testimony alone may establish the occurrence of the claimed in-service stressor. If the evidence establishes that the veteran was a prisoner-of-war under the provisions of 3.1(y) of this part and the claimed stressor is related to that prisoner-of-war experience, in the absence of clear and convincing evidence to the contrary, and provided that the claimed stressor is consistent with the circumstances, conditions, or hardships of the veteran's service, the veteran's lay testimony alone may establish the occurrence of the claimed in-service stressor. (Authority: 38 U.S.C. 1154(b))

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Appendix C: Excerpts from VBA's Adjudication Procedures Manual Concerning the Adjudication Of Claims For PTSD.

POSTTRAUMATIC STRESS DISORDER (PTSD)

The issue of service connection for PTSD is the sole responsibility of the rating specialist at the local level. Central Office opinion or guidance may be requested on complex cases.

a. **Stressors.**

In making a decision, exercise fair, impartial, and reasonable judgment in determining whether a specific case of PTSD is service connected. Some relevant considerations are:

(1) PTSD does not need to have its onset during combat. For example, vehicular or airplane crashes, large fires, flood, earthquakes, and other disasters would evoke significant distress in most involved veterans. The trauma may be experienced alone (rape or assault) or in the company of groups of people (military combat).

(2) A stressor is not to be limited to just one single episode. A group of experiences also may affect an individual, leading to a diagnosis of PTSD. In

some circumstances, for example, assignment to a grave registration unit, burn care unit, or liberation of internment camps could have a cumulative effect of powerful, distressing experiences essential to a diagnosis of PTSD.

(3) PTSD can be caused by events which occur before, during or after service. The relationship between stressors during military service and current problems/ symptoms will govern the question of service connection. Symptoms must have a clear relationship to the military stressor as described in the medical reports.

(4) PTSD can occur hours, months, or years after a military stressor. Despite this long latent period, service-connected PTSD may be recognizable by a relevant association between the stressor and the current presentation of symptoms. This association between stressor and symptoms must be specifically addressed in the VA examination report and to a practical extent supported by documentation.

(5) Every decision involving the issue of service connection for PTSD alleged to have occurred as a result of combat must include a factual determination as to whether or not the veteran was engaged in combat, including the reasons or bases for that finding. (See *Gaines v. West,* 11 Vet. App. 113 (1998).)

b. Evidence of Stressors in Service

(1) Conclusive Evidence.

Any evidence available from the service department indicating that the veteran served in the area in which the stressful event is alleged to have occurred and any evidence supporting the description of the event are to be made part of the record. Corroborating evidence of a stressor is not restricted to service records, but may be obtained from other sources (see *Doran v. Brown,* 6 Vet. App. 283 (1994)). If the claimed stressor is related to combat, in the absence of information to the contrary, receipt of any of the following individual decorations will be considered evidence of participation in a stressful episode:

Air Force Cross
Air Medal with “V” Device
Army Commendation Medal with “V” Device
Bronze Star Medal with “V” Device
Combat Action Ribbon
Combat Infantryman Badge
Combat Medical Badge
Distinguished Flying Cross
Distinguished Service Cross

Joint Service Commendation Medal with “V” Device
Medal of Honor
Navy Commendation Medal with “V” Device
Navy Cross
Purple Heart
Silver Star

Other supportive evidence includes, but is not limited to, plane crash, ship sinking, explosion, rape or assault, duty on a burn ward or in graves registration unit. POW status which satisfies the requirements of 38 CFR 3.1(y) will also be considered conclusive evidence of an in-service stressor.

(2) Evidence of Personal Assault

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Personal assault is an event of human design that threatens or inflicts harm. Examples of this are rape, physical assault, domestic battering, robbery, mugging, and stalking. If the military record contains no documentation that a personal assault occurred, alternative evidence might still establish an in-service stressful incident. Behavior changes that occurred at the time of the incident may indicate the occurrence of an in-service stressor. Examples of behavior changes that might indicate a stressor include (but are not limited to):

• Visits to a medical or counseling clinic or dispensary without a specific diagnosis or specific ailment;

• Sudden requests that the veteran’s military occupational series or duty assignment be changed without other justification;

• Lay statements indicating increased use or abuse of leave without an apparent reason such as family obligations or family illness;

• Changes in performance and performance evaluations;

• Lay statements describing episodes of depression, panic attacks, or anxiety but no identifiable reasons for the episodes;

• Increased or decreased use of prescription medications;

• Increased use of over-the-counter medications;

• Evidence of substance abuse such as alcohol or drugs;

• Increased disregard for military or civilian authority;

• Obsessive behavior such as overeating or undereating;

• Pregnancy tests around the time of the incident;

• Increased interest in tests for HIV or sexually transmitted diseases;

• Unexplained economic or social behavior changes;

• Treatment for physical injuries around the time of the claimed trauma but not reported as a result of the trauma; and

• Breakup of a primary relationship.

In personal assault claims, secondary evidence may need interpretation by a clinician, especially if it involves behavior changes. Evidence that documents such behavior changes may require interpretation in relationship to the medical diagnosis by a VA neuropsychiatric physician.

(3) Credible Supporting Evidence.

A combat veteran's lay testimony alone may establish an in-service stressor for purposes of service connecting PTSD (*Cohen v. Brown,* 94-661 (U.S. Ct. Vet. App. March 7, 1997)). However, a noncombat veteran's testimony alone does not qualify as "credible supporting evidence" of the occurrence of an inservice stressor as required by 38 CFR 3.304(f). After-the-fact psychiatric analyses which infer a traumatic event are likewise insufficient in this regard (*Moreau v. Brown*, 9 Vet. App. 389 (1996)).

d. Incomplete Examinations and/or Reconciliation of Diagnosis.

If an examination is received with the diagnosis of PTSD which does not contain the above essentials of diagnosis, return the examination as incomplete for rating purposes, note the deficiencies, and request reexamination.

(1) Examples of an unacceptable diagnosis include not only insufficient symptomatology, but failure to identify or to adequately describe the stressor, or failure to consider prior reports demonstrating a mental disorder which could not support a diagnosis of PTSD. Conflicting diagnoses of record must be acknowledged and reconciled.

(2) Exercise caution to assure that situational disturbances containing adjustment reaction of adult life which subside when the situational disturbance no longer exists, or is withdrawn, and the reactions of those without neurosis who have "dropped out" and have become alienated are not built into a diagnosis of PTSD.

e. Link Between In-service Stressor and Diagnosis.

Relevant specific information concerning what happened must be described along with as much detailed information as the veteran can provide to the examiner regarding time of the event (year, month, day), geographical location (corps, province, town or other landmark feature such as a river or mountain), and the names of others who may have been involved in the incident. The examining psychiatrist or psychologist should comment on the presence or absence of other traumatic events and their relevance to the current symptoms. Service connection for PTSD will not be established either on the basis of a diagnosis of PTSD unsupported by the type of history and description or where the examination and supporting material fail to indicate a link between current symptoms and an in-service stressful event(s).

f. Review of Evidence

(1) If a VA medical examination fails to establish a diagnosis of PTSD, the claim will be immediately denied on that basis. If no determination regarding the existence of a stressor has been made, a discussion of the alleged stressor need not be included in the rating decision.

(2) If the claimant has failed to provide a minimal description of the stressor (i.e., no indication of the time or place of a stressful event), the claim may be denied on that basis. The rating should specify the previous request for information.

Excerpts from VBA's Adjudication Procedures Manual concerning the development of PTSD claims based on personal assault

5.14 POST TRAUMATIC STRESS DISORDER (PTSD)

PTSD Claims Based on Personal Assault

(2) Because assault is an extremely personal and sensitive issue, many incidents of personal assault are not officially reported, and victims of this type of in-service trauma may find it difficult to produce evidence to support the occurrence of the stressor. Therefore, alternative evidence must be sought.

(4) (a) Service records not normally requested may be needed to develop this type of claim. Responses to the development letter attachment shown in Exhibit B.11 may identify additional information sources. These include:

A rape crisis center or center for domestic abuse,

A counseling facility,

A health clinic,

Family members or roommates,

A faculty member,

Civilian police reports,

Medical reports from civilian physicians or caregivers,

A chaplain or clergy, or

Fellow service persons.

(b) Any reports from the military police, shore patrol, provost marshal's office, or other military law enforcement.

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Appendix D: Detailed Guideline For the GAF

Use of the GAF score (DSM-IV Axis V) as a clinical outcome measure has gained increased prominence in both private and public mental health settings. In the late 1990's, the Department of Veterans Affairs mandated that a GAF score be assigned at regular intervals for veterans receiving care in the system. Disability boards have at times also employed the GAF as an index of a claimant's functional status as part of the process of determining eligibility for benefits. The GAF is appealing as a rating of functioning because it is:

1) widely available

2) intuitive in its intended goal

3) ostensibly time-efficient, and

4) a scaled value linked to symptoms or functioning

The appeal of GAF is also understandable in the context of Compensation and Pension determinations because it is viewed as a quick and easy measure to assign and one that is easily understood by a wide range of people without advanced education or special training. Existing literature on the development of the GAF indicates that it was to serve as a global summary estimation of the veteran's functioning excluding medical problems. The DSM-IV states: " Axis V is for reporting the clinician's judgment of the individual's overall level of functioning...The reporting of overall functioning on Axis V is done using the Global Assessment of Functioning (GAF) Scale. The GAF Scale is to be rated with respect only to psychological, social, and occupational functioning. Do not include impairment in functioning due to physical (or environmental) limitations. (p. 30).

The actual GAF rating is the lowest level of either symptom severity or functioning, and this is based on the clinician's opinion, formed from the available clinical data and history. As the fifth axis in the DSM profile, it represents the severity of Axis I (Clinical Disorders) and Axis II (Personality Disorders) or Axis IV (Psychosocial and Environmental Factors). The GAF Scale, ranging from 0 - 100, and descriptors of levels of symptoms and functioning for each 10- point, decile band (e.g., 81-90, 91-100) are listed in the DSM-IV (p. 32), although "0", which equals insufficient information, is not an allowed option for rating veterans according to VHA Directive # 97-059. Very little instruction is included in the DSM-IV for how to assign ratings using the scale, and herein lies one of the fundamental problem with assigning GAFs in PTSD cases. As a score based primarily on the rater's impressions and synthesis of data, solid reliability and validity ultimately determines how useful the GAF scores ultimately can be. Without clear definitions of symptom severity and functional severity —- as they relate to PTSD, and without more detailed instructions for using the GAF scale itself, the clinician is left to decide what to rate and how to do it using personal standards. If the main goal of assigning a GAF score was simply for the individual clinician to have a global rating that they would use personally, then applying their individual interpretation of the scale definitions and the rating process would have limited impact outside of their practice or caseload.

However, in the context of Compensation and Pension determinations, consistency and accuracy in ratings needs to be based on a set of standards that are common to all who determine the GAF score and to those who subsequently interpret them when determining benefits.

While no information on the reliability and validity of the GAF is included in the DSM-IV, these psychometric features of the Global Assessment Scale (GAS) were formally examined and published by the GAS authors (Enidcott, Spitzer, Fleiss & Cohen,1976). The GAF and the GAS are almost identical to each other in content, with the exception of some re-arrangement of rating descriptions and examples for the categories. Across five GAS standardization studies reported, the intraclass correlation of the GAS ranged from .61 -.91 with a standard error of measurement of between 5 and 8 points, meaning that the actual GAF score would normally be expected to fall within a +/- 5 to 8 point range around the score. Given the similarities of the GAS and the GAF, the GAS psychometric properties may be true for the GAF as well. Regarding validity, GAS ratings, as measures of overall severity, examined at admission and 6-months later showed more sensitivity to change than single symptoms measures. Correlations of GAS ratings and independent measures of Symptom Criteria were the highest for items representing psychosis and overt behavioral disorganization and low for affect and anxiety-related criteria.

1. GAF Reliability.

Reliability is necessary for GAF scores to be meaningful in the C&P determination process. Reliability in this context is consistency in assigning GAF ratings. If an individual clinician had high reliability with him or herself, they would apply similar standards to the rating process for all GAFs they assigned, and their GAF ratings would be the same or very similar if they rated the same patients again with the same information. For high *inter-rater* reliability (agreement between raters), different clinicians would arrive at the same or very similar GAF scores if they rated the same patient, presumably because they used the same definitions and applied the same standards to the rating process (vs. simple chance agreement). To achieve consistency, rating scales must use clear definitions for what is to be rated and then specify clear procedures for assigning ratings. This removes or minimizes the need for the rater to make judgments based on their individual perspective. The existing literature shows that in the absence of systematic training with the GAF, reliability is generally poor. Wide variability in GAF ratings is a logical result if each clinician must arrive at their own understanding of what to rate and how to rate it. To deal with this issue, some clinical settings attempt to improve reliability by conducting *Consensus Review Groups* to reach agreement on assigned GAFs. In the

process, local groups of clinicians can increase inter-rater reliability as a result of the group discussion that shapes raters agreement with each other. While this "local standard approach" calibrates the set of raters to each other and results in higher consistency, the GAFs from this setting may not agree with GAFs assigned by other settings for the same patient. Evidence suggests that differences among groups of raters may result in part because clinicians may use different perspectives when they rate symptom severity vs. functional impairment. Also, some raters may average symptom occurrence or functionality over time, while others rate the most recent episode or lowest level of these two components. In disorders like PTSD where symptom severity and functionality can vary, these two approaches will potentially yield very different GAF scores.

2. GAF Accuracy.

Reliability is understandably a main focus because unreliable ratings clearly limit the validity of the GAF. However, complete reliability does not necessarily equal validity; as would be true when all raters agree on a GAF value, but it is the wrong value (i.e., 50 is the consensus GAF, but in reality it should be 30). This might happen when groups of clinicians work toward consensus in their setting, and in the process impose their viewpoints on how to interpret what a GAF score at a given level should be. For example, after years working as a clinician with PTSD veterans, those veterans who have severe symptoms, resulting in multiple personal problems and poor occupational histories, may unintentionally become the norm. By comparison, a veteran who is working steadily, for instance as a long-distance truck driver, may stand out in a positive way as someone who functions in spite of his/her symptoms. In contrast to the symptomatic and unemployed veteran, he *is generally* functioning better. If this same veteran presented clinically with an episode of increased depression, active suicidal preoccupation, increased irritability, and had initiated a beating of someone who cut him off on the road while he was driving, his GAF scale score for current functioning would place him in the 11-20 band that characterizes someone who is in Some Danger of Hurting Self or Others. In deciding between the two possibilities, symptoms or functioning, symptoms in this case are worse, and *the GAF score is based on which of the two is worse*. If during the process of reviewing the case information, the clinician applies an "averaging" type of reasoning in the form of: "...well, this was only one episode, and he is working most of the time, and things could be worse (or other veterans are worse off than this), and he shouldn't be labeled because of this one incident", then a higher and inaccurate GAF (one that represents a better functional rating) is at risk of being chosen

3. GAF Accuracy and PTSD.

A number of challenges to creating accurate GAFs face the clinician who is tasked with assigning scores for PTSD patients. First, the GAF AXIS V examples for symptoms contained in the DSM-IV do not represent PTSD directly. Also, in cases of chronic PTSD, comorbidity with other diagnoses is common, including substance abuse, major depression, features of other anxiety disorders like panic and OCD, and personality disorders. To assess symptom severity in the context of comorbidity, the clinician must somehow weigh the combined impact of all conditions, but without directions or examples. Second, general descriptors like Mild, Moderate, Serious, etc., that characterize the various 10- point decile bands are open to interpretation and will likely be based on the clinician's own standards. Third, the clinician must decide what qualifies as a symptom or functional problem to rate. Some symptoms can also be considered functional problems (e.g., PTSD Hypervigilance and Avoidance of people and places). Fourth, making GAF ratings for the 50 - 100 range (moderate symptoms to superior functioning) is less complicated than for the 1- 50 range because the higher ranges reflect low symptomatology

4. Resolution of the GAF Scale.

The GAF scale is organized into ten decile (10-point) bands. The DSM-IV adds a note suggesting that the rater "use intermediate codes when appropriate, e.g., 45, 68, 72)", but gives only general guidance on exactly how to arrive at these intermediate values. In supplementary GAF material, Dr. Michael First (1995) , the editor of text and criteria for the DSM-IV, suggested using a process where the GAF rater first identifies a decile band that best fits the patient, then decides if the level of symptoms or functioning was nearer to the top of the bandwidth, nearer the middle or nearer the bottom. Depending on this decision by the rater, either a 7, 5 or 2 would be selected to refine and select the final GAF (for example: 47, 45 or 42 within the 41 - 50 decile band). Using this procedure, the finest resolution under the best circumstances is about 3-points, and more practically —- 5 or 10 points because ratings tend to cluster at the middles and ends on the scale (e.g., 45, 50, 55, 60, 65). The difference between raters assigning GAFs for the same patient could vary by 20 points if for example one rater considered the symptoms mild and the other thought they were toward the moderate - severe end of the decile. Thus, using cutoffs that set strict thresholds is unwise and unsupported by both the inherent resolution of the GAF scale and the data showing that raters typically use larger rating intervals.

5. Assigning Separate GAFs by Condition.

Various parts of the foregoing discussion bear on this issue. For a number of reasons, creating the equivalents of PAFs should not be done, although reports from the field indicate that clinicians are being asked to assign PAFs using the GAF scale. First, by name alone, it is clear that the GAF was designed to be a "Global" index of functioning; one that represents in a single value the veteran's functional status. No published information in the DSM-IV instructs users in a valid method for partitioning the GAF by each comorbid clinical condition, using either separate sets of symptoms for each diagnoses or Social and Occupational / School functioning (although supplementary material suggests that a separate GAF might be created for all symptoms and another for general social/occupational functioning). While it might appear from the descriptors in DSM-IV (i.e., mild, moderate, serious) that separate ratings by diagnosis could be made (e.g., only for depression symptoms, only for anxiety symptoms, only for substance abuse symptoms), the separate ratings that would result have no validated relationship to each other, and no established means for integrating them into a value that considers the combined effect of having them all concurrently.

Second, if "PAFs" are requested for a disability determination, it is likely that multiple conditions exist comorbidly, and having separate ratings of severity of dysfunction would fit with a process of assigning a percentage of service connection to each particular disorder. In PTSD, depression and substance use frequently coexist and veterans have long-standing problems in occupational, interpersonal, social, familial and psychological domains. Attempting to attribute a portion of the functional problems to depression and another to substance use and another to PTSD, as if they were independent of each other, is beyond the capability of the GAF scale. This is an instance of incompatibility between the capabilities of the GAF scale and the compensation review process. While the logic of separate ratings by disorder may make sense from an adjudication perspective, it is not clinically validated, and "PAFs" assigned in this manner should be seriously questioned for their validity as evidence in the disability determination proceedings.

Some Considerations for Making GAF Ratings

Given the GAF considerations described above, clinicians who assign GAF ratings should: a) attend available trainings, b) study available GAF materials carefully, c) try to assign scores as accurately as possible by adhering to the definitions provided, and d) strive to become consistent with themselves in choosing their GAF ratings.

Outcome data from GAF trainings have shown that raters can have a bias against assigning low GAF scores for PTSD vignettes. This bias, conscious or not, means that all decile bands do not have an equal chance of being selected, and that some will be chosen more than others independently of the case information. For the GAF to be meaningful, it must accurately reflect the Current Severity of the veteran's symptoms or functioning. For PTSD cases used as part of organized GAF training, it was typically true that the GAF ratings made before training were too high. This reflected various biases and beliefs of the raters regarding what defined a functional problem, and equally important, the rater's personal perspective on what qualified as a Mild, Moderate, and Serious level of severity. Using the exact same case information, one rater's standard for Mild Severity might be another rater's standard for Moderate Severity.

In clinical PTSD contexts, and for those veterans filing valid claims for disability from PTSD attributed to military experiences, symptoms are usually chronic and their overall level of functioning is often poor. GAFs for the majority of these cases will be 50 and under. While many claimants will easily receive a PTSD diagnosis because they meet multiple criteria under DSM-IV Sections B, C, and D, the process of rating PTSD symptom-severity using available information for the GAF scale is difficult. Examples given in the DSM-IV for serious symptoms (41-50 decile band) include: suicidal ideation, severe obsessional situations, and frequent shoplifting. In PTSD contexts, suicidal ideation is often persistent and chronic, and combined with many other symptoms. Regarding these other symptoms, PTSD clinicians would likely agree that regular dissociative flashbacks and high hyperarousal with hit-the-deck startle response is more serious than frequent shoplifting or obsessional rituals. Yet, this is a personal judgment without corroboration in the DSM-IV to serve as a calibration point. Creating ratings of functional impairment using the DSM-IV examples is easier because they represent the impact of symptoms in domains that are common across all diagnoses including PTSD. Applying the DSM-IV examples of social and occupational problems to PTSD patients can be done more easily than for the symptom severity levels.

In making ratings, clinicians should be cognizant of the presence of *Violence Toward Self and Others* in the veteran's history. The decile band 11-20 (Some Danger of Hurting Self or Others) gives as examples: a) suicide attempts without clear expectation of death; and b) frequently violent; while the decile band 1-10 (Persistent Danger of Severely Hurting Self or Others) lists: a) recurrent violence, and b) serious suicidal act with clear expectation of death. Incidents while driving in traffic are frequently reported as the impetus for aggression towards others, and at times the beating of other drivers; while participating in physical fights is reported as a means of managing anxiety, releasing tension and counteracting depressed mood. In either case, the veteran or others could be

hurt. While these events may be episodes of aggression vs. continuous aggression, they are significant features that drop the GAF into the lower decile ranges if they are current when the veteran is assessed. If these features are present clinically, they should not be overlooked or minimized by the clinician when making GAF ratings.

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APPENDIX E: Global Assessment of Functioning (GAF) Scale

Consider psychological social, and occupational functioning on a hypothetical continuum of mental health-illness. Do not include impairment in functioning due to physical (or environmental) limitations.

Code (Note: Use intermediate codes when appropriate, e.g., 45, 68, 72.)

100 – 91: Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.

90 – 81: Absent or minimal symptoms (e.g., mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g., an occasional argument with family members).

80 – 71: If symptoms are present they are transient and expectable reactions to psychosocial stressors (e.g., difficulty concentrating after family argument); no more than slight impairment in social, occupational, or school functioning (e.g., temporarily falling behind in schoolwork).

70 – 61: Some mild symptoms (e.g., depressed mood and mild insomnia) OR some difficulty in social, occupational, or school functioning (e.g., occasional truancy, or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships.

60 – 51: Moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with peers or co-workers).

50 – 41: Serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job).

40 – 31: Some impairment in reality testing or communication (e.g., speech is at times illogical, obscure, or irrelevant) OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).

30 – 21: Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) OR inability to function in almost all areas (e.g., stays in bed all day; no job, home, or friends).

20 – 11: Some danger of hurting self or others (e.g., suicide attempts without clear expectation of death; frequently violent; manic excitement) OR occasionally fails to maintain minimal personal hygiene (e.g., smears feces) OR gross impairment in communication (e.g. largely incoherent or mute).

10 – 1: Persistent danger of severely hurting self or others (e.g., recurrent violence) OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.

0: Inadequate information.

The rating of overall psychological functioning on a scale of 0-100 was operationalized by Luborsky in the Health-Sickness Rating Scale (Luborsky L: “Clinicians’ Judgments of Mental Health.” *Archives* of *General Psychiatry* 7:407-417, 1962). Spitzer and colleagues developed a revision of the Health-Sickness Rating Scale called the Global Assessment Scale (GAS) (Endicott J, Spitzer RL. Fleiss JL, Cohen J: “The Global Assessment Scale: A Procedure for Measuring Overall Severity of Psychiatric Disturbance.” *Archives of General Psychiatry 33:766-771,* 1976). A modified version of the GAS was included in DSM-III-R as the Global Assessment of Functioning (GAF) Scale.

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APPENDIX F: Scoring Rules for Mississippi and PCL-22

Mississippi Scale for Combat-Related PTSD (M-PTSD)

The M-PTSD was originally developed to assess the domain of DSM-III PTSD symptoms and various associated features in combat-exposed Vietnam veterans (Keane et al., 1988), and was subsequently revised to conform to DSM-III-R criteria. The M-PTSD is a 35-item Likert-scaled questionnaire providing a continuous measure of PTSD symptom severity. Internal consistency for the scale was reported to be .94 (Keane et al., 1988), and the test-retest reliability coefficient is .97 (Keane et al., 1988). Factor analytic studies of the M-PTSD have yielded dimensions of intrusive re-experiencing/numbing-avoidance, anger/lability, social alienation, and sleep problems, which correspond to DSM-III-R symptomatic criteria for PTSD (Keane et al, McFall, Smith, Mackay, & Tarver, 1990). Preliminary validation studies using the M-PTSD demonstrated excellent agreement (Kappa = .75) between PTSD diagnoses made by the M-PTSD and the Structured Clinical Interview for DSM-III-R among Vietnam veteran psychiatric patients (Kulka et al., 1988). Sensitivity of the M-PTSD in identifying validated PTSD cases is 93%, and specificity is 88% for various non-PTSD comparison groups (Keane et al., 1988; McFall et al., 1990).

Mean M-PTSD scores among Vietnam veterans have been reported to be 104 among help-seeking patients from a Vet Center and 130 among VA medical center psychiatric patients with PTSD (Keane et al., 1988; McFall et al., 1990). The optimal cutting score for accurately classifying individuals with or without PTSD has varied from study to study, but has ranged between 100 and 107 (Keane et al., 1988; McFall et al., 1990; Watson, 1990)

PTSD Checklist (PCL)

The PCL (Weathers et al., 1993) is a 17-item self-report scale for assessing PTSD symptoms over a variable span of time (one week or one month), appropriate to the context of administration. A version of the PCL is available for assessment of veterans exposed to military traumas (PCL-M) as well as patients exposed to nonmilitary forms of stress (PCLC). The PCL scales are useful as continuous measures of PTSD symptom distress, but can also aid in making a categorical diagnosis of PTSD by summing items across the three DSM-IV symptom clusters of the disorder. Test-retest reliability is .96, and internal consistency is very high (alpha=.93). Convergent validity is supported by high correlations with the Mississippi scale for PTSD (.93), Impact of Event Scale (.90), MMPI PTSD subscale (.77), and the Combat Exposure Scale (.46). The Kappa coefficient for the PCL is reported to be .64. Cross validation studies, on

independent samples of Persian Gulf theater veterans, substantiates the aforementioned psychometric properties of the PCL. The PCL can be conveniently administered and scored, and would be appropriate for use as a PTSD screening instrument.

Mean PCL scores are 63.6 (SD=14.1) for Vietnam veterans with PTSD, and 34.4 (SD=14.1) for non-PTSD subjects. A PCL cutting score of 50 provides the optimal diagnostic sensitivity (.82) and specificity (.83).

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APPENDIX G: Examples of PTSD Symptom Narratives In Compensation and Pension Examination Reports

CASE I: PTSD DIAGNOSIS

Example of Trauma History

Mr. Jones served in the USMC from August 1966 to August 1969. He volunteered for duty in Vietnam at the age of 18, serving a total of 13 months in that country. He primarily served in the XXXX area from February 1967 through March 1968. His MOS was that of an Amtrak driver, though he actually spent ten months of his duty in a combined action unit with Vietnamese militia. This primarily involved his living in a village with Vietnamese citizens, where he worked in intelligence and also trained and fought with villagers against the Viet Cong.

This individual was exposed to heavy combat for at least ten months of his tour of duty in the combined action unit, engaging the enemy at least twice per week in fire fights, with the exception of December 1967 when he was exposed to daily fire from the enemy. He was involved in a number of combatant roles, including participation in well over 50 combat patrols and ambush operations. In addition, he occasionally participated in river boat patrols where he was fired upon. There was frequent exposure to mines and booby traps, recurrent sniper fire, mortar and rocket attacks and frequent ambushing of his unit by enemy soldiers. He maintains that his village was surrounded by the enemy on at least 30 separate occasions, creating much apprehension that his outfit would be overrun and destroyed. Although his unit primarily fought the Viet Cong, they also engaged NVA soldiers in fire fights. During his tour, Mr. Jones maintains that he was nearly always in danger of being injured or killed, with many near misses. In addition, he

witnessed the killing and wounding of American and enemy soldiers on at least 50 separate occasions. Of the 14 Marines in his unit, nine were killed and five were seriously injured. Mr. Jones received four wounds during one particularly severe attack by the enemy, including a gunshot wound to his right bicep, resulting in permanent nerve damage.

This individual is able to describe in considerable detail a number of specific combat traumas he endured. The most severe battle occurred on January 2, 1968, during the Tet Offensive. At that time, Mr. Jones unit was ambushed and destroyed by the villagers with whom they had been living and working for several months. At 1 a.m., his unit was attacked and pinned down in dwellings where they were surrounded by the enemy. Mr. Jones witnessed the slaughter of his own men, but somehow, miraculously, escaped to safety after having been wounded four separate times. He was prepared to kill himself with a hand grenade rather than be captured while he attempted to escape through the bush. He was finally rescued by American forces, being found unconscious in the brush with a hand grenade from which the pin had been pulled clenched to his chest. He recalls another incident when a truck of Army personnel struck a mine and blew up. He was involved for two days in policing the area by picking up various body parts of severely dismembered soldiers. Yet another tragedy occurred when Mr. Jones witnessed his best friend fall to his death from a rope suspended from a helicopter which had suddenly come under fire while engaged in a construction project. Mr. Jones believes that the circumstances contributing to this unfortunate outcome were largely his “fault.”

The veteran claims that his only disciplinary infraction during the military was a “write-up” for having long hair. He maintains that he was nearly abstinent from abuse of substances while in the Service, except for the use of rice wine while in Vietnam. He was discharged honorably with the rank of E-5. Mr. Jones received the Purple Heart for wounds sustained in action and the Navy Commendation Medal with a Combat V for meritorious action while trying to save others during the January 2 assault.

Diagnostic Formulation: Example of Description of PTSD Symptoms

The veteran meets the DSM-IV criteria for Post Traumatic Stress Disorder, chronic, severe. He maintains that he has intrusive, distressing recollections of the aforementioned traumatic experiences on a daily basis. He is awakened from his sleep at least once per week by nightmarish dreams of being overrun and of picking up the bodies of dead soldiers. Although he is oddly attracted to reminders of his wartime experience (displaying his medals at home, watching combat movies), he maintains at the same time that he experiences intense

psychological distress when exposed to events that resemble or remind him of his Vietnam experiences. Indeed, he became quite upset during the interview while recounting his combat experiences.

He makes rather extreme efforts to avoid intrusive and painful recollections, to the extent that he gambles compulsively to generate a sense of excitement as well as distract him from inner preoccupation. There is no amnesia for his traumatic events; on the contrary, he remembers nearly every detail quite vividly. There has been a notable and chronic loss of interest in activities and generalized anhedonia since his return from Vietnam, as he has given up most enjoyable pursuits with the exception of working over 60 hours per week, visiting his girlfriend, and gambling. Although formerly quite estranged socially, he appears to be re-establishing meaningful connections with family members and his girlfriend. He endorses the symptom of emotional numbing, maintaining that he is generally emotionally under-reactive and somewhat callous, finding it particularly difficult to express tender and loving feelings toward others. Perhaps most noteworthy, this individual seems to have a sense of a fore-shortened future, feeling as though he "died over there and (is) just a shell." He seems to be remarkably shortsighted, making few plans for his future other than having vague hopes for marriage to his girlfriend.

There appears to be some modest sleep disturbance, as he awakens briefly once or twice per night. Generally, he claims he is not particularly irritable or angry, having gotten in only six fights since his service days, the last one being over two years ago. However, he maintains that he has intense anger towards the Vietnamese, fearing loss of control of aggressive impulses toward them. He reveals that in 1980 he made a misguided attempt to ram his car into a Vietnamese restaurant. The veteran endorses other symptoms of arousal that seem related to his combat experiences — he is very hypervigilant, easily startled, and physiologically aroused by combat related stimulation such as helicopters. Once of his most bothersome symptoms seem to be guilt about having survived Vietnam while other soldiers died, as well as about acts of brutality towards enemy soldiers and self-perceived failures to rescue friends killed by the enemy.

The patient maintains that many of these symptoms have been present since he was 19, and have been present over 90% of the time during the last five years. They seem to be intensified during the month of January each year, the anniversary of the date when his unit was overrun. Other points of heightened symptom severity occurred in the mid-1970's when he was depressed and suicidal, and during 1980 when Vietnamese refugees began traveling to the U.S. Although he recognizes the irrational quality of his current hatred towards

Vietnamese people, he is quite disdainful of them and fears that he may attack them if provoked.

This patient also meets the criteria for major depression, recurrent, of moderate severity. In particular, he has periods of despondent mood accompanied by anhedonia, a 20-pound weight loss, sleep disturbance, psychomotor retardation, and notable loss of energy and fatigue. He has been self-condemning, feeling quite worthless and inadequate. It appears his current episode of depression has been most severe since about January 1987, to the extent that he lost 20 pounds, withdrew for days at a time on his couch, and, again, ruminated about killing himself with exhaust fumes. There have been approximately 30 such episodes since he was 25, though the current episode is evidently the most severe.

The veteran also meets the criteria for Obsessive Compulsive Disorder, in particular, compulsive gambling. However, it is our opinion that his compulsive gambling is closely linked with his PTSD symptoms, in that they represent deliberate attempts to ward off intrusive memories of a painful nature.

The veteran appears to suffer primarily from symptoms of PTSD, with Major Depression and Compulsive Disorders secondary. It appears that PTSD symptoms of intrusive re-experiencing are most predominant, whereas numbing and avoidant defensive symptoms are present to a lesser degree. Distressing degrees of guilt as well as symptoms of autonomic arousal are also quite noteworthy. With respect to the latter, it should be mentioned that Mr. Jones participated in a research investigation where assessments of his physiological reactivity to combat films were made. He demonstrated observable increases in heart rate and blood pressure, as well as heightened epinephrine response to combat films. Although data from this procedure are in no way a conclusive means of diagnosing PTSD, there is research support demonstrating that such response patterns distinguish veterans with PTSD from non-PTSD psychiatric patients.

CASE II: PTSD Diagnosis

Military History: Example of Trauma History

The veteran, Mr. Smith, enlisted in the Marine Corps, serving from 1965-1977 as an infantry officer. He obtained the rank of First Lieutenant while serving in Vietnam, and was ultimately discharged as a Captain under honorable conditions. Mr. Smith eagerly volunteered for duty in Vietnam, serving 12 months

aboard an aircraft carrier off the coast of Vietnam (June 1969 to June 1970), and another eight months as an infantry officer in Vietnam from September 1970 to April 1971. He was 23 years of age when he was sent to Vietnam.

As a platoon commander, Mr. Smith reports he was exposed to “heavy combat,” staging over 100 patrols and ambushes, and having frequent contact with the enemy throughout the duration of his duty. He reports that his unit was surrounded by the enemy on two occasions, and that approximately 25% of the men in his unit were either killed in action or wounded. Though he did not directly fire rounds at the enemy, he was in charge of directing attacks against the enemy in his role as a field commander. He maintains that there were at least 50 occasions in which he was in danger of being injured or killed, either from scattered, harassing sniper fire or from more direct confrontations with the enemy. He maintains that he was not directly involved in killing any of the enemy himself, though he directed fire at the enemy, which did kill and wound the enemy. Mr. Smith was wounded on one occasion when a mortar round hit near him, throwing shrapnel into his arms, chest, and legs, and contributing to a permanent condition of tinnitus, which annoys him considerably. Mr. Smith reports at least one episode of hand-to-hand confrontation with the enemy, when he was exploring a tunnel in the dark and came upon four NVA officers whom he dragged from the tunnel with considerable risk to his own life. The veteran is particularly guilty about one occasion where he led his men into an area that was heavily booby-trapped, resulting in the death of one man and the serious wounding of another four men. The veteran becomes very despondent and tearful when describing this event even today, condemning himself for having failed to prevent this outcome, despite the facts of the case, which do not suggest any negligent conduct on his part. The veteran earned a Bronze Star for valor by exposing himself while wounded to “intense hostile fire and directing the activities of his men.” He also obtained the Purple Heart, the Cross of Gallantry, and the Combat Action Ribbon. Throughout his tour in Vietnam, the veteran maintains that he was somewhat overzealous, being enthusiastic about his Vietnam duty and often taking excessive risks by exposing himself to needless danger while assuming responsibilities that he admits would have been better left to other men in his platoon. In addition to combat exposure, the veteran maintains that he witnessed the torture and mutilation of enemy soldiers.

While in Vietnam, Mr. Smith maintains that he was nearly totally abstinent from alcohol, and did not use illicit drugs. His military career came to an abrupt end when he was charged with attempted murder for obtaining a pistol he planned on using to shoot a superior officer who assigned him to a duty station against his liking. He was hospitalized involuntarily at the Bethesda Naval Hospital from January to May 1977 following this incident, and was terminated from the military shortly thereafter to his great disappointment. Apparently, this was a very

uncharacteristic behavior for Mr. Smith, who maintains that he otherwise had a spotless military record with no infractions for conduct problems.

Diagnostic Formulation: Description of PTSD Symptoms

The veteran meets the criteria for Post Traumatic Stress Disorder, chronic, severe. He maintains that he has intrusive, unpleasant thoughts regarding his experiences in Vietnam, which occur several times per day on a nearly daily basis. Moreover, his sleep is chronically disturbed, as he awakens nearly every night with troubling dreams and nightmares about the incident in which he is carrying to safety men who had been wounded in a heavily booby-trapped area where he had to lead them. The veteran is easily reminded of his Vietnam experiences by environmental stimulation, which provides him occasion to ruminate about troubling events (his chronic tinnitus resulting from a mortar explosion near his head is a constant reminder of the war). He maintains that alcohol is one of the few means he has to block preoccupation with intrusive imagery as well as to permit him freedom from troubling and disrupted sleep. The veteran has had less frequent, though quite disturbing, flashback phenomena, the most recent incident being the one where he was wandering around the neighborhood armed and wearing combat fatigues. There is a marked evidence of emotional numbing and constriction to ward off powerful feelings, which have been observed to easily overwhelm him. Despite these efforts, the veteran admits his involvement in repeated dangerous stunts to give him “an adrenaline high” that attempts to replicate the excitement and thrill of combat. (For example, the veteran still frequently hunts rattlesnakes in the wilderness without any weapon and wearing only tennis shoes, catching the snakes by hand.) Consistent with a diagnosis of PTSD, the veteran has a long history of fractured and disrupted relationships that have left him feeling quite alienated and unable to tolerate intimacy. One of his most severe symptoms seems to be guilt, particularly about having not done enough to save his men from being wounded/killed during the aforementioned incident. Moreover, he is preoccupied with having survived Vietnam at all, having expected to die, and feeling as though better men than he were killed. Startle response is evident, with the veteran being jumpy and easily aroused by sounds resembling the environment in Vietnam. He is markedly hypervigilant, needing to keep his back to walls and finding it intolerable to allow others to position themselves where he cannot see them. During our observation of him, he rather ritualistically sat in a corner near an open window day after day without changing his position in the group rooms. Psychophysiological assessment conducted in our facility revealed that Mr. Smith showed marked elevations in blood pressure and heart rate while viewing Vietnam combat films, further documenting his autonomic arousability.

The weight of the clinical evidence points to a marked change in functioning for this individual, from his premilitary to postmilitary adjustment. That is, prior to entering the military and prior to his Vietnam combat experience, this individual appeared to be performing at an exceptional level of adjustment in most spheres of psychosocial functioning. However, since his discharge from the military in 1977, his course has been marked by steady deterioration in which he is clearly achieving beneath his potential, and has a history checkered with disrupted occupational functioning, impaired interpersonal relations, subjective unhappiness, and somewhat compulsive involvement in dangerous stunts that reflect poor judgment and court disaster.

Case III: PTSD Diagnosis with Sexual Harassment/Sexual Assault

Example of Pre- Military and Military History

Ms. Jones is a 40 year old, African American woman who served in the Army from 1980 to 1984. Ms. Jones described a fairly chaotic childhood occurring prior to her military service. She was the youngest of five siblings and her older two sisters report being physically and sexually abused by their alcoholic father. Ms. Jones does not recall specifics of her own sexual abuse by her father, but states that she “believes” she was sexually molested by him. Her parents reportedly separated when Ms. Jones was 10 years old and she has had no contact with her father since. Despite her early difficulties at home, Ms. Jones graduated from high school and reported fairly normal relationships with her peers. She did report feeling that she “did not quite fit in with others.” In retrospect, she attributes this to her struggle over her sexual orientation. Ms. Jones experimented with alcohol in high school but denied any alcohol and/or substance abuse history. She enlisted in the Army after completing high school in order to “make a new life for herself and eventually go to college.”

Initially, during her service, Ms. Jones adjusted well to the military and very much enjoyed her service. Although she was unable to be open about her sexual orientation, she was able to develop a number of friendships and reported feeling mostly “at ease” for the first time in her life. She received positive evaluations from her superior officers and considered whether she would remain in the Army to pursue a military career. However, in 1983, Ms. Jones reported that a group of male servicemen began to sexually harass her. They frequently made sexual comments as she walked by, grabbed her buttocks on several occasions, and asked her whether she had ever “had a real man.” Ms. Jones felt uncomfortable and unsafe around these men and avoided walking alone as a result. Despite her efforts at avoiding contact with the servicemen, Ms. Jones reported that she

found herself cornered by one of the men (a higher ranking officer). The officer had been drinking, as was apparent due to the smell of his breath. Ms. Jones attempted to leave the room but the officer was blocking the door. He threatened Ms. Jones, stating that she “would need to sleep with him or else he would make sure everyone knew she was gay.” He also told her there was no use trying to leave since his friends would be waiting for her outside. Ms. Jones feared for her life and was terrified that the other men would also rape her. In addition, she feared being discharged from the military. She reported feelings of terror and helplessness at the time of the assault. Immediately following the assault, Ms. Jones returned to her room, feeling numb.

After this assault, the sexual harassment by the other servicemen appeared to escalate. Ms. Jones feared that the officer had told them about the assault and her sexual orientation. She felt unable to tolerate the harassment and reacted tearfully on each occasion. Her response, unfortunately, only provoked further harassment. She became increasingly distressed and isolated from others, living in constant fear of being assaulted and harassed. Ms. Jones did not report her assault or harassment to higher authorities because she feared retaliation from her harassers. Rather than remaining in the service and suffer further harassment, Ms. Jones decided to leave the military in 1984 and was honorably discharged.

Description of PTSD Symptoms

Ms. Jones meets the criteria for PTSD, chronic, severe. She has intrusive, distressing recollections of the assault and harassment daily, which she described as “very disturbing.” She also reported having repetitive nightmares approximately two to three times per week in which she is being teased, harassed, and surrounded by 5 servicemen. She awakes from her nightmare short of breath and has significant difficulty returning to sleep. In addition, Ms. Jones reported that, several times a week, certain triggers, such as television programs on the military or recruitment advertisements for the military, cause her to have flashbacks of her assault. She also reported having “daydreams” daily, during which she is suddenly taken back to her memory of being harassed. She described that when she comes out of the “dream”, she sometimes forgets where she is and will often ask others what they were saying. This was observed several times during the interview. In addition, upon cues associated with her assault and harassment, Ms. Jones frequently becomes nauseous and at times tearful. In addition, she exhibits muscle tension, shortness of breath, and psychomotor agitation. These physiological indictors were evident throughout the interview when Ms. Jones was describing the assault and harassment as well as her daily recollections of each.

Ms. Jones also exhibits persistent avoidance of trauma-related cues and numbing. Ms. Jones exerts effort daily to avoid thoughts of her adult sexual assault. Despite her considerable distress, she has not discussed this assault and harassment with anyone, including her sisters. Her avoidance was also apparent in the interview. In particular, Ms. Jones seemed quite uncomfortable from the onset of the interview. She had difficulty maintaining eye contact and frequently offered short answers to questions. She also became tearful when asked about her trauma history and acknowledged her discomfort in discussing these events. Her attempts at avoidance also take the form of complete isolation from others, with the exclusion of her two sisters. She avoids being alone with men and has quit jobs when she has had a male supervisor who she feels she "cannot trust." Ms. Jones also reported a notable decrease in her interest in pleasurable activities since her return from the service. For example, she used to enjoy frequenting sporting events and concerts, but feels uncomfortable doing so due to the large number of people present. She stated that she feels uncomfortable anywhere in which a large number of men congregate. Ms. Jones also cannot remember important aspects of the traumatic incident. For example, she is unclear as to the date of the sexual assault, although she recalls specific details about what she was wearing and details regarding the location of the assault and the smell of her assailant. Ms. Jones also exhibits significant detachment from others. Although as a child Ms. Jones felt she "did not fit in," she had established a number of strong peer relationships while in the military. However, after her assault, she became increasingly isolative and detached. She cut off ties with her peers and has not been in contact with any of them for years. Ms. Jones does have some continued contact with her sisters but "has no friends." In addition, Ms. Jones feels incapable of experiencing normal emotions. She reported feeling numb "everyday," and cannot remember when she last felt happiness and love.

Ms. Jones also reported severe symptoms of increased arousal attributable to her traumatic experiences. She has significant difficulty falling asleep on a daily basis and experiences mid-sleep awakenings several times a week, usually due to the occurrence of a nightmare (described above). She has difficulty returning to sleep and receives an average of only 3-4 hours of sleep a night. Ms. Jones also reported frequent irritability and some outbursts of anger that typically occur on the job. These outbursts have resulted in Ms. Jones being fired and/or disciplined on a number of occasions. In addition, Ms. Jones exhibits and reported significant concentration difficulties. Her inability to remain focused was evident throughout the interview, especially during discussions of traumarelated material. Ms. Jones stated that her difficulty concentrating is a "daily thing" that has resulted in problems at work. Finally, Ms. Jones reported that she pays excessive attention to "where she is and where others are at all times." She says

she is most vigilant when on public transportation, at work with men, or in a crowded place (which she tries to avoid).

In addition to the symptoms described above, Ms. Jones reported that she is depressed. She cries uncontrollably at times and has limited interest in any activities. She feels a sense of hopelessness and worthlessness and experiences chronic suicidal ideation. In addition, after dismissal from her last job two months ago, she reported that she has lost ten pounds. She also described having limited energy for anything and extreme difficulty getting herself motivated to leave the house.

Overall, it is clear that Ms. Jones has demonstrated a significant change in functioning as a result of the harassment and assault she experienced in the military. She is currently presenting with severe impairments in both social and occupational functioning, evidenced by her social isolation and difficulty maintaining employment. Although it is likely that her trust in others (in particular, men) was also significantly impacted by her childhood trauma and chaotic home environment, she had no previous disciplinary problems in school or the service and had established strong relationships with her peers prior to the events described above. Ms. Jones had also proven to be a hard and reliable worker while in the Army and received positive reviews by her supervising officers. Her symptoms of PTSD and depression were also not present prior to the military assault and harassment and the symptoms began immediately following the reported incidents. In addition, her re-experiencing symptoms are central to the military assault and harassment, rather than her possible childhood abuse. The timing and content of the symptoms clearly suggest that they are related

CASE IV: PTSD Diagnosis

Example of Entire Report

ASSESSMENT REPORT

Mr. Xxxxx is a 72-year-old, married, Caucasian male.

PREMILITARY HISTORY

Mr. Xxxxx's premilitary adjustment was average to good. He was born in Massachusetts. He was the youngest of 18 children. He lived with his parents and siblings, though his older siblings gradually married and moved out of the

home. Mr. Xxxxx stated that his family was poor, but they always had food and clothing. His father was a brick worker, and his mother stayed at home to care for the children. Mr. Xxxxx stated that he was close with his parents and siblings. In terms of discipline, he stated that at times he was spanked, but that he would also be punished by having privileges taken away or being given a chore.

Mr. Xxxxx stated that he enjoyed school and interacted well with other children. He achieved grades at approximately a C level. His conduct was good, and he denied repeating grades or any learning difficulties. He played baseball, hockey, and basketball with neighborhood friends, but was not part of a school team.

Mr. Xxxxx reported very limited use of alcohol and no use of drugs prior to the service ("a few sips of alcohol with my parents," "I drank a beer after high school graduation").

MILITARY HISTORY

Mr. Xxxxx was drafted into the Army on October 30, 1944, when he was 18 years old. He was initially sent to Germany in March of 1945, by way of France, but spent most of his time in Austria. Mr. Xxxxx was trained as a rifleman, but served in combat as both a rifleman and scout as part of the 44th infantry division. He attained the rank of Corporal. He was honorably discharged in August of 1946.

Mr. Xxxxx's duty in World War II would be classified as mainly combat. His report on the combat scale indicated that he had moderate to heavy exposure to combat.

Mr. Xxxxx experienced numerous combat experiences, too many of which to described in this report. Two particularly traumatic events occurred during his service that continue to distress him.

1) Mr. Xxxxx was sworn in and went through infantry training with a friend. He then served in World War II in the same unit with this friend. Mr. Xxxxx stated that in one particular combat situation his friend jumped on top of an activated German grenade and saved the lives of Mr. Xxxxx and those soldiers around him. Mr. Xxxxx described experiencing tremendous fright, knowing that if his friend did not do that, they all would have died. Shortly after, he also experienced significant guilt because of his friend's death. He described, "I wanted to jump in the line of fire so I could be with him (in heaven)."

2) Mr. Xxxxx reported that two weeks prior to the event described above, he reported that he was riding in a truck with several other soldiers. A grenade fell

out of one of the soldier's pockets ("I can still hear the click and hissing"). He stated that he and the other men jumped from the truck. Mr. Xxxxx stated that he was very scared for his life. Two men were killed during this incident.

In addition to these stressors mentioned above, Mr. Xxxxx stated that he was also troubled by seeing numerous dead and wounded American soldiers, as well as German civilians, including women, children, and the elderly. Mr. Xxxxx's score on the Combat Exposure Scale of 32 was indicative of moderate to heavy combat exposure, suggesting that Mr. Xxxxx probably was exposed to a whole series of difficult combat experiences typical of that level of exposure.

POST-MILITARY HISTORY AND CURRENT FUNCTIONING

Mr. Xxxxx returned home to Massachusetts following his service. He described that during the first winter he returned, he carried a gun and "took lots of walks to do some thinking." Mr. Xxxxx stated, "I wanted so much to forget everything, but it is impossible to forget the bad things."

Mr. Xxxxx reported that he tried to return to his old job as an apprentice in a shipyard. However, he stated that his job was no longer available, and he instead worked as a machinist. Mr. Xxxxx stated that he liked his job, and often worked overtime. He described, "I plunged myself into it, and worked (overtime) to be a good worker, but it also had the bonus of getting my mind off (the war)." Difficulties with sleeping and frequent nightmares were particularly distressing and affected his work. His nightmares would escalate prior to important meetings at work and made him feel "jittery."

Mr. Xxxxx reported that his symptoms of PTSD were clearly present immediately when he returned from the war. However, because he was able to distract himself with his work, he was able to function fairly successfully. Mr. Xxxxx's symptoms later exacerbated when he retired in 1988 and had "more time to think." He was therefore less able to control his symptoms. Although retired, he initially continued to do consulting until 1993. During this time, he reported that he did a fair amount of traveling. He stated that long plane trips gave him time to think about World War II, and his symptoms of PTSD worsened. When Mr. Xxxxx stopped this consulting, he reported that his symptoms became even worse. He stated that whereas previously he could distract himself from his memories through work, he no longer was able to use this coping mechanism. His ability to work and distract himself is still of concern.

At the outset of the assessment he stated, "I would like to be evaluated in the VA to see if I'm capable of working physically. I feel I can, but I'm not sure if I can do

it mentally because I can't sleep or get (the war) off my mind. The biggest thing I've lost is not working since I retired."

Mr. Xxxxx's retirement and associated increase in PTSD symptomatology have also caused difficulty with his family relationships. Mr. Xxxxx met his current wife in 1948 and married her in 1950. They had one son who was born in 1954. Mr. Xxxxx described being easily frustrated and irritable with his wife and son. He stated, "I realize I am wrong afterwards, but I can't help acting like I do." Mr. Xxxxx reported that he also has one or two close friendships. He stated that he never told his friends about the war and grew distant from them because he was "afraid they would think I was an awful person." Finally, Mr. Xxxxx stated that his symptoms of PTSD also affected him during his personal time, both before and after his retirement. Specifically, during his personal time, he did not have his work to distract himself and he would be very distressed by intrusive thoughts of the war.

Mr. Xxxxx denied use of alcohol more than occasionally, and never used drugs.

ASSESSMENT RESULTS

Mr. Xxxxx was assessed for possible presence of posttraumatic stress disorder (PTSD) by clinical interview, psychometric testing, and mental status examination.

Mental Status and Behavior/affect during the assessment:

Mr. Xxxxx was alert and oriented X3. He was dressed casually, and sometimes came to sessions unshaven. Mr. Xxxxx's speech was somewhat pressured, but of normal tone. He was very talkative, though he responded to redirection. Mr. Xxxxx's thought process was logical and goal directed, though frequently he would tell lengthy stories about his experiences in the war that were marked by circumlocution. He denied ever experiencing hallucinations or delusions. Mr. Xxxxx's stated moods were anxious and depressed, and his affect was consistent with this report. When talking about things that made him upset or anxious, Mr. Xxxxx would frequently shake his hands and was observed to be distressed. Likewise, when he was discussing his past traumatic experiences, Mr. Xxxxx would often cry. Mr. Xxxxx endorsed having passive thoughts of suicidal ideation ("I just like to go to sleep and have it over"). He denied current suicidal intent or plan.

Interview:

The interview data are consistent with a DSM-IV diagnosis of PTSD. Mr. Xxxxx currently meets the following PTSD diagnostic criteria:

(A) Exposure to a recognizable stressor as noted above by combat history and traumatic events (see above).

(B) Re-experiencing of the trauma:

Mr. Xxxxx reported having daily unwanted memories of his traumatic experiences in World War II. He stated that he tries to keep busy to eliminate these thoughts, although this is more difficult to do when he is driving or flying. He described that the thoughts, “go with me wherever I go.”

Mr. Xxxxx stated that 1-2 times per week he has nightmares related to World War II. In particular, he reported having a recurrent nightmare during which 30 troops line up and he marches them to the front. He described, “I’m always the only survivor, and I’m tired and frightened. All the men are the same height and hair as my buddy who was killed. Sometimes I wake up and I can’t breathe.” The dream sequence then repeats, and he goes back to march 30 more troops in clean uniforms into battle. Mr. Xxxxx stated that this sequence can recur 15 times in a night. He stated that when he wakes from his nightmares, it takes him approximately 2 hours to fall back to sleep.

Mr. Xxxxx reported that approximately 1-2 times per month he will experience flashbacks. He stated that they occurred more frequently when he first returned from the war. He described, “I would re-live it. I would yell and scream for everybody to hit the dirt.” More recently, he stated that two weeks ago, he was outside in his yard and heard noises in the bushes and believed someone was sneaking around. He described, “I knew where I was, but for a moment there was the fear that came back. I hear a shot and feel like I’m back as a scout and can’t see my guys because I wandered off too far.”

Mr. Xxxxx stated that several times a week he will become emotionally upset when reminded of the war. This was observed in the interview, during which Mr. Xxxxx cried easily when discussing his memories. He stated, “I never know what’s going to trigger it.” Mr. Xxxxx reported that he will also have a physiological response to reminders. He stated that his heart will race and he will feel like he cannot breathe. At times, this escalates to the level of a panic attack.

(C) Persistent avoidance of stimuli associated with the trauma or numbing of general responsiveness (not present before the trauma):

Mr. Xxxxx stated that he avoids having thoughts and feelings related to his experiences in the war. He will go to great lengths to avoid thinking about the war. For example, he stated that he will try to watch television to distract himself, although this is not always effective. He described, “When I have an avalanche of thinking, unless you chase me with a gun, nothing helps.” Mr. Xxxxx further stated that he avoids watching war movies, as well as going to cemeteries or on nearby roads, because they remind him of death. Moreover, he indicated that at times it is difficult for him to go to the VA (“something grips at me”), although this does not stop him from attending his appointments.

Mr. Xxxxx reported that there are portions of time during his experiences that he cannot remember. In particular, he stated that he is unable to remember the 10 days after his friend died, even with considerable effort. Alternatively, he described, “I clearly remember my buddy dying and the few hours after-that’s the part I wish I couldn’t remember.”

(D) Persistent symptoms of increased arousal (not present before the trauma):

Mr. Xxxxx stated that he has nightly difficulties with sleeping. Mr. Xxxxx described that part of his difficulty with sleeping is related to nightmares and being fearful to go to sleep. He will also lay awake with memories. He reported that it takes him approximately 45 minutes to an hour to fall asleep. He also will have mid-sleep and early morning awakenings. Mr. Xxxxx currently sleeps about 6 hours per night, though he would like to sleep for 8 hours.

Mr. Xxxxx reported difficulties with irritability, and that he will at times become verbally abusive towards his wife and daughter. Mr. Xxxxx stated that his symptoms of irritability increased after he retired. He described, “There was a big difference when I retired and I found myself thinking about the war.”

Mr. Xxxxx described difficulties with concentration much of the time. He stated, “My memories of the war sneak in and it affects everything that I think and do.” He reported that his difficulties with concentration also increased after he retired and “had more time to think about the war.”

Mr. Xxxxx stated that he is always on alert. He reported that he will check his home for safety multiple times. He described, “I’m always on alert for things to happen so I’m ready.” He stated that he is particularly on alert when cars drop off money at a bank or store, and that he has a fear that someone will shoot him in

the head while driving. Mr. Xxxxx stated that he also is startled easily and often feels “jumpy.”

Depressive Symptoms:

Mr. Xxxxx reported a number of symptoms of depression. He endorsed feelings of depressed mood and loss of interest in doing activities that he would normally enjoy. Mr. Xxxxx reported that his energy and appetite are poor (“I don’t enjoy food like I used to”). He reported symptoms of guilt, difficulty concentrating, and difficulties sleeping. As mentioned previously, he indicated that at times he has thoughts of wishing he were dead, though denied any current plan to attempt suicide.

It was further evaluated whether these depressive symptoms might be part of a Bipolar Disorder. Mr. Xxxxx denied any manic symptoms consistent with this diagnosis. However, his medical records indicate that current and past treatment providers have felt that Mr. Xxxxx has exhibited manic/hypomanic symptoms at times. Therefore, a diagnosis of Bipolar I or II should be further evaluated longitudinally. It has been our impression that Mr. Xxxxx exhibits hypomanic-like symptoms that may actually be a manifestation of prominent anxiety, as well as a tendency to express himself in a dramatic and emotional fashion.

Current Medications:

Mr. Xxxxx is currently taking Imipramine (25 mg/three times per day) and Lorazepam.

Psychological Treatment History:

Mr. Xxxxx has an extended treatment history with the Brockton VA. He stated that he was seeing Ms Y., MSW, from 1994 to 1999 for both individual therapy and a World War II group medications simultaneously, and associated side effects.

Psychometric Testing:

Mr. Xxxxx completed a MMPI-2. Validity scales of the MMPI suggest that the scales should be interpreted with caution. The profile is indicative of a person who’s abilities to cope with stressors are low. It also is suggestive of a person who is experiencing emotional pain, and has difficulty controlling emotions and

behaviors. There is a tendency to admit psychological problems, to be self-critical, and to believe that they have insufficient skills to handle problems.

The interpretive code type that conforms to the high-point scales in the profile was 8-7. This configuration is a variation of the modal 2-8/8-2 profile of other combat veterans with chronic PTSD who are evaluated at the Boston DVAMC. Individuals who obtain this code type on the MMPI-2 are described as frequently worrying, irritable, nervous, agitated, and socially withdrawn. The profile is also suggestive of a person who tends to be guilty and depressed. These individuals have a tendency to feel inferior, be self-critical, and overreact to minor problems. Mr. Xxxxx's profile was also elevated on scales 6, 3, and 2. This is suggestive of a person who is depressed and has a number of somatic complaints. Further, such individuals may be overly sensitive and concerned that they have not been treated fairly in life.

Mr. Xxxxx scored a 40 on the special PTSD subscale of the MMPI. Patients who have scored 28 and above on this scale have been diagnosed as having PTSD in 82% of the cases examined.

Mr. Xxxxx also completed the Multidimensional Personality Questionnaire. His profile on this measure was suggestive of a person who has few experiences of joy and excitement, and is seldom really happy. The person likes to be alone, and can be distant with others, often preferring to work things out on his/her own. Such individual are nervous, feel vulnerable and sensitive, and are prone to worrying and irritability. Guilt and distress occur at a high frequency even with everyday life conditions. Such individual also have a tendency to react catastrophically to minor mishaps and daily hassles. They may feel mistreated or that others wish to do him/her harm. Finally, such individuals may become readily absorbed in vivid and compelling recollections and imaginings.

Mr. Xxxxx obtained a score of 140 on the Mississippi Scale for Combat-Related PTSD. This score exceeds the cut-off of 107, and is consistent with a diagnosis of PTSD.

Mr. Xxxxx's score of 44 on the Beck Depression Inventory was indicative of severe levels of depression. His scores of 34 on the Beck Anxiety Inventory also indicated that he has severe levels of anxiety.

In summary, the psychometric findings are consistent with information gathered during the diagnostic and social history interviews for presence and level of symptomatology. The pattern among the psychometric findings supports a diagnosis of PTSD.

Psychophysiological Assessment:

Mr. Xxxxx was evaluated for his appropriateness to have a psychophysiological assessment. This assessment measures the veteran's cognitive, behavioral, and physiological response to combat scenes as compared to non-combat (control) scenes. The assessment was not deemed necessary at this time because Mr. Xxxxx's diagnosis of PTSD is clear.

SUMMARY AND RECOMMENDATIONS

In summary, Mr. Xxxxx functioned fairly well prior to the military. However, related to his experiencing several life threatening events during his service, his functioning declined following the military. Mr. Xxxxx met criteria for PTSD immediately when he returned from World War II. His primary coping strategy was to immerse himself in his work as a means of distracting himself from his memories of the war. Consequently, his functioning was still in the range of fair to good following the military. However, when Mr. Xxxxx retired, his primary coping strategy was no longer available. He had more time to think about his past, and his symptoms correspondingly increased. Currently, Mr. Xxxxx is quite symptomatic and is very distressed. This, in turn, has caused discord within his family, and has particularly affected his relationships with his son and wife.

The following recommendations are made:

1) Mr. Xxxxx has been receiving treatment from the VA for a number of years. It is recommended that Mr. Xxxxx seek treatment there for continuity in his care. We have reviewed their treatment plan and it appears to be the best course of action at this time.

2) Mr. Xxxxx reported fair to good functioning for 50 years while working. It is our recommendation that it is extremely important for him to remain active, whether that is in a work environment, in a volunteer position, and/or being active in clubs or other organizations.

3) Diagnostically, there is a question whether or not there is a bipolar process. Data from this evaluation could not support that diagnosis. Though he exhibits hypomanic-like symptoms, it was our impression that these may actually be manifestations of significant anxiety and a tendency towards expressing himself in an exaggerated manner. However, a trial on a mood stabilizer would be valuable to evaluate the effects of this type of medication on his mood.

DSM-IV PROFILE

Axis I 309.89 PTSD
296.33 Major Depression, recurrent, moderate
R/O Bipolar Disorder I and II
Axis II Deferred
Axis III Hypertension (by self report)
Axis IV Retired
Axis V Global Assessment of Functioning
Current GAF: 42
Highest GAF past year: 42

CASE V: PTSD Diagnosis

Example of Entire Report

REPORT OF PSYCHOLOGICAL ASSESSMENT

Xxxxx Xxxxxx is a 59 year-old, remarried, non-service connected, white male referred by Dr. Y. of the V.A. for psychological assessment. Please refer to earlier report for additional background information. The following is a partial evaluation of Mr. Xxxxxx's psychological status.

Military History

Patient enlisted in the Army during June of 1954. He served approximately 21 months in Germany as a tank driver. He attained the rank of corporal (Sp-3) while in Germany. He was honorably discharged during June of 1957 as an Sp-3.

The patient's unit was in Germany and Hungary as the Cold War began to intensify. During this time period American troops in Europe were still referred to as the Army of Occupation. Mr. Xxxxxx stated that his company was the only heavy armored American unit in Europe at the time, and that they were on alert for all but one of the months he was stationed there. He was a witness to the Berlin Wall going up, and was fired upon by Russian forces during the Hungarian Revolution. Upon return from Germany the patient was stationed at Fort Carson Colorado where he was assigned to infantry training, a job for which he felt completely unprepared as a tank crewman. The patient's duty in Europe would

be classified as mainly “combat ready”. His report on combat scales indicate that he had light to moderate exposure to combat. Patient reports that none of the men in his unit were killed or wounded while he was stationed in Europe, but that a number of people died while he was stateside, as detailed below. Patient received severe wounds during a training accident and spent several weeks in the hospital.

Military events which patient considered particularly traumatic included:

Europe:

1) The continual tension of being on alert in Europe for 20 months.

2) Witnessing a French tank explode when a crewman dropped a cannon shell which detonated.

3) Being fired upon by Russian and East German troops while under orders not to return fire.

4) Accidentally driving his tank off of a pontoon bridge into the water during the winter. The tank immediately filled with freezing water and gasoline. The patient had frost-bite, and most likely would have died if not for an officer who quickly moved him to the tank’s exhaust to warm him.

5) While driving a tank upon which two squads of troops rode, the patient drove off the road and the tank track caught a piece of concertina wire which whipped across the tank’s top wounding many of the soldiers, including one who lost both legs. The patient takes sole responsibility for this event, even though no disciplinary charges were brought against him.

Fort Carson Colorado:

6) Witnessing a training accident where a recruit dropped a grenade and it detonated in a crowd, killing everyone present. This occurred during a class the patient was responsible for teaching.

7) While setting up an obstacle course with TNT charges, the patient and the company demolitions expert were blown out of a hole when the TNT was accidentally detonated from a remote control board. The patient had noticed that the wires they were to use for detonation were “live”, and he told this to the sergeant who felt no charge when he touched them, and proceeded to wire the TNT. The patient observed people near the control board and thought someone

was brushing against the switch, he turned to tell the sergeant this just as the TNT detonated. The sergeant was killed instantly and the patient awoke in the hospital.

Assessment Results

Patient was assessed for possible presence of posttraumatic stress disorder (PTSD) by clinical interview, and psychometric testing.

Interview: Interview data are consistent with a DSM-III-R diagnosis of PTSD. PTSD diagnostic criteria which the patient meets include:

A) exposure to a recognizable stressor as noted above by military history and traumatic events (see above).

B) re-experiencing of the trauma (need 1):

The patient experiences intrusive and distressing recollections of military events on average twice per week. Intensity is moderate and he reports that he can suppress memories with effort, and that he is very practiced at this. Over the course of the evaluation intrusions have increased in frequency and intensity even though actual discussion of the events has been limited due to the availability of a past Compensation Exam Report. Intense psychological distress at exposure to events that symbolize or resemble an aspect of the traumatic events occurs once or twice per week, and is extremely upsetting to the patient. His inability to control his reactivity to these cues seems to result in an intensity of reaction that is dramatically increased from that he reports to uncued intrusions. The patient reports two severe dissociative episodes related to being blown up with the sergeant. These have both occurred since 1985, but none recently. Mr. Xxxxxx reports that he will wake from a military trauma related nightmare once or twice per week, and that on these occasions his distress is such that he cannot return to sleep for the rest of the night.

C) persistent avoidance of stimuli associated with the trauma or numbing of general responsiveness (not present before the trauma) (need 3):

The patient reports that he makes daily efforts to avoid thoughts or feelings associated with his trauma. His avoidance is severe and requires considerable effort on his part. He distracts himself as much as possible, drank heavily in the past, worked long hours prior to being disabled, and attempts to suppress

thoughts. The patient makes dramatic efforts to avoid activities or situations that arouse recollections of the traumas. Externally cued memories are very upsetting to him and he avoids parades, music concerts, his Vietnam veteran neighbor, his brother who wants to talk about the military generally, obituaries in the newspaper, military-related movies, films containing violence generally, guns, 4th of July celebrations, other veterans, and news programs related to the military. As an example of his avoidance the patient described attending a coming home party for his nephew who participated in Operation Desert Storm. When guests asked about the war the patient felt unable to remain in the house and he left with no explanation. He has not spoken to his sister since that time, and she does not know why he left the party. Since leaving the military, the patient shows markedly diminished interest in significant activities, including hunting, music concerts, social events generally, fishing and camping. The patient reports feelings of detachment or estrangement from others since the early 1970's when he stopped drinking alcohol. Feelings of detachment and estrangement are severe and almost constant. The patient feels he will not be trusted by others generally, and feels unable to talk to his mother, his siblings, and sometimes not even his wife. Mr. Xxxxxx expressed marked emotional numbing which has been his usual state for many years. Often he feels unable to love anyone. The patient describes a strong sense of foreshortened future. He stated he felt this way all the time, and that he could die "any day now". He made clear that he was not speaking of suicidal thoughts, but that his future will be cut short at some point. The patient stated that he has felt this way since the mid 1970s.

D) persistent symptoms of increased arousal (not present before the trauma) (need 2):

The patient describes nightly problems with sleep onset, mid, and early awakenings. His sleep loss is profound, and he frequently fears falling asleep. Mr. Xxxxxx states that this has been the case since his discharge from the Army. The patient reports chronic irritability and outbursts of anger on a daily basis. His anger is severe, including verbal or physical aggression. He states that when angered he is prepared for a physical confrontation and has no regard for his own physical safety, in spite of the fact that he has severe physical limitations. The patient reports daily concentration difficulties dating to the 1970s when he would occasionally drive his truck to the wrong stop on his route necessitating unloading his tractor trailer from front to back, the reverse of what one would usually do. He also remarked when asked this question that he had that day driven to the wrong part of town on his way to the hospital, and could not remember where he was supposed to be going.

The patient displays severe symptoms of hypervigilence and feels this way all of the time. He keeps a knife by his bedside, and states he has “ever since the service” (37 years). He describes himself as “paranoid” stating he trusts no one, will not ever live on the first floor of any building due to easy access through windows, can’t stand to have anyone behind him while walking on the street, or in an elevator; will avoid large crowds because he cannot observe everyone. In restaurants he sits with his back to a wall and “watches everyone like a hawk”, and if he cannot get a “safe” seat he will leave the restaurant. He states that he and his wife no longer go to the movie theater together because he insists upon sitting in the last row in the back, which she does not like. Several times per week the patient will hear a noise in his apartment during the night and he will search each room while carrying the knife from his bedside. Mr. Xxxxxx reports a severe startle response once or twice per month including sustained arousal following the initial reaction. Physiologic reactivity upon exposure to trauma related cues occurs once or twice per week and consist of tachycardia, sweating, difficulty catching his breath, and visible trembling.

Mental status:

The patient is a 57 year-old man who appears his stated age. He was casually and neatly dressed and walked with the aid of a cane. His mood and affect were congruent, anxious and dysphoric. There was no evidence of a thought disorder. When discussing traumatic events he expressed a great deal of sadness, guilt, and shame. There was no evidence of suicidal or homicidal thoughts. Although abstraction abilities were not formally tested the patient’s thought processes were concrete and goal directed. Memory and concentration problems were not evident within session, but there was some noticeable forgetfulness between sessions. The patient stated that he suffered a head and back injury in 1985, and that he has been unemployed since that time. He reports that neuropsychological testing revealed some deficits, including reading difficulties (grade level 3 to 4) and poor concentration. The present writer has not reviewed these records. Given the patient’s reading problems only relatively brief psychometric instruments with a direct bearing upon a PTSD diagnosis were administered to him by reading the items and response choices.

Psychometric Testing:

Patient scored a 36 on the special PTSD subscale of the MMPI. Vietnam combat veteran patients who have scored 30 and above on this scale have been diagnosed as having PTSD in 82% of the cases examined.

Patient scored 149 on the Mississippi Scale for Combat-Related PTSD. This score exceeds the 107 cutoff used with Vietnam combat veterans, and is consistent with a diagnosis of PTSD.

SUMMARY

Patient presents with symptoms consistent with a diagnosis of PTSD (DSM-IV Axis I 309.89 Posttraumatic stress disorder). Additionally, he reports some symptoms of depression, and a history of alcohol abuse which clearly was an attempt to self-medicate symptoms of PTSD.

CASE VI: PTSD Diagnosis

The patient reports that within six months of being discharged from the Army, he started to feel depressed, and could not remember a time from the time that he was discharged until present where he actually felt joy in his life. It was within one year of his military injury that he began to experience significant nightmares three to four times per week, of people in uniform chasing him with guns and his not being able to run away or escape them. The nightmares became so intense that he would wake up in the middle of the night with his hands around his wife's throat or thrash in the bed and hit her or kick her while asleep. When he awoke the next morning, he had no recollection of this. Subsequently, his wife divorced him, though he has had other female bed partners who have been the recipient of similar such violence while he is asleep. These nightmares persist to the present time.

He also experienced recurrent and intrusive distressing recollections of the event including images and perceptions, 20-30 times per week, which he rated as "severe" in interfering with functioning. He would frequently become overwhelmed while in crowds, fearing eminent danger. The patient reports, "I don't like crowds. I don't think that anyone in particular is trying to harm me, but it feels that people are following me and trying to do something to me. I just have to run and escape those situations." Currently, he avoids all crowds, and ultimately all situations that make him feel suspicious and paranoid. He also reports excessive startle when people come up behind him, and when he is awakened by surprise.

Beginning about thirty years ago, the patient has experienced dissociative periods, about 1-2 per month, when he did not know where he was. The last

period occurred about one month prior to his last admission. During these times, he could be walking on the street or driving in his care and the next thing that he would remember would be 15-20 minutes later, when he may be sitting on the ground, may be at home, or may be in a strange place. He does not know what has happened during this time lapse.

The patient feels chronically anxious and has felt so the majority of his adult life, with an impending sense of doom, especially when he leaves familiar environment. He also has an inability to recall many aspects of being shot, and has feelings of detachment and estrangement from others. He has had throughout his adult life, a foreshortened sense of future, that he would die at a much younger age.

CASE VII: PTSD Diagnosis

Veteran's positive symptoms of PTSD since Vietnam include:

1. Persistently re-experiencing the traumatic event in:

• Intrusive thoughts: "especially on rainy cloudy days and when I'm walking at night."

• Nightmares of Vietnam: "roommates rigged up an alarm system that keeps me from leaving the room, because I was sleep walking when I first got here."

• Recent flashbacks

• Intense psychological distress with symbolic events

2. Persistent avoidance of associated stimuli, including:

• Trying to avoid thoughts or feelings associated with the trauma. While he is a Domiciliary Resident, he finds that "it's hard to avoid activities or situations that arouse recollections of the trauma." For instance, he "sees guys walking around with fatigues, etc."

• Psychogenic amnesia

• Diminished interest in significant activities

• Feelings of detachment or estrangement from others

• Restricted range of affect: “unable to have loving feelings,” “don’t trust easily,” tends to wonder, “why are you being so nice to me, what do you want to do? I try not to but I can’t help it.”

• Avoidance about thought of the future: “afraid to look into the future, I don’t even go there.”

3. Persistent symptoms of increased arousal manifested in:

• A sleep disorder: “difficulty falling and staying asleep.” “When night comes, I automatically wake up.”

• Distractibility: “things easily distract me.”

• Irritability or outbursts of anger.

• Impaired concentration

• Hypervigilance

• Exaggerated startle response

• Physiologic reactivity upon exposure to events that symbolize the trauma: “heart races.”

• The veteran also experiences depressive symptoms and “survivor guilt.”

CASE VIII: PTSD Diagnosis

The veteran reported that he is moderately to severely depressed. He denied suicidal/homicidal ideation. He said he becomes extremely angry and frustrated at times. The veteran reported that he has distressing dreams and nightmares now about once a week that he remembers, although he wakes up more frequently in the night in cold sweats though unaware of a nightmare. He reported that he has recurrent intrusive recollections of his experiences in

Vietnam, not only of the rocket attacks but also of other things that happened, and he said that he feels guilty that he came back when so many of his friends didn't given that his life is so unproductive. The veteran reported psychological distress and reactivity on exposure to cues, events, and reminders of his experiences in Vietnam. He also reported efforts to avoid thoughts, feelings, activities, and conversations that arouse recollections of his experiences. He keeps to himself, doesn't like to be around people, stays away from anything on television that might arouse memories. He has become particularly isolative. He describes a recent event in which he went to a Christmas tree lighting ceremony where there were fireworks. This caused feelings of distress, fear, tension, and anxiety and he had to leave the event. He described edginess and hypervigilance, and an exaggerated startle response. He gave various examples of this, including recently being in a friend's body shop when somebody dropped a metal bar. He said the noise scared him to the point that "he was going to have a heart attack." The veteran also reported a loss of interest, feelings of detachment, and not feeling close to anyone, restricted affect, a sense of fore-shortened future, sleep disturbances described earlier, irritability, and difficulty concentrating.

Results of psychological testing revealed a score on the Mississippi Scale which fell in the high and significant range. It should be noted that this is exactly the same score that he reported when he was evaluated two years ago. His CES was in the moderate range and a few points lower than it was previously reported in his interview of two years ago. The validity scales on the MMPI-II are moderately elevated but still considered to be interpretable for the purposes of this interview. It is particularly noted that these scores on the validity scales are not as elevated as is often seen in veterans being evaluated for compensation for PTSD. The PK Scale on the MMPI-II is in the significant range. The clinical scales are suggestive of the presence of difficulty concentrating, depression, apathy, feeling isolated and distant from others, sleep disturbances, and interpersonal isolation and withdrawal. Thinking may be confused and there may be feelings of guilt and a sense of personal inadequacy.

In summary, The veteran was interviewed and evaluated to rule in / rule out PTSD associated with a specific stressor event. The veteran did report this as his primary stressor event. He also presented with symptoms of PTSD which he directly related to that event. The veteran does have a history of drug use and dependence but this does not negate the presence of PTSD. Also many of the symptoms of PTSD overlap with depression and the clinical notes throughout his C-file indicate the presence of depression. These are entirely consistent with each other. While his last C & P evaluation did not attribute these symptoms to PTSD, based on this interview, the review of the records as noted in this report, and the consistency of reports noted throughout the records from at least

19xxpresent, and his very early complaint of “nerve problems” in 19xx, it is considered most likely that the veteran is suffering from PTSD and an associated major depression and that this is long-term and chronic.

CASE IX: NO PTSD Diagnosis

Secondary to his exposure to the traumas cited above, the veteran reports occasional distressing recollections, especially when he is exposed to war-related movies and the current Bosnian crisis. He reports waking up in a cold sweat occasionally and yelling “watch out,” according to his wife. He denies memory of his dreams. He reported no incidents of flashbacks. He was quite tearful in discussing the possibilities that he shot an enemy officer during the last stay in the field.

In terms of persistent avoidance and numbing symptoms, the veteran described not wanting to converse about Vietnam, not being able to watch war movies, and an inability to continue hunting activities.

In terms of persistent symptoms of arousal, the veteran described his sleep as “pretty good, “ although he stated that he wakes up 2-3 nights a week in a “cold sweat.” He described no problems with his temper control, and no difficulty concentrating. He described no hyper-vigilant symptoms, but did describe an exaggerated startle response, onset since his return from Vietnam.

Test Results:

The veteran’s responses to psychometric testing appear to be valid. Such individuals are usually described as relatively free of stress, yet willing to admit to minor faults and problems. Such individuals are frequently focused most strongly on the wide variety of physical ailments from which they suffer. It is frequently found that such individuals exhibit somatic problems in response to stress. In terms of emotional distress, such individuals are usually described as very tense and anxious, as well as depressed and alienated from others, and have relatively poor interpersonal relationships as a result. Although the focus of somatic complaints is consistent with the veteran’s presentation, the finding of poor relationships, depression, and unhappiness is inconsistent with his demeanor during the interview as well as his verbal report. The veteran’s completion of the CES yielded a sore suggestive of moderate to heavy combat exposure, which is not consistent with his reported duties in the military. His completion of the

Mississippi scale yielded a score below the cutoff suggestive of possible PTSD. His completion of the Keane PTSD Scale also did not reach the level suggestive of possible PTSD. These results are not consistent with the diagnosis of combat-related PTSD.

Summary:

C-file, background, behavioral observations, and test results are not suggestive of a diagnosis of PTSD. The veteran did not report symptoms of a severity suggestive of this disorder, nor did test results suggest possible PTSD. He did not report clear recurrent and intrusive recollections of the traumatic event. He reported dreams that were sufficiently distressing to awaken him, but he has no memory of these dreams. Given his recent [traumatic events], it is conceivable that his dreams are related to these experiences as well as perhaps Vietnam. Finally, the veteran's current distress appears to be largely an attempt to adjust to his status as unemployed/retired, since 1998, to which he has responded with symptoms of anxiety, not reaching the level of intensity, frequency, or duration indicative of a clinical disorder.

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Appendix H: Social History Questionnaire *

I. Identifying Information:
Name: _____ Date: _____
Address:_____ DOB: _____
SS#: _____
Race: _____
Who are you currently living with?_____
For how long?_____
What is your relationship? ❑ parent ❑ child ❑ spouse ❑ friend ❑ relative

Premilitary History

Who were you raised by? Biological / adoptive / foster / step parents /other_____
Until what age? ____,

Age at enlistment / draft /commission into the military_____
How would you describe your caretakers (type of work, personality):
(mother, father, other)
_____
_____
____
Check any that you feel you experienced during childhood:
❏ Physical abuse / Assault
❏ Sexual abuse / Assault / Molestation
❏ Emotional abuse
❏ Neglect
❏ Witness of Domestic Abuse
❏ Severe stressor
❏ Unwanted sexual advance
❏ Motor Vehicle Accident
❏ Death of family member or close friend
❏ Natural Disaster
❏ Community violence
How many siblings do you have (indicate if step, adoptive)_____
_____
____
What are their names and current ages
_____
_____
____
_____
____
What type of relationship / contact do you currently have with your parents_____
____
What type of relationship/ contact do you currently have with your siblings_____
____
Prior to entering the service, how many years of schooling did you complete?
_____
Did you earn a high school diploma?
_____
Years of College_____Degrees?
_____
How would you describe yourself during the time prior to entry into the military_
_____
How would you describe your pre-military adjustment:

❑ very good ❑ good ❑ average ❑ marginal ❑ poor.

***This Social History Questionnaire may be included in re-exams, for the purpose**
of expediting completion of the social and industrial survey.

How would you describe:
School / grades: ❑ very good ❑ good ❑ average ❑ marginal ❑ poor.
Discipline (suspensions from school, police intervention, etc) _____
General behavior /
attitude_____
Sports_____
____
Social (friends, dating, hobbies)
_____
Did you have any history of trouble as a youth?
_____
If so, please describe
_____
Substance usage prior to military
_____
Any associated problems:
_____
Pre-military health-related problems (history of hospitalization, significant illness, injury, including head injury) _____
What were pre-military
stressors:_____
at what ages _____,
Did stressors result in academic problems, hospital, jail, mental symptoms, treatment, etc)
_____
Medications taken regularly prior to military: _____
Psychiatric history prior to
military:_____
Family history of psychiatric problems:
_____

Military History

Military branch of service:
❑ Army ❑ Air Force ❑ Navy ❑ Marines ❑ Coast Guard o National Guard
Dates of Service: from _____ to _____.

Duty Stations and dates:
_____
Primary duty
_____
Other duties
_____
Combat tours _____ Combat unit_____
Location
_____
Dates _____to _____.
Rank attained while in combat_____.
Type of discharge:
❏ honorable ❏ dishonorable ❏ general ❏ other than honorable
Medals awarded
_____

Post-Military History

Education and Employment History:

Education history following active
duty_____
Certificate(s) / degree(s) achieved.
_____
Number of jobs held since active
duty_____
Type of
jobs_____
Longest time employed at one job:
_____
Any problems in jobs (conflict, resulting in firing, etc.) _____
_____
____
Are you currently: ❏ unemployed ❏ employed.
Current occupation
_____
length of time at this job has been _____.

Post Military Stressors:

Post-military stressors and significant losses: (i.e., academic / occupational / financial / health / marital problems, separation/divorce, hospital, jail, emotional/ mental symptoms, hospitalization, treatment, etc.) _____

_____
_____
_____
_____

Legal History:

Do you have any legal incidents (i.e., reckless driving, DWI, theft, assault, etc.)
_____
_____
Dates for each:
_____
_____
_____
What were the results: (i.e., incarceration, payroll, etc.) _____
_____
_____

Substance Abuse/Alcohol History & Treatment:

Please describe your use of alcohol and drug (s) since military duty: _____
_____
_____
Age of onset:_____,
Types of
substances:_____
Last usage:_____,
Related psychosocial problems (marital, occupational):
_____
_____
_____
Withdrawal problems:
_____
Related health problems:
_____
Diagnoses received related to substance use:
_____
_____
_____
Treatment related to substance use:
_____
_____
_____

Medical History:

Significant illnesses and injuries:
_____
Hospitalizations:_____
___
Current medications:
_____
Current disability rating :
_____
Current subjective mental/emotional complaints:
_____
_____
____
Current psychiatric treatment:
_____
_____
____
Number of inpatient hospitalizations for mental /emotional /substance use complaints:_____
_____
The extent of time lost from work over the past 12 month period_____
_____
____
Do you feel that time lost from work is due to your mental / emotional complaints?
_____

Marital/Relationship History:

Current Marital Status: ❑ Married ❑ Divorced ❑ Separated
Previous marriages: (onset and length of time for each, reason for divorce): ___
_____
____
Children's ages
_____
How would you describe your current significant relationship with partner: ____
_____
____
How would you describe your current relationship with children:_____
_____
____

What is your current attitude towards social interactions in general: _____
_____
____
How do you feel others in your life view you: _____
_____
___.
Social support & hobbies:
_____.

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Appendix I: References

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