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JRRD Guest Editorial

Compensation examinations for PTSD—An opportunity for treatment?

Veterans who undergo compensation examinations to determine eligibility for service-connected compensation have strong feelings about the process. A recent story aired by *60 Minutes* on the compensation and pension evaluation process was titled, "Delay, Deny and Hope That I Die," capturing the anguish compensation evaluations can evince [1]. A veteran at a recent hearing sponsored by the Veterans Benefits Administration (VBA) vividly described the anger he felt about the compensation evaluator: "The guy is getting a check to deny our services" [2].

When the response to a posttraumatic stress disorder (PTSD) claim is an evaluation without a concurrent offer of treatment, a potentially adversarial situation is made worse. The compensation examiner has a responsibility to the VBA to obtain information to adjudicate a claim, and as such, the examination serves a societal need rather than a treatment need. In fulfilling this societal need, compensation examiners are put into an evaluative role that can alienate the veteran being evaluated [3]. For example, the compensation examiner may have to collect information about traumatic issues that the veteran is unprepared to address therapeutically. A compensation examination focuses on data collection rather than addressing veteran distress. In addition, a compensation interview often has more time constraints than multisession clinical treatment, and the veteran may feel rushed. Limited time is available to focus on helping the veteran process his or her subjective experience. An examiner must consider not only the veteran's perspective but also alternative sources of data and may ask questions that challenge the veteran's version of events.

Even the expression of empathy during an evaluation can be complicated [4]. The empathic listening that mental health clinicians are trained in may trigger unrealistic wishes for help from veterans asked to describe private thoughts and traumatic events. Such wishes may be evoked by the evaluation setting. Evaluations are usually performed in Department of Veterans Affairs (VA) clinicians' professional offices, by VA clinicians in their professional garb, with clinicians identified by their titles (social worker, doctor, etc.)—all of these features are associated with being offered succor. At the end of the encounter, the compensation examiner concludes the evaluation and writes a report that may lead to a denial of benefits. The empathy may be seen as artificial and worsen veterans' frustration with the compensation process. The Veterans Health Administration (VHA) suffers collateral damage by administering examinations that may result in the denial of benefits by the VBA.

In my opinion, OIF/OEF (Operation Iraqi Freedom/Operation Enduring Freedom) veterans applying for service-connected compensation for PTSD should routinely be offered an on-site treatment referral immediately following

the compensation examination. I focus on OIF/OEF veterans because their eligibility for treatment does not depend on the results of their compensation examination—all OIF/OEF veterans are eligible for VA treatment for 5 years after their discharge from the military. In addition, many recently discharged OIF/OEF veterans' first contact with the VA is through a compensation examination. In this editorial, I describe the steps from deciding to apply for service-connected compensation through the immediate postexamination period and then consider the effect of linking evaluation and treatment referrals during the compensation evaluation.

WHICH ELIGIBLE VETERANS ACTUALLY APPLY FOR SERVICE-CONNECTED COMPENSATION FOR PTSD?

Through the end of 2009, approximately 1.1 million OIF/OEF veterans had left Active Duty out of a total of 1.7 million veterans who had served [5]. A significant proportion of them will develop PTSD. In the *New England Journal of Medicine*, Hoge et al. indicate that between 12 and 20 percent of returning OIF/OEF combat troops met screening criteria for PTSD [6], and an analysis of a broader sample of returning OIF/OEF personnel identified 9.8 percent who met the screening threshold for PTSD [7]. It is of concern, but not surprising, that a comprehensive analysis of veterans treated at the VA between 2004 and 2008 suggested that the rates of mental illness have increased with successive cohorts [8].

Based on the number of compensation claims that have been filed to date and the number filed in past wars, a conservative estimate is that a full 50 percent of OIF/OEF veterans will apply for some service-connected compensation, which is only slightly higher than the 44 percent of Gulf War veterans who applied [9]. It is likely that a majority of those who apply are actually those who are at least partially disabled. In studies describing pre-OIF/OEF cohorts, award rates ranging from 33 to 72 percent for PTSD have been reported [10]. More recently, a review of 2,400 PTSD claims decided during 2007 and 2008 indicated that 42.5 percent were denied and an additional 2.9 percent were rated at 0 percent (veterans had the diagnosis but were not disabled by it); 1.54 percent were rated at 100 percent and the rest fell in between as shown in the **Figure** (unpublished data).*

Qualitative data and surveys of veterans from other conflicts who applied for service-connected compensation for PTSD indicate that for the majority, the motivations for seeking service-connected compensation are complex, with financial gain being only one of many motivations [11]. A substantial proportion of applications are filed many years after discharge from military service, not at the earliest opportunity, and many veterans apply after triggering issues other than the first onset of symptoms. In a survey by Sayer et al., 439 veterans presenting for compensation examinations were asked to rate their agreement with presented reasons for seeking service-connected compensation for PTSD [11]. Although no item concerning financial reasons was endorsed by a majority of the veterans, majorities endorsed items suggesting that the application was motivated by a

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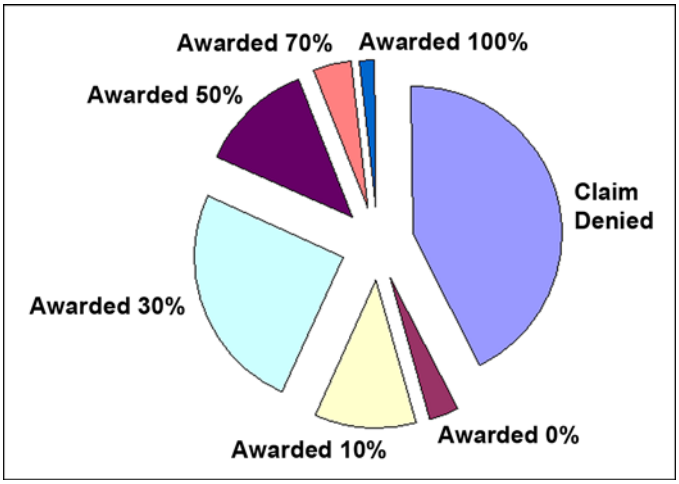

Figure.
Service-connected compensation awards from sample of posttraumatic stress disorder claims, 2007 to 2008 (N = 2,400).

desire for validation: "It will show that there is a reason for my problems," and "If I get service-connection for PTSD, I will feel that justice has been served for what I went through." Another class of items that was less frequently endorsed related to being accepted by others, such as "My family wants me to become service-connected for PTSD." The authors' abstract summarizes the implications of these findings: "Overall, findings suggest that individuals seeking disability benefits may have unmet mental health care needs" [11].

Items describing financial considerations were endorsed by substantial minorities of veterans, especially those who were indigent. Veterans who did not endorse financial reasons may have been influenced by the stigma associated with seeking disability benefits. Qualitative studies of applicants for Social Security disability benefits for psychiatric conditions describe a period of resistance to admitting disability and considerable ambivalence about seeking benefits [12]. A purely evaluative stance by a compensation examiner is ill-suited to exploring these complex feelings about seeking disability. The benefits evaluation process may overemphasize the financial motivations of veterans seeking disability and under-address the psychological aspects of the application for disability. Successful treatment for veterans at this stage can have far-reaching benefits.

DISTRESS DURING PTSD CLAIMS APPLICATION PROCESS

To apply for benefits, a veteran sends a claim to the VBA, where staff ask the local VHA treatment facility to arrange a compensation examination. The compensation examiner reviews the existing records (armed service personnel, combat, medical, and psychiatric); conducts a face-to-face psychiatric interview; and writes a report outlining the examiner's conclusions concerning diagnosis, functional impairment, and relationship of impairment to military service. The examiner's report is reviewed by a VBA claims officer who determines whether an award is warranted and, if so, the percentage of full disability benefits that should be awarded. Overall, the application process is arduous and involves describing the traumatic symptoms (and usually the trauma itself) in considerable, and potentially painful, detail.

In a prospective study, Spoont et al. evaluated 109 veterans at the time they applied for service-connected compensation for PTSD and again at the time of the examination [13]. Veterans' PTSD symptoms and functional impairment had significantly worsened between the time of their initial application and their examination [12]. Unemployed veterans had significantly greater increases in their PTSD and functional impairment than those who were employed, perhaps reflecting the examination's greater financial importance to them. This study had no control group, so it is possible that symptoms worsened for reasons unrelated to the compensation examination. However, the veterans in this study were completing research assessments and were assured that their ratings would not be used in their compensation applications, so it is unlikely the distress was feigned. In other studies with psychological tests collected as part of the compensation examination, veterans apparently exaggerated their distress during the examination itself [14–15].

Veterans' reports that the compensation application process is stressful [16] have been corroborated by the Veterans Service Organization staff who help them with the application process [17]. Veterans Service Officers agree with statements indicating that veterans often have these negative experiences. For instance, 70 percent of surveyed Veterans Service Officers agree with the statement "Veterans become very upset discussing military experiences as part of the claim" and 57 percent agree that "Veterans are often not able to handle denial of service-connection for PTSD." Significant proportions of Veterans Service Officers chose ratings that were critical of examiners. For example, 42 percent disagreed with the statement that "Veterans' problems are generally understood by people involved in the Compensation and Pension process" and a full 36 percent disagreed with the statement "Veterans can trust the PTSD evaluators."

ENGAGING IN VA TREATMENT BEFORE APPLYING FOR SERVICE-CONNECTED COMPENSATION

A substantial proportion of veterans presenting for compensation examinations have not received VA services before. In a review of administrative records from 452 veterans who obtained service-connected compensation for PTSD, only 112 had been using mental health services before initiating their claim [18]. Another study of veterans filing PTSD claims found that those receiving mental health services when they applied were disproportionately younger, married, and dependent on public insurance. Surprisingly, service use was not associated with having more severe self-reported symptoms of PTSD [19]. It is not known whether the studies of service use also apply to OIF/OEF veterans because few OIF/OEF veterans were enrolled in those studies. Large majorities of veterans in those studies were Vietnam-era veterans with chronic PTSD who had accumulated long-term comorbidities [20–21].

It has been asserted that veterans who receive service-connected compensation are not motivated to benefit from PTSD treatment [22], but the preponderance of data have demonstrated that veterans with PTSD, including substantial proportions who are service-connected, benefit from targeted psychotherapies [23–25]. There have been reports of veterans engaging in mental health treatment around the time they filed disability claims and subsequently disengaging from treatment after the claim was awarded, with the inference being that these veterans engage in treatment in a perfunctory way solely to enhance their claims for service-connected compensation [26]. Such a pattern would suggest the futility of engaging veterans in treatment at the time of compensation applications, but the weight of retrospective evidence is that treatment engagement and gains are not time-limited benefits that fade after awards of service-connected compensation for PTSD are made. Awards of service-connected compensation for PTSD have not been associated with poorer treatment outcomes or less treatment engagement in several retrospective analyses [27–29].

Our group reviewed the VA charts and compensation reports of 62 consecutive OIF/OEF veterans who underwent compensation examinations at the VA Connecticut Healthcare System for initial service-connected compensation for PTSD during the 6-month period following July 1, 2008, to estimate use of substance abuse and mental health services. Of the 61 percent (38/62) who were diagnosed with PTSD on the compensation examinations, 50 percent (19/38) had had psychiatric treatment at VA within the previous 3 months and virtually the same percentage (53%, 20/38) had a mental health visit in the 3 months following the compensation exam. Of the examinees, five had at least a rule-out substance abuse diagnosis made (other than alcohol use) but only one had received any substance abuse treatment at the VA during the 3 months before the evaluation. These results are consistent with findings in veterans from earlier conflicts, suggesting that large proportions of veterans are not receiving VA treatment for the claimed disability, and they suggest that treatment engagement is not facilitated by completing a compensation examination.

Evidence exists that OIF/OEF veterans have particular difficulty engaging in mental health treatment. A survey of combat troops returning from OIF/OEF indicated a large gap between veterans' perceived needs for mental health treatment and their having received it; only 23 to 40 percent of those whose responses suggested a psychiatric disorder had sought mental health care [6]. A corroborating, more recent article found significantly lower rates of session attendance and higher rates of treatment dropout in a cohort of OIF/OEF veterans compared with rates in Vietnam-era veterans [30].

ROLE DEFINITION IN COMPENSATION EXAMINATION

VA compensation examiners complete online training to become credentialed to conduct compensation examinations. In this training videotape, the compensation examiner explains to a veteran that the purpose of the examination is not to conduct counseling but to "document your experiences." VA

regulations further reinforce this boundary between the evaluator and the clinician by noting that the evaluation should be conducted by someone who is not providing clinical care to the claimant. The Automated Medical Information Exchange worksheets for conducting the compensation examination require a directive interview to elicit the plethora of specific information that is requested, and there is no recommendation in the worksheets that treatment be offered.

These procedures are consistent with the tradition in psychiatry that "clinical" and "forensic" functions be performed by separate clinicians, and disability evaluations have been considered to be a particular type of forensic evaluation [31]. The American Academy of Psychiatry and the Law Ethics Guidelines recommend this explicitly: "At the beginning of a forensic evaluation, care should be taken to explicitly inform the evaluee that the psychiatrist is not the evaluee's 'doctor.'" Acknowledging the fact that evaluees may fall into the patient role anyway because of setting, wish, and having vented, the guidelines continue, "Psychiatrists have a continuing obligation to be sensitive to the fact that although a warning has been given, the evaluee may develop the belief that there is a treatment relationship" [32].

The agency affiliation of the examining clinician may not be clear to veterans filing claims. Qualitative data suggests that veterans who undergo compensation examinations report not understanding the distinction between an evaluative examination and a treatment examination—after all, both are conducted by mental health professionals.* Veterans may not make the distinction between the VHA staff who conduct examinations and the VBA staff who decide claims and dispense benefits. Both are "VA staff."

Compensation and pension examination reports are available to VA clinicians but are in a different portion of the VA's electronic medical record than most other clinical information and, in my experience, are infrequently consulted by clinicians. Compensation examiners have access to clinical records for the period preceding the examination and are expected to dictate a report soon after interviewing the veteran. Thus, appointments made or kept after the interview are not typically part of the examiner's report. However, attendance at subsequent treatment might be an issue if the veteran's claim is reevaluated (e.g., if a denied claim is appealed).

PROPOSED TREATMENT REFERRAL AFTER COMPENSATION EXAMINATION

I propose that the institutional and procedural steps that convey that compensation examinations for veterans with PTSD claims are purely evaluative be amended to add that all OIF/OEF veterans who undergo these examinations be offered VA treatment. Ideally, this would involve the following:

- Correspondence from the VBA to veterans applying for service-connected compensation would explain how to access treatment for PTSD at the local VHA facilities.
- The compensation examiner would explain that the veteran's application was filed with the VBA branch of VA and that the examiner is conducting the exam to assist the VBA branch. The examiner would explain that a separate treatment service is available to treat PTSD and other disorders that may help relieve their distress.
- Compensation examiners would be directed to make a referral to treatment at the end of the examination with wording as follows: "I have been interviewing you so that the Veterans Benefits Administration can decide on your claim, and I have not been treating your distress. I can refer you to a clinician here whose job will be to help you with the issues you raised. That person will not be doing an evaluation of your claim and can focus on helping you."
- A therapist trained to treat PTSD and related conditions would be available to see veterans immediately after the compensation examination. Alternatively, an on-site OIF/OEF coordinator could coordinate the clinical referrals.

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It is important that the treatment be seen as voluntary. To prevent veterans from feeling coerced into treatment, examiners could explain that the treatment referral is separate from the evaluation and the report of the interview will be completed without feedback to the examiner concerning whether the veteran attended treatment or not. It is also important that treatment not be seen as a way to gather further information to disprove the veteran's compensation claim, a distinction that can be made by the treating clinician and examiner.

One concern is that veterans will engage in treatment in order to further compensation claims. However, there have only been scattered reports of such financially motivated treatment seeking and little available data document the prevalence of the belief that seeking psychiatric treatment buttresses a compensation claim. Another concern is that veterans seeking treatment after a compensation examination will avoid issues in therapy that he or she believes might weaken the service-connected compensation claim. Anecdotal evidence to the contrary comes from an ongoing study by our group in which 25 veterans presenting for compensation evaluations of mental health claims have participated in subsequent occupational counseling. Despite a warning on the study consent form that there is a risk that information discussed during counseling may be entered into their VA charts and eventually be seen by someone rating the veteran's disability, there has not been any apparent avoidance of sensitive topics by veterans worried about the effect on a service-connected compensation claim.

The fact that not all veterans evaluated for PTSD will ultimately be service-connected for it is not a reason to not offer treatment. Veterans who are not judged to be service-connected for PTSD may nevertheless have a treatable cause of distress. Clinical treatment involves a period of history-taking and negotiation of a treatment plan between patient and clinician. During this time, the veteran can begin treatment for the causes of distress, be they PTSD or a diagnosis with symptoms that overlap those of PTSD, including depression, anxiety, substance abuse, and personality disorders.

CONCLUSIONS

The VHA's mission is to improve veterans' health. Identifying and evaluating PTSD claims among OIF/OEF veterans and not treating them is inherently problematic. Compensation examinations are a common point of contact with the VA for OIF/OEF veterans and an opportunity to invite veterans reporting distress to obtain effective treatments to which they are entitled by law. Virtues of this approach include (1) that it targets a high-priority, high-risk group of veterans and (2) that veterans' early experience with the VA is treatment-oriented and not solely evaluative. Providing PTSD treatment at the time of evaluation is not likely to eliminate all the problematic aspects of the compensation evaluation, but it is far more likely to help than to cause harm [10,33]. Ultimately, whether offering PTSD treatment at the time of the compensation examination is cost-effective is an empirical question, but sufficient evidence exists of OIF/OEF veterans' PTSD symptomatology and distress at the time of compensation examination to justify offering available mental health treatments after all compensation examinations.

Considerable public pressure exists to improve the process of evaluating compensation claims and engaging veterans in treatment. Combining the disability evaluation with treatment was a theme voiced by the Department of Defense's Senior Medical Advisor, Noel Howard, MD, at a public meeting to review the criteria for service-connected PTSD: "Marrying the disability evaluation up with treatment and rehabilitation—I think that's been also a theme of today's session, and I would emphasize the need for transition to ego-building occupational and social functioning" [2]. In testimony to the House Committee on Veterans Affairs, Linda Bilmes called for something very much like the proposed approach for returning OIF/OEF veterans: "VBA should shift its focus away from claims processing and onto rehabilitating and reintegration of veterans" [34]. Engaging veterans in treatment should be part of the compensation examination process.

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