

Free Executive Summary

PTSD Compensation and Military Service



Committee on Veterans' Compensation for
Posttraumatic Stress Disorder, National Research
Council

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Summary

The scars of war take many forms: the limb lost, the illness brought on by a battlefield exposure, and, for some, the psychological toll of encountering an extreme traumatic event. The mission of the Department of Veterans Affairs (VA) “to care for him who shall have borne the battle” is met through a series of benefits programs for veterans and their dependents. One of these programs—the provision of compensation to veterans whose disability is deemed to be service-connected—has risen in public prominence over the past few years. While several factors have contributed to this development, three that have received particular notice are the increase in the number of veterans seeking and receiving benefits, the concomitant increase in benefits expenditures, and the prospect of a large number of veterans of Operation Iraqi Freedom and Operation Enduring Freedom entering the system.

Compensation claims for posttraumatic stress disorder (PTSD) have attracted special attention. PTSD, in brief, is a psychiatric disorder that can develop in a person who experiences, witnesses, or is confronted with a traumatic event, often one that is life-threatening. PTSD is characterized by a cluster of symptoms that include:

- reexperiencing—intrusive recollections of a traumatic event, often through flashbacks or nightmares;
- avoidance or numbing—efforts to avoid anything associated with the trauma and numbing of emotions; and
- hyperarousal—often manifested by difficulty in sleeping and concentrating and by irritability.

A 2005 investigation by the VA Office of the Inspector General found that the number of beneficiaries receiving compensation for PTSD increased significantly during Fiscal Years 1999–2004, growing by 79.5 percent, from 120,265 to 215,871 cases (DVA, 2005). The report of that investigation noted:

During the same period, PTSD benefits payments increased 148.8 percent from \$1.72 billion to \$4.28 billion. Compensation for all other disability categories only increased by 41.7 percent. While veterans being compensated for PTSD represented only 8.7 percent of all claims, they received 20.5 percent of all compensation benefits.

Against this backdrop, VA's Veterans Benefits Administration (VBA) asked the National Academies to convene a committee of experts to address several issues surrounding its administration of veterans' compensation for PTSD.

INTENT AND GOALS OF THE STUDY

The committee was charged with reviewing:

1. VA's compensation practices for PTSD, including examining the criteria for establishing severity of PTSD as published in the Schedule for Rating Disabilities;
2. the basis for assigning a specific level of compensation to specific severity levels and how changes in the frequency and intensity of symptoms affect compensation practices for PTSD;
3. how VA's compensation practices and reevaluation requirements for PTSD compare with those of other chronic conditions that have periods of remission and return of symptoms; and
4. strategies used to support recovery and return to function in patients with PTSD¹ (Szybala, 2006).

These four general charges were operationalized into a series of issues that VA identified as being of particular interest. The committee organized these into three general categories: those related to the PTSD compensation and pension (C&P) examination, the evaluation of PTSD disability claims, and other PTSD compensation issues.

REPORT SYNOPSIS

The committee reached a series of findings and conclusions that form the foundation for its recommendations for action and further research. In addition, it drew some general observations from its examination of VA's PTSD disability compensation system. The sections below are synopses of the content of report Chapters 4–7 and highlight their major points.

The PTSD Compensation and Pension Examination

For veterans presenting for PTSD compensation, the C&P examination provides a clinical evaluation by a mental health professional where information is gathered to:

- establish the presence or absence of a diagnosis of PTSD;
- determine the severity of PTSD symptoms; and
- establish a logical relationship between exposure to military stressors and current PTSD symptomatology (VBA, 2002).

¹ A separate National Academies committee is addressing PTSD treatment issues; its report will be released later in 2007. This report limits its review of the topic to the effect of compensation on strategies used to support recovery and return to function in patients with PTSD

While it develops much of the same information as a conventional mental-health examination, the intent of the C&P examination is to generate documentation for disability evaluation purposes rather than to inform a treatment strategy.

VA identified several issues related to the conduct of C&P exams that were of particular interest: the role of the Global Assessment of Functioning (GAF) score² in evaluating PTSD; the division of symptoms among PTSD and comorbid disorders; the value of standardized testing in the conduct of examinations; and the scientific literature regarding the length of time between the occurrence of the stressor thought to be associated with an applicant's PTSD and the appearance of symptoms.

The committee concluded that the GAF score has limited usefulness in the assessment of the level of disability for PTSD compensation. The score is only marginally applicable to PTSD because of its emphasis on the symptoms of mood disorder and schizophrenia and its limited range of symptom content. The social and functional domains of the score provide some information, but if these are the sole domains of interest, better measures of them exist. Importantly, the GAF has not to date been shown to have good psychometric properties (i.e., good reliability) within the VA system and, particularly, within samples of veterans suffering from PTSD.

Because the GAF is widely used within VA, it may not be possible to quickly implement changes regarding it without disrupting the delivery of PTSD services. Given this, the committee recommends that, in the short term, VA ensure that its mental-health professionals are well informed about the uses and limitations of the GAF and—to the extent possible—are trained to implement the GAF in a consistent and uniform manner. VA should also provide periodic, mandatory retraining to minimize drift and variation in scoring over time and between facilities. In the longer term, the committee recommends that VA identify and implement an appropriate replacement for the GAF: one or more measures that focus on the symptoms of PTSD used to define the disorder and on the other domains of disability assessment.

PTSD is marked by high rates of comorbidity. Some studies have found that more than 80 percent of people who have a diagnosis of PTSD also have major depressive disorder or some other psychiatric disorder. This presents a challenge for the VA disability system, which is built around the separate evaluation and compensation of each diagnosed service-connected disorder. The committee did not identify any scientific literature on separating the symptoms of PTSD from those of another existing mental disorder. Such separation—while required by the C&P system—is seldom useful from a clinical perspective. Clinicians are often able to offer an informed opinion on this question, but this is a professional judgment and not an empirically testable finding. To ameliorate the difficulties encountered in dealing with situations where PTSD co-exists with other mental disorders, the committee recommends that a standardized training program be developed for clinicians conducting compensation and pension psychiatric evaluations. This training program should emphasize diagnostic criteria for PTSD and comorbid conditions with overlapping symptoms as delineated in the *DSM* and include example cases that illustrate appropriate documentation of exam results for C&P purposes.

A number of psychological tests have been developed to assess PTSD; some have been designed specifically for veterans and subjected to research to assess their psychometric properties. The committee responsible for the 2006 Institute of Medicine (IOM) report *PTSD: Diagnosis and Assessment* concluded that while standardized testing of veterans presenting with

² The GAF score is a standardized measure of symptoms and psychosocial function, with 100 representing superior mental health and psychosocial function and 0 representing the worst possible state.

possible PTSD may be useful in identifying individuals who might benefit from further assessment, it was not a substitute for a thorough clinical evaluation by an experienced mental health professional. This committee concludes that this is also true of testing for compensation and pension purposes. It understands the appeal of an administratively straightforward requirement that certain psychological tests be applied across the board in PTSD C&P examinations. However, this strategy does not recognize the diversity of the claimant population, and it imbues test results with an inappropriate level of certainty. Malingering—an issue that has received some public attention—cannot be reliably identified through testing alone. The committee believes that testing may be a useful adjunct to the PTSD C&P examination but recommends that the choice of whether to test and which tests are appropriate be left at the discretion of the clinician, the person who is best able to evaluate the individual circumstances of the case.

Because some veterans who have been separated from service for an extended period of time have filed first-time claims for PTSD compensation, interest has arisen in issues concerning the time between exposure to a stressor and the appearance of symptoms related to it. The committee's review found abundant scientific evidence indicating that PTSD can develop at any time after exposure to a traumatic stressor, including cases where there is a long time interval between the stressor and the recognition of symptoms. Some of these cases may involve the initial onset of symptoms after many years of symptom-free life, while others may involve the manifestation of florid symptoms in persons with previously undiagnosed subclinical or subsyndromal PTSD. The determinants of delayed-onset PTSD are not well understood. It is hypothesized that the impact of the aging process on neurologic and mental state, changes in social circumstances (retirement, loss of spouse, and the like), changes in health circumstances (disease onset or exacerbation), and exposure to other stressors may all play roles. The scientific literature does not identify any differences material to the consideration of compensation between these delayed-onset or delayed-identification cases and those chronic PTSD cases where there is a shorter time interval between the stressor and the recognition of symptoms.

Summary Findings and Conclusions

The GAF score has limited usefulness in the assessment of the level of disability for PTSD compensation.

There is no scientific guidance addressing the separation of symptoms of comorbid mental disorders for the purpose of identifying their relative contributions to a subject's condition.

Standardized psychological testing of claimants may be a useful adjunct to the PTSD C&P examination but it is not a substitute for a thorough clinical evaluation.

PTSD can develop at any time after exposure to a traumatic stressor. The scientific literature does not identify any differences material to the consideration of compensation between delayed-onset or delayed-identification cases and those chronic PTSD cases where there is a shorter time interval between the stressor and the recognition of symptoms.

Summary Recommendations

In the short term, VA should ensure that its mental-health professionals are well informed about the uses and limitations of the GAF and trained to implement it in a consistent and uniform manner. In the longer term, VA should identify and implement an appropriate replacement for the GAF. The research needed to accomplish this effort should be facilitated.

A standardized training program should be developed for clinicians conducting C&P evaluations for PTSD. Training should emphasize diagnostic criteria and comorbid conditions with overlapping symptoms, and include example cases that illustrate appropriate documentation of exam results for C&P purposes.

The choice of whether to conduct psychological testing of claimants and of which tests are appropriate should be left at the discretion of the examining clinician.

The Evaluation of PTSD Disability Claims

Information developed in the C&P claims and examination process is used by VBA personnel informally referred to as *raters* to determine whether an identified disability is connected to a claimant's military service and, if it is, what level of impairment is associated with it. Raters use criteria and decision rules set out in the VA Schedule of Rating Disabilities (VASRD) to make their decisions.

VA asked the committee to address several issues related to the rating criteria currently used to rate disability for veterans with service-connected PTSD. These included whether the current rating schedule—which applies to all mental disorders—is appropriate for evaluating PTSD and what criteria should be included in any revised schedule. The committee also offered comments on the training of raters.

38 CFR §4.130 sets out a single set of rating criteria for all mental disorders except eating disorders. The committee found that these criteria are at best a crude and overly general instrument for the assessment of PTSD disability, and it recommends that rating criteria specific to PTSD and based on the *DSM* be developed. It is beyond the scope of this committee to specify the criteria and disability levels, but the committee does offer a framework for establishing them. The primary element that distinguishes this framework from the current rating criteria is that it takes a multidimensional approach. In the current scheme, occupational impairment drives the determination of the rating level. Under the committee's framework, the psychosocial and occupational aspects of functional impairment would be separately evaluated, and the claimant would be rated on the dimension on which he or she is more affected. The committee believes that the emphasis on occupational impairment in the current criteria unduly penalizes veterans who may be symptomatic or impaired in other dimensions but capable of working, and thus it may serve as a disincentive to both work and recovery.³ While impairment of earning capacity is specified as the criterion for establishing ratings and this would seem to suggest that a focus on occupational function is appropriate, there is abundant evidence that both VA and the Congress

³ *A 21st Century System for Evaluating Veterans for Disability Benefits* (IOM, 2007) addresses the more general issues of how VA should conceptualize disability for rating purposes and how system-wide revisions to the rating schedule should be implemented

take other criteria into account when setting ratings policy. The committee believes that it is appropriate to apply this broader approach to PTSD ratings.

While the committee was able to obtain some data on the characteristics of PTSD beneficiaries and the details of their compensation over time, other information that would have helped inform the committee's evaluations were not available. To address these data gaps, the committee recommends that data fields recording the application and reevaluation of benefits should be preserved over time, rather than being overwritten when final determinations are made, and that they be gathered and coded at two points in the process where there is currently little information available: before claims are made, and after compensation decisions are rendered. Data such as these will facilitate more informed future analyses of PTSD disability compensation issues.

PTSD can be a chronic condition that may exhibit periods of remission and return of symptoms. It and other conditions characterized by remitting and relapsing symptoms present a challenge for raters because it can be difficult to assign a level of disability to them. Moreover, the absence of disabling symptoms does not mean that the subject is free from the effects of the disorder. The committee found that the criteria used for rating remitting/relapsing conditions vary in how the frequency and effect of symptoms are factored, in whether response to treatment is considered, in the level of disability assigned to various degrees of impairment, and in whether nonoccupational impacts are addressed. As noted above, PTSD is managed differently from other conditions in that it is subject to the general mental disorders ratings schedule rather than a specific set of criteria, and the committee recommends that this be changed.

Determining ratings for mental disabilities in general and for PTSD specifically is more difficult than for many other disorders because of the inherently subjective nature of symptom reporting. In order to promote more accurate, consistent, and uniform PTSD disability ratings, the committee recommends that VA establish a specific certification program for raters who deal with PTSD claims, with the training to support it, as well as periodic recertification. PTSD certification requirements should be regularly reviewed and updated to include medical advances and to reflect lessons learned. The program should provide specialized training on the psychological and medical issues (including common comorbidities) that characterize the claimant population, and guidance on how to appropriately manage commonly-encountered ratings problems. The committee believes that rater certification will foster greater confidence in ratings decisions and in the decision-making process. Requiring certification may also necessitate that some ratings be done at a facility other than the one closest to the veteran in order to ensure that a qualified rater performs the evaluation in a timely manner. VA therefore needs to manage reviews by certified raters in a manner that facilitates open communications between clinicians, remote raters, and other dispersed personnel and ensures that the claimants and those who help them are not disadvantaged.

Summary Findings and Conclusions

The VASRD criteria for rating mental disorders disability levels are at best a crude and overly general instrument for the assessment of PTSD disability.

The VASRD does not use consistent criteria for rating remitting/relapsing conditions. PTSD is managed different from other remitting/relapsing conditions because it is subject to a general ratings schedule rather than a specific set of criteria.

Summary Recommendations

New VASRD rating criteria specific to PTSD and based on the *DSM* should be developed and implemented. A multidimensional framework for characterizing PTSD disability—detailed in the body of this report—should be considered when formulating these criteria.

VA should establish a specific certification program for raters who deal with PTSD claims, with the training to support it and periodic recertification.

Data fields recording the application and reevaluation of benefits should be preserved over time rather than being overwritten when final determinations are made. Data should also be gathered at two points in the process where there is currently little information available: before claims are made and after compensation decisions are rendered.

Other PTSD Compensation Issues

The committee also addressed some compensation issues that were not specific to the C&P examination or the rater's evaluation but instead entailed broader considerations. These broader considerations include barriers or disincentives to recovery, the effect of disability compensation on recovery, the advisability of periodic reexamination of PTSD compensation beneficiaries, and gender and military assault.

Research reviewed by the committee indicates that compensation does not in general serve as a disincentive to seeking treatment. Because PTSD may follow a remitting/relapsing course, the definition of "recovery" is problematic. The literature on recovery indicates that it is influenced by several factors, and the independent effect of compensation on recovery is difficult to disentangle from these. As noted above, the committee believes that the rating criteria for PTSD should be changed to remove the focus on occupational impairment from the definition of the higher levels of disability because this may remove a disincentive for some to engage in work. The committee recommends that VA consider instituting a set long-term minimum level of benefits⁴ that would be available to any veteran with service-connected PTSD at or above some specified rating level without regard to that person's state of health at a particular point in time after the C&P examination. Providing a guaranteed minimum level of benefits would take explicit account of the remitting/relapsing nature of chronic PTSD by providing a safety net for those who might be asymptomatic for periods of time. A properly designed set of benefits could eliminate uncertainty over future timely access to treatment and financial support in times of need and would in part remove the incentive to "stay sick" that some suggest is a flaw of the current system. However, any such change in policy would require careful study of a number of factors, including the needs of the beneficiaries, the new incentives that it would create, its possible effect on compensation outlays and demand for other VA resources, the maintenance of fairness with other conditions that have a remitting/relapsing nature, and the program details—which benefits were made available and under what circumstances—that would be most likely to promote wellness.

Neither federal regulation nor published VA materials offers advice to raters on how often or under what circumstances reevaluations of PTSD disability should take place. The committee

⁴ In this context, "benefits" comprise the full range of services provided by VA, including forms of assistance such as preferred access to VA medical facilities. It does not necessarily mean a long-term minimum rating or level of compensation.

recommends that this determination be made on a case-by-case basis using information developed in a clinical setting, such as a C&P examination. It recommends that specific guidance on the criteria for setting case-specific VA-initiated reevaluations be established so that the reevaluations can be administered in a fair and consistent manner; furthermore, VBA should collect and analyze data on VA and veteran-initiated reevaluations so that the system can be improved in the future. The committee does not believe it is appropriate to mandate across-the-board periodic reexaminations for beneficiaries already being compensated for PTSD. Such a strategy would not take the diversity of the beneficiary population into account and would unduly single out veterans with PTSD for scrutiny. Within the context of VA's limited resources, the committee believes that it would be best to invest in thorough C&P evaluations for new applicants—including the clinician's determination noted above—rather than in the blanket review of past decisions.

Available research suggests that female veterans are less likely to receive service connection for PTSD and that this may be a consequence of the relative difficulty of substantiating exposure to non-combat traumatic stressors—notably, military sexual assault (MSA). The committee believes that it is important to gain a better understanding of the sources of this disparity and to better facilitate the substantiation of MSA-related traumas in both women and men when they do occur. It therefore recommends that VBA gather more detailed data on the determinants of service connection and ratings level for MSA-related PTSD claims, including the gender-specific coding of MSA-related traumas for analysis purposes; and develop and disseminate reference materials for raters that more thoroughly address the management of MSA-related claims. Training and testing on MSA-related claims should be a part of the certification program recommended above for raters who deal with PTSD claims.

Summary Findings and Conclusions

Research reviewed by the committee indicates that PTSD compensation does not, in general, serve as a disincentive to seeking treatment.

It is not appropriate to require across-the-board periodic reexaminations for veterans with PTSD service-connected disability.

Summary Recommendations

VA should consider instituting a fixed long-term minimum level of benefits that would be available to any veteran with service-connected PTSD at or above some specified rating level without regard to that person's state of health at a particular point in time after the C&P examination.

The determination of whether and when reevaluations of PTSD beneficiaries are carried out should be made on a case-by-case basis using information developed in a clinical setting. Specific guidance on the criteria for such decisions should be established so that these can be administered in a fair and consistent manner.

VBA should collect and analyze data on reevaluations so that the system can be improved in the future.

VA should conduct more detailed data gathering on determinants of service connection and rating levels for military sexual assault-related PTSD claims and develop and disseminate reference materials for raters that more thoroughly address the management of such claims. More research is also needed on gender differences in vulnerability to PTSD.

General Observations

In addition to answering the specific questions posed in the charge, the committee made some general observations that flowed from its examination of VA's PTSD disability compensation system. These deal with the overall conduct of the system.

There are three general observations that capture the committee's thinking on the issue of PTSD disability compensation practices.

1. The key to proper administration of VA's PTSD compensation program is a thorough C&P clinical examination conducted by an experienced professional. This echoes the conclusion of an earlier IOM committee that examined issues regarding the diagnosis and assessment of PTSD, which found that:

[A]n optimal assessment of a patient consists of a face-to-face interview in a confidential setting with a health professional experienced in the diagnosis of psychiatric disorders. It is critical that adequate time be allocated for that assessment. Depending on the mental and physical health of the veteran, the veteran's willingness and capacity to work with the health professional, and the presence of comorbid disorders, the process of diagnosis and assessment will likely take at least an hour or could take many hours to complete. (IOM, 2006)

Many of the problems and issues identified in the report can be addressed by consistently allocating and applying the time and resources needed for a thorough PTSD C&P clinical examination. This measure will facilitate:

- more comprehensive and consistent assessment of veteran reports of exposure to trauma;
- more complete assessment of the presence and impact of comorbid conditions;
- the conduct of standardized psychological testing where appropriate;
- more accurate assessment of the social and vocational impacts of identified disabilities;
- evaluation of any suspected malingering or dissembling using multiple strategies including standardized tests, if appropriate, and clinical face-to-face assessment;
- more detailed documentation of the claimant's condition to inform the rater's decision (and thus potentially lead to better and more consistent decisions); and
- an informed, case-specific determination of whether reexamination is appropriate and, if so, when.

VA may well incur increased up-front costs by implementing more consistently detailed examinations for all veterans who present for initial and review C&P evaluations for PTSD. It is not possible, though, to make an informed estimate of what the additional costs may be because the total will depend on many variables whose values are not available or are difficult to derive from public sources—notably, the time currently spent on examinations and the costs associated with those examinations. Further uncertainty is introduced by the fact that a change in policies regarding the exams may lead to changes in the number and characteristics of claimants.

2. An informed evaluation of the PTSD compensation system will not be possible until VA implements a comprehensive data collection, analysis, and publication effort. The report identifies a number of instances where there are gaps in the data and in the research literature regarding PTSD disability compensation issues and offers some specific recommendations to address them. Some data sought by the committee were not available because they were in various cases not collected, not coded, collected but not retained, annotated only in hardcopy files rather than placed in a database, or spread among the VBA and the VHA databases in ways that made retrieval and integration difficult or impossible. The data are handled this way because they are being collected for disparate purposes—the VBA data being primarily associated with the documentation of the delivery of compensation while the VHA data are used to fulfill its mission as a health care delivery network.

The committee believes that an informed evaluation of the PTSD compensation system will not be possible until VA implements a comprehensive and integrated data collection, analysis, and publication effort. This effort should be focused on data useful to research, policy, and planning purposes. It will allow VA to:

- evaluate inter-rater reliability and generate information that can be used to promote the accuracy and validity of ratings;
- more easily determine whether examinations and benefits are being properly and consistently managed throughout the VA system;
- establish whether there are subsections of the population that differ in ways that require the particular attention of the system (such as the elderly, certain racial or ethnic groups, female veterans, those just returning from combat, those with relatively low or with high levels of disability, those with particular comorbidities, and the like); and, most importantly;
- evaluate what is working and what isn't and determine where resources should be focused.

More widely and systematically collecting data for research, policy, and planning purposes and assembling these data in more user-friendly forms will allow VA to better conduct the kinds of analyses needed to make informed decisions about the scope and magnitude of the problems that exist within the PTSD disability compensation system and the best approaches to addressing them, as well as to better project the resources needed to serve future veteran populations.

3. One cannot look at the effect of compensation in isolation. VA offers a range of benefits to veterans with service-related disabilities that is unmatched by civilian benefits systems, including compensation, pension, comprehensive medical care, vocational rehabilitation, employment counseling, education and training, home loans, housing assistance, and other supports to veterans and their families.⁵ It is beyond the scope of this committee to make recommendations regarding the general conduct of the VA benefits and services program. However, the committee notes that a complete evaluation of the strategies for reducing disincentives and maximizing incentives for achieving optimal mental functioning would include the examination of the role of all of these services as well as of the coordination among them. Currently, coordination between VBA- and VHA-administered services is limited, and there is no process in place for individual case planning and management, for integration of services, or

⁵ More severely disabled veterans are eligible for additional and greater benefits, depending on the nature of their disability.

for evaluation of opportunities for providing incentives for improvements in health and function. VA has the opportunity to adopt this broader vision of benefits provision, and the committee believes that PTSD may be a good test case for an integrated benefits approach. As one component of this approach, VA should evaluate the feasibility of decoupling the seeking of PTSD disability through the C&P system from some form of priority access to VHA-provided mental-health services.

The committee is acutely aware that resource constraints—on both funds and staff—limit the ability of VA to deliver services and force difficult decisions on allocations among vital efforts. It believes that increases in the number of veterans seeking and receiving disability benefits for PTSD, the prospect of a large number of veterans of Operation Iraqi Freedom and Operation Enduring Freedom entering the system, and the profound impact of the disorder on the nation's veterans make changes in PTSD C&P policy a priority deserving of special attention and action by VA and the Congress.

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Committee on Veterans' Compensation for Posttraumatic Stress Disorder

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NANCY C. ANDREASEN, M.D., Ph.D. (*Chair*), Andrew H. Woods Chair of Psychiatry and Director, Neuroimaging Research Center, University of Iowa Carver College of Medicine, Iowa City, IA

JACQUELYN C. CAMPBELL, Ph.D., R.N., F.A.A.N., Professor and Anna D. Wolf Chair, The Johns Hopkins School of Nursing, Baltimore, MD

JUDITH A. COOK, Ph.D., Professor of Psychiatry and Director, Center on Mental Health Services Research and Policy, University of Illinois, Chicago, IL

JOHN A. FAIRBANK, Ph.D., Associate Professor of Medical Psychology, Duke University Medical Center; Co-Director, National Center for Child Traumatic Stress; Durham, NC

BONNIE L. GREEN, Ph.D., Professor of Psychiatry and Director, Georgetown Center for Trauma and the Community, Georgetown University Medical School, Washington, DC

DEAN G. KILPATRICK, Ph.D., Distinguished University Professor and Director, National Crime Victims Research and Treatment Center, Medical University of South Carolina, Charleston, SC

KURT KROENKE, M.D., Professor of Medicine, Division of General Internal Medicine and Geriatrics, Indiana University, IN

RICHARD A. KULKA, Ph.D., Senior Vice-President of Strategic Business Development, Abt Associates Inc.; and Senior Research Scientist, Center for Demographic Studies at Duke University; Durham, NC

PATRICIA M. OWENS, M.P.A., Independent Consultant, Minisink Hills, PA

ROBERT T. REVILLE, Ph.D., Director, RAND Institute of Civil Justice, Santa Monica, CA

DAVID S. SALKEVER, Professor of Public Policy, University of Maryland-Baltimore County, Baltimore, MD; and Research Associate, National Bureau of Economic Research, Cambridge, MA

ROBERT J. URSANO, M.D., Professor of Psychiatry and Neuroscience, Chair, Department of Psychiatry, and Director, Center for the Study of Traumatic Stress, Uniformed Services University of the Health Sciences, Bethesda, MD

Gulf War and Health Committee Liaison

JANICE L. KRUPNICK, Professor of Psychiatry, Georgetown University, Washington, DC

Consultants

ROBERT J. EPLEY, Independent Consultant, Waxhaw, NC

CAROL S. NORTH, M.D., M.P.E., Nancy and Ray L. Hunt Professor of Crisis Psychiatry, UT Southwestern Medical Center; and Director, Program in Trauma and Disaster, VA North Texas Health Care System, Dallas, TX

ALFRED V. RASCON, Reserve Major, U.S. Army Medical Service Corps, Laurel, MD

Program Staff

DAVID A. BUTLER, Ph.D., Senior Program Officer; Study Director

AMY R. O'CONNOR, M.P.H., Research Associate

JON Q. SANDERS, B.A., Program Associate

EILEEN SANTA, M.A., Research Associate

FREDERICK (RICK) ERDTMANN, M.D., M.P.H., Director, Board on Military and Veterans Health and Medical Follow-up Agency

CHRISTINE HARTEL, Ph.D., Director, Board on Behavioral, Cognitive, and Sensory Sciences

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Reviewers

This report has been reviewed in draft form by individuals chosen for their diverse perspectives and technical expertise, in accordance with procedures approved by the NRC's Report Review Committee. The purpose of this independent review is to provide candid and critical comments that will assist the institution in making its published report as sound as possible and to ensure that the report meets institutional standards for objectivity, evidence, and responsiveness to the study charge. The review comments and draft manuscript remain confidential to protect the integrity of the deliberative process. We wish to thank the following individuals for their review of this report:

Kathryn Karusaitis Basham, Ph.D., M.S.W., Professor and Chair, Human Behavior in the Social Environment Sequence; Smith College School for Social Work

Lisa B. Dixon, M.D., M.P.H., Professor, Department of Psychiatry and Director, Division of Services Research, University of Maryland School of Medicine; and VA Capitol Health Care Network Mental Illness Research, Education, and Clinical Center

Edna B. Foa, Ph.D., Professor, Department of Psychiatry and Director, Center for the Treatment and Study of Anxiety, University of Pennsylvania

Richard G. Frank, Ph.D., The Margaret T. Morris Professor of Health Economics, Department of Health Care Policy, Harvard Medical School

Nathan Hershey, L.L.B., Professor, Health Policy and Management, University of Pittsburgh Graduate School of Public Health

David Silbersweig, M.D., Stephen P. Tobin and Dr. Arnold M. Cooper Professor in Consultation Liaison Psychiatry, Department of Psychiatry, Weill Medical College of Cornell University

Robert D. Sparks, M.D., Board of Directors, The TASER Foundation

Although the reviewers listed above have provided many constructive comments and suggestions, they were not asked to endorse the conclusions or recommendations nor did they see the final draft of the report before its release. The review of this report was overseen by **Dan G. Blazer, M.D., Ph.D.**, Duke University Medical Center and **Edward B. Perrin, Ph.D.**, University of Washington School of Public Health. Appointed by the National Research Council and Institute of Medicine, they were responsible for making certain that an independent examination of this report was carried out in accordance with institutional procedures and that all review comments were carefully considered. Responsibility for the final content of this report rests entirely with the authoring committee and the institution.

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