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ABSTRACT

According to the 2018 Report of the Department of Veterans Office of Inspector General, military sexual trauma ("MST") is on the rise, increasing 10% from the previous year. The Inspector General also found that the Department of Veteran Affairs ("VA") improperly processed 49% of MST claims in the six-month time period reviewed. During this same time period, veterans' benefits appeals took an average of seven years to complete, with one in fourteen veterans dying while the appeal was pending. These grim statistics, combined with an adjudication process described as an administrative "hamster wheel," are untenable in a benefits system statutorily designed to be non-adversarial and veteran friendly.

The advocate's job is to help the veteran receive the full extent of allowable compensation and to do so as expeditiously as possible. This article is intended to guide the veteran's advocate through the administrative claims process, highlighting the major components of the process and the core legal concepts applicable to cases involving MST. The article will also identify the myriad of disabilities that can arise from MST, which are not limited to only mental health issues, so that veterans are properly rated for each and every symptom related to the trauma. Our hope is that this article provides a workable roadmap for the advocate, leading to better quality VA decision-making earlier in the VA adjudication process and better representation for veterans suffering from lasting effects of MST.

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* This Article was written by Professor Angela K. Drake, Director of the Veterans Clinic at the University of Missouri School of Law and Charlotte Burgess-Mundwiller, a recent graduate and former Veterans Clinic student at the University of Missouri School of Law.

This Article was written as an act of gratitude to those survivors of MST who allowed the clinic to work on their cases. These veterans educated us immensely, on both professional and personal levels, by demonstrating resiliency in the face of doubt, and persistence in the face of adversity.

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I. INTRODUCTION

In recent years, the Department of Veteran Affairs ("VA") improved its policies concerning Military Sexual Trauma ("MST") by leaps and bounds; however, room remains for improvement. The spread of the "Me Too" movement helped reduce the stigma surrounding sexual trauma and increased calls for accountability and support. However, the era of "don't ask, don't tell" sustained a mindset of ignorance in several aspects of the military, not just sexual orientation.[1] Many victims of MST experienced total dismissal of their trauma or were too afraid to tell their story. The repercussions of this mentality are severe: silence affects the victims both mentally and legally.[2] MST can cause a wide array of symptoms, including difficulties in maintaining relationships with others and experiencing suicidal thoughts. Legal recourse is also more difficult when the victim did not report the assault or receive contemporaneous treatment.[3]

Dealing with MST is difficult and different for every veteran but getting the disability compensation contemplated by law should not be. [4] This Article discusses the statistics surrounding MST victims, common symptomatology, current and past hurdles victims have faced, and arguments advocates should consider so that veterans receive the full extent of the compensation they deserve. This Article further analyzes whether the rating system that the VA uses to compensate veterans for MST properly takes into account the various aspects of MST symptomatology. This rating system is used for all mental health claims, from post-traumatic stress disorder ("PTSD") to schizophrenia, arising from any number of situations – from combat incidents to MST.[5] As the understanding of the impact and effects of sexual trauma changes, the manner in which cases are analyzed should be adjusted accordingly.

This Article begins with an in-depth look into the background of MST, including its definition and the statistics relating to gender and location. Then, this Article discusses the VA Ratings Schedule, with an analysis of key legal concepts underlying the veterans' benefits system including "the presumption of soundness." Proper clinician training and protocol is also discussed. This

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1. "Under this policy, but not the law, servicemembers are not to be questioned nor allowed to discuss their 'same-sex orientation.'" David F. Burrelli, *Don't Ask Don't Tell: The Law and Military Policy on Same-Sex Behavior*, CONG. RES. SERV. (2010), https://fas.org/sgp/crs/misc/R40782.pdf [perma.cc/2ZDF-MW7A].

2. Kathryn Mammel, Rose Carmen Goldberg, & Sopen Shah, *Battle for Benefits: VA Discrimination Against Survivors of Military Sexual Trauma* 1, AM. C.L. UNION (2013), https://www.aclu.org/sites/default/files/assets/lib13-mst-report-11062013.pdf [perma.cc/M3JP-S7P7].

3. *Id*. at 3.

4. This article focuses on disability benefits compensation. For MST survivors, VA provides free healthcare for all physical and mental health conditions determined by their VA provider to be related to MST. 38 U.S.C. § 1720D (2012).

5. 38 C.F.R. § 4.130 (2019).

Article concludes with the identification of common MST diagnoses and a discussion of various ways to maximize VA benefits under the governing law.

II. BACKGROUND

A. Military Sexual Trauma Defined

MST is defined by statute as "psychological trauma, which in the judgment of a mental health professional employed by the Department, resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the veteran was serving on active duty, active duty for training, or inactive duty training."[6] While sexual assault is physical in nature, sexual harassment is "repeated, unsolicited verbal or physical contact of a sexual nature which is threatening in character."[7] Under the VA's definition of MST, combat is not a requirement for MST nor is it a requirement to qualify for disability benefits from the VA. MST is not a psychological disorder or a diagnosis that can be treated.[8] Rather, it is considered an underlying event that may result in various disabilities that need treatment.[9]

The Annual Report on Sexual Assault in the Military released by the Department of Defense ("DOD") determined that one in three servicemembers reported being assaulted in 2018, whereas one in fourteen servicemembers reported being assaulted in 2006.[10] However, these studies only address *reported* assaults. It is highly likely many assaults were not reported, especially male assaults on other males. The recent increase in reporting likely correlates with public awareness from the Me Too movement, lessening stigma around sexual assaults generally.

B. Servicewomen and Military Sexual Trauma

In a recent Senate Armed Services Committee hearing, Senator Martha McSally revealed her own experience with sexual assault while serving in the

6. 38 U.S.C. § 1720D (2012).

7. *Military Sexual Trauma*, U.S. DEP'T OF VETERANS AFF. (2018), https://www.ptsd.va.gov/understand/types/sexual_trauma_military.asp [perma.cc/9RRB-6H6X].

8. *Military Sexual Trauma: Disability Compensation for Conditions Related to Military Sexual Trauma (MST)*, U.S. DEP'T OF VETERANS AFF., VETERANS BENEFITS ADMIN. (last updated Aug. 2018), https://www.benefits.va.gov/BENEFITS/factsheets/serviceconnected/MST.pdf [perma.cc/HF38-39UM] [hereinafter *Military Sexual Trauma*].

9. *Id.*

10. Terri Moon Cronk, *DOD Releases Latest Military Sexual Assault Report*, U.S. DEP'T OF DEF. (2017), https://www.defense.gov/News/Article/Article/1168765/dod-releases-latest-military-sexuL-assault-report/ [perma.cc/T2ME-ATLX].

Air Force.[11] McSally explained that she did not immediately report the assaults because she "didn't trust the system at the time."[12] She further stated that she was "horrified" about how her account was handled when she did report it years later. She said, "[L]ike many victims, I felt like the system was raping me all over again."[13] McSally's experience – like many others – underscores the reality that sexual assault does happen in the military, and many assaults go unreported.

According to the DOD, in fiscal year 2017, 5277 servicemembers reported sexual assault, with 4,193 of the victims being female.[14] Statistically, women were victims in 80 percent of the reported sexual assaults.[15] A study conducted in 2016 by the Journal of Military Medicine interviewed fifty-two women from World War II to the present about sexual assault incidents.[16] Some of these servicewomen did report their sexual assault experiences but were accused of fabricating the assault or were even blamed for the incident.[17] Others reported they did not come forward because they had seen firsthand that the accused were not held accountable.[18] While many of these instances happened to women in service from 1979 to 1992, these reports illustrate the barriers servicewomen face when considering whether to report a sexual assault. The numbers released by the DOD and the experiences shared by servicewomen demonstrate a clear need for education and acknowledgment of sexual assaults and the resulting MST present within the military.

C. Servicemen and Military Sexual Trauma

According to the 2017 DOD study, while the majority of victims of military sexual assault were women, roughly eighteen percent of the victims were

11. Emily Cochrane & Jennifer Steinhauer, S*enator Martha McSally Says Superior Officer in the Air Force Raped Her*, N.Y. TIMES (Mar. 9, 2019), https://www.nytimes.com/2019/03/06/us/politics/martha-mcsally-sexual-assault.html [perma.cc/N8AF-EMMB].

12. *Id*.

13. *Id*.

14. Lisa Ferdinando, *DoD Releases Annual Report on Sexual Assault in Military*, U.S. DEP'T OF DEF. (May 1, 2018), https://dod.defense.gov/News/Article/Article/1508127/dod-releases-annual-report-on-sexual-assault-in-military/ [perma.cc/FDG5-5Y4V].

15. *Id*.

16. *See generally* Kristina B. Wolff; Peter D. Mills, *Reporting Military Sexual Trauma: A Mixed-Methods Study of Women Veterans' Experiences Who Served from World War II to the War in Afghanistan,* 181 MIL. MED. 840 (2016), http://www.academia.edu/28907960/Reporting_Military_Sexual_Trauma_A_Mixed-Methods_Study_of_Women_Veterans_Experiences_Who_Served_From_World_War_II_to_the_War_in_Afghanistan [perma.cc/QA9U-KG46].

17. *Id*. at 845

18. *Id*.

men[19] Studies indicate that there are several barriers and myths that make reporting rape difficult for men.[20] Irrespective of sexual orientation, a serviceman may not report an assault out of fear that his sexuality may be questioned by others in his unit.[21] Furthermore, the serviceman may think coming forward will cause those in his unit to consider him a traitor or a snitch.[22] Studies have also shown that men are more likely to leave an assault unreported because they often believe they can cope and are less deserving of help than a woman who has been sexually assaulted.[23]

D. LGBTQ+ Servicemembers and Military Sexual Trauma

Unfortunately, there is little data on the prevalence of MST among the transgender and LGBTQ+ military community. However, a study published in 2016 sought to quantify MST experienced by transgender servicemembers.[24] The researchers analyzed the number of transgender servicemembers treated at the VA from 2000 to 2013. According to the study, one in five transgender men and one in seven transgender women experienced MST.[25] The degree of MST found in transgender women was much higher than that of cisgender men.[26]

However, the study expressly noted that this number is not a complete representation of MST experienced by this population in light of the fear to report among victims.[27] The actual amount of MST experienced by

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19. DEP'T OF DEFENSE, *Appendix B: Statistical Data on Sexual Assault* (2017), http://sapr.mil/public/docs/reports/FY17_Annual/Appendix_B_Statistical_Data_on_Sexual_Assault.pdf (stating, "Of the 4,606 assaults reported, 832 were reported by men.").

20. *See, e.g.,* Denise M. Eckerlin et al., Military Sexual Trauma in Male Service Members, 116 AM. J. NURSING 9 (2016), https://www.nursingcenter.com/cearticle?an=00000446-201609000-00024&Journal_ID=54030&Issue_ID=3641478#P19 [perma.cc/FGR6-4X7S].

21. *See generally* J.A. Turchik et al., *Perceived Barriers to Care and Provider Gender Preferences among Veteran Men Who Have Experienced Military Sexual Trauma: A Qualitative Analysis*, 10 PSYCHOL. SERVS. 213, 213–22 (2013), https://pdfs.semanticscholar.org/c84d/981966015069e22db4e1355cb41d8197529e.pdf [perma.cc/2AME-5UQE].

22. *Naval Inspector General Report to VCNO*, OFF. OF THE NAVAL INSPECTOR GEN. 21 (2004), https://www.governmentattic.org/2docs/Navy-Sexual-Assault-Study_2004.pdf [perma.cc/4SSQ-4EG6].

23. Turchik, *supra* note 21, at 213–22.

24. *See generally* Jan A. Lindsay et al., *Mental Health of Transgender Veterans of the Iraq and Afghanistan Conflicts Who Experienced Military Sexual Trauma*, 29 J. TRAUMATIC STRESS 563–67 (2016).

25. *Id*.

26. *Id*.

27. *Id*.

transgender servicemembers is likely much higher. Transgender servicemembers could not serve openly when this study was conducted in 2013, and they still cannot serve to this day.[28] While President Obama lifted the ban disallowing transgender servicemembers in 2016, President Trump again banned "transgender individuals with a history of gender dysphoria" from serving in the military.[29] Due to the current administration's policy, servicemembers might not report MST out of fear of reprisal or fear of a potential loss of benefits.

Currently, the official policy of the DOD remains as follows: (1) transgender persons with a history of gender dysphoria cannot serve in the military in most circumstances; (2) those persons who "require or have undergone gender transition are disqualified" from serving; and (3) transgender persons who do not have a history of gender dysphoria and qualify to serve in the military may serve "in their biological sex."[30]

Studies dealing with MST among LGBTQ+ servicemembers are difficult to find. A study conducted between 2012 and 2013 surveyed LGBTQ+ servicemembers asking them about both sexual orientation discrimination and MST.[31] This study recorded a high number of MST cases, with LGBTQ+ women more likely to report a sexual assault than LGBTQ+ men.[32] As mentioned above, there has been little research on these issues, and it is likely the number of LGBTQ+ servicemembers that have experienced MST is higher. Though "don't ask, don't tell" has been repealed, many servicemen and servicewomen who identify as LGBTQ+ fear further oppression that would result from reporting a sexual assault.[33]

E. Military Locations with the Highest Risk of Military Sexual Trauma

Recently, the DOD asked the Rand Corporation, a non-profit research organization, to conduct a study analyzing the location of sexual assaults.[34] The

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28. *Id*.

29. *Id*. In January 2019, the Supreme Court lifted two injunctions and allowed the Trump Administration's policy to take effect. See Adam Liptak, *Supreme Court Revives Transgender Ban for Military Service*, NY Times (Jan. 22, 2019), https://www.nytimes.com/2019/01/22/us/politics/transgender-ban-military-supreme-court.html?login=smartlock&auth=login-smartlock [perma.cc/32WE-F2T5].

30. *Department of Defense Report And Recommendations On Military Service By Transgender Persons*, U.S. DEP'T OF DEFENSE 5 (2018), https://partner-mco-archive.s3.amazonaws.com/client_files/1521898539.pdf [perma.cc/2BN3-TTPK].

31. *Despite Policy Changes, LGBT Military Personnel Still Experiencing Sexual Trauma and Discrimination*, CUNY SCH. OF PUB. HEALTH (2018), http://sph.cuny.edu/2018/01/08/lgbt-military-personnel/ [perma.cc/XMS2-55HM].

32. *Id*.

33. *Id*.

34. Caitlin Doornbos, *Study Reveals Navy Installations Carry Most Risk of Sexual Assault, but Not Why,* STARS AND STRIPES (Oct. 26, 2018),

study analyzed data from the Navy, Marine Corps, and Air Force.[35] Results showed that servicemembers in the Air Force were the least likely to be sexually assaulted while those in the Navy were most likely to experience a sexual assault.[36]

Furthermore, a clear pattern emerged during the study. According to the Rand Corporation, servicemembers have a higher risk of sexual assault if stationed on a ship, whether at sea or grounded.[37] Another pattern occurred across the military branches in the study: a heightened risk of sexual assault exists within combat units.[38] This was especially true for men installed in combat units within the Army.[39] This study further exemplifies a trend of increased sexual assault within combat zones.[40]

In 2012, an anonymous VA survey found that half of the women questioned reported being sexually harassed and one in four women reported being sexually assaulted while deployed in Afghanistan.[41] Unfortunately, this study did not identify any reasons underlying the increased risk of sexual harassment and assault in war zones.

MST can affect any servicemember regardless of race, gender, or sexual orientation. Though specific demographics, military branches, and units have heightened risks of sexual assaults, every servicemember should be educated about the possibility of MST, the treatment options available, and the availability of disability compensation for lasting effects.

III. VA'S RATING PROCESS

In order to be compensated under federal benefits law, a veteran's current diagnosed disability(ies) must be the result of or aggravated by the veteran's service in the military.[42] There must be a "nexus" between the current disability and the event in service, and this nexus is often in the form of a medical opinion.[43] When these elements are satisfied, a veteran's disability is "service connected," and the question of the amount of money to be paid for the disability is presented. In determining the proper amount of compensation, the

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https://www.stripes.com/news/study-reveals-navy-installations-carry-most-risk-of-sexual-assault-but-not-why-1.553658 [perma.cc/X267-FUBE].

35. *Id.*

36. *Id*.

37. *Id*.

38. *Id*. (stating, "U.S. Pacific Fleet, U.S. Fleet Forces Command, U.S. Forces Command, Pacific Air Forces and others with *direct combat roles* were among the commands with the highest total and command-specific risk.").

39. *Id*.

40. *Id*.

41. *Id*.

42. Caluza v. Brown, 7 Vet. App. 498, 504 (Vet. App. 1995).

43. *Id.*

veteran's symptoms associated with the service-connected diagnosis are evaluated by a medical examiner whose findings are then reviewed by an adjudicator who follows manuals and policies, discussed in depth below.

MST can cause an array of physical issues and mental disorders, which can significantly affect a veteran's everyday life.[44] These disorders are separately analyzed under the VA Schedule for Rating Disabilities ("Schedule"). The Schedule includes a rating formula, which applies to all mental health diagnoses except eating disorders, as well as rating guidelines for various diagnostic codes.[45] The Schedule is authorized by 38 U.S.C. § 1155, which provides, "[T]he Secretary shall adopt and apply a schedule of ratings of reductions in earning capacity from specific injuries or combination of injuries."[46]

In evaluating the veteran's claim to determine the proper rating, a medical examiner uses a Disability Benefits Questionnaire ("DBQ"). The DBQ is a form document that asks the examiner to check symptoms in a manner that allows the adjudicator to match the marked symptoms with the Schedule.[47] So, for example, a paratrooper with a knee injury would be seen by an examiner who would fill out a "Knee and Lower Leg Conditions" DBQ, Form 21-0960M-9. This DBQ is modeled after the provisions in the Schedule related to the knee, 38 C.F.R. 4.71(a). If the examiner marked on the DBQ – at the proper prompt point – that the veteran's range of motion was limited to thirty degrees with regard to knee flexion, then 4.71a instructs the veteran's knee disability would be rated at twenty percent.

The Schedule provides rating ranges for each diagnosed disability from zero percent to one hundred percent, where appropriate, in ten percent increments.[48] This means that if the paratrooper is rated at twenty percent for the knee injury due to flexion in the knee limited to thirty degrees, he will receive less compensation than if he had been rated at thirty percent, which would be the corresponding rating if his flexion was limited to fifteen degrees.

As of July 2019, the monthly compensation amounts for a single veteran without children are as follows:[49]

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44. *Military Sexual Trauma*, *supra* note 8.

45. 38 C.F.R. § 4.130 (2019).

46. 38 C.F.R. § 4 (2019); 38 U.S.C. § 1155 (2012).

47. *Disability Benefits Questionnaires (DBQs)*, U.S. DEP'T. OF VETERANS AFF. (Jan. 18, 2018), https://www.benefits.va.gov/compensation/dbq_disabilityexams.asp [perma.cc/8CXS-ANH7].

48. *Veterans Compensation Benefits Rate Tables*, U.S. DEP'T OF VETERANS AFF. (2018), https://www.benefits.va.gov/compensation/resources_comp01.asp [perma.cc/DR74/HZL2].

49. *Id.*

Basic Rates	Monthly Compensation
10%	$140.05
20%	$276.84
30%	$428.83
40%	$617.73
50%	$879.36
60%	$1,113.86
70%	$1,403.71
80%	$1,631.69
90%	$1,833.62
100%	$3,057.13

It is important to remember that under federal veterans' benefits law, each disability is entitled to a separate rating.[50] If the paratrooper also suffered a back injury, both the back and the knee are entitled to separate ratings. Similarly, for a survivor of MST, diagnoses may include mental health and physical disabilities. For example, an MST claimant may assert claims for PTSD and pelvic floor dysfunction, as well as hip and knee problems resulting from the pelvic floor dysfunction. Each of these four disabilities claimed by the MST victim would be separately rated if service connection is established.[51]

When multiple ratings are in effect, the ratings are "combined" in a non-mathematical manner, in order to determine the veterans "combined rating." The dollar amounts in the table above are paid based upon the combined rating.[52]

The rating guideline for mental disorders is found in 38 C.F.R. § 4.130, which sets out a formula for rating discussed more fully below. This section of the Schedule is applied to diagnoses made pursuant to the most recent edition

50. *Compensation: Benefit Rates*, U.S. DEP'T OF VETERANS AFF. (Dec. 7, 2018), https://www.benefits.va.gov/compensation/rates-index.asp [perma.cc/V7LH-5U3B].

51. *Id*.

52. *Id.* A combined rating of three disabilities, rated separately at 60 percent, 40 percent, and 20 percent would combine to equal a final rating of 80 percent. *Id.*

of the Diagnostic and Statistical Manual of Mental Disorders ("DSM-5").[53] The DSM-5 is released by the American Psychiatric Association, and it defines and classifies all mental disorders. The VA requires that the DSM-5 be satisfied when applying the Schedule.[54]

The VA claims process is statutorily designed to be a non-adversarial and pro-claimant process.[55] There are a variety of veteran-friendly attributes to the VA compensation system, including the following: no statute of limitations for asserting a claim;[56] a statutory "duty to assist" the veteran in securing information needed to properly substantiate a claim;[57] and the lenient "as likely as not" evidentiary standard.[58] The VA also has a duty to maximize benefits for the veteran to secure the highest level of established scheduler compensation.[59] Despite these veteran friendly safeguards, questions remain as to whether the Schedule in this non-adversarial and pro-claimant system properly accounts for all of the symptoms and diagnoses arising from MST.

A. The Presumption of Soundness

Before turning to MST symptomatology and the applicability of the Schedule, it is important to understand the legal concept known as the "presumption of soundness" found in veterans' benefits law. Any disability resulting from service, including those that are a result of MST, must be evaluated with the "presumption of soundness" in mind.[60] The presumption of soundness exists by statutory mandate:

> [E]very veteran shall be taken to have been in sound condition when examined, accepted, and enrolled for service, except as to defects, infirmities, or disorders noted at the time of the examination, acceptance, and enrollment, or where clear and unmistakable evidence demonstrates that the injury or disease existed before acceptance and enrollment and was not aggravated by such service.[61]

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53. 38 C.F.R. § 4.130 (2019).

54. *Id.*

55. Gallegos v. Principi, 16 Vet. App. 551, 555 (Vet. App. 2003) (Steinberg, J., concurring).

56. Manio v. Derwinski, 1 Vet. App. 140, 144 (Vet. App. 1991).

57. 38 U.S.C. §§ 5106, 5107 (2012).

58. Jones v. Shinseki, 23 Vet. App. 382, 388 (Vet. App. 2010).

59. Morgan v. Wilkie, 31 Vet. App. 162, 167 (Vet. App. 2019). This duty to maximize includes using secondary service connection theories, discussed below, as well as using analogous ratings and multiple diagnostic codes where necessary to account for all symptoms. *Id.*

60. 38 C.F.R. § 3.304 (2019); 38 U.S.C. § 1111 (2012).

61. 38 U.S.C. § 1111 (2012).

With regard to mental health issues, the presumption of soundness means that the VA cannot deny a claim based upon pre-service incident(s) or diagnoses if a servicemember's entrance exam –the "Report of Medical History" – was negative for mental health issues without meeting a very high evidentiary burden.[62] For example, if a servicemember was sexually assaulted prior to service but her service entrance medical exam was not marked for any mental health related issues, the presumption of soundness must apply.

It is important to remember that MST, by definition, occurs *during* military service. Advocates should resist any attempt by a Compensation and Pension Examiner or Adjudicator to attribute mental health disabilities to sexual abuse prior to service. If the entrance exam does not show any mental health condition, the presumption of soundness applies, and the VA has the burden to show by clear and unmistakable evidence that the mental health issue existed prior to service *and* was not aggravated during service. This is the plain mandate of the statute.

However, if at the time of the entrance exam, the servicemember is shown to have a history of pre-service mental health conditions, these conditions would be considered "together with all other material evidence in determinations as to inception."[63] These determinations cannot be based on history alone and instead must also be based on "clinical factors pertinent to the basic character, origin and development of such injury or disease."[64] In such a situation, the facts may establish that the mental health disability must be service connected based on an "aggravation" theory.[65] In other words, aggravation of a pre-service condition properly results in VA disability compensation, including aggravation of a mental health condition.

Where a case of aggravation is presented, the issue becomes one of properly rating the disability. The rating regulations provide that the degree of disability over and above the degree existing at the time of entrance into the active service is the proper rating.[66] The adjudicator should deduct the pre-existing degree from the current degree of disability. The benefit of the doubt goes to the veteran when the degree of diagnosis at the time of entrance into the service is not diagnosable. No deduction is applied if the disability is currently rated at 100%.

The presumption of soundness requirement creates a fair playing field for MST victims and alleviates possible blame on past events for the results of

62. This form is similar to what individuals fill out when seeing a doctor before a visit. Specific boxes must be checked by the servicemember concerning all body parts and issues. See *DD Form 2807–1 Report of Medical History,* U.S. DEP'T OF DEF. (Oct. 2018), https://www.esd.whs.mil/Portals/54/Documents/DD/forms/dd/dd2807-1.pdf [perma.cc/K54R-M2FU].

63. 38 C.F.R. § 3.304(b)(1) (2019).

64. *Id.*

65. 38 U.S.C. §§ 1110, 1131 (2012).

66. 38 C.F.R. § 4.22 (2019).

MST where the events were never noted before the claim of MST. The presumption of soundness should be carefully analyzed and invoked in order to ensure that all of the symptoms of MST victims are properly rated.

B. VA Clinician Training

1. The 2018 Directive

The Veterans Health Administration ("VHA") requires that VA and VA contract examiners complete mandatory training ("MTT") covering a variety of topics – including MST – in order to properly treat veterans.[67] Clinicians must complete this MTT annually to remain in good standing with the VA.[68]

In May 2018, the VHA updated its policies on MST treatment by clinicians by releasing VHA Directive 1115.[69] Specifically, the Directive discussed and further implemented appropriate MST programming, responsibilities, and best practices for the VA.[70] The Office of Mental Health and Suicide Prevention is responsible for providing outreach, improving education, and promoting national policy on MST.[71] The Veterans Integrated Service Network Director, who manages one of several VA systems of medical care, must appoint an MST Point of Contact who is required to communicate with national leaders on MST-related policies and ensure that veterans have "access to specialized sexual trauma-related residential care." The Director is responsible for appointing an MST Coordinator as well as making sure that every veteran seen at a VA facility is screened for MST.[72] The Director must also ensure that MST-related care is available to those veterans being treated for MST through inpatient and outpatient care, and ensure enough clinicians are employed to adequately treat MST patients.[73] The Directive also added gender-sensitivity as a new responsibility of the Director.[74] This means that facilities must have services appropriate to meet the needs of men and women veterans and allow for gender preference when a veteran is picking a clinician for treatment.[75] Finally, the Director is responsible for ensuring a veteran will not be charged for receiving MST-

67. *How to Access Mandatory Training for Trainees,* DEP'T OF VETERANS AFF., OFF. OF ACAD. AFFILIATIONS (2018), https://www.va.gov/oaa/mandatory.asp [perma.cc/3MAS-9T9L].

68. *Id*.

69. *VHA Directive 1115: Military Sexual Trauma (MST) Program*, DEP'T OF VETERANS AFF., VETERANS HEALTH ADMIN. T-1 (May 8, 2018) https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=6402 [perma.cc/45JB-GVRA].

70. *Id*.

71. *Id*. at 3.

72. *Id*.

73. *Id*. at 4

74. *Id.*

75. *Id*.

related care and also ensuring that the clinicians overseen by the Director receive the VHA's mandatory MST training.[76]

The Director must also ensure that the clinicians' staff is aware of mandatory screening, how to properly document MST-related treatment, MST-related terms, and the sensitivity and privacy needed to help veterans being treated for MST.[77] The Facility MST Coordinator is responsible for implementing MST-related policy within the facility, providing information and education to veterans and staff regarding MST-related healthcare issues, and engaging the facility in outreach within the community and other Veteran Centers.[78]

Specifically, the Directive updated the eligibility for veterans to receive MST-related services.[79] Now, services can be provided for those veterans who experienced sexual trauma during inactive duty training.[80] Furthermore, it allows for counseling services at Veteran Centers without a referral.[81] As mentioned above, gender-neutral services must be provided at each facility.[82] Finally, the Directive requires that each facility has an MST Coordinator that is a licensed clinician and has "extensive knowledge of issues arising in the clinical care of MST survivors."[83]

2. The Disability Examiners Training Module

The Disability and Medical Assessment/Disability Examination Process training module that is required to be taken by all VA and VA contract disability examiners, also known as "Compensation and Pension" examiners, provides some insight into the areas clinicians are required to master to gain accreditation and diagnose and treat veterans with MST.[84] The module discusses definitions related to VA and DOD policies and programs addressing MST; what clinicians should consider when assessing MST disability claims; and the mental and physical effects that MST has on a veteran.[85] The guide further discusses the possible mental or physical conditions that either men or women can experience in relation to MST:[86]

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76. *Id*.
77. *Id*.
78. *Id.* at 8.
79. *Id*. at T-1.
80. *Id*.
81. *Id*.
82. *Id*.
83. *Id*.
84. *DMA Military Sexual Trauma and the Disability Examination Process Training Module,* U.S. DEP'T OF VETERANS AFF., DEP'T OF MED. ASSISTANCE, at 1 [hereinafter *Training Module*].
85. *Id*.
86. *Id*. at 5; *see also* Rachel Kimerling et al., *The Veterans Health Administration and Military Sexual Trauma*, 97 AM. J. OF PUB HEALTH 2160, 2163 (2007)

Physical Health	Mental Health
Liver Disease	Posttraumatic Stress Disorder
Chronic pulmonary disease	Depression and other mood disorders
Obesity, weight loss, hypothyroidism	Substance use disorders
HIV/AIDS	

These possible symptoms are covered in the training module so that clinicians remember to note them and connect them with the possibility of MST as the underlying cause.[87] As the module instructs, clinicians could easily be the first person with whom the veteran with an MST history may see. Collecting proper and complete information is therefore critical.[88]

The training module illustrates several different scenarios, showing the range of MST symptoms and experiences.[89] Each example describes different people and events including differences with regard to race, gender, age, years of service, victim's conduct after sexual trauma, and the possible symptoms that can be attributed to MST.[90]

After an overview of the symptomatology of MST and its effects on veterans, the training module discusses MST-related disability claims specifically.[91] Importantly, the module discusses the pros and cons that servicemembers may consider when filing a disability claim with the VA:[92]

87. *Training Module*, *supra* note 84, at 5.
88. *Id*.
89. *Id*. at 10–11.
90. *Id*.
91. *Id*. at 18.
92. *Id*.

Pros	Cons
Financial assistance	Requires disclosure to an unknown examiner
Potential for Validation	Potential for feeling invalidated if a claim is denied
Acknowledgement of traumatic experience	Requires confronting painful memories
	Requires admitting to having difficulties
	Requires dealing with a government agency
	May provoke feelings of dependency
	Difficulty or inability to complete the PTSD Statement in Support of Claim secondary to Personal Assault

This chart prepares clinicians to candidly and informatively discuss claim submission with the veteran.[93]

The module then discusses the importance of conducting a trauma-sensitive interview and the methods used to do so.[94] The module discusses several interview techniques including: reducing "the power differential" between clinician and the veteran; helping the veteran to feel as in control as possible; and respecting the veteran's reactions to his or her symptoms and experiences.[95]

With regard to the MST disclosure, the module suggests that in the event a veteran discloses MST during an examination, the clinician should react with empathy and validation, normalize the experience by telling the veteran that other veterans have also experienced MST, and offer information about the services and treatments offered for a veteran experiencing MST.[96] The training module warns the clinician to avoid re-victimization of the veteran.[97] Specifically, a clinician who is not providing therapy for MST or MST-related symp-

93. *Id*.
94. *Id*. at 19.
95. *Id*. at 20.
96. *Id*. at 21.
97. *Id*.

toms but who is conducting an examination should not request a detailed account of the sexual trauma.[98] Re-experiencing of the trauma should occur only when the veteran is being treated by a mental health professional.[99] That said, the examiner should properly document any information about a trauma that the veteran discloses unprompted.[100]

This clinical guide provides healthcare professionals with the tools needed to properly respond, examine, and treat veterans with MST. Requiring clinicians to complete training on MST helps alleviate errors in documenting the possible connections between the behavior a veteran currently exhibits with symptoms that may not seem to be related. Furthermore, training clinicians on the sensitivity of the subject and providing guidance on how to handle the situation should lead to an environment in which victims feel comfortable coming forward to receive the help they need.

C. Requirements under 38 C.F.R. § 3.304

In addition to presumption of soundness, the governing regulation for direct service connection claims, 38 C.F.R. § 3.304, should be carefully analyzed and understood by an advocate assisting the MST survivor. This regulation discusses the evidence necessary to substantiate a VA disability claim in various circumstances.[101] For instance, under section (d), service-connection for an injury that was either "incurred or aggravated during combat" can be satisfied by lay evidence alone – evidence from the veteran herself – if it "is consistent with the circumstances, conditions, or hardships of such service even though there is no official record of such incurrence or aggravation."[102]

Section (f) discusses the requirements for PTSD specifically.[103] The disorder must be diagnosed under DSM V, linked by medical evidence to an in-service stressor, and corroborated by credible supporting evidence that the stressor occurred.[104] Under (f)(1), a veteran's lay testimony alone can establish the in-service stressor if the PTSD was diagnosed during service, as long as there is no "clear and convincing evidence to the contrary," and the stressor is "consistent with the circumstances, conditions, or hardships of the veteran's service."[105] Similar evidentiary requirements exist for combat stressors under (f)(2).[106] Subsection (f)(3) also allows for lay testimony from the veteran alone if the in-service stressor is "related to the veteran's fear of hostile military or

98. *Id*.
99. *Id*.
100. *Id*.
101. 38 C.F.R. § 3.304 (2019).
102. § 3.304(d).
103. § 3.304(f).
104. *Id*.
105. § 3.304(f)(1).
106. § 3.304(f)(2).

terrorist activity" *and* a VA psychiatrist "confirms that the claimed stressor is adequate to support a diagnosis of PTSD and that the veteran's symptoms are related to the claimed stressor."[107] Unfortunately, "hostile military or terrorist activity" does not include sexual assault, according to the cases.[108]

Oddly, under (f)(5), veterans that claim they suffer PTSD resulting from an in-service personal assault have a higher burden of proof.[109] To substantiate claims based upon assault, veterans must provide more than lay testimony.[110] However, evidence other than a veteran's service record corroborating the in-service stressor or a diagnosis may be taken into account.[111] For example:[112]

Sources of records include, but are not limited to:	Manifestations of behavioral changes include, but are not limited to:
• Law enforcement authorities • Rape crisis centers • Mental health counseling centers • Hospitals • Physicians • Pregnancy tests • Tests for sexually transmitted diseases • Statements from: ▪ Family members ▪ Roommates ▪ Fellow servicemembers ▪ Clergy members	• Requests for transfer to another military duty assignment • Deterioration in work performance • Substance abuse • Episodes of depression, panic attacks, or anxiety without an identifiable cause • Unexplained economic or social behavior changes • Other unexpected behavioral changes, such as overly controlling perfectionistic behavior.

While more evidence than the veteran's lay testimony is required to substantiate a PTSD based upon MST claim, the VA will not deny a PTSD claim that is based on in-service personal assault without first advising the claimant of the evidence the claimant can use to substantiate a stressor. This evidence

107. § 3.304(f)(3).

108. Acevedo v. Shinseki, 25 Vet. App. 286, 292 (Vet. App. 2012); Hall v. Shinseki, 717 F.3d 1369, 1372–73 (Fed. Cir. 2013)

109. *Id*.

110. §§ 3.304(f)(4), 3.304(f)(5).

111. § 3.304(f)(5).

112. *Id.*

includes information from sources other than the veteran's service records or evidence of behavior changes, both of which may constitute credible supporting evidence of the stressor.[113] The VA will allow the veteran the opportunity to furnish this type of evidence or advise the VA of potential sources of such evidence in order for the VA to obtain it.[114] After the VA receives this evidence, the VA may give the evidence to a medical or mental health professional in order to determine if the evidence corroborates an in-service personal assault on the veteran.[115]

In *Molitor v. Shulkin*,[116] the Court of Appeals for Veterans Claims provided an important evidentiary aid to the victims of MST by highlighting the importance of the VA's statutory "duty to assist" a veteran in the submission of his or her claim.[117] Ms. Molitor claimed she was raped in Germany while serving in the Army as part of a Military Police ("MP") initiation/hazing ceremony.[118] She did not report this rape for fear of retaliation.[119]

The VA denied her claim after numerous Compensation and Pension exams because it found the evidence did not corroborate the alleged rape.[120] The VA did not find Ms. Molitor credible and determined that her PTSD did not result from MST.[121]

During the course of her appeal, Ms. Molitor explained the MP "initiation rape," her unit information, the location and approximate date of the incident, as well as the names and ranks of five witnesses.[122] She explained to the VA that she physically retaliated against one assailant, implying that he may have sustained injuries that could be reflected in his service medical records.[123] She identified four women by name and rank who were stationed in Germany with her at the time, including one whom she believed had also been raped in service and had committed suicide.[124] Ms. Molitor asked the VA to review the records of these servicemembers for corroborating evidence.[125] The VA did not pull these records as requested, leading to the appeal.[126]

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113. *Id*.
114. *Id*.
115. *Id*.
116. 28 Vet. App. 397 (Vet. App. 2017).
117. *Id.* at 409–410; *see also* 38 U.S.C. § 5103A (2012). The duty to assist is an important mandate in the paternalistic, non-adversarial veterans' benefits system. *See* Henderson ex rel. Henderson v. Shinseki, 562 U.S. 428, 431–32 (2011).
118. *Molitor*, 28 Vet. App. at 399.
119. *Id.*
120. *Id.* at 401.
121. *Id.*
122. *Id.* at 400, 408.
123. *Id.* at 408.
124. *Id.*
125. *Id.* at 401.
126. *Id.*

The *Molitor* court held that where a veteran pursuing service connection for PTSD based on assault adequately identifies relevant records of fellow servicemembers that may aid in corroborating the assault, the VA must either attempt to obtain the records or tell the veteran why it will not undertake such efforts.[127] The *Molitor* decision gave teeth to VA General Counsel Precedent Opinion 05-14, which implemented the VA's statutory duty to assist a veteran in the development of his or her claim in assault cases.[128] When representing an MST survivor, the advocate should strive to collect evidence on behalf of the veteran on his or her own initiative. After *Molitor*, the advocate should also remind the VA of its duty to assist and provide names of corroborating witnesses so that VA can comply with its duty to assist.

The law as found in 38 C.F.R. § 3.304(f)(5) is frustrating due to the heightened evidentiary burden it places on veterans to substantiate disability claims resulting from MST.[129] The other sections within the regulation provide that lay evidence from the veteran alone is sufficient evidence to substantiate a disability claim, but this standard is not available for those assaulted while serving our nation who now suffer from PTSD.[130] Instead, MST veterans suffering from PTSD need corroborating evidence supporting their claim.[131] Often this evidence can be difficult to provide, as many victims of sexual assault – like Ms. Molitor – do not tell anyone about their assault while in service.[132] As discussed above, veterans may not tell others of the assault because they feel shame or fear reprimand.[133] Those examining, treating, or representing veterans and those adjudicating their claims must be cognizant of this fear. Proving an MST claim requires attention to details within the claimant's service records as well as research into possible symptoms exhibited and documented outside of the service records. Finally, a careful cataloguing of witnesses is critical in order to help the veteran collect statements and invoke the VA's duty to assist.

D. Personal Trauma Requirements under the Adjudication Manual

The VA M21-1 Adjudication Manual ("Manual"), which VA adjudicators are bound to follow when processing a disability claim, defines personal

127. *Id.* at 398.

128. *Id.* at 410. The General Counsel determined that the duty to assist requires the VA to make reasonable efforts to obtain records from fellow servicemembers when such records are identified by the claimant, are relevant and would assist in substantiating the claim, and the records can be disclosed under the Privacy Act. *Id.* The proper parameters of the duty to assist, including seeking consents from the witnesses and claimant, is beyond the scope of this Article but worthy of scholarly review.

129. 38 C.F.R. § 3.304(f)(5) (2019); *Molitor*, 28 Vet. App. at 402–03, 411.

130. § 3.303

131. *Molitor*, 28 Vet. App. at 404.

132. *See e.g.*, Wolff & Mills, *supra* note 16.

133. *Id*.

trauma as "stressor events involving harm perpetrated by a person who is not considered an enemy force."[134] Under this definition, MST is considered a subset of personal trauma.[135]

The Manual requires that adjudicators follow specific steps when an MST claim is reviewed.[136] First, the adjudicator must obtain any and all service treatment records and the personnel folder of the claiming veteran.[137] Next, the adjudicator must contact the claimant if she determines the claim is based on MST.[138] After initiating contact, the adjudicator must determine whether or not the claimant submitted the proper form – VA Form 21-0781a.[139] This form asks for the date and location of the incident, the unit assignment of the servicemember and the dates assigned, a description of the incident, and any other sources that could corroborate the incident, such as the law enforcement authorities or a rape crisis clinic.[140] If the form is not submitted, the adjudicator must again contact the veteran by letter, allow thirty days for response, and then continue on to the next step in the reviewing process.[141] For MST claims, the letter must contain specific language parroting the evidentiary avenues discussed in 3.304(f)(5) as well as the contact information for the MST coordinator at the VA Regional Office.[142]

Next, the Manual instructs the adjudicator to review the available evidence.[143] If the adjudicator determines that there is supporting credible evidence that the stressor occurred, she must annotate the credible evidence and request an examination from a psychologist.[144]

If there is not enough supporting credible evidence, in the opinion of the adjudicator, she must again review VA Form 21-0781a for a detailed account of the stressor and determine if this account allows for additional research.[145] If additional research is not called for after this review, the adjudicator must

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134. *M21–1 Adjudication Manual: Claims for Service Connect (SC) for Post-Traumatic Stress Disorder (PTSD)*, U.S. DEP'T OF VETERANS AFF. (2018), https://www.knowva.ebenefits.va.gov/system/templates/self-service/va_ssnew/help/customer/locale/en-US/portal/554400000001018/content/554400000014906/M21-1-Part-IV-Subpart-ii-Chapter-1-Section-D-Claims-for-Service-Connection-SC-for-Post-Traumatic-Stress-Disorder-PTSD#5 [perma.cc/5DDV-V9XU] [hereinafter *Claims for Service*].

135. *Id*. at IV.ii.1.D.5.a.

136. *Id*. at IV.ii.1.D.5.c.

137. *Id.*

138. *Id*.

139. *Id*. at IV.ii.1.D.5.d.

140. *VA Form 21-0781a*, U.S. DEP'T OF VETERANS AFF. (2017), https://www.vba.va.gov/pubs/forms/vba-21-0781a-are.pdf [perma.cc/33WH-EV2H].

141. *Claims for Service*, *supra* note 133, at IV.ii.1.D.5.

142. *Id*. at IV.ii.1.D.2.i.; IV.ii.1.D.5.d.

143. *Id*. at IV.ii.1.D.3.b.

144. *Id*. at IV.ii.1.D.1.f.

145. *Id*.

send a letter to the claimant asking for more details.[146] After another thirty day period,[147] the adjudicator must obtain any additional alternative sources of evidence and determine if they are credible supporting evidence of the stressor.[148] If the additional evidence is credible, it should be annotated and an examination should be requested.[149]

If the evidence is still not credible in the adjudicator's opinion, the adjudicator must then review the claimant's record for behavioral changes during or after the stressor.[150] If there are changes that may be a marker of personal trauma, the evidence must be annotated and an exam must be requested.[151] A marker includes different kinds of changed behavior, such as increased use of leave with no reason, changes in performance or substance use. If there is no evidence of a potential marker, the disability claim should be referred for rating activity, meaning the claim will be denied .[152]

The Manual specifically discusses *AZ v. Shinseki*.[153] This Federal Circuit case involved two veterans who filed for disability compensation, asserting PTSD as a result of MST.[154] The VA denied their claims in part because their service records did not include any reports of the assaults.[155] The Federal Circuit overruled the VA's decision, explaining that "the absence of a service record documenting an unreported sexual assault is not pertinent evidence that the sexual assault did not occur."[156] In its ruling, the court first cited to the many DOD reports showing that a large amount of sexual assaults go unreported.[157] The court relied upon its prior decision in *Fagan v. Shinsenki*, which concluded that the absence of records "provides neither positive nor negative support for service connection.[158] The court specifically found, "the absence of a report of an unreported sexual assault is too ambiguous to have probative value."[159] This holding set an important precedent, as it strengthened potential disability claims related to MST by recognizing that a large number of assaults are not reported – a circumstance that should not be held against the veteran. Finally, the Manual directs when an examination based on personal trauma *must* be requested.[160] According to the Manual:

146. *Id*. at IV.ii.1.D.2.i.
147. *Id*.
148. *Id*. IV.ii.1.D.5.c.
149. *Id*. IV.ii.1.D.1.f.
150. *Id*.
151. *Id*.
152. *Id*. at IV.ii.1.D.5.d
153. *Id*. at IV.ii.1.D.5.b.
154. AZ v. Shinseki, 731 F.3d 1303, 1305–06. (Fed. Cir. 2013).
155. *Id.*
156. *Id.* at 1306.
157. *Id.*
158. *Id. citing* Fagan v. Shinseki, 573 F.3d 1282, 1289 (Fed. Cir. 2009).
159. *Id.*
160. *Claims for Service*, *supra* note 133, at IV.ii.1.D.6.c.

an examination will *always* be needed when a thorough review shows:

- A current medical diagnosis of PTSD or the Veteran's lay statements describing PTSD symptoms;
- Credible supporting evidence of the personal trauma incident *or* evidence of a marker in the in-service or post-service records;
- Indication that the PTSD symptoms may be associated with the claimed MST stressor (established by applying a *low threshold* and *liberal approach* satisfied by virtue of a current diagnosis or symptoms and the presence of a marker); and
- Medical evidence adequate for rating purposes is not already of record.[161]

The Manual further states that cases involving evidence based solely on behavioral changes almost always require an examination because the possible marker is not enough to establish that a stressor occurred without a medical opinion.[162] Specifically, an exam by a qualified examiner is necessary to determine "whether a medical opinion can provide evidence for occurrence of the claimed in-service personal trauma stressor based on the marker and the veteran's lay statement, and whether the claimed stressor is related to current PTSD symptoms."[163]

The detailed steps outlined in the Manual underscore the importance of providing all relevant information at the outset of a claim so that there is as little delay as possible, and so that the correct conclusion can be reached expeditiously. Each time an adjudicator must request more information, time is added to the process. To prevent this, proper forms should be used and double checked, alternative evidence and any evidence of behavior changes should be included at the start of the claim, and statements in support of the claim should be submitted by those with firsthand knowledge of the incident or markers. The veteran and his or her representative should remain vigilant for letters from VA concerning the claim and respond promptly.

E. The 2018 OIG Report

While the Manual appears complete and thorough, there remains an issue as to whether its procedures are being followed. The Office of the Inspector General ("OIG") is charged with overseeing the VA by reviewing and auditing the VA's programs and operations.[164] In 2018, the OIG released a report – "Denied Posttraumatic Stress Disorder Claims Related to Military Sexual

161. *Id*. (emphasis added).

162. *Id*.

163. *Id*.

164. *Denied Posttraumatic Stress Disorder Claims Related to Military Sexual Trauma*, U.S. DEP'T OF VETERANS AFF., OFF. OF INSPECTOR GEN. (Aug. 21, 2018), https://www.va.gov/oig/pubs/VAOIG-17-05248-241.pdf [perma.cc/4E5F-QS82].

Trauma" – which provided results of its comprehensive review of the adjudicatory system. The report was specifically conducted to determine whether staff correctly processed claims in accordance with 2011 policies designed to "ensure consistency, fairness, and a 'liberal approach' regarding the types of evidence VA would accept to support and identify stressors related to MST."[165]

Sadly, according to the report, almost half (49%) of the MST claims that were denied from April 1 to September 30 in 2017 were incorrectly processed.[166] Of these cases, 28% contained evidence sufficient to request a medical examination for the veteran but the exam was never requested.[167] Another 13% of the cases resulted in a claim denial due to issues with employees not retrieving proper evidence, such as private treatment records,[168] while 11% were denied because the adjudicator never contacted the veteran by letter and phone to corroborate the claim was filed.[169] Furthermore, the VA denied 10% of the cases based on insufficient or contradictory medical opinions.[170]

The report determined that the training required has not been updated since 2014, even though the Adjudication Manual has been changed since the last update.[171] The report also determined that the training had several issues including: "misstating the MST Coordinator's duties and responsibilities"; failing to discuss "how to rate claims where a diagnosis other than PTSD was provided"; and "including incomplete information regarding what constitutes an insufficient or inadequate examination."[172] The OIG also noted that the training is only required to be taken once, and there are no refresher courses offered annually or biannually, even though the policies and procedures at the VA are often revised and updated.[173] The report reminded readers (including the VA) that denied claims are not only a cause of undue stress for the veteran but also an impediment to treatment.[174]

In order to decrease the alarmingly high number of claims denied in error, the report offered several solutions. The report first highlighted that there is no specialization requirement for adjudicators processing MST claims.[175] The OIG believed that requiring claims processors to specialize in MST claims would result in more consistency and accuracy. To be sure, the VA routinely trains adjudicators to be case specific. For instance, claims arising out of the contaminated water at Camp Lejeune are sent to and reviewed in the same place – Louisville, Kentucky. Adjudicators are able to gain expertise by adjudicating

165. *Id.*
166. *Id*. at ii.
167. *Id*.
168. *Id.*
169. *Id*.
170. *Id*.
171. *Id.*
172. *Id.*
173. *Id.*
174. *Id.*
175. *Id.*

all claims in the same place due to "focused training and repetition."[176] Having all of the claims in the same place and adjudicated by the same people creates more expertise. Creating a similar adjudication hub for MST cases may be one way to reduce the number of MST claims wrongfully denied.

The VA did respond positively to the discrete recommendations in the OIG report. The VA stated it would develop a plan to review the wrongfully denied MST claims from October 1, 2016 to June 30, 2018.[177] After a review, the VA said it will "take corrective action and report back to the OIG."[178] The VA commented that it will issue guidance to create a more specialized group of MST processors.[179] The VA also agreed that each processor must have a 90 percent accuracy rate on at least ten cases, with each case being subject to a second review until the accuracy rate is achieved.[180] The VA committed to updating its MST processor training and the MST development checklist that processors utilize.[181] Finally, the VA stated it will conduct a "focused" review of all claims denied in 2019 and will take corrective action upon finding errors made during the processing of the claim.[182]

IV. ANALYSIS

This section of the Article highlights key issues a zealous advocate should consider in individual MST cases. First, this section describes and applies common symptoms of MST to the current Rating Schedule and identifies potential errors that should be avoided. Second, this section identifies and discusses the disorders commonly associated with MST. These disorders are analyzed separately below, providing a road map to maximize the benefits a veteran who has experienced MST could receive. Finally, this section concludes with a discussion of special monthly compensation – a statutory benefit that provides compensation over and above a 100% rating in applicable and limited situations.

A. The General Rating Formula Applicable to Mental Health Claims

As explained above, a determination that a current mental health issue is related to military service is required to be rated under the VA Rating Schedule.[183] Under the current Schedule, disorders are assigned their own diagnostic

176. *Id.*
177. *Id.*
178. *Id.*
179. *Id.*
180. *Id.*
181. *Id.*
182. *Id.*
183. *Id.* at IV.ii.1.D.3.c.

code.[184] The diagnostic codes relating to mental health include: schizophrenia (9201-9211); posttraumatic stress disorder (9411); anxiety disorders (9400-9413); mood disorders such as bipolar disorder (9431-9435); and eating disorders (9520-21).[185] Despite the fact that each mental health diagnosis has its own code, one "general rating formula" ("formula") is applied to all mental health diagnostic codes pursuant to 38 C.F.R. § 4.130, except for eating disorders.[186]

The formula provides for percentages from 0% to 100% depending on the severity of the veteran's symptoms.[187] The formula gauges occupational and social impairment generally and then lists specific symptoms such as panic attacks, suicidal ideation, and spatial disorientation as factors to consider in various brackets ranging from 0 percent to 100 percent.[188]

While the formula covers a wide array of discrete symptoms that can relate to various mental health diagnoses, it fails to specifically and precisely describe some of the difficult symptoms that MST survivors experience. For example, MST survivors report a wide array of symptoms including dealing with body image issues, problems with intimacy and sexuality, confusion about gender identity or sexual orientation, and difficulties with medical procedures like rectal or vaginal exams.[189] None of these symptoms are expressed as such in the formula. The issue of properly accounting for these symptoms in the formula is discussed in the next section.

B. Common Symptoms of MST and Their Relationship to the Formula

The DBQ for mental disorders other than PTSD and Eating Disorders is found in VA Form 21-0963P-2.[190] The DBQ for PTSD is found in VA form 21-0963-2.[191] Each of these DBQs have sections regarding symptomatology that track verbatim the language found in the formula. Examiners are also asked in the DBQ to opine whether symptoms can be differentiated among the mental diagnoses.

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184. *Id.*

185. 38 C.F.R. § 4.130 (2019).

186. *Id*. This Formula is attached in Appendix A.

187. *Id*.

188. *Id*.

189. *Training Module*, *supra* note 84, at 6.

190. *Mental Disorders (Other Than PTSD and Eating Disorders) Disability Benefits Questionnaire*, U.S. DEP'T OF VETERANS AFF. (May 2018), https://www.vba.va.gov/pubs/forms/VBA-21-0960P-2-ARE.pdf.

191. *Review Post Traumatic Stress Disorder (PTSD) Disability Benefits Questionnaire*, U.S. DEP'T OF VETERANS AFF. (May 2018), https://www.vba.va.gov/pubs/forms/VBA-21-0960P-3-ARE.pdf.

As noted above, experiencing MST trauma can cause a wide range of symptoms, many of which are not identified in the formula. The VA itself has identified several symptoms that survivors may experience. These include:[192]

- Strong emotions: feeling depressed; having intense, sudden emotional responses; feeling angry or irritable all the time;
- Feelings of numbness: feeling emotionally "flat"[193]; difficulty experiencing emotions like love or happiness;
- Trouble sleeping: trouble falling or staying asleep; disturbing nightmares;
- Difficulties with attention, concentration, and memory: trouble staying focused; frequently finding their mind wandering; having a hard time remembering things;
- Problems with alcohol or other drugs: drinking to excess or using drugs daily; getting intoxicated or "high" to cope with memories or emotional reactions; drinking to fall asleep;
- Difficulty with things that remind them of their experiences of sexual trauma: feeling on edge or jumpy all the time; difficulty feeling safe; going out of their way to avoid reminders of their experiences;
- Difficulties with relationships: feeling isolated or disconnected from others; abusive relationships; trouble with employers or authority figures; difficulty trusting others;
- Physical health problems: sexual difficulties; chronic pain; weight or eating problems; gastrointestinal problems;
- Other disorders most associated with MST besides PTSD are depression, other mood disorders, and substance use disorders.

When the wording in the formula is applied broadly, many of the potential symptoms described above should fall within its parameters.[194] It is the job of a careful advocate to remain on alert for the symptoms that may need further explanation in order to properly pin them to a descriptor found in the formula. It is important to remember that factors listed in the formula are "examples" of conditions that warrant a certain rating, and not an exhaustive list.[195] In addition, if symptoms are not accounted for in the formula, yet are nonetheless attributable to the disability, the advocate should remind the VA to assign an analogous rating and use another diagnostic code that captures the symptom.[196]

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192. *Military Sexual Trauma*, *supra* note 7.

193. "a term used for the absence or apparent absence of emotional response to any situation or event." *Flat Affect*, PSYCHOLOGY DICTIONARY (May 11, 2013), https://psychologydictionary.org/flat-affect/ [perma.cc/5BJV-7T9B].

194. 38 C.F.R. § 4.130 (2019).

195. Mauerhan v. Principi, 16 Vet. App. 436, 442 (Vet. App. 2002); *see also* 38 C.F.R. § 4.1 (2019) ("This rating schedule is primarily a *guide* in the evaluation of disability.") (emphasis added).

196. Morgan v. Wilkie, 31 Vet. App. 162, 167 (Vet. App. 2019).

Using the common MST symptom of sexual difficulty as an example,[197] one will note the symptom is not specifically mentioned in the formula nor does it appear on the Disability Benefits Questionnaire for PTSD.[198] This does not mean, however, that the symptom should not be evaluated. Advocates should interview the client to secure the underlying details of the sexual dysfunction and provide a statement from the claimant and other witnesses. Once armed with this evidence, the advocate should argue that sexual difficulty is an example of "deficiencies in . . . family relations," and "inability to maintain effective relationships" – both of which are symptoms entitling a veteran to a 70% rating.[199] Astute and thorough C&P examiners may know to ask about MST specific symptoms and may also comment on them on the DBQ (under Section VIII in the form which asks about "other symptoms not listed"); however, the form does not prompt examiners to ask or record these symptoms[200].

Advocates must be vigilant to seek the highest possible rating and work the MST attributable symptoms into either the broad parameters in the formula or find other diagnostic codes to use.

C. MST-Related Disabilities May Include Both Mental Health and Physical Disabilities

An understanding of the myriad of disorders and symptoms arising from MST is essential to maximizing the veteran's benefits. After understanding the range of possible issues and after careful review of the veteran's medical and mental health records, advocates can then determine how to prepare and file a complete disability claims form, highlighting symptoms as necessary. This section identifies several common diagnoses related to MST as well as possible claims arising from a "secondary service connection" theory and "special monthly compensation" provisions found in the law.

With regard to "secondary service connection," it is important to understand that service connection for a current disability can be established in more ways than one. Commonly, service connection is made on either a "direct" or a "secondary" service connection basis.[201] When there is a direct causative link between the disability diagnosed and an event that occurred during military service, a "direct" service connection is established.[202] For example, PTSD as a result of MST would be compensable based upon "direct service connection."

197. *Military Sexual Assault*, *supra* note 7.

198. *Review Post Traumatic Stress Disorder (PTSD) Disability Benefits Questionnaire*, U.S. DEP'T OF VETERANS AFF. (May 2018), https://www.vba.va.gov/pubs/forms/VBA-21-0960P-3-ARE.pdf [perma.cc/8RE3-RUU7].

199. 38 C.F.R. § 4.130 (2019).

200. *Review Post Traumatic Stress Disorder (PTSD) Disability Benefits Questionnaire*, *supra* note 198.

201. 1 VETERANS BENEFITS MANUAL § 3.4 (2018).

202. *Id*.

Secondary service connection is established when a "current disability is the result of a primary medical condition and that primary medical condition is itself connected to the period of military service."[203] 38 C.F.R. § 3.310 states, "[A] disability which is proximately due to or the result of a service-connected disease or injury shall be service-connected." The regulations further explain, "when service connection is thus established for a secondary condition, the secondary condition shall be considered a part of the original condition." In rating these conditions, the adjudicator "determines whether it is at least as likely as not that each claimed secondary condition was caused by the primary service-connected condition." Even if the claim is secondary, it is nonetheless evaluated and given a discrete rating percentage. Then, an overall percentage rating of the primary condition and all secondary conditions is produced by using the VA's combined ratings table.

A common example of secondary service connection arises where the veteran's right knee is injured in service during a ruck march and years later his left knee is symptomatic as a result of the left knee compensating for the loss of use from the right knee. In such a situation, the right knee is service connected on a direct basis and the left knee is service connected on a secondary basis. Both knees receive their own rating.

In the MST context, assume a veteran is sexually assaulted while serving in the military and was victimized in a gang rape. Later, the veteran is diagnosed with PTSD and the VA grants service connection for the mental disorder based upon the MST stressor. As the years go on, the veteran develops hip issues and urinary problems and is diagnosed with Pelvic Floor Dysfunction ("PFD"). The treating physician states that it is "as likely as not" the PFD is the result of the rape. The veteran also suffers from sleep apnea, and her knee hurts.

In such a situation the PTSD and PFD are directly linked to the assault that occurred during service making both disabilities compensable based upon direct service connections. The sleep apnea claim may be a secondary service connected disability based upon recent studies that show that a correlation between sleep apnea and PTSD.[204] The knee injury, which arose because of the hip problems, which were part and parcel of the PFD diagnosis by the doctor, could be service connected on a secondary service connection basis.

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203. *Id*.

204. *See* Barry J. Krakow, Victor A. Ulibarri, Bret A. Moore, & Natalia D. McIver, *Posttraumatic Stress Disorder and Sleep-Disordered Breathing: A Review of Comorbidity Research.* SLEEP MED. REV. 24 (2015) (discussing emerging research showing that sleep apnea and PTSD co-occur "more frequently than expected.")

1. Mental Health Diagnoses

a. PTSD Diagnosis and the Requirements under DSM-5

In order to be service connected for PTSD, a veteran must be evaluated and receive medical evidence supporting a diagnosis of PTSD. This evaluation must meet the criteria set out in the DSM-5 consisting of criterion A through H.[205] However, the DBQ currently in use is the VA Form 21-0960P3 which follows the criteria listed by the DSM-IV, with six categories – A-F.[206] This form is filled out by a psychiatrist or psychologist.[207]

Criterion A requires that the veteran be exposed to "death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence."[208] The veteran must be exposed in one of the following ways: "direct exposure, witnessing the trauma, learning that a relative or close friend was exposed to a trauma, or by indirect exposure to aversive details of the trauma, usually in the course of professional duties."[209]

Criterion B requires that "the traumatic event be persistently re-experienced by either unwanted upsetting memories, nightmares, flashbacks, emotional distress after traumatic reminders, or physical reactivity after exposure to traumatic reminders."[210]

Under Criterion C, the veteran must practice "avoidance of trauma-related stimuli after the trauma, by way of trauma-related thoughts or feelings or trauma-related reminders."[211]

Criterion D necessitates two symptoms demonstrating "negative alterations in cognitions and mood."[212] Examples include feelings of isolation, a diminished interest in daily activities, and "negative affect or difficulty experiencing positive affect."[213]

Criterion E requires two symptoms dealing with "trauma-related arousal and reactivity that began or worsened after trauma."[214] These symptoms include "irritability or aggression, risky or destructive behavior, hyper vigilance, heightened startle reaction, difficulty concentrating, and difficulty sleeping."[215]

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205. *DSM-5 Criteria for PTSD*, BRAINLINE (Feb. 22, 2018), https://www.brainline.org/article/dsm-5-criteria-ptsd [perma.cc/TP58-D8E9].

206. *Id.* Appendix C contains the PTSD DBQ, listing the PTSD diagnostic criteria.

207. *Review Post Traumatic Stress Disorder (PTSD) Disability Benefits Questionnaire*, *supra* note 198.

208. *DSM-5 Criteria for PTSD*, *supra* note 205.

209. *Id*.

210. *Id*.

211. *Id*.

212. *Id.*

213. *Id.*

214. *Id*.

215. *Id*.

Criterion F simply specifies that the "symptoms last for more than 1 month," while Criterion F requires that the symptoms mentioned in the criteria above "create distress or functional impairments."[216]

b. Requirements for Chronic Adjustment Disorder under DSM-5

While it is common for a veteran to be diagnosed with PTSD after suffering MST, occasionally a veteran will not present with all the criterion necessary for a PTSD diagnosis. However, that veteran may still be suffering from a mental health disability. One common disability is Chronic Adjustment Disorder ("CAD").

The DSM-5 defines CAD as "the presence of emotional or behavioral symptoms in response to an identifiable stressor(s) occurring within 3 months of the onset of the stressor(s)."[217] Similar to PTSD, symptoms in addition to exposure to a stressor must be present for a CAD diagnosis.[218] Either "distress that is out of proportion with expected reactions to the stressor" or clinically significant symptoms that "cause marked distress and impairment in functioning" must be present.[219] Furthermore, it is required that the "distress and impartment are related to the stressor and are not an escalation of existing mental health disorders . . . the reaction isn't part of normal bereavement," and "[o]nce the stressor is removed or the person has begun to adjust and cope, the symptoms must subside within six months."[220]

The DSM-5 specifies several different types of CAD.[221] These include adjustment disorder with depressed mood, anxiety, mixed depressed mood and anxiety, disturbance of conduct, mixed disturbance of emotions and conduct, and unspecified.[222] Each type requires a stressor that precipitates distressful symptoms and is time-sensitive.[223]

c. Comorbidity

Comorbidity is "the occurrence of more than one illness or condition at the same time."[224] This section discusses the disorders that can be diagnosed at the same time as PTSD without falling under its umbrella of symptoms. Co-

216. *Id*.

217. Tanya J. Peterson, *Adjustment Disorder DSM-5 Criteria*, THE HEALTHY PLACE (last updated Oct. 24, 2018), https://www.healthyplace.com/ptsd-and-stress-disorders/adjustment-disorder/adjustment-disorder-dsm-5-criteria [perma.cc/7NZB-3VGN].

218. *Id.*

219. *Id.*

220. *Id.*

221. *Id.*

222. *Id.*

223. *Id.*

224. *Comorbidity*, COLLINS ENGLISH DICTIONARY (2018).

morbid conditions could be related to MST, and the careful advocate should ask the doctor to evaluate each mental health diagnosis, whether it is related to the MST and whether the symptoms can be differentiated from any other mental diagnoses.

i. Major Depressive Disorder

According to the Cognitive Processing Therapy Manual for Veterans written by Patricia Resick, Professor in Psychiatry and Behavioral Sciences at Duke University, Major Depressive Disorder occurs in around half of veterans with PTSD and with substance abuse issues.[225] Major Depressive Disorder "is the most common comorbid disorder with PTSD" and "often secondary to PTSD."[226]

The DSM-5 requires that an individual must experience five or more of the following symptoms during a two-week period, with one of the symptoms being either depressed mood or loss of interest, in order for a diagnosis of Major Depressive Disorder:

1. Depressed mood most of the day, nearly every day;
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day;
3. Significant weight loss when not dieting or weight gain, or decrease or increase in appetite nearly every day;
4. A slowing down of thought and reduction of physical movement observable by others;
5. Fatigue nearly every day;
6. Feelings of worthlessness or excessive guilt nearly every day;
7. Diminished ability to think or concentrate, or indecisiveness, nearly every day;
8. Recurrent thoughts of death or suicide ideation.[227]

Furthermore, the symptoms must cause "significant distress or impairment in social, occupational, or other important areas of functioning" and cannot "be a result of substance abuse."[228]

For physicians, the ability to realize that a veteran may present several disorders and then properly classify these separate disorders is essential to maximizing VA benefits. Here, a veteran could be diagnosed with both PTSD and Major Depressive Disorder and be rated separately for each mental condition diagnosed. For instance, the PTSD DBQ contains a section for "Differentiation

225. Patricia A. Resick et al., *Cognitive Processing Therapy: Veteran/Military Version*, U.S. DEP'T OF VETERANS AFF. 11 (2008), https://www.apa.org/ptsd-guideline/treatments/cognitive-processing-therapist.pdf [perma.cc/3REY-U4MM].

226. *Id*. at 12.

227. Jessica Shelton, *Depression Definition and DSM-% Diagnostic Criteria*, PSYCOM (2018), https://www.psycom.net/depression-definition-dsm-5-diagnostic-criteria/#dsm-5diagnosticcriteria [perma.cc/NJ9K-D4NN].

228. *Id*.

of Symptoms."[229] In this section, the psychiatrist or psychologist must determine whether the veteran is diagnosed with more than one mental disorder.[230] If so, the form goes on to ask if the psychiatrist or psychologist can differentiate the symptoms "attributable to each diagnosis."[231] If the symptoms can be separated out into two separate mental disorders, the veteran may be able to receive benefits for each condition separately if both diagnosed disabilities are the result of events in military service, or one is related by secondary service connection to the other. If symptoms cannot be separated, the advocate should argue the veteran should receive the benefit of the doubt, and all symptoms should be reviewed and counted under the formula discussed above.

ii. Obsessive Compulsive Disorder

According to Resick, disorders associated with anxiety, such as Obsessive-Compulsive Disorder ("OCD"), are also commonly comorbid with PTSD.[232] OCD can be severe enough that it must be treated before the PTSD, while in other instances both can successfully be treated at the same time.[233]

The DSM-5 requires the presence of obsessions, compulsions, or both to be present in order to diagnose OCD.[234] The DSM-5 defines obsessions as "Recurrent and persistent thoughts, urges, or impulses that are experienced, at some time during the disturbance, as intrusive and unwanted, and that in most individuals cause marked anxiety or distress."[235] Furthermore, the individual must also be "attempting to ignore or suppress such thoughts, urges, or images, or to neutralize them with some other thought or action."[236] Compulsions, on the other hand, are defined as "repetitive behaviors or mental acts that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly and the behaviors or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation."[237] However, these behaviors or mental acts are not connected in a realistic way with what they are designed to neutralize or prevent, or they are clearly excessive.[238] Furthermore, the obsessions or compulsions must be (1) "time-consuming . . . or cause clinically significant distress or impairment in

229. *Review Post Traumatic Stress Disorder (PTSD) Disability Benefits Questionnaire*, *supra* note 198.

230. *Id.*

231. *Id*.

232. Resick et al., *supra* note 225, at 13.

233. *Id*.

234. *Clinical Definition of OCD*, BEYONDOCD.ORG (2018), http://beyondocd.org/information-for-individuals/clinical-definition-of-ocd [perma.cc/R6RP-G8BU].

235. *Id.*

236. *Id*.

237. *Id.*

238. *Id*.

social, occupational, or other important areas of functioning"; (2) "not attributable to the physiological effects of a substance . . . or another medical condition"; and (3) "not better explained by the symptoms of another mental disorder."[239] Finally, the clinician must specify whether the symptoms are tic-related (the veteran has a tic disorder, meaning he or she has one or more tics that cannot be controlled)[240] and whether the veteran presents with the above symptoms and has good or fair insight into the disorder, poor insight, or absent or delusional beliefs associated with the disorder.[241]

As mentioned above, OCD and other anxiety disorders are common disorders diagnosed along with PTSD.[242] A veteran's advocate must recognize this comorbidity and work towards maximizing the veteran's benefits by securing a rating for the OCD if it is secondary to the PTSD or a direct result of the MST.

d. Substance Use Disorder

Another common secondary service connected disability in PTSD cases is Substance Use Disorder. DSM-5 parcels out Substance Abuse Disorders based on the substance, such as alcohol, tobacco, or opioids.[243] Furthermore, Substance Abuse Disorder is measured from mild to severe. Mild substance abuse disorder only requires two or three symptoms from a list of eleven common symptoms, whereas severe substance disorder requires six or more symptoms to be present.[244] Federal law allows veterans to receive disability compensation for Substance Abuse Disorder if the disorder is secondary to the veteran's primary service-connected disability.[245] For instance, if a veteran is service-connected for PTSD and develops substance abuse disorder due to the PTSD, because of self-medicating, the disorder can be service-connected as a secondary condition. The law does not stop there: a veteran can be service-connected for diseases aggravated by or resulting from the secondary service-

239. *Id*.

240. *Id.*

241. *Diagnosing Tic Disorders,* CTR. FOR DISEASE CONTROL AND PREVENTION (2018), https://www.cdc.gov/ncbddd/tourette/diagnosis.html [perma.cc/XK9E-KH7B].

242. Resick et al., *supra* note 225, at 13.

243. *Substance-Related and Addictive Disorders*, AM. PSYCHIATRIC ASS'N (2013), https://www.psychiatry.org/file%20library/psychiatrists/practice/dsm/apa_dsm-5-substance-use-disorder.pdf [perma.cc/3NEM-PVFT]; *see also DSM-5 SUD Diagnosis Reference Guide CCCAODS*, CONTRA COSTA BEHAV. HEALTH, https://cchealth.org/aod/pdf/DSM-5%20Diagnosis%20Reference%20Guide.pdf [perma.cc/75ET-2PUU].

244. *Substance-Related and Addictive Disorders*, *supra* note 243.

245. INST. OF MED. OF THE NAT. ACAD., A 21ST CENTURY SYSTEM FOR EVALUATING VETERANS FOR DISABILITY BENEFITS 281 (Michael McGeary et al. eds., 2007).

connected substance abuse.[246] An example of this would be cirrhosis of the liver that resulted from alcoholism, with the substance abuse disorder determined to be secondary to PTSD.[247]

2. Disabilities Other Than Mental Health Diagnoses Arising from Military Sexual Trauma

Disabilities arising from MST are not limited to mental health issues. Common physical issues identified in the DMA include the following: liver disease, chronic pulmonary disease, obesity, weight loss, hypothyroidism, and HIV/AIDS.[248] Research has also shown that chronic pain and gynecological issues can be associated with MST.[249]

In addition, Irritable Bowel Syndrome ("IBS") is a gastrointestinal disorder that causes chronic or recurrent bowel abnormalities resulting in abdominal pain.[250] According to a study published by Alimentary Pharmacology and Therapeutics, "women veterans report high frequency of physical and sexual traumas," and these traumas are "independently associated with an elevated risk of [IBS]."[251] Over 30% of the women that participated in the study and experienced trauma in the military – with MST being the most prevalent – reported having IBS.[252] If the IBS is a physical result of the sexual assault, then the disability will be considered a direct service connection; however, if the IBS is diagnosed as a mental health diagnosis directly caused by the sexual assault, then the IBS would be considered a secondary service connection. In either case, it should be service connected.

Finally, sleep apnea is a condition that some medical treatises have found to be correlated to PTSD.[253] If the sleep apnea requires use of a CPAP machine, the veteran is entitled to a 50% rating under diagnostic code 6847 for the sleep apnea alone.

These various issues highlight the need for veterans' advocates to carefully review all of the veteran's medical records, symptoms, and diagnoses. Each of the veteran's symptoms should be reviewed and accounted for when representing a victim of MST, and symptoms should be reviewed through the years in the event of a later manifestation of condition that can be service connected.

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246. *Id*.
247. *Id*.
248. *Id*.
249. *Id*.
250. D.L. White et al., *Trauma History and Risk of the Irritable Bowel Syndrome in Women Veterans*, 32 ALIMENTARY PHARMACOLOGY & THERAPEUTICS 551, 552 (2010).
251. *Id*.
252. *Id.*
253. *See* Krakow et al., *supra* note 205, at 24.

D. Special Monthly Compensation

Special Monthly Compensation is money provided to veterans *in addition to* the compensation tied to their percentage rating.[254] This compensation is designed to provide additional money based on noneconomic factors, including personal inconvenience, social inadaptability, or the profound nature of the disability.[255] While many of the levels of special monthly compensation ("SMC") involve the loss of use of senses, organs, or extremities, there are some options that advocates should research and consider for those suffering from MST.[256] The Compensation Table for SMC is attached hereto as Table B. The different levels of SMC are described by an alphabetical number, corresponding to the statutory authority.[257] We discuss possible SMC situations in MST cases.

MST survivors may qualify for SMC(s) where the veteran has a 100% rating plus an additional 60% or higher rating, or is housebound.[258] The 60% or higher disability rating under SMC(s) requires involvement of a different bodily system than the bodily system underlying the 100% rating.[259] For example, where a veteran is rated 100% due to asthma – controlled with high dosages of daily corticosteroids – and is also rated 70% for PTSD related to MST, the veteran should be entitled to additional money per month under SMC(s). Using the schedule above, the veteran would be entitled to $3,057.13 (100% rating) plus $347.88 (SMC(s)). Likewise, a veteran could receive the same benefit if the veteran is rated at 100% disabled and is also determined to be housebound.[260]

A more likely scenario for an MST survivor involves a VA benefit known as "Total Disability Based on Individual Unemployability," ("TDIU").[261] TDIU "may be assigned where a person who fails to meet the 100% scheduler rating percentage is, nevertheless, unable to secure a substantially gainful occupation based on service connected-disability."[262] This benefit is a "gap filler," designed to help veterans who have very high scheduler ratings but who are not rated at 100%. This is an important benefit because the difference in compensation between a 90% rating and a 100% rating is in excess of $1,000 as the chart above demonstrates.

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254. 1 VETERANS BENEFITS MANUAL § 5.7 (2018).

255. *Id.*

256. *Id.*

257. For example, SMC(s) is drawn from 38 U.S.C. § 1114 (2012).

258. To be housebound, a veteran must be "'substantially confined' as a direct result of service-connected disabilities to his or her dwelling or immediate premises" and "it is reasonably certain that the disability or disabilities will continue throughout his or her lifetime." 1 VETERANS BENEFITS MANUAL § 5.7 (2018).

259. *Id*.

260. *Id.*

261. 1 VETERANS BENEFITS MANUAL § 5.5 (2018).

262. *Id*.

In order to receive TDIU, a veteran generally must have certain minimum scheduler ratings.[263] Specifically, the veteran must have a combined rating of 70% with one rating at 40% or a combined rating of 60% arising from common etiology.[264] Further, the veteran must establish that service connected disabilities preclude the veteran from a "substantially gainful occupation."[265] Substantial gainful occupation is not defined by the VA, however, the synonymous "substantial gainful employment" is defined in the Adjudication Manual as "employment at which non-disabled individuals earn their livelihood with earnings comparable to the particular *occupation* in the community where the [v]eteran resides. It suggests a living wage."[266]

In practice, this would mean that a veteran rated at 70% for PTSD who is receiving TDIU, and who is also rated at 60% for a different disability, such as asthma, could receive Special Monthly Compensation Benefits.[267] Under *Bradley v. Peake*, the VA should consider SMC in this situation because the award of TDIU satisfies the 100% scheduler requirement for purposes of SMC(s).[268]

Finally, when considering SMC for MST survivors, it is important to remember that categories compensate for loss of use, not necessarily physical loss of a limb.[269] For example, if the veteran suffers from erectile dysfunction because of medication taken for mental health treatment, that veteran is entitled to SMC(k) and an additional $108.57 per month.[270]

A veteran's advocate should always consider each and every one of the veteran's disabilities and not just those related to the MST in order to properly maximize the veteran's benefits. The veteran could be entitled to SMC based on the disorders resulting from the MST, as well as other disabilities incurred in service.

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263. *Id*.

264. 38 C.F.R. § 4.16(a) (2019). If the veteran does not meet the scheduler requirement but nonetheless has an exceptional disability picture, 4.16(b) provides the veteran can ask VA for an "extraschedular" rating.

265. 38 C.F.R. § 4.16(a) (2019) ("Total disability ratings for compensation may be assigned, where the schedular rating is less than total, when the [veteran] is, in the judgment of the rating agency, unable to secure or follow a substantially gainful occupation as a result of service-connected disabilities….Marginal employment shall not be considered substantially gainful employment. For purposes of this section, marginal employment generally shall be deemed to exist when a veteran's earned annual income does not exceed the amount established by the U.S. Department of Commerce, Bureau of the Census, as the poverty threshold for one person.").

266. MANUAL M21-1, IV.ii.2.F.1.c (change date Apr. 19, 2018) [*available at* http://www.knowva.ebenefits.va.gov]

267. 1 VETERANS BENEFITS MANUAL § 6.2 (2018).

268. Bradley v. Peake, 22 Vet. App. 280, 292 (Vet. App. 2008).

269. 1 VETERANS BENEFITS MANUAL § 5.7 (2018).

270. *Id*.; *see also* App. B.

VI. CONCLUSION

Advocating for a veteran who has experienced MST can be difficult. There may be little evidence of the assault, symptoms may manifest in physical problems that at first seem unrelated to MST, and assimilating the veteran's mental disability symptoms into the formula can be frustrating. The veteran may be hesitant to talk about the personal details involved in both the assault and the after effects. However, with the proper tools and research, an advocate can maximize benefits for the veteran. Keeping up to date on the constant changes the VA makes to its policies is vital, and creating a network of attorneys, clinicians, and those well versed in VA disability benefits ensures that the advocate has access to a wealth of knowledge and understanding of the subject.

The VA has worked towards a liberal approach for MST-related claims. However, the 2018 OIG report clearly shows that there is much more work to be done by the VA to lessen errors and better compensate veterans. Advocates who recognize the hurdles and find ways to navigate through them can help reduce the number of erroneous claim denials and lessen heartaches for veterans already victimized in their military service. Veterans suffering from MST have incurred unimaginable physical and psychological wounds, all while serving our country. These men and women deserve support and attention throughout the disability compensation process, regardless of age, gender, ethnicity, or the current or past political climate. We have a duty to make a change and to serve those who have served us.

APPENDIX A

9440 Chronic adjustment disorder[271]

General Rating Schedule for Mental Disorders

Total occupational and social impairment, due to such symptoms as: gross impairment in thought processes or communication; persistent delusions or hallucinations; grossly inappropriate behavior; persistent danger of hurting self or others; intermittent inability to perform activities of daily living (including maintenance of minimal personal hygiene); disorientation to time or place; memory loss for names of close relatives, own occupation, or own name	100
Occupational and social impairment, with deficiencies in most areas, such as work, school, family relations, judgment, thinking, or mood, due to such symptoms as: suicidal ideation; obsessional rituals which interfere with routine activities; speech intermittently illogical, obscure, or irrelevant; near-continuous panic or depression affecting the ability to function independently, appropriately and effectively; impaired impulse control (such as unprovoked irritability with periods of violence); spatial disorientation; neglect of personal appearance and hygiene; difficulty in adapting to stressful circumstances (including work or a worklike setting); inability to establish and maintain effective relationships	70
Occupational and social impairment with reduced reliability and productivity due to such symptoms as: flattened affect; circumstantial, circumlocutory, or stereotyped speech; panic attacks more than once a week; difficulty in understanding complex commands; impairment of short- and long-term memory (e.g., retention of only highly learned material, forgetting to complete tasks); impaired judgment; impaired abstract thinking; disturbances of motivation and mood; difficulty in establishing and maintaining effective work and social relationships	50
Occupational and social impairment with occasional decrease in work efficiency and intermittent periods of inability to perform occupational tasks (although generally functioning satisfactorily, with routine behavior, self-care, and conversation normal), due to such symptoms as: depressed mood, anxiety, suspiciousness, panic attacks (weekly or less often), chronic sleep impairment, mild memory loss (such as forgetting names, directions, recent events)	30
Occupational and social impairment due to mild or transient symptoms which decrease work efficiency and ability to perform occupational tasks only during periods of significant stress, or; symptoms controlled by continuous medication	10
A mental condition has been formally diagnosed, but symptoms are not	

271. 38 C.F.R. § 4.130 (2019).

> severe enough either to interfere with occupational and social functioning or to require continuous medication 0

APPENDIX B

Special Monthly Compensation (SMC) Rate Table

SMC	Rate	Payment variation
K	**$108.57**	Usually added to other rate or paid as the rate when percentage is zero.
Q	**$67**	Paid in place of a rate.

Without Children

Dependent Status	L	L 1/2	M	M 1/2	N
Veteran Alone	**$3,804.04**	**$4,000.69**	**$4,198.14**	**$4,486.58**	**$4,775.68**
Veteran with Spouse	**$3,974.49**	**$4,171.14**	**$4,368.59**	**$4,657.03**	**$4,946.13**
Veteran with Spouse and One Parent	**$4,111.28**	**$4,307.93**	**$4,505.38**	**$4,793.82**	**$5,082.92**
Veteran with Spouse and Two Parents	**$4,248.07**	**$4,444.72**	**$4,642.17**	**$4,930.61**	**$5,219.71**
Veteran with One Parent	**$3,940.83**	**$4,137.48**	**$4,334.93**	**$4,623.37**	**$4,912.47**
Veteran with Two Parents	**$4,077.62**	**$4,274.27**	**$4,471.72**	**$4,760.16**	**$5,049.26**
Additional A/A spouse.	**$156.32**	**$156.32**	**$156.32**	**$156.32**	**$156.32**

Dependent Status	N 1/2	O/P	R.1	R.2/T	S
Veteran Alone	**$5,055.60**	**$5,338.04**	**$7,627.64**	**$8,749.09**	**$3,421.90**
Veteran with Spouse	**$5,227.05**	**$5,508.49**	**$7,798.09**	**$8,919.54**	**$3,592.35**
Veteran with Spouse and One Parent	**$5,363.84**	**$5,645.28**	**$7,934.48**	**$9,056.33**	**$3,279.14**
Veteran with Spouse and Two Parents	**$5,500.63**	**$5,782.07**	**$8,071.67**	**$9,193.12**	**$3,865.93**
Veteran with One Parent	**$5,193.39**	**$5,474.83**	**$7,764.43**	**$8,885.88**	**$3,558.69**
Veteran with Two Parents	**$5,330.18**	**$5,611.62**	**$7,901.22**	**$9,022.67**	**$3,695.48**
Additional A/A spouse.	**$156.32**	**$156.32**	**$156.32**	**$156.32**	**$156.32**

With Children

Dependent Status	**L**	**L 1/2**	**M**	**M 1/2**	**N**
Veteran with Spouse and One Child	**$4,099.32**	**$4,295.97**	**$4,493.42**	**$4,781.86**	**$5,070.96**
Veteran with One Child	**$3,918.03**	**$4,114.68**	**$4,312.13**	**$4,600.57**	**$4,889.67**
Veteran with Spouse, One Parent and One Child	**$4,236.11**	**$4,432.76**	**$4,630.21**	**$4,918.65**	**$5,207.75**
Veteran with Spouse, Two Parents and One Child	**$4,372.90**	**$4,569.55**	**$4,767.00**	**$5,055.44**	**$5,344.54**
Veteran with One Parent and One Child	**$4,054.82**	**$4,251.47**	**$4,448.92**	**$4,737.36**	**$5,026.46**
Veteran with Two Parents and One Child	**$4,191.61**	**$4,388.26**	**$4,585.71**	**$4,874.15**	**$5,163.25**
Add for Each Additional Child Under Age 18.	**$84.69**	**$84.69**	**$84.69**	**$84.69**	**$84.69**
Each Additional Schoolchild Over Age 18.	**$273.58**	**$273.58**	**$273.58**	**$273.58**	**$273.58**
Additional A/A spouse.	**$156.32**	**$156.32**	**$156.32**	**$156.32**	**$156.32**

Dependent Status	**N 1/2**	**O/P**	**R.1**	**R.2/T**	**S**
Veteran with Spouse and One Child	**$5,351.88**	**$5,633.32**	**$7,922.92**	**$9,044.37**	**$3,717.18**
Veteran with One Child	**$5,170.59**	**$5,452.03**	**$7,741.63**	**$8,863.08**	**$3,535.89**
Veteran with Spouse, One Parent and One Child	**$5,488.67**	**$5,770.11**	**$8,059.71**	**$9,181.16**	**$3,853.97**
Veteran with Spouse, Two	**$5,625.46**	**$5,906.90**	**$8,196.50**	**$9,317.95**	**$3,990.76**

Parents and One Child					
Veteran with One Parent and One Child	**$5,488.67**	**$5,770.11**	**$8,059.71**	**$9,181.16**	**$3,853.97**
Veteran with Two Parents and One Child	**$5,444.17**	**$5,725.61**	**$8,015.21**	**$9,136.66**	**$3,809.47**
Add for Each Additional Child Under Age 18.	**$84.69**	**$84.69**	**$84.69**	**$84.69**	**$84.69**
Each Additional School-child Over Age 18.	**$273.58**	**$273.58**	**$273.58**	**$273.58**	**$273.58**
Additional A/A spouse.	**$156.32**	**$156.32**	**$156.32**	**$156.32**	**$156.32**

APPENDIX C

OMB Control No. 2900-0779
Respondent Burden: 30 Minutes
Expiration Date: 05/31/2021

Department of Veterans Affairs

REVIEW POST TRAUMATIC STRESS DISORDER (PTSD) DISABILITY BENEFITS QUESTIONNAIRE

IMPORTANT - THE DEPARTMENT OF VETERANS AFFAIRS (VA) ***WILL NOT PAY*** OR ***REIMBURSE*** ANY EXPENSES OR COST INCURRED IN THE PROCESS OF COMPLETING AND/OR SUBMITTING THIS FORM. PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN INFORMATION BEFORE COMPLETING THIS FORM.

NAME OF PATIENT/VETERAN

PATIENT/VETERAN'S SOCIAL SECURITY NUMBER

___ - ___ - ____

NOTE TO PSYCHIATRIST/PSYCHOLOGIST - Your patient is applying to the U. S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the veteran's claim. Please note that this questionnaire is for disability evaluation, not for treatment purposes. VA reserves the right to confirm the authenticity of ALL DBQs completed by private health care providers.

NOTE: If the Veteran experiences a mental health emergency during the interview, please terminate the interview and obtain help, using local resources as appropriate. You may also contact the Veterans Crisis Line at 1-800-273-TALK (8255). Stay on the Crisis Line until help can link the Veteran to emergency care.

The following health care providers can perform REVIEW examinations for PTSD: a board-certified or board-eligible psychiatrist; a licensed doctorate-level psychologist; a doctorate-level mental health provider under the close supervision of a board-certified or board-eligible psychiatrist or licensed doctorate-level psychologist; a psychiatry resident under close supervision of a board-certified or board-eligible psychiatrist or licensed doctorate-level psychologist; a clinical or counseling psychologist completing a one-year internship or residency (for purposes of a doctorate-level degree) under close supervision of a board-certified or board-eligible psychiatrist or licensed doctorate-level psychologist; or a licensed clinical social worker (LCSW), a nurse practitioner, a clinical nurse specialist, or a physician assistant, under close supervision of a board-certified or board-eligible psychiatrist or licensed doctorate-level psychologist

SECTION I - DIAGNOSTIC SUMMARY

NOTE: This section should be completed based on the current examination and clinical findings.

1. DOES THE VETERAN NOW HAVE OR HAS HE OR SHE EVER BEEN DIAGNOSED WITH PTSD?

☐ YES ☐ NO *(If "Yes," continue to complete this Questionnaire)*
(If no diagnosis of PTSD, and the veteran has another Axis I and/or II diagnosis, then continue to complete this Questionnaire and/or VA Form 21-0960P-1, Eating Disorders Disability Benefits Questionnaire)

SECTION II - CURRENT DIAGNOSES

2A. LIST CURRENT DIAGNOSES

DIAGNOSIS #1: _____

ICD CODE: _____ INDICATE THE AXIS CATEGORY: ☐ AXIS I ☐ AXIS II

COMMENTS, IF ANY: _____

DIAGNOSIS #2: _____

ICD CODE: _____ INDICATE THE AXIS CATEGORY: ☐ AXIS I ☐ AXIS II

COMMENTS, IF ANY: _____

DIAGNOSIS #3: _____

ICD CODE: _____ INDICATE THE AXIS CATEGORY: ☐ AXIS I ☐ AXIS II

COMMENTS, IF ANY: _____

DIAGNOSIS #4: _____

ICD CODE: _____ INDICATE THE AXIS CATEGORY: ☐ AXIS I ☐ AXIS II

COMMENTS, IF ANY: _____

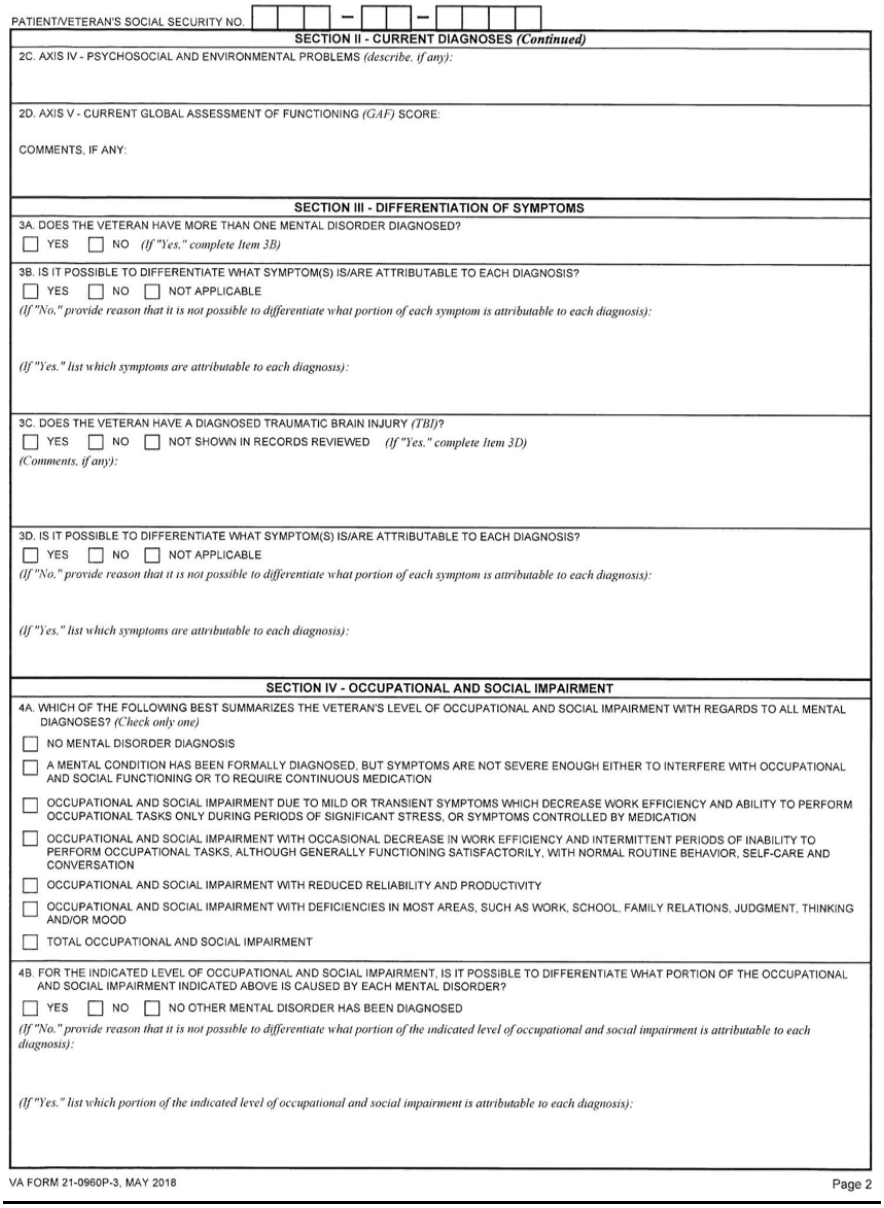
IF ADDITIONAL DIAGNOSES, DESCRIBE USING ABOVE FORMAT

2B. AXIS III - MEDICAL DIAGNOSES *(to include TBI)*:

ICD CODE: _____

COMMENTS, IF ANY:

VA FORM MAY 2018 **21-0960P-3** SUPERSEDES VA FORM 21-0960P-3, FEB 2015, WHICH WILL NOT BE USED. Page 1



PATIENT/VETERAN'S SOCIAL SECURITY NO. ☐☐☐ – ☐☐ – ☐☐☐☐

SECTION II - CURRENT DIAGNOSES *(Continued)*

2C. AXIS IV - PSYCHOSOCIAL AND ENVIRONMENTAL PROBLEMS *(describe, if any):*

2D. AXIS V - CURRENT GLOBAL ASSESSMENT OF FUNCTIONING *(GAF)* SCORE:

COMMENTS, IF ANY:

SECTION III - DIFFERENTIATION OF SYMPTOMS

3A. DOES THE VETERAN HAVE MORE THAN ONE MENTAL DISORDER DIAGNOSED?

☐ YES ☐ NO *(If "Yes," complete Item 3B)*

3B. IS IT POSSIBLE TO DIFFERENTIATE WHAT SYMPTOM(S) IS/ARE ATTRIBUTABLE TO EACH DIAGNOSIS?

☐ YES ☐ NO ☐ NOT APPLICABLE

(If "No," provide reason that it is not possible to differentiate what portion of each symptom is attributable to each diagnosis):

(If "Yes," list which symptoms are attributable to each diagnosis):

3C. DOES THE VETERAN HAVE A DIAGNOSED TRAUMATIC BRAIN INJURY *(TBI)*?

☐ YES ☐ NO ☐ NOT SHOWN IN RECORDS REVIEWED *(If "Yes," complete Item 3D)*

(Comments, if any):

3D. IS IT POSSIBLE TO DIFFERENTIATE WHAT SYMPTOM(S) IS/ARE ATTRIBUTABLE TO EACH DIAGNOSIS?

☐ YES ☐ NO ☐ NOT APPLICABLE

(If "No," provide reason that it is not possible to differentiate what portion of each symptom is attributable to each diagnosis):

(If "Yes," list which symptoms are attributable to each diagnosis):

SECTION IV - OCCUPATIONAL AND SOCIAL IMPAIRMENT

4A. WHICH OF THE FOLLOWING BEST SUMMARIZES THE VETERAN'S LEVEL OF OCCUPATIONAL AND SOCIAL IMPAIRMENT WITH REGARDS TO ALL MENTAL DIAGNOSES? *(Check only one)*

☐ NO MENTAL DISORDER DIAGNOSIS

☐ A MENTAL CONDITION HAS BEEN FORMALLY DIAGNOSED, BUT SYMPTOMS ARE NOT SEVERE ENOUGH EITHER TO INTERFERE WITH OCCUPATIONAL AND SOCIAL FUNCTIONING OR TO REQUIRE CONTINUOUS MEDICATION

☐ OCCUPATIONAL AND SOCIAL IMPAIRMENT DUE TO MILD OR TRANSIENT SYMPTOMS WHICH DECREASE WORK EFFICIENCY AND ABILITY TO PERFORM OCCUPATIONAL TASKS ONLY DURING PERIODS OF SIGNIFICANT STRESS, OR SYMPTOMS CONTROLLED BY MEDICATION

☐ OCCUPATIONAL AND SOCIAL IMPAIRMENT WITH OCCASIONAL DECREASE IN WORK EFFICIENCY AND INTERMITTENT PERIODS OF INABILITY TO PERFORM OCCUPATIONAL TASKS, ALTHOUGH GENERALLY FUNCTIONING SATISFACTORILY, WITH NORMAL ROUTINE BEHAVIOR, SELF-CARE AND CONVERSATION

☐ OCCUPATIONAL AND SOCIAL IMPAIRMENT WITH REDUCED RELIABILITY AND PRODUCTIVITY

☐ OCCUPATIONAL AND SOCIAL IMPAIRMENT WITH DEFICIENCIES IN MOST AREAS, SUCH AS WORK, SCHOOL, FAMILY RELATIONS, JUDGMENT, THINKING AND/OR MOOD

☐ TOTAL OCCUPATIONAL AND SOCIAL IMPAIRMENT

4B. FOR THE INDICATED LEVEL OF OCCUPATIONAL AND SOCIAL IMPAIRMENT, IS IT POSSIBLE TO DIFFERENTIATE WHAT PORTION OF THE OCCUPATIONAL AND SOCIAL IMPAIRMENT INDICATED ABOVE IS CAUSED BY EACH MENTAL DISORDER?

☐ YES ☐ NO ☐ NO OTHER MENTAL DISORDER HAS BEEN DIAGNOSED

(If "No," provide reason that it is not possible to differentiate what portion of the indicated level of occupational and social impairment is attributable to each diagnosis):

(If "Yes," list which portion of the indicated level of occupational and social impairment is attributable to each diagnosis):

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PATIENT/VETERAN'S SOCIAL SECURITY NO. ☐☐☐ – ☐☐ – ☐☐☐☐

SECTION IV - OCCUPATIONAL AND SOCIAL IMPAIRMENT *(Continued)*

4C. IF A DIAGNOSIS OF TBI EXISTS, IS IT POSSIBLE TO DIFFERENTIATE WHAT PORTION OF THE OCCUPATIONAL AND SOCIAL IMPAIRMENT INDICATED ABOVE IS CAUSED BY THE TBI?

☐ YES ☐ NO ☐ NO DIAGNOSIS OF TBI

(If "No," provide reason that it is not possible to differentiate what portion of the indicated level of occupational and social impairment is attributable to each diagnosis):

(If "Yes," list which portion of the indicated level of occupational and social impairment is attributable to each diagnosis):

SECTION V - CLINICAL FINDINGS

1. EVIDENCE REVIEW

5A. IF ANY RECORDS (EVIDENCE) WERE REVIEWED, PLEASE LIST:

2. RECENT HISTORY (SINCE PRIOR EXAM)

5B. RELEVANT SOCIAL/MARITAL/FAMILY HISTORY:

5C. RELEVANT OCCUPATIONAL AND EDUCATIONAL HISTORY:

5D. RELEVANT MENTAL HEALTH HISTORY, TO INCLUDE PRESCRIBED MEDICATIONS AND FAMILY MENTAL HEALTH:

5E. RELEVANT LEGAL AND BEHAVIORAL HISTORY:

5F. RELEVANT SUBSTANCE ABUSE HISTORY:

5G. SENTINEL EVENT(S) (OTHER THAN STRESSORS):

5H. OTHER *(If any)*:

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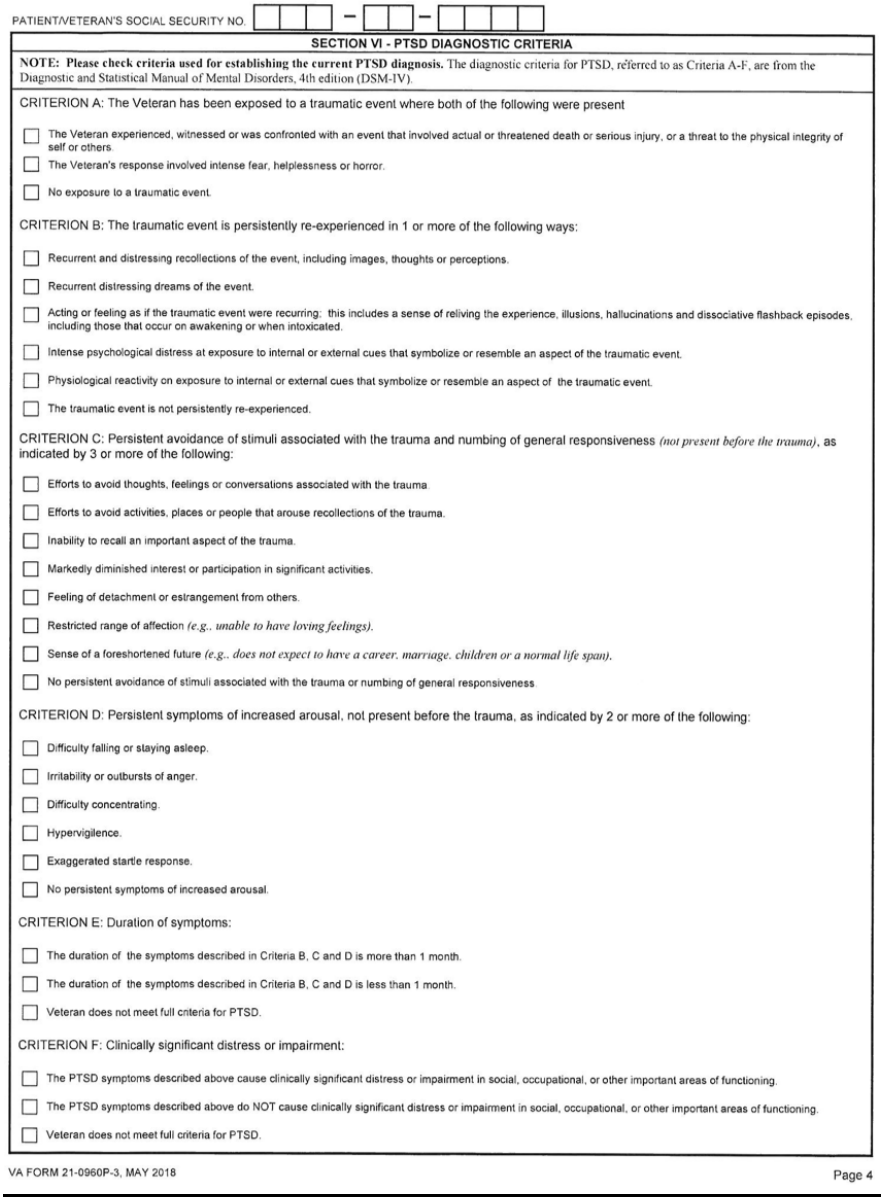

PATIENT/VETERAN'S SOCIAL SECURITY NO. ☐☐☐ – ☐☐ – ☐☐☐☐

SECTION VI - PTSD DIAGNOSTIC CRITERIA

NOTE: Please check criteria used for establishing the current PTSD diagnosis. The diagnostic criteria for PTSD, referred to as Criteria A-F, are from the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV).

CRITERION A: The Veteran has been exposed to a traumatic event where both of the following were present

- ☐ The Veteran experienced, witnessed or was confronted with an event 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.
- ☐ No exposure to a traumatic event.

CRITERION B: The traumatic event is persistently re-experienced in 1 or more of the following ways:

- ☐ Recurrent and 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: this includes a sense of reliving the experience, illusions, hallucinations and dissociative flashback episodes, including those that 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.
- ☐ The traumatic event is not persistently re-experienced.

CRITERION C: Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness *(not present before the trauma)*, as indicated by 3 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.
- ☐ Feeling of detachment or estrangement from others.
- ☐ Restricted range of affection *(e.g., unable to have loving feelings)*.
- ☐ Sense of a foreshortened future *(e.g., does not expect to have a career, marriage, children or a normal life span)*.
- ☐ No persistent avoidance of stimuli associated with the trauma or numbing of general responsiveness.

CRITERION D: Persistent symptoms of increased arousal, not present before the trauma, as indicated by 2 or more of the following:

- ☐ Difficulty falling or staying asleep.
- ☐ Irritability or outbursts of anger.
- ☐ Difficulty concentrating.
- ☐ Hypervigilence.
- ☐ Exaggerated startle response.
- ☐ No persistent symptoms of increased arousal.

CRITERION E: Duration of symptoms:

- ☐ The duration of the symptoms described in Criteria B, C and D is more than 1 month.
- ☐ The duration of the symptoms described in Criteria B, C and D is less than 1 month.
- ☐ Veteran does not meet full criteria for PTSD.

CRITERION F: Clinically significant distress or impairment:

- ☐ The PTSD symptoms described above cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- ☐ The PTSD symptoms described above do NOT cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- ☐ Veteran does not meet full criteria for PTSD.

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PATIENT/VETERAN'S SOCIAL SECURITY NO. ☐☐☐ – ☐☐ – ☐☐☐☐

SECTION VII - SYMPTOMS

7. FOR VA RATING PURPOSES, CHECK ALL SYMPTOMS THAT APPLY TO THE VETERAN'S DIAGNOSES:

- ☐ Depressed mood
- ☐ Anxiety
- ☐ Suspiciousness
- ☐ Panic attacks that occur weekly or less often
- ☐ Panic attacks more than once a week
- ☐ Near-continuous panic or depression affecting the ability to function independently, appropriately and effectively
- ☐ Chronic sleep impairment
- ☐ Mild memory loss, such as forgetting names, directions or recent events
- ☐ Impairment of short and long term memory, for example, retention of only highly learned material, while forgetting to complete tasks
- ☐ Memory loss for names of close relatives, own occupation, or own name
- ☐ Flattened affect
- ☐ Circumstantial, circumlocutory or stereotyped speech
- ☐ Speech intermittently illogical, obscure, or irrelevant
- ☐ Difficulty in understanding complex commands
- ☐ Impaired judgment
- ☐ Impaired abstract thinking
- ☐ Gross impairment in thought processes or communication
- ☐ Disturbances of motivation and mood
- ☐ Difficulty in establishing and maintaining effective work and social relationships
- ☐ Difficulty adapting to stressful circumstances, including work or a work like setting
- ☐ Inability to establish and maintain effective relationships
- ☐ Suicidal ideation
- ☐ Obsessional rituals which interfere with routine activities
- ☐ Impaired impulse control, such as unprovoked irritability with periods of violence
- ☐ Spatial disorientation
- ☐ Persistent delusions or hallucinations
- ☐ Grossly inappropriate behavior
- ☐ Persistent danger of hurting self or others
- ☐ Neglect of personal appearance and hygiene
- ☐ Intermittent inability to perform activities of daily living, including maintenance of minimal personal hygiene
- ☐ Disorientation to time or place

SECTION VIII - OTHER SYMPTOMS

8. DOES THE VETERAN HAVE ANY OTHER SYMPTOMS ATTRIBUTABLE TO PTSD (AND OTHER MENTAL DISORDERS) THAT ARE NOT LISTED ABOVE?

☐ YES ☐ NO *(If "Yes," describe):*

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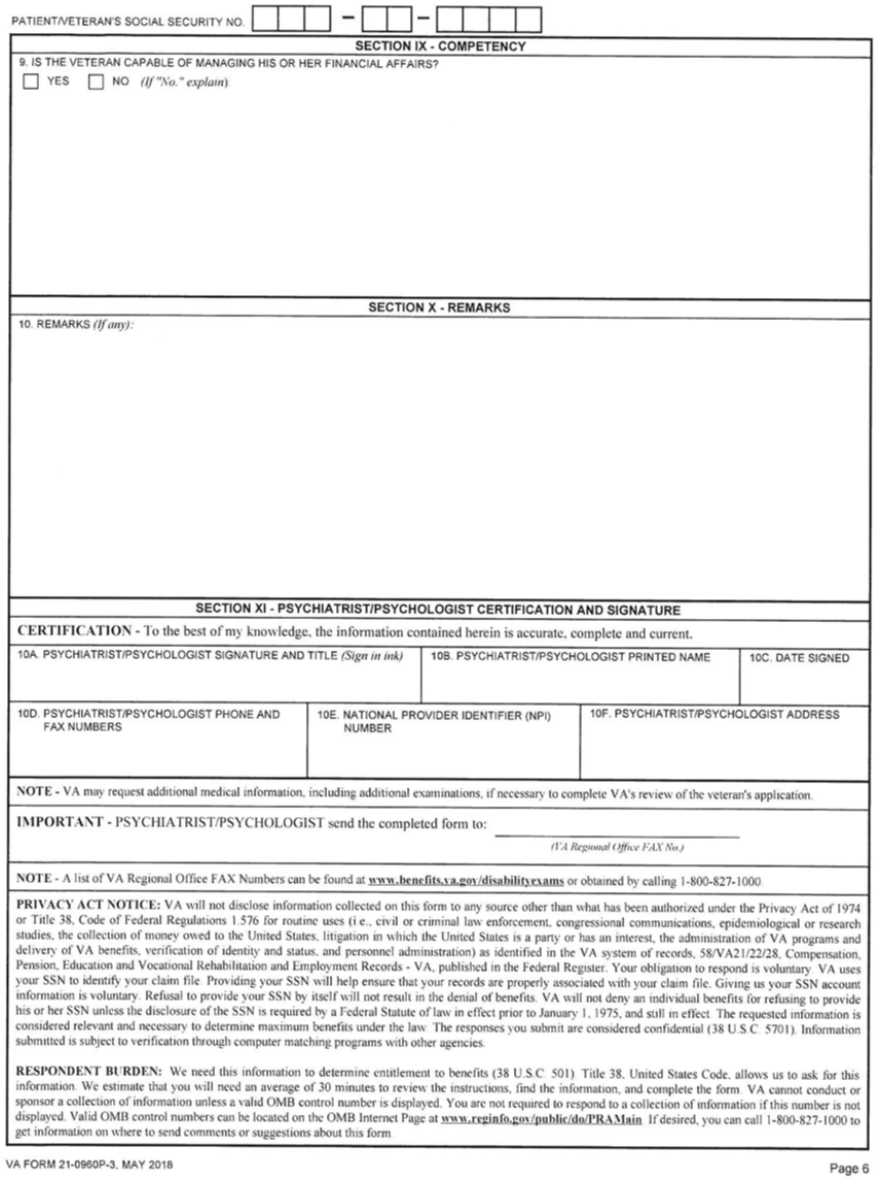

PATIENT/VETERAN'S SOCIAL SECURITY NO. ☐☐☐ – ☐☐ – ☐☐☐☐

SECTION IX - COMPETENCY

9. IS THE VETERAN CAPABLE OF MANAGING HIS OR HER FINANCIAL AFFAIRS?

☐ YES ☐ NO *(If "No." explain)*

SECTION X - REMARKS

10. REMARKS *(If any):*

SECTION XI - PSYCHIATRIST/PSYCHOLOGIST CERTIFICATION AND SIGNATURE

CERTIFICATION - To the best of my knowledge, the information contained herein is accurate, complete and current.

10A. PSYCHIATRIST/PSYCHOLOGIST SIGNATURE AND TITLE *(Sign in ink)*	10B. PSYCHIATRIST/PSYCHOLOGIST PRINTED NAME	10C. DATE SIGNED

10D. PSYCHIATRIST/PSYCHOLOGIST PHONE AND FAX NUMBERS	10E. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER	10F. PSYCHIATRIST/PSYCHOLOGIST ADDRESS

NOTE - VA may request additional medical information, including additional examinations, if necessary to complete VA's review of the veteran's application.

IMPORTANT - PSYCHIATRIST/PSYCHOLOGIST send the completed form to: _____

(VA Regional Office FAX No.)

NOTE - A list of VA Regional Office FAX Numbers can be found at **www.benefits.va.gov/disabilityexams** or obtained by calling 1-800-827-1000.

PRIVACY ACT NOTICE: VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58/VA21/22/28, Compensation, Pension, Education and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is voluntary. VA uses your SSN to identify your claim file. Providing your SSN will help ensure that your records are properly associated with your claim file. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by a Federal Statute of law in effect prior to January 1, 1975, and still in effect. The requested information is considered relevant and necessary to determine maximum benefits under the law. The responses you submit are considered confidential (38 U.S.C. 5701). Information submitted is subject to verification through computer matching programs with other agencies.

RESPONDENT BURDEN: We need this information to determine entitlement to benefits (38 U.S.C. 501). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 30 minutes to review the instructions, find the information, and complete the form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at **www.reginfo.gov/public/do/PRAMain**. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

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