

UNRAVELING THE PTSD PARADOX: A PROPOSAL TO SIMPLIFY THE ADJUDICATION OF CLAIMS FOR SERVICE CONNECTION FOR POSTTRAUMATIC STRESS DISORDER

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INTRODUCTION

There are two related misconceptions about posttraumatic stress disorder (PTSD) and military service that are central to understanding the treatment of American military veterans diagnosed with this disorder: (1) the suspicion that PTSD is an ordinary reaction to extraordinary war trauma only recently pathologized as a psychiatric disorder,² and (2) the belief that all veterans of a period of war, to a greater or lesser extent, suffer from PTSD.³ A latent cultural commitment to this “Paradox of

¹ Associate Counsel at the Board of Veterans’ Appeals (Board) in Washington, D.C. I am greatly indebted to Terrence Griffin, my fellow Counsel at the Board, for his contributions to the historical narrative of the laws and regulations governing veterans’ benefits claims for posttraumatic stress disorder (PTSD). I would also like to express my appreciation to my husband, James Mayes, a Veteran of the Army and Army National Guard, for providing additional context on military service and military culture where necessary to facilitate my understanding of the astonishing variety of incidents that might, and do, happen during military service.

² Compare Katherine N. Boone, *The Paradox of PTSD*, WILSON Q., Autumn 2011, at 18-19 (arguing that the *Diagnostic and Statistical Manual of Mental Disorders’ (DSM)* “mechanistic” definition of PTSD simply correlates a sufficient degree of stress to a convenient disorder, resulting in “the illness’s paradox: If you react normally to trauma, you have a disorder; if you react abnormally, you don’t.”), with Dana Becker, 5 *Myths About Stress*, WASH. POST, Mar. 31, 2013, at B2 (“The idea that PTSD is a normal reaction to abnormal events has been gaining popularity since the mid-1980s. But most people who have been through traumatic events don’t develop PTSD. Although about 60 percent of U.S. adults say they have had at least one traumatic experience, the average prevalence of PTSD is between 6.8 percent and 7.8 percent. We can’t call PTSD a normal reaction and a psychiatric disorder at the same time.”).

³ Boone, *supra* note 2, at 22. “We were shot at and we were hit with [improvised explosive devices] throughout the whole deployment. I guess I really should have gotten

PTSD” informed both the historical development of the disorder in the psychiatric community and, as a direct result, the regulations governing entitlement to disability compensation benefits for PTSD for military veterans.⁴ This concern with the validity of PTSD as a diagnostic category as well as an individual diagnosis, and the perception that its application among military veterans may prove to be limitless, has profound implications during a time when nearly 400,000 veterans receive disability compensation benefits for PTSD, at a cost of approximately \$4 billion per year.⁵ Despite worry about “diagnostic bracket creep,” which can be described as, essentially, the concern that “you and I are the only two people in the U.S. without a psychiatric diagnosis,”⁶ veterans who do not suffer from PTSD substantially outnumber those diagnosed with the disorder.⁷ As explained by the Executive Director of the

PTSD. Everybody in my platoon *should* have.” *Id.* (quoting a Veteran); see MARGARET C. HARRELL & NANCY BERGLASS, CTR. FOR A NEW AM. SEC., EMPLOYING AMERICA’S VETERANS: PERSPECTIVES FROM BUSINESSES 24 (2012) (quoting one employer’s concern that “I’ve heard about some veterans coming back and going on rampages. . . . I always wonder if it is a possibility,” and another employer hypothesizing that “[t]he media propagates the notion that all vets have PTSD”).

⁴ See generally Boone, *supra* note 2, at 18-19 (coining the term “Paradox of PTSD” to describe what the author views as the problematic pathologizing of normal reactions to trauma and the normalization of abnormal reactions inherent in the diagnosis of PTSD); Richard J. McNally, *The Expanding Empire of Posttraumatic Stress Disorder*, 8 MEDSCAPE GEN. MED. 9 (Apr. 10, 2006), <http://www.medscape.com/viewarticle/528984> (arguing that the “conceptual bracket creep in the definition of trauma whereby ordinary stressors are now deemed capable of producing PTSD” reduces the causal significance of the stressor itself in favor of “preexisting personal vulnerability factors” and “undercuts the very rationale for having a diagnosis of PTSD in the first place”). Part I, *infra*, will discuss the historical intertwining of concerns with bracket creep and the additional evidentiary burdens ultimately placed on veterans’ compensation benefit claimants to establish service connection for PTSD.

⁵ Ted Speroff & Patricia Sinnott, *Compensation and Pension Examination for PTSD*, FORUM—TRANSLATING RESEARCH INTO QUALITY HEALTH CARE FOR VETERANS (VA Health Servs. Research & Dev. Serv., Wash., D.C.), May 2012, at 7.

⁶ Margaret Wentz, *Is Your Sanity at Stake? If You Haven’t Been Diagnosed with a Mental Disorder, There Must Be Something Wrong with You*, GLOBE & MAIL, July 4, 2009, at A19 (quoting a psychological expert discussing the negative connotations of bracket creep).

⁷ VA estimates that almost thirty-one percent of Vietnam veterans, ten percent of Desert Storm veterans, eleven percent of Afghanistan veterans, and twenty percent of veterans of the war in Iraq have PTSD. Nat’l Insts. of Health, *PTSD: A Growing Epidemic*, 4 NIH MEDLINEPLUS 10 (2009), available at <http://www.nlm.nih.gov/>

Department of Veterans Affairs (VA) National Center for PTSD, the view that “PTSD is a normal reaction to combat” trivializes the disorder, evinces a lack of understanding of PTSD, and “does a great disservice to millions of people with PTSD.”⁸

Recent advances in neurological testing and other medical research have allowed for significant recent scientific gains in the field of psychiatry, including a growing understanding of the underlying physiology behind the symptoms of PTSD.⁹ Studies have found evidence of “[u]nrestrained activation of the sympathetic nervous system” associated with behavioral symptoms related to sublimating trauma, even outside of dangerous or stressful situations, and neuroimaging allows researchers to compare and document differences in brain activity between subjects with and without a history of PTSD.¹⁰ In the intersection of the fields of psychiatry and neurology, the ever-growing accumulation of scientific evidence weighs decisively against the

medlineplus/magazine/issues/winter09/articles/winter09pg10-14.html. As a general matter, researchers note that the concept of PTSD as an entirely environmentally caused disorder has been increasingly challenged as it became clear “that traumatic events were much more prevalent than had been assumed” and “typically only a minority of individuals developed PTSD afterwards.” Chris R. Brewin et al., *Reformulating PTSD for DSM-V: Life After Criterion A*, 22 J. TRAUMATIC STRESS 366, 366 (2009).

⁸ Matthew J. Friedman, *Letters: Understanding PTSD*, WILSON Q., Winter 2012, at 8, 9 (2012).

⁹ See Charles F. Reynolds, III et al., *The Future of Psychiatry as Clinical Neuroscience*, 84 ACAD. MED. 446, 446, 449 (2009). “Now . . . with the tools of modern neuroscience, a deeper understanding of causal pathways to major neuropsychiatric illness is evolving, thus rendering artificial the boundary between psychiatry and neurology.” *Id.* at 446 (advocating the integration of psychiatry and neurology into a field of “clinical neuroscience” to reflect the erosion of the traditional boundary between mental disorders of unknown etiology, formerly assigned to psychiatry, and mental disorders of known etiology, which, once the cause is discovered, are typically reassigned to the field of neurology). See generally NEUROPSYCHOLOGY OF PTSD: BIOLOGICAL, COGNITIVE, AND CLINICAL PERSPECTIVES (Jennifer J. Vasterling & Chris R. Brewin eds., 2005) (providing a thorough examination of the neuropsychology of PTSD).

¹⁰ Ayesha S. Ahmed, *Post-Traumatic Stress Disorder, Resilience and Vulnerability*, 13 ADVANCES IN PSYCHIATRIC TREATMENT 369, 370-71 (2007); Robert W. Van Boven et al., *Advances in Neuroimaging of Traumatic Brain Injury and Posttraumatic Stress Disorder*, 46 J. REHABILITATION RES. & DEV. 717, 719-20 (2009) (reviewing various imaging techniques used for identifying PTSD).

PTSD paradox: PTSD is not a mere pathologizing of a normal reaction to trauma.¹¹

Unfortunately, while our scientific understanding of PTSD has steadily increased over time, the regulations governing awards of disability compensation benefits for PTSD continue to reflect the concern that the diagnostic category of PTSD will continually broaden until there is no remaining distinction “between normality and disorder.”¹² This concern has manifested in a heightened evidentiary burden in PTSD claims that does not apply to claims for benefits for any other mental disorder.¹³ Further, this additional evidentiary burden was created by lifting one of the diagnostic criteria, the stressor criterion, out of the realm of medical evidence and setting it firmly in place as a factual determination to be made by the adjudicator.¹⁴

As a result, 38 C.F.R. § 3.304(f), the regulation governing the adjudication of claims for service connection for PTSD, has more value as a historical lesson on the impact of implicit policy concerns in an organic common law system than as a useful tool for evaluating claims for benefits for PTSD. Furthermore, recent regulatory efforts to relax the evidentiary requirements in claims

¹¹ Compare Ahmed, *supra* note 10, at 370-72 (explaining the genetic, biologic and psychosocial factors that can cause someone to be either vulnerable or resilient to incurring PTSD); Jonathan E. Sherin & Charles B. Nemeroff, *Post-Traumatic Stress Disorder: The Neurobiological Impact of Psychological Trauma*, 13 *DIALOGUES IN CLINICAL NEUROSCIENCE* 263, 271-74 (2011) (explaining neurobiological factors of PTSD); and Van Boven, *supra* note 10, with Sena Moran et al., *Posttraumatic Growth: Helping Clients Overcome Trauma*, 43 *J. APPLIED REHABILITATION COUNSELING* 12 (2012) (endorsing the concept of “posttraumatic growth” as a positive response to trauma, as opposed to PTSD as a negative response); see also Stephen Joseph, *Letters: PTSD Reconsidered*, *WILSON Q.*, Spring 2012, at 8, 8 (2012) (explaining how the concept of “posttraumatic growth” frames posttraumatic stress as a normal process in life and is distinct from PTSD, which describes only the “abnormal state characterized by dysfunction of some mental mechanism”).

¹² Boone, *supra* note 2, at 22.

¹³ See 38 C.F.R. § 3.304(f) (2012) (requiring credible supporting evidence of the claimed in-service stressor in order to establish service connection for PTSD in most instances).

¹⁴ See *infra* Part I.C.

for compensation benefits for PTSD have not created the flexibility necessary to allow for the efficient and timely adjudication of these claims. The five exceptions to the regulation's credible supporting evidence rule, including the most recent regulation promulgated on July 12, 2010,¹⁵ have multiplied the number of fact-intensive determinations required, and, furthermore, enshrined now-defunct diagnostic criteria among the elements needed to establish service connection for PTSD as a result of exposure to hostile military or terrorist activity.¹⁶

To create the flexibility necessary to adapt to the increasingly dynamic fields of psychiatry and psychology, VA must eliminate the artificial barrier between claims for PTSD and claims for all other mental disorders and reduce the complexity

¹⁵ Stressor Determinations for Posttraumatic Stress Disorder, 75 Fed. Reg. 39,843 (July 13, 2010) (codified at 38 C.F.R. § 3.304(f)(3)); see Department of Veterans Affairs, Fact Sheet: New Regulations on PTSD Claims (July 12, 2010), http://www.va.gov/ptsd_qa.pdf (explaining that 38 C.F.R. § 3.304(f)(3) "liberalizes the evidentiary standard" for service connection for PTSD).

¹⁶ See *infra* Part II. The most recent version of the *Diagnostic and Statistical Manual of Mental Disorders*, relied upon by clinicians in assigning psychiatric diagnoses, was published in 2013. THE DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (Am. Psychiatric Ass'n 5th ed.) (2013) [hereinafter DSM-5]; see also THE DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (Am. Psychiatric Ass'n 1st ed.) (1952); THE DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (Am. Psychiatric Ass'n 2d ed.) (1968) [hereinafter DSM-II]; THE DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (Am. Psychiatric Ass'n 3d ed.) (1980) [hereinafter DSM-III]; THE DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (Am. Psychiatric Ass'n 3d ed.-rev.) (1987) [hereinafter DSM-III-R]; THE DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (Am. Psychiatric Ass'n 4th ed.) (1994) [hereinafter DSM-IV]; THE DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (Am. Psychiatric Ass'n 4th ed.-rev.) (2000). The APA dropped the traditional practice of numbering editions with roman numerals in order to allow for "incremental updates . . ." to be identified with decimals, e.g., "DSM-5.1, DSM-5.2, etc.," that "will not be tied to a static publication date but rather to scientific advances." American Psychiatric Association, DSM-5 Development, Frequently Asked Questions (2012), <http://www.dsm5.org/about/pages/faq.aspx>. The DSM-5 also eliminated the "A2 Criterion" for a PTSD diagnosis, which required a response of "fear, helplessness, or horror." See Matthew J. Friedman et al., *Considering PTSD for DSM-5*, 28 DEPRESSION & ANXIETY 750, 755-64 (2011). However, this now-discarded diagnostic criterion is still an element needed to establish service connection for PTSD under 38 C.F.R. § 3.304(f)(3).

of the rules governing the award of compensation benefits for PTSD by repealing 38 C.F.R. § 3.304(f), the special regulation that pertains only to the award of compensation benefits for PTSD. Instead, claims for benefits for PTSD should be adjudicated under the general three-element service connection regulation found at § 3.303(a)¹⁷ that serves as a catch-all for all service connection claims not specially governed by another regulation, and requires only: “(1) the existence of a present disability; (2) inservice incurrence or aggravation of a disease or injury; and (3) a causal relationship between the present disability and the disease or injury incurred or aggravated during service.”¹⁸

Part I will trace the development of the credible supporting evidence rule¹⁹ as a historical outgrowth of the interaction between policy concerns about uncontrollable costs, malingering, and bracket creep; the focus on the environmental cause of PTSD in the third and third revised editions of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-III and DSM-III-R)*; and VA’s lack of familiarity with the role of a newly created reviewing court. Part II will explain how past regulatory efforts to promulgate rules relaxing the evidentiary requirements for qualifying veterans have been ensnared by inherent problems of excessive tailoring and regulatory accretion. Part III discusses the significant and continuing risk of error due to separation created between the development and adjudication of PTSD claims and claims for service connection for other mental disorders caused by the differing elements and evidentiary requirements needed to establish entitlement to benefits. Lastly, Part IV will discuss the merits of repealing § 3.304(f) and returning adjudication of PTSD claims to the general provisions governing claims for service connection under § 3.303(a).

¹⁷ 38 C.F.R. § 3.303(a).

¹⁸ *Morris v. Shinseki*, 678 F.3d 1346, 1353 (Fed. Cir. 2012) (quoting *Shedden v. Principi*, 381 F.3d 1163, 1167 (Fed. Cir. 2004)).

¹⁹ See *Moran v. Principi*, 17 Vet. App. 149, 159 (2003) (explaining the requirement in 38 C.F.R. § 3.304(f) that the record contain credible supporting evidence that the claimed in-service stressor occurred).

I. PERPETUATING THE PARADOX: MISUNDERSTANDING PTSD AS AN ENVIRONMENTALLY CAUSED DISORDER

Advocacy of the belief that PTSD is an environmentally caused disorder, from its initial inclusion in the *DSM-III* through the present, perpetuates the continuing paradoxical belief that the number of people suffering from PTSD includes both everyone and no one. From one perspective, there should be less concern about malingering,²⁰ or the fabrication or exaggeration of symptoms, in claims for PTSD benefits than in other claims for psychiatric disorders because of the existence of the stressor criterion, which grounds the diagnosis of PTSD in a concrete event that can be, at least theoretically, conclusively proven or disproven. From the opposite perspective, the existence of a stressor criterion hardly places any limitation on the psychiatric diagnosis of PTSD when it seems that nearly any veteran who served during a period of war can claim a stressor sufficient to support the diagnosis that is not implausible on its face.

Accordingly, VA has grown accustomed to the reassuring presence of the language in the current regulation requiring independent supporting evidence of the stressful event, beyond a veteran's own statements, before compensation benefits for PTSD may be awarded, as it appears to provide a clear and just limit on the number of PTSD claims granted.²¹ However, the focus on the stressor at the time of publication of the *DSM-III* and *DSM-III-R*

²⁰ See Katherine Dubyak, *Close, But No Cigar: Recent Changes to the Stressor Verification Process for Veterans with Post-Traumatic Stress Disorder and Why the System Remains Insufficient*, 21 FED. CIR. B.J. 655, 679-80 (2012) (showing that concerns with malingering are unwarranted as studies have not shown a relationship between "symptom exaggeration and compensation seeking behavior"; VA's own internal study attributed unverifiable stressors to administrative problems, such as missing documents, rather than fraud; and physicians are trained to identify false claims with the assistance of validity scales in psychological tests).

²¹ See 38 C.F.R. § 3.304(f); *see also* Dizoglio v. Brown, 9 Vet. App. 163, 166 (1996) (noting that regulations require evidence corroborating a claimed stressor to warrant service connection for PTSD in most instances).

eventually gave way to serious consideration of the merits of dropping the stressor requirement altogether by the committees reviewing the fourth and fifth editions of the *DSM* (*DSM-IV* and *DSM-5*),²² VA's focus on the stressor as an evidentiary matter requiring corroborating evidence should similarly subside in favor of a more robust analysis of the existence of a present disability and nexus. However, without direct regulatory action, stressor-obsession will continue as the predictable result of the contemporaneous combination of concerns about the extent of erroneously granted claims, the past incorporation of the *DSM-III* and its treatment of PTSD as an environmentally caused disorder into the rating code, and the particular historical moment corresponding to the creation of a reviewing court, the United States Court of Appeals for Veterans Claims (CAVC).²³

A. Supremacy of the Stressor: The Invention of Criterion A

In 1941, psychiatrist Abraham Kardiner published his findings from working with World War I veterans suffering from “war neuroses,” which ultimately served as the clinical foundation for the diagnosis of PTSD; the characteristic symptoms were a history of “exposure to traumatic events; trauma fixation and distorted perception of self, others, events, and environment; nightmares; limited ability to engage in normal activities; chronic irritability; and susceptibility to aggressive outbursts.”²⁴ However,

²² Richard J. McNally, *Conceptual Problems with the DSM-IV Criteria for Posttraumatic Stress Disorder*, in *POSTTRAUMATIC STRESS DISORDER: ISSUES AND CONTROVERSIES* 1, 2 (Gerald M. Rosen ed., 2004) (relating that the *DSM-IV* PTSD committee discussed the possibility of eliminating the stressor criterion from the *DSM-IV* diagnostic criteria for PTSD altogether in order to bring “PTSD in line with most other *DSM* syndromes that do not specify a causal event in the diagnostic criteria”); Friedman, *supra* note 16, at 750-55 (discussing the evidence in favor of eliminating the stressor requirement considered by the *DSM-5* PTSD committee).

²³ The United States Court of Appeals for Veterans Claims (CAVC) was originally known as the United States Court of Veterans Appeals. See Veterans Programs Enhancement Act of 1998, Pub. L. No. 105-368, § 511, 112 Stat. 3315, 3341. For the sake of consistency, this paper will use the current title of the CAVC throughout.

²⁴ COMM. ON VETERANS' COMP. FOR POSTTRAUMATIC STRESS DISORDER, INST. OF MED. & NAT'L RES. COUNCIL, PTSD COMPENSATION AND MILITARY SERVICE 42

initial efforts to reduce the incidence of these symptoms focused not on treatment, but on screening out more than one million “psychologically unfit” inductees during World War II in an attempt to reduce the costs of providing treatment and benefits to the substantial number of veterans suffering from neuropsychiatric disorders following World War I.²⁵ Post-service benefits following World War II took the form of the Serviceman’s Readjustment Act of 1944,²⁶ which also aimed to reduce the costs of providing benefits to veterans through reintegration efforts intended to help veterans assimilate back into civilian society with minimal lingering effects of war.²⁷ The original *DSM* was published by the American Psychiatric Association during the Korean War, and included the diagnosis “gross stress reaction,” based in part on Kardiner’s findings.²⁸ VA’s Schedule for Rating Disabilities, first introduced in 1945, was updated accordingly.²⁹

The second edition of the *DSM* (*DSM-II*) was published during the Vietnam War, and gross stress reaction was curiously eliminated as an independent diagnosis; instead, “[f]ear associated with military combat” was listed as one of three examples under the diagnostic category “[a]djustment reaction of adult life.”³⁰ Experts “suspected that gross stress reaction was omitted to reduce the financial liability of the VA following the Vietnam War.”³¹ In

(2007) [hereinafter PTSD COMPENSATION AND MILITARY SERVICE] (citing ABRAHAM KARDINER, *THE TRAUMATIC NEUROSES OF WAR* (1941)).

²⁵ *Id.* at 43 (internal quotation marks omitted).

²⁶ Pub. L. No. 78-346, 58 Stat. 284.

²⁷ PTSD COMPENSATION AND MILITARY SERVICE, *supra* note 24, at 44-45.

²⁸ *Id.* at 46. Comprehensive new regulations were promulgated in 1961, extending the allowance of disability compensation benefits to veterans diagnosed with disorders that manifest after separation from active military service, “when all the evidence, including that pertinent to service, establishes that the disease was incurred in service.” Title 38—Pensions, Bonuses, and Veterans’ Relief, 26 Fed. Reg. 1561, 1580 (Feb. 24, 1961) (codified at 38 C.F.R. § 3.303(d)).

²⁹ PTSD COMPENSATION AND MILITARY SERVICE, *supra* note 24, at 45.

³⁰ *DSM-II*, *supra* note 16, § 307.3; see John P. Wilson, *The Historical Evolution of PTSD Diagnostic Criteria: From Freud to DSM-IV*, 7 J. TRAUMATIC STRESS 681, 689-91 (1994) (describing the changes to the *DSM-II*).

³¹ PTSD COMPENSATION AND MILITARY SERVICE, *supra* note 24, at 46 (internal

the absence of a sufficiently descriptive diagnosis, psychiatrists often continued to diagnose emotional distress resulting from combat as “war neurosis” or “post-Vietnam syndrome,” which placed the focus squarely on the events of war, rather than the individual characteristics of the patient.³² Furthermore, these ad hoc diagnoses were inconsistent with the rating schedule’s focus on utilizing the *DSM*-approved categories alone.³³ Advocates of the existence of war neurosis claimed that veterans experiencing these symptoms were not abnormal; rather, they endorsed the normalcy of trauma resulting from the abnormal experience of war.³⁴ This resulted in disproportionate concern with the character of the precipitating event over the particular constellation of symptoms associated with individuals thought to be suffering from the disorder.³⁵

When the *DSM-III* adopted the label “post-traumatic stress disorder,”³⁶ or PTSD, to describe stress reactions to trauma in accordance with the recommendations of the Vietnam Veterans Working Group in 1980, the diagnostic focus remained, predictably, on the traumatic event itself as the key diagnostic indicator of PTSD.³⁷ The *DSM-III* stressor criterion, an oddity among *DSM* diagnoses, required the existence of “a recognizable stressor that would evoke significant symptoms of distress in almost everyone.”³⁸ This language emphasizes the particular etiological understanding of PTSD held by the proponents of its

quotation marks omitted).

³² Wilbur J. Scott, *PTSD in DSM-III: A Case in the Politics of Diagnosis and Disease*, 37 SOC. PROBS. 294, 308 (1990).

³³ See Part 4—Schedule for Rating Disabilities: Extension of Convalescent Rating Periods, 41 Fed. Reg. 34,256, 34,258-59 (Aug. 13, 1976) (revising 38 C.F.R. § 4.130).

³⁴ Scott, *supra* note 32, at 308.

³⁵ See *id.*

³⁶ *DSM-III*, *supra* note 16, §§ 308.30, 309.81.

³⁷ See Scott, *supra* note 32, at 305-07. The diagnosis of PTSD “de-emphasized the distinction between humanly produced and naturally occurring disasters, but otherwise appeared almost exactly as the Working Group had prepared it.” *Id.* at 307.

³⁸ *DSM-III*, *supra* note 16, §§ 308.30, 309.81; see Mary Tramontin, *Exit Wounds: Current Issues Pertaining to Combat-Related PTSD of Relevance to the Legal System*, 29 DEV. MENTAL HEALTH L. 23, 24 (2010) (discussing the *DSM-III* diagnostic criteria).

inclusion in the *DSM*; namely, that it is the “magnitude of the stressor” that is responsible for the resulting pathological state,³⁹ and that PTSD is a “normal human reaction to abnormally stressful life-events.”⁴⁰ The stressor criterion was further refined upon revisions to the *DSM* in 1987 to require an event that was both objectively significantly stressful and “outside the range of usual human experience,”⁴¹ which continued to emphasize “the rare occurrence of the stressor and its nearly universal ability to evoke symptoms.”⁴² A list of common characteristics of qualifying stressors was also provided, including a threat to the life or physical integrity of oneself or others and the witnessing of horrific trauma, like mutilation or violent death.⁴³

³⁹ Wilson, *supra* note 30, at 692 (emphasis omitted).

⁴⁰ *Id.* Wilson elaborates on the nature of the PTSD stressor:

Clearly, [the statement that “the existence of a recognizable stressor that would evoke significant symptoms of distress in almost everyone”] is of etiological significance since it implies that the *magnitude of the stressor* is sufficient to generate traumatic reactions in almost everyone which, in turn, might develop into a pathological state. In this regard it is possible to see how researchers . . . indicated that, to a large extent, PTSD can be thought of as the normal human reaction to abnormally stressful life-events. In this perspective the reactions and symptoms of the syndrome are expectable, predictable, and normative. However, the psychopathology of traumatic reactions is discerned when the presence of the symptoms persists and exerts an adverse effect on adaptive functioning. *Thus, there is not only a continuum of symptom severity but also a continuum of pathological impact on psychosocial functioning.* Further, the concept of a continuum of symptom severity and pathological impact then implies that there are variables and processes that moderate both manifestations. . . . [R]esearchers have postulated that personal variables (e.g., personality traits) or environmental factors (e.g., level of perceived social support) influence the specific patterns of PTSD expression.

Id.

⁴¹ DSM-III-R, *supra* note 16, § 309.89; see Tramontin, *supra* note 38, at 24.

⁴² Elizabeth A. Brett et al., *DSM-III-R Criteria for Posttraumatic Stress Disorder*, 145 *AM. J. PSYCHIATRY* 1232, 1233 (1988).

⁴³ DSM-III-R, *supra* note 16, § 309.89; see Wilson, *supra* note 30, at 693-94.

B. Informal Early Agency Rules for PTSD Claims

Upon the addition of PTSD to the *DSM-III* in 1980, VA began to process service connection claims for the new diagnosis of PTSD. This began a full decade of policy shifts that fluctuated between reliance on expert medical evidence and reliance on mandatory service record corroboration of the claimed stressor. On March 17, 1980, VA issued a program guide revision that instructed rating boards to award benefits in cases of delayed onset of symptoms where the “life threatening episode,” as described by the examiner, “is consistent with the nature, character and circumstances of the veteran’s service as evidenced by his or her military records.”⁴⁴ However, a June 30, 1981, revision to the program guide retreated back to requiring stressor determinations from both the examiner and the rating board, as the fact finder.⁴⁵ Specifically, rating boards were directed to identify the “existence of a recognizable stressor or accumulation of stressors that would evoke significant symptoms of distress in almost everyone” and to describe the “nature and severity” of the identified stressor or stressors.⁴⁶

Then, in 1982, VA conducted a review of PTSD claims adjudicated over the last two years and found that a

⁴⁴ DEP’T OF VETERANS AFFAIRS, PG 21-1, § 0-12, CHANGE No. 282, RATING PRACTICES AND PROCEDURES: DISABILITY: MENTAL DISORDERS (revised Mar. 17, 1980).

⁴⁵ DEP’T OF VETERANS AFFAIRS, PG 21-1, § 0-12, CHANGE No. 312, RATING PRACTICES AND PROCEDURES: DISABILITY: MENTAL DISORDERS (revised June 30, 1981). During this period, decisions at the Regional Office level were made by a three-person rating board consisting of a medical specialist, legal specialist, and occupational specialist, and on appeal to the Board of Veterans’ Appeals (Board), cases were considered by a three-member panel consisting of two attorneys and a licensed physician, which may account for some of the fluidity between medical and factual determinations. See Charles L. Cragin, *The Impact of Judicial Review on the Department of Veterans Affairs’ Claims Adjudication Process: The Changing Role of the Board of Veterans’ Appeals*, 46 ME. L. REV. 23, 24-25 (1994). See generally Charles L. Cragin, *A Time of Transition at the Board of Veterans’ Appeals: The Changing Role of the Physician*, 38 FED. BAR NEWS & J. 500 (1991) (discussing the role of physicians at the Board historically and in the future).

⁴⁶ DEP’T OF VETERANS AFFAIRS, PG 21-1, § 0-12, CHANGE No. 312, RATING PRACTICES AND PROCEDURES: DISABILITY: MENTAL DISORDERS (revised June 30, 1981).

“considerable number . . . lack[ed] . . . objective evidence of identifiable stressors.”⁴⁷ Consequently, a new standard adopted on May 3, 1982, required objective evidence of a life-threatening stressor in service, supported by evidence other than a veteran’s statements and substantiated by the available service records, unless the service records established that the veteran was wounded as a result of enemy action, served in combat against the enemy, or was a prisoner of war.⁴⁸ The determination on the occurrence of a claimed stressful event thus became primarily a matter for the fact finder, until four years later.⁴⁹ At that time, the increased evidentiary burdens placed on establishing a stressor were reduced in favor of obtaining more detailed medical evidence from the examination report.⁵⁰ Examiners were specifically asked to provide a full description of a veteran’s past and present symptoms, a diagnosis, a history of the stressful events claimed, and identification and description of a relationship between those past events and the current symptoms.⁵¹ This change was also short-lived; after the publication of the *DSM-III-R* in 1987, the guidelines were again rescinded in favor of more restrictive procedures associated with concerns about malingering, as outlined in a 1989 change to the *VA Adjudication Procedure Manual, M21-1*.⁵² This revision provided that a veteran’s statements were

⁴⁷ DEP’T OF VETERANS AFFAIRS, DVB CIRCULAR 21-82-7, POST-TRAUMATIC STRESS DISORDER RATINGS (May 3, 1982).

⁴⁸ *Id.*

⁴⁹ DEP’T OF VETERANS AFFAIRS, DVB CIRCULAR 21-86-10, POST-TRAUMATIC STRESS DISORDER (Sept. 4, 1986).

⁵⁰ *Id.*

⁵¹ *Id.*

⁵² VA ADJUDICATION PROCEDURE MANUAL M21-1, pt. I, change 475 (Jan. 25, 1989) [hereinafter M21-1]. VA’s General Counsel issued a precedential opinion concerning the M21-1 in 1992, noting that “VA Manual M21-1 is issued by the Chief Benefits Director and its provisions are intended to provide uniform procedures for the adjudication of claims for pension, compensation, dependency and indemnity compensation, accrued amounts, burial allowance and servicemen’s indemnity.” DVA Op. Gen. Counsel Prec. 07-92, ¶ 4 (Mar. 17, 1992) (internal quotation marks omitted). VA’s General Counsel further noted that the “procedures set forth in this manual are intended to be binding only upon VA officials within the Veterans Benefits Administration (VBA) who are responsible for initially adjudicating claims for benefits.” *Id.*

insufficient to establish the existence of the stressor and required that “[s]ervice records . . . support the assertion that the veteran was subjected to a stressor of sufficient gravity to evoke symptoms in almost anyone.”⁵³

In 1988, the Veterans’ Judicial Review Act (VJRA) became law,⁵⁴ bringing VA’s era of “splendid isolation”⁵⁵ to a close. The VJRA established the CAVC and instituted a “reasons and bases” requirement for claims on appeal to the Board of Veterans’ Appeals (“Board”), mandating a full discussion of the factual and legal basis for all determinations made in order to facilitate a veteran’s understanding of the basis for the decision as well as the CAVC’s review.⁵⁶ In *Fugere v. Derwinski*,⁵⁷ the CAVC found that VA’s practice of amending, adding, and deleting sections of the M21-1 violated the notice and comment procedures governing formal agency rulemaking under the Administrative Procedure Act (APA), voluntarily adopted in 1972, whenever those changes are substantive and affect the rights of the claimant.⁵⁸

⁵³ M21-1, *supra* note 52.

⁵⁴ Pub. L. No. 100-687, 102 Stat. 4105 (1988) (codified at 38 U.S.C. §§ 7251-7299 (2006)).

⁵⁵ Robert L. Rabin, *Preclusion of Judicial Review in the Processing of Claims for Veterans’ Benefits: A Preliminary Analysis*, 27 STAN. L. REV. 905, 905 (1975).

⁵⁶ 38 U.S.C. § 7104(d) (2006). “Each decision of the Board shall include . . . a written statement of the Board’s findings and conclusions, and the reasons or bases for those findings and conclusions, on all material issues of fact and law presented on the record.” *Id.*

⁵⁷ 1 Vet. App. 103 (1990).

⁵⁸ *Id.* at 110; *see* 5 U.S.C. § 553 (governing notice and comment rulemaking under the Administrative Procedure Act (APA)); 38 C.F.R. § 1.12 (1973) (adopting APA rulemaking procedures); DVA Op. Gen. Counsel Prec. 7-92, ¶¶ 4-6 (Mar. 17, 1992) (discussing requirements for notice and comment rulemaking as relevant to the M21-1). “The days when benefits or entitlements were considered to be mere privileges are long past. It is now well recognized that ‘the interest of an individual in continued receipt of [Social Security disability] benefits is a statutorily created “property” interest protected by the Fifth Amendment.’” *Fugere*, 1 Vet. App. at 108 (alteration in original) (quoting *Mathews v. Eldridge*, 424 U.S. 319, 332 (1976)). For further commentary on the CAVC’s initial enforcement of the notice and comment procedures of the APA, *see* Michael P. Horan et al., *The Case of Brown v. Gardner: The First Test of the Veterans’ Judicial Review Act*, 4 FED. CIR. B.J. 137 (1994). “The APA evidences Congress’ intent that ‘administrative policies affecting individual rights and obligations be promulgated pursuant to certain stated procedures so as to avoid the inherently arbitrary nature of

Therefore, when the Veterans Benefits Administration (VBA) changed its adjudication procedures for PTSD on March 26, 1991, for the purpose of explicitly relieving combat veterans and former prisoners of war from the evidentiary burden of producing supporting evidence of an in-service stressor, VA's Office of the General Counsel found the change to be in violation of the APA.⁵⁹ Under the holding in *Fugere*, the Office of the General Counsel found that this action constituted a violation of the APA's notice and comment rule-making procedures, explaining that "an agency cannot avoid rulemaking procedures simply by placing a rule in a manual rather than in the Code of Federal Regulations."⁶⁰ This initiated the process that eventually led to the promulgation of a regulation governing the adjudication of claims for PTSD, proposed on August 5, 1992, and promulgated on May 19, 1993.⁶¹ This regulation was, and continues to be, codified at 38 C.F.R. § 3.304(f).

Prior to the promulgation of § 3.304(f), the CAVC issued decisions in the cases of *Wood v. Derwinski*⁶² and *Wilson v. Derwinski*,⁶³ both notable for their legacy of standing for propositions that simply are not found in the language of either decision. *Wood* is commonly cited for the proposition that the Board is not required to accept a veteran's "uncorroborated account of his Vietnam experiences."⁶⁴ Less cited is the holding that "[i]t was reasonable, therefore, for the [Board] to require, *in this case*, some corroboration of the events that appellant alleges

unpublished ad hoc determinations." *Id.* at 155 (quoting *Morton v. Ruiz*, 415 U.S. 199, 232 (1974)).

⁵⁹ DVA Op. Gen. Counsel Prec. 7-92.

⁶⁰ *Id.* ¶ 6.

⁶¹ Direct Service Connection (Post-traumatic Stress Disorder), 57 Fed. Reg. 34,536 (proposed Aug. 5, 1992); Direct Service Connection (Post-traumatic Stress Disorder), 58 Fed. Reg. 29,109 (May 19, 1993) (codified at 38 C.F.R. § 3.304(f)).

⁶² 1 Vet. App. 190 (1991), *motion for reconsideration denied*, 1 Vet. App. 406 (1991).

⁶³ 2 Vet. App. 614 (1992).

⁶⁴ *Wood*, 1 Vet. App. at 192. A search of the decisions of the Board on Westlaw, conducted on November 12, 2013, for "1 Vet. App. 190" within the same paragraph as "uncorroborated" results in hits in 2,236 decisions, dated through August 28, 2013.

happened to him in Vietnam.”⁶⁵ In *Wood*, the Board assessed the evidence in favor and against the Veteran’s claim and found that the greater weight of the evidence was against the claim for PTSD.⁶⁶ In other words, *Wood*, on its face, stands only for the uncontroversial holdings that the Board provided adequate reasons and bases for its decision and that its factual findings were not clearly erroneous.⁶⁷

In *Wilson*, the CAVC reviewed a Board decision that incorporated the 1988 adoption of the *DSM-III* diagnostic criteria for PTSD in 38 C.F.R. Part 4 into its analysis of a service connection claim for PTSD adjudicated under § 3.303(a).⁶⁸ The Veteran submitted an affidavit from a VA physician on (1) the validity of his diagnosis of PTSD, (2) the causal relationship between the PTSD and his military service, and (3) the sufficiency of the stressor claimed by the Veteran “to produce and justify a diagnosis of [PTSD].”⁶⁹ However, the Board, upon conducting a

⁶⁵ *Wood*, 1 Vet. App. at 193 (emphasis added).

⁶⁶ *Id.* at 191-93.

⁶⁷ The CAVC clarified its holding as follows:

Appellant now argues in his brief that, particularly because the health professionals accepted his Vietnam experiences as truthful, the [Board] was required to do the same. That misconceives the role of the [Board]. The [Board] has the duty to assess the credibility and weight to be given to the evidence. Such assessments will be overturned only if “clearly erroneous.”

Of course, if the [Board] decision fails to give sufficient “reasons or bases” for accepting or rejecting critical evidence, expert or otherwise, then a remand for further proceedings may be appropriate. However, in this case, we find the [Board] opinion concerning this evidence to be both plausible and adequately explained.

Id. at 193 (citations omitted).

⁶⁸ *Wilson*, 2 Vet. App. at 616; 38 C.F.R. § 3.303(a) (2012); see *id.* § 4.125 (1988) (providing that the “psychiatric nomenclature employed is based upon the [DSM-III]”); *id.* § 4.126 (providing that “[a] diagnosis not in accord with [the American Psychiatric Association] manual is not acceptable for rating purposes”).

⁶⁹ *Wilson*, 2 Vet. App. at 616 (alteration in original).

detailed factual investigation of the Veteran's claimed stressors, only found evidence weighing against the occurrence of the claimed events.⁷⁰

The CAVC, upon review of the Board's decision, found that the analysis offered for the decision was a "model of how facts should be evaluated and weighed."⁷¹ Consequently, it is clear from the text of the decision in *Wilson* that the strength of the Board's decision rested on the detail of its analysis and fact finding, rather than adherence to any bright-line rule governing the weighing of the evidence of the stressor. However, one year later, in the CAVC's decision in *Hayes v. Brown*,⁷² *Wood* and *Wilson* are cited in support of the proposition that it was "reasonable for the [Board] to require some corroboration of the stressors claimed by appellant in support of his claims for service connection for PTSD," where service records did not indicate combat service or exposure to "more than the ordinary stressful environment experienced by all those who served in Vietnam."⁷³

On May 19, 1993, a month after the decision in *Hayes*, VA published the final rule establishing the need for credible supporting evidence to establish an in-service stressor, except in cases involving combat veterans or prisoners of war.⁷⁴ One commenter objected that the *Wood* decision required corroboration of the stressor in all cases, as if it were "a judicial edict preventing VA from establishing service connection for PTSD in any case unless it is able to obtain absolute proof that the claimed in-service stressor actually occurred."⁷⁵ VA accepted that the holding in *Wood* required "some corroboration" of the alleged stressor, objecting only on the basis of VA's statutory authority to create

⁷⁰ *Id.* at 616-17.

⁷¹ *Id.* at 618.

⁷² 5 Vet. App. 60 (1993).

⁷³ *Id.* at 67.

⁷⁴ Direct Service Connection (Post-traumatic Stress Disorder), 58 Fed. Reg. 29,109 (May 19, 1993).

⁷⁵ *Id.* at 29,110.

rules governing the nature and extent of proof and evidence required to establish entitlement to a benefit.⁷⁶ The more accurate answer would have been that the CAVC had not established any minimum corroboration requirement in *Wood*, but that VA was nevertheless authorized to create one under the authority granted by Congress in the enabling statute recognizing its subject matter expertise.⁷⁷ In *Dizoglio v. Brown*,⁷⁸ the CAVC confirmed that the proper interpretation of § 3.304(f) is that a veteran's "testimony, by itself, cannot, as a matter of law, establish the occurrence of a noncombat stressor."⁷⁹

C. The Problem of "After-the-Fact" Medical Evidence

Another effect of the passage of the VJRA was the explicit separation of medical and legal fact finding. In *Colvin v. Derwinski*,⁸⁰ the CAVC held that the Board had to obtain independent medical evidence where needed to make a decision on a claim and could not weigh its own unsubstantiated medical opinions against the other medical evidence of record.⁸¹ This decision ended the Board's practice of using three-member panels, consisting of two lawyers and a medical expert, to decide cases.⁸² It also necessitated a plethora of clarifying decisions differentiating legal fact finding from medical determinations.⁸³

⁷⁶ *Id.*

⁷⁷ See 38 U.S.C. § 501(a)(1) (2006).

⁷⁸ 9 Vet. App. 163 (1996).

⁷⁹ *Id.* at 166.

⁸⁰ 1 Vet. App. 171 (1991).

⁸¹ *Id.* at 175.

⁸² James D. Ridgway, *The Veterans' Judicial Review Act Twenty Years Later: Confronting the New Complexities of the Veterans Benefits System*, 66 N.Y.U. ANN. SURV. AM. L. 251, 272-73 (2010).

⁸³ See, e.g., *Horn v. Shinseki*, 25 Vet. App. 231, 242 (2012) (finding that if an in-service Medical Evaluation Board report does not "contain sufficient discussion" of its medical conclusions, "the Board must obtain further medical evidence"); *Stefl v. Nicholson*, 21 Vet. App. 120, 124-25 (2007) (discussing the need for the Board to obtain an adequate medical opinion so it does not rely on its own lay opinion); *Pond v. West*, 12 Vet. App. 341, 345 (1999) (noting that the Board can only reject medical evidence based on other independent medical evidence).

In *Hamilton v. Derwinski*,⁸⁴ a Veteran who served as a small arms repairman in service filed a claim with VA for service connection for PTSD on the basis of his traumatic experiences in Vietnam.⁸⁵ At no time during the proceedings were any of his claimed stressors verified.⁸⁶ His private therapist sent a letter to VA “recommending further psychiatric examination for personality disorder, alcoholism, and possible PTSD,”⁸⁷ but a VA physician diagnosed atypical personality disorder, a developmental reading disorder, alcohol abuse in remission, and resulting distortions in social adaptation resulting from those diagnoses, and found that the Veteran’s “combat experience and reaction to it” did not support a diagnosis of PTSD.⁸⁸ Following an initial denial of the claim for service connection, the Veteran’s claim was reopened and additional records were obtained showing a diagnosis of “post-traumatic stress disorder, post-Vietnam,” minimal brain dysfunction, and possible mental retardation, as well as a report of a two-day psychiatric commitment to the New Hampshire Hospital with diagnoses of atypical depression and antisocial personality disorder.⁸⁹

On appeal, the Board remanded the claim for a VA psychiatric examination, and the Veteran was diagnosed with PTSD as well as “alcohol abuse, mixed developmental disorder, and stress from the Vietnam War.”⁹⁰ On subsequent remand from the Board, two additional VA psychiatric examiners found that the Veteran “currently clearly meets the diagnostic criteria for post-traumatic stress disorder” and that “there are events and stressors that would be markedly disturbing to almost anyone.”⁹¹ Nevertheless, the Board denied the Veteran’s claim on the basis

⁸⁴ 2 Vet. App. 671 (1992).

⁸⁵ *Id.* at 671-72.

⁸⁶ *Id.* at 672-73.

⁸⁷ *Id.* at 672.

⁸⁸ *Id.*

⁸⁹ *Id.*

⁹⁰ *Id.*

⁹¹ *Id.* at 673 (internal quotation marks omitted).

that all three examiners relied on an uncorroborated history not found elsewhere in the record.⁹² The CAVC found this reason insufficient to justify disregarding the medical opinions obtained on remand and cited the holding in *Colvin* prohibiting the Board from refuting expert medical opinions with its own unsubstantiated medical conclusions.⁹³

However, one year later in *Swann v. Brown*,⁹⁴ the CAVC held that the Board is not bound to accept medical diagnoses of PTSD premised on unverified accounts of events recalled nearly twenty years later.⁹⁵ The Veteran seeking PTSD benefits served in the Air Force in Vietnam as a refueling operator with a supply squadron at Tuy Hoa Air Base.⁹⁶ The following account is quoted from the CAVC's decision:

Appellant claimed that upon arrival to Tan Son Nhut Air Base in Saigon, Vietnam, he was given a series of shots that made him ill. That night he lay in a tent, "nauseated, scared, and hurting with pain and cramps" as a mortar attack went on in the camp. Appellant stated that while everyone else ran to the bunkers, he had to lie there, too ill to move. He recalled the "feeling of helplessness, fear, and pain." The next day, appellant was flown to his permanent station, Tuy Hoa Air Base. He was assigned to the 96th Combat Support Group Base Fuels. He serviced airplanes which he claims he later found out were spraying Agent Orange. In May 1967, during

⁹² *Id.* at 674.

⁹³ *Id.* (citing *Colvin v. Derwinski*, 1 Vet. App. 171, 175 (1991)). In a similar holding, the CAVC held that the Board erroneously relied on its own unsubstantiated medical opinion to buttress a denial of service connection for PTSD. *Cosman v. Principi*, 3 Vet. App. 503, 505-06 (1992). The Board reached its own conclusion that the Veteran's post-service alcoholism, in the absence of other characteristics of PTSD, was not indicative of the existence of the disorder. *Id.* at 506.

⁹⁴ 5 Vet. App. 229 (1993).

⁹⁵ *Id.* at 233.

⁹⁶ *Id.* at 230.

a mortar attack on the base, a mortar concussion knocked him over, and he hurt his knees. He was put on crutches for three weeks. Appellant then related how South Korean Army soldiers (known as the ROKs) killed a Viet Cong and hung the body in a tree near the flight line for weeks. Appellant recalled the sight and smell, seeing the flesh falling from the corpse little by little, and wondering if he would be next.⁹⁷

VA examination resulted in a diagnosis of bipolar disorder by history, in partial remission; no PTSD diagnosis was given.⁹⁸ However, a private psychiatrist who treated the Veteran over eight separate sessions sent a letter to VA diagnosing PTSD, secondary to Vietnam, and a manic type bipolar disorder.⁹⁹ A subsequent VA examination that included formal psychological testing, including the Minnesota Multiphasic Personality Inventory, resulted in diagnoses of PTSD and bipolar disorder by two different VA psychiatrists.¹⁰⁰

The Board initially denied the claim on the basis that the Veteran's occupational specialty, medals for commendable service rather than valor, and the benefit seeking context in which he gave the account of his stressors all weighed against establishing the traumatic events in service.¹⁰¹ The Board also found that the medical evidence did not establish a link between the diagnosis and service, and, further, that the stressors related by the Veteran were insufficient to produce a posttraumatic stress reaction.¹⁰² Following a remand from the CAVC for consideration of additional VA medical evidence, the Board denied the claim a second time on the basis of the lack of extraordinary environmental stress

⁹⁷ *Id.* at 230-31.

⁹⁸ *Id.* at 231.

⁹⁹ *Id.*

¹⁰⁰ *Id.*

¹⁰¹ *Id.*

¹⁰² *Id.*

in service, the considerable passage of time between the alleged stressors and the first diagnosis of PTSD, and the inability of the Veteran to corroborate the accounts of the body in the tree and the mortar attacks with independent evidence.¹⁰³

The CAVC upheld the Board's denial on the basis that the Veteran was not exposed to an extraordinarily stressful environment, and that his "accounts of the two mortar attacks at Tan Son Nhut Air Base and Tuy Hoa Air Base, and of the Viet Cong corpse hanging in the tree, even if true, do not portray situations where appellant was exposed to more than an ordinary stressful environment."¹⁰⁴ The CAVC's own opinion went even further by implying that watching a brutalized human corpse decompose in a tree next to your daily job site over a period of weeks was neither "outside the range of usual human experience" nor "markedly distressing to almost anyone."¹⁰⁵

The holdings in *Hamilton* and *Swann* are difficult to resolve. The Board's failure to apply the combat presumption was one of the bases for the remand in *Hamilton*, but there is no explicit indication that the Board considered the application of the combat presumption in *Swann*.¹⁰⁶ Additionally, the Board's determination on the sufficiency of the stressor in *Hamilton*, though not explicitly a medical question under the law at that time, was arguably a more significant violation of the holding in *Colvin* than its determination that the diagnoses were inadequate since they were based on an allegedly inaccurate history provided by the Veteran.¹⁰⁷

¹⁰³ *Id.* at 232.

¹⁰⁴ *Id.* at 233.

¹⁰⁵ See DSM-III-R, *supra* note 16, § 309.89. At the time the CAVC decided *Swann*, Criterion A of the diagnostic criteria for PTSD in the DSM III-R contained a less specific "objective" standard of having "experienced an event that is outside the range of usual human experience and that would be markedly distressing to almost anyone." *Id.*

¹⁰⁶ *Swann*, 5 Vet. App. at 232-33; *Hamilton v. Derwinski*, 2 Vet. App. 671, 675 (1992).

¹⁰⁷ See *Hamilton*, 2 Vet. App. at 674.

The question of the utility of medical evidence in evaluating the credibility of the stressor was finally squarely addressed in *Moreau v. Brown*.¹⁰⁸ In *Moreau*, the only evidence establishing the stressor claimed by the Veteran, other than his own testimony, was the medical opinions relating his PTSD to the claimed in-service stressor, including one opinion wherein the VA examiner asserted that “I have no doubt as to his honesty in his reports.”¹⁰⁹ The CAVC held that “credible supporting evidence of the actual occurrence of an in-service stressor cannot consist solely” of medical statements finding a veteran credible and relating his PTSD to events experienced in service, or, in other words, “after-the-fact medical nexus evidence.”¹¹⁰

The CAVC, curiously, found that the language of the regulation, requiring both (1) medical nexus evidence *and* (2) credible supporting evidence of the stressor, limited the applicability of medical opinions to the nexus element lest the credible supporting evidence requirement be interpreted out of the regulation.¹¹¹ However, not every statement in a medical opinion constitutes medical nexus evidence, which is strictly the link between the injury claimed and the current diagnosis.¹¹²

¹⁰⁸ 9 Vet. App. 389 (1996).

¹⁰⁹ *Id.* at 395.

¹¹⁰ *Id.* at 396; *accord* *YR v. West*, 11 Vet. App. 393, 397-98 (1998); *Anglin v. West*, 11 Vet. App. 361, 367-68 (1998); *Cohen v. Brown*, 10 Vet. App. 128, 145 (1997). In *Patton v. West*, the CAVC recognized an exception to this rule in cases involving personal assault. 12 Vet. App. 272, 280 (1999). Shortly thereafter, in 2000, 38 C.F.R. § 3.304(f) was proposed to be amended to allow for consideration of evidence other than a veteran’s service records, including certain types of medical evidence, in cases of personal assault. Post-Traumatic Stress Disorder Claims Based on Personal Assault, 65 Fed. Reg. 61,132 (proposed Oct. 16, 2000). In *Menegassi v. Shinseki*, the U.S. Court of Appeals for the Federal Circuit (Federal Circuit) confirmed that under the 2000 amendment to 38 C.F.R. § 3.304(f), now codified at subsection (5), “medical opinion evidence may be submitted for use in determining whether the occurrence of a stressor is corroborated” in PTSD claims involving personal assault. 638 F.3d 1379, 1382 (Fed. Cir. 2011).

¹¹¹ *Moreau*, 9 Vet. App. at 396. See generally Karl N. Llewellyn, *Remarks on the Theory of Appellate Decision and the Rules or Canons About How Statutes Are to Be Construed*, 3 VAND. L. REV. 395 (1950) (presenting the definitive argument on the flexibility of the rules of construction in case law).

¹¹² See 38 C.F.R. § 3.304(f) (2012); see also *Daye v. Nicholson*, 20 Vet. App. 512, 515

Furthermore, § 3.304(f) requires (1) a *DSM* diagnosis of PTSD, (2) medical nexus evidence, *and* (3) credible supporting evidence that the in-service stressor occurred, and it is routine for a medical opinion to establish both the diagnosis and the nexus elements without any question of risk to the integrity of either of those elements.¹¹³

In *Moreau*, the physician's statement on the veteran's credibility could not, by itself, establish any of the elements of a claim for service connection.¹¹⁴ If a statement on a veteran's credibility alone could constitute medical nexus evidence, there would be no limit on the evidence created or even mentioned by a physician that could be characterized as medical nexus evidence during adjudication. This is an absurd result,¹¹⁵ particularly where a broadly interpreted rule excluding consideration of relevant evidence is based on the inclusion and placement of the word "and" to mean that (1) the medical nexus requirement and credible supporting evidence requirement are mutually exclusive such that evidence establishing one element cannot be weighed in favor of the other, and (2) separate statements included in the same document constitute the same evidence where they are from the same source.

(2006) (citing the requirement set forth in § 3.304(f) that "[t]o support a claim for service connection for PTSD, a claimant must present evidence of (1) a current diagnosis of PTSD; (2) credible supporting evidence that the claimed in-service stressor actually occurred; and (3) medical evidence of a causal nexus between the current symptomatology and the claimed in-service stressor").

¹¹³ 38 C.F.R. § 3.304(f).

¹¹⁴ See *Moreau*, 9 Vet. App. at 395-96.

¹¹⁵ For example, veterans will sometimes have photographic evidence related to the claimed in-service stressful event. Under the holding in *Moreau*, any photograph a veteran brings to his medical examination, including a photograph of himself standing in the midst of the devastation caused by a mortar strike in Vietnam, once described by the examiner in the examination report would become medical nexus evidence that could not be used to establish the occurrence of the stressor. See Glen Staszewski, *Avoiding Absurdity*, 81 IND. L.J. 1001, 1064 (2006) (putting forth the argument that "the absurdity doctrine promotes equal protection and due process norms without the serious institutional concerns that would be presented by more aggressive approaches to constitutional adjudication").

II. PITFALLS OF THE QUEST FOR THE PERFECT RULE: THE 2010 LIBERALIZING REGULATION

Since the date of its promulgation, five exceptions have been added to 38 C.F.R. § 3.304(f) to relax the evidentiary requirements needed to establish service connection for PTSD, or, in the case of claims for PTSD premised on personal assault, to provide additional notice and assistance with evidentiary development.¹¹⁶ Overall, the history since the establishment of the credible supporting evidence rule reflects the intent to liberalize the evidentiary requirements for establishing service connection for PTSD by allowing additional categories of veterans to establish the occurrence of the stressor on the basis of their testimony alone.¹¹⁷ In 2010, VA created another exception to the rule for veterans who claimed a stressor related to fear of hostile military or terrorist activity, including exposure to an “improvised explosive device; vehicle-imbedded explosive device; incoming artillery, rocket, or mortar fire; grenade; small arms fire, including suspected sniper fire; or attack upon friendly military aircraft.”¹¹⁸

This regulation was promulgated with the purpose of simplifying development and research for claims filed by

¹¹⁶ See, e.g., Post-Traumatic Stress Disorder Claims Based on Personal Assault, 67 Fed. Reg. 10,330, 10,332 (Mar. 7, 2002) (providing that evidence other than a veteran’s service records, including medical evidence, may corroborate the occurrence of a stressor); Posttraumatic Stress Disorder, 74 Fed. Reg. 14,491 (Mar. 31, 2009) (eliminating the requirement of evidence corroborating the occurrence of the claimed in-service stressor when PTSD is diagnosed in service).

¹¹⁷ Nathaniel J. Doan & Barbara C. Morton, *A New Era for Establishing Service Connection for Posttraumatic Stress Disorder (PTSD): A Proposed Amendment to the Stressor Verification Requirement*, 2 VETERANS L. REV. 249, 254, 257 (2010).

¹¹⁸ Stressor Determinations for Posttraumatic Stress Disorder, 75 Fed. Reg. 39,843, 39,852 (July 13, 2010) (codified at 38 C.F.R. § 3.304(f)(3) (2012)). *Id.* at 39,843 (eliminating the need for corroborating evidence of the in-service stressor when the “stressor claimed by a veteran is related to the veteran’s fear of hostile military or terrorist activity and a VA psychiatrist or psychologist, or a psychiatrist or psychologist with whom VA has contracted, 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, provided that the claimed stressor is consistent with the places, types, and circumstances of the veteran’s service”).

qualifying veterans by acknowledging the inherently stressful nature of serving in an area with ongoing hostile military or terrorist activity.¹¹⁹ Under the new provision, codified at § 3.304(f)(3), a veteran's testimony may establish the occurrence of a stressful event, if consistent with the places, types, and circumstances of his or her service, provided that a VA psychologist or psychiatrist confirmed the sufficiency of a veteran's stressor and related it to his or her symptoms.¹²⁰

A. Rules or Standards?

The 2010 regulation may have been intended to serve as a bright-line rule, but it behaves more like a standard. A rule aims to specify, in advance, the legal outcome of any case adjudicated under the rule, no matter the factual particulars.¹²¹ A standard is a less definite principle that requires the adjudicator to balance competing factors in the context of a particular case after the particular facts of that case are known.¹²² Judge Posner described the difference between rules and standards in the context of contract damages in *Mindgames, Inc. v. Western Publishing Co., Inc.*:¹²³

A rule singles out one or a few facts and makes it or them conclusive of legal liability; a standard permits consideration of all or at least most facts that are relevant to the standard's rationale. A speed limit is a rule; negligence is a standard. Rules have the advantage of being definite and of limiting factual inquiry but the disadvantage of being inflexible,

¹¹⁹ Stressor Determinations for Posttraumatic Stress Disorder, 74 Fed. Reg. 42,617 (proposed Aug. 24, 2009).

¹²⁰ 38 C.F.R. § 3.304(f)(3); Stressor Determinations for Posttraumatic Stress Disorder, 75 Fed. Reg. at 39,843.

¹²¹ Cass R. Sunstein, *Problems with Rules*, 83 CALIF. L. REV. 953, 961-62 (1995).

¹²² Dale A. Nance, *Rules, Standards, and the Internal Point of View*, 75 FORDHAM L. REV. 1287, 1295-96 (2006).

¹²³ 218 F.3d 652 (7th Cir. 2000).

even arbitrary, and thus overinclusive, or of being underinclusive and thus opening up loopholes (or of being *both* over- and underinclusive!). Standards are flexible, but vague and open-ended; they make business planning difficult, invite the sometimes unpredictable exercise of judicial discretion, and are more costly to adjudicate—and yet when based on lay intuition they may actually be more intelligible, and thus in a sense clearer and more precise, to the persons whose behavior they seek to guide than rules would be.¹²⁴

In essence, the practical difference between a rule and a standard is the degree of discretion afforded to the decision maker.¹²⁵ Here, the 2010 regulation exhibits all of the complexity of a standard, as well as the underinclusivity of a rule.

B. A Complex Rule

Factors controlling the complexity of a legal rule include the density of regulation, or how “numerous and encompassing” the legal rules are; the technicality of the subject matter, essentially the degree of “sophistication or expertise” required to understand and apply the rules; the extent of institutional differentiation, or, in other words, the number of relevant authorities creating the rules; and the degree of indeterminacy allowed by the flexibility or multifaceted character of the rule.¹²⁶ The more complex the rule, generally speaking, the greater the transaction costs associated

¹²⁴ *Id.* at 657.

¹²⁵ Frank Cross et al., *A Positive Political Theory of Rules and Standards*, 2012 U. ILL. L. REV. 1, 16.

¹²⁶ Peter H. Schuck, *Legal Complexity: Some Causes, Consequences, and Cures*, 42 DUKE L.J. 1, 3-4 (1992). Schuck also notes that “agency officials possess strong incentives to elaborate legal networks that meet all of [these] complexity criteria. . . . [T]he nature of their tasks ordinarily ensures that their rules will usually be intelligible only to cognoscenti in the field.” *Id.* at 30-31.

with administering it.¹²⁷ Here, VA, like most other agencies, has sought to fill the totality of the regulatory space accorded to veterans' benefits with rules governing all aspects of procedure and substantive decision making, to degrees of varying specificity. Additionally, the degree of necessary expertise and familiarity with the relevant law, medical evidence, and military records is significant.¹²⁸ Further, there are numerous relevant authorities, including the statutory scheme and regular statutory amendments passed by the legislature;¹²⁹ precedent set by the courts that review decisions on benefits claims: the CAVC, the United States Court of Appeals for the Federal Circuit (Federal Circuit), and, ultimately, the Supreme Court of the United States (Supreme Court);¹³⁰ binding opinions issued by the Office of the General Counsel; the formal rules and regulations promulgated by the agency; Memoranda of the Chairman of the Board outlining various procedures; the *M21-1*,¹³¹ and other various interagency memoranda.¹³² These three

¹²⁷ *Id.* at 18.

¹²⁸ For example, when faced with proposed changes to the rating criteria for traumatic brain injury (TBI), the labor union representing VA Regional Office employees objected that "RO employees . . . are generally not brain surgeons with law degrees." James D. Ridgway, *Changing Voices in a Familiar Conversation About Rules vs. Standards: Veterans Law at the Federal Circuit in 2011*, 61 AM. U. L. REV. 1175, 1185 (2012) (citing Ridgway, *supra* note 82, at 284 (quoting the American Federation of Government Employees representative's comments on the proposed rating criteria for TBI). The rules for evaluating the severity of impairment from TBI were amended, with multiple changes made in response to comments received, effective October 23, 2008, and are codified at 38 C.F.R. § 4.124a (2012). Compare Schedule for Rating Disabilities; Evaluation of Residuals of Traumatic Brain Injury (TBI), 73 Fed. Reg. 432, 436-38 (proposed Jan. 3, 2008), with Schedule for Rating Disabilities; Evaluation of Residuals of Traumatic Brain Injury (TBI), 73 Fed. Reg. 54,693, 54,705-708 (Sept. 23, 2008).

¹²⁹ For example, in 2012, Congress passed and the President signed into law the Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012, Pub. L. No. 112-154, 126 Stat. 1165.

¹³⁰ See Paul R. Gugliuzza, *Veterans Benefits in 2010: A New Dialogue Between the Supreme Court and the Federal Circuit*, 60 AM. U. L. REV. 1201, 1202-03 (2011) (raising the possibility that the Supreme Court of the United States is taking more of an interest in veterans' benefits cases; though concluding that it is too early to tell); see also *Henderson v. Shinseki*, 131 S. Ct. 1197 (2011); *Shinseki v. Sanders*, 556 U.S. 396 (2009).

¹³¹ The M21-1 has been revised on multiple occasions since its initial publication. See generally VA ADJUDICATION PROCEDURE MANUAL REWRITE M21-1 MR (2013) [hereinafter M21-1 MR].

¹³² See generally Charles A. Breer & Scot W. Anderson, *Regulation Without Rulemaking*:

factors contributing to complexity are virtually unavoidable in the context of veterans' benefits; the degree of indeterminacy, however, may be directed by the rulemaker.

Here, for reasons born of the best intentions, discussed further below, the multitude of elements that must be negotiated in applying the 2010 liberalizing amendment creates enough additional adjudicatory complexity to frustrate the goal of efficiency and prevent predictable outcomes for veterans filing these claims. The exception does not create the type of bright line rule that facilitates straightforward adjudication; rather, it creates a morass of minor determinations, beginning with an assessment of whether a veteran's claimed stressor involves "fear" and ending with an assessment of whether the claimed stressor is consistent with the "places, types, and circumstances" of his service.¹³³

As explained in the *Federal Register*, the exception requires that four major elements be met, with two of those elements requiring two factual determinations each:

First, the veteran must have experienced, witnessed, or have been confronted by an event or circumstance that involved actual or threatened death or serious injury, or a threat to the physical integrity of the veteran or others, and the veteran's response to the event or circumstance must have involved a psychological or psycho-physiological state of fear, helplessness, or horror. Second, a VA psychiatrist or

The Force and Authority of Informal Agency Action, 47 ROCKY MT. MIN. L. FOUND. § XX.02.5 (2001), <http://www.dgslaw.com/images/materials/379427.pdf> (reviewing informal actions by administrative agencies outside of the scope of APA notice and comment rulemaking); see also *supra* Part I:B (discussing VA's early internal guidelines regarding PTSD claims).

¹³³ 38 C.F.R. § 3.304(f)(3) (2012). "Just as it is a mistake to assume that because some judges ignore rules most judges do so, it is also a mistake to assume that because rules sometimes constrain, they usually constrain." Frederick Schauer, *Formalism*, 97 YALE L.J. 509, 530 (1988).

psychologist, or a psychiatrist or psychologist with whom VA has contracted, must confirm that the claimed stressor is adequate to support a diagnosis of PTSD and that the veteran's symptoms are related to the claimed stressor. Third, there must be in the record no clear and convincing evidence to the contrary, and fourth, the claimed stressor must be consistent with the places, types, and circumstances of the veteran's service.¹³⁴

Where a rule does not clearly delineate the scope of each exception to it, the adjudicator is obligated to make additional factual determinations to rule the facts of a case out or bring the case within the scope of one or more exceptions. It is axiomatic that "as the number of rules increases, the effort and information required to comply with them increase as well,"¹³⁵ but in the context of veterans' benefits adjudication, this effect is multiplied further, due to the "reasons and bases" standard of review on appeal to the CAVC.¹³⁶ All decisions of the Board must include a full statement of the reasons or bases for the findings and conclusions on "all material issues of fact and law presented" in the record on appeal.¹³⁷ The CAVC has interpreted this language as a standard of review on appeal requiring each Board decision to (1) identify and discuss the relevant evidence, (2) identify and discuss the governing law, and (3) fully explain a valid basis for each factual or legal determination made that is not favorable to a veteran.¹³⁸ This standard is unusual as it essentially gives the

¹³⁴ Stressor Determinations for Posttraumatic Stress Disorder, 75 Fed. Reg. 39,843, 39,845 (July 13, 2010) ("Because all of these requirements must be met for the veteran's lay testimony alone to establish the occurrence of the claimed stressor, we believe the likelihood of fraud to be minimal.").

¹³⁵ J.B. Ruhl & James Salzman, *Mozart and the Red Queen: The Problem of Regulatory Accretion in the Administrative State*, 91 GEO. L.J. 757, 759 (2003).

¹³⁶ See *supra* note 56 and accompanying text.

¹³⁷ 38 U.S.C. § 7104(d)(1) (2006).

¹³⁸ James D. Ridgway, *Why So Many Remands?: A Comparative Analysis of Appellate Review by the United States Court of Appeals for Veterans Claims*, 1 VETERANS L. REV. 113, 136 (2009) (citing *Abernathy v. Principi*, 3 Vet. App. 461, 465 (1992), *Fallo v.*

CAVC an opportunity to pre-review the case and find it wanting if the reasons for every factual and legal determination are not clearly explained in the decision.

Furthermore, in practice, the reasons and bases standard of review shifts the burden from the appellant to the Board, which must essentially prove that the determination made on each issue of fact or law raised in the case was correct.¹³⁹ It has been observed that this standard is “one of the most demanding rubrics of appellate review known in the American legal system.”¹⁴⁰ Unsurprisingly, it is a very time-consuming standard to meet, and has resulted in substantial increases in the time required to decide a case before the Board.¹⁴¹ If this standard is not met, claims are often remanded for additional development prior to final adjudication, perhaps multiple times, a process that has been described as the veterans’ benefits “hamster wheel.”¹⁴² Since the rate of affirmance on appeal drops as the level of complexity rises, the wheel spins ever longer and faster, and, if the case becomes increasingly more complex every time it is appealed to the CAVC, statistical trends indicate that the Board’s decision may be

Derwinski, 1 Vet. App. 175, 177 (1991); Gilbert v. Derwinski, 1 Vet. App. 49, 57 (1991); Sammarco v. Derwinski, 1 Vet. App. 111, 113-14 (1991)). “The statement must be adequate to enable a claimant to understand the precise basis for the Board’s decision, as well as to facilitate review in this Court.” Allday v. Brown, 7 Vet. App. 517, 527 (1995).

¹³⁹ Ridgway, *supra* note 138, at 137 (explaining that “the reasons or bases requirement gives the CAVC broad license to remand cases if it is not comfortable that the [Board] fully considered all potential theories or procedures in support of the claim”).

¹⁴⁰ Ridgway, *supra* note 82, at 273; see generally *Why Are Veterans Waiting Years on Appeal?: A Review of the Post-Decision Process for Appealed Veterans’ Disability Benefits Claims: Hearing Before the H. Subcomm. on Disability Assistance and Memorial Affairs of the H. Comm. on Veterans’ Affairs*, 113th Congress (June 18, 2013) (Submission For The Record of James D. Ridgway, Professorial Lecturer in Law, George Washington University Law School) (discussing the system effects of the VJRA and the resulting legal complexity of veterans’ law).

¹⁴¹ “[T]he expanded ‘reason or bases’ requirement of the VJRA . . . resulted in the need for more formal, complex and lengthier Board decisions.” Bill Russo, *Ten Years After the Battle for Veterans Judicial Review: An Assessment*, 46 FED. L. 26, 28 (1999) (alteration in original) (quoting Charles L. Cragin, former Chairman of the Board).

¹⁴² Coburn v. Nicholson, 19 Vet. App. 427, 434 (2006) (Lance, J., dissenting).

progressively less likely to be affirmed.¹⁴³

C. An Inflexible Standard

In the comments to the rulemaking proposed on August 24, 2009, and adopted as a final rule effective July 13, 2010, one commenter raised an objection to the list of examples likely to cause “fear of hostile military or terrorist activity” on the grounds that it would result in the rejection of stressors from events like the injuring or killing of civilians.¹⁴⁴ VA disagreed, and explained that inclusion of the language “actual or threatened death or serious injury, or a threat to the physical integrity of the veteran *or others*” is not limited to military personnel and would include actual or threatened death, injury, or threat to the physical integrity of civilians, as members of the class of “others.”¹⁴⁵ The comments also note that the proposed rule specifically referred to stressors based on “constant vigilance against unexpected attack, the absence of a defined front line, the difficulty of distinguishing enemy combatants from civilians, the ubiquity of improvised explosive devices, caring for the badly injured or dying, duty on the graves registration service, and being responsible for the treatment of prisoners of war,” quoting from the Institute of Medicine’s (IOM’s) study of veterans with PTSD who served in Vietnam, the Gulf War, Operation Enduring Freedom, and Operation Iraqi Freedom.¹⁴⁶

¹⁴³ See Ridgway, *supra* note 138, at 119. The effect of multiplying PTSD regulations is just as analogized by J.B. Ruhl and James Salzman in their 2003 article on the complex systems effects caused by regulatory accretion: “Like Lewis Carroll’s Red Queen, we seem to run faster and faster only to keep from falling further behind.” Ruhl & Salzman, *supra* note 135, at 769 (quoting Robert A. Kagan, *What Socio-Legal Scholars Should Do When There Is Too Much Law to Study*, 22 J.L. & Soc’y 140, 140 (1995)).

¹⁴⁴ Stressor Determinations for Posttraumatic Stress Disorder, 75 Fed. Reg. 39,843, 39,844 (July 13, 2010); Stressor Determinations for Posttraumatic Stress Disorder, 75 Fed. Reg. 41,092 (July 15, 2010) (correcting the effective and applicability dates from July 12, 2010, to July 13, 2010).

¹⁴⁵ Stressor Determinations for Posttraumatic Stress Disorder, 75 Fed. Reg. at 39,844 (internal quotation marks omitted).

¹⁴⁶ *Id.* at 39,845 (quoting Stressor Determinations for Posttraumatic Stress Disorder, 74 Fed. Reg. 42,617, 42,618 (proposed Aug. 24, 2009); INST. OF MED., GULF WAR

This response does not fully address the effect of the operative limiting word in the regulation, which is “fear.” Furthermore, the proposed rule actually omitted the examples of caring for the injured or dying, duty on the graves registration service, and treatment of prisoners of war from the quotation taken from the IOM study.¹⁴⁷ Consequently, as these examples were not considered as part of the context for the proposed rule during the notice and comment period, and, further, do not involve fear of any hostile activity, it is difficult to see how the scope of the regulation could be expanded to apply to veterans dealing with symptoms from the types of experiences discussed by the commentator.

Indeed, subsequent case law shows that any interpretation relaxing the meaning of “fear of hostile military or terrorist activity” enough to allow for consideration of claims not listed among the examples provided under 38 C.F.R. § 3.304(f)(3) is likely to be narrow. In the recent decision in *Hall v. Shinseki*,¹⁴⁸ the Federal Circuit held that “§ 3.304(f)(3) can apply only if a veteran’s claimed in-service PTSD stressor relates to an event or circumstance that a veteran experienced, witnessed, or was confronted with and that was perpetrated by a member of an enemy military or by a terrorist,”¹⁴⁹ despite the explicit statement in the published notice of the final rule that the regulation “is not limited to any particular class of individuals.”¹⁵⁰

The Federal Circuit explained that this holding was not at odds with the response to the public comments published with the final rule, finding that the purpose of that response was to extend the scope of the regulation to enemy action against civilians and

AND HEALTH, VOL. 6: PHYSIOLOGIC, PSYCHOLOGIC, AND PSYCHOSOCIAL EFFECTS OF DEPLOYMENT-RELATED STRESS 2 (2008) [hereinafter IOM STUDY].

¹⁴⁷ Stressor Determinations for Posttraumatic Stress Disorder, 74 Fed. Reg. at 42,618; see IOM STUDY, *supra* note 146, at 2.

¹⁴⁸ 717 F.3d 1369 (Fed. Cir. 2013).

¹⁴⁹ *Id.* at 1372.

¹⁵⁰ Stressor Determinations for Posttraumatic Stress Disorder, 75 Fed. Reg. at 39,844.

domestic activity carried out by a domestic enemy.¹⁵¹ Although the statement of the commentator, as described in the comments on the final rule, does not indicate whether the hypothetical situations envisioned were restricted to the killing of civilians by the enemy only,¹⁵² or included deaths caused by the veteran or other service members, review of the scientific literature indicates that limiting the issue to the former situation ignores what is possibly the most significant established cause of PTSD.¹⁵³

As a policy matter, this is a significant regulatory oversight. The National Center for PTSD's quarterly journal reported that combat guilt from killing was the most significant predictor of both suicide attempts and a preoccupation with suicide.¹⁵⁴ Killing, regardless of role, has been found to be a better predictor of chronic PTSD symptoms than other indicators.¹⁵⁵ Even when "controlling for combat exposure, taking another life was a significant predictor of PTSD symptoms, alcohol abuse, anger, and relationship problems among Iraq War veterans."¹⁵⁶ As an example, Karl Marlantes, a decorated Vietnam Veteran and author of the best-selling Vietnam War novel *Matterhorn*, tells a story in his

¹⁵¹ *Hall*, 717 F.3d at 1372-73.

¹⁵² Stressor Determinations for Posttraumatic Stress Disorder, 75 Fed. Reg. at 39,844. The Federal Circuit essentially defines "hostile" as limited to only (1) military activity by a member of enemy forces or (2) terrorist activity. *Hall*, 717 F.3d at 1372 (explaining that the examples listed in the regulation, read in conjunction with the context surrounding the use of the word "hostile," "indicate that the 'event or circumstance' must have been part of terrorist activity (which is innately hostile) or part of enemy military activity (since only enemy, not friendly forces, are hostile)") (quoting 38 C.F.R. § 3.304(f)(3)).

¹⁵³ See, e.g., Shira Maguen & Brett Litz, *Moral Injury in Veterans of War*, 23 PTSD RESEARCH Q. 1, 2 (2012) (noting that killing and injuring others had an association with PTSD even when there was broader exposure to combat); Brett T. Litz et al., *Moral Injury and Moral Repair in War Veterans: A Preliminary Model and Intervention Strategy*, 29 CLINICAL PSYCHOL. REV. 695, 697-98 (2009) (discussing the relationship between killing others and PTSD).

¹⁵⁴ Maguen & Litz, *supra* note 153, at 2.

¹⁵⁵ Litz et al., *supra* note 153, at 697; see DAVE GROSSMAN, ON KILLING: THE PSYCHOLOGICAL COST OF LEARNING TO KILL IN WAR AND SOCIETY (rev. ed. 2009) (providing an overview of the psychological cost of reducing the natural aversion to killing through conditioning).

¹⁵⁶ Litz et al., *supra* note 153, at 697.

memoir in which he was asked by a counselor to role play talking to the family of the enemy soldier he killed while attending a group therapy weekend with his wife.¹⁵⁷ He was initially angry, but suddenly found himself “wailing like a frightened child” as a result of the unexpected “torrent of terrible memories and remorse.”¹⁵⁸ These sobbing spells continued for the next thirty years.¹⁵⁹

Some researchers have characterized this type of disorder as “moral injury,” which, much like PTSD, involves reconciling dissonance.¹⁶⁰ In cases of moral injury, dissonance is created by an act of transgression that violates deeply held ethical beliefs.¹⁶¹ This dissonance has been described as follows:

[M]oral injury involves an act of transgression that creates dissonance and conflict because it violates assumptions and beliefs about right and wrong and personal goodness. How this dissonance or conflict is reconciled is one of the key determinants of injury. If individuals are unable to assimilate or accommodate (integrate) the event within existing self- and relational-schemas, they will experience guilt, shame, and anxiety about potential dire personal consequences (e.g., ostracization). Poor integration leads to lingering psychological distress, due to frequent intrusions, and avoidance behaviors tend to thwart successful accommodation.¹⁶²

Specific diagnosis based on these types of symptoms may eventually evolve into another differentiated diagnosis alongside PTSD now that in the *DSM-5*, PTSD has been removed from the

¹⁵⁷ KARL MARLANTES, *WHAT IT IS LIKE TO GO TO WAR* 49-50 (2011).

¹⁵⁸ *Id.* at 50.

¹⁵⁹ *Id.*

¹⁶⁰ See generally Maguen & Litz, *supra* note 153 (describing the concept of moral injury); Litz et al., *supra* note 153 (further describing the concept of moral injury).

¹⁶¹ Litz et al., *supra* note 153, at 698.

¹⁶² *Id.*

category of anxiety disorders and placed into a new category of “Trauma- and Stressor-Related Disorders.”¹⁶³ However, at this time, no differentiation between “moral injury” and PTSD appears to exist in either the *DSM-IV* or the *DSM-5*.¹⁶⁴ As a result, any current regulation governing benefits for PTSD should aim to account for this type of posttraumatic disorder as a matter of policy due to its sheer prevalence and the severity of the consequences of failing to treat these veterans.¹⁶⁵ Consequently, any regulation promulgated for the purposes of (1) ensuring that VA’s adjudication process for PTSD claims is consistent with the current medical science and (2) simplifying and improving the PTSD claims adjudication process that excludes PTSD claims associated with guilt, shame, anxiety, or similar symptoms resulting from events associated with moral injury is manifestly underinclusive.¹⁶⁶

D. Pitfalls of Administrative Rules: The Framing Effect, Excessive Tailoring and Regulatory Accretion

The problems with 38 C.F.R. § 3.304(f)(3) outlined above are not particular to this situation, but have been observed to result from the process of agency rulemaking generally. In deciding how best to create policy, administrative agencies generally have a choice between agency rulemaking and agency adjudication.¹⁶⁷ Rulemaking is viewed as the better procedure for weighing policy concerns and investigating issues of fact before adopting

¹⁶³ See *DSM-IV*, *supra* note 16, § 309.81; *DSM-5*, *supra* note 16, § 309.81.

¹⁶⁴ *DSM-IV*, *supra* note 16, § 309.81; *DSM-5*, *supra* note 16, § 309.81.

¹⁶⁵ See DUBYAK, *supra* note 20, at 680-82 (detailing the significant social and economic costs of untreated PTSD).

¹⁶⁶ See *id.* at 675-78 (providing a more thorough discussion of the underinclusiveness of 38 C.F.R. § 3.304(f)(3)).

¹⁶⁷ The benefits and drawbacks of either approach have been discussed at length in the scholarly literature. See generally Warren E. Baker, *Policy by Rule or Ad Hoc Approach—Which Should It Be?*, 22 LAW & CONTEMP. PROBS. 658 (1957) (discussing and comparing the two approaches); Ronald A. Cass, *Models of Administrative Action*, 72 VA. L. REV. 363 (1986) (same); Jeffrey J. Rachlinski, *Rulemaking Versus Adjudication: A Psychological Perspective*, 32 FLA. ST. U. L. REV. 529 (2005) (same); David L. Shapiro, *The Choice of Rulemaking or Adjudication in the Development of Administrative Policy*, 78 HARV. L. REV. 921 (1965) (same).

a rule that comprehensively decides “a large number of related claims.”¹⁶⁸ However, while rulemaking is inherently an exercise in line-drawing that will always result in rules that are overinclusive or underinclusive,¹⁶⁹ or both, adjudicatory proceedings allow for individualized application of the relevant law to the specific factual circumstances of a particular case.¹⁷⁰

Additionally, the cognitive features of different regulatory problems will tend to lead to particular types of solutions.¹⁷¹ For example, where, as with the revisions to § 3.304(f)(3), the agency must make a decision between different scenarios expected to lead to different levels of positive gain, as opposed to a decision between avoiding two different levels of expected loss, decision makers will exhibit a bias toward making risk-averse choices.¹⁷² This framing effect¹⁷³ would predict that a rule framed as “liberalizing” the evidentiary standards in a claim for service connection for PTSD would be conservative in scope, a prediction that is realized by the language of § 3.304(f)(3).¹⁷⁴

¹⁶⁸ Cass, *supra* note 167, at 394; see Lumen N. Mulligan & Glen Staszewski, *The Supreme Court's Regulation of Civil Procedure: Lessons from Administrative Law*, 59 UCLA L. REV. 1188, 1207-15 (2012) (providing a concise overview of the benefits of rulemaking over adjudication).

¹⁶⁹ See *Haas v. Peake*, 525 F.3d 1168, 1193 (Fed. Cir. 2008).

¹⁷⁰ Jim Rossi, *Making Policy Through the Waiver of Regulations at the Federal Energy Regulatory Commission*, 47 ADMIN. L. REV. 255, 275 (1995).

Of course, no one argues that rulemaking should be favored in all instances. An inherent value to adjudication is its particularism, which is antithetical to rulemaking. In many instances, particularism may be preferable to generic rules. For example, when due process considerations demand individualized determinations, agencies should be required to proceed by adjudication rather than by rulemaking.

Id. at 275 n.99.

¹⁷¹ See generally Rachlinski, *supra* note 167 (discussing the various cognitive limitations of adjudication and rulemaking).

¹⁷² See *id.* at 533-34.

¹⁷³ See generally Amos Tversky & Daniel Kahneman, *The Framing of Decisions and the Psychology of Choice*, 211 SCIENCE 453 (1981) (discussing how the framing of an issue can affect how it is perceived).

¹⁷⁴ 38 C.F.R. § 3.304(f)(3) (2012). For example, the majority of comments received in response to the proposed rule disagreed with the requirement that the diagnosing

Similarly, when engaged in rulemaking, as opposed to adjudication, the agency will not have the benefit of seeing the issue repeatedly in different contexts; rather, the rulemaking authority will likely frame the problem by reference to the status quo, and, as described above, the cost of change is expected to be privileged over any expected benefit.¹⁷⁵ Conversely, an adjudicator will be presented with an ever-varying array of frames, which can significantly reduce the incidence of any framing effect bias.¹⁷⁶ The exposure to multiple frames is not only valuable for reasons of variability; repetition of similarities in the factual situations presented allows for the fact finder to take full advantage of the “remarkable human ability to categorize.”¹⁷⁷ Agencies engaged primarily in rulemaking, on the other hand, cannot rely on the adjudicator’s innate ability of pattern recognition or the inferential process of identifying sensible categories.¹⁷⁸

professional be affiliated with VA as they believed it was too restrictive. See Stressor Determinations for Posttraumatic Stress Disorder, 75 Fed. Reg. 39,843, 39,846-849 (July 13, 2010); see also Dubyak, *supra* note 20, at 676-78 (outlining the main problems with the “VA psychiatrist or psychologist” requirement).

¹⁷⁵ Rachlinski, *supra* note 167, at 546-47.

¹⁷⁶ *Id.*

¹⁷⁷ *Id.* at 549. Modern theories of categorization in the brain generally follow either the prototype model or the exemplar model. The prototype model posits that all members of a category do not seem to have equal status as members, generally featuring either a best example that serves as a cognitive reference point or a concept of a central statistical tendency. See generally Michael I. Posner & Steven W. Keele, *On the Genesis of Abstract Ideas*, 77 J. EXPERIMENTAL PSYCHOLOGY 353 (1968) (describing the prototype as a central tendency). The exemplar model explains categorization by reference to the similarity of the item to be categorized with a number of specific instances, perhaps as many as we can readily access, in the category. See generally WILLIAM K. ESTES, CLASSIFICATION AND COGNITION (1994) (reviewing the adaptive network model of cognition and the exemplar model of categorization); Lance J. Rips et al., *Concepts and Categories: Memory, Meaning, and Metaphysics*, in THE OXFORD HANDBOOK OF THINKING AND REASONING 177, 183-85 (Keith J. Holyoak & Robert G. Morrison eds., 2012) (comparing the prototype and exemplar models).

¹⁷⁸ Rachlinski, *supra* note 167, at 546-47. “The human brain seems quite adept at identifying patterns. Experts on artificial intelligence have as yet been unable to simulate the human power to identify structures and patterns. . . . In the development of the common law . . . judges have relied heavily on pattern recognition abilities.” *Id.* at 549.

Critically, the very expertise gained by an agency during the investigative fact finding that accompanies the proposal and final publication of a rule may lead to overconfidence.¹⁷⁹ The ability to adopt any solution deemed to be the best resolution of the issue, combined with the detailed and nuanced understanding of the scientific evidence and competing policy concerns that come with the expertise acquired during the fact finding process, can result in excessive tailoring of the rule.¹⁸⁰ Excessive tailoring may result in a solution so linked to the details of the specific situation considered by the rulemaking body that the rule might ultimately “fail to address the broader social problem” that was the initial stated reason for its creation.¹⁸¹ In other words, a resulting rule that is too complex to allow for simple and predictable resolution of the issue and too underinclusive to fully address the policy goals justifying its promulgation is the predictable result of creating yet another standard intended to provide some advantage to certain claimants over the status quo in an area subject to varied and constantly fluctuating factual scenarios.

And yet, agencies will continue to promulgate more rules. Regulatory growth is the rule, not the exception.¹⁸² This phenomenon is known as the problem of regulatory accretion, that is, the tendency of law and regulation to beget ever more law and regulation, and it is a natural consequence of a rule-based system.¹⁸³ However, accretion creates additional burdens. This effect is not limited to “effort burdens,” the straightforward increase in effect caused by having to do the same thing twice instead of once, but also includes “information burdens,” the need to acquire the data, evidence, or information to plug into the

¹⁷⁹ *Id.* at 547-49.

¹⁸⁰ *Id.* at 547-48 (explaining excessive tailoring in rulemaking by analogy to the tendency of multiple regression analyses to “overfit” the data).

¹⁸¹ *Id.* at 547.

¹⁸² *See* Ruhl & Salzman, *supra* note 135, at 775.

¹⁸³ *See id.* at 776-82 (explaining why the forces of culling, deregulation, and ossification fail to counteract or balance the effects of regulatory accretion).

regulatory equation.¹⁸⁴ Additional fact finding effort is involved, and, critically, with every additional variable, the fact finder will run up against the same problems with the quality and availability of the evidence.¹⁸⁵ Consequently, even though the regulation promulgated in 2010 was intended to reduce the need for available evidence, it is unlikely to have the effect intended, as it created four elements, two with subparts, which require evidentiary findings before the benefit of the rule can be applied.¹⁸⁶

Lastly, regulatory accretion leads to “system burdens,” or the way in which an increasing number of rules creates not only the need for additional effort and additional information, but also increases the number of interactions *between* the rules, creating the possibility of compounding effort burdens, increasingly complex information burdens, and, perhaps most distressingly, *more rules*.¹⁸⁷ Consider the clause of the 2010 regulation that provides that the claimed stressor must be “consistent with the places, types, and circumstances of the veteran’s service.”¹⁸⁸ VA’s responses to the comments to the proposed rule indicate that the

¹⁸⁴ *Id.* at 799.

¹⁸⁵ Ruhl and Salzman address these problems:

The data may be prone to error, or there may be errors in the collection and communication of the data. The data may be subject to time lag fluctuations, bottlenecks, and other costs not associated solely with the problem-solver’s effort. Even where no individual problem imposes unreasonable error or cost constraints, the aggregate exercise of collecting data subject to quality problems may expose the problem-solver to significant risk of failure, regardless of effort. Even so, the stoic problem-assigner may decide that the information demanded is necessary and the number of problems is appropriate, so it is up to the problem-solver, if it wishes to be considered a good apple, to “go the extra mile” to find more accurate and efficient ways of gathering the data.

Id.

¹⁸⁶ 38 C.F.R. § 3.304(f)(3) (2012); Stressor Determinations for Posttraumatic Stress Disorder, 75 Fed. Reg. 39,843, 39,845 (July 13, 2010).

¹⁸⁷ Ruhl & Salzman, *supra* note 135, at 800-06 (providing a summarized description of system burdens).

¹⁸⁸ 38 C.F.R. § 3.304(f)(3).

rule that the claimed stressor must be “consistent with the places, types, and circumstances of the veteran’s service,” consistent with 38 U.S.C. § 1154(a), is not meaningfully different from the “circumstances, conditions, or hardships of . . . service” standard stated in the combat presumption provided to veterans claiming diseases, events, or injuries that happened during combat service under 38 U.S.C. § 1154(b)¹⁸⁹ and 38 C.F.R. § 3.304(d),¹⁹⁰ when applied to the context of claims for service connection to PTSD under the exception in 38 C.F.R. § 3.304(f)(3), which would erode the distinction between § 1154(a) and 1154(b).¹⁹¹ Further, the same rulemaking also states an explicit requirement that *all three* criteria, i.e., (1) places, (2) types, and (3) circumstances of service, must be consistent with the stressor,¹⁹² which looks more like a step-by-step analysis than a holistic assessment of the totality of the evidence under § 1154(a), thereby complicating the existing legal interpretation of that statutory section.

Furthermore, that interpretation also implies that the disjunctive conjunction “or” in the aforementioned combat presumption is invested with meaning, though that meaning would create two very different standards. A greater degree of consistency would be required to meet the elements of the exception to the credible supporting evidence rule under 38 C.F.R. § 3.304(f)(3) than would be required to meet the elements of the combat presumption, even though a veteran who is entitled to the combat presumption, like a veteran who meets the criteria of § 3.304(f)(3), does not need to show credible supporting evidence of the claimed stressor under § 3.304(f)(2).¹⁹³ Lastly, the response in the *Federal Register* providing the interpretation that all three parts of the time, place, and circumstances of service requirement

¹⁸⁹ 38 U.S.C. § 1154(b) (2006).

¹⁹⁰ 38 C.F.R. § 3.304(d).

¹⁹¹ See *Stressor Determinations for Posttraumatic Stress Disorder*, 75 Fed. Reg. at 39,845.

¹⁹² *Id.*

¹⁹³ See 38 C.F.R. § 3.304.

must be met¹⁹⁴ cited to *Watson v. Department of Navy*,¹⁹⁵ a case on appeal from the Merit Systems Protection Board.¹⁹⁶ This citation to case law arising from a dispute before a different federal agency creates another possible rule allowing for the establishment of precedentially binding rules of interpretation across areas of law under the jurisdiction of the Federal Circuit, and one with a high propensity for burdensome system effects given the number of enumerated lists of criteria present in the statutes and regulations governing veterans' disability compensation benefits. The barrier created between PTSD claims and claims for other psychiatric disorders during development and adjudication is another example of system burdens created by not only the addition, but also the interaction of rules.

III. OLD RULES MEET NEW NOSOLOGY: CLEMONS AND PROBLEMS WITH ALTERNATIVE PSYCHIATRIC DIAGNOSES

There are special considerations to working effectively with the principles of medical and scientific disciplines that are as rapidly developing and constantly subject to progressive revision and change as psychiatry and psychology.¹⁹⁷ The discovery

¹⁹⁴ Stressor Determinations for Posttraumatic Stress Disorder, 75 Fed. Reg. at 39,844.

¹⁹⁵ 262 F.3d 1292 (Fed. Cir. 2001).

¹⁹⁶ *Id.* at 1295.

¹⁹⁷ Cf. Cia Bearden, *The Reality of the DSM in the Legal Arena: A Proposition for Curtailing Undesired Consequences of an Imperfect Tool*, 13 Hous. J. HEALTH L. & POL'Y 79 (2012) (discussing the development, uses, and criticisms of the *DSM*). As Bearden points out,

[T]he *DSM-III* contained cautionary language regarding its reliability in the treatment of mental illness, stating that, making a *DSM-III* diagnosis represents an initial step in a comprehensive evaluation leading to the formulation of a treatment plan. Additional information about the individual being evaluated beyond that required to make a *DSM-III* diagnosis will invariably be necessary.

Id. at 83 (internal quotation marks omitted).

of multiple psychiatric diagnoses in the record may represent disagreement between mental health professionals, correction of an earlier diagnosis, progression of the disorder into a different diagnosis, revision to the diagnostic categories due to increased medical or scientific knowledge of the relevant disorders, or multiple morbidities.¹⁹⁸ Further, these changes are expected to progressively represent foundational shifts to the entire medical classification system, or nosology, underlying the current psychiatric diagnostic categories.¹⁹⁹ Consequently, a commitment to careful development, consideration, and adjudication of diagnostic issues is particularly important in the context of claims for benefits for psychiatric disorders. Conversely, the “credible supporting evidence of the stressor” requirement in a PTSD claim has built an artificial wall premised on the existence of clearly delineated and stable diagnostic categories that is not supported by medical science and results in inefficient and inaccurate processing of psychiatric claims.

¹⁹⁸ *Id.* at 90.

Compounding this issue is the instance of multiple disorders with the same or similar symptoms (particularly notable in the areas of depression and anxiety). Comorbidity (the concurrent existence of more than one illness) occurs when a patient meets the baseline criteria for multiple diagnoses. Because all symptoms are weighted equally, and many symptoms give rise to a multitude of diagnoses, “[t]here are several hundred statistically possible variations and combinations of symptom patterns that could, conceivably, meet diagnostic criteria.”

Id. (alteration in original) (footnotes omitted) (quoting Larry E. Beutler & Mary L. Malik, *Diagnosis and Treatment Guidelines: The Example of Depression*, in *RETHINKING THE DSM: A PSYCHOLOGICAL PERSPECTIVE* 251, 255 (Larry E. Beutler & Mary L. Malik eds., 2002)).

¹⁹⁹ See generally Eric D. Jackson, *Organizing Madness: Psychiatric Nosology in Historical Perspective*, 4 *INQUIRY* 63 (2003) (providing an overview of the historical development of psychiatric nosology from the nineteenth century to the *DSM-IV*); Randolph M. Nesse & Dan J. Stein, *Towards a Genuinely Medical Model for Psychiatric Nosology*, 10 *BMC MED.* 5 (2012) (discussing the limitations the current DSM categories place on nosological progress and proposed solutions).

A. Scope of Claims and Multiple Diagnoses

Psychiatry “has taken a largely descriptive and categorical approach to diagnosis.”²⁰⁰ Psychiatrists evaluate constellations of symptoms to establish diagnoses, resulting in what is still, in many ways, “a practical art with scientific aspirations.”²⁰¹ However, the reliance on descriptive criteria to determine a diagnosis does not mean that psychiatry is not concerned with establishing the etiology of mental disorders; “[r]ather, it represents a strategic mode of dealing with the frustrating reality that, for most of the disorders [psychiatrists] currently treat, there is only limited evidence for their etiologies.”²⁰² Or, in other words, the need for a system of diagnosis ensures that even “if all the king’s horses and all the king’s men cannot quite put the psychiatric Humpty Dumpty together, we can be sure they will continue trying.”²⁰³

A psychiatric diagnosis, in other words, is less a conclusive identification of a disorder than a clinical measure of the disorder the psychiatrist is trying to assess.²⁰⁴ This is not to say that important advances are not frequently made. Most recently, the decision to include a dimensional diagnosis component in the *DSM-5*,²⁰⁵ as well as the contributions of neuroscience to the understanding of the etiology of psychiatric illness, “rendering artificial the boundary between psychiatry and neurology,”²⁰⁶ are expected to dramatically increase the clinical and scientific utility of *DSM* diagnosis.²⁰⁷

²⁰⁰ Reynolds, III et al., *supra* note 9, at 447.

²⁰¹ Leston Havens, *Historical Perspectives on Diagnosis in Psychiatry*, 26 *COMPREHENSIVE PSYCHIATRY* 326, 334 (1985).

²⁰² Dan J. Stein, *Philosophy and the DSM-III*, 32 *COMPREHENSIVE PSYCHIATRY* 404, 408 (1991) (internal quotation marks omitted).

²⁰³ Havens, *supra* note 201, at 334.

²⁰⁴ Helena Chmura Kraemer, *DSM Categories and Dimensions in Clinical and Research Contexts*, 16 *INT’L J. METHODS PSYCHIATRIC RES.* S8, S8 (2007).

²⁰⁵ *DSM-5*, *supra* note 16, at 12-13.

²⁰⁶ Reynolds, III et al., *supra* note 9, at 446.

²⁰⁷ See *DSM-5*, *supra* note 16, at 12-13.

Dimensional diagnosis is a revision to the binary, categorical approach psychiatry has taken to symptom assessment and diagnosis in previous versions of the *DSM*.²⁰⁸ A dimensional diagnosis will list all of the patient's symptoms, not just those matching the criteria for the diagnosed disorder, and will assess the severity of those symptoms as part of the initial assessment.²⁰⁹ The *DSM* will still allow for the sole use of categorical diagnosis for clinicians who prefer that diagnostic method, but a dimensional component, as a scientific matter, will continue to add value in the form of meaningful statistical variations between individuals within the same diagnostic category.²¹⁰ Critically, dimensional diagnoses allow for clinicians to account for multi-morbidity, frequently seen in cases of, for example, major depressive episode comorbid with generalized anxiety disorder and antisocial personality disorder comorbid with substance abuse. Dimensional diagnoses also facilitate the identification of "cross-cutting" symptoms, like panic attacks, currently grouped with anxiety disorders but seen across several types of psychiatric disorders.²¹¹

²⁰⁸ See Kraemer, *supra* note 204, at S10. Kraemer discusses categorical versus binary diagnoses further:

A categorical diagnosis (at least in the way that term is used in DSM) has only two values: The patient is either positive (thought to have the disorder) or negative (thought not to have the disorder). Generally a categorical measure is one with two or more discrete non-ordered responses, and, technically, DSM uses binary diagnoses, but to avoid confusion we will continue to use the term most often used: categorical diagnosis.

Id.

²⁰⁹ See Fact Sheet, Am. Psychiatric Ass'n, Section III (2013), <http://www.psychiatry.org/File%20Library/Practice/DSM/DSM-5/DSM-5-Section-III.pdf>.

²¹⁰ Kraemer, *supra* note 204, at S11 (explaining that a dimensional diagnosis is "virtually never" unneeded or impossible and that, for purposes of research and treatment, dimensional diagnoses will allow researchers to determine if, for instance, different treatment options, like cognitive behavioral therapy versus self-help, are more effective for patients with different levels of severity of symptoms associated with the diagnosed disorder).

²¹¹ See Robert F. Krueger & Serena Bezdjian, *Enhancing Research and Treatment of Mental Disorders with Dimensional Concepts: Toward DSM-V and ICD-11*, 8 *WORLD PSYCHIATRY* 3, 5 (2009).

Consequently, while understandable given the relative advancements in psychiatry at that time, VA may have been excessively optimistic in citing the “rapid and profound” advances made in psychiatry that “extended to the entire medical profession a better understanding of and deeper insight into the etiological factors, psychodynamics, and psychopathological changes” to justify the incorporation of the *DSM* categories into the rating code in 1976.²¹² The effect of changes in diagnosis had been discussed in the rating code since 1961 under 38 C.F.R. § 3.344, and “[r]ating boards encountering a change of diagnosis” were advised to “exercise caution in the determination as to whether a change in diagnosis represents no more than a progression of an earlier diagnosis, an error in prior diagnosis or possibly a disease entity independent of the service-connected disability.”²¹³ In 1988, this instruction was restated in a separate section under § 4.128, in essentially the same language, emphasizing the importance of paying attention to changes in diagnosis when rating psychiatric disabilities.²¹⁴

In 1995, VA proposed to alter the language slightly to reflect current medical terminology and combined this provision with the new rule explicitly requiring a remand for a new examination where the diagnosis provided failed to conform with the *DSM* under § 4.125.²¹⁵ The new regulation required determination of whether a change in diagnosis was a “progression of the prior diagnosis, correction of an error in the prior diagnosis, or development of a new and separate condition.”²¹⁶ Commenters on the proposed rule suggested that VA add a fourth reason of “the

²¹² Extension of Convalescent Rating Periods, 41 Fed. Reg. 34,256, 34,258 (Aug. 13, 1976).

²¹³ Title 38—Pensions, Bonuses, and Veterans’ Relief, 26 Fed. Reg. 1561, 1587 (Feb. 24, 1961).

²¹⁴ Nomenclature and Descriptive Terms for Mental Disorders, 53 Fed. Reg. 21, 23 (Jan. 4, 1988).

²¹⁵ Schedule for Rating Disabilities; Mental Disorders, 60 Fed. Reg. 54,825, 54,826 (proposed Oct. 26, 1995).

²¹⁶ Schedule for Rating Disabilities; Mental Disorders, 61 Fed. Reg. 52,695, 52,700 (Oct. 8, 1996); see 38 C.F.R. § 4.125(b) (2012).

use of a new diagnostic term not previously available to rating agencies,” but the agency responded that, as the new rule explicitly required only *DSM-IV* diagnoses, diagnostic terms that postdate the *DSM-IV* would not be valid for rating purposes.²¹⁷ This provision raises a significant concern with VA’s current practice of requiring independent evidence of the existence of a stressor, which functionally serves as an elevated evidentiary requirement on the incurrence element of a service connection claim, when considered in conjunction with the very real possibility of a change in diagnosis.²¹⁸

If, for example, a veteran was diagnosed with an adjustment disorder with depression at discharge and service connected for those conditions and then, over time, PTSD symptoms of re-experiencing the stressful event, avoidance, numbing, and hyperarousal appeared after a latency period, VA would be forced to either violate the requirements of § 4.125(b), under which a veteran’s change in diagnosis from adjustment disorder with depression to PTSD would constitute the progression of a prior diagnosis, warranting continued service connection for an acquired psychiatric disorder rated as PTSD, or follow the stressor corroboration requirements of § 3.304(f). Further, under the new regulation promulgated in July 2010, VA might be required to obtain an opinion as to both the sufficiency of the stressor and the relationship of the stressor to a veteran’s PTSD symptoms before the rating for a service-connected psychiatric disorder could be adjudicated.²¹⁹ If that examiner, even though not explicitly asked to clarify the diagnosis, ultimately determined that a

²¹⁷ Schedule for Rating Disabilities; Mental Disorders, 61 Fed. Reg. at 52,699; *see infra* Part IV.C., (discussing the effect of removing the requirement of a *DSM-IV* diagnosis from the rating code).

²¹⁸ *See* 38 C.F.R. § 3.304(f); *see also Nat’l Org. of Veterans’ Advocates, Inc. v. Sec’y of Veterans Aff.*, 330 F.3d 1345, 1351 (Fed. Cir. 2003) (upholding the credible supporting evidence requirement as an explanation of “the nature and extent of proof and evidence necessary to establish” the in-service occurrence of a stressor (citing 38 U.S.C. § 501(a) (2006))).

²¹⁹ 38 C.F.R. § 3.304(f)(3).

diagnosis of PTSD was not warranted, the veteran's disability rating could be subject to a reduction and service connection for PTSD would be denied, all resulting from a significant increase in the symptoms associated with the veteran's service-connected psychiatric disorder.

B. Lost in the PTSD Pipeline

As multiple diagnoses are regularly seen in psychiatric claims due to the prevalence of comorbid disorders and changing diagnoses, the CAVC held in *Clemons v. Shinseki*,²²⁰ that a claim for service connection for PTSD cannot be properly denied without consideration of other psychiatric diagnoses reasonably encompassed by a veteran's PTSD claim.²²¹ This decision was foreshadowed by the *Hayes v. Derwinski*²²² decision in 1991, where the CAVC found that the Board improperly declined to take jurisdiction over the issue of service connection for a panic disorder without consideration of whether the issue was distinct from the claim for benefits for PTSD,²²³ particularly where the RO adjudicated the issue of "post-traumatic stress disorder with panic disorder" and the VA examiner diagnosed both PTSD and a panic disorder.²²⁴

In *Clemons*, VA attempted to argue that a claim for PTSD was separate from a claim for other psychiatric diagnoses because the Veteran specifically filed a claim for the diagnosis of PTSD only.²²⁵ However, unlike in *Hayes*, the CAVC did not find that the issues were intertwined.²²⁶ Rather, it found that the Veteran

²²⁰ 23 Vet. App. 1 (2009).

²²¹ *See id.* at 5.

²²² 3 Vet. App. 7 (1991).

²²³ *Id.* at 9.

²²⁴ *Id.*; *see supra* note 211 and accompanying text (noting that some disorders manifest symptoms capable of cross-cutting many *DSM-IV* diagnoses); *but see* *Boggs v. Peake*, 520 F.3d 1330, 1337 (Fed. Cir. 2008) (treating separate diagnoses as separate claims in the context of a petition to reopen a previously denied claim).

²²⁵ *Clemons*, 23 Vet. App. at 1-2.

²²⁶ *See id.* at 3 ("Because we find that Mr. Clemons submitted only one claim over which

had only ever submitted one claim for benefits for a psychiatric disorder, characterized by certain symptoms,²²⁷ and that a veteran is a layperson who is not expected to have either the “legal or medical knowledge to narrow the universe of his claim or his current condition to PTSD.”²²⁸

Therefore, the CAVC held that the intent of a claimant is of paramount importance in determining a claim’s breadth.²²⁹ Consequently, the CAVC held that a veteran’s claim for PTSD could not be limited only to that diagnosis, but included all other diagnosed psychiatric disabilities reasonably encompassed by the veteran’s description of the claim, the symptoms described, and the evidence obtained during the development of the claim.²³⁰ The holding in *Clemons* essentially creates three duties: (1) a duty to weigh and assess the nature of the current condition to determine the breadth of the claim;²³¹ (2) a duty to obtain a medical opinion if the nature of the current condition cannot be determined on the evidence of record;²³² and (3) a duty to include an explanation of

we have jurisdiction, we reject the parties’ characterization that Mr. Clemons had multiple, separate claims that were inextricably intertwined.”).

²²⁷ *Id.* at 5.

²²⁸ *Id.* (citing *Ingram v. Nicholson*, 21 Vet. App. 232, 256 (2007) (“[A] sympathetic reading of the appellant’s pleadings cannot be based on a standard that requires legal sophistication beyond that which can be expected of a lay claimant and consider whether the appellant’s submissions, considered in toto, have articulated a claim.” (alteration in original))).

²²⁹ *Id.* (“[T]he RO has no duty to read the mind of the claimant, [but] . . . should construe a claim based on the reasonable expectations of the non-expert, self-represented claimant and the evidence developed in processing that claim.”).

²³⁰ *Id.* (“Although the appellant’s claim identifies PTSD without more, it cannot be a claim limited only to that diagnosis . . . Reasonably, the appellant did not file a claim to receive benefits only for a particular diagnosis, but for the affliction his mental condition, whatever that is, causes him.”).

²³¹ *Id.* at 6. The CAVC found that the Board “erred when it failed to weigh and assess the nature of the current condition the appellant suffered when determining the breadth of the claim before it.” *Id.* Further, the CAVC explained that VA should confront the “difficult questions of what current mental condition actually existed, and whether it was incurred in or aggravated by service,” instead of denying the claim when the diagnosis hypothesized by the Veteran, a layperson, proves incorrect. *Id.*

²³² *Id.* “If the factfinder cannot [determine the nature of the condition] without resorting to speculation or his own opinion, additional medical evidence may have to

the reasons and bases for the diagnoses included or not included in the scope of the claim.²³³

Conflict between *Clemons* and the additional evidentiary requirements needed to establish claims for PTSD is of even greater concern than the potential conflict with the application of § 4.125(b). In cases where a veteran files a traditional claim for service connection under § 3.304(f) and no exception applies, the examination that could result in the diagnosis of another disorder might never be provided if no evidence of the claimed stressor beyond that veteran's own statements can be located, notwithstanding the fact that a diagnosis of any other mental disorder might eliminate the need for independent supporting evidence of the stressful in-service event altogether.²³⁴ This result would be not only contrary to the holding in *Clemons*, but also to the holding in *McLendon v. Nicholson*,²³⁵ which provides that VA has a duty to provide a veteran with a VA examination whenever there is "competent evidence of a current disability," including "persistent or recurrent symptoms of a disability[;] evidence establishing that an event, injury, or disease occurred in service"; and an indication that the disability or symptoms may be associated with service or with another service-connected disability, but there is "insufficient competent medical evidence on file" for the VA to make a decision on the claim.²³⁶

be developed, unless the medical evidence itself indicates that determining the cause is speculative." *Id.* (citing *Colvin v. Derwinski*, 1 Vet. App. 171, 172 (1991)).

²³³ *Id.*; see 38 U.S.C. § 7104(d) (2006); see also *Ridgway*, *supra* note 138, at 136-37 (discussing the "reasons or bases" requirement).

²³⁴ For example, if a veteran had a valid *DSM* diagnosis of generalized anxiety disorder rather than PTSD, and a competent mental health professional related his generalized anxiety disorder to an event in service, the adjudicator would be permitted under the statutes and regulations to find that his testimony, if competent and credible, established the occurrence of that event, without any need to develop independent supporting evidence. See 38 U.S.C. § 1154(a); 38 C.F.R. § 3.159(a)(2) (2012); see, e.g., *Layno v. Brown*, 6 Vet. App. 465, 469 (1994) (holding that a claimant is competent to report observable symptoms that require only personal knowledge, not medical expertise, as they come to the claimant through his senses).

²³⁵ 20 Vet. App. 79 (2006).

²³⁶ *Id.* at 81; see 38 U.S.C. § 5103A(d); 38 C.F.R. § 3.159(c)(4).

As a result, the credible supporting evidence rule subverts a veteran's right to an examination, both in the context of a claim for service connection benefits for PTSD, and, particularly, where a veteran's reported symptoms may have resulted in an alternative psychiatric diagnosis that allowed for the second, incurrence element of a service connection claim to be established on the basis of a veteran's competent and credible lay testimony alone. Compounding the conflict between the stressor requirement and *McLendon*, the credible supporting evidence rule, even where an exception applies, results in the treatment of PTSD as a completely separate and distinct psychiatric disorder, unrelated to claims for compensation benefits for anxiety, adjustment disorder, or depression, even if those disorders are attributed to events the same or similar to the traumatic stressors related to PTSD.

The mere existence of a separate regulation with separate evidentiary requirements creates "PTSD tunnel vision," narrowing the chances that claim reviewers will even identify alternative or coexisting psychiatric conditions upon initial review of the file, much less schedule a veteran for an examination on the basis of those alternative diagnoses. This problem is not likely to improve as additional provisions are added to the regulation, however liberalizing. Rather, the increase in complexity of development and adjudication of PTSD claims is likely to further exacerbate the cognitive barrier between PTSD claims and claims for other psychiatric disorders, resulting in unnecessarily delayed claims, inefficient development and adjudication, erroneously assigned later effective dates, and, most importantly, a significant risk that "the nature of the appellant's current condition may never be properly adjudicated by the Secretary."²³⁷

²³⁷ *Clemons*, 23 Vet. App. at 8 (explaining that piecemeal adjudication of diagnoses that may be related to the same disability cannot properly account for the possibility that "multiple diagnoses may represent subjective differences of opinions of examiners, rather than multiple conditions").

IV. THE CASE FOR SIMPLIFICATION

Rather than layer additional presumptive categories onto an already creaky framework, the better way to facilitate the timely processing of PTSD claims is to simplify adjudication of service connection for PTSD, and ensure consideration of all psychiatric diagnoses in the record, by repealing § 3.304(f) in its entirety.²³⁸ Then, PTSD claims would revert to the general service connection three-element criteria under § 3.303(a).²³⁹ This would allow for a comprehensive, fact-driven analysis of the existence and scope of the present disability; incurrence resulting from an event, disease, or injury in service; and the evidence of a nexus between the in-service incident and the current disability, and would, perhaps paradoxically, streamline the adjudication of claims for service connection for PTSD and other psychiatric disorders by maximizing the informed exercise of adjudicatory discretion.

A. Reduce Compliance Burdens Through Rule Reduction and Compliance Outreach

This Article does not contend that the mere repeal of § 3.304(f) will result in a reduction of compliance burdens on the greater VA compensation benefits system as a whole.²⁴⁰ However,

²³⁸ Alternatively, Katherine DUBYAK proposes a repeal of the credible supporting evidence rule only, as well as a rule creating a presumption that the claimed in-service stressor actually occurred on the basis of the Veteran's lay testimony where two separate mental health professionals confirm the diagnosis of PTSD, in the absence of clear and convincing evidence to the contrary. DUBYAK, *supra* note 20, at 678-83. Although there is evidence to support the notion that a diagnosis of PTSD lends more support to the incurrence element of a service connection claim than to a diagnosis of any other mental disorder, this proposal would set up yet another differentiated standard for PTSD claims compared to other psychiatric claims and would create a risk of the same issues discussed in *Clemons*.

²³⁹ In *Arzio v. Shinseki*, the Federal Circuit held that § 3.304(f) subordinated the general requirements of § 3.303(a) to the specific requirements of § 3.304(f) in the particular context of PTSD and did not create an independent means of recovery. 602 F.3d 1343, 1346-47 (Fed. Cir. 2010).

²⁴⁰ See Ruhl & Salzman, *supra* note 135, at 833 (explaining that "post-promulgation rule-culling actions, from careful repeal of specific rules to wholesale deregulation,

as a result of the specific and unique provisions pertaining to the adjudication of claims for benefits for PTSD presently, resulting in a separateness that leads to the overly narrow developmental scope applied to PTSD claims, the regulation is a good candidate for targeted culling due to the limited effects it would be expected to have on other regulations that do not share the same evidentiary standards or language. Further, the rules currently governing service connection for PTSD are not, strictly speaking, being repealed in the argument for simplification presented here, as disability compensation benefits will still be granted for PTSD under § 3.303(a); rather, they are being reduced into a simplified text.

Most importantly, though, repealing 38 C.F.R. § 3.304(f) would reduce the effort and information compliance burdens involved in adjudicating claims for benefits for PTSD, as this action would reduce the number of theories of entitlement considered and the number of elements adjudicated.²⁴¹ It would also reduce the number of system burdens by allowing for proper consideration of § 4.125(b), even when a diagnosis of PTSD is alleged, and would eliminate the need for separate VA compensation and pension examinations for PTSD and nearly every other psychiatric disorder, as the questions asked to the examiner would no longer be formally differentiated.

Further, if, instead of eliminating the formal stressor verification process and the special notice rules found under § 3.304(f)(5), these evidentiary avenues are expanded as applicable

cannot readily identify which laws exacerbate the compliance burdens that flow from accretion”).

²⁴¹ See *Robinson v. Peake*, 21 Vet. App. 545, 553 (2008), *aff'd sub nom.* *Robinson v. Shinseki*, 557 F.3d 1355 (Fed. Cir. 2009) (requiring the Board to consider all theories of entitlement to VA benefits that are either raised by the claimant or reasonably raised by the record); *Moody v. Principi*, 360 F.3d 1306, 1310 (Fed. Cir. 2004) (“VA has a duty to fully and sympathetically develop a . . . claim to its optimum” by “determin[ing] all potential claims raised by the evidence [and] applying all relevant laws and regulations.” (internal quotation marks omitted)).

to all service connection claims, a reduction in system burdens would be expected from this application of compliance assistance theory. Regulators can and should help regulated parties keep pace with the demands of accretion through compliance outreach through what would constitute, essentially, a voluntary expansion of the duties to notify and assist on the part of the agency.²⁴²

B. Increase the Quantity of Completed Claims by Focusing on the Quality of the Evidence

As with the example above, future rules governing the adjudication of claims for benefits for PTSD and other psychiatric disorders should look less at what adjudicators are doing with the record and more at what record is getting to the adjudicators. VA should be able to ask whether the examiner, as a trained observer of human behavior in a clinical setting, has any relevant expertise in making in-person credibility assessments of patients. The examiner, as an expert, may be able to comment on the statistical likelihood of the occurrence of the stressor in the presence of a veteran's particular constellation of symptoms or specific symptoms of avoidance or re-experiencing that correlate in a non-obvious way to the type of trauma claimed. In other words, examiners should be asked whether the determination that a veteran's PTSD is related to service is (1) based on the existence of PTSD symptoms and apparent evidence of a sufficient stressor, alone, or (2) supported by specific symptoms corresponding to the type of stressor claimed or otherwise indicative of a particular relationship between symptoms and the claimed event.

The stressor is both a part of the diagnostic criteria for PTSD under the *DSM*'s Criterion A and establishes the incurrence element in a service connection claim. As such, there is overlap, and the response has been to pull the occurrence of the stressor out from under the diagnostic criteria as a medical determination.

²⁴² See Ruhl & Salzman, *supra* note 135, at 839-40 (discussing compliance assistance theory).

However, if the stressor has already been established by a competent relevant professional, and the incurrence element is met by the existence of a stressor, it would be better policy to acknowledge that if $A = B$, then $B = A$, instead of nullifying a determination made by a treating psychiatrist pursuant to treatment—the same type of determination that the psychiatrist likely makes every day in the course of treating patients with mental health problems—in order to insist on a months-long verification process by military historians.²⁴³

C. Evolve with the *DSM-5*

With regard to important changes in the *DSM-5*, it should be noted at the outset that the criterion requiring a response of fear, helplessness, or horror has been dropped from the diagnostic criteria, as it was found not to be related to PTSD, or even possibly inversely related given the delayed onset of symptoms frequently seen with the disorder and the numbed response to the stressor often seen clinically, in general, and in military populations, in particular.²⁴⁴ Additionally, although the A1, or Stressor, Criterion has been retained in the *DSM-5*, this appears to be solely for the reason that it was not inconsistent with the other diagnostic criteria in the *DSM-5* and informed a coherent heuristic understanding of the nature of the disorder.²⁴⁵ In other words, the case for retaining the stressor criterion is not based on any need to retain it for

²⁴³ Another possible means of increasing the available avenues of evidentiary discovery would be to extend the special notice provisions under 38 C.F.R. § 3.304(f)(5) (2012), currently limited to personal assault claims, to all claims for service connection for PTSD, all claims for service connection for psychiatric disorders, or all claims for service connection generally. After all, the type of evidence solicited from a veteran under subsection (f)(5) may permissibly be considered in all other service connection claims, and, further, the notice requirements clearly evidence a belief in the utility of soliciting this evidence. Consequently, it is difficult to understand what opposing concerns might weigh against soliciting alternative sources of evidence that may help establish the claimed in-service event, particularly in a PTSD case, where that evidence is, as a matter of law, necessary to establish service connection in the absence of an applicable exception. See 38 C.F.R. § 3.304(f)(5).

²⁴⁴ See Friedman et al., *supra* note 16, at 755-56.

²⁴⁵ See *id.* at 752-54 (providing a general discussion of the A1 Criterion).

diagnostic accuracy,²⁴⁶ whereas researchers in favor of eliminating the stressor criterion show that 95.5% to 96.6% of persons meeting the B through F criteria had previously been exposed to a sufficient stressor.²⁴⁷

However, VA will not be able to consider the effect of any of these changes when adjudicating claims for benefits for PTSD until the rules requiring *DSM*-compliant psychiatric diagnoses are amended to show the current edition, or to avoid naming a particular edition. In 1995, when the *DSM-IV* was released, VA General Counsel issued an opinion addressing the issue of whether VA must follow the guidelines under *DSM-III*, named in the rating code, when a new version had been released.²⁴⁸ The opinion explains that regulations cannot “be ignored on the basis that [they have] become outdated,” and, furthermore, notes that the specific criteria in the rating schedule were dependent on the previous version of the *DSM*.²⁴⁹ This opinion concerns the publication of the *DSM-IV* and specifically addresses the change from the objective stressor criterion (“would evoke significant symptoms of distress in most people”²⁵⁰) in prior editions to the subjective standard (“involve[s] intense fear, helplessness, or horror”²⁵¹) in the *DSM-IV*.²⁵²

²⁴⁶ Additionally, as mentioned above PTSD has been moved into its own category of stress and trauma related disorders, and out of the anxiety category, along with Acute Stress Disorder, Adjustment Disorders, Reactive Attachment Disorder, and a new diagnosis of Disinhibited Social Engagement Disorder, which is differentiated from Reactive Attachment Disorder. John M. Grohol, *DSM-5 Changes: PTSD, Trauma & Stress-Related Disorders*, PSYCH CENT. PROF., <http://pro.psychcentral.com/2013/DSM-5-changes-ptsd-trauma-stress-related-disorders/004406.html> (last updated Nov. 4, 2013). PTSD also now includes two subtypes, PTSD Preschool Subtype and PTSD Dissociative Subtype. *Id.* Lastly, there are now four clusters of symptoms instead of three: re-experiencing the event, heightened arousal, avoidance, and negative thoughts and mood or feelings. *Id.*

²⁴⁷ Friedman et al., *supra* note 16, at 753.

²⁴⁸ DVA Op. Gen. Counsel Prec. 10-95 (Mar. 31, 1995).

²⁴⁹ *Id.* ¶ 12.

²⁵⁰ *DSM-III*, *supra* note 16, § 309.81.

²⁵¹ *DSM-IV*, *supra* note 16, § 309.81.

²⁵² DVA Op. Gen. Counsel Prec. 10-95, ¶ 7.

The next year, VA addressed the reason for naming a specific version of the *DSM* in response to three comments suggesting that the rating schedule cite only “the current edition of the DSM” instead of naming a specific edition, such as the *DSM-III* or *DSM-IV*.²⁵³ The response explained that “VA does not avoid the need to revise the rating schedule by referring to the ‘current edition’ of the DSM” instead of the *DSM-III* or *DSM-IV*, as the revision to the code in 1996 did not just revise the language governing the version of the *DSM* to be used, but also made substantive revisions to the schedule on the basis of the altered criteria in the *DSM-IV*.²⁵⁴ Otherwise, a change to the “current edition” of the *DSM-IV* while the old regulations were still in use would result in internal inconsistencies in the rating schedule.²⁵⁵

However, this Article also declines to comment on the utility of psychological testing for diagnostic purposes for the reason that the current regulatory amendment concerned the rating code only, and it would serve no purpose to address diagnostic issues in the rating code. All references to the edition of the *DSM* occur in 38 C.F.R. Part 4, and, in fact, all references to the *DSM*, named or otherwise, have been confined to the rating schedule, except that, unfortunately, § 3.304(f) specifically states that PTSD will not be service connected without a diagnosis consistent with § 4.125(a), or, in other words, a *DSM-IV* diagnosis.²⁵⁶ Eliminating the special regulatory provisions pertaining to the grant of service connection for PTSD would fully address the issue; in the interim, the reference to § 4.125(a) in § 3.304(f) must be eliminated or replaced with language referring to the current version of the *DSM*.

The specific reference to § 4.125(a) was added, ironically, as a more flexible replacement for language that had specifically

²⁵³ Schedule for Rating Disabilities; Mental Disorders, 61 Fed. Reg. 52,695, 52,696 (Oct. 8, 1996) (internal quotation marks omitted).

²⁵⁴ *Id.*

²⁵⁵ *Id.*

²⁵⁶ 38 C.F.R. § 3.304(f) (2012).

mentioned the objective standard for the sufficiency of the stressor.²⁵⁷ This objective standard stood in stark contrast to the then-newly-adopted *DSM-IV*'s subjective sufficiency standard, which, the Court determined in *Cohen v. Brown*,²⁵⁸ was a "medical question requiring examination and assessment" by a VA examiner.²⁵⁹ Therefore, the provision pertaining to PTSD diagnosis refers only to § 4.125(a) in order to facilitate a smooth transition through different versions of the *DSM*, but is also arguably the only regulatory reference preventing VA from adopting the *DSM-5* criteria for PTSD diagnosis when adjudicating a claim for service connection before it is formally adopted into the rating schedule. The operative lesson is that changing the rules governing the award of PTSD benefits does not simplify the process, but instead ties the hands of the adjudicators when exercise of discretion may have otherwise allowed the adjudication of claims for service connection for PTSD under the new *DSM-5* criteria. Lastly, in order to prepare for the dimensional, cross-sectional, and less category-specific diagnoses likely to be produced by the *DSM-5*, and as the data shows that veterans receiving benefits for PTSD are more likely to have comorbid disorders than not, § 4.125(b) should be amended to instruct the adjudicator to consider the possibility of comorbid diagnoses.

D. Stop Fighting the Last War

The current credible supporting evidence rule is a holdover from the conflict in Vietnam, the suspicion surrounding the validity of the psychiatric diagnosis of PTSD, and, quite possibly, the result of the burden placed on the agency when the conflict in Vietnam ended and veterans began filing claims *en masse*, combined with the suspicion that greeted those veterans when they returned home

²⁵⁷ See DVA Op. Gen. Counsel Prec. 10-95, ¶¶ 4-8 (discussing the differences between *DSM-III* and *DSM-IV* requirements and the implications for VA adjudicators).

²⁵⁸ 10 Vet. App. 128 (1997).

²⁵⁹ *Id.* at 142.

from the horrors of that war.²⁶⁰ None of these cultural forces exist today, yet we are still beholden to the framework that was adopted prior to the start of the Persian Gulf War Era on August 2, 1990.²⁶¹ The creation of additional provisions relaxing or suspending the credible supporting evidence rule in certain cases meeting special enumerated criteria will not solve the problem, and, conversely, is destined to lead to further complexity, delay, and frustration of VA's policy goals. The 2010 regulation reflects a broadened understanding of the concept of "combat" in relation to the likelihood of the occurrence of a stressor sufficient to cause PTSD, but correcting the problems of the Vietnam era will never help us catch up to where we are today, twenty-three years after the start of the Persian Gulf War Era. In other words, over-reliance on the thorough but time-intensive rulemaking process does not prepare the VA benefits system to fight the last war.

The men and women in active service today are already experiencing a different type of warfare, undefined by any theater of war, and in some cases without even the personal physical risk inherent in traditional combat scenarios. Military action conducted under the authority of the Authorization for Use of Military Force against terrorists will not necessarily relate to any defined geographical location,²⁶² and a drone pilot sitting at a computer console in the suburbs does not experience "fear" of incoming mortar fire or IEDs, but does show significant incidence rates for several psychiatric disorders, including PTSD.²⁶³ A recent study showed that drone pilots receive mental health diagnoses at a rate equivalent to pilots who fly in aircraft, much higher than the

²⁶⁰ MARLANTES, *supra* note 157, at 176-77 (describing how the author was jeered, shunned, ostracized by signs at restaurants and bars that said "No military!" and, finally, spit on by a young woman on a train).

²⁶¹ See 38 C.F.R. § 3.2 (showing the official beginning date of the Persian Gulf War).

²⁶² See Authorization for Use of Military Force, Pub. L. No. 107-40, 115 Stat. 224 (2001).

²⁶³ Rachel Martin, *Report: High Levels of 'Burnout' in U.S. Drone Pilots*, NAT'L PUB. RADIO (Dec. 18, 2011, 6:01 PM), <http://www.npr.org/2011/12/19/143926857/report-high-levels-of-burnout-in-u-s-drone-pilots>. Seventeen percent of active duty drone pilots are "clinically distressed," and twenty-nine percent report a lesser level of burnout and fatigue that does not rise to the level of affecting their work and family. See *id.*

rates of mental health diagnosis seen among non-pilot Air Force personnel.²⁶⁴ The Air Force currently employs only 1,300 drone pilots,²⁶⁵ but the Pentagon projects a need for more than 2,000 by 2015.²⁶⁶

Though the veterans of the current war who are suffering from PTSD are significantly outnumbered by those who experienced the same trauma but do not show the characteristic symptom cluster identified with the disorder, it is nevertheless true that every war, by definition, increases the rate of trauma experienced by our men and women in uniform to a tipping point, necessitating a corresponding battle against the societal and economic effects of PTSD. Like the war that caused it, each historical battle against PTSD is unique and requires its own strategy. Here, the current rise in the incidence of PTSD corresponds with a time of rapid and meaningful scientific advancement in our ability to conclusively diagnose PTSD. Consequently, taking advantage of the current landscape means ending unfounded concerns with malingering; relying on better evidence based on the new, more refined B through F criteria and, as it becomes available, reliable neurological and biological data; and creating the room necessary to adjust both to rapid advances in the scientific field of psychiatry, or, as it might ultimately be called, neuropsychology, and to ever-shifting stressor scenarios. This informed, flexible focus may not only allow us to fight the current war on PTSD; it may even allow for the anticipation of the next one.

²⁶⁴ Hernando J. Ortega, Jr., Editorial, *Challenges in Monitoring and Maintaining the Health of Pilots Engaged in Telewarfare*, 20 MED. SURVEILLANCE MONTHLY REP. 2, 2 (2013).

²⁶⁵ Nidhi Subbaraman, *Drone Pilot Burnout Triggers Call for Recruiting Overhaul*, NBC News (May 17, 2013, 4:15 AM), <http://www.nbcnews.com/technology/drone-pilot-burnout-triggers-call-recruiting-overhaul-1C9910483>.

²⁶⁶ Elisabeth Bumiller, *A Day Job Waiting for a Kill Shot a World Away*, N.Y. TIMES (July 29, 2012), <http://www.nytimes.com/2012/07/30/us/drone-pilots-waiting-for-a-kill-shot-7000-miles-away.html>.

CONCLUSION

The proposal to simplify the adjudication of PTSD claims by eliminating the current complex regulatory framework and returning service connection adjudications for the disorder back to the traditional three-element analysis under § 3.303(a), requiring only a determination of whether the essential elements of a service connection claim—(1) current diagnosis, (2) incurrence in service, and (3) nexus—are substantiated by the evidence, not only provides immediate benefits to the adjudication of current PTSD claims, but also prepares VA for the future. That future includes the potential for significant gains in the accuracy of psychiatric diagnosis, likely to result in additional differentiation of symptom clusters currently lumped together by statistical association under the PTSD label.

Retaining flexibility in adjudication and focusing efficiency efforts on quality-driven evidentiary development procedures, such as increasing the reliability of diagnosis and the quality of rationale provided in VA compensation and pension psychiatric examination reports, will better equip VA to quickly adapt to the rapid advances in psychiatric diagnosis expected as the psychiatric community moves away from strict adherence to clearly delineated categories, lacking internal correlation to any shared etiology, toward an era of data-driven research. The identification of mental disorders is evolving to reflect the diagnostic gains made possible by the use of functional magnetic resonance imaging and other technological advancements, which offers the promise of conclusive data on the underlying physiological and neurological etiology of mental disorders, as well as the associated symptom clusters. Additionally, the *DSM* is evolving toward a model of dimensional diagnoses, resulting in weighted, multi-symptom diagnoses that would be mistaken for several coexistent diagnoses under the current regulations. VA must also adopt a parallel posture of adaptability and discard the rigid categorical framework governing service connection benefits not only for PTSD, but also for mental disorders generally. By keeping the regulations governing service

connection for PTSD and other psychiatric claims as elementary as possible, we can foster agility over complexity, evidence informed by relevant expertise over evidence measured by the time it took to acquire it, and an open-minded cognitive posture ready to adapt to the constantly changing frames of stressor scenarios produced by the rapidly shifting face of American military action.