



Review

Why are Iraq and Afghanistan War veterans seeking PTSD disability compensation at unprecedented rates?



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ABSTRACT

The wars in Iraq and Afghanistan have produced historically low rates of fatalities, injuries, and post-traumatic stress disorder (PTSD) among U.S. combatants. Yet they have also produced historically unprecedented rates of PTSD disability compensation seeking from the U.S. Department of Veterans Affairs. The purpose of this article is to consider hypotheses that might potentially resolve this paradox, including high rates of PTSD, delayed onset PTSD, malingered PTSD, and economic variables.

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1. Introduction

As of the late spring of 2012, 45% of veterans of the wars in Afghanistan and Iraq have applied for service-connected disability compensation for psychiatric and nonpsychiatric medical problems and 28% of have already secured it (Marchione, 2012) as compared to 14% of other veterans (Bureau of Labor Statistics, 2013). Moreover, the average number of medical conditions cited by each disability applicant has ranged from eight to nine, increasing to as many as 14 conditions per applicant during the past year

(Marchione, 2012). Importantly, these figures apply to all veterans of these two wars, not merely those with combat experience.

This is a historically unprecedented rate of seeking disability compensation. The percentage of World War II, Vietnam, and Persian Gulf War veterans who have received disability compensation for any reason are 11%, 16%, and 21%, respectively (Marchione, 2012). The average number of conditions cited per applicant has risen dramatically as well. For example, World War II recipients averaged two conditions per veteran, whereas Vietnam recipients averaged about four conditions per veteran (Marchione, 2012). Taken together, these data imply that our recent veterans suffer from far more disabling psychiatric and nonpsychiatric medical problems than have veterans of previous conflicts.

Posttraumatic stress disorder (PTSD) is the third most prevalent service-connected disability for veterans receiving compensation

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at the end of the fiscal year 2012 (572,612 veterans); the first and second most common disabilities are tinnitus and hearing loss, respectively (Department of Veterans Affairs [VA] Veterans Benefits Administration, 2012). For veterans whose compensation commenced in 2012, mental disorders increased by 30.3% from 2011. Of veterans receiving compensation for mental disorders, 75% of recent veterans are compensated for PTSD as compared to 58% for veterans overall. In fact, 6.8% of all veterans receiving compensation for any disability are receiving it for PTSD. Moreover, those receiving disability for mental disorders receive far more compensation than do veterans with nonpsychiatric medical disabilities. That is, 34.9% of those with mental disorders, such as PTSD, are receiving compensation at the 70% rate or higher, whereas only 3.8% are receiving ratings at this level for all other conditions.

Although recent data are difficult to locate, one report from early 2012 estimated that about 35% of Iraq and Afghanistan veterans seeking disability compensation include a claim for PTSD (Veterans for Common Sense, 2012). This report, based on primary source records from the VA, indicates that 7.8% ($n = 119,446$) of all Iraq and Afghanistan veterans are already receiving VA disability for PTSD, with almost as many claims pending as have been approved.

The purpose of our article is to consider hypotheses for the extraordinarily high rate of disability seeking among veterans of Afghanistan and Iraq. In this essay, we do not purport to conduct a comprehensive review of the epidemiology of PTSD, and nor do we purport to conduct a comprehensive review of the authenticity of PTSD disability claims. Rather, our purpose is to evaluate data relevant to hypotheses advanced to explain the skyrocketing rate of disability claims from these two recent conflicts.

2. Combat casualty rates in Afghanistan and Iraq

Population statistics about the percentage of soldiers killed in action (KIA) or wounded in action (WIA) provide no comfort to families that have lost loved ones or to wounded service members who remain physically incapacitated for life. Nor do incidence rates for PTSD matter much if one happens to be among the men and women who have developed the disorder. Yet quantitative data are essential to gauge the toll of war and to plan services for those in need. These data play a vital role in organizing efforts to help troubled veterans return to productive, rewarding lives back home.

As of the spring of 2012, the annual death rate for troops deployed to Afghanistan and Iraq combined was .0027 (www.defense.gov/news/casualty.pdf). Hence, for every 100,000 military personnel serving in these war zones, 270 have died. How does this rate compare with those of previous wars? The American death rate for the Persian Gulf War was .00017; for every 100,000 troops, 17 died. The American military death rate for the Vietnam War was .0067 (Leland & Oborceanu, 2010). Thus, for every 100,000 military personnel, 670 died. The rate for World War II was .0250; for every 100,000 military personnel, 2500 died (Leland & Oborceanu, 2010). The rate for Union forces during the American Civil War was .1647; for every 100,000 military personnel, 16,470 died (Leland & Oborceanu, 2010). Hence, the death rates for Americans in the Vietnam War, World War II, and the Civil War were approximately 2.5, 9, and 61 times more lethal than the wars in Afghanistan have been. As Goldstein (2011) and Pinker (2011) have documented, these data indicate that the lethality of war has diminished over time.

Yet as wars have gotten less deadly for military personnel, the percentage of veterans receiving disability compensation has risen dramatically. This would be understandable if the rate of serious, but nonfatal, combat wounds increased, compensating for the sharp decrease in the rate of combat fatalities. Therefore, perhaps service members who would have appeared in the KIA statistics

in the past now appear in the WIA statistics. If so, then this might explain the extremely high rate of disability applications.

In fact, military personnel survive their wounds today more often than in the past, thanks to improvements in military medicine and body armor. The survival rate for wounded military personnel has increased from 76% during the Vietnam War (Gawande, 2004) to over 95% for the wars in Afghanistan and Iraq (Marchione, 2012).

Do the improved odds of wounded troops surviving explain the increase in compensation seeking? Has the WIA rate increased as the KIA rate has decreased? The answer is "no." In fact, not only has the KIA rate been much lower for the recent wars than in previous ones, the WIA rate has likewise been lower. As of the spring of 2012, the percentage of troops wounded in Afghanistan and Iraq combined is .0206 (2060 per 100,000; www.defense.gov/news/casualty.pdf), relative to .0347 (3473 per 100,000) for the Vietnam War and .0416 (4160 per 100,000) for World War II (Leland & Oborceanu, 2010). The Persian Gulf War had a wounded rate of .00208 (208 per 100,000). Therefore, the WIA rate does not compensate for the decrease in the KIA rate, and the increased rate of disability applications is not easily explainable by an elevated WIA rate. Indeed, among the servicemembers wounded in Iraq or Afghanistan, fewer than 15,000 required medical evacuation from the theater of action (Gade, 2013). Given that more than 2.4 million have served in these conflicts, the proportion of those seriously injured is very small, indeed (i.e., .00625). For example, fewer than 2000 servicemembers required amputation of a limb (Gade, 2013).

However, many claims, such as chronic back problems, tinnitus, headaches, or partial hearing loss are service-connected but unlikely to appear in the WIA statistics (Stiglitz & Bilmes, 2008, pp. 65–66). Accordingly, these nonpsychiatric diagnoses will constitute a sizable number of the total disability applications.

3. How common is PTSD among recent veterans?

The 45% rate of disability seeking includes psychiatric as well as general medical problems, and PTSD, for example, does not appear in the WIA column. About 400,000 Iraq and Afghanistan veterans have sought mental health care from the VA system (Marchione, 2012). Accordingly, have the two recent wars produced historically unprecedented numbers of PTSD cases that might explain the historically unprecedented rate of compensation claims?

Shortly after the invasion of Iraq in 2003, Alfonso Batres, chief of readjustment counseling services for the VA cautiously conjectured that as many as 30% of all troops deployed to Iraq would develop PTSD (Dentzer, 2003). Presumably, he based his prediction on data from the National Vietnam Veterans Readjustment Study (NVVRS; Kulka et al., 1990), an epidemiological survey indicating that 30.9% of all men who had served in the Vietnam War had developed PTSD, and that 15.2% still had the disorder in the late 1980s. A landmark study involving a reanalysis of the NVVRS requiring war-related onset of the disorder, archival corroboration of traumatic events, and at least "mild" impairment reduced the prevalence by 40% (i.e., 30.9% to 18.7%, and 15.2% to 9.1%; Dohrenwend et al., 2006, 2007). A slightly stricter definition of impairment ("modest"), reduced the current (late 1980s) prevalence by 65% (i.e., 15.2% to 5.4%; McNally, 2007). Nevertheless, Batres's prediction of 30% was reasonable in 2003, prior to reanalyses of the NVVRS.

A report issued by the Institute of Medicine (IOM, 2012) concluded, "Recent estimates of the prevalence of PTSD in 2.6 million U.S. service members who have served in Iraq or Afghanistan since 2001 (including those who are currently there and 900,000 of whom have been deployed more than once) range from 13% to 20%" (IOM, 2012, p. 1). In contrast, a team of British researchers examining the methodologically stronger studies estimated

that between 2.1% and 13.8% of American and British service members have developed PTSD (Sundin, Fear, Iverson, Rona, & Wessely, 2010). Using slightly different methods in their review, Richardson, Frueh, and Acierno (2010) reached nearly identical conclusions.

Interestingly, even the IOM's low estimate of 13% is over three times higher than the deployment-attributable rate arising from Smith et al.'s (2008) study, the methodologically strongest one on American military service persons deployed to Iraq and Afghanistan. Oddly, the IOM ignored Smith et al.'s study when considering PTSD rates.

Smith et al. (2008) used data from the U.S. Millennium Cohort, a prospective, longitudinal investigation of active duty and Reserve/National Guard personnel. Assessing 47,837 members of the Armed Forces, they found that 4.3% of personnel deployed to Afghanistan and Iraq developed PTSD. Among the subset reporting combat exposure, 7.6% developed PTSD, whereas only 1.4% of those denying combat exposure did so. Among the group of military personnel that had never deployed overseas, 2.3% developed PTSD from stateside traumatic events (e.g., accidents on bases).

Smith et al.'s (2008) study has many methodological virtues. It avoids biases associated with convenience samples, it has a very large number of subjects, and it excludes those with predeployment PTSD, thereby providing estimates of PTSD attributable to military trauma alone and not to trauma occurring prior to subjects joining the armed forces. That is, it provides an incidence rate, not merely a prevalence rate.

Ruling out subjects whose PTSD predates their deployment overseas provides a much better estimate of war-attributable PTSD than do prevalence estimates that confound preexisting PTSD and war-related PTSD. For example, Hoge et al. (2004) found that as many as 5% of combat troops qualified for PTSD prior to their deployment to Iraq, whereas 12.6% qualified for PTSD following combat exposure in Iraq. If one rules out preexisting PTSD among Hoge et al.'s combatants, one arrives at a deployment-attributable rate of PTSD of 7.6%—precisely the same estimate reported by Smith et al. (2008) for military personnel exposed to combat in Iraq and Afghanistan. However, individuals whose military service worsened their preexisting PTSD are eligible for disability benefits as are those with deployment-attributable PTSD.

Finally, Smith et al. (2008) ensured that self-reported data on PTSD symptoms were unconnected with their official records or kept in their military files. Keeping research data separate from the service person's official records may foster candid symptom reporting among those worried about the potential stigma of admitting mental health problems.

4. Hypotheses that may resolve the paradox

We next consider several hypotheses that may resolve the paradox posed by the historically unprecedented rates of PTSD disability compensation seeking in the VA.

4.1. Do questionnaire assessments underestimate the rate of PTSD?

The gold standard for diagnosing PTSD is a structured diagnostic interview. Yet the vast majority of large studies on PTSD associated with service in Iraq and Afghanistan rely on self-report questionnaires, such as versions of the Posttraumatic Checklist (PCL; Weathers, Litz, Herman, Huska, & Keane, 1993). Although it does not gauge impairment, the PCL does map clearly onto DSM-IV PTSD symptoms. Is it possible that such questionnaires underestimate the true rate of PTSD in studies such as Hoge et al. (2004) and Smith et al. (2008)?

A relatively small epidemiological study ($n=382$) by Engelhard et al. (2007) suggests that the opposite may hold. That is, questionnaires may overestimate the rate of PTSD as diagnosed by structured clinical interview. Engelhard et al. found that 21% of Dutch infantry veterans of Iraq met symptomatic criteria for PTSD on a questionnaire, but this rate dropped to 12% on structured interview. The rate dropped to 4% when impairment was required and when the interviewer ruled out stressors unrelated to deployment (e.g., learning about the death of a family member back in Holland).

Arbisi et al. (2012) administered the military version of the PCL to 348 National Guardsmen returning from a combat deployment in Iraq. They also interviewed them with the Clinician-Administered PTSD Scale (CAPS) (Blake et al., 1995), and found that 6.5% met criteria for PTSD. Using a CAPS diagnosis as the gold standard, Arbisi et al. examined the predictive validity of the PCL. Even when they identified the best cut scores for identifying cases of PTSD, they found that rates of false positives ranged from 65% to 76%.

Taken together, these data suggest questionnaires do not underestimate the rate of PTSD. If anything, they overestimate it.

4.2. Can delayed-onset PTSD explain the increase in disability-seeking?

Delayed onset PTSD denotes a syndrome emerging after six months have elapsed following the traumatic event, and it seldom occurs in people who have not already been suffering from sub-threshold levels of PTSD symptoms (Andrews, Brewin, Philpott, & Stewart, 2007). People rarely, if ever, experience no acute PTSD symptoms whatsoever, but then experience the full-blown syndrome more than six months after the trauma.

Although reliance on retrospective data has hampered interpretation of research on delayed onset PTSD (Andrews et al., 2007), recent work has partly avoided this and other limitations of early work on this topic. Aggregate longitudinal data on American and British service personnel returning from deployments in the recent wars show that the percentage of subjects qualifying for a PTSD diagnosis rises slightly within the first 6 to 12 months following their return home (Sundin et al., 2010). It is unclear whether this reflects new, full-blown onset of the disorder, minimization of symptoms at the last assessment prior to returning home, or failure of symptoms to remit that personnel originally regarded as normal stress reactions that were present all along.

Goodwin et al. (2012) conducted one of the most rigorous studies done on delayed onset PTSD. In this prospective, cohort investigation, Goodwin et al. assessed 1397 British military personnel, who had completed their service in Iraq, at two time points. The first assessment occurred between 2004 and 2006; it involved subjects completing the PTSD Checklist-Civilian version (PCL-C; Weathers et al., 1993) in reference to PTSD symptoms present during the previous month, and the second assessment occurred between 2007 and 2009; it, too, involved subjects completing the PCL-C in reference to PTSD symptoms present during the previous month. The researchers defined cases of probable PTSD as those with a score of at least 50 on the PCL-C and defined cases of sub-threshold PTSD as those scoring 40 through 49 on the PCL-C. They defined cases of delayed onset PTSD as those qualifying for PTSD at the second assessment, but not at the first assessment.

Goodwin et al. found that 3.5% of their subjects developed delayed onset PTSD. Of the 44 subjects who met criteria for delayed onset PTSD at the second assessment, 12 had met criteria for subthreshold PTSD at time one (i.e., PCL-C scores ranging from 40 through 49). PTSD overall was uncommon; 94% of the subjects ($n=1213$) were free of probable PTSD at both the first and second assessments. The 44 delayed onset cases represented 46% of all cases of PTSD in this study (delayed onset plus normal onset). Hence, the rate of delayed onset PTSD was low among all military

personnel returning from Iraq (3.5%), but among those who did qualify for probable PTSD following their deployment, nearly half (46%) exhibited delayed onset. These data suggest that delayed onset PTSD may play a small role in explaining the rise in disability claims.

4.3. Can malingering explain the increase in disability seeking?

Since 1999, there has been a massive increase in the number of applicants seeking service-connected disability compensation for PTSD from Vietnam-era veterans. In virtue of the apparent rarity of extremely delayed PTSD among war veterans (Andrews et al., 2007; Frueh, Grubaugh, Yeager, & Magruder, 2009; Goodwin et al., 2012), this raises the question of whether malingering or symptom overreporting is driving a significant portion of these new applications. Most veterans seeking PTSD treatment within the VA system apply for disability compensation, and psychological measures point to a widespread pattern of symptom overreporting, as measured by standardized validity scales of psychological instruments, such as the Minnesota Multiphasic Personality Inventory (MMPI; Frueh, Hamner, Cahill, Gold, & Hamlin, 2000). One study designed specifically to examine malingering found that 53% of 74 veterans seeking treatment for PTSD showed clear evidence of symptom exaggeration on a standardized forensic interview; only 23% did not show evidence of exaggeration (Freeman, Powell, & Kimbrell, 2008). Likewise, standardized assessments in one study indicated that more than 50% of recent veterans evaluated for mild traumatic brain injury (mTBI) were malingering (Denning, 2012).

The VA Office of the Inspector General (VAOIG, 2005) launched an investigation to ascertain the basis for this surge in claims decades after the end of the Vietnam War. The VAOIG team reported that from 1999 to 2004, the number of veterans receiving disability compensation for all health problems increased by 12.2%, yet the number of veterans received disability compensation for PTSD increased by 79.5%.

To solve this mystery, the VAOIG team randomly selected 2100 PTSD cases from seven VA hospitals who had received judgments awarding them disability compensation for PTSD at the 50% level or higher. The VAOIG team examined the files of the compensation and pension (C & P) assessors, noting whether the clinician had documented whether the applicant had encountered traumatic stressors. The VAOIG investigators discovered that 25.1% of the veterans with service-connected disability compensation had no evidence of trauma exposure noted in their clinical files. The absence of documentation ranged from a high of 40.7% in Oregon to a low of 11% in Maine. The absence of documentation does not confirm fraud on the part of the applicant; overworked C&P evaluators may have cut corners, neglecting to obtain the veteran's military file (i.e., the DD-201) to corroborate the veteran's report of war trauma.

However, other findings in the DVOIG report provide cause for concern. The DVOIG team discovered that the veterans with service-connected disability compensation awards that were less than 100% continued in treatment for PTSD. The modal patient reported getting worse over time until he finally attained a service-connected disability rating of 100%. At this point, mental health visits plummeted by 82%, and many patients terminated treatment altogether despite, presumably, being more psychiatrically impaired than ever. Yet this group evinced no drop in nonpsychiatric health visits. This suggests that some veterans may use mental health visits to document the severity of their disability to strengthen their compensation claim, rather than to alleviate psychiatric symptoms.

Sparked by Burkett and Whitley's (1998) work, Frueh et al. (2005) consulted archival data for 100 patients assessed for PTSD in a South Carolina VA hospital who had reported war-related trauma in Vietnam. Using the patients' DD-201 records, they examined

whether accounts of trauma in the clinical files were consistent with data in the DD-201 records. The DD-201 records corroborated the self-reported trauma noted in the clinical files for only 41% of the patients. Nevertheless, 94% received a diagnosis of PTSD. The DD-201 records confirmed that another 20% had served in Vietnam, yet there was no evidence of these patients having received the medals awarded to those with combat experience (e.g., Combat Infantryman's Badge). For another 32%, the DD-201 records listed a military occupational specialty far removed from the battlefield (e.g., clerk). Finally, another 7% had either never served in Vietnam or had never been in the military at all. Remarkably, patients in the uncorroborated group reported exposure to atrocities at more than twice the rate of patients in the corroborated group (28% versus 12%). Taken together, these findings give cause for concern about malingering in the VA system (McNally & Frueh, 2012) even though they do not provide a precise prevalence estimate of the problem.

Replying to our commentary on this issue (McNally & Frueh, 2012), Marx et al. (2012) expressed a relatively sanguine view of data suggestive of malingering, concluding that veterans rarely fabricate trauma histories and PTSD symptoms for financial gain. Their view is somewhat surprising in that several of Marx's co-authors had recommended "that patients whose continued receipt of financial benefits is contingent upon maintaining PTSD symptoms, or who are awaiting a decision concerning the possibility of receiving financial benefit, should be excluded from clinical trials" (Charney et al., 1998, p. 7). If clinical researchers followed this suggestion, they would exclude as many as 94% of veterans seeking treatment within the VA system for PTSD (Frueh et al., 2000).

In any event, Marx et al. (2012) interpret the massive increase in claims noted by the DVOIG investigators as reflective of delayed onset PTSD, perhaps resulting from disinhibition of hitherto untroubling memories of war trauma attributable to an aging brain. However, they did not explain why continued participation in treatment would result in clinical deterioration followed by prompt termination in treatment once the veteran achieved 100% disability compensation. Are treatments in the VA system so toxic that they worsen the psychological status of patients, or do patients exaggerate their clinical decline until they secure the maximum financial compensation possible for PTSD?

Marx et al. (2012) did not answer these questions, but they did cite several clinical trials purportedly showing that response to treatment was unrelated to disability status (Monson et al., 2006; Schnurr et al., 2007). Others have reached a broadly similar conclusion (Belsher, Tiet, Garvert, & Rosen, 2012). However, one study concerned female veterans, not male combat veterans (Schnurr et al., 2007), and none of the studies distinguished between veterans who were applying for disability compensation, but who had not secured it yet, and veterans who were not involved with VA disability compensation at all. Instead, most comparisons concerned veterans seeking disability and veterans who already were already receiving disability. The logical flaw in this comparison is that veterans who are awarded disability continue to have significant incentives to maintain (or increase) their disability status and their benefits. Moreover, as everyone familiar with the VA system knows, engaging in treatment, but failing to improve significantly, can support one's claim for disability compensation. Hence, an important question concerns how many of these veterans remain in treatment, recover from PTSD, and then rescind their disability compensation once they have recovered from PTSD and become capable of entering the civilian workforce.

One could argue that continuing to cash disability checks after one has recovered from PTSD would itself count as de facto malingering. Analogously, people who have lost their jobs are eligible for unemployment compensation, but once they obtain new jobs, they no longer are entitled to government paychecks. One might object that people with PTSD may relapse after an

initial recovery, and thus they should be entitled to disability compensation indefinitely. Yet no one would countenance such an argument for unemployment compensation. The government does not permit unemployment compensation to continue after workers obtain new jobs to cover them in the event that their employer may lay them off from their new job. Rather, they once again become eligible for unemployment benefits if they lose their new job. Accordingly, veterans who recover from PTSD, but then relapse, would be eligible for disability compensation once again if their symptoms impair their ability to secure gainful employment.

Ironically, debates about malingering (Jackson et al., 2011; Marx et al., 2012; McNally & Frueh, 2012), especially concerning failures to document exposure to Criterion A1 traumatic stressors (Frueh et al., 2005), have become moot. That is, in an apparent effort to speed up the claims process, the federal government no longer requires documentation of exposure to a traumatic stressor for a veteran to qualify for PTSD (Department of Veterans Affairs, 2010). That is, proving that one served in a war zone where one had reason to fear encountering a trauma, including one that never materialized, certifies the veteran as a trauma survivor potentially eligible for a compensable PTSD diagnosis.

Although anyone, in principle, can experience a trauma, epidemiological data show that deployment without combat exposure does not elevate risk for PTSD (Fear et al., 2010). For example, Smith et al. (2008) found a numerically higher rate of PTSD among never-deployed troops (2.3%) than among deployed troops that never experienced combat (1.4%; e.g., firefights, explosions of improvised explosive devices, mortar attacks). Thus, there is virtually no "mere deployment" effect.

As Dao (2012) mentioned, dispensing with the requirement that veterans must document exposure to a traumatic stressor has prompted "concerns that the change will open the door to a flood of fraudulent claims." Gade (2013) predicted that this move should increase illegitimate as well as legitimate claims. Indeed, as one seasoned clinician specializing in the assessment and treatment of PTSD in the VA system observed, "Now that no proof of trauma is necessary, we have torrents of clear malingerers coming in and the entire picture is clearly changed. Really, the debate [about risk of malingering] is over when they openly say, 'I need help with my bills, so I'm filing a claim.'" Concerned that such candor might imperil one's career in the VA, this clinician requested anonymity.

Fortunately, the chances of recovery from PTSD have never been better than today as the VA has mandated prolonged exposure (PE) and cognitive processing therapy (CPT), two evidence-based treatments developed by Edna B. Foa and Patricia A. Resick, respectively (Foa, Gillihan, & Bryant, 2013; Karlin et al., 2010; McNally, 2012). Some very preliminary data are promising. Tuerk et al. (2011) reported that of the 66% of veterans of the wars in Iraq and Afghanistan who completed a program of prolonged exposure (PE), 74% had posttreatment PTSD scores that fell well below the clinical cutoff for PTSD. Although the dropout rate was rather high, these data suggest that the treatment is reasonably effective. The authors did not mention whether these 74% rescinded any disability compensation they had been receiving or whether they were able to secure gainful employment once they recovered from PTSD. Moreover, some patients may enjoy improvements in their clinical status, yet be reluctant to disclose such improvements on this questionnaire for fear of losing their disability compensation payments.

A key measure of the effectiveness of VA clinical services and programs will be the ability of PTSD patients to rescind their disability compensation and return to productive lives in their community. Mere symptom reduction is insufficient evidence of improvement. Indeed, the diagnosis of PTSD requires evidence of impairment (or, redundantly, clinically significant distress; McNally, 2011, p. 64–68).

The VA central office requires administration of the PCL to all veterans with PTSD every 90 days to track their symptoms. Although these data do not arise from randomized controlled trials, they nevertheless provide insight into whether veterans are responding to treatment. To our knowledge, these effectiveness data have yet to receive public dissemination or scientific analysis. If the mandated evidence-based treatments work as well as everyone hopes, symptoms would recede for most patients, thereby enabling recovered veterans to dispense with disability compensation as they join the civilian workforce. We encourage the VA to examine and disseminate the clinical outcome results of this extensive, national database.

Taken together, the foregoing considerations suggest that the rise in disability claims may partly be attributable to individuals without PTSD claiming that they suffer from the disorder. Whether such claims constitute malingering or the misconstrual of transient emotional responses to war as symptoms of disorder remains unclear. As Gade (2013, p. 57) has observed, "the VA now actively pursues patients who might have the condition [PTSD], using public-awareness campaigns such as 'PTSD Awareness Month' (June)." The VA routinely screens veterans for PTSD, including those seeking help for nonpsychiatric medical problems. Although this process will identify undiagnosed sufferers of the disorder, it may also encourage veterans to construe transient emotional reactions as symptoms of PTSD. Unwittingly fostering an expectation of permanent disability may be an unexpected consequent of such well-intentioned efforts at outreach.

4.4. Can economics explain the increase in disability seeking?

Analyzing a massive federal dataset, labor economists Angrist, Chen, & Frandsen (2010) concluded that financial need, not psychiatric disorder, is the primary driver of the skyrocketing rate of disability claims among veterans of the Vietnam era. Their analyses revealed that the increase chiefly occurs among veterans whose limited vocational skills reduce their ability to make a decent living. Moreover, Angrist et al. found that combat exposure (and hence PTSD) among these men could not account for the increase in claims.

Accordingly, they concluded, "This leaves the attractiveness of VDC [veterans' disability compensation] for less-skilled men and the work disincentives embedded in the VDC system as a likely explanation for our findings" (p. 824). Analyzing data from Australian veterans of the Vietnam War, Siminski (2013) found that service-connected disability payments functioned as work disincentives.

The United States has taken several years to recover economically from the Great Recession of 2008, and some recent veterans may have encountered difficulties obtaining jobs after separating from the service. Perhaps economic factors play a role in skyrocketing disability claims for recent veterans as Angrist et al. have shown they do for aging Vietnam veterans. Certainly chronic unemployment can place an immense psychological and financial burden on those unable to find decent jobs in the civilian sector. After proudly serving one's country during wartime, it is profoundly demoralizing to find oneself among the unemployed. The shame and psychological stress of unemployment can sometimes be fatal; it can contribute to suicide attempts (Gilligan, 2011, p. 158–159).

In fact, the suicide rate among military personnel has risen dramatically, surpassing the civilian rate for those of the same age bracket and possibly reaching an unprecedented rate for military during wartime (Frueh & Smith, 2012). Among U.S. Army personnel, suicide rates increased by more than 80% between 2004 and 2008, reaching a rate in 2008 (20.2 per 100,000) that surged past the age- and sex-matched civilian rate of 18 per 100,000 (Bachynski et al., 2012). Although clinician-diagnosed mental illness, especially

alcohol-related disorders, anxiety disorders, PTSD, and adjustment disorder increase risk for suicide, soldiers who had deployed abroad were not significantly at greater risk for dying by suicide than soldiers who had never deployed. Indeed, 31% of the suicide deaths occurred among soldiers who had never deployed.

Veterans struggling unsuccessfully to secure decent jobs may be especially prone to interpret their normal emotional stress responses to having served in a war zone as symptoms of PTSD, and to seek help for the disorder in order to obtain disability compensation to help pay the bills. It is surely better to obtain disability payments for injuries, psychological as well as physical, sustained as a warrior than to receive welfare. Indeed, from being a valued member of a highly trained, professional armed forces unit, to being another nameless member of the unemployable segment of America's rejected class is a very difficult transition. Shame motivates righteous anger and steps to restore one's pride (Gilligan, 2011, pp. 97–122). These psychological motives, plus the need to pay the rent and buy the groceries may drive many veterans to seek disability compensation as a way of meeting both kinds of needs in troubled economic times.

The stress of chronic unemployment may play a role in some disability applicants, especially among younger veterans. Moreover, psychiatric and medical problems may impede veterans' job-finding efforts. For example, the unemployment rate in the United States was 7.6% in May 2013 (Bureau of Labor Statistics, 2013). Although the unemployment rate for veterans of Iraq and Afghanistan has been improving, it was still 9.9% in 2012, and 20% for veterans in the 18–24 age range relative to 16.4% for nonveterans in this age range (Bureau of Labor Statistics, 2013). By way of comparison, the United States unemployment rate was 25% in 1933, the worst year of the Great Depression (Romer, 1992).

4.5. The medical model versus social model of disability

Finally, as Gade (2013) observed, another factor driving the increase in disability applicants is that the VA uses the medical model of disability. According to this model, judgments of disability rest on a diagnosis, and the severity of the problem determines the disability rating. Hence, a soldier with service-connected partial hearing loss automatically qualifies as disabled even if he is a fully functioning member of society. Accordingly, the VA does not award compensation on the grounds of disability (i.e., incapacitation), but rather awards it based on a medical diagnosis regardless of whether it prevents social and occupational functioning.

In contrast, the social model of disability, embodied in the 1990 Americans with Disabilities Act, considers the degree to which the problem impedes social and occupational functioning. As Gade (2013) has pointed out, few veterans applying for disability compensation are disabled in the sense that most people understand the term: incapacitated and unable to support oneself financially.

Gade argues that many veterans, even seriously wounded ones, can rejoin society without joining the ranks of the permanently disabled. Gade himself is a case in point. He is a Lieutenant Colonel and Assistant Professor in the Department of Social Sciences at the United States Military Academy. Decorated for valor, he was wounded twice fighting in Iraq, lost one leg and nearly his life, and after more than 40 operations was able to continue his military service teaching political science at West Point.

5. Closing remarks

As a number of authors have argued, the VA's disability policies are flawed and in several ways detrimental to many veterans and the credibility of the VA system (Frueh, Grubaugh, Elhai, & Buckley, 2007; Gade, 2013; McNally & Frueh, 2012). Voicing concerns about

malingering, inappropriate allocation of disability benefits, or iatrogenic effects of disability policies in the VA system often leads to swift condemnation of being "anti-veteran." This criticism misses the mark. Our aim is to ensure that all veterans needing treatment for PTSD receive the best evidence-based care available to ensure that they flourish as fully functioning citizens, but failure to respond to treatment, resulting in chronic disability, ought to be the point where the disability safety net comes into play. Veterans should first undergo PE or CPT before pursuing certification as disabled and running the risk of psychiatric invalidism.

Moreover, clinical resources are finite, and hence veterans suffering from severe PTSD must receive top priority, not those simulating the disorder to obtain compensation payments. Veterans whose educational or occupational limitations result in their seeking compensation to survive economically certainly need help, but of a different sort. The recent expansion of training programs to help military personnel successfully transition into the civilian economy is an important step in this direction. Regulatory changes for some occupations would also aid this transition. For example, veterans who served as medics in the military must surmount additional training and educational hurdles to obtain employment in the civilian sector as emergency medical technicians even though their military training fully qualifies them for these jobs (C-SPAN Congressional Hearings, July 25, 2012 (C-Span, 2012)). Their military certification should be deemed equivalent to civilian certification.

Finally, the best treatments will arise from the best science. Accordingly, we must maintain the integrity of the scientific database on PTSD by ensuring that only those veterans truly suffering the disorder participate in research studies (Charney et al., 1998).

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