Instruction

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Originating Office:	ORDP ODP
Title:	**Policy Reminders for Evaluating Posttraumatic Stress Disorder (PTSD)**
Type:	AM - Admin Messages
Program:	**Disability**
Link To Reference:	See **References** at the end of this AM.

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Purpose:

This Administrative Message provides guidance to State and Federal adjudicators (including the Office of Disability, Adjudication, and Review (ODAR) hearing offices) about evaluating disability claims that include an allegation, assessment, or diagnosis of PTSD.

A. Background

Posttraumatic Stress Disorder (PTSD) is a mental disorder that can develop after a person (of any age) experiences or witnesses a traumatic event such as exposure to war, threatened or actual physical or sexual assault, a violent crime or serious accident, or natural disaster. The Diagnostic and Statistical Manual of Mental Disorders- Fifth Edition (DSM-5) 1/. classifies PTSD under Trauma- and Stressor-Related Disorders.

People experience, perceive, and deal with traumatic and stressful events in different ways. Not everyone who experiences a traumatic event will develop PTSD. Among those who do, a traumatic event may cause mild PTSD symptoms in one person but may prove devastating for someone else. There is also disparity among people as to when PTSD symptoms manifest after trauma. While symptoms usually begin within three months after the event, a delay of months, or even years, is possible 2/, 3/. Similarly, symptoms can resolve within three months or persist longer than twelve months. They can sometimes persist for decades. Symptoms may also improve and then re-occur or intensify in response to a variety of triggers such as reminders of the original trauma or new traumatic events.

Given the great variation in severity, onset, and duration of symptoms, evaluating disability claims involving PTSD can be challenging. Another characteristic of trauma-and stressor-related disorders that can complicate the disability adjudication process is that individuals may experience feelings of anxiousness, shame, fear, or guilt in association with the event and may be reluctant to discuss the event, let alone seek treatment.

B. Policy reminders and guidance
1. Documenting and evaluating severity

PTSD can be disabling under our rules either alone, or in combination with another impairment(s). In order to find disability, evidence must be sufficient to establish the existence of a severe medically determinable impairment (MDI) that either:

(a) meets or medically equals a listing,

(b) for Title XVI child claims, functionally equals the listings, or

(c) for adults, supports an allowance at step five of the sequential evaluation process.

We generally evaluate PTSD under the listing 12.15 in claims for adults, and under listing 112.15 in claims for children under age 18.

Consistent with policy and guidance outlined in the Mental Disorders introductory text, we document cases involving PTSD with evidence from medical and nonmedical sources. 4/ As with claims involving other mental disorders, we must consider psychosocial supports, structured settings, living arrangements, and treatment in reaching a determination. 5/

We will find a claimant to have an MDI of PTSD when there is objective medical evidence from an acceptable medical source (AMS) 6/ to support this MDI. For purposes of Social Security disability evaluation, objective medical evidence consists of signs, laboratory findings, or both. 7/ However, in the evaluation of claims involving PTSD there are currently no laboratory findings to confirm that a person has PTSD. Consequently, we must rely on psychiatric signs as objective medical evidence. We define psychiatric signs as medically demonstrable phenomena that indicate specific psychological abnormalities, e.g., abnormalities of behavior, mood, thought, memory, orientation, development, or perception. 8/ When reviewing a claim, we must be careful to distinguish between symptoms (which are the claimant's description of his or her physical or mental impairments) and signs (which are one or more anatomical, physiological, or psychological abnormalities that can be observed, apart from the claimant's statements of his or her symptoms) in order to establish an MDI for program purposes. Once we determine that there is an MDI of PTSD we must determine

whether the PTSD could reasonably produce the claimant's alleged symptoms as the first step of the symptoms evaluation process described in SSR 16-3p. 9/. There are four symptom clusters associated with PTSD:10/.

> **1. Intrusion**: Intrusive symptoms involve memories of the event that repeatedly and uncontrollably invade one's thoughts (for example, nightmares and dissociative reactions in which the individual acts as if the traumatic event(s) were recurring).
>
> **2. Avoidance**: This cluster involves persistent avoidance of stimuli associated with the traumatic event(s) (for example, avoidance of or efforts to avoid people or places associated with the event or distressing memories, thoughts, or feelings about the traumatic event(s)).
>
> **3. Changes in mood and cognition**: Negative alterations in mood and cognition associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred (for example, feelings of detachment or estrangement from others or an inability to remember a key part of the traumatic event).
>
> **4. Arousal and hyper-reactivity**: Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred (for example, sleep disturbance or being very watchful of one's surroundings (hypervigilance)).

These four symptom clusters are similar to the medical criteria in paragraph A of listings 12.15 and 112.15. The purpose of the paragraph A criteria is to ensure that the mental disorder we are evaluating under the listings is significant enough to consider at Step 3 of the sequential evaluation process. The paragraph A criteria acts as an initial "gatekeeper" that screens in impairments that may result in listing-level functional limitations. We do not use the paragraph A criteria to establish the mental disorder MDI, as part of our Step 2 analysis. The paragraph A criteria are a much higher threshold than establishing an MDI.

According to the DSM-V, PTSD has high rates of co-occurrence, or comorbidity, with other mental disorders. Common comorbid diagnoses in adults and older children include depressive, bipolar, anxiety, and substance use disorders. In young children, the most common comorbid diagnoses are oppositional defiant disorder and separation anxiety disorder.

When documenting and evaluating claims involving PTSD, it is important to remember:

- The claimant is not required to submit original documentation proving the traumatic event occurred (for example, official documentation of assault or confirmation by law enforcement that the claimant witnessed a school shooting). There must be evidence indicating that the person has reported the traumatic event to a social worker, counselor, or other health care provider at some point;
- Since the traumatic event is unique to the person experiencing it, an adjudicator should not discount an allegation of PTSD because of his or her personal belief that the event was of insufficient consequence to cause PTSD. The event itself is NOT the disabling factor, but rather how the person experiences, perceives, and deals with it. Determination of disability focuses on the medical evidence that reflects how the claimant has responded to the event and how he or she now functions because of it;
- PTSD may result from experiencing one traumatic event, but also from experiencing or witnessing multiple traumatic events; and
- Adjudicators must consider whether the claimant's PTSD has lasted or is expected to last for a continuous period of at least 12 months. The duration requirement for all claimants under Title II and Title XVI begins at the time that a person is continuously unable to engage in substantial gainful activity (SGA) because of an MDI(s). See DI 25505.030 for detailed instructions on evaluating the duration requirement.

2. Evaluating claims involving no treatment history, sporadic treatment history, or with possible evidentiary inconsistencies

When documenting and evaluating claims involving PTSD, it is important to remember:

- Some claimants may have experienced a traumatic event(s) and may allege symptoms commonly associated with PTSD, but may not have sought treatment for PTSD or another mental disorder and may not have all the medical evidence needed to evaluate the case. A consultative examination (CE) may be appropriate in these cases (see DI 22505.012 for guidance);
- We do not discount a claimant's allegations because the traumatic event did not occur recently. People with PTSD may be uncomfortable discussing the traumatic event(s) and resulting symptoms, and may delay reporting those symptoms to health care

providers. This is especially true in cases involving sexual violence, domestic abuse, and child abuse;

- We do not discount the symptoms a claimant reports because of the length of time between the traumatic event and the time the symptoms appeared, as medical research supports that people can exhibit a "delayed expression" of symptoms. 11/. While symptoms usually begin within the first three months after the trauma, some people may not express a full range of symptoms until many months, or even years, after the traumatic event. The DSM-5 classifies PTSD with "delayed expression" if the full diagnostic criteria are not met until at least six months after the event, although the onset and expression of some symptoms may be immediate;
- The medical record may not document the traumatic event consistently across the records of each provider. This inconsistency is common, given that people with PTSD may not report the traumatic event to every provider, or each provider may not provide an identical account of the claimant's statements;
- The medical record may not document the same symptoms consistently across the records of each provider. The fact that a claimant discloses symptoms of PTSD to one provider and not to another does not necessarily reflect an inconsistency with the claimant's self-report;
- The medical record may not document specifics regarding the frequency of symptoms (for example, "daily intrusive thoughts since the last visit"). Instead, the records may simply state, "patient has intrusive thoughts." The claimant or a nonmedical source who knows the claimant well is the best source of information in this instance;
- If any of the evidence in the record is inconsistent, we will consider the relevant evidence and see if we can determine whether the claimant is disabled based on the evidence we have. We will resolve the inconsistency when it is material to the disability determination, as we do with all medical evidence; and 12/.
- After making every reasonable effort to obtain needed evidence from the claimant's medical source(s), and prior to ordering a CE, it is important that we carefully consider which source can best provide the needed evidence. For instance, if we need additional

functional information, re-contacting the claimant's own medical source or a non-medical source may be most productive. If a CE is necessary, remember that the claimant's own medical source is generally the preferred CE provider (see DI 22510.010 Selecting a Qualified Medical Source to Perform a Consultative Examination (CE)). This policy is especially important in claims involving trauma-or stress-related disorders, as people with these disorders may be particularly reluctant to discuss the traumatic event, or their response to the traumatic event, with an unfamiliar CE provider.

3. Adjudicative value of information from non-medical sources such as family and friends

Because people with PTSD are often reluctant to discuss their experiences with medical professionals, information from nonmedical sources about the claimant's functioning can be extremely informative.

- Medical sources typically have fewer opportunities to observe a claimant. Family and friends regularly interact with the claimant and are able to offer crucial information about his or her functioning.
- Family members or friends may have insight into how the person functioned prior to the traumatic event, how the person may have structured his or her life to avoid specific symptom triggers as much as possible, and what may happen when the claimant experiences disruptions to that structure.
- Educational personnel (for example, teachers, classroom aides, daycare center workers, and counselors) who regularly interact with the claimant can provide helpful information about how the impairment has affected the person's behavior or day-to-day functioning. Information from this type of source is particularly helpful in child claims and claims involving young adults who are still in school.
- Examples of useful information that a nonmedical source might provide:

  EXAMPLE 1: The person avoids being in rooms in which all the doors are closed, must always sit with his or her back to the wall, does not converse with certain types of people (such as with males when the person was assaulted by a man), or avoids certain odors.

EXAMPLE 2: A domestic partner may report that the person is sleeping in a separate bed because he or she fights during sleep or wakes up with soaked sheets from sweating during nightmares.

EXAMPLE 3: A friend or family member may also indicate that the person has withdrawn from social contacts, or will not go into crowded places because of hypervigilance.

EXAMPLE 4: A teacher reports that a child is frequently absent, often receives disciplinary action due to not following classroom rules, and has been asking to stay inside during recess instead of going outside to play with the rest of the class.

4. Drug addiction and alcoholism (DAA)

DAA often co-occurs with PTSD. The key factor we examine in determining whether DAA is material to the determination of disability is whether we would still find a claimant disabled if he or she stopped using drugs or alcohol. We make a DAA materiality determination when we have objective medical information from an AMS that establishes a medically determinable substance use disorder, and we find the claimant disabled considering all impairments, including the DAA.

As in claims involving other mental disorders, like schizophrenia, we must use caution when evaluating the effects of DAA in relation to PTSD. When it is not possible to separate the mental restrictions of DAA from the mental restrictions of PTSD, a finding of "not material" is appropriate. See Evaluating Cases Involving Drug Addiction and Alcoholism (DAA) SSR 13-2p in section DI 90070.041, for detailed instructions about making the materiality decision.

5. Determining onset

The established onset date (EOD) is the date that a claimant first meets the definition of disability and all the relevant entitlement or eligibility factors. Adjudicators should establish the EOD as of the date of the traumatic event, if the traumatic event caused the disabling impairment, the medical evidence supports it, and the claimant meets the technical requirements for disability on that date. However, if there is a delay between the traumatic event(s), onset of symptoms, and functional limitations, it may not be appropriate to establish the EOD as of the date of the traumatic event. Adjudicators need to establish the EOD based on each claim's pertinent medical, technical, and vocational factors.

You can also find more information and links to additional resources at www.ptsd.va.gov.

1/ Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V), American Psychiatric Association (2014).
2/ Ibid.
3/ University of Pennsylvania. “Post-Traumatic Stress Disorder.” Department of Psychiatry, Perelman School of Medicine, University of Pennsylvania. http://www.med.upenn.edu/ctsa/ptsd_symptoms.html
4/ See 20 CFR Part 404, Subpart P, Appendix 1, §§ 12.00C and 112.00C.
5/ See 20 CFR Part 404, Subpart P, Appendix 1, §§ 12.00D and 112.00D.
6/ See 20 CFR 404.1521 and 416.921.
7/ See 20 CFR 404.1502(f) and 416.902(f).
8/ See 20 CFR 404.1502(g) and 416.902(g).
9/ See 20 CFR 404.1529, 416.929.
10/ Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V), American Psychiatric Association (2014).
11/ Andrews B, Brewin CR, Philpott R, Stewart L: Delayed-onset posttraumatic stress disorder: a systematic review of the evidence. Am J Psychiatry 164(9):1319–1326, 2007.
12/ See 20 CFR 404.1520b (b) and 416.920b (b).

References:

DI 22505.008 Developing Supplemental Evidence
DI 22511.007 Sources of Evidence
DI 22511.011 Contacting Claimants and Collateral Sources
DI 22511.013 Technical Requirements When Securing Collateral Evidence
DI 23020.050 Disability Determination Services (DDS) Instructions for Identifying, Developing, and Processing Military Casualty/Wounded Warrior (MC/WW Cases)
DI 24501.020 Establishing a Medically Determinable Impairment (MDI)
DI 24515.001 Evaluating the Evidence
DI 25501.200 Overview of Onset Policy
DI 25505.025 Duration Requirement for Disability