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PG 21-1
Section 0-12 (Revised)
Change 282

RATING PRACTICES AND PROCEDURES

DISABILITY

MENTAL DISORDERS

1. Psychoneurosis. Drastic reductions in evaluations should not be made in ratings for psychoneurosis when a reduction to an intermediate rate is more in consonance with the degree of disability. Moreover, the general policy to be observed is gradual reduction in rates to afford the veteran all possible opportunities of adjustment.

2. Latent Schizophrenia. Several cases have been brought to our attention where regional office rating boards have accorded service connection for latent schizophrenia. To clear up any misconceptions, some explanation is provided.

Generally speaking, latent schizophrenia is not a proper disability for service connection. While the Diagnostic and Statistical Manual of Mental Disorders, 1968 Edition, American Psychiatric Association, lists the diagnosis in the same section as psychoses, careful reading of the diagnostic requirements clearly reveals that an essential element to the diagnosis is a history entirely free of psychotic episodes. Following a psychotic reaction, the disability must be reclassified for proper diagnosis. Therefore, latent schizophrenia is not a true psychosis. Since it also does not qualify as a neurosis, there is no basis for service connection for such a condition.

Claims for service connection for latent schizophrenia should be handled similarly to claims for service connection for personality disorders. While the condition is not a disability within the meaning of applicable laws, superimposed psychotic reactions in service or within the presumptive period would be a proper basis for service connection.

3. Post-traumatic Stress Neurosis (Disorder). The type of disorder contemplated under this diagnostic classification is a psychiatric disorder having its onset as an incident of armed conflict or enemy action, or following bombing, shipwreck, or internment under inhumane or severely deprived conditions or similar life threatening episodes. To justify the clinical diagnosis and to assure uniformity of its use, the following findings should appear in the clinical examination presented by the examiner.

a. A recognizable stressor that would be expected to evoke significant symptoms in almost all individuals, that is, a life threatening episode under circumstances mentioned above. It is important that this stress be described as to its nature and severity and also in time sequence, that is, whether it occurred while on active duty, before service or since discharge therefrom.

b. Re-experiencing the traumatic event either by a recurrent and intrusive recollection of the event, dream of the event, or suddenly acting or feeling as if the traumatic event were occurring because of an association with an environmental or ideational stimulus.

c. Numbing of response to or involvement with the external world beginning some time after the traumatic event as shown by markedly diminished interest in one or more significant activities, feeling of detachment or estrangement from others, or marked constriction of affective responses.

d. At least two of the following symptoms that were not present prior to the traumatic event:

(1) Hyperalertness or exaggerated startle response.

(2) Initial, middle or terminal sleep disturbance.

(3) Guilt about surviving when others have not, or about behavior required to achieve survival.

(4) Memory impairment or trouble concentrating.

(5) Avoidance of activities that arouse recollection of the traumatic event.

(6) Intensification of symptoms by exposure to events that symbolize or resemble the traumatic event.

When an examination is received with the diagnosis of post-traumatic stress neurosis (disorder) which does not show the foregoing findings, it should be returned as inadequate for rating purposes setting forth the reasons why the examination is inadequate.

The post-traumatic stress neurosis (disorder) is divided into acute and chronic. These episodes which are acute and transitory reactions

subside without recurrence and present no residual disability. They may not, of course, be service connected. It is also to be noted that some of the above-mentioned symptoms may occur episodically, and in between episodes the patient will not show symptomatology. On being questioned, however, the individual will disclose residuals such as nightmares, startle patterns, and problems with socialization.

Care should also be taken to assure that transient situational disturbances containing adjustment reaction of adult life which subside when the situational disturbance no longer exists or is withdrawn, and the reactions of those without neurosis who have "dropped out" and become alienated are not erected into a diagnosis of post-traumatic stress neurosis (disorder).

The diagnosis of post-traumatic stress neurosis (disorder) will appear more frequently after October 1, 1980, which is the date set for use by VA health clinics. When that diagnosis is presented upon examination supported by clinical findings set forth above, it will be accepted for rating purposes and evaluated by analogy to diagnostic code 9400, anxiety neurosis, with evaluations ranging from 0% to 100% under the general rating formula on page 125-4R of the Schedule for Rating Disabilities.

When this disorder is initially manifested during service and recorded in service department clinical records, generally under such outdated terminology as "shell shock" or "combat fatigue" or words of similar import, there should be no hesitancy in granting service connection even though there may be a lapse of a considerable period of time between the psychic trauma and its chronic manifestations. When initial clinical manifestation occurs at a date remote from service termination, service connection should still be granted if the life threatening episode, described by the examiner, is consistent with the nature, character and circumstances of veteran's service as evidenced by his or her military records.