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RE: Proposed Changes
DEPARTMENT OF VETERANS AFFAIRS
38 CFR Parts 3 and 4 RIN 2900–AQ73
Schedule for Rating Disabilities:
Neurological Conditions and Convulsive Disorders
[FR Doc. 2024-25665 Filed 11-8-24; 8:45 am]
VA-2024-VBA-0026-0001

I am a psychologist with over 20 years of experience related to evaluating disability claims.

VA's approach harms Veterans by preventing them from having some potential secondary service connections accurately and appropriately evaluated (ex: depression, chronic insomnia, etc.). This is something that can lead to the VA not fully addressing the impairment that Veterans experience in their daily lives (this is discussed further below).

VA's approach asks raters, who are not health care professionals, to evaluate whether something like depression, chronic insomnia, etc. is a symptom of another disorder or is a "separate and distinct" disorder-- something that is often likely to be a fallacious false dichotomy— and can also lead to Veterans not receiving the benefits they may deserve.

I have concerns related to the proposals and would like to point out opportunities for improvement.

- The proposals rely on the rater to "evaluate" whether impairments are symptoms of a single disorder versus reflecting a separate and distinct diagnosis from that disorder (yet the rater is not a medical professional and in many instances making the distinction may be arbitrary). I also provide "bonus commentary" (as an illustrative example for the above) in relation to the VA's guidance (aka changes) related to insomnia which, in my view, did not go through the proper rulemaking procedure. This bonus commentary involves evaluating insomnia as a symptom versus a disorder which is also an issue at play in this proposal.

- In the proposed approach there is an overreliance on terms like "objective" and "subjective" in a manner that lacks utility for examiners and used in a way that could mislead finders of fact. It is something that could lead to confusion, unreliability and high variability between examiners and raters. Likewise, other qualitative terms like "mildly interfere" and "moderately interfere" are also likely to lead to wide variability between

raters. These qualitative descriptors, when psychological testing is involved, can also lead to the impression of greater objectivity than actually exists.

The proposals rely on the rater to "evaluate" whether impairments are symptoms of a single disorder versus reflecting a separate and distinct diagnosis from that disorder (yet the rater is not a medical professional and in many instances making the distinction may be arbitrary). I also provide "bonus commentary" (as an illustrative example for the above) in relation to the VA's guidance (aka changes) related to insomnia which, in my view, did not go through the proper rulemaking procedure. This bonus commentary involves evaluating insomnia as a symptom versus a disorder which is also an issue at play in this proposal.

Raters should not be in charge of determining whether a residual is a "symptom" or a "separate and distinct formal diagnosis;" raters are not medical professionals. A medical professional should be involved in evaluating the nature and impact of impairments. In addition, this distinction by the VA can be arbitrary and not consistent with the scientific consensus in the field. I am offering my commentary on the VA's guidance on insomnia below as a clear example of this.

The proposal notes that the rater will be instructed "how to evaluate symptoms versus separate and distinct diagnoses." However, the rater is not a medical professional. This is something that should be done by a medical professional. The proposal notes "for example when an impairment such as depression is noted as a symptom versus a formal diagnosis, then it will be evaluated using the GRF for Specified Neurological Conditions. Conversely, if there is a formal diagnosis, then the disorder will be evaluated separately" as a mental disorder. While something like this is going on now, it is a process plagued with errors- errors that the VA desperately needs to reduce since there are already too many errors. The VA is asking raters to do incredible mental gymnastics when they are not even medical professionals. Even more amusing, this example of depression is highly concerning. "Depression" is not a single symptom—depression is an allegation, or a medical opinion related to an entire cluster of signs and symptoms—it is not a single, homogenous symptom that can be evaluated adequately by a rater.

In my experience working with these claims, I have often come across instances where VA raters have erred by missing diagnoses that are clearly listed as diagnoses in the records. The VA's rules would have us believe that raters, who are currently erring by not recognizing diagnoses clearly listed in the records, can adequately determine whether something is a symptom or a diagnosis (when this distinction is often fallacious to begin with). These proposals allow raters to continue to err by pretending they themselves evaluated the depression, insomnia or other "symptom" when they themselves are not even medical professionals. These types of mental gymnastics lead to excessive inconsistencies and Veterans having to repeatedly file claims in order to be appropriately evaluated by an actual medical professional- this should be corrected in order to help reduce the excessive amount of errors the VA has been racking up (and to be able to treat Veterans fairly). It would also mean, for example, that the depression associated with a neurological condition would be evaluated accurately and considered both in the context of the rating schedule for neurological conditions and in the context of the rating schedule for mental disorders.

This makes a difference. As the proposal notes, "if depression is a separate and distinct formal diagnosis, it will be service connected on a secondary basis" and evaluated under the mental disorders. The VA is perpetuating a similar error currently with insomnia disorder. This is discussed in the next section below.

The VA's guidance (aka changes) related to insomnia did not go through the proper rulemaking procedures. The guidance is wrong (and even includes inaccurate misquotations from the DSM-5).

I disagree with the relatively recent changes the VA added with guidance on insomnia disorder- they are wrong.

First, this guidance is, in fact, substantive changes which should have gone through the proper rulemaking process. There should have been an opportunity for the public to comment on these substantial, material changes. Had there been an adequate opportunity for the public to comment on these changes, the VA's error could have clearly been pointed out to the VA. Instead, countless Veterans are likely to be hurt by these changes which are based on a misquotation and inaccurate interpretation of the DSM-5. The VA cannot argue that the guidance on insomnia has always been the VA's approach, as the VA used a misinterpretation related to changes with the DSM-5 as the rationale for their changed policy guidance related to insomnia.

As above with the depression example (with depression as a "symptom" versus a "distinct formal diagnosis," whether the Veteran will be able to receive service connection for that "impairment" as a secondary condition is in peril (often with no actual medical professional being the one to make that determination).

However, the VA's guidance is also simply wrong in relation to insomnia and also based on a blatant misquotation from the DSM-5. This error should be corrected immediately.

The insomnia disorder guidance I refer to:

https://www.knowva.ebenefits.va.gov/system/templates/selfservice/va_ssnew/help/customer/locale/en-US/portal/554400000001018/content/554400000180520/M21-1-Part-V-Subpart-iii-Chapter-13-Mental-Disorders#1l

V.iii.13.1.l. Considering SC for Insomnia
Carefully consider the evidence of record when deciding SC for insomnia. Insomnia is generally considered a symptom of another disability due to coexisting medical or neurological conditions. Insomnia can occur as an independent condition or can be a symptom associated with another mental disorder (for example, major depressive disorder), medical condition (for example, pain), or another sleep disorder (for example, a breathing-related sleep disorder).

When insomnia is adequately identified as a symptom of another underlying disability, SC should be established for that diagnosis rather than for "insomnia," and the insomnia symptoms should be included in the evaluation for the primary SC disability. A separate evaluation is not warranted for insomnia that is considered secondary to, or a symptom of, another disability.

However, SC can be established on a direct basis for "insomnia" in the absence of a known or established underlying etiology if there is an event in service (such as a diagnosis of primary insomnia or insomnia disorder in service)
a current diagnosis of insomnia disorder meeting DSM-5 diagnostic criteria a nexus establishing

insomnia disorder post service is connected to the event in service, and the condition is not associated with any other disease or injury.

Important: A separate SC evaluation for a diagnosis of insomnia disorder is only warranted if all other potential causes are ruled out and SC can be established on a direct basis.

Notes:
DSM-5 revised the diagnostic terminology from "primary insomnia" to "insomnia disorder." In both the current and prior versions of DSM, the diagnostic criteria includes ruling out all other potential causes. Accordingly, a valid diagnosis of insomnia disorder meeting DSM-5 criteria means that the insomnia condition is not caused by (or secondary to) any other condition.

When evaluating insomnia disorder, rate analogously under an appropriate DC in 38 CFR 4.130.
Reference: For more information on analogous ratings, see
38 CFR 4.20
M21-1, Part V, Subpart iv, 1.C.2, and
M21-1, Part V, Subpart ii, 3.D.1.c.

The clarification from the VA above oversimplifies and misrepresents what is actually in the DSM-5-TR about insomnia disorder as well as what is in the international classification of sleep disorders, third edition- text revision.

The VA has misquoted and misinterpreted the DSM-5. Whoever wrote the guidance also appears to have not adequately grasped why the DSM-5 changed the approach related to a "primary" insomnia. The author(s) of the insomnia guidance continue to appear overly focused on making a clear distinction between primary and secondary insomnia, something that the field no longer views as realistic, or even evidence based. The VA's guidance errs by attempting to preserve clear distinctions between primary and secondary insomnia despite the field no longer agreeing with this overly simplistic approach. I discuss this more in the section below related to the diagnostic manual from the American Academy of Sleep Medicine (AASM). For example, The AASM noted on pg. 31 of their manual (the ICSD-3-TR) that the nosology for ICSD-3 is a "marked departure" from the ICSD-2's conceptual framework; the AASM notes "the previous insomnia nosology of the ICSD-2 promoted the concept that insomnia can exist as a primary sleep disorder or arise as a secondary form of sleep disturbance related to an underlying primary psychiatric, medical, or substance use disorder. However, differentiation between primary and secondary subtypes is difficult, if not impossible. More importantly, even when another condition initially causes the insomnia, it often develops into an independent disease entity that merits clinical attention… insomnia disorder seems best viewed as a comorbid disorder that warrants separate treatment attention." The VA's guidance reads as if it is desperately attempting to preserve an approach that the field long ago abandoned. This is also reflected in what the DSM-5 actually says (as noted the DSM-5 does not say what the VA guidance says that it does).

On. Pg. 410 of the DSM-5-TR, as a note below the diagnostic criteria for insomnia disorder, the DSM-5 notes that "the diagnosis of insomnia disorder is given whether it occurs as an independent condition or is comorbid with another mental disorder… persistent insomnia is a risk factor for

depression, anxiety disorders, and alcohol use disorder and is a common residual symptom after treatment for these conditions." The DSM-5 notes that "it is often impossible to establish the precise nature of the relationship between these clinical entities, and the relationship may change over time. ***Therefore, in the presence of insomnia and a comorbid disorder, it is not necessary to make a causal attribution between the two conditions.***" This is literally the opposite of what the author(s) of the VA's guidance about insomnia implied that the DSM-5 said. I will address this in more detail, with an example, below.

The VA's guidance related to insomnia disorder also assumes that the chronic sleep impairment from insomnia is already considered in the rating of other disorders– however, it often may not be (and it typically isn't with physical conditions).

The VA's guidance on insomnia above can make sense in relation to mental health cases where chronic sleep impairment is actually evaluated and considered in the mental disorders rating schedule, but it can potentially lead to a high number of times when it isn't adequately reflected in the rating when it is secondary to physical conditions. This is in part due to misguided cautions against pyramiding- essentially rating the impact of the same disorder more than once. The caution against pyramiding can often be abused, misunderstood and misused by VA raters and VA policy in general (I addressed this more in my response to the proposed changes for the mental disorders rating schedule), public comments that I made related to the mental disorder proposals in 2022 which I hope the VA will consider.

If insomnia is "caused" by a physical condition the impact of that insomnia on a Veteran's daily life is often not considered in the rating for that physical condition, thus there is no threat of pyramiding. Realistically, the impact of the insomnia had never been considered under that physical condition. There is no mechanism to consider it. The impact of insomnia is different from those physical symptoms alone. The Veteran with only an insomnia disorder diagnosis (instead of also a mental health disorder) could therefore be out of luck in having the VA recognize the impairment from that (and unfortunately may never even have a medical professional make that determination if it is left up to a rater).

An example of a physical condition which sometimes leads to chronic insomnia/ chronic sleep impairment is tinnitus. Not everyone with tinnitus has chronic insomnia/ chronic sleep impairment, however some people with tinnitus experience significant chronic sleep impairment (insomnia disorder) associated with their tinnitus. At the moment of writing this tinnitus is being rated by the VA at 10%. **It is telling that tinnitus currently only gets a 10% rating, yet chronic sleep impairment under the mental disorders rating schedule falls in the 30% rating. The impact of any chronic insomnia caused by tinnitus is therefore clearly not reflected by default on a tinnitus case and there is no pyramiding supported given that chronic sleep impairment from tinnitus was not considered and certainly isn't reflected in the 10% tinnitus rating alone.** All of the impact of tinnitus defaults to 10%, yet the symptom of chronic sleep impairment such as chronic insomnia is at the 30% level in the current (as of 2024) mental disorders rating schedule. So taking the above guidance *"the insomnia symptoms should be included in the evaluation for the primary SC disability. A separate evaluation is not warranted for insomnia that is considered secondary to, or a symptom of, another disability"* and applying it to something like tinnitus, for

example, where there is no real mechanism in the rating to also rate chronic sleep impairment like insomnia, subjectivity and inconsistency can get introduced which likely will harm the Veteran. Raters may also be asked to function like a medical professional when they aren't medical professionals. The 30% chronic insomnia/sleep impairment will not be recognized.

THE VA's GUIDANCE MISQUOTED THE DSM-5; now raters who aren't medical professionals are being instructed with inaccurate quotes from a text they likely have no access to or professional training in.

The diagnostic criteria for Insomnia Disorder under DSM-5-TR (pg. 410) includes "coexisting mental disorders and medical conditions do not adequately explain the predominant complaint of insomnia."

This is NOT the same thing as the VA guidance would suggest. The VA guidance suggests "the diagnostic criteria includes ruling out all other potential causes. Accordingly, a valid diagnosis of insomnia disorder meeting DSM-5 criteria means that the insomnia condition is not caused by (or secondary to) any other condition." However, this statement in the VA guidance is a gross mischaracterization of DSM-5. **It does not actually say this. This statement in the guidance is clearly wrong. As noted above, the DSM-5 also offers guidance that is completely the opposite of what the VA's guidance says.**

DSM-5 notes that the mental disorder or medical condition alone should not **adequately explain** the insomnia. Also, **NOWHERE** in the DSM-5 does it say that "ruling out all other potential causes" is required- this statement is also blatantly incorrect. As noted above, Pg. 410 of the DSM-5-TR also says the opposite of what is implied by the VA's guidance, that "the diagnosis of insomnia disorder is given whether it occurs as an independent condition or is comorbid with another mental disorder" and "it is often impossible to establish the precise nature of the relationship between these clinical entities, and the relationship may change over time. Therefore, in the presence of insomnia and a comorbid disorder, it is not necessary to make a causal attribution between the two conditions."

We can apply the above by continuing with our example of tinnitus. The scientific evidence supports that tinnitus alone does not adequately explain insomnia disorder or chronic sleep impairment.

- (remember "*adequately explain*" is what the DSM-5-TR **actually says**)
- (it also describes mental and medical conditions as "coexisting" and not that they are the same impairment)

For example, Barry & Marks (2023) note "a significant proportion of individuals with distressing tinnitus also report insomnia. Limited, but emerging, evidence suggests that tinnitus-related insomnia cannot be explained only by the presence of tinnitus and that sleep-related cognitive-behavioral processes may play a key role in exacerbating tinnitus-related insomnia."
[Barry G, Marks E. Cognitive-behavioral factors in tinnitus-related insomnia. Front Psychol. 2023 Mar 17;14:983130. doi: 10.3389/fpsyg.2023.983130. PMID: 37008859; PMCID: PMC10064054].

The physiological effects of tinnitus do not lead to insomnia disorder. The impact of tinnitus, in some but not all people, can trigger significant cognitive and behavioral effects which lead to insomnia/ chronic sleep impairment. This is NOT the same thing as tinnitus alone. Tinnitus can

trigger thoughts and behaviors, in some individuals, which promote the development of an insomnia disorder. This includes "dysfunctional beliefs" and "catastrophization."

Physical conditions (ex: tinnitus) can be a precipitating factor for insomnia, but they are not necessarily a perpetuating factor that prolongs chronic sleep impairment/ an insomnia disorder.

According to the three-factor (3P) model of insomnia, there are three primary factors that contribute to the development of chronic insomnia: (1) predisposing factors — traits or conditions (e.g., high emotional reactivity) that increase one's vulnerability to developing insomnia; (2) precipitating factors — situational conditions (e.g., stressful life events) that trigger the onset of insomnia; and (3) ***perpetuating factors — behaviors and cognitions that contribute to the transition from acute to chronic insomnia and maintain the disorder long term.***
[*Walker J, Muench A, Perlis ML, Vargas I. Cognitive Behavioral Therapy for Insomnia (CBT-I): A Primer. Klin Spec Psihol. 2022;11(2):123-137. doi: 10.17759/cpse.2022110208. PMID: 36908717; PMCID: PMC10002474*].

Tinnitus itself isn't the perpetuating factor- that is the mental health/sleep disorder piece reflected in the insomnia disorder diagnosis (i.e. the associated "behaviors and cognitions"). The 10% tinnitus rating reflects that trigger, but the perpetuating factors that can develop and lead to additional functional impairment are what is reflected in the 30% chronic sleep impairment rating/ insomnia disorder diagnosis.

The VA's guidance not only incorrectly quotes and mischaracterizes the DSM-5, but it is also inconsistent with the American Academy of Sleep Medicine's International Classification of Sleep Disorders, third edition (ICSD-3-TR).

The ICSD-3-TR should be considered relevant to this discussion on insomnia- in fact even more relevant than the DSM-5. This is supported by the DSM-5 itself. On pg. 407 of the DSM-5-TR, for example, the DSM-5-TR notes that the DSM-5 is a simplified approach "intended for use by mental health and general medical clinicians who are not experts in sleep medicine… in contrast, the International Classification of Sleep Disorders, 3rd edition (ICSD-3)… reflects the science and opinions of the sleep specialist community, and has been prepared by and for sleep specialists."

The ICSD-3-TR is the diagnostic manual from the American Academy of Sleep Medicine (AASM). It contains the current perspective and scientific advances from experts in the field of Sleep Medicine. The wording for Chronic Insomnia Disorder includes the phrasing that "the sleep disturbance and associated daytime symptoms are not ***solely*** due to another current sleep disorder, medical disorder, mental disorder, or medication/substance use." The inclusion of solely can be seen as a similar approach to DSM-5's indication that the insomnia is not adequately explained by another condition.

In relation to this criterion of not "solely" being due to another disorder, the AASM provided notes (see pg 34). They noted that "comorbidity does not preclude the independent diagnosis of chronic insomnia disorder. Evidence has clearly shown that even when a co-occurring disorder has instigated the insomnia, the sleep disturbance often transforms into an independent, self-sustaining disorder. By the time such a patient presents with an insomnia complaint to a health care provider, the insomnia is usually either independent of the comorbidity or shares a reciprocal

relationship with it. It is therefore difficult to determine, in practice, if an insomnia disorder is solely due to" another disorder.

On pg. 30-31 of the ICSD-3-TR, the American Academy of Sleep Medicine notes "insomnia symptoms often accompany comorbid medical illnesses, mental disorders, and other sleep disorders. Insomnia symptoms may also arise with the use, abuse, or exposure to certain substances. A separate insomnia disorder diagnosis ***is warranted*** when the insomnia symptoms are persistent and result in distress or impairment." This statement from the American Academy of Sleep Medicine contradicts the incorrect policy guidance the VA gave (noted above).

The AASM noted on pg. 31 that the nosology for ICSD-3 is a "marked departure" from the ICSD-2's conceptual framework; the AASM notes "the previous insomnia nosology of the ICSD-2 promoted the concept that insomnia can exist as a primary sleep disorder or arise as a secondary form of sleep disturbance related to an underlying primary psychiatric, medical, or substance use disorder. However, differentiation between primary and secondary subtypes is difficult, if not impossible**. More importantly, even when another condition initially causes the insomnia, it often develops into an independent disease entity that merits clinical attention… insomnia disorder seems best viewed as a comorbid disorder that warrants separate treatment attention**."

Above I describe a model of chronic insomnia that includes predisposing and precipitating factors (as well as perpetuating factors). On pg. 42 of the ICSD-3-TR the AASM clearly indicates that other disorders can be precipitating factors for a chronic insomnia disorder. For example, the AASM notes "…**medical disorders such as gastroesophageal reflux disease or conditions that result in chronic pain, breathing difficulties, or immobility can also lead to chronic insomnia disorder."** This indication related to precipitating factors from the AASM is also consistent with what I wrote above in the example related to tinnitus.

The American Academy of Sleep Medicine's perspective on chronic insomnia also contradicts the clearly erroneous VA guidance on insomnia noted above, guidance that did not go through the proper rulemaking process and that is based on misinterpretations and misquotations from the DSM-5.

- The VA's guidance related to insomnia disorder misquotes and mischaracterizes what is actually in the DSM-5-TR diagnostic criteria- this error should be corrected IMMEDIATELY as it is likely harming Veterans every day (a similar danger appears in the current proposals in relation to having raters—not medical professionals— "evaluate" symptoms that have a high likelihood of being related to diagnosable disorders that should be evaluated by health care professionals).
- The insomnia guidance reflects a clear misunderstanding of chronic sleep impairment and insomnia disorder
- It misuses and confuses pyramiding and relies on non-medical professionals to "evaluate" symptoms, leading to excessive errors and likely harm to Veterans
- It confuses precipitating factors– triggers– like tinnitus (10%) with the perpetuating factors that subsequently can develop in some cases (behaviors and cognitions) that lead to chronic sleep impairment (30%)/ an insomnia disorder.
- Insomnia disorder secondary to physical conditions like tinnitus should be something the VA addresses in order to reflect the chronic sleep impairment– perpetuating factors– that

can sometimes but not always develop (ex: how can a 10% tinnitus already reflect the presence of a 30% chronic sleep impairment?).

- The VA's guidance essentially requiring that service connection be essentially only *on a direct basis for "insomnia" in the absence of a known or established underlying etiology if there is an event in service (such as a diagnosis of primary insomnia or insomnia disorder in service)* is contrary to the actual scientific consensus in the field.
- The VA's guidance requiring that the *condition is not associated with any other disease or injury* is contrary to the actual scientific consensus in the field.
- The *"Important:"* guidance from the VA noting *"A separate SC evaluation for a diagnosis of insomnia disorder is only warranted if all other potential causes are ruled out and SC can be established on a direct basis"* is not only contrary to the scientific consensus in the field, it is actually wrong and mischaracterizes what the DSM-5 actually says. It is blatantly wrong. **These are the types of errors that would have been caught had the VA not tried to sneak these changes in as clarifications rather than the changes that they are- something that should have been done through the rulemaking process.**
- These are clearly and unmistakably not clarifications of things that have always been, when a misinterpretation and misquotation of changes related to DSM-5 were used as their justification- these are substantial changes and a deviation from current practice which should have gone through the rulemaking process.

The VA should take swift steps to remedy this error and stop using the insomnia guidance immediately.

Additional thoughts on the proposal:

In the proposed approach there is an overreliance on terms like "objective" and "subjective" in a manner that lacks utility for examiners and used in a way that could mislead finders of fact. It is something that could lead to confusion, unreliability and high variability between examiners and raters. Likewise, other qualitative terms like "mildly interfere" and "moderately interfere" are also likely to lead to wide variability between raters. These qualitative descriptors, when psychological testing is involved, can also lead to the impression of greater objectivity than actually exists.

Under evaluation of cognitive impairment and other residuals of TBI not otherwise classified, the "subjective symptoms" section is particularly troublesome. The indication related to three or more subjective symptoms "mildly interfering" or "moderately interfering" reflects qualitative terminology that is poorly flushed out and uses examples with little grounding in functional impairment. It is essentially a symptom list laundered through the unreliable and inconsistent opinions of an examiner. In addition, there is little evidence to support the symptoms chosen or guidance related to what "frequent" means in relation to insomnia or what a "daily mild to moderate headache" is in this context (and defining mild by saying something else that is mild to moderate seems like a poor example as does defining moderate by giving an example of something that is "markedly" impacted like fatigability). This reflects the difficult job of trying to take something highly subjective and symptom based and pretend that the VA can define that well. However, the VA should be more inclined to give a clearer picture of what someone at that level is actually functioning like in their daily life and encourage examiners to focus on functioning rather than a poorly-supported and defined symptom list or poorly-anchored qualitative term (ex: mild, moderate, marked, severe, extreme, etc.).

At times the VA's proposal seems to convince itself that there is a clear and distinct separation between the objective and subjective, such as with 8046 Cerebral arteriosclerosis where it labels "purely" subjective complaints. However, "purely" subjective complaints can be assessed by well-trained health care professionals who can observe signs related to these complaints and obtain a detailed history related to the functional impact of these complaints. Subjective complaints can in some ways be observed. Using phrasing like "purely subjective" may have the unfortunate consequence of leading people to believe that they cannot be evaluated through any means other than self-report, a belief that is inaccurate. Treating "purely" subjective and objective as complete opposites also can be misleading. "Objective" evidence may not be so objective.

Supposedly "objective" evidence is sometimes only as good as test and the person interpreting it, and not all tests are that good (and not all people interpreting tests interpret them in an evidence based manner). Not all tests adequately measure what they say they are trying to measure. In addition, there are test results and then there is the subsequent interpretation of these results which is not the same thing. A test result is a test result, it is not always a clear, objective picture of functional impairment in someone's daily life- this is particularly relevant in relation to cognitive testing. Cognitive testing often does not lead to an objective quantification of actual real-world functional impairment. Instead, cognitive testing can lead to qualitative descriptors like mild, moderate and severe which are not evidence based (and this is even openly admitted in the manuals for the test and statements from psychological and neuropsychological professional organizations). These "objective" tests often do not lead to an objective determination of a Veteran's ability to sustain functioning in relation to a given functional ability or setting.

This leads to a huge problem and opportunity for change in relation to some of the facets for TBI such as the memory, attention, concentration, executive functions facet. Simply stating things like "objective evidence on testing of mild impairment" or moderate or severe is likely to lead to an overreliance on qualitative descriptions from testing results which is anything but objective once we get to the part about interpreting qualitative ranges of test scores with very little supporting scientific evidence to say that these mild, moderate and severe ranges on testing lead to mild, moderate and severe real work functional impairment. "Objective" testing is good, but the VA must also add in real world functional descriptions providing examples of what mild, moderate and severe functional impairment actually looks like in someone's daily life (and not as a simple, unsupported symptom list either). Test selection can also impact this as well. For example, simply having a MoCA is unlikely to identify many of the memory, attention, concentration and executive functioning issues Veterans with TBI can experience or help to determine the severity of many of these impairments reliably, as the test is not designed for this. If the VA wants "objective" evidence the VA should incorporate more evidence based suggestions related to what that objective evidence might actually be, and what that objective evidence might look like at each level of impairment.

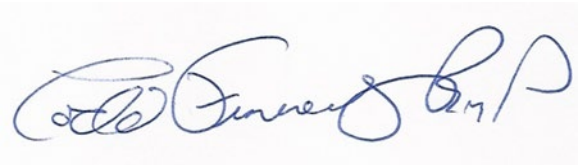
The interpretation of "objective" psychological testing results can often be highly subjective (the application of these so-called objective results to poorly supported qualitative descriptions of mild, moderate and severe impairment ranges and the prediction of untested, real world functional impairment is in fact not so objective after all).

When evaluating impairment, it is important to know things like how independent someone is in an ability/ how much assistance they need, how appropriate their actions/behaviors are, how effective

they are at it, and how long they can sustain an ability. In relation to symptoms- what is the frequency of it, the intensity of it and the duration of it, for example. However, on certain facets the VA is relying on only one factor such as frequency while failing to assess other factors like those just noted. For example, many facets focus on frequency, but this can be misleading without additional context and relevant factors like duration and intensity. For example, something that occurs at a frequency of five times a day for a duration of five minutes could be much less impairing than something that only happens once a week but for an entire day. Thus, the high frequency without considering intensity or duration can be misleading. In addition, symptom count alone (the total number of symptoms) does not necessarily correlate well with overall functional impairment, particularly in situations where some symptoms could be much more impairing than others. For example, we could compare someone who endorses a number of depression symptoms at a mild frequency, intensity and duration versus someone who endorses a fewer number of symptoms overall, but to the level of even making serious suicide attempts and requiring intensive interventions like psychiatric hospitalizations. The person with fewer overall symptoms could potentially be much more impaired due to the functional impact of those symptoms, even though their symptom count is smaller.

The VA's proposed changes should do more to focus on functioning and assess a wider range of factors relevant to impairment. This was also a concern of mine when I made public comments in 2022 in relation to the VA's proposed changes for mental disorders, comments you can read here:

https://nexusletters.com/2022/04/05/dr-finnertys-public-comments-vas-proposed-changes-to-the-mental-disorders-rating-schedule/



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Dr. Todd Finnerty is a psychologist in private practice in Columbus, Ohio. He has significant training related to PTSD, including VA-specific training through the contractors VES and QTC. Dr. Finnerty has had the same amount of training or more training than the third-party contractors used by the VA. In the past Dr. Finnerty has performed hundreds of examinations on veterans for VA third-party contractors. Dr. Finnerty also helps make decisions on Social Security disability claims for the state of Ohio and has substantial experience in evaluating impairment. In this role Dr. Finnerty was named the 2012 "Disability Review Physician of the Year" by the National Association of Disability Examiners, Great Lakes Region and the 2010 "Consultant of the Year" by the Ohio Association of Disability Examiners. He has training in behavioral sleep medicine and is a member of the American Academy of Sleep Medicine and the Society of Behavioral Sleep Medicine. Dr. Finnerty is a forensic specialist and adheres to the American Psychological Association's Ethical Principles of Psychologists and Code of Conduct as well as the APA's Specialty Guidelines for Forensic Psychology (https://www.apa.org/practice/guidelines/forensic-psychology). These guidelines include the responsibilities of integrity, impartiality and fairness and note: "When offering expert opinions to be relied upon by a decision maker, providing forensic therapeutic services, or teaching or conducting research, forensic practitioners strive for accuracy, impartiality, fairness, and independence. Forensic practitioners recognize the adversarial nature of the legal system and strive to treat all participants and weigh all data, opinions, and rival hypotheses impartially. When conducting forensic examinations, forensic practitioners strive to be unbiased and impartial, and avoid partisan presentation of unrepresentative, incomplete, or inaccurate evidence that might mislead finders of fact. This guideline does not preclude forceful presentation of the data and reasoning upon which a conclusion or professional product is based." While it would be convenient if Veterans in need of first or second opinions on mental health related claims could seek them from treatment providers at the VA, VA policy outlined in VHA Directive 1134(2) Provision of Medical Statements and Completion of Forms by VA Health Care Providers recommends that VA mental health treatment providers not complete forms such as "mental health DBQ's" in order to "maintain the integrity of the patient-provider relationship." Therefore, both the VA and Veterans often must seek forensic specialists outside of a treatment relationship to provide opinions related to their case.

Dr. Finnerty also writes a blog at https://NexusLetters.com