[redacted] Licensed Psychologist

Date: December 4, 2019

Re: [redacted]
Date of Birth: [redacted]

With respect to the matter of Mr. [redacted], what follows are my opinions, rendered to a reasonable degree of psychological and medical certainty, regarding the question whether Mr. [redacted] experienced traumatic events during his Naval career which led to the development of Post Traumatic Stress Disorder (PTSD) and other mental health conditions.

Disclosure Statements
I have been a Licensed Psychologist since May 1996. During my career I have worked in private medical practices, outpatient mental health and public health clinics, and in an inpatient psychiatric hospital. I have also worked with active duty military personnel and their families from Fort Bragg, N. C. and at Camp Lejeune, N. C. in a Regimental Aide Station. In addition, I have provided Compensation and Pension examinations for Veteran's Affairs since 2016.

To the best of my recollection, I have had no contacts with Mr. [redacted] This report is completely free from subjective bias of any kind and reflects entirely an objective review of Mr. [redacted]'s military records. I have reviewed the records provided to me, including the following:

- Records of medical and mental health services provided to Mr. [redacted] that were received in both VA medical facilities and in a private mental health practice

- Department of Veteran Affairs Rating Decisions

- Documents prepared during Mr. [redacted]'s appeal of VA rating decisions, including his Statement in Support of Claim for Service Connections for Post-Traumatic Stress Disorder (PTSD); a statement prepared by his wife; a statement prepared by his private mental health provider, [redacted], MA, and a statement prepared by [redacted] Ph.D.

- Mr. [redacted]'s Certificate of Release or Discharge from Active Duty (DD-214)
- Mr. [redacted]'s copy of his daughter's Certificate of Death
- Military Service Treatment Records (STRs) and post-service Private Medical Records(PMRs)
- VA Claims File

Any recommendations offered in this evaluation are provided for guidance and do not constitute a recommendation that specific claims or administrative action be made or enforced. I declare under penalty of perjury that the information contained in this report is true and correct, to the best of my knowledge and belief.

Summary of Medical History and Pertinent Facts

[redacted] joined the US Navy in June 1996 and served until he was discharged in September 1999. Records indicate that he had no physical or mental health conditions when he enlisted that would affect his Naval service. He served as an aviation bosun's mate and was deployed to the Middle East aboard the USS Carl Vinson in 1998. This ship was deployed as a support for the bombing strikes against Iraq that were taking place to support US ground troops during Operation Desert Fox.

While Mr. [redacted] was stationed in the middle east aboard the USS Carl Vinson his wife gave birth to their first child, a daughter born on March 10, 1999. This daughter was born at 21 weeks gestation and died shortly after her birth. In Statement(s) in Support of Claim for Service Connection for Post-Traumatic Stress Disorder (PTSD) that Mr. [redacted] has filed, he reported that he was deployed while his wife was pregnant but in March 1999 was told to see the Chaplain aboard the ship who informed him that his daughter had been born but was not expected to live. He also reported that he was initially told that he would not be able to leave the ship to return home to support his wife and daughter and became very upset. He was eventually granted leave and returned home to Seattle, flying through Dubai where he was detained. When he arrived at the Bremerton Naval Hospital, he was able to hold his daughter who had died prior to his arrival. In addition, Mr. [redacted] reported that his wife informed him that her request to transfer their daughter to another hospital with NICU services had been denied. Finally, Mr. [redacted] reported that his wife was so distraught by their daughter's premature birth and death that she attempted suicide by swallowing pills and he found her and called 911 for medical assistance.

In his statement, Mr. [redacted] also reported that, following his daughter's death and his wife's attempted suicide, he became "angry, anxious, and depressed" and drank alcohol heavily for the next 16 years. He also reported that he would have angry outbursts in

front of his children (three daughters born after these incidents). In addition, he reported that he has had years of employment difficulties (including write-ups and dismissals) because of his anger management problems. At the time he wrote the statement, Mr. [redacted] estimated that he had had at least twenty different employers since 1999. Fortunately, because of these difficulties, Mr. [redacted] and his wife have sought out mental health treatment to resolve marital and family issues, and Mr. Chapman has stopped drinking alcohol.

Mr. [redacted]'s report is substantiated by a similar report made by his wife, [redacted] dated October 10, 2013. In addition to reporting the same circumstances surrounding their daughter's death, Mrs. [redacted] reported that her husband "never really processed the whole thing – just drank the pain away. Since then he's had panic attacks. He's very distant with the family – especially the kids when they were babies". She also reported that "He has a lot of anger issues".

On November 7, 2013, Mr. [redacted] filed a disability claim with the Department of Veterans Affairs for service connection for Post Traumatic Stress Disorder (PTSD) and several other medical conditions. In the decision about this claim, rendered on November 7, 2014, Mr. [redacted]'s request for service connections for PTSD was denied for the following reasons:

"The evidence does not show an event, disease, or injury in service. Your service treatment records do not contain complaints, treatment, or diagnosis of this condition. We have not found that you experienced a stressful event in service, including fear of hostile military or terrorist activity. The evidence does not show a current diagnosed disability.

Your service treatment records were negative for treatment or a diagnosis of any mental disorder.
VA Medical Center (VAMC) – Palto Alto treatment records show you were diagnosed with attention deficit hyperactivity disorder, adjustment reaction, received counseling for marital and partner problems, as well as alcohol dependence, with no confirmed diagnosis of PTSD……..

A diagnosis of posttraumatic stress disorder must meet all diagnostic criteria as stated in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. The evidence does not show a confirmed diagnosis of posttraumatic stress disorder which would permit a finding of service connection."

A review of Mr. [redacted]'s medical records both supports and challenges the above-mentioned findings. As noted, his VA medical records indicate that he was diagnosed and treated with Methylphenidate HCL 10 mg for Attention Deficit Hyperactivity Disorder (ADHD). Furthermore, these records also indicate that, when seen by Laurie

Weston, MD, a VA psychiatrist, Mr. [redacted] requested family therapy to address relationship difficulties and parenting skills.

In addition, a review of his active duty medical treatment records does not indicate that he was ever diagnosed or treated for any mental health conditions. This is not surprising, given that research has suggested that military members are reluctant to admit to mental health concerns for many reasons. First, because of the negative stigma surrounding mental disorders, military members are discouraged from seeking mental health treatment. Secondly, PTSD can go undiagnosed because symptoms may not manifest themselves until many years after a person experiences a stressful event. (1)

A review of Mr. [redacted]'s VA records does, however, indicate that he was diagnosed and treated for PTSD, and was also diagnosed with other mental health conditions, including Alcohol Abuse and Generalized Anxiety Disorder. For example, in a January 7, 2016 report, Dale Smith, Ph.D., a Clinical Psychologist employed by the VA, noted that the "Veteran's PCL-5 score was a 44 (with a cut-off score of 38 suggestive of a PTSD diagnosis) and Veteran's PHQ-9 score was a 6 (which is suggestive of a mild depression)". He also noted that Mr. [redacted] had recently been referred to the PTSD Outpatient Clinic at the VAMC. Records also indicated that, in addition to individual and group psychotherapy Mr. [redacted] was treated with psychotropic medications, including Bupropion HCL 150 mg and Divalproex 500 mg.

As another example, in a June 23, 2015 VA Psychiatry Treatment Note prepared by [redacted] MD, she reported that Mr. [redacted]'s mental health problems, including "dysthymic presentation, reports of irritability, feeling emotionally distant from his children and reports of anxiety (suggestive of) depression" may have been "trigger(ed) by loss of newborn daughter". In a follow-up VA mental health treatment note, Dr. W[redacted] reported that "PTSD screen today was positive". He scored a 4 on the PTSD 4Q, a positive score and indictor of current PTSD symptoms.

After being evaluated and treated at the VAMC, Mr. [redacted] requested authorization for follow-up mental health treatment through a private provider closer to his residence. He reported that his employer was not supportive of him taking time off from his job to participate in treatment. In the request for authorization for outpatient services it was noted that Mr. [redacted] had a positive PTSD screen, and that he also was suffering from Alcohol Abuse in early remission.

Mr. [redacted] was authorized to receive treatment from [redacted] LMHC in Shelton, Washington. Ms. [redacted] submitted a Statement in Support of Claim on 4-6-17 noting that she had been working with Mr. [redacted] since 4-26-16. She noted that he was demonstrating symptoms of anxiety, angry outbursts, conflict with supervisors, and depression which he was self-medicating with alcohol. She also noted that he had been involved in drunk driving incidents but had stopped drinking on February 21, 2016. In

addition, she reported that he was having marital problems due to his angry outbursts, and problems at work resulting in warnings to keep his emotions in check. Ms. [redacted] recommended that Mr. [redacted] be service connected for PTSD.

As noted above, Mr. [redacted] has received several mental health diagnoses in the past few years, including PTSD, ADHD, Generalized Anxiety Disorder, Alcohol Abuse Disorder, and Major Depressive Disorder. This is not uncommon among individuals experiencing PTSD and may, in fact, account for the confusion in his diagnoses. In one study it was estimated that 84% of individuals with PTSD meet criteria for at least one other psychiatric disorder, making it easy to overlook the possibility that an individual is suffering from PTSD. Comorbid disorder such as major depression, alcohol abuse, substance abuse, specific phobias, panic disorder, schizophrenia, and antisocial and borderline personality disorder may all be diagnosed first, thereby relegating the individual's trauma history to the background (2). The National Comorbidity Study in the USA estimated that 59% of men with PTSD and 44% of women with PTSD met criteria for three or more psychiatric diagnoses (3, 4).

Unfortunately, research has also demonstrated that one of the significant problems related to undiagnosed PTSD is difficulties in educational and occupational environments. It has been noted that individuals with severe mental illnesses have a "lack of attachment to the workforce" and that the unemployment rate among individuals with severe mental illness is among the highest of all disability groups (5,6). These findings are consistent with Mr. [redacted]'s report of his frequent employment problems that have resulted in warnings and dismissals.

Contrary to the finding of the Veteran Affairs that Mr. [redacted] does not meet diagnostic criteria for diagnosis of PTSD in accordance with the DSM-V, his records suggest a different finding, as discussed below.

Post Traumatic Stress Disorder (F43.10)

Criterion A: Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s).
2. Witnessing, in person, the event(s) as it occurred to others.
3. Learning that the traumatic event(s) occurred to a close family member of close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s).

Mr. [redacted]'s records indicate that he meets Criterion A, 2 & 3 when he learned of his infant daughter's death and when he witnessed his wife after she had attempted suicide.

Criterion B: Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s) beginning after the traumatic event(s) occurred.

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).
2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).
3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring.
4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

In a January 30, 2017 Psychiatry Note recorded by [redacted] MD, it is reported that Mr. [redacted] is "doing better with medication but still struggles with some nightmares".

Criterion C: Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:

1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

Mr. [redacted]s wife reported that he has been "very distant with the family – especially the kids when they were babies". In addition, records indicate that Mr. [redacted] began using excessive amounts of alcohol in order to cope with the stress he was feeling following the traumatic events to which he was exposed.

Criterion D: Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Inability to remember an important aspect of the traumatic event(s).
2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world.
3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.

4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).
5. Markedly diminished interest or participation in significant activities.
6. Feelings of detachment or estrangement from others.
7. Persistent inability to experience positive emotions.

Throughout Mr. [redacted]'s VA treatment records, it is noted that he has been experiencing significant problems with anger and irritability that have led to problems both in the work and home environment. In addition, Mr. Chapman's wife has reported that he was "very distant with the family – especially the kids when they were babies".

Criterion E: Marked alterations in arousal or reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.
2. Reckless or self-destructive behavior.
3. Hypervigilance.
4. Exaggerated startle response.
5. Problems with concentration.
6. Sleep disturbance.

Mr. [redacted]'s records include many notations of problems he has experienced with irritable and angry behavior. He has also experienced sleep disturbances, and melatonin was recommended as a sleep aide. He has also experienced concentration problems, but these existed prior to the traumas that he experienced.

Criterion F: Duration of the disturbance (Criteria B, C, D, and E) is more than 1 month.

This duration is documented by Mr. [redacted]'s records.

Criterion G: The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Records document that Mr. [redacted] has experienced occupational difficulties, as well as marital and family difficulties. In the past he requested marital and family counseling at the VAMC.

Criterion H: The disturbance is not attributable to the physiological effects of a substance (e.g. medication, alcohol) or another medical condition.

Mr. [redacted] did use alcohol heavily in the past but began this after experiencing the traumas. In addition, he no longer drinks alcohol.

Summary and Conclusions

Mr. [redacted] served in the US Navy from June 1996 until September 1999, working as an aviation bosun's mate aboard the USS Carl Vinson. While deployed to the Middle East he was informed that his wife had gone into premature labor and had delivered their daughter at 22 weeks gestation. He was initially denied the opportunity to leave the ship and return home to help his wife, but after being granted permission he flew home and was able to hold his daughter after she was deceased. Mr. [redacted] and his wife both report being upset that their daughter was not flown to another hospital where she might benefit from NICU treatment. Following his daughter's death, Mr. [redacted]'s wife attempted suicide by swallowing pills and he was able to render assistance by calling 911.

Mr. [redacted] filed a request for service connection for PTSD on November 7, 2013, and this was denied on November 7, 2014. In the denial of this request it was stated that Mr. [redacted]'s military treatment records do not indicate that he was diagnosed or treated for any mental health conditions while on active duty. However, as discussed above, it is not unusual for active duty military personnel to be guarded about mental health conditions and not seek treatment for many reasons.

This denial also noted that there were no indications in Mr. [redacted]'s VAMC treatment records that he had been diagnosed and treated for PTSD. However, a review of records reveals that this is not accurate, as discussed in the information presented above.

Finally, this denial states that Mr. [redacted]'s symptoms have not and are not consistent with a diagnosis of PTSD, as defined by the American Psychiatric Association's DSM-V. This finding is refuted in the discussion found above.

It is my professional opinion that Mr. [redacted] symptoms meet diagnostic criteria for a diagnosis of PTSD, (F43.10). Therefore, it is at least as likely as not that Mr. [redacted]'s claim of PTSD was incurred in or related to an in-service stressor-related event.

It is also my professional opinion that Mr. [redacted]s symptoms meet diagnostic criteria for a diagnosis of Alcohol Use Disorder, severe, in sustained remission (F10.20). Therefore, it is also as likely as not that Mr. Chapman's diagnosed Alcohol Use Disorder was incurred in or related to the PTSD that he experienced resulting from an in-service stressor.

Respectfully submitted,

[redacted]

Amalia I. O'Neill, Ph.D.

[redacted]

[redacted]

[redacted] Licensed Psychologist #[redacted]
Licensed Health Services Provider

References

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