



BOARD OF VETERANS' APPEALS

DEPARTMENT OF VETERANS AFFAIRS

WASHINGTON, DC 20420

IN THE APPEAL OF
GENE A. TROTMAN

DOCKET NO. 08-14 281

)
)
)

DATE

12 JUL 2012

On appeal from the
Department of Veterans Affairs Regional Office in Hartford, Connecticut

THE ISSUE

Entitlement to service connection for an acquired psychiatric disability, currently diagnosed as posttraumatic stress disorder (PTSD) and major depressive disorder.

REPRESENTATION

Appellant represented by: Margaret Middleton, Attorney

ATTORNEY FOR THE BOARD

C. C. Dale, Associate Counsel

INTRODUCTION

The Veteran had active duty service from April 1972 to October 1973.

IN THE APPEAL OF
GENE A. TROTMAN

This matter comes before the Board of Veterans' Appeals (Board) on appeal from a November 2007 rating decision by a Regional Office (RO) of the Department of Veterans Affairs (VA) located in Hartford, Connecticut that denied a petition to reopen a claim for service connection for PTSD.

In January 2010, the Board granted the Veteran's petition to reopen the claim for service connection for PTSD.

The Veteran has submitted additional evidence since the agency of original jurisdiction's (AOJ) last supplemental statement of the case. In June 2012 the Veteran through his representative waived review by the AOJ. 38 C.F.R. § 20.1304.

During the pendency of the appeal, the United States Court of Appeals for Veterans Claims (Court) held that a claim for service connection for a psychiatric disability encompasses all psychiatric symptomatology, regardless of how that symptomatology is diagnosed. *Clemons v. Shinseki*, 23 Vet. App. 1 (2009). In the present case, the Board has considered the issue of service connection for the Veteran's psychiatric disability, regardless of diagnosis. *See id.*

A review of the Virtual VA paperless claims processing system does not show pertinent records that are not currently associated with the claims folder.

FINDINGS OF FACT

1. There is credible supporting evidence of an in-service stressor that has served as the basis for currently diagnosed PTSD.
2. The Veteran's current psychiatric disability is the result of an in-service stressor.

IN THE APPEAL OF
GENE A. TROTMAN

CONCLUSION OF LAW

The criteria for service connection for a psychiatric disability, currently, currently diagnosed as PTSD and major depression, are met. 38 U.S.C.A. §§ 1110, 5107(b) (West 2002); 38 C.F.R. §§ 3.102, 3.303, 3.304 (2011).

REASONS AND BASES FOR FINDINGS AND CONCLUSION

Duty to Notify and Assist

The Veterans Claims Assistance Act of 2000 as amended (VCAA) and implementing regulations impose obligations on VA to provide claimants with notice and assistance. 38 U.S.C.A. §§ 5102, 5103, 5103A, 5107, 5126 (West 2002 & Supp. 2011); 38 C.F.R. §§ 3.102, 3.156(a), 3.159, 3.326(a) (2011).

As the Board is granting the claim for service connection for PTSD, the claim is substantiated, and there are no further VCAA duties. *Wensch v. Principi*, 15 Vet App 362, 367-68 (2001); *see also* 38 U.S.C.A. § 5103A(a)(2) (Secretary not required to provide assistance "if no reasonable possibility exists that such assistance would aid in substantiating the claim").

Laws and regulations

Service connection will be granted for a disability resulting from disease or injury incurred in or aggravated by active service. 38 U.S.C.A. § 1131; 38 C.F.R. § 3.303.

Establishing service connection generally requires competent evidence of (1) a current disability; (2) in-service incurrence or aggravation of a disease or injury; and (3) a nexus between the claimed in-service disease or injury and the present disability. *Shedden v. Principi*, 381 F.3d 1163, 1167 (Fed. Cir. 2004); *see Caluza v. Brown*, 7 Vet. App. 498, 506 (1995), *aff'd per curiam*, 78 F.3d 604 (Fed. Cir. 1996) (table); *see also Shedden v. Principi*, 381 F.3d 1163, 1167 (Fed. Cir. 2004); *Hickson v. West*, 12 Vet. App. 247, 253 (1999); 38 C.F.R. § 3.303.

IN THE APPEAL OF
GENE A. TROTMAN

Under 38 C.F.R. § 3.303(b), an alternative method of establishing the second and third *Shedden/Caluza* element is through a demonstration of continuity of symptomatology. *Barr v. Nicholson*, 21 Vet. App. 303 (2007); *see Savage v. Gober*, 10 Vet. App. 488, 495-97 (1997); *see also Clyburn v. West*, 12 Vet. App. 296, 302 (1999).

Continuity of symptomatology may be established if a claimant can demonstrate (1) that a condition was "noted" during service; (2) evidence of post- service continuity of the same symptomatology; and (3) medical or, in certain circumstances, lay evidence of a nexus between the present disability and the post-service symptomatology. *Savage*, 10 Vet. App. at 495-96; *see Hickson*, 12 Vet. App. at 253 (lay evidence of in-service incurrence sufficient in some circumstances for purposes of establishing service connection); 38 C.F.R. § 3.303(b).

In relevant part, 38 U.S.C.A. § 1154(a) (West 2002) requires that VA give "due consideration" to "all pertinent medical and lay evidence" in evaluating a claim for disability or death benefits. *Davidson v. Shinseki*, 581 F.3d 1313 (Fed. Cir. 2009).

The Federal Circuit has held that "[l]ay evidence can be competent and sufficient to establish a diagnosis of a condition when (1) a layperson is competent to identify the medical condition, (2) the layperson is reporting a contemporaneous medical diagnosis, or (3) lay testimony describing symptoms at the time supports a later diagnosis by a medical professional." *Jandreau v. Nicholson*, 492 F.3d 1372, 1377 (Fed. Cir. 2007); *see also Buchanan v. Nicholson*, 451 F.3d 1331, 1337 (Fed. Cir. 2006) ("[T]he Board cannot determine that lay evidence lacks credibility merely because it is unaccompanied by contemporaneous medical evidence").

"Symptoms, not treatment, are the essence of any evidence of continuity of symptomatology." *Savage v. Gober*, 10 Vet. App. at 496 (*citing Wilson v. Derwinski*, 2 Vet. App. 16, 19 (1991)). Once evidence is determined to be competent, the Board must determine whether such evidence is also credible. *See Layno v. Brown*, 6 Vet. App. at 469 (distinguishing between competency ("a legal concept determining whether testimony may be heard and considered") and

IN THE APPEAL OF
GENE A. TROTMAN

credibility ("a factual determination going to the probative value of the evidence to be made after the evidence has been admitted"))).

Service connection may also be granted for a disease first diagnosed after discharge when all of the evidence, including that pertinent to service, establishes that the disease was incurred in service. 38 C.F.R. § 3.303(d).

Service connection for PTSD requires medical evidence diagnosing the condition in accordance with 38 C.F.R. § 4.125(a); a link, established by medical evidence, between current symptoms and an in-service stressor; and credible supporting evidence that the claimed in-service stressor occurred. 38 C.F.R. § 3.304(f); American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV).

The Veteran does not report a PTSD stressor incurred in combat or involving fear of hostile military or terrorist activity. 38 C.F.R. § 3.304(f)(3). Rather, he reports his stressor involves the threat of personal assault.

If a PTSD claim is based on in-service personal assault, evidence from sources other than the Veteran's service records may corroborate his account of the stressor incident. Examples of such evidence include, but are not limited to: records from law enforcement authorities, rape crisis centers, mental health counseling centers, hospitals, or physicians; pregnancy tests or tests for sexually transmitted diseases; and statements from family members, roommates, fellow service members, or clergy. 38 C.F.R. § 3.304(f)(5) (2011).

Evidence of behavior changes following the claimed assault is one type of relevant evidence that may be found in these sources. Examples of behavior changes that may constitute credible evidence of the stressor include, but are not limited to: a request for a transfer to another military duty assignment; deterioration in work performance, substance abuse, episodes of depression, panic attacks, or anxiety without an identifiable cause; or unexplained economic or social behavior changes.
Id.

IN THE APPEAL OF
GENE A. TROTMAN

VA may submit any evidence that it receives to an appropriate medical or mental health professional for an opinion as to whether it indicates that a personal assault occurred. *Id.* A medical examination can also provide evidence of the claimed stressor, i.e. of behavior changes in response to the stressor. *Mengassi v. Shinseki*, 638 F.3d 1379 (Fed. Cir. 2011).

Analysis

The first element of a successful claim for PTSD, is whether there is credible supporting evidence of an in-service stressor. The Veteran's claimed stressor involves a personal assault. Hence, the liberalizing provisions of 38 C.F.R. § 3.304(f)(5) apply and sources other than service records may be used to corroborate the stressor.

The Veteran initially reported the stressor to healthcare providers in December 2000, although the lay statements report that he had told other of the incident as early as 1980. The Board considers the Veteran's narrative itself to be plausible. *Buchanan*.

The Veteran's narrative has generally been consistent over several decades, but has variations on some details, such as the fate of the victim or recollection of the victim's name. *Compare* January 2002 VA examination report; February 2002 Veteran statement; August 2003 Dr. J.F. report; August and October 2006 VA treatment records; May 2007 VA treatment records, August 2010 VA examination report; and Dr. A.W. December 2011 evaluation. However, on one occasion the Veteran stated that he had witnessed multiple assaults and was also physically assaulted during incarceration. *See* October 2007 VA treatment records.

Review of the service records confirms that the Veteran was placed in a stockade in August 1973 on AWOL charges. These records show that he experienced severe depression necessitating medical intervention during incarceration. They also reflect that he became suicidal at the prospect of returning to confinement and needed tranquilizers. Diagnoses given during service included a personality disorder and adjustment reaction. However, they did not include any reports

IN THE APPEAL OF
GENE A. TROTMAN

alluding to the narrative of witnessing prison guard brutality and being threatened with physical and sexual assault while incarcerated. At a minimum, the available service records are not inconsistent with the Veteran's reports. The available service records provide support for the Veteran's narrative since they confirm an instance of incarceration and a major depressive episode at that time. *Buchanan*.

The Veteran's representative indicated that they had contacted the Air Force to obtain records that would verify the victim's incarceration, but had been informed by Air Force counsel that inmate records from the 1970s had been destroyed. *See* June 2012 representative statement.

There are numerous lay and healthcare provider statements of record suggesting behavior changes in response to the stressor. Since the claim is based on personal assault, these reports may provide credible evidence of the stressor. 38 C.F.R. § 3.304(f)(5).

The Veteran's brother testified at the January 1992 hearing that the Veteran had a drastic personality change following service. The Veteran had vague recollections of his time in incarceration, recalling that he had psychiatric treatment and apparently used tranquilizers. He reported that after service he had significant difficulties with interpersonal relationships.

Recent statements from family members indicate that the Veteran underwent a drastic personality change when he returned from service. *See* December 2011 statements from Veteran's Legal Brief. In most reports, the Veteran has denied any significant psychological problems prior to service, and the lay statements submitted on his behalf support his reports. There is nothing inherently implausible about the reported recollections of the Veteran's behavior following service by his friends and family. *Caluza*.

Both the Veteran's current and former spouses recalled that the Veteran mentioned an unspecified troubling incident while incarcerated during service. *See* December 2011 statements from J.T. and S.R. These reports buttress the Veteran's reports of a stressor. *Id.*

IN THE APPEAL OF
GENE A. TROTMAN

However, there is some evidence that the Veteran may have had social-psychological difficulties prior to the occurrence of the stressor, which raises the issue of inconsistency in the lay reports of a personality change. *Id.* Personnel records showed that the Veteran had marital and psychiatric difficulties resulting in his AWOLs. *See* June 1973 psychological evaluation. Some medical records reference problems with school, a citation for disturbing the peace, and an alcoholic father. *See* May 1997 state disability evaluation; October 2006 VA mental health clinic intake evaluation; August 2010 VA examination report. In addition, the Veteran's sister characterized their childhood as financially difficult and noted that their father was an alcoholic. However, she did not recall any violent behavior by him. *See* December 2011 statement by F.W.

Notably, the records suggesting preexisting psychiatric difficulties do not suggest that the Veteran had formal psychological treatment or had been given a psychiatric diagnosis prior to service. At enlistment the Veteran denied depression or any nervous disorder. *See* March 1972 Medical History Questionnaire. The reports of the Veteran's substance abuse history clearly indicate that it began following service. September 1991 Mother's statement; January 1992 RO hearing; December 2000 VA treatment records; January 2002 VA examination report; August 2003 Dr. J.F. report; December 2011 S.R. statement.

Although there is some conflicting evidence about the Veteran's psychiatric state prior to the reported stressor, the Board considers the numerous lay statements submitted on behalf of the Veteran to be generally plausible and internally consistent. The reports alluding to preexisting psychiatric disabilities are vague. *See* May 1997 state disability evaluation; October 2006 VA mental health clinic intake evaluation; August 2010 VA examination report.

They suggest that the Veteran had unspecified behavior problems and academic difficulties in high school, but do not suggest any psychiatric treatment or substance abuse problems prior to service. Overall, these reports are too vague and unspecific to undermine the numerous lay statements showing a drastic change in personality following service. Accordingly, the Board finds that the Veteran's friends and

IN THE APPEAL OF
GENE A. TROTMAN

family's reports showing a significant change in personality following to be probative. *Buchanan*.

There are several statements from healthcare professionals regarding the veracity of the Veteran in reporting the stressor. The comments from the two VA examiners that interviewed the Veteran did not reflect that they rejected his credibility in relating the stressor despite the absence of corroborating service records. *See* January 2002 and August 2010 VA examination reports. However, the March 2012 VHA examiner was more circumspect, noting that there were some varying details in the Veteran's narrative that undermined his veracity. Nonetheless, he did not reject the Veteran's reports outright. *See* March 2012 VHA opinion. In sum, there are no medical opinions weighing against the Veteran's veracity in reporting the stressor.

Dr. A.W. and the Veteran's current VA treating psychiatrist provided opinions that strongly support the Veteran's credibility in his reports of the stressor. *See* October 2011 VA treatment records; December 2011 Dr. A.W. evaluation. Dr. A.W. opined that the Veteran did not have malingering behavior. More poignantly, the VA treating psychiatrist stated "I do not believe he would have the capability to fabricate and sustain a false trauma narrative and PTSD symptoms over the years in multiple psychiatric settings." The treating VA psychiatrist has extensive familiarity with the Veteran's psychiatric state and history. Dr. A.W. based his opinion on an extensive review of the record, quantitative testing, and an interview with the Veteran. Hence, the Board considers their reports to be highly persuasive evidence that the Veteran is credible in reporting his stressor. *Caluza*; 38 C.F.R. § 3.304(f)(5).

Overall, there is evidence that the Veteran may have had some psycho-social difficulties prior to the stressor. However, these records are vague and do not suggest that the Veteran had formal psychiatric treatment or substance abuse disorders. There are numerous lay statements attesting to the Veteran's greatly increased social function prior to service. The clinicians' opinions given in October and December 2011 are highly persuasive that the Veteran's stressor reports are

IN THE APPEAL OF
GENE A. TROTMAN

credible. *See id.* Accordingly, the Board finds that there is credible evidence of a stressor involving personal assault. 38 C.F.R. § 3.304(f)(5).

The next issue for consideration is whether the Veteran has a PTSD diagnosis related to the reported in-service stressor. As an initial matter, the Board notes that the Veteran and other lay persons are competent to describe readily observable psychiatric symptoms. *Layno*. However, the determination of PTSD as a psychiatric diagnosis is a complex medical question beyond the capabilities of lay observation, and the Veteran is not shown to be a medical professional. Thus, his and any other lay assertions are not competent evidence to establish a PTSD diagnosis and have no probative value for purposes of showing a PTSD diagnosis. *See Davidson*, 581 F.3d at 1316; *Jandreau*, 492 F.3d at 1376-77; 38 C.F.R. § 3.304(f).

The medical evidence supporting the claim includes various VA treatment records reflecting a longstanding diagnosis of PTSD mostly on a historical basis, the October 2011 statement from the Veteran's treating psychologist, and Dr. A.W.'s December 2011 medical opinion. In contrast, March 2012 VHA opinion weighs against the claim.

When evaluating conflicting medical evidence, the Board must analyze its credibility and probative value, account for evidence which it finds to be persuasive or unpersuasive, and provide reasons for rejecting any evidence favorable to the Veteran. *See Masors v. Derwinski*, 2 Vet. App. 181 (1992); *Hatlestad v. Derwinski*, 1 Vet. App. 164 (1991); *Gilbert v. Derwinski*, 1 Vet. App. 49 (1990). In evaluating medical opinions, the Board may place greater weight on one medical professional's opinion over another's depending on such factors such as reasoning employed by the medical professionals, and whether or not and to what extent they review prior clinical records and other evidence. *Gabrielson v. Brown*, 7 Vet. App. 336 (1994).

A PTSD diagnosis was not entertained by healthcare professionals until December 2000. *See* substance abuse treatment records from December 2000. During the pendency of the appeal, several healthcare providers have provided either a PTSD diagnosis or PTSD diagnosis by history. *See* VA treatment records from April

IN THE APPEAL OF
GENE A. TROTMAN

through October 2007 and October 2011. However, review of the numerous VA treatment records does not show that examiners expressly detailed how the Veteran's psychiatric symptoms met each DSM-IV criterion for PTSD or otherwise included an explanation for the diagnosis. Most of the diagnoses were made on a historical basis. Nonetheless, the VA treatment records reflect PTSD findings based upon interviews of the Veteran by mental health care professionals. Accordingly, the Board considers the VA treatment records showing a PTSD diagnosis to be of some probative value. *See id.*; *see Nieves-Rodriguez v. Peake*, 22 Vet. App. 295 (2008) (the probative value of a medical opinion depends on its rationale and consideration of an accurate record).

In August 2010, the VA examiner agreed with the PTSD by history diagnosis. However, she opined that the Veteran had exposure to several traumatic incidences during his lifetime and that it was impossible to determine whether the in-service incident caused current PTSD symptoms. The Board considers her opinion to be equivocal as she indicated a PTSD diagnosis was present, but could not state whether the in-service stressor was responsible for it. As the August 2010 VA medical opinion is equivocal, it is entitled to minimal probative weight. *See Hood v. Shinseki*, 23 Vet. App. 295, 296 (2009); *Nieves-Rodriguez*.

In October 2011, the Veteran's treating VA psychiatrist opined that the Veteran had PTSD. He cited extensive clinical treatment of the Veteran since 2007 and his review of prior medical records. He explained why he did not believe malingering behavior was present. The Board considers his report to be highly probative as he has had extensive interaction with the Veteran in clinical settings and familiarity with the Veteran's medical history. *Nieves-Rodriguez*.

In December 2011, Dr. A.W. opined that the Veteran had a current PTSD diagnosis related to the in-service stressor. He based his opinion upon interview of the Veteran, review of the entire record, phone conversation with the treating VA psychiatrist, and clinical testing. He supported his opinion with an extensive rationale. He detailed how the Veteran had symptoms meeting each criterion that constituted a DSM-IV PTSD diagnosis. He considered the possibility of malingering behavior, but determined that it was not present based upon review of

IN THE APPEAL OF
GENE A. TROTMAN

the record, clinical testing, and interview observations. He cited the particular behavioral manifestations as being congruent with the stressor. He noted difficulty with authority figures, obsession over the fate of the victim, and feelings of guilt. He explained that the mechanism for the current PTSD symptoms was a distorted thought pattern resulting in poor choices. Given that Dr. A.W. had a fully informed review of the record and provided a detail rationale, his opinion has substantial probative value. *See Nieves-Rodriguez.*

The March 2012 VHA examiner provided a negative opinion. He reviewed the claims folder, but did not interview the Veteran. He carefully examined the Veteran's medical history in light of each DSM-IV PTSD criterion and found insufficient evidence of PTSD symptoms meeting each criterion. He noted that the Veteran's major depressive disorder and polysubstance dependence produced symptoms (such as sleep impairment) that would overlap with PTSD. He discounted the PTSD diagnosis given by VA clinicians as being based on a historical basis without careful consideration of the DSM-IV criteria and additional psychiatric disorders. He concluded that the Veteran's psychiatric symptomatology is better characterized by non-PTSD diagnoses. The March 2012 VHA opinion is based upon a thorough review of the record, with the exception of Dr. A.W.'s December 2011 evaluation and October 2011 VA treating psychiatrist's statement. The Board considers the opinion to be highly probative. *See Nieves-Rodriguez.*

Unfortunately, the March 2012 VHA examiner did not have an opportunity to review Dr. A.W.'s opinion. It is possible that his opinion may have been significantly revised or augmented in light of the conflicting opinions.

The most detailed analyses of whether the Veteran met the criteria for a PTSD diagnosis was provided by Dr. A.W.'s evaluation and the March 2012 VHA medical opinion. Both clinicians detailed each DSM-IV PTSD criterion and explained how the Veteran's symptoms related to those criteria, but reached opposite conclusions. *Nieves-Rodriguez.*

The Board considers the evidence to be in relative equipoise regarding the presence of a PTSD diagnosis related to the in-service stressor. Dr. A.W. conducted his

IN THE APPEAL OF
GENE A. TROTMAN

December 2011 evaluation based upon interview of the Veteran, quantitative clinical testing, and consideration of the current treating VA psychologist's opinion. Dr. A.W. is trained as a forensic psychiatrist, which involves expertise in evaluating malingering behaviors. These factors make Dr. A.W.'s opinion highly persuasive. *Gabrielson*. The March 2012 VHA examiner is a specialist in geriatric psychiatry. Although he is certainly competent to provide psychiatric medical opinions, the Board acknowledges that there are psychiatric specialties that more closely related to PTSD. However, he provided a thorough and detailed rationale for his negative opinion that is consistent with the record. It too is also highly probative. *Nieves-Rodriguez*.

In sum, the medical evidence of a PTSD diagnosis to be in relative equipoise. The record includes credible supporting evidence for the occurrence of the reported stressor. By resolving reasonable doubt in favor of the Veteran, the Board finds that there is medical evidence showing a PTSD diagnosis related to an in-service stressor. Service connection for PTSD is warranted. 38 C.F.R. §§ 3.102, 3.304(f)(5).

The Veteran's underlying psychiatric disability has been given various diagnoses over the years, in addition to PTSD. The evidence supports a finding that the psychiatric disability, regardless of diagnosis, was incurred in active service.

ORDER

Service connection for an acquired psychiatric disability is granted.



Mark D. Hindin
Veterans Law Judge, Board of Veterans' Appeals