DEPARTMENT OF THE NAVY
BOARD FOR CORRECTION OF NAVAL RECORDS
2 NAVY ANNEX
WASHINGTON DC 20370-5100

JRE
Docket No: 1176-01
21 January 2003

[redacted]

[redacted]

This is in reference to your application for correction of your naval record pursuant to the provisions of title 10 of the United States Code, section 1552.

A three-member panel of the Board for Correction of Naval Records, sitting in executive session, considered your application on 16 January 2002. Your allegations of error and injustice were reviewed in accordance with administrative regulations and procedures applicable to the proceedings of this Board. Documentary material considered by the Board consisted of your application, together with all material submitted in support thereof, your naval record and applicable statutes, regulations and policies. In addition, the Board considered the advisory opinion furnished by a designee of the Specialty Advisor for Psychiatry dated 27 September 2002, a copy of which is attached.

After careful and conscientious consideration of the entire record, the Board found that the evidence submitted was insufficient to establish the existence of probable material error or injustice. In this connection, the Board substantially concurred with the comments contained in the advisory opinion. In addition, it was not persuaded that you lacked mental responsibility when you committed the offenses for which you received nonjudicial punishment. Accordingly, your application has been denied. The names and votes of the members of the panel will be furnished upon request.

It is regretted that the circumstances of your case are such that favorable action cannot be taken. You are entitled to have the Board reconsider its decision upon submission of new and material evidence or other matter not previously considered by the Board. In this regard, it is important to keep in mind that a presumption of regularity attaches to all official records.

Consequently, when applying for a correction of an official naval record, the burden is on the applicant to demonstrate the existence of probable material error or injustice.

Sincerely,

W. DEAN PFEIFFER
Executive Director

Enclosure

NATIONAL NAVAL MEDICAL CENTER
ADULT OUTPATIENT BEHAVIORAL HEALTHCARE CLINIC
8901 WISCONSIN AVENUE
BETHESDA, MARYLAND 20889-5600

27 September 2002

FROM: CAPT [redacted], MC, USAF

TO: CAPT [redacted], MC, USN
Specialty Advisor for PSYCHIATRY
Naval Medical Center
San Diego, CA 92134

VIA: Service Chief, Outpatient Behavioral Healthcare Clinic, NNMC

SUBJECT: APPLICATION FOR CORRECTION OF NAVAL RECORDS OF [redacted]

REF: (a) 10 U.S.C. 1171
(b) Board for Correction of Naval Record letter of 7 August 2001

ENCL: (1) BCNR File
(2) Service record
(3) Medical records
(4) VA records

1. Per your request for review of the subject's petition for a correction of his Navy records, and in response to reference (b), I thoroughly reviewed enclosures (1) through (4). Of note, no documentation of the charges that led to non-judicial punishment was provided in this packet. I cannot comment on the patient's mental status at the time of the alleged offenses and therefore cannot render any opinion as to whether the Board should set aside his non-judicial punishment on the basis of a mental disorder.

2. Review of available service records revealed:
   a. Active duty service in the USMC from 7 October 1997 through 20 October 2000. He was a Rifleman for the majority of that time. The patient earned a Sea Service Deployment Ribbon, a Letter of Appreciation and a Rifle Sharpshooter Badge during his service. He was discharge with a General Discharge under Honorable Conditions.

3. Review of available Navy medical records revealed:
   a. SF88, Report of Medical History, signed and dated by the patient 25 August 1997. In section 11, which asked the patient to respond to the question "Have you ever had or have you now," under the statements "frequent trouble sleeping," "depression or excessive worry," "loss of memory or amnesia," "nervous trouble of any sort," and "periods of unconsciousness," he checked the column labeled "No." There is no record of a waiver for any prior mental health treatment accompanying the SF88.
   b. The above statements contradicted information found in several other places in the medical record. For example, an SF600, Chronological Record of Medical Care, dated 31 March 1998 from 3/7 MCAGCC 29 Palms documented not only current "depressed mood and irritability" but also a significant previous psychiatric history. The psychiatric history included "depression at age 9-10 with a three to four month hospitalization at 'Bedford Meadows'," in Texas, and outpatient follow-up. Involvement with counseling at age 14-15 for problems related to the patient's family was also documented in the note. The patient failed to report either the hospitalization or the counseling on SF88.

c. SF 513, Consultation Sheet completed 28 April 1998 from Mental Health Department, Naval Hospital 29 Palms contained further details. The patient was referred to Mental Health approximately six months after coming on active duty, with five weeks at his duty station, with a chief complaint that "the USMC was not what [he] expected." He endorsed transient homicidal ideation toward his company commander because of the "degree to which he [pushed]" the unit during "humps." The patient indicated that he had been on medication during and after his hospitalization at age 10, but discontinued it under his mother's direction. He also indicated that he was involved in counseling until approximately one year prior to enlistment. During this evaluation, the patient denied childhood physical or sexual abuse. Mental status evaluation at the time of the evaluation was significant for tearfulness and for a "pessimistic outlook and the position that it would not be worth living if he [could not] get an honorable or general discharge from the USMC." No symptoms of elevated mood, euphoria or grandiosity were noted, and the depressive symptoms were judged not severe enough to warrant a diagnosis of major depression. He was diagnosed with Adjustment Disorder with mixed emotional features, and returned to duty with restrictions for dangerous equipment and firearms and a temporary 1:1 watch. The note also indicated possible Personality Disorder, but fell short of making the diagnosis.

d. A follow-up note dated 6 May 1998 indicated that the patient was doing much better than on initial assessment, was looking forward to a deployment to Kuwait, and that the suicide risk was "acceptable." As a result, the 1:1 watch was discontinued, and the patient was returned to full duty with instruction to take the provider's next available appointment. The patient was a no-show to an appointment scheduled for 29 May 1998. The treating psychiatrist documented that he notified the patient's command about the no-show. No further psychiatric outpatient visits were documented in the chart. Of note, the patient presented to the Batallion Aid Station for evaluation of knee pain on 25 June 1998.

e. SF504, Clinical History, from 4 August 2000, documented a psychiatric admission for suicidality and homicidality. It was signed by LT Loomis, staff psychiatrist, and documented that in January of 2000, the patient and his wife of 2 months underwent marriage counseling and were later divorced in May of 2000. Per the record, the patient also participated in individual counseling and anger management classes around the same time. The record further indicated that a "pill overdose" prompted the psychiatric hospitalization at age 10. As in the previous documents cited above, the patient became suicidal and homicidal in the context of stressors, at this time his stressors included failure to be promoted to E4, his ex-wife's refusal to communicate with him, and several legal charges. Of note, the patient tested positive for cannabinoids on a routine urine drug screen at the time of psychiatric admission. He also endorsed a history of at least two episodes of childhood sexual abuse, but declined to provide any further details.

f. The Mental Health Services Narrative Summary dated 9 August 2000 indicated a discharge diagnosis of cyclothymic disorder based on his history of mood swings and depressed mood, not ever fully meeting criteria for either mania or major depression. Therapy with Lithium was initiated to assist with mood swings. A diagnosis of Personality Disorder NOS with antisocial and narcissistic features was also given at the time of discharge. The patient was recommended for expeditious administrative separation on the basis of personality disorder.

g. An outpatient clinic note dated 5 September 2000 indicated that the patient's mother, a registered nurse, was calling the clinic to question the diagnosis and ask about disability benefits. After listening to her concerns and description of some behaviors he exhibited while on leave (including reckless driving, borrowing and spending money, being quick to anger) the diagnosis of cyclothymic disorder was reconsidered but left unchanged.

4. Review of available VA records revealed:
    a. Initial Outpatient evaluation on 18 December 2000 at the VA North Texas Health Care System. He presented with pressured speech and request for refill of Lithium, and was referred for further evaluation of mood disorder and evaluation for participation in a research protocol.
    b. The next note, dated 27 December 2000 indicated that he presented a day late for participation in a research protocol, did not meet criteria for emergency referral or evaluation and was sent home with instructions to return the next day. He was admitted on December 28 2000 for hypomanic symptoms and to participate in a research study on bipolar disorder being conducted at that time. His lithium was discontinued and he was started on the study medication as per the protocol. Of note, during the intake evaluation, he denied any previous psychiatric hospitalizations prior to the year 2000, and also denied a history of childhood sexual abuse. He did endorse that his long-standing personal and family practice of Wicca, currently at odds with his mother's practice of Christianity.
    c. Hospital course was marked by overall cooperation with protocol and staff, with "immature, child-like behavior" noted on several occasions. Diagnostically, the attending psychiatrist noted onset of mild PTSD symptoms related to experiences the patient had while on active duty. Also, the attending psychiatrist performed a Structured Clinical Interview for the DSM (SCID), which, according to the note, "confirmed the diagnosis of Bipolar Disorder."
    d. During outpatient follow-up while on the study medication, the patient endorsed a previous history of head injury with loss of consciousness while playing football. The age at the time of injury was not indicated in the note.
    e. While on the study medication, the patient developed waxing and waning manic and depressive symptoms, often related to psychosocial stressors (social isolation, conflict with parents, and difficulty finding employment). On 8 March 2001, the patient was hospitalized for depressive symptoms, including suicidal ideation with plan to shoot himself with a gun he owned. Though there was no diagnostic test to confirm it, the notes indicated that he may have used marijuana in the days prior to the onset of his depressed mood. He was discharged from the research protocol as a result of his hospitalization, and his medications were changed to depakote 1000 mg po qhs, celexa 20 mg po qd and ativan 2 mg po qhs prn insomnia. He was discharged on 14 March 2001.
    f. After discharge, the patient continued to be depressed, and his celexa was increased to 30 mg po qd, and he was given clonazepam 0.5 to 1 mg po qhs prn insomnia.

5. Discussion:
    a. [redacted]n was formally evaluated by several different mental health providers on several occasions during his military career. Based on the data available at the time of these evaluations, he was never found to have an Axis I psychiatric condition of sufficient severity to disqualify him from continued service in the USMC. Despite his initial hospitalization at the VA (to participate in a VA sponsored research protocol), his only other hospitalization since discharge from the USMC was for depressed mood and suicidal ideation. [redacted] has a history of chronic dysphoria, mood swings and suicidal ideation and was hospitalized for the same reasons while he was on active duty.
    b. By history, he met criteria for an Axis II diagnosis of Personality Disorder Not Otherwise Specified, with Antisocial and Narcisisstic traits. This Axis II diagnosis led to a finding of not fit for continued military service, and he was discharged from the USMC on that basis. Based on my evaluation of the records, I believe this is the correct diagnosis and that the administrative discharge was appropriate. [redacted]n also demonstrates traits consistent with borderline personality disorder, such as severe mood swings, and this diagnosis was appropriately considered during his psychiatric hospitalization while he was still on active duty.
    c. Importantly, [redacted] falsified his entry SF88 by failing to disclose his previous hospitalization for suicide attempt at age 10, as well his history of head injury and loss of

consciousness. Had this information been disclosed as required by law, it is unlikely that [redacted] would have met enlistment standards, or been able to obtain a waiver for his condition. As troubling, in the context of attempting to obtain disability benefits, he selectively omitted his history of suicide attempt or his previous hospitalization and treatment with medication. Without this information, the VA physician made the erroneous conclusion that [redacted] symptoms originated during active duty service. By definition, personality traits have an enduring and pervasive quality beginning in adolescence or early adulthood. In [redacted] case, his poor coping and vulnerability to stressors was evidenced early in childhood. Again, I concur with the diagnosis of Cyclothymic Disorder, but feel that it is appropriate to add the specifier, "Existed Prior to Enlistment," to capture the mood disturbance that led [redacted] to seek mental health treatment prior to enlistment.

d. Per the record, despite severe interpersonal and religious conflicts, [redacted] mother has been intimately involved in helping him to obtain help for his mental health. According to the record, she supervised his discontinuation of medication within two months of his hospitalization when he was 10 years old. She may have had prior knowledge of his involvement with counselors, and possibly of his history of childhood sexual abuse. She figured prominently in [redacted] initial hospitalization at the VA, ie., it was a phone call from her that prompted a same-day hospitalization over concerns that he was beginning to exhibit manic symptoms.

6. Opinion and Recommendations:
   a. I concur with the diagnosis of Cyclothymic Disorder, but feel that the specifier, "Existed Prior to Enlistment," should be added. The condition, by definition, is not severe enough to warrant a Medical Evaluation Board proceeding, and none should be undertaken now.
   b. If [redacted] persists in his pursuit of service connected disability, I recommend that he also be investigated for fraudulent enlistment based on the abundant evidence in the medical record.

POC for this BCNR evaluation is [redacted] at telephone number (301) 295-0500.

[redacted]

Service
[redacted] NNMC