No. 23-713

IN THE

Supreme Court of the United States

JOSHUA E. BUFKIN AND NORMAN F. THORNTON,
Petitioners,

v.

DENIS MCDONOUGH,
SECRETARY OF VETERANS AFFAIRS,
Respondent.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FEDERAL CIRCUIT

JOINT APPENDIX

Melanie L. Bostwick
Counsel of Record
ORRICK, HERRINGTON & SUTCLIFFE LLP
2100 Pennsylvania Avenue, NW
Washington, DC 20037
(202) 339-8400
mbostwick@orrick.com

Counsel for Petitioners

Elizabeth B. Prelogar
Solicitor General
Counsel of Record
DEPARTMENT OF JUSTICE
950 Pennsylvania Avenue, NW
Washington, DC 20530
(202) 514-2217
SupremeCtBriefs@usdoj.gov

Counsel for Respondent

PETITION FOR WRIT OF CERTIORARI FILED DECEMBER 29, 2023
CERTIORARI GRANTED APRIL 29, 2024

TABLE OF CONTENTS

Page

LOCAL TITLE: GENERAL INFORMATION CBCB
STANDARD TITLE: ADMINISTRATIVE NOTE
DATE OF NOTE: FEB 27, 2014@09:00
ENTRY DATE: FEB 27, 2014@09:00:23
AUTHOR: GOOS,ROBERT B
EXP COSIGNER:
INSTITUTION: PUEBLO CBOC
DIVISION: PUEBLO CBOC
URGENCY:
STATUS: COMPLETED

The following letter was prepared for this veteran:

2/27/2014

To whom it may concern,

I am the attending physician for Mr. Joshua Bufkin at the Pueblo VA clinic. I performed a comprehensive psychiatric evaluation and have seen him for regular followup visits over this last year. He suffers from severe Posttraumatic Stress Disorder. He worked in the military in intelligence and had planned on making a career in the military. His wife was suffering from depression and he was presented by his superiors with a choice. They said that they could not afford to have a serviceman's wife commit suicide, so he was told he would have to either divorce her or leave the military. He felt he was being forced to decide his wife's fate, to stay in the service he would have to abandon her and be responsible if she commited suicide. He chose to leave the service, but the anger and powerlessness he felt has never left him. He is hypervigilant for anything that might endanger him or his family. He

feels great distrust for others and responds quickly with anger if he feels any threat. For many years he slept with a gun next to his bed, but because of ongoing nightmares, he put it away. He has avoidance behaviors, and cannot be around people for long, especially large groups of people. He has prominent emotional numbing. He startles easily, has prominent hyperarousal which he can't shut down. He can't have people walking behind him without tremendous anxiety, fear or anger. Anger is extremely quick to erupt and he worries about carrying out this anger in violence. Sleep has been impaired and he does have nightmares.

It is clear to me that in every aspect he meets criteria for Posttraumatic Stress Disorder and it is quite disabling for him. He has been coming in for treatment for the last year but continues symptomatic and it effects every aspect of his life. It is my opinion that the primary stressor was this perceived threat to his wife's life, this perception that those in power did not care if his wife lived or died that has led to his current condition. It disrupts significantly his interpersonal, social, and certainly his occupational functioning and will likely do so far into the future.

Thank you for your consideration of this matter. If you have any questions about this, I can be reached at 719-584-5112 or 719-543-7889.

Sincerely,

Robert B. Goos, MD
Staff Psychiatrist
Pueblo VA CBOC

/es/ Robert B. Goos, M.D.
Psychiatrist
Signed: 02/27/2014 09:01

** PROGRESS NOTES **********

LOCAL TITLE: C&P PSYCH
STANDARD TITLE: PSYCHIATRY C & P EXAMINATION CONSULT
DATE OF NOTE: JUN 11, 2015@13:00
ENTRY DATE: JUN 17, 2015@11:46:44
AUTHOR: WEBSTER,DAVID C
EXP COSIGNER:
INSTITUTION:
DIVISION: CHEYENNE VAMROC
URGENCY:
STATUS: COMPLETED

Initial Post Traumatic Stress Disorder (PTSD)
Disability Benefits Questionnaire
* Internal VA or DoD Use Only *

Name of patient/Veteran: Bufkin,Joshua E

SECTION I:
---

1. Diagnostic Summary

Does the Veteran have a diagnosis of PTSD that conforms to DSM-5 criteria based on today's evaluation?
[ ] Yes [X] No

If no diagnosis of PTSD, check all that apply:

[X] Veteran's symptoms do not meet the diagnostic criteria for PTSD under DSM-5 criteria

[X] Veteran has another Mental Disorder diagnosis. Continue to complete this Questionnaire and/or the Eating Disorder Questionnaire:

2. Current Diagnoses

---

a. Mental Disorder Diagnosis #1: Adjustment Disorder with Mixed Disturbance of Emotions and Conduct, Persistent form

ICD code: 309.4

Comments, if any:

This is a very complex case. The veteran reports a longstanding pattern of depressed mood, angry outbursts and rumination about his administrative separation from the Air Force in 2006, after being in the military only six months. The onset of the condition was sometime shortly after separation in 2006 (as evidenced by the Air Force psychiatrist stating the veteran did not have a mental health condition at the time of discharge), but the consequences continue to affect him to the present day (states "I was meant to be in the military", and he continues to be married to the woman who coerced him to leave the military). The diagnosis that most accurately describes this pattern of symptoms is Adjustment

Disorder with Mixed Disturbance of Emotions and Conduct, Persistent form.

Veteran's claim is for PTSD and the veteran has been diagnosed with PTSD by a past VA treating psychiatrist who wrote a letter in support of the veteran's claim. However I note the psychiatrist has not been able to review the military medical/mental health records (specifically the treatment document from the Air Force psychiatrist and the Training Record note, both of which give specific details of events leading up to the veteran being granted a Hardship Discharge) and must rely solely on the veteran's report of events. I point out to VBA that diagnoses are often changed as additional information becomes available, and I think it is entirely possible that if the VA psychiatrist had the opportunity to review the relevant military records that would have a significant impact on their diagnostic deliberations.

When strictly adhering to the diagnostic requirements for PTSD in the DSM-5 there are three specific requirements that MUST be present for a diagnosis of PTSD to be accurately given. These three basic requirements are 1) exposure to a PTSD trauma event that meets the DSM-5 definition, 2) problems due to persistent re-experiencing that trauma event in the form of intrusive unwanted memories of the trauma event, recurring nightmares of the

event, or flashbacks of the event, and 3) avoidance of stimuli associated with that event...These are absolute requirements for a diagnosis of PTSD, unless ALL THREE are present no diagnosis of PTSD can accurately be given, and this is clearly stated in the DSM-5. Therefore, for example, if a man directly experiences a PTSD trauma event but does not re-experience the trauma event, he does not meet the DSM-5 requirements for PTSD. (NOTE TO VBA RATER…this is why PTSD symptom checklists such as was used with this veteran are so often incorrect, these symptom checklists make no effort to insure that an actual DSM-5 defined PTSD trauma event occurred, and are the actual basis of "re-experiencing trauma memories, avoidance of trauma memories, etc.)

In the case at hand the veteran submitted a list of claimed "trauma events" to VBA. In the exam today when asked about recurring intrusive memories or nightmares of trauma events, the veteran reported he generally slept well and denied recurring nightmares of any trauma events. The only "intrusive memories of a trauma" that he identified was that he was "always mad at the military for the way they treated me." It's important to note here that the fact that the other claimed trauma events submitted by the veteran (in his report to me today) are not resulting

in recurrent intrusive memories or recurring nightmares of these events. This means that BY DSM-5 DEFINITION he cannot have PTSD based on these events (regardless of whether they meet the DSM-5 definition of a PTSD trauma event).

Furthermore in regards to his report of "always being mad at the military for the way they treated me" (VA mental health treatment note dated Apr 17, 2015 states "Mr. Bufkin always thought of his discharge as a personal affront to his abilities in the Air Force") this fails to meet all three of the DSM-5 requirements for PTSD. First, no matter how "unfairly" or "uncaring" or "rejecting" the veteran perceives the military's actions to be, these actions very clearly in no way meet the DSM-5 definition of a PTSD trauma event (as defined on page 271 of the DSM-5, "exposure to actual or threatened death, serious injury, or sexual violence"). Secondly, in order to meet the DSM-5 definition of "intrusive memories", the memories have to be unwanted. The veteran very directly states that he wants to think about these memories, they are not "intrusive" as defined by the DSM…finally, in regards to the DSM-5 requirement of "avoidance" the veteran very clearly states that he makes no effort to avoid memories of "how the military treated him." In fact, as he stated, he does not "want to forget" these memories and

instead dwells on them daily to remind himself of how he was "mistreated" by the military.

For the sake of thoroughness I will address the letter in support of PTSD from the VA psychiatrist. The VA psychiatrist states "the primary stressor was this perceived threat to his wife's life, this perception that those in power did not care if his wife lived or died". In regards to the statement "the primary stressor was this perceived threat to his wife's life" the psychiatrist is referring to the fact that the veteran's wife wanted him to leave the military and in an attempt to coerce him she began making suicidal threats and gestures. This is reported by the veteran today and is documented in the military medical records.

It is certainly possible that an actual suicide attempt could meet the DSM-5 requirements of a PTSD trauma event, but there is no indication that there was a suicide attempt in this case. Suicide threats and gestures, especially when there is a long history of these behaviors (which is how the veteran described his wife's suicidal threats and gestures to the Air Force psychiatrist) but no actual attempts, do not in my opinion represent the PTSD trauma definition of a significant "threat to life." In fact I asked the veteran if his wife ever made a suicide attempt and

he stated "no, she never actually cut herself, she would just make marks on her arm" in a pretty dismissive manner, which I interpreted as his recognizing that her suicidal threats and gestures were manipulative but not an actual life threatening event.

Furthermore as noted above, when I asked the veteran about intrusive memories/nightmares/flashbacks, he did not report any recurring intrusive memories/nightmares/flashbacks about his wife's suicidal threats or gestures....Even if the veteran's wife's suicidal threats and gestures did meet the DSM-5 definition of a PTSD trauma event, if he is not having recurring intrusive memories or nightmares or flashbacks OF THAT CLAIMED EVENT then he does not meet the three required elements for a PTSD diagnosis.

Finally, DSM-5 definition of a PTSD trauma event is quite specific, and the psychiatrist's statement that "this perception that those in power did not care if his wife lived or died" is not relevant to the definition of a PTSD trauma event. I point out that the veteran did not live with his wife at that time, she did not live on base, she did not seek mental health treatment from the military, reportedly was "uncooperative with treatment efforts", etc., and in effect the military was

powerless over her actions...even if his perception of them being "uncaring" was accurate, it has nothing to do with the DSM-5 definition of a PTSD trauma event.

Finally, to give context for my conclusions I will relate key portions of the military medical documentation relevant to the case at hand. While the military medical document is often consistent with the veteran's report of events, there are some key differences which help to clarify the diagnostic issues.

Here is a summary of history based on military records. Military administrative/mental health records indicated the veteran joined the Air Force and did well in basic training. He married his wife shortly after completing Basic and entered into his required Individual Training to become a Security Forces airman (military police). His wife remained at her home. He began repeatedly failing his required training classes, and could not progress to being assigned to a job if he could not pass these classes (insteady he likely would be separated from the military). His Air Force instructions meet with him to try and determine why he was having problems. He requested a meeting with Air Force mental health which was arranged. He told the Air Force psychiatrist (and me today) that his new wife did not want him to be in the military,

and that she wanted him to quit and come home to her. He stated that she had a long history of making suicidal threats and gestures, and began making suicidal threats if he did not leave the Air Force. Conflict between them over his being in the military resulted in significant stress for him, making it difficult for him to concentrate in his classes, resulting in his failures in training tests...in addition he was apprehensive about how his wife would handle his first duty assignment once he completed training (he was scheduled to be stationed in Germany)...In support of this I note that Military Record of Administrative Training Action dated Feb 16, 2006 states after failing a written measurement for the second time during his training he was sent to mental health and ended up being evaluated by Lt Col Wasileski, Chief of the Behavioral Evaluation Service who concluded "AB Bufkin has legitimate and significant marital problems…impacting his training performance"…the document goes on to recommend that AB Bufkin be recommended for separation with the opportunity to return to active duty and to the course at a later date if his humanitarian situation were lessened to the point where he could be effective."

In contrast to the veteran's report to his VA psychiatrist that the Air Force "forced him to choose between his wife and a

hardship discharge, the military records document that he was repeatedly failing his required training classes. If he could not pass these classes he could not perform his job and it would lead to either reassignment to a much simpler career field in the Air Force (such as cook), or more likely to an administrative discharge for "Inability to adapt...Unsuitability", or some similar reason...

Military medical records clearly show this is not a case of "Air Force could not afford to have a serviceman's wife commit suicide at the veteran states", rather it was a case of the Air Force intervening with an airman who was unable to pass required training classes...military mental health records indicated he was failing his classes due to marital stressors (A letter from Air Force Psychiatrist Lt Col Wasileski dated Jan 27, 2006 in summary says that the veteran's wife has a very long history of serious mental health problems including making suicidal threats as well as a history of non-fatal self-injurious behaviors and has been uncooperative with her medical providers…spouse does not want him in the military...veteran's problems are directly related to this, no other mental health diagnoses), but the fact remains that he was failing required training classes and therefore unable to progress in the military, causing the military to take action. Finally, in the same letter which

recommends the veteran be separated from the service, the psychiatrist states "AB Bufkin reviewed the contents of this letter, and fully concurs with its statements. AB Bufkin believes it is in the best interest of his family and the USAF that he be separated from the service." Based on this the veteran was granted a Hardship Discharge six months after he entered the Air Force. This is a non-prejudicial discharge, as opposed to possible negative discharges that could have been used such as "Personality Disorder" or "Unsuitability."

To summarize the military records, the veteran wanted to be in the Air Force, his newly married wife did not want him to be in the Air Force and attempted to coerce him with threats of suicide, as a consequence of this conflict his performance in the Air Force deteriorated and he did not pass required training classes. He requested to speak to mental health and explained what was happening, and subsequently was granted a non-prejudicial discharge with his consent six months after entering the military.

Given the above, from a diagnostic standpoint one might wonder why the veteran continues to be consumed with rage at the Air Force for his discharge. More to the point, one has to wonder why the veteran is angry at the Air Force

rather than his wife, since she actively campaigned and ultimately was successful in getting him to separate from the Air Force…. Given the fact that the veteran's intense, explosive anger is a very significant factor in his life, the underlying cause of the anger is a key diagnostic issue. In my opinion it is more likely than not that the veteran's very understandable anger towards his wife for coercing him to leave the military is viewed by the veteran as "unacceptable", and he has displaced it onto the military instead. In addition as noted earlier by one of his treatment providers, the veteran always thought of his discharge as a personal affront to his abilities in the Air Force, making it a "narcissistic injury" leading to "outrage." This makes it fairly easy to "rationalize" that his anger is caused by the military "bad treatment of him." Unfortunately to maintain his marriage and avoid the conflict that anger towards his wife would cause, he must continue to avoid the fact that his wife coerced him to quit the military by continuing to direct his thoughts/anger at the Air Force. This likely explains why he dwells obsessively on being treated "badly" by the military, and why he resists treatment efforts to get him to stop dwelling on this…

Finally, the last key symptom is the veteran's "hypervigilance/paranoia." He reports that he must be on guard for

attempts at "being attacked." Superficially this sounds like the PTSD symptom of hypervigilance…however, PTSD hypervigilance is geared to protecting oneself from a re-occurrence of the trauma event. Therefore, people with PTSD from tornados are hypervigilant for signs of another tornado, people with PTSD from a serious car accident are hypervigilant while in cars, people with PTSD from a personal assault (such as a combat veteran) are hypervigilant of another personal assault, etc…In the veteran's case there are no claimed PTSD trauma events involving a personal assault and he denies ever being assaulted. Beyond this in describing why he is on guard the veteran stated that "if you are nice to people, they will take advantage of you", this has more of an defensive personality trait quality to it. I also note when I inquired about interpersonal conflict in the work setting the veteran stated that generally he did not have problems with males "because they avoid me due to my anger" but he was often angry with female co-workers who were "sexually suggestive" towards him by making sexual commits, making sexually suggestive movements with their fingers, or touching him in a sexual manner…this again had an odd somewhat narcissistic/paranoid quality to it.

This leads me to conclude that there are some underlying personality traits that

drive some of the veteran's behaviors/thoughts, particularly his suspicious, almost "paranoid" attitude (as well as given his very short time in the military his "over-identification" as a "bred to be warrior" so to speak) . However, the veteran denies any evidence of a personality disorder during childhood, and the Air Force psychiatrist specifically denied that the veteran had Axis I or Axis II conditions at the time of her examination. Therefore I conclude that it is likely that the veteran has some personality "traits" that do not quite rise to the level of personality disorder, but do fuel his "paranoia". As often is the case with personality traits, these behaviors/attitudes/thoughts are often not caused by "conscious decisions" but are instead below the level of the patient's awareness...

b. Medical diagnoses relevant to the understanding or management of the Mental Health Disorder (to include TBI): no contributing factors

3. Differentiation of symptoms

---

a. Does the Veteran have more than one mental disorder diagnosed?

[ ] Yes [X] No

c. Does the Veteran have a diagnosed traumatic brain injury (TBI)?

[ ] Yes [ ] No [X] Not shown in records reviewed

4. Occupational and social impairment

---

a. Which of the following best summarizes the Veteran's level of occupational and social impairment with regards to all mental diagnoses? (Check only one)

   [X] Occupational and social impairment with deficiencies in most areas, such as work, school, family relations, judgment, thinking and/or mood

b. For the indicated level of occupational and social impairment, is it possible to differentiate what portion of the occupational and social impairment indicated above is caused by each mental disorder?

[ ] Yes [ ] No [X] No other mental disorder has been diagnosed

c. If a diagnosis of TBI exists, is it possible to differentiate what portion of the occupational and social impairment indicated above is caused by the TBI?

[ ] Yes [ ] No [X] No diagnosis of TBI

SECTION II:

Clinical Findings:

---

1. Evidence review

In order to provide an accurate medical opinion, the Veteran's claims folder must be reviewed.

a. Medical record review:

Was the Veteran's VA e-folder (VBMS or Virtual VA) reviewed?
[X] Yes [ ] No

Was the Veteran's VA claims file (hard copy paper C-file) reviewed?
[ ] Yes [X] No

If yes, list any records that were reviewed but were not included in the Veteran's VA claims file:

If no, check all records reviewed:

- [ ] Military service treatment records
- [ ] Military service personnel records
- [ ] Military enlistment examination
- [ ] Military separation examination
- [ ] Military post-deployment questionnaire
- [ ] Department of Defense Form 214 Separation Documents
- [X] Veterans Health Administration medical records (VA treatment records)
- [ ] Civilian medical records
- [ ] Interviews with collateral witnesses (family and others who have known the Veteran before and after military service)
- [ ] No records were reviewed
- [X] Other:
  included past and current mental health treatment notes from the Denver VA

b. Was pertinent information from collateral sources reviewed?

[X] Yes [ ] No

If yes, describe:

lay statesments from the veteran's wife and mother concerning "changes" after leaving the military

2. History

---

a. Relevant Social/Marital/Family history (pre-military, military, and post-military):

Pre-military: family - parents divorced when he was 18, two siblings…father was an Army drill instructor and was very authoritarian…but veteran denies any physical or sexual abuse

Post-military: social - married, no children…veteran reports his marriage is strained due to his irritability, and he has no friends…he enjoys working on cars but notes he gets very angry and has cost himself a lot of money breaking parts when working by himself on car…also reports that he is frequently selling his car and buying a new car trying to make himself happier but this doesn't work…

b. Relevant Occupational and Educational history (pre-military, military, and post-military):

Pre-military: school - high school graduate, no problems

Military: Air Force Sep 2005 to Mar 2006//Rank E-2//MOS Security Forces Helper

(still in initial stages of his training at time of separation)//deployed to combat zone – none

Married after he entered the Air Force, veteran stated his wife did not want him to stay in the Air Force and began making suicidal threats/gestures if he didn't come home…conflict/distress over this resulted in his poor school performance and he started repeatedly failing required training classes. Asked to see mental health as a result, received a mental health evaluation and was granted a "Hardship" discharge.
Post-military: occupational - employee at the Denver VA/Pueblo Clinic in IT since 2010…veteran says his technical knowledge is good but his supervisor tells him his customer service is affected by his irritability and he struggles with his motivation at times…states most of his male co-workers just avoid him but he gets angry at the sexually suggestive comments/behaviors his female co-workers make…reports he had comments about his irritability at his previous job working for DOD IT as well, in fact he was told he had to be careful or he would create a "hostile work environment"/educational - has earned certifications

c. Relevant Mental Health history, to include prescribed medications and family mental health (pre-military, military, and post-military):
Pre-military: mental health--family history - none//patient history - none…veteran notes

that he internalized anger when he was young and it never caused any problems, did well in school, played sports, socialized with others, etc. without any evidence of impairment
Military: mental health treatment - reports he saw a psychiatrist Lt Col who gave him a choice, divorce his wife or take a hardship discharge…Military Record of Administrative Training Action dated Feb 16, 2006 states after failing a written measurement for the second time during his training he was sent to mental health and ended up being evaluated by Lt Col Wasileski, Chief of the Behavioral Evaluation Service who concluded "AB Bufkin has legitimate and significant marital problems…impacting his training performance"…the document goes on to recommend that AB Bufkin be recommended for separation with the opportunity to return to active duty and to the course at a later date if his humanitarian situation were lessened to the point where he could be effective."

A letter from Lt Col Wasileski dated Jan 27, 2006 in summary says that the veteran's wife has a very long history of serious mental health problems including making suicidal threats as well as a history of non-fatal self-injurious behaviors and has been uncooperative with her medical providers…spouse does not want him in the military and veteran is concerned about how his wife would react to the stressors of living abroad (his first duty assignment was

scheduled to be in Germany) without the support of her extended family.
Post-military: Mental Health Treatment - diagnosed with PTSD by Robert Goos in May 2013 at the Denver VA, currently on Escitalopram and Lorazepam, getting Alpha Stimulation treatment as well

d. Relevant Legal and Behavioral history (pre-military, military, and post-military):
Pre-military: legal - none
Military: disciplinary actions - none
Post-military: legal - none

e. Relevant Substance abuse history (pre-military, military, and post-military):
Pre-military: alcohol/drugs - no problems
Military: alcohol/drugs - no problems
Post-military: alcohol/drugs - no problems

f. Other, if any:
No response provided.

3. Stressors

Describe one or more specific stressor event(s) the Veteran considers traumatic (may be pre-military, military, or post-military):

a. Stressor #1: Veteran reports he has constant thoughts of "being forced by the Air Force to choose between his wife and his Air Force career

Does this stressor meet Criterion A (i.e., is it adequate to support the diagnosis of PTSD)?
[ ] Yes [X] No

Is the stressor related to the Veteran's fear of hostile military or terrorist activity?
[ ] Yes [X] No

Is the stressor related to personal assault, e.g. military sexual trauma?
[ ] Yes [X] No

4. PTSD Diagnostic Criteria

No response provided

5. Symptoms

For VA rating purposes, check all symptoms that actively apply to the Veteran's diagnoses:

[X] Depressed mood
[X] Anxiety
[X] Suspiciousness
[X] Mild memory loss, such as forgetting names, directions or recent events
[X] Impaired judgment
[X] Disturbances of motivation and mood
[X] Difficulty in establishing and maintaining effective work and social relationships
[X] Difficulty in adapting to stressful circumstances, including work or a worklike setting

6. Behavioral Observations

MENTAL STATUS EXAM: alert, coherent, fully oriented, dressed in clean casual clothes, polite and cooperative in manner, thought processes were logical and goal oriented, affect was tense/dysphoric, denied current thoughts of suicide, no evidence of a formal thought disorder

7. Other symptoms

Does the Veteran have any other symptoms attributable to PTSD (and other mental disorders) that are not listed above?

[ ] Yes [X] No

8. Competency

Is the Veteran capable of managing his or her financial affairs?

[X] Yes [ ] No

9. Remarks, (including any testing results) if any

No remarks provided.

NOTE: VA may request additional medical information, including additional examinations if necessary to complete VA's review of the Veteran's application.

****

Medical Opinion
Disability Benefits Questionnaire

Name of patient/Veteran: Bufkin,Joshua E

Indicate method used to obtain medical information to complete this document:

[ ] Review of available records (without in-person or video telehealth examination) using the Acceptable Clinical Evidence (ACE) process because the existing medical evidence provided sufficient information on which to prepare the DBQ and such an examination will likely provide no additional relevant evidence.
[ ] Review of available records in conjunction with a telephone interview with the Veteran (without in-person or telehealth examination) using the ACE process because the existing medical evidence supplemented with a telephone interview provided sufficient information on which to prepare the DBQ and such an examination would likely provide no additional relevant evidence.
[ ] Examination via approved video telehealth
[X] In-person examination

Evidence review

Was the Veteran's VA claims file reviewed? Yes

If yes, list any records that were reviewed but were not included in the Veteran's VA claims file:
VA medical records (including his treating VA)

MEDICAL OPINION SUMMARY

RESTATEMENT OF REQUESTED OPINION

a. Opinion from general remarks: Does the veteran have a diagnosis of mental health condition (also claimed as PTSD, depression, and anxiety) that is at least as likely as not incurred in or caused by his wife's mental health illness which led to his eventual discharge during the service?

b. Indicate type of exam for which opinion has been requested: Initial PTSD

TYPE OF MEDICAL OPINION PROVIDED: [MEDICAL OPINION FOR DIRECT SERVICE CONNECTION]

b. The condition claimed was less likely than not (less than 50% probability) incurred in or caused by the claimed in-service injury, event or illness.

c. Rationale: 1) The veteran does not meet the DSM-5 diagnostic requirements for PTSD. I explained this is great detail in my exam report and refer the VBA rater to the narrative of the Diagnostic section for the unavoidably long explantation.

2) Veteran does in fact currently have symptoms of depression/anxiety which I have diagnosed as Chronic Adjustment Disorder. However, based on the military mental health documentation this condition was not present while the veteran was in the military. The onset was sometime after leaving the military, and could have presented as quickly as

within days of leaving the military...the question about whether the symptoms are "caused by wife's mental health illness" requires a detailed explanation. In military medical notes the veteran reported his wife had "Bipolar Disorder." In the veteran's VA mental health treatment notes he has referred to his wife as "having Bipolar Disorder" or "being Depressed." However in my exam I specifically asked if the veteran's wife had ever been diagnosed or treated for Bipolar Disorder and he said no (!!??) I realize this seemingly contradicts his earlier reports to others but this is exactly what he told me...I can only assume either the veteran or his wife has "self-diagnosed" her with Bipolar Disorder or Depression...given this state of affairs I cannot state that "his wife's mental health illness" led to his eventual discharge during service.

In contrast, it is very clear both by the veteran's report and the military medical documentation that shortly after he married his wife she attempted to coerce him to leave the military by making threats of suicide if he did not. The stress of their conflict caused him to perform poorly in training and he began repeatedly failing required training tests. Given his wife's opposition to his staying in the military and her manipulative attempts to coerce him to leave, it ultimately led to his Hardship Discharge...

****

/es/ DAVID C. WEBSTER, Ph.D.
CHIEF OF PSYCHOLOGY
Signed: 06/17/2015 11:46

LOCAL TITLE: COMPENSATION & PENSION
STANDARD TITLE: C & P EXAMINATION NOTE
DATE OF NOTE: JUL 08, 2015@14:00
ENTRY DATE: JUL 08, 2015@15:05:30
AUTHOR: SARFF,PHILIP
EXP COSIGNER:
URGENCY:
STATUS: COMPLETED

COMPENSATION AND PENSION EXAMINATION REPORT (FREE TEXT)
==========

Review Post Traumatic Stress Disorder (PTSD)
Disability Benefits Questionnaire

Name of patient/Veteran: Norman Thornton (T0097)

SECTION I:
---

1. Diagnostic Summary

Does the Veteran now have or has he/she ever been diagnosed with PTSD?
[X] Yes [ ] No
ICD Code:

Vet was last seen for a C&P Post-traumatic stress disorder (Review) exam by Dr. Goldberg on 7/5/11. Diagnostic impressions included Post-traumatic stress disorder and GAF was 59.

2. Current Diagnoses

---

a. Mental Disorder Diagnosis #1: Post-traumatic stress disorder, with depressive features

ICD Code:

Comments, if any (including causation/exacerbation): This is the condition for which the vet is SC. His treating provider, Dr. Kumar, had designated his PTSD as a "dissociative type." However, medical records (including a neurology consult in 2012) note periods of confusion and memory lapses that do not appear to be trauma-based. He has been described during these events as not being overly upset or "acting out" a trauma and he says behaves as if he normally would. This would be anything BUT a trauma-based dissociative episode. As a rule, people with PTSD do not dissociate unless they are in the middle of a flashback. He does report having a few traditional dissociative periods that could be connected to PTSD, such as waking up from a nightmare choking his wife or waking up outside as if he were on guard duty.

b. Medical diagnoses relevant to the understanding or management of the Mental Health Disorder (to include TBI): See medical records

ICD code:

Comments, if any:

3. Differentiation of symptoms

---

a. Does the Veteran have more than one mental disorder diagnosed?

[ ] Yes [X] No

b. Is it possible to differentiate what symptom(s) is/are attributable to each diagnosis?
[ ] Yes [ ] No [X] Not applicable (N/A)

If no, provide reason that it is not possible to differentiate what portion of each symptom is attributable to each diagnosis:

If yes, list which symptoms are attributable to each diagnosis:

c. Does the Veteran have a diagnosed traumatic brain injury (TBI)?
[ ] Yes [ ] No [X] Not shown in records reviewed
Comments, if any:

d. Is it possible to differentiate what symptom(s) is/are attributable to each diagnosis?
[ ] Yes [ ] No [X] Not applicable (N/A)

If no, provide reason that it is not possible to differentiate what portion of each symptom is attributable to each diagnosis:

If yes, list which symptoms are attributable to each diagnosis:

4. Occupational and social impairment

---

a. Which of the following best summarizes the Veteran's level of occupational and social

impairment with regards to all mental diagnoses? (Check only one)

[ ] No mental disorder diagnosis
[ ] A mental condition has been formally diagnosed, but symptoms are not severe enough either to interfere with occupational and social functioning or to require continuous medication
[ ] Occupational and social impairment due to mild or transient symptoms which decrease work efficiency and ability to perform occupational tasks only during periods of significant stress, or; symptoms controlled by medication
[ ] Occupational and social impairment with occasional decrease in work efficiency and intermittent periods of inability to perform occupational tasks, although generally functioning satisfactorily, with normal routine behavior, self-care and conversation
[X] Occupational and social impairment with reduced reliability and productivity
[ ] Occupational and social impairment with deficiencies in most areas, such as work, school, family relations, judgment, thinking and/or mood
[ ] Total occupational and social impairment

b. For the indicated level of occupational and social impairment, is it possible to differentiate what portion of the occupational

and social impairment indicated above is caused by each mental disorder?

[ ] Yes [ ] No [X] No other mental disorder has been diagnosed

If no, provide reason that it is not possible to differentiate what portion of the indicated level of occupational and social impairment is attributable to each diagnosis:

If yes, list which portion of the indicated level of occupational and social impairment is attributable to each diagnosis:

c. If a diagnosis of TBI exists, is it possible to differentiate what portion of the occupational and social impairment indicated above is caused by the TBI ?

[ ] Yes [ ] No [X] No diagnosis of TBI

If no, provide reason that it is not possible to differentiate what portion of the indicated level of occupational and social impairment is attributable to each diagnosis:

If yes, list which portion of the indicated level of occupational and social impairment is attributable to each diagnosis:

SECTION II:

Clinical Findings:

---

1. Evidence review

In order to provide an accurate medical opinion, the Veteran's claims folder must be reviewed.

a. Medical record review:

Was the Veteran's VA e-folder (VBMS or Virtual VA) reviewed?
[X] Yes [ ] No

Was the Veteran's VA claims file reviewed?
[ ] Yes [X] No

If yes, list any records that were reviewed but were not included in the Veteran's VA claims file:

If no, check all records reviewed:

[ ] Military service treatment records
[ ] Military service personnel records
[ ] Military enlistment examination
[ ] Military separation examination
[ ] Military post-deployment questionnaire
[ ] Department of Defense Form 214 Separation Documents
[X] Veterans Health Administration medical records (VA treatment records)

Vet has been followed by Dr. Kumar for psychiatric care since about 2003. Working diagnosis is Post-

traumatic stress disorder, with "dissociative type". It was noted on 1/22/15 that he will have episodes of losing time for up to two days.

Vet was seen for a neuropsychological screening consult in 2012 using the RBANS. Problems were noted with concentration, but not memory.

[ ] Civilian medical records
[ ] Interviews with collateral witnesses (family and others who have known the Veteran before and after military service)
[ ] No records were reviewed
[ ] Other:

b. Was pertinent information from collateral sources reviewed?

[ ] Yes [ ] No

If yes, describe:

2. Recent History (since 7/5/11)

---

a. Relevant Social/Marital/Family history:

Vet is married, but has been separated for two years; they were separated because of a "combination of things", including his "disabilities"; she also was online talking with an old boyfriend, and he gave him an ultimately. He has no children with her, but she had a daughter from a previous marriage.

His two children are 24 (son) and 22 (daughter); he reports having good relationships with his two kids.

"They think the world of me." He talks to one or both almost daily.

Vet has a younger brother, and they are not real close; he also has half-sister who is a lot younger than he. He also had a brother who died as a child.

His parents are divorced, since he was about 13. He says his relationship with his mother is great, but he is less close with his father. He says that his father had cheated on his mother, and he still has some resentment about that and other issues from childhood.

Vet lives in a mobile home alone.

Vet reports having friends, including several 4-5 close friends that he sees on a regular basis. He does medieval re-enactments through a world-wide club of 180,000 people. He goes to 2-3 events per year; there are meetings and practice sessions in between events. He has done chain mail jewelry and some costume work.

b. Relevant Occupational and Educational history:

Vet has been doing mostly "side jobs" over the past 4-5 years. He last worked over the Christmas holiday for greeting card company. He also worked at a motel doing handyman and maintenance jobs, but he was told that he showed up to work one day without being asked to come. He was accused of being unreliable. "I lose days. I lose time." He finds

more work during the summer months, including mowing grass.

His income comes from SC pension and his side

Vet had worked as a contract carpenter for several years; he and his brother closed the business to free up personal time and because of financial issues. He believes he did well with that, and they specialized in remodeling and special projects.

Vet says his main barrier to work, now, he believes, is sudden intense fatigue that comes out of nowhere. "Part of it is memory", i.e., he has forgotten to go places.

c. Relevant Mental Health history, to include prescribed medications and family mental health:

Vet has been followed by Dr. Kumar for psychiatric care for several years. He does not recall the name of his medication, but recognizes "paroxetine". He believes the medication helps, in the sense that he knows when he misses doses.

Vet has had no therapy, other than with Dr. Kumar.

d. Relevant Legal and Behavioral history:

None

e. Relevant Substance abuse history:

Vet drinks "here and there" and will "very rarely" will drink too much. He denies use of illicit drug use.

f. Relevant Medical (Non-Mental Health) history, to include prescribed medications.

Vet has migraines, for which he takes medication; he has migraines at various frequency. This month has been good, last month was "hell." He has found they are triggered by beer or hard cheese.
He has chronic fatigue syndrome, for which he take no medication.
Vet has had memory lapses, or episodes, where he does things and does not remember what he was doing. He states that he is "doing whatever I normally do".
He has these incidents at various frequencies, as well. He does not recall seeing neurology, but CPRS has notes from 2012.

g. Other, if any: None

3. PTSD Diagnostic Criteria

Please check criteria used for establishing the current PTSD diagnosis. The diagnostic criteria for PTSD, are from the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5). The stressful event can be due to combat, personal trauma, other life threatening situations (non-combat related stressors.) Do NOT mark symptoms below that are clearly not attributable to the criteria A stressor/PTSD. Instead, overlapping symptoms clearly attributable to

other things should be noted under #5 - "Other symptoms".

Criterion A: Exposure to actual or threatened a) death, b) serious injury, c) sexual violation, in on or more of the following ways:

[X] Directly experiencing the traumatic event(s) [presumed due to SC status]

[X] Witnessing, in person, the traumatic event(s) as they occurred to others [presumed due to SC status]

[ ] Learning that the traumatic event(s) occurred to a close family member or close friend; cases of actual or threatened death must have been violent or accidental; or, experiencing repeated or extreme exposure to aversive details of the traumatic events(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse); this does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

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:

[X] Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s) [these might happen 2-3 times per week, often with a guilt overtone)

[X] Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s)[he has been told he has awakened in the middle of the night doing various things, like choking his wife)

[ ] Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings)

[X] Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s) [he was extremely vague; he talked about a recent incident when a man had some kind of episode at an re-enactment event; his response to that episode was to sob for an hour because he believes the man did not get treated properly in the process; he reacts to jack hammers and the sound of helicopters, as well]

[ ] Marked physiological reactions to internal or external cues that

symbolize or resemble an aspect of the traumatic event(s).

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

[X] Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

[X] 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) [he avoids branding because of the smell; he avoids shooting his gun]

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:

[ ] Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).

[X] Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad,: "No one can be trusted,: "The world is completely dangerous,: "My whole nervous system is permanently ruined").

[ ] Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead to the individual to blame himself/herself or others.

[ ] Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).

[ ] Markedly diminished interest or participation in significant activities.

[ ] Feelings of detachment or estrangement from others.

[ ] Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings.)

Criterion E: Marked alterations in arousal and 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:

[X] Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.
[ ] Reckless or self-destructive behavior.
[X] Hypervigilance.
[ ] Exaggerated startle response.
[X] Problems with concentration.
[X] Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

Criterion F:

[X] The duration of the symptoms described above in Criteria B, C, and D are more than 1 month.
[ ] Veteran does not meet full criteria for PTSD

Criterion G:

[X] The PTSD symptoms described above cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
[ ] The PTSD symptoms described above do NOT cause clinically

significant distress or impairment in social, occupational, or other important areas of functioning.

[ ] Veteran does not meet full criteria for PTSD

Criterion H:

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

4. Symptoms

For VA rating purposes, check all symptoms that apply to the Veterans diagnoses:

[X] Depressed mood (when he feels down, it can last for a day or two)

[X] Anxiety (he says he feels anxious often, and it can be "about anything"; he sometimes is puzzled why he feels that way, and it simply comes over him; irritability also can happen like this; he is more likely to feel anxious around "civilians" vs. people who had been in the military)

[ ] Suspiciousness

[ ] Panic attacks that occur weekly or less often

[ ] Panic attacks more than once a week

[ ] Near-continuous panic or depression affecting the ability to function

independently, appropriately and effectively

[X] Chronic sleep impairment (vet has trouble getting to sleep and staying asleep; he is not sure how long it takes to get to sleep; it might take an hour, and has not been to sleep at all for a couple days; he reports that he has nightmares at various frequencies, depending on what is going on in his life; he is more likely to have then when he talks to a military friend; he has sleep apnea, but cannot tolerate the mask; he feels tired most of the time)

[X] Mild memory loss, such as forgetting names, directions or recent events

[ ] Impairment of short- and long-term memory, for example, retention of only highly learned material, while forgetting to complete tasks

[ ] Memory loss for names of close relatives, own occupation, or own name

[ ] Flattened affect

[ ] Circumstantial, circumlocutory or stereotyped speech

[ ] Speech intermittently illogical, obscure, or irrelevant

[ ] Difficulty in understanding complex commands

[ ] Impaired judgment

[ ] Impaired abstract thinking

[ ] Gross impairment in thought processes or communication

[ ] Disturbances of motivation and mood

[ ] Difficulty in establishing and maintaining effective work and relationships

[X] Difficulty in adapting to stressful circumstances, including work or a worklike setting ("it depends on my day"; he has more trouble with his own stress, vs. his kids')

[ ] Inability to establish and maintain effective relationships
[ ] Suicidal ideation
[ ] Obsessional rituals which interfere with routine activities
[ ] Impaired impulse control, such as unprovoked irritability with periods of violence
[ ] Spatial disorientation
[ ] Persistent delusions or hallucinations
[ ] Grossly inappropriate behavior
[ ] Persistent danger of hurting self or others
[ ] Neglect of personal appearance and hygiene
[ ] Intermittent inability to perform activities of daily living, including maintenance of minimal personal hygiene
[ ] Disorientation to time or place

5. Mental Status and Behavioral Observations:

Veteran presented for the evaluation as alert and oriented to person, place, and time. He interacted in a logical, coherent, and very cooperative fashion. Observed affect was even-keeled, and he appeared to be in no acute distress. He notes that his mood tends to vary. He says he does get depressed sometimes and may wake up "absolutely pissed off", but is not sure why. Speech was normal for rate and volume,

and he was frank. No signs of thought disorder, hallucinations, or delusions.

General Appearance and Observed hygiene: Casually dressed; plainly groomed

Psychomotor: Gait was not observed via telehealth.

Insight: Fair

Concentration: Vet notes that his focus is pretty good "most of the time."

6. Other symptoms

Does the Veteran have any other symptoms attributable to PTSD (and other mental disorders) that are not listed above?
[ ] Yes [X] No

If yes, describe:

7. Competency

Is the Veteran capable of managing his or her financial affairs?
[X] Yes [ ] No

If no, explain:

8. Remarks, (including any testing results) if any:

None

9. Reliability and credibility of self-report:

Average
10. The purpose of the evaluation and limits of confidentiality were discussed and the veteran gave informed consent. Yes [X] No [ ]
TELEHEALTH: The veteran gave informed consent to conduct this examination via
telehealth: Yes [X] No [ ]
11. Veteran was told that the examiner would be typing their information into a computerized record during the interview and [ ] did [X] did not raise objects to that. If veteran objected, please describe their objection and the examiner's reaction to it:
12. Time spent in evaluation:
Clinical interview: 50 minutes
Record review: 10 minutes
Additional report preparation (after interview): 10 minutes

/es/ Philip L Sarff, Ph.D, LP
Psychologist
Signed: 07/08/2015 15:05

DEPARTMENT OF VETERANS AFFAIRS

UNITED STATES OF AMERICA

Initial Post-Traumatic Stress Disorder (PTSD) – DSM V

Disability Benefits Questionnaire

LAST NAME, FIRST NAME, MIDDLE NAME (*SUFFIX*): JOSHUA BUFKIN E	**SOCIAL SECURITY NUMBER:** [REDACTED]	**TODAY'S DATE** 04/19/2018
HOME ADDRESS: [REDACTED] FOUNTAIN, CO 80817	**EXAMINING LOCATION AND ADDRESS:** VES	
HOME TELEPHONE: [REDACTED]		

CONTRACTOR:	**VES NUMBER:**	**VA CLAIM NUMBER:**
VES	[REDACTED]	

IMPORTANT—THE DEPARTMENT OF VETERANS AFFAIRS (VA) WILL NOT PAY OR REIMBURSE ANY EXPENSES OR COST INCURRED IN THE PROCESS OF COMPLETING AND/OR SUBMITTING THIS FORM. PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN INFORMATION BEFORE COMPLETING THIS FORM.

NOTE TO PSYCHIATRIST/PSYCHOLOGIST—Your patient is applying to the U. S. Department of Veterans Affairs (VA) for disability benefits. VA will

consider the information you provide on this questionnaire as part of their evaluation in processing the veteran's claim. Please note that this questionnaire is for disability evaluation, not for treatment purposes. This evaluation should be based on DSM-5 diagnostic criteria.

NOTE: If the Veteran experiences a mental health emergency during the interview, please terminate the interview and obtain help, using local resources as appropriate. You may also contact the Veterans Crisis Line at 1-800-273-TALK (8255). Stay on the Crisis Line until help can link the Veteran to emergency care.

Mental Health professionals with the following credentials are qualified to perform initial C&P examinations for mental disorders. They are: a Board Certified psychiatrist; psychiatrist who have successfully completed an accredited psychiatry residency and who are appropriately credentialed and privileged; licensed doctorate-level psychologist; non-licensed doctorate level psychologists working toward licensure under close supervision by a board certified or board eligible psychiatrist or licensed doctoral level psychologist; psychiatry resident under close supervision by a board-certified or board eligible psychiatrist or licensed doctoral level psychologist; psychology residents under close supervision of a board eligible psychiatrist or licensed doctoral level psychologist.

NOTE: Close supervision means that the supervising psychiatrist or psychologist met with the

Veteran and conferred with the examining mental health professional in providing the diagnosis and the final assessment. The supervising psychiatrist or psychologist co-signs the examination report.

SECTION I – DIAGNOSTIC SUMMARY

1. DIAGNOSTIC SUMMARY
This section should be completed based on the current examination and clinical findings.

Does the Veteran have a diagnosis of PTSD that conforms to DSM-5 criteria based on today's evaluation?
[] Yes [X] No

ICD Code: _____

If no diagnosis of PTSD, check all that apply:
[X] Veteran's symptoms do not meet the diagnostic criteria for PTSD under DSM-5 criteria
[] Veteran does not have a mental disorder that conforms with DSM-5 criteria
[X] Veteran has another Mental Disorder diagnosis. Continue to complete this Questionnaire and/or the Eating Disorder Questionnaire.

2. CURRENT DIAGNOSES

2A. Mental Disorder Diagnosis #1:

Intermittent Explosive Disorder

ICD Code: F63.81

Comments, if any:

The veteran's main complaint is his frequent outbursts of anger that seem to be unprovoked. He endorses having outbursts where he becomes physically aggressive to himself or inanimate objects or verbally aggressive to his family members. He has been reprimanded at work for being verbally aggressive as well. This aggression is grossly disproportionate to the magnitude of the psychosocial stressors.

Mental Disorder Diagnosis #2:

Chronic Adjustment Disorder with mixed disturbance of emotion and conduct, persistent form

ICD Code: F43.25

Comments, if any:

The veteran does not meet criteria for PTSD due to the fact that he did not endorse any stressors that meet criteria for Criterion A.

Mental Disorder Diagnosis #3:

ICD Code: _____

Comments, if any:

Mental Disorder Diagnosis #4:

ICD Code: _____

Comments, if any:

If additional diagnoses, describe using above format:

2B. Medical diagnoses relevant to the understanding or management of the Mental Health Disorder *(to include TBI)*:

The veteran notes that he has severe GERD, which makes him vomit at times.

ICD code: K21

Comments, if any:

3. DIFFERENTIATION OF SYMPTOMS

3A. Does the Veteran have more than one mental disorder diagnosed?
[X] Yes [] No

If "Yes," complete Item 3B.

3B. Is it possible to differentiate what symptom(s) is/are attributable to each diagnosis?
[X] Yes [] No [] Not applicable

If "No," provide reason that it is not possible to differentiate what portion of each symptom is attributable to each diagnosis and discuss

whether there is any clinical association between these diagnoses:

If "Yes," list which symptoms are attributable to each diagnosis and discuss whether there is any clinical association between these diagnoses:

Intermittent Explosive Disorder: angry outbursts, verbal and physical aggression
Adjustment disorder: depression, anger
All other symptoms overlap
There is a clinical association. When the veteran experiences stress, he experiences an inability to adjust to it, lashing out in anger instead.

3C. Does the Veteran have a diagnosed traumatic brain injury *(TBI)*?
[] Yes [] No [X] Not shown in records reviewed

(If "Yes," complete Item 3D)

Comments, if any:

3D. Is it possible to differentiate what symptom(s) is/are attributable to each diagnosis?
[] Yes [] No [X] Not applicable

If "No," provide reason that it is not possible to differentiate what portion of each symptom is attributable to each diagnosis:

If "Yes," list which symptoms are attributable to each diagnosis:

4. OCCUPATIONAL AND SOCIAL IMPAIRMENT

4A. Which of the following best summarizes the Veteran's level of occupational and social impairment with regards to all mental diagnoses? (*Check only one*)

[] No mental disorder diagnosis

[] A mental condition has been formally diagnosed, but symptoms are not severe enough either to interfere with occupational and social functioning or to require continuous medication

[] Occupational and social impairment due to mild or transient symptoms which decrease work efficiency and ability to perform occupational tasks only during periods of significant stress, or symptoms controlled by medication

[X] Occupational and social impairment with occasional decrease in work efficiency and intermittent periods of inability to perform occupational tasks, although generally functioning satisfactorily, with normal routine behavior, self-care and conversation

[] Occupational and social impairment with reduced reliability and productivity

[] Occupational and social impairment with deficiencies in most areas, such as work, school, family relations, judgment, thinking and/or mood

[] Total occupational and social impairment

4B. For the indicated level of occupational and social impairment, is it possible to differentiate what portion of the occupational and social impairment indicated above is caused by each mental disorder?
[] Yes [X] No[] No other mental disorder has been diagnosed

If "No," provide reason that it is not possible to differentiate what portion of the indicated level of occupational and social impairment is attributable to each diagnosis:

The veteran struggles with both disorders concurrently, so it is not possible to determine what portion of the impairment is attributable to each diagnosis.

If "Yes," list which portion of the indicated level of occupational and social impairment is attributable to each diagnosis:

4C. If a diagnosis of TBI exists, is it possible to differentiate what portion of the occupational and social impairment indicated above is caused by the TBI?
[] Yes [] No [X] No diagnosis of TBI

If "No," provide reason that it is not possible to differentiate what portion of the indicated level of occupational and social impairment is attributable to each diagnosis:

If "Yes," list which portion of the indicated level of occupational and social impairment is attributable to each diagnosis:

SECTION II – CLINICAL FINDINGS

1. EVIDENCE REVIEW

In order to provide an accurate medical opinion, the Veteran's claims folder must be reviewed.

Evidence reviewed (check all that apply):
[] Not Requested [] No records were reviewed
[] VA claims file (hard copy paper C-file)
[X] VA e-folder (VBMS or Virtual VA)
[] CPRS
[] Other (please identify other evidence reviewed):

Evidence Comments:

Veteran brought in a list of his current mental health medications.

2. HISTORY

2A. Relevant social/marital/family history (pre-military, military, and post-military):

Pre-military

The veteran was born in Clarksville, TN. His father was in the Army, so he was raised in Texas, Louisiana and Colorado. He was raised by his mother "a majority of the time." His parents were married until he was around 20 years old. His father was in and out due to deployments. He has one brother and one sister. He gets along with his mother well. His father does not talk to him or his siblings. He does get along with his brother and sister.

He denies any significant childhood trauma.

Military

The veteran joined the military in 2005. He joined the Air Force. He was in the service for six months. His highest rank was E-3. He was not deployed. His discharge was "a hardship discharge."

Post-military

The veteran is currently married and has been since 2005. This is his first marriage. He does not have any children. He notes that he and his wife have been getting along well lately, but that there have been issues in the past.

He does not have any friends he spends time with. For fun, the veteran likes to watch TV and play video games.

2B. Relevant occupational and educational history (pre-military, military, and post-military):

Pre-military

The veteran graduated from high school in May 2001. The veteran went to college at Pikes Peak Community College where he studied Computer Science. He obtained credits but no degree from this. He did "modeling" after he graduated from high school. "Truthfully, I did everything but porn."

Military

The veteran was in security forces while he was in the service. He notes that this is not what he wanted to do.

Post-military

The veteran "bounced around" after he discharged from the service. He applied for a police department job. "I got all the way to the end and then they asked me if I would have a problem putting down a suspect. I told her no, and they said that I failed the psychological part. She told me I was too gung ho." He worked in security, then started work at Ft. Carson as a general services contractor. He has been in this position for 8 years. He currently works full time in this position. He does not like the job, but he does like the paycheck. He is taking classes for a

BS in Homeland Security. It's a field in Criminal Justice with an emphasis on homeland security.

2C. Relevant mental health history, to include prescribed medications and family mental health (pre-military, military, and post-military):

Pre-military

The veteran denies any personal or family mental health history prior to his time in the service.

Military

In the military, the veteran and his wife had problems. "It was being apart problems. She would miss me, so we spent a lot of my paychecks getting her to come to see me. We would be having sex and she would tell me I was hurting her. She would lay there and cry. She started to see a doctor who diagnosed her with endometriosis. They checked and there was nothing wrong with her. We started to see a marriage counselor. The counselor said it was my fault because of the way I approached her. This went on for 10 years. There was times that I've had women that approached me. I have done bad things with women that I'm sorry for, but it was because I felt my marriage was going down the toilet. I wanted someone to want me instead of feeling like I was hurting them.

The veteran notes that he was discharged about six months after going in. "I would talk to her

every day and she would cry. She had a mental episode where she went to the mental health hospital. She was having a hard time with me gone, so I called the mental health providers about it. They told me I could divorce my wife and stay in the military, or I could go home and never come back.

Post-military

The veteran first started to notice himself having mental health difficulties within a year of his discharge. He notes that his mood would "go up and down. My temper would flare up and I would hit things, never my wife, but just things." He remembers that he would cry a lot, but he does not know why. "Then it started with my wife." After he started to have problems with his wife, he noticed extreme anger. "I would get so angry I would punch myself in the face. I finally started seeing Dr. Goos and he gave me lots of different kinds of medication. Things have gotten better with my wife, she still doesn't trust me." He describes a time when his wife jumped out and scared him. "I don't remember, so I don't know if I blacked out. As soon as I realized it, I let her go, but it made me feel like a criminal." He notes that he wakes in the middle of the night with weapons in his hands. "So my wife made me take away my weapons." He notes that he has difficulties with his mother, "like she'll say something that makes me mad and I'll hit myself instead of hitting her. We are not speaking right now because she's scared of me." He shares that

he has a lot of hypervigilance. “Not only do I watch what everyone does, but I was so ready to hurt someone if they looked at me wrong. I have gotten into verbal stuff with people but I’ve never hit anyone. People tell me I look pissed off all the time. I stay away from people. I don’t have friends. I have had thoughts of killing people, and I plan it out. It’s not just a thought. But I’ve never acted on it. I’m not thinking any of those things today. I have thoughts about suicide. The only reason I haven’t is because I believe in God and I don’t want to go to hell.” He is not having any suicidal thoughts today. “I will be honest, I hate life. My doctor told me I see things black and white. It’s either one way or the other way, nothing in between. I don’t get much pleasure out of stuff. Since I’ve been married to my wife, I’ve gone through 34 cars. I’m never satisfied. I should be grateful about the amount of money I make. I really wanted to be a career military, but it didn’t work out.”

The veteran is currently taking: Lamotrigine 200mg, Escitalopram (Lexapro) 20mg, Zolpidem tartrate 5mg, Lorazepam 1ml.

The veteran notes that he is “really tired a lot. If I lay on the couch, I can sleep. But if I go to the bed, I can’t sleep unless I take my medicine.” He does not feel rested when he wakes. He notes that he does have nightmares when he does not take his medicines. He notes that his nightmares include “me killing people.” He is a restless sleeper when he does not take his medicines.

The veteran notes that his appetite is "okay." He has not thrown up due to GERD for a while.

His memory is impaired. "It's not good." He has trouble remembering things his wife has said or asked him to do. "I'll ask her a question and then ask her the same question a few minutes later." He can't remember what he's eaten. "The other thing that kinda sucks right now is I'm going back to school. I can't remember or take notes on what he's saying, so I take a little recorder." He notes that his wife creates his calendar for him, so he does not miss appointments. "I can't get words out. I pause for a minute and I can't get it out." Recently, the veteran is having trouble with concentration. "I get bored easily. I bounce from activity to activity but I can't keep attention."

The veteran's mood has "sucked" recently. "There was a time a few weeks ago when I just started crying, and then I was happy. I get somber and then the other day I threw a tool and broke a ladder after I got mad. I get pissed and tell her to not say anything. It's all over the place, it's like a roller coaster."

The veteran notes that he struggles with anxiety when he drives. "It's a feeling of scared." He also notes that he gets nervous every time he goes to class. "When I get in the classroom, I get ok." He also notes that he doesn't look people in the eyes anymore.

The veteran notes that his libido has dropped significantly lately.

2D. Relevant legal and behavioral history (pre-military, military, and post-military):

Pre-military
No relevant history based on current exam and review of any available medical records.

Military

No relevant history based on current exam and review of any available medical records.

Post-military

The veteran notes that he was working at a clinic in Pueblo two years ago, and the police came to his workplace because they were told he was exhibiting threatening behavior. He was assessed by a psychologist, who "let him go." He now works from home and cannot return to his workplace.

2E. Relevant substance abuse history (pre-military, military, and post-military):

Pre-military
No relevant history based on current exam and review of any available medical records.

Military

No relevant history based on current exam and review of any available medical records. **Post-military** No relevant history based on current exam and review of any available medical records

2F. Other, (if any):

None.

3. STRESSORS

The stressful event can be due to combat, personal trauma, other life threatening situations (non-combat related stressors).

NOTE: For VA purposes, "fear of hostile military or terrorist activity" means that a veteran experienced, witnessed, or was
confronted with an event or circumstance that involved actual or threatened death or serious injury, or a threat to the physical integrity of the Veteran or others, such as from an actual or potential improvised explosive device; vehicle-imbedded explosive device; incoming artillery, rocket, or mortar fire; grenade; small arms fire, including suspected sniper fire; or attack upon friendly military aircraft.

Describe one or more specific stressor event(s) the Veteran considers traumatic (may be pre-military, military, or post-military):

3A. Stressor #1:

The veteran states that he was told to leave the military because his wife was having mental health problems.

Does this stressor meet Criterion A (i.e., is it adequate to support the diagnosis of PTSD)?
[] Yes [X] No

Is the stressor related to the Veteran's fear of hostile military or terrorist activity?
[] Yes [X] No

If "No", explain:

This was due to his wife's medical problems.

Is the stressor related to in-service personal assault, e.g. military sexual trauma?
[] Yes [X] No

If "Yes", please describe the markers that may substantiate the stressor:

3B. Stressor #2:

Does this stressor meet Criterion A (i.e., is it adequate to support the diagnosis of PTSD)?
[] Yes [] No

Is the stressor related to the Veteran's fear of hostile military or terrorist activity?
[] Yes [] No

If "No", explain:

Is the stressor related to in-service personal assault, e.g. military sexual trauma?
[] Yes [] No

If "Yes", please describe the markers that may substantiate the stressor:

3C. Stressor #3:

Does this stressor meet Criterion A (i.e., is it adequate to support the diagnosis of PTSD)?
[] Yes [] No

Is the stressor related to the Veteran's fear of hostile military or terrorist activity?
[] Yes [] No

If "No", explain:

Is the stressor related to in-service personal assault, e.g. military sexual trauma?
[] Yes [] No

If "Yes", please describe the markers that may substantiate the stressor:

3D. Additional stressors: If additional stressors, describe (list using the above sequential format):

4. PTSD DIAGNOSTIC CRITERIA

NOTE: Please check criteria used for establishing the current PTSD diagnosis. Do **NOT** mark symptoms below that are clearly not attributable to the criteria A stressor/PTSD. Instead, overlapping symptoms clearly attributable to other things should be noted under #7—Other symptoms. The diagnostic criteria for PTSD, referred to as Criteria A-H, are from the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5).

Criterion A: Exposure to actual or threatened a) death, b) serious injury, c) sexual violation, in one or more of the following ways:

[] Directly experiencing the traumatic event(s)
[] Witnessing, in person, the traumatic event(s) as they occurred to others
[] Learning that the traumatic event(s) occurred to a close family member or close friend; cases of actual or threatened death must have been violent or accidental; or, experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse); this does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related

[X] No criterion in this section met.

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:

[] Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).

[] Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).

[] Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.)

[] Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

[] Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

[X] No criterion in this section met.

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:

[] Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

[] 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).
[X] No criterion in this section met.

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:

[] Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).
[] Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad," "No one can be trusted," "The world is completely dangerous," "My whole nervous system is permanently ruined").
[] Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead to the individual to blame himself/herself or others.
[X] Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).
[X] Markedly diminished interest or participation in significant activities.
[X] Feelings of detachment or estrangement from others.
[] Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings.)

[] No criterion in this section met.

Criterion E: Marked alterations in arousal and 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:

[X] Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.
[X] Reckless or self-destructive behavior.
[X] Hypervigilance
[] Exaggerated startle response.
[X] Problems with concentration.
[X] Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).
[] No criterion in this section met.

Criterion F:

[] Duration of the disturbance (Criteria B, C, D, and E) is more than 1 month.
[X] No criterion in this section met.

Criterion G:

[] The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
[X] No criterion in this section met.

Criterion H:

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

[X] No criterion in this section met.

Criterion I: Which stressor(s) contributed to the Veterans PTSD diagnosis?

[] Stressor #1
[] Stressor #2
[] Stressor #3
[] Other, please indicate stressor number (i.e. stressor #4, #5, etc.) as indicated above:

[X] No criterion in this section met.

5. SYMPTOMS

For VA rating purposes, check all symptoms that apply to the Veteran's diagnoses:

[X] Depressed mood
[X] Anxiety
[X] Suspiciousness
[] Panic attacks that occur weekly or less often
[] Panic attacks more than once a week
[] Near-continuous panic or depression affecting the ability to function independently, appropriately and effectively
[X] Chronic sleep impairment
[X] Mild memory loss, such as forgetting names, directions or recent events
[] Impairment of short- and long-term memory, for example, retention of only highly learned material, while forgetting to complete tasks
[] Memory loss for names of close relatives, own occupation, or own name
[] Flattened affect

[] Circumstantial, circumlocutory or stereotyped speech
[] Speech intermittently illogical, obscure, or irrelevant
[] Difficulty in understanding complex commands
[X] Impaired judgment
[] Impaired abstract thinking
[] Gross impairment in thought processes or communication
[X] Disturbances of motivation and mood
[X] Difficulty in establishing and maintaining effective work and social relationships
[X] Difficulty in adapting to stressful circumstances, including work or a work like setting
[] Inability to establish and maintain effective relationships
[X] Suicidal ideation
[] Obsessional rituals which interfere with routine activities
[] Impaired impulse control, such as unprovoked irritability with periods of violence
[] Spatial disorientation
[] Persistent delusions or hallucinations
[] Grossly inappropriate behavior
[X] Persistent danger of hurting self or others
[] Neglect of personal appearance and hygiene
[] Intermittent inability to perform activities of daily living, including maintenance of minimal personal hygiene
[] Disorientation to time or place

6. BEHAVIORAL OBSERVATIONS

The veteran appeared for his appointment on time. He was dressed in shorts and a t-shirt. He sat on the edge of his chair and moved his head in what appeared to be a motor tic movement throughout the interview. He was very polite and cooperative and appeared to answer the questions to the best of his ability. His speech was WNL. His thoughts were somewhat paranoid and narcissistic in nature, as the veteran continually talked about women asking him to engage with them sexually. He used terms such as "throwing themselves at me" to describe this behavior. He was alert and oriented x4. He denied any current SI or HI.

7. OTHER SYMPTOMS

Does the Veteran have any other symptoms attributable to PTSD (and other mental disorders) that are not listed above?
[] Yes [X] No

If "Yes," describe:

8. COMPETENCY

Is the Veteran capable of managing his or her financial affairs?
[X] Yes [] No

If "No," explain:

9. REMARKS (INCLUDING ANY TESTING RESULTS), IF ANY:

The veteran notes that he feels suicidal often, but that he does not hurt himself because of his religion.
I believe this Veteran/Service Member should be considered an INCREASED but not current imminent risk.
The veteran was equipped with the VA Crisis line number.

SECTION III – PSYCHIATRIST/ PSYCHOLOGIST CERTIFICATION AND SIGNATURE

CERTIFICATION – To the best of my knowledge, the information contained herein is accurate, complete and current.

10A. PSYCHIATRIST/ PSYCHOLOGIST SIGNATURE AND TITLE:	/s/ Rebecca Richey, Phys.D, LCSW
10B. PSYCHIATRIST/ PSYCHOLOGIST PRINTED NAME:	REBECCA M. RICHEY, PsyD
10C. DATE SIGNED	04/19/2018
10D. PSYCHIATRIST/ PSYCHOLOGIST PHONE AND FAX NUMBERS:	1-877-637-8387 Fax: 1-800-320-3908
10E. PSYCHIATRIST/ PSYCHOLOGIST NATIONAL PROVIDER IDENTIFIER (NPI)	1033230990 / PSY.0004113 CO

NUMBER AND MEDICAL LICENSE NUMBER AND STATE:	
10F. PSYCHIATRIST/ PSYCHOLOGIST ADDRESS:	VA-DENVER CO B&M VADCO 14142 DENVER WEST PARKWAY BLDG 51 – SUITE 285, LAKEWOOD, CO 80401
10G. PSYCHIATRIST'S SPECIALTY:	Psychologist

NOTE: VA may request additional medical information, including additional examinations, if necessary to complete VA's review of the Veteran's application.

DEPARTMENT OF VETERANS AFFAIRS
EASTERN COLORADO
HEALTH CARE SYSTEM
1055 Clermont Street
Denver, Colorado 80220
303-399-8020

To: Joshua Bufkin

12/23/2019

Joshua suffers from chronic PTSD due to a number of issues, but the primary issue is that he was essentially forced out of the military due to intense family problems that put him in a very difficult psychological situation. He had to choose between his goal of making a career in the military or keep his marriage intact. There was no good solution. He decided to save his marriage, and is still happily married, but the sense of loss of losing his military career has been very difficult for him. He has tried to find another career that is as satisfying, but has not been able to so far. Some examiners do not consider this to be PTSD, but it was clearly traumatic for Joshua. At a minimum, he has developed a severe anxiety disorder.

/s/

Charles Mellon, MD
Psychiatrist
Pueblo VA