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

CRS
Docket No: 3010-00
11 July 2001

[redacted]

Dear [redacted]

This is in reference to your application for correction of your naval record pursuant to the provisions of Title 10, 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 11 July 2001. 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 the Bureau of Medicine and Surgery undated, a copy of which is attached. The Board also considered your rebuttal statement of 19 December 2000.

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. The Board also concluded that the psychiatric problems from which you suffered during the period of your service were not sufficiently mitigating to warrant recharacterization. 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

Copy to: Disabled American Veterans

NATIONAL NAVAL MEDICAL CENTER
DEPARTMENT OF PSYCHIATRY
OUTPATIENT DIVISION
BEHTESDA, MARYLAND 20889-5600

From: LT [redacted], MC, USNR
To: CAPT William Nash, Specialty Advisor for Psychiatry, Chief BUMED, Naval Hospital, San Diego, CA 92134-5000

Via: Chairman, Department of Psychiatry, NNMC

Subj: APPLICATION FOR CORRECTION OF NAVAL RECORDS [redacted]

Ref: (a) 10 U.S.C. 1171
(b) Board for Corrections of naval Records letter of 20 June 2000

Encl: (1) BCNR File
(2) Service Records/Medical 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 have thoroughly reviewed enclosures (1) and (2).
2. Review of available Navy medical records revealed:

a. SF 502, Narrative Summary, dated 01 MAR 1988 from Naval Hospital, San Diego, which summarized inpatient care received from 16 FEB 1988 to 03 MAR 1988 for acute mental status and blood pressure changes in the context of longstanding difficulties with poly-substance abuse and an admission urine toxicology screen positive for THC and amphetamines. The reports by [redacted] documented also a long history of multiple somatic complaints, difficulties with focal "anxiety" complaints, and difficulties with alcohol abuse. The acute onset of mental status changes characterized by paranoid ideation, rapid/pressured speech and perceptual disturbances were documented as resolved by hospital day three. Symptom onset, which was three days prior to admission, coincided with the use of THC and amphetamines. He was reported to have eaten and slept well during his hospital course, with no evidence of a major affective disorder or thought disorder, per the record. He received only propranolol, which was tapered, then stopped. An ARS consultation was also executed, the results of which indicated that the patient suffered from alcohol and amphetamine dependence and TCH abuse. He was diagnosed with amphetamine intoxication (resolved), alcohol dependence, amphetamine abuse, and cannabis abuse. He was found to be fully fit for duty pending legal intervention. Further recommendations included level III treatment while on active duty, attendance of Alcoholics Anonymous, command administered disulfiram (250 mg PO QD), and follow-up psychiatric appointments.

b. SF 513, Consultation Sheet, dated 09 JAN 1987 from Fleet Mental Health Unit, Naval Station San Diego, was initiated to rule out "conversion" disorder or reaction in the setting of two "hyperventilation" episodes with unclear precipitating stressors. The report by [redacted] revealed a history of two focal, circumscribed episodes of intense anxiety with peripheral hyperautomonic signs previously diagnosed as a "hypoglycemic reaction." The latter of the two episodes occurred 6 days prior to evaluation. Though he noted no acute precipitating stressors, the patient noted that he was under some financial strain due to "wrecking (his) car and a "DUI" charge in SEPT 1986. He also noted feeling as though he was in a "rut" in the USN, along with "fatigue and (decreased) motivation." His level of alcohol use at that time was one six-pack per week. He denied drug abuse. Mental status examination at that time revealed "appropriate" behavior with "no evidence of psychomotor agitation or retardation." Furthermore, there was no evidence of disturbed thought processes, pressured

speech, cognitive problems, or problems with judgement. His mood was described as "worried and angry." He was diagnosed with somatization disorder, with a "rule-out" for panic disorder. He was found fully fit for duty, and "fully responsible for his actions." He was to return to the clinic for psychological testing. Note: I was unable to find the results of said testing in the patient's medical record.

c. SF 513, Consultation Sheet, dated 31 OCTOBER 1984 from Bremerton, WA, was initiated for suspected "hysteria, conversion, malingering" for recurrent complaints of conjunctivitis with negative ophthalmologic workup. According to the report by [redacted] the patient reported suffering from conjunctivitis complaints when shipboard and in the shipyard. Since being reassigned to working with computer programs and data, his complaints attenuated. Social history revealed that the patient was raised in a mobile, broken home, in which he endured physical abuse. Mental status examination revealed that the patient was fully alert and oriented, with no clinical evidence of a major affective disorder, thought disorder, organic brain disease or psychotic process. The results of an MMPI given on 16 OCTOBER 1984 reflected a more significant level of psychological maladjustment. According to the testing, the patient was determined as being likely to possess "significant psychological problems," a negative self-image, fear of emotional involvement and likely to "display depressive and hysterical features," where "unusual physical complaints and pervasive apathy (might) be present." Furthermore, this adjustment was "likely" thought to be "chronic and resistant to change." The result of this composite evaluation were diagnoses of somatization disorder, with a diagnosis of personality disorder being deferred (though prominent borderline, schizoid and dependent features were noted). He was found to be fully fit for duty, and the patient was urged to participate in group psychotherapy offered by the evaluator's clinic. No further follow-up was recommended.

d. SF 600, Chronological Record of Medical Care, from USS Enterprise, dated 05 APR 1982, was documented results of a psychological evaluation per the request of the ship's SMO for further evaluation of a "possible seizure disorder, anxiety disorder and problems coping with military life at sea." Per this report by [redacted] the patient's mental status examination at the time of evaluation was "unremarkable." The patient was described as "mildly anxious, frustrated and unhappy with sea duty." Furthermore, the evaluator was of the opinion that the interview suggested that the patient possessed a personality style in which "tension, stress tends to be expressed in psychosomatic ways." Though no specific diagnosis was documented, the patient was found to be fit for duty.

e. SF 513, Consultation Sheet, dated 16 JUN 1981 from NRMC Bremerton, was initiated for further evaluation and treatment of possible "manic-depressive illness." According to the report by [redacted] the patient reported problems beginning six months prior to the evaluation when, upon completing his active training program, he noted intermittent and episodic anxiety complaints and ruminative thoughts, accompanied by unfitful sleep and appetite disruption. He noted that his routine duties were found to be "extremely tedious, boring and mundane," per the record. He was described as delivering his history in a "most lucid and coherent fashion." Though his mood was noted as being "one of mild disgruntlement" with mood congruent affect, there was no evidence of bipolar disorder, underlying thought disorder or organic brain dysfunction at the time of evaluation. His judgement was reported as "excellent." He was diagnosed as having a "situational disturbance with mixed emotional features, remedied with flurazepam 15-30 mg QHS for a limited period of time. It was also requested that the patient begin outpatient psychotherapy. He was returned for full duty.

f. SF 513, Consultation Sheet, dated 11 MAY 1982, from NRMC Branch Clinic, USS Enterprise, was initiated for further evaluation of an apparent difficulty tolerating life aboard ship. According to the report by [redacted] MC, USN, the patient missed a ship's movement, reporting that he could not handle the "physical tension and emotional pressure" in

that environment. He also complained of headaches, inability to sleep well, irritability and general nervousness with mental confusion. He provided that the solution would be to "get off the ship" and transfer to short duty, where he believed that he would be fine. It was noted that one year prior to this evaluation, the patient engendered similar complaints as the ship was readying for sea. A psychiatric evaluation then was found to be normal. The patient's history was also remarkable for seizures as a child and two other such episodes later in life but prior to enlistment, for which he received medications. He discontinued these medications upon entering the military because they made him "feel like a zombie." On mental status examination, his mood was described as normal, with an "appropriately labile" affect. He noted that all of his problems had "just arisen," per record, and that the ship was to blame for his problems. At the time of evaluation, the patient had been off of the ship for ten days, and reported that he felt much improved. An MMPI was given, revealing "hysteroid" traits with evidence of difficulty in social situations requiring expression of anger, strong needs to be liked, and an emphasis on conventionality. The result of the composite evaluation was a diagnosis of mixed personality disorder. He was found to be fully fit for duty. It was also determined that, at the time of his offense, he did not suffer from a mental disease or disorder such that he could not distinguish right from wrong.

3. Review of the service record revealed:
   a. The patient completed basic training and Machinist Mate Class-A school, and Naval Nuclear Power School, along with Operational Training at SIC Nuclear Submarine Prototype NPTU (Windsor, CT) before his first assignment aboard the U.S.S. Enterprise (19 DEC 1978 to 01 OCT 1980). This was followed by assignments at SIMA, SD (02 OCT 1980 to 01 DEC 1985) and aboard the U.S.S. New Jersey (02 DEC 1985 to 25 MAR 1988).
   b. Evaluations from each of the patient's duty stations ranged from 3.4 to 4.0, with recommendations for retention and advancement until duties aboard the U.S.S. New Jersey where he received ratings ranging from 1.0 to 3.8. He was not recommended for re-enlistment for use of marijuana, and waived his administrative discharge board in favor of an other than honorable discharge.
   c. The patient completed the Naval Substance Abuse Prevention Program as provided by the University of Arizona (06 MAR 1987).
   d. The patient has received the Sea Service Deployment Ribbon, the Humanitarian Service Medal and Good Conduct Award.

4. Review of the VA file revealed:
   a. Letter from the patient's treating physician, [redacted] dated 11 APRIL 2000, was written indicating that the patient has received a diagnosis of "a Bipolar condition" for which he is being treated with valproic acid. He notes that the patient had attended school at Western Illinois University but did not return this past semester. He is viewed as being uncomfortable in interpersonal settings, and sensitive to authority. He notes that it is "believable" that the patient had attempted to manage his affective discomfort by abusing substances, noting that his "avoid(ance)" may have also precluded more effective coping.
   b. Rating Decision, dated 05 OCT 1998, listing a jurisdiction of 30% for a "rapid cycling bipolar disorder." There is no documentation of an evaluation that led to this jurisdiction, nor is there any documentation available in this file of treatment received at the VA for any mental health concerns.
   c. Notice of Decision (Fully Favorable), Social Security Administration, dated 19 AUG 1999, was adjudicated and drafted. This document described mental health contacts subsequent to the patient's leaving the service. His abilities were judged as being moderately limiting.

4. Discussion:

   a. The patient was evaluated by mental health on numerous occasions, both before and during the time of the patient's misconduct that led to his discharge. The outcomes of each of these evaluations were determinations that the patient was fit for duty, with several providing clinical evidence of chronic difficulties with substance misuse and clinical and psychmometric data

suggestive of long-standing characterological difficulties. There is no documentation in the records reviewed consistent with a condition of such severity so as to adversely impact upon his judgement such that the patient could not distinguish right from wrong, and could not adhere to the right. The evaluations judged the patient as fully fit for duty and did not evidence the presence of significant mood or psychotic thought processes occurring outside the context of substance use.

b. There was no additional documentation in the patient's medical record of treatment in a mental health facility during his period of active duty.

c. There were no clinical records of any treatment received at a VA facility available for review other than the aforementioned.

5. Opinion and Recommendations: There is insufficient evidence in the information provided to support a recharacterization of the patient's discharge.

William V. Bobo
LT, MC, USNR

John Lyszczarz
LCDR, MC, USNR