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**INDEPENDENT PSYCHOLOGICAL EVALUATION**

**Name**

**Date of Birth:** February**: xxxxx**

**Date of Evaluation:** October 27, 2017

**Chronological Age:** 46 years

**REASON FOR REFERRAL:**

Mr.xxxxxx was a self referred for a psychological

evaluation for posttrauma stress, and other possible service

connected mental disorders. This is a **CONFIDENTIAL** evaluation and it should not be released to other agencies or individuals

without the expressed written consent of the client or legal

guardian.

**TESTS ADMINISTERED/EVALUATION TECHNIQUES:**

Clinician Administered PTSD Scale for DSM-V

Post-Traumatic Stress Disorder Checklist (PCL-M)

Minnesota Multiphasic Personality Inventory-2RF (MMPI)

Millon Clinical Multiaxial Inventory

Mississippi Scale for Combat Related PTSD (Mississippi)

Beck Anxiety Inventory

Combat Exposure Survey (CES)

Test of Memory Malingering

Behavioral Observations

Clinical Interview of Claimant

Personal VA file Review, C-file as such unavailable

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**BACKGROUND INFORMATION:**

Mr. lives in xxxx, Indiana with his wife and

five of his seven children, two are grown. He has been married to his second wife for about eighteen years. His first marriage was for about two years and ended in divorce. He graduated xxxxx High School in xxxxxx in 1989 and earned an associate’s degree in robotics from xxxxx University in 1998. He was enrolled in a regular education program where he reportedly made average grades. He joined the Marine Corps reserves in 1989 and his unit was activated and served in Operation Desert Storm combat in Bahrain, was given an honorable discharge and an MOS of 0311. He served in the national guard with a 11B MOS,both being that of infantry. He is currently working for xxxxxx Company as a waste water operator and has done this work for the past 10 years. He reportedly has no felony record, only a minor misdemeanor relative to his divorce. His physical health is reportedly normal, save service Gulf War related issues. He has taken Zoloft and Abilify for depressive symptoms for the past four months and is treated for posttrauma stress by the Vincennes VA clinic, where he is getting monthly individualized psychotherapy for what the VA diagnosed as PTSD in 2016. He admits a history of alcohol abuse, but denies drug abuse. He reportedly was drinking heavily after Desert Storm and lost 35 pounds his first year back stateside. His mother

corroborated his statement about his weight loss and drinking.

He reportedly was drinking to excess for about two years before he reportedly stopped drinking on his own for a while, without

participation in an alcohol treatment program. He later admitted

that he is still drinking on the weekends in the amount of one to two wine glasses of wine. He reportedly was last intoxicated on alcohol five or six years ago. At age 14 he reportedly was

drinking and put his head through a window after showing off for girls and says this was misconstrued as a suicide attempt. He

reportedly was hospitalized after blacking out with

a high blood alcohol content and was court ordered to go through

alcohol counseling. He reportedly has not drank to excess for almost many years. He contends that his sleep is “not good at all” with him getting up 10 to 15 times a night. His appetite is reportedly varied with him not eating some days. There is no reported history of psychiatric hospitalization or other mental health intervention. He reportedly has never attempted suicide, but has thought about it many times since his honorable discharge from the military and once noted before he entered the military. At one time he reportedly had a rope around his neck before stopping himself and just last year reportedly put a loaded gun in is mouth ready to pull the trigger.

**BEHAVIORAL OBSERVATIONS:**

Mr.xxxxxxx was a pleasant and cooperative individual with

whom to work. He performed right-handed. Mr. xxxxxx’s gait,

posture and limb use were unremarkable. Mr. xxxxx was attired

in casual clothes that were clean. His grooming was adequate. Mr. xxxxxx’s speech was clearly articulated and relevant to the

topics of discussion. Mr. xxxxxx’s affect was stable and

situation appropriate. He was oriented to person, place, time and testing situation.

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**TEST RESULTS AND INTERPRETATIONS:**

The Minnesota Multiphasic Personality Inventory-2 Revised

Form is the oldest and most widely used and researched objective

personality inventory, since its inception in about 1939. It’s

latest revision is a broad band test designed to assess a number

of major personality and emotional disorders. A degree of

cooperation and commitment to the task of completing the

inventory is required.

The test provides internal checks to see if these requisites

are satisfied. The **validity indices** suggest a useable profile,

with consistent reporting of personality factors, without

evidence of significant under-reporting or over-reporting of

psychopathology on the nine validity scales.

The **psych-five scales** are indicative of maladaptive

aggression and introversion. There is some evidence of a thought

disorder. There is no under constraining of feelings. There is

not an abnormal degree of negative emotional experiences.

The **profile of externalizing, interpersonal and interests**

scales do not give evidence of a substantial juvenile conduct

history, despite the incident that got him hospitalized after

drinking and putting his head through a window (this suggests his premilitary emotional history was not abnormal, but was slight above average at a t score of 63). The substance abuse scale is elevated (t-69), raising the issue of whether he might still be drinking, despite his report that he has not drank to excess in nearly 5 - 6 years (with his mother suspecting the contrary in her buddy statement). The aggressive behavior scale is marked elevated, just as the psych-five aggression scale was elevated in the anteceding paragraph. His energy level is low, suggestive of a possible depressive or PTSD feature. There are no reported significant family problems, though he has five minors and a wife in the home, so maybe this is an area where he can draw strength.

On the IPP scales he describes himself has having strong opinions and standing up for himself and possibly having leadership qualities. He is reporting social avoidance, but not shyness or social anxiety. Mr. xxxxxx reports that he dislikes people and dislikes being around them.

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The **profile of somatic/cognitive and internalizing scales**

are indicating a moderate degree of malaise and of not being in

good health. He complains of excessive gastrointestinal problems

and significant memory and cognitive deficits. He endorses three

of the four suicidal ideation items, raising a red flag high into the air and suggesting the possible need for in-patient

psychiatric intervention and suicide precautions at home and in

the community. A sense of hopefulness is expressed and Mr.

xxxxxx is not showing self-doubt. Mr. xxxxxx is reporting an

abnormal degree of anxiety (t-92), but the stress and worry scale is normal. He reportedly is anger prone (in addition to the high aggression scales and the suicidal ideation) and this is further cause for concern over his personal mental health and of public safety. This issue of homicidal ideation is raised in light of his Marine experience, his penchant for guns, his road rage, report of knocking out of another driver, as well as his reported history of fights. He does not admit to having restricting general or specific fears.

Finally, the **profile of higher-order and restructured**

**clinical scales** shows an abnormal degree of generalized

maladjustment (this is contrary to his assessment with the same

scales three months ago in his C&P). He is showing significant

emotional distress. There is an indication of a thought disorder

(as mentioned on a previous scale in this assessment instrument).

His behavior is unreasonably unconstrained and may result in

acting out of antisocial impulses. He is depressed and is

reporting a large number of bodily complaints, mostly of a

gastrointestinal nature. Further, Mr. xxxxxx is distrustful,

antisocial, paranoid, and anxious.

The Millon Clinical Multiaxial Inventory identifies

personality characteristics and assesses clinical syndromes in

the context of a personality pattern. It focuses on

psychopathological problems and helps generate treatment options. Two thresholds for clinical significance are used here. Scores at or above 85 (\*\*) are highly significant and are the primary focus of treatment. Scores of greater than 75 (\*), but less than 85 are clinically useful in understanding the dynamics of behavior,

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but are of secondary concern in the treatment plan. The validity

scale suggests he was paying attention to the questions with a

raw score of zero.

Clinical Personality Patterns Base Rate Score

1 asocial......................................78\*

2 avoidant.....................................85\*\*

3 submissive...................................14

4 histrionic...................................40

5 narcissistic.................................57

6 aggressive...................................83\*

7 compulsive...................................62

8 negativistic.................................75\*

Severe Personality Pathology Base Rate Score

S schizoid.....................................69

C borderline...................................69

P paranoid.....................................55

Clinical Syndrome Scales Base Rate Score

A anxiety......................................89\*\*

H somatoform...................................60

N hypomanic....................................0

D dysthymic....................................86\*\*

B alcohol abuse................................55

T drug abuse...................................64

SS psychotic thinking..........................69

CC psychotic depression........................62

PP psychotic delusions.........................51

Three of the above scales are in the very significant range

of emotional maladjustment: avoidant, anxiety and dysthymic.

Anxiety is the most prominent emotional feature. This is

indicative of a constant and confusing undercurrent of tension,

sadness and anger. Mr. McGuire is vacillating between a desire

for affection, fear and numbing of feelings. The feelings of

anger, sadness and aggression again are seen on this scale, as on the MMPI subscales. Lesser but significant elevations are noted on the asocial, aggressiveness and negativistic scales. He is asocial, which may speak to a schizoid affectivity. He may

respond to others with passive-aggression, be a contrarian and

want to do the opposite of what is proposed or demanded by

others.

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The Beck Anxiety Inventory is a 21-item Likert scale that

measures symptoms of anxiety and helps to differentiate between

various types of anxiety. The scoring guidelines suggest that

total scores from 0-7 reflect a minimal level of anxiety. Scores

from 8-15 represent mild anxiety. Scores from 16-25 reflect

moderate anxiety and scores from 26 to 63 indicate severe

anxiety.

On this scale his raw score of 34 is in the severe anxiety

range. He reportedly is unable to relax. He suffers heart

pounding, hand trembling, abdominal discomfort and face flushing. The Combat Exposure Scale (CES) a subjective measure of wartime stressors experienced by combatants. Higher exposure to combat is correlated with higher degrees of posttrauma stress. Scores of zero to eight are categorized as light exposure, 9-16 are light to moderate, 17 to 24 are moderate, 25-32 moderate to heavy, and 33 to 41 are heavy exposure to combat.

Mr. xxxxxx’s combat exposure raw score was 16 and in the

light to moderate. He reportedly went on many recon and

counterinsurgency patrols, mostly as a point man. He was under

indirect enemy fire when a patriot missile shot down a skud

missile and the missile shrapnel fell on his platoon. On another

occasion a chemical reportedly was released on his platoon and

turned his clothing blue and he and fellow soldiers suffered flu-like symptoms. He says three individuals he knows were

casualties, one of which was shot in a friendly fire incident..

He reportedly washit by shrapnel, but it did not penetrate his protectiveclothing. He was nearly attacked by friendly fire and had gunstrained on him by other national troops. He reportedly was inconstant fear of being shot by a sniper, as he almost alwayswalked point.The Post-Traumatic Stress Disorder Checklist (PCL-M) is a measure of the B, C and D criteria for Post-Traumatic Stress Disorder as set forth in the Diagnostic and Statistical Manual-V. To meet this standard the A criteria of a critical incident must first be identified. Patients need to endorse at least one B items, 3 C items and 2 D items to meet the minimal standard of having PTSD plus it is recommended that the minimal raw score of 50 be achieved.

Mr. xxxxxxx’s raw score was 65 and in the positive range for

a diagnosis of PTSD. He rated himself more than positive enough

B, C and D criteria for a diagnosis of PTSD.

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The Mississippi Scale for Combat Related Post Trauma Stress

Disorder is a 35-item Likert questionnaire completed by the

patient. Veterans are classified into one of three categories

based on their mean score and standard deviation: Post Traumatic

Stress Disorder mean 130, standard deviation 18; Other

Psychological Disorders mean 86, standard deviation 26; and well

adjusted mean 76 standard deviation 18. Mr. xxxxxxx’s raw score of 155 is positive for a diagnosis of Posttraumatic Stress of moderate to severe severity.

The Clinician Administered PTSD Scale for DSM-V is the

comprehensive gold standard for assessing Posttraumatic Stress

Disorder, as developed by the National Center for Posttraumatic

Stress Disorder and as used by the Veterans Administration for

determining the severity and duration of PTSD. It uses the

specific criterion developed by the authors of the Diagnostic and Statistical Manual-5 for diagnosing PTSD.

Mr. xxxxxx says the most traumatic event that happened in

Desert Storm was having the skud missile blow up over his head

when he was next to an ammo dump. He reportedly was peppered with a great deal of shrapnel, but was not wounded because he was in protective battle clothing. Mr. xxxxxx reportedly is 30% service connected for irritable bowel syndrome. Mr.xxxxxx reportedly has unwanted memories of his combat experience about three days a week. He says the memories bother him the most when he is not busy. He says the smell of diesel fuel produces a strong physical memory of his work in a battle zone and elicits unwanted and disturbing memories. He reportedly never remembers his dreams, but shakes, sweats and moves around restless in bed. (Maybe he is repressing distressing dreams.) His wife reportedly is now sleeping in a separate bedroom and has done so for about the past nine years because of his tumultuous sleep. He denies

experiencing flashbacks of the events of battle, but he is again

saying he has trouble with his memory and has spaced out while

driving and became disoriented. Is this a dissociative flashback? He reportedly cannot wear the safety mask he is provided at work because the mask reminds him of his combat battle mask to protect himself from chemical assaults. This is risky behavior given the nature of his work. He often becomes upset when he hears a loud unexpected bang or loud noise, which is a common symptom of PTSD. His physical reactions include shaking, hands sweating, an upset stomach, panic attacks with heart racing and rapid breathing. He avoids war movies and going

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on Face Book because of war associations and people in general upset him too much. He reportedly is yet to make a visit to the Veterans Hospital without breaking down and crying. He is afraid the VA will find out that he has had suicidal thoughts and take his guns. He reportedly does not go anywhere without a gun. Mr.

xxxxxxx reportedly has been having trouble with his short term

memory lately. He reports buddies deployed with him often tell

him of important events that he has no recollection of them

having occurred. He reportedly blames himself and the government

for his combat experiences. He reportedly no longer does much,

but work and stay home with his family (restricted activities),

but has made efforts to be more outgoing since his therapy at the VA. He reportedly has no friends, but rarely sees a few of his veteran associates. Mr.xxxxxx reported has felt irritable and six weeks ago beat someone up. He reportedly has been stabbed in fights three times, once with a beer bottle. Mr. xxxxxx reportedly is hyperalert and went into his shed at gunpoint recently because he thought someone was in there. He reportedly is easily startled and after a recent explosion nearly jumped out of his shoes (he has denied an exaggerated startle response in the past). He reportedly does not have a problem with people coming up from behind him, but says he is always watchful. He reportedly has trouble with his concentration, noting he forgets a topic of conversation and forgets what word he wanted to use. He says it takes him about an hour to fall asleep when going to bed. After sleeping for an hour or two he often has to get out of bed and stay up for a while. The Test of Memory Malingering (TOMM) is a brief visual

recognition test designed to help discriminate between

individuals with true memory impairment and malingerers.

According to the author, it is a first step in verifying whether

an individual is falsifying memory impairment. Directions were

given orally in English by the examining psychologist with care

taken not to reveal the name of the test, as suggested by the

publisher. On trial one, Mr. xxxxxxx answered 49 of 50 items correctly. Trial two improved to 50 items correct and optional trial three (long term retention) was deferred because trials one and two adequately answered the designed clinical question, “Is Mr.

xxxxxxx malingering or not?”. This is not the performance of a

malingerer and strongly argues against such a contention.

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**SUMMARY:**

xxxxxxx is a 46-year-old United States Marine Corps

veteran of Operation Desert Storm. He experiences a great deal of depression, anxiety, anger and social withdrawal. He meets the A to H diagnostic criteria for Posttraumatic Stress Disorder. This apparently was not a preexisting condition when he enlisted, nor was Major Depressive Disorder. Had either been a preexisting condition, he would have been summarily discharged, when he was questioned in boot camp by the Naval Lt. Commander, looking into allegations of his emotional instability and substance abuse. If this were a problem he could have been passed over at the time of his recruitment, or initial orientation, or basic training and infantry training, but he was not. The military had ample opportunities to discharge Mr. xxxxxxxx as mentally unfit for duty. Instead he was honorable discharged with a perfect reinlistment code, twice promoted and was allowed to serve in the national guard for several years. Any preexisting minor depression, could have been aggravated by his deployment into combat and morphed into the more severe PTSD with its comorbid depressive and anxiety features. There is only flimsy speculation that he had any premilitary mental illnesses. It would be only speculation with a poor data base to suggest that his trauma during active military had any nexus to any preexisting depression. It is as likely as not that his PTSD had its origins in his participation in Desert Storm and not some seeds planted in adolescent drinking. Therefore, the review of his military record, the current examination and buddy letters suggest that it is more likely than not that Mr. xxxxxxx’s PTSD is the product of his light to moderate combat exposure during operation desert storm and not from earlier indiscretions of adolescence.

Depression, anxiety and thought disorders are typical associated

features of PTSD and often have diagnostic significance for the

diagnosis of PTSD. PTSD is often confused with these three

separate diagnoses, as noted by the National Center for PTSD, the DSM-5 and the examiners extensive training in this area. Both suicidal and homicidal precautions need to be taken with the veteran. Consider random drug and alcohol screening to assure sobriety.

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**ICD-10 DIAGNOSIS:**

Posttraumatic Stress Disorder with depression, anxiety and high

suicide risk Rule out Continuous or Intermittent Alcohol Abuse Disorder Global Assessment of Functioning: Current 65; Highest in Past Year 65

If I or my office can be of further assistance in the

rehabilitative or evaluative process of this veteran, please do

not hesitate to write or call.

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Record Review Notes Based on 19 e-mails, with multiple

attachments of VA reports, equivalent of a c-file review, my

notes only not for grammatical review.

9/27/17 reports he has been diagnosed with PTSD by his local

VAMC, C&P psychologist changed dx to Major Depression,

preexisting and not aggravated by service in Gulf.

9/27/17 Therapist (nurse practiconer?) at VAMC is Rhonda Bray,

who he says disagrees strongly with the VA psychologist, but she

reportedly “ Likely would not verbalize her opinion to the VA lest she lose credibility by challenging a PHD VA Psychologist”.

He says he had 18 year of being symptom free of depression before his deployment.

Attachment 8pp, VA personal info 8/17, VA problem list PTSD,

noncompliance with medication regime, smoker, bloating, htn, 8

lipid, sleep do, testicular dysfunc, examiner dx mdd existed

prior to service, hx of depression and etoh abuse 88 and 89,

active duty 90-91 need aggravation opinion

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Attachment: 27 pp, Personal Info Report 7/17, in person examstates, <50% likely SC, 87 hand through window while drunk, sig hx of depress suicidal ideas sober and drunk, stopped from killing self while drunk, distress before deployment (does not mean distress before military), see mother’s report, reserved after deployment no longer close relations with friends and family. Not the same way that left for desert Storm. p7 Lost much weight after coming home. Dx MDD, “overall emotional stress is relatively low per MMPI2-rf, marital difficulty and interpersonal anger, no intrustive or avoidant sx, buddy reports consistent w MDD, no intrusive sx, interaction w coworkers and managers strained due to antisocial–tim xxxxxx, wife says p8 anx, anger mood, depress off and on in past struggle with anx and dep when military talk, self medicate with etoh, broke hand in fit of rage, consider etoh do include consideration of tbi, only one mental dx??? no dx tbi, p12 did not mention his national guard only his active duty usmc, honorable, e3, no prior mental heath tx before st. Louis va, p13 notes va dx of Ptsd, zoloft helping and starting to go out, says va improperly dx of PTSD, no documentation of intrusive sx, sleep difficulty up 5x/nt, checks locks= not hypervigilant , denies sI or HI, thinking of melatonin, nightmares not PTSD intrusive type, no recall (possible suppression??? again ) p14

no mental health tx in service, 1987 put head through glass

drunk, said depressed at x, interview said one x excessive

drinking not depressed to me, Second incident of etoh abuse 12/89 suspended from school hospitalized overnight 0.27 bal. P15 two etoh serving per week and no more than 5 serving/x n over a year (get a date on this exam). Talks of a buddy statement of 5/17 so this must be recent. Wife says he may be drinking more than he lets on p16 Ptsd A yes meets, skud and friendly fire, Saudi’s pointing guns, p17-18 no B to I criteria No, anx, p19 impulse control good, The remainder of this attachment is about why he does not have criteria of PTSD, MMPI-2rf valid, says only mild level of distress, Wm. R. Long 7/17

Personal Letter 1/17 8 pages

Same Day 6 more attachments, buddy letter mom notes lost weight

and changed after coming back from overseas, 2 foremen note

problems consistent with his reports of aggression and antisocial behavior at work

9/27 seven more attachments, dd214

9/27 rebutal letters, he has researched §3.306 Aggravation of

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preservice disability, suggesting if a mental condition existed

before he was in the service, he is entitled to a finding of

inservice aggravation of a preexisting condition. He is claiming

this was not a natural progression of his depression or whatever. Rebut the idea that symptoms were absent between discharge and 3-5 years ago. Claims examiner did not take into account the VA therapists assessment that he has PTSD, saying the basis of the dx is unclear.

C&P disagreement 7/25/17 7p, says premiliary are minor incidents

as a teen that did not result in a diagnosis of MDD, thought

combat duty had no bearing on mental illness quotes §4.124 dx

md’s On page 4 of the document he brings up the issue of the MMPI saying he was not emotionally distressed, but these goes on to describe ways to show he was emotionally distressed and had MDD.

This was exactly what I (Dr. Coyle) was thinking after reading

the C&P and after giving the same test again three months later,

finding him severely emotionally distressed.

Medical disagreement 8/31/17 3p, questions basis for establishing clearly and unmistakably premilitary history said he was depressed. I (Coyle) can agree with what he is saying here based on this current assessment, record review and the possible biasof the VA’s C&P examiner.

Attachment Title “Full VA file” 9/27/17 124pp

p4 dx PTSD 3/17 Bray, c&P Long 8/17, prior review, rx for mood

P10 pdsd dx, p38 MMPI mild level of clinical distress

9/27 5 attachments, med report questioned in service, talked of

significant hx of feeling depressed and of si stopped from

killing self with gun 12/89. Further military notes by LtCdr

Beaugrand dx etoh abuse., statement in support of claim 6/17 8/17

personal narrative p2, state in support of claim va form

9/28 denial letter 2p

va form 21-0960p2 Ready to fill out p5

10/23 most recent VA mental health pp11, dx ptsd, sleeping

problem, distrust others, hypervigilant.