BOARD OF VETERANS' APPEALS

FOR THE SECRETARY OF VETERANS AFFAIRS

IN THE APPEAL OF
THOMAS R. BACKLUND
Represented by
Florida Department of Veterans Affairs

SS [redacted]
Docket No. 14-20 277A

DATE: December 5, 2019

ORDER

Entitlement to service connection for an acquired psychiatric disorder to include schizophrenia, depression and posttraumatic stress disorder (PTSD), is denied.

FINDING OF FACT

The preponderance of evidence is against a finding that the Veteran's acquired psychiatric disorder to include schizophrenia, depression and PTSD is related to the Veteran's active duty service.

CONCLUSION OF LAW

The criteria for service connection for an acquired psychiatric disorder to include schizophrenia, depression and PTSD, have not been met. 38 U.S.C. §§ 1110, 1112, 1131, 5103(a), 5103A; 38 C.F.R. §§ 3.159, 3.303, 3.307, 3.309.

REASONS AND BASES FOR FINDING AND CONCLUSION

The Veteran served in active duty service with the Army from September 1976 to May 1977.

This matter is on appeal from a November 2011 rating decision. The Veteran was afforded a December 2017 hearing before the undersigned Judge. A transcript of the hearing has been associated with the claims record. The Board remanded this appeal in March 2018 and June 2019 for additional development.

Service Connection

Service connection may be granted for a disability resulting from disease or injury incurred in or aggravated by service. 38 U.S.C. § 1110; 38 C.F.R. § 3.303(a). Service connection may also be granted for any disease diagnosed after discharge, when the evidence, including that pertinent to service, establishes that the disease was incurred in service. 38 C.F.R. § 3.303(d).

As a general matter, service connection for a disability requires evidence of: (1) the existence of a current disability; (2) the existence of the disease or injury in service, and; (3) a relationship or nexus between the current disability and any injury or disease during service. *Shedden v. Principi*, 381 F.3d 1163 (Fed. Cir. 2004).

Service connection for PTSD requires medical evidence diagnosing the condition in accordance with 38 C.F.R. § 4.125 (a); a link, established by medical evidence, between current symptoms and an in-service stressor; and credible supporting evidence that the claimed in-service stressor occurred. 38 C.F.R. § 3.304 (f). When the evidence does not establish that a Veteran is a combat Veteran, the assertions of service stressors are not sufficient to establish the occurrence of such events. Rather, the reported service stressors must be established by official service record or other credible supporting evidence. 38 C.F.R. § 3.304 (f); *Pentecost v. Principi*, 16 Vet. App. 124 (2002).

Generally speaking, a medical opinion diagnosing PTSD does not suffice to verify the occurrence of the claimed in-service stressors. See *Cohen v. Brown*, 10 Vet. App. 128, 142 (1997). That is to say, a stressor usually cannot be established as having occurred merely by after-the-fact medical nexus evidence. *Moreau v. Brown*, 9 Vet. App. 389, 395-396 (1996); Cf. *Menegassi v. Shinseki*, 628 F.3d 1379 (Fed. Cir. 2011) (under 38 C.F.R. § 3.304 (f)(5), pertaining to in-service personal assault, medical opinion evidence may be submitted for use in determining

whether a claimed stressor occurred, and such opinion evidence should be weighed along with the other evidence of record in making this determination. Id at 1382 & n. 1.).

Lay evidence may be competent evidence to establish incurrence. See *Davidson v. Shinseki*, 581 F. 3d 1313 (Fed. Cir. 2009). Lay evidence can be competent and sufficient to establish a diagnosis of a condition when: (1) a layperson is competent to identify the medical condition, (e.g., a broken leg); (2) the layperson is reporting a contemporaneous medical diagnosis; or (3) lay testimony describing symptoms at the time supports a later diagnosis by a medical professional. However, competent medical evidence is necessary where the determinative question is one requiring medical knowledge. *Jandreau v. Nicholson*, 492 F.3d 1372 (Fed. Cir. 2007).

Special consideration must be given to claims for service connection for PTSD based on personal assault as a result of the sensitivity and difficulty in establishing proof of the assault in such claims. *Patton v. West*, 12 Vet. App. 272 (1999). Medical evidence may be used to corroborate the Veteran's claimed stressor in personal assault PTSD claims. Further, the Veteran may use evidence other than the service treatment records to corroborate the account of the stressor incident. 38 C.F.R. § 3.304 (f)(5). This evidence includes, but is not limited to: medical records, police records, statements from the Veteran's family and friends, and changes in behavior, to include, substance abuse, a request for a transfer to another military duty assignment, and unexplained changes in social behavior. This evidence is still subject to a credibility analysis. *Menegassi v. Shinseki*, 638 F.3d 1379, 1382 (Fed. Cir. 2011).

Examples of such evidence include evidence of behavior changes following the claimed assault. Examples of behavior changes that may constitute credible evidence of a stressor include deterioration in work performance and episodes of depression, panic attacks, or anxiety without an identifiable cause, or unexplained economic or social behavioral changes. 38 C.F.R. § 3.304 (f)(5) also provides that VA may submit any evidence that it receives to an appropriate medical or mental health professional for an opinion as to whether it indicates that a personal assault occurred. In *Menegassi v. Shinseki*, 628 F.3d 1379 (Fed. Cir. 2011), the Federal Circuit held that under 38 C.F.R. § 3.304 (f)(5), medical opinion evidence may be submitted for use in determining whether there was occurrence of a claimed

stressor, and such opinion evidence should be weighed along with the other evidence of record in making this determination.

The Board must analyze the credibility and probative value of the evidence, account for the evidence which it finds to be persuasive or unpersuasive and provide the reasons for its rejection of any material evidence favorable to the claimant. *See Wensch v. Principi*, 15 Vet. App. 362, 367 (2001). Board determinations with respect to the weight and credibility of evidence are factual determinations going to the probative value of the evidence. *Layno v. Brown*, 6 Vet. App. 465, 469 (1994).

In relevant part, 38 U.S.C. § 1154 (a) requires that the VA give "due consideration" to "all pertinent medical and lay evidence" in evaluating a claim to disability. Lay evidence can be competent and sufficient to establish a diagnosis of a condition when (1) a layperson is competent to identify the medical condition, (2) the layperson is reporting a contemporaneous medical diagnosis, or (3) lay testimony describing symptoms at the time supports a later diagnosis by a medical professional." *Jandreau v. Nicholson*, 492 F.3d 1372, 1377 (Fed. Cir. 2007). In fact, competent medical evidence is not necessarily required when the determinative issue involves either medical etiology or a medical diagnosis. Id. at 1376-77; *see also Buchanan v. Nicholson*, 451 F.3d 1331, 1337 (Fed. Cir. 2006); *Davidson v. Shinseki*, 581 F.3d 1313 (Fed. Cir. 2009).

When a claimant seeks benefits and the evidence is in relative equipoise, the claimant prevails. 38 U.S.C. § 5107(b); *see Gilbert v. Derwinski*, 1 Vet. App. 49 (1990); 38 C.F.R. § 3.102. The preponderance of the evidence must be against the claim for benefits to be denied. See *Alemany v. Brown*, 9 Vet. App. 518 (1996).

Acquired psychiatric disorder to include schizophrenia, depression and PTSD

The Veteran contends that his acquired psychiatric disorder is related to his active duty service.

Review of the Veteran's medical treatment record shows diagnoses for several mental disorders including schizoaffective disorder, depression, PTSD and drug related disorders. In a July 2019 VA examination, the Veteran was diagnosed with

depressive schizoaffective disorder, moderate cannibis use disorder, and other specified trauma and stressor related disorder. Accordingly, the Veteran finds the Veteran has a current diagnosis of an acquired psychiatric disorder.

Review of the Veteran's service treatment records (STR) shows the Veteran did not report any psychiatric health issues on his enlistment or separation examination; however, the STR does show the Veteran was treated in October 1976 for anxiety and in April 1977 for depression. As such, the Board finds the Veteran had in-service record of complaints and treatment for an acquired psychiatric.

In the October 1976 STR record, the Veteran reported "multiple somatic complaints", identifying them with a physiological etiology. The treating physician noted the Veteran as "quite anxious" and wanted a mental hygiene consultation. In the following consultation report, the treating psychologist found the Veteran as:

> "Immature, inability to handle the pressures of Army life... comes across as having a negative attitude, no motivation – [the Veteran] states that if he can't get out he'll probably go AWOL."

On April 16, 1977, the treating physician reported the Veteran as "quite depressed" as a result of being placed on kitchen patrol duty and given no other duties other than using weapons. The Veteran reported feeling humiliated and stated this "permanent" kitchen patrol duty is related to his decision to become a "conscientious objector" (CO) and meant to try and change his mind. The Veteran also alleged that he saw a psychiatrist at a different military base and was given a recommendation as an emotionally disturbed person (EDP). Review of the STRs does not show records of this previous visit or recommended finding.

On April 28, 1977, it was noted the Veteran "appears depressed" and was prescribed Valium. On April 29, 1977, the Veteran was brought in by his commanding officer for taking 14 Valium pills; the Veteran admitted taking 9 Valium within one hour and was noted with a "don't care attitude." The treating physician gave an impression of depression. In the May 1977 separation examination, the Veteran reported no psychiatric or mental issues.

Review of the Veteran's military personnel record shows that in February 1977 the Veteran was permanently disqualified from Airborne training; it was noted that the Veteran was not adaptable due to lack of motivation and self-imposed withdrawal.

In a May 4, 1977 psychiatrist evaluation, the Veteran was diagnosed with a "immature personality" with "acute situational maladjustment associated with failure to adjust to Army life."

In a May 16, 1977 memorandum proposing the Veteran's separation from service, the commanding officer stated his reasons for the Veteran's separation was because of the Veteran's "demonstrated inability to adjust to or meet mission requirements in a garrison environment." The commanding officer noted the Veteran's performance was marked by "continuing series of rationalizations as to why [the Veteran] is unable to perform adequately" to include depression, personal problems, matters of conscience and poor relationship with chain of command. The commanding officer found that these excuses reoccur on a rotating basis based on what the Veteran deemed "most appropriate for any given circumstances."

Review of the Veteran's medical treatment record shows that in May 2005, the Veteran was admitted as new patient complaining of having a schizophrenic disorder for 20 years. The Veteran also reported late because the "voices were telling him not to go... does not obey the voices which are usually on his side." In April 2006 the Veteran was noted with a history of schizoaffective disorder and reported abstinence from alcohol and non-prescribed medication for the past 8 months.

In December 2010, the Veteran submitted a claim for compensation for a mental condition to include bipolar and schizophrenia and stated this disability began in 1977.

In a submitted February 2011 private physician statement, the physician diagnosed the Veteran with bipolar disorder and opined the Veteran to be totally and permanently disabled from seeking or sustaining any type of employment due to the diagnosed disability. The physician did not provide an opinion on the etiology of the disability or whether it was related to his active duty service. A second February 2011 VA physician statement also indicated the Veteran as totally and

permanently disabled from seeking employment due to several diagnoses including bipolar but did not provide an opinion on whether the diagnosed bipolar condition was related to the Veteran's service.

The Veteran was afforded a March 2011 VA examination. The examiner diagnosed the Veteran with mixed-type schizoaffective disorder and cocaine dependence dating to 2005. The examiner upon review of the claims record noted the Veteran's complaints in the STRs regarding his depression due to extended kitchen patrol and feeling this was punishment for considering conscientious objector status. The Veteran at this examination did not recall ever saying this.

The Veteran reported an onset of auditory hallucination symptoms during basic training due to harsh treatment and verbal abuse from the instructor but did not disclose these symptoms during service. The Veteran stated that after separation from service he initially used alcohol to cope with voices, then changed various drugs and substances to cope with his hallucinations. The Veteran also claimed an onset of mood swings during service that persisted after service. The Veteran stated using substances to cope with mental problems until the mid-1980s with a clinic and remained there until transferring care to VA in 2005. The Veteran reported being married twice, both ending in divorce; the Veteran stated the first wife was a schizophrenic who threatened to kill him, and the second wife was a cocaine user which led to marital problems. The examiner also noted the Veteran had been hospitalized 6 times between 1999 and 2007 for overdoses of prescribed medication.

The examiner opined the Veteran's schizoaffective disorder is less likely as not caused by or result of mental problems noted in service. The examiner found the documented depressive feelings in the Veteran's STRs was related to not liking service life and issues over conscientious objector status resulting in extended kitchen patrol duty. The examiner did not find evidence in the Veteran's STRs to support the Veteran's claims of mood swings or hallucinations occurring in service. The examiner noted the Veteran claimed having ongoing problems after separation but self-medicated with substances and did not seek treatment until 8 years after separation from service. The examiner stated that while it was possible the Veteran's reported version of history was accurate, it was not supported by the documentation in the Veteran's claims record.

In a May 2011 mental health social work assessment, the Veteran was noted with a history of bipolar schizoaffective disorder and cocaine/polysubstance dependence.

In a submitted December 2011 notice of disagreement (NOD) and July 2014 form 9 statement, the Veteran stated that he was treated for his mental condition in service and that after separation he continued to suffer from this condition and self-medicated with over the counter medication. The Veteran stated that he only sought treatment after the condition became unbearable. The Veteran asserted that the rigorous environment of military life was the cause of his mental status and the treatment he received from his superiors was the cause of his discharge and carried over to his continued treatment today.

In a submitted October 2013 VA psychiatrist statement, the psychiatrist gave diagnoses of bipolar schizoaffective disorder, anxiety disorder, polysubstance dependence and borderline personality disorder, and stated the Veteran had been treated since 2011. The psychiatrist did not provide an opinion regarding the Veteran's diagnosed conditions in relation to his active duty service.

In a June 2016 medical treatment record, the Veteran reported being molested by his sister and then by members of the Big Brother/Big Sister organization. The Veteran stated using drugs since he was 12 and last used them in January 2016. IN a July 2016 psychology note, the Veteran was given provisional diagnoses of bipolar schizoaffective disorder, and other specified trauma and stressor related disorder. The Veteran then reported an incident of MST in service where he was restrained and sexually assaulted in a hotel room by fellow soldiers; the Veteran stated that his history of alcohol and illicit substance use problems originated from his efforts to forget this MST.

In August 2016 report for seizures, it was noted the Veteran was a fairly poor historian. The Veteran then reported that he was a victim of a brutal sexual assault in the military where he was sexually assaulted by 3 men who told him they were going to show him around town and introduce him to some women. The treating physician gave assessments of PTSD and schizoaffective disorder but did not provide an opinion of the etiology of the diagnoses in relation to his reported MST or stressors in service.

In January 2017 the Veteran denied a history of PTSD but reported a history of MST and that he only began to acknowledge the abuse during therapy. The Veteran indicated sexual abuse as a child and being sexually assaulted in service. The Veteran was assessed with PSTD/depression/anxiety/schizoaffective disorder. No opinion was provided.

In March 2017 the Veteran reported he was sexually abused by his sister as a child and again for two years by a member of the Big Brother organization. The Veteran stated that he was honorably discharged from his military service early due to a drug problem and he was sexually assaulted while in service. The Veteran also stated that he saw five psychiatrists while in service but could not recall the reasons for the visits.

In April 2017 the Veteran filed a compensation claim for an "acquired mental health condition due to MST on active duty and residuals."

The Board notes that in June 2017 attempts were made to obtain documents and information to corroborate the Veteran's reported MST. It was noted that the Veteran was sent a letter in May 2017 and asked to fill out forms and identify any records for VA to obtain and corroborate the Veteran's reported MST. The Veteran did not provide any response to VA's request.

At the December 2017 hearing, the Veteran denied having any mental health issues or treatment prior to entering the military. The Veteran testified that regarding incidents that caused him to seek mental hygienist that "[in the Veteran's] day, you didn't talk about things like that or you get a general medical... I wanted to stay in." The Veteran stated that he went to seek the mental hygienist because of recurrent nightmares about his drill sergeant verbally abusing him. The Veteran stated that he currently still has those nightmares.

When asked whether the Veteran had any hallucinations during service, the Veteran answer that he did not experience any hallucinations, including hearing voices, during his service and testified that he currently has those hallucinations. The Veteran then shortly followed up that he "might have, might not have" hallucinations during service, citing that it has been 40 years since.

The Veteran testified that following separation from service, he self-medicated for a little bit and was not aware of VA service until he states reporting to VA in 2011 to seek mental health treatment. The Veteran stated that because of his self-medication he became an addict.

The Veteran testified the reason why he believed his current hallucinations and schizophrenia is the same issue he had during service was because the person he hallucinated is the same drill sergeant he described verbally abusing him during these manifestations.

When asked about MST, the Veteran stated that in his day it was never talked about in the service. The Veteran testified that members of his platoon sexually assaulted him when they found out that he wanted out of the service, telling him that he "wasn't a man deserving of being treated like a man."

The Board remanded this appeal in March 2018 to obtain private treatment records.

In a submitted July 2018 VA physician statement, the physician stated the Veteran demonstrated occupational impairment and unable to engage in full occupational activities with no foreseeable improvement. The physician did not discuss the Veteran's mental disorder diagnoses or provide any opinion in relation to the Veteran's service.

In November and December 2018, the Veteran requested referral to the MST program, stating that it "is the source of my issues." In the March 2019 supplemental statement of the case (SSOC), it was noted that the Veteran did not response or identify any new documents to associate with the claims records to support his appeal.

The Board remanded this appeal in June 2019 to obtain a VA examination to determine the nature and etiology of any current psychiatric disorder.

In June 2019 the Veteran reported intrusive memories secondary to childhood and military sexual trauma and described PTSD-related experiences of his drill sergeant verbally abusing him. The treating physician gave a diagnostic impression of bipolar disorder based on history as well as various substance use disorders.

The Veteran was afforded a July 2019 VA examination. The examiner did not find a diagnosis of PTSD, but found other diagnoses for depressive schizoaffective disorder, other specified trauma and stressor related disorder, and moderate cannabis use disorder.

The examiner found that review of the records indicated the Veteran was molested by one of his sisters and then later sexually abused by a Big Brother from the Big Brother/Big Sister organization for two years.

The Veteran reported that he left the military "because I was made for a wartime Army not peacetime Army – only so many times you can go around the Island." The Veteran reported hearing voices and sexual abuse "military-style."

The Veteran stated that his mental health symptoms began while in the military and these symptoms included "hearing voices, I still remember my drill sergeant's name and I hear his voice when I close my eye four or five times a day." The examiner noted that when the Veteran was asked about the voices, the Veteran responded that he could hear his drill sergeant's voice 24 hours a day. The Veteran could not recall the reason he was evaluated by psychologist or psychiatrists while in the military. The examiner noted review of the records indicated symptoms of anxiety and depressed mood in service but none relating to hallucinations or delusions. The examiner also noted that the in-service treatment occurred prior to the Veteran's reported MST.

The Veteran reported that his mental health treatment began while in the military. The Veteran stated that after separation he did not have mental health treatment again until the late 1990s although the examiner noted VA records indicated treatment at a behavioral health clinic at some point. The Veteran reported a psychiatric hospitalization in 2003 and 2004, and other psychiatric hospitalization in 2019.

The Veteran denied using alcohol prior to entering the military and stated that while in the military he drank every weekend until he was drunk. The Veteran reported that he started using marijuana from the age of 12 because "I was sexually abused – I had it hidden for 42 years – and I used marijuana to keep the military sexual trauma out of my head."

The examiner reviewed the Veteran's claimed stressors. The Veteran first claimed a stressor from sexual abuse by the Big Brother organization for two years. The examiner found this a valid stressor to support the diagnosis of PTSD but a pre-military stressor. The Veteran then claimed a stressor that in 1976 his "Drill sergeant flashes in my head three or four times a day and said that I am not worth the air I am breathing – his air." The examiner did not find this stressor valid to support a diagnosis of PTSD.

The Veteran finally claimed a stressor that in May 1977 just prior to separation from the military "some guys" found out that the Veteran was getting out of the service early and they decided to throw him a party. The Veteran reported that the men told him that they were going to show him a good time and would get him a girl. The Veteran stated that they then grabbed him and poured alcohol down his throat before sexually assaulting him, telling him that he wasn't a man and he would be treated like a lady. The examiner found this reported stressor adequate to support the diagnosis of PTSD and related to an in-service personal assault or MST.

However, the examiner noted the Veteran denied that there were any markers to support the trauma. The Veteran stated that he did not report the trauma because "I just wanted to get the hell out of the military – I did not want to look back." The examiner noted the Veteran separated from service in May 31, 1977 and the Veteran reported the MST occurred in May 1977. The examiner found that markers were unlikely because the Veteran separated from service the same month as the alleged stressor. The examiner again noted the Veteran's other mental health complaints for anxiety and depression in-service were made before the Veteran's alleged May 1977 MST.

The examiner opined the Veteran's diagnosed mental disorders were less likely than not incurred in or caused by his service. The examiner found the Veteran with a complicated history involving significant substance abuse, mental health problems that include hallucinations and medical problems including epilepsy; the examiner found these problems made the Veteran a weak historian and difficult to provide details.

The examiner found that the Veteran's reported MST occurred the same month as his separation in May 1977; as such, the examiner stated that there was little opportunity for markers to be found in the Veteran's records. The Veteran's in-service records treating anxiety and depressed mood occurred prior to the Veteran's reported MST and therefore cannot be considered markers. The examiner found that review of the Veteran's mental health records did not provide strong support for a diagnosis of PTSD; and his mild trauma symptoms to include nightmares and insomnia could be related to the Veteran's reports of molestation and sexual abuse by the Big Brother organization during his childhood.

The examiner stated that while "it is possible that the MST occurred" the examiner did not find it strongly supported by the record. The examiner opined the diagnosed Other specified trauma and stressor related disorder is likely due to multiple stressors reportedly experienced; however, the examiner found they could not determine if the symptoms were due to service without resorting to mere speculation and therefore found the diagnosed disorder less likely than not incurred in or caused by service or the Veteran's reported stressors.

The examiner found it difficult to contend that the Veteran's in-service symptoms of anxiety and depressed mood lead to his current diagnosis of schizoaffective disorder. The examiner found there was no strong support for symptoms between the Veteran's separation and 2005, noting the Veteran denied treatment between 1977 and the late 1980s. The examiner stated that usually individuals with mental conditions as strong as schizoaffective disorder require treatment; as such, the examiner determined it was more likely that the Veteran's schizoaffective disorder began several years after his separation from service. The examiner could not determine that the Veteran's schizoaffective disorder is due to service without resorting to mere speculation; accordingly, the examiner opined the Veteran's schizoaffective disorder and cannabis use disorder is less likely than not incurred in or caused by service.

The Board acknowledges the Veteran's assertions that his acquired psychiatric disorder was related to his military service. Certainly, he is competent to describe experiencing symptoms. Indeed, treatment records corroborate at least to some extent the Veteran's history of reported symptoms. Nevertheless, a lay person, the Veteran does not have the training or expertise to render a competent opinion

which is more probative than the VA examiner's opinion on this issue, as this is a medical determination that is complex. See *Jandreau v. Nicholson*, 492 F.3d 1372, 1376-77 (Fed. Cir. 2007); *Barr v. Nicholson*, 21 Vet. App. 303, 309 (2007); *Layno v. Brown*, 6 Vet. App. 465, 469-71 (1994)). Here, the VA examiner considered the in-service treatment and the Veteran's report of symptomatology thereafter. The examiner still found that it was unlikely that his in-service problems were related to any current disability. The Board finds that the Veteran's opinion is outweighed by the competent opinion of the VA examiner. See id.; see also *King v. Shinseki*, 700 F.3d 1339, 1345 (Fed. Cir. 2012).

Furthermore, the Board notes that review of the claims record show several inconsistencies in the Veteran's reported history and symptoms of his acquired psychiatric disorder. Such inconsistencies include the May 2017 Veteran's statement that he left service due to a drug problem conflicting with the May 1977 commanding officer's recommendation of separation based on the Veteran's inability to adjust to "garrison life" using a "rotating basis" of excuses and his later July 2019 examination statement on his separation from service "because I was made for a wartime Army not peacetime Army"; his March 2011 and July 2019 statements of auditory hallucinations arising during service conflicting with his December 2017 testimony where he denied having such hallucinations during service or otherwise could not definitely state that such symptoms arose during his service; and examiner findings that the Veteran's extensive history of substance abuse and other medical problems made him a weak historian and unable to provide details.

Given the inconsistencies of the statements made by the Veteran compared to the findings in the claims record, the Board affords the Veteran's statements less probative weight and outweighed by VA examinations of record performed by professionals.

Based on the above, the Board finds that the competent evidence on record is against a finding of service connection for the Veteran's acquired psychiatric disorder. Although the Veteran's STR shows complaints and treatments for anxiety and depression, the Veteran's separation examination did not report or find any mental issues. Review of the medical treatment record shows the earliest competent documentation of the Veteran's treatment for an acquired psychiatric

disorder was in 2005, decades after separation from service. Although the Veteran asserts that he was treated prior to seeking VA treatment, he did not identify or provide information to obtain these records. The Veteran asserted MST as a stressor causing his acquired psychiatric disorder, however as the Veteran separated from service shortly after his asserted MST, review of the record does not show any markers to support a finding of a personal assault in service or following separation; the Veteran at his July 2019 examination also denied markers resulting from his alleged MST and did not provide or respond to requests for information to support or identify markers relating to his alleged MST.

The July 2019 VA examiner considered the Veteran's report of symptoms to include his reported stressors to include MST but provided reasoned analysis of the case to support their opinion that the Veteran's current acquired psychiatric disorder was not related to the in-service treatment of anxiety and depression or his reported stressors to include MST.

The Board thus finds that the weight of the competent and probative evidence is against a finding of service connection for the Veteran's acquired psychiatric condition. In reaching this conclusion, the Board has considered the applicability of the benefit-of-the-doubt doctrine. However, as the preponderance of the evidence is against the claim, that doctrine is not applicable. 38 C.F.R. § 3.102; *Gilbert v. Derwinski*, 1 Vet. App. 49, 54-56 (1990).

MICHAEL LANE
Veterans Law Judge
Board of Veterans' Appeals

Attorney for the Board J. Yang, Attorney-Advisor

The Board's decision in this case is binding only with respect to the instant matter decided. This decision is not precedential, and does not establish VA policies or interpretations of general applicability. 38 C.F.R. § 20.1303.