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Psychiatry and the Military: An Update

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The United States has been a nation and an army at war essentially since September 11, 2001. Not surprisingly, rates of posttraumatic stress disorder (PTSD) and other psychological consequences of combat are increasing. Service members with mental health consequences from impact the military justice and disability systems. To complicate matters, PTSD, although a well-recognized and validated psychiatric disorder, has also long been a disorder associated with malingering, both for the purposes of allegedly avoiding prosecution or punishment and to obtain increased compensation.

Mental health professionals' task is further complicated by the "signature wound" in this "global war on terror": traumatic brain injury. There are many causes of head trauma, including blast exposure, gunshot wounds, motor vehicle injury, and other accidents. The severely wounded are routinely screened for head trauma. However, others may simply be knocked unconscious and not present for treatment. They may develop difficulty concentrating or irritability and be misdiagnosed or not receive any medical treatment.

Military forensic psychiatrists currently serve in the Army, Navy, and Air Force. Forensic psychiatry in the military has many similarities to forensic psychiatry as practiced in the civilian world, with some key differences. This article accentuates some of the differences, especially those heightened by the global war on terror. It opens with a description of military law and the role of psychiatry in the courts-martial system. The next section deals with the disability

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system. The article closes with an update on psychological autopsies. A full discussion of the military forensic psychiatry issues and the military legal system is beyond the scope but may be found in other sources [1]. Case examples, which represent composites rather than actual patients, are used to demonstrate the issues.

THE PSYCHIATRIST AND THE CRIMINAL JUSTICE SYSTEM

Case Example 1

A solider shot and killed his wife 6 days after returning from Iraq, following her request for a divorce. He was referred to a military forensic psychiatrist for a "sanity board." Upon examination, he admitted hypervigilance, sleeping with his weapon, nightmares, anxiety, and intrusive memories. He also complained of hearing voices that told him to shoot his wife. The physical exam and psychological testing revealed a previously undiagnosed mild traumatic brain injury. (Case example to be continued.)

The birth of United States military law can be traced to the first US Articles of War enacted on June 30, 1775, and established by the Continental Congress. They consisted of 69 separate articles governing the conduct of the Continental Army [1,2]. Congress enacted today's Uniform Code of Military Justice (UCMJ) in 1950 [3–5]. The UCMJ combined the laws formerly governing the Army, Navy, and Air Force into one uniform code. As a result, the United States military follows a separate system of criminal justice and has hierarchical sources of rights. Sources of law include the US Constitution; federal statutes, the UCMJ; executive orders containing the Military Rules of Evidence (MRE); Department of Defense (DoD) directives; service directives; and federal common law. The US Constitution applies to service members when not superseded by military necessity or operational necessity [4,5].

The UCMJ established the three levels of courts-martial. General courts-martial are analogous to felony trials, and special courts-martial are analogous to misdemeanor trials. The summary court-martial, which is comparable to a justice of the peace court, is a single-officer court with significantly limited authority [4]. The Fifth Amendment of the Constitution specifically denies the right to grand jury indictment to service members [4]. In place of the grand jury, the military states that no case may be referred to a general court-martial unless there has been an Article 32 investigation [4].

An Article 32 investigation is an open hearing designed to inquire into the facts of the case surrounding the charges. Although similar to civilian preliminary and grand jury hearings, an Article 32 investigation is a more protective procedure because it affords the opportunity for discovery, to confront adverse witnesses, and to present evidence. Additionally, the recommendation of the Article 32 investigating officer is advisory only and not a final decision [4].

Forensic Evaluations or "Sanity Boards"

There are many military settings in which the issue of criminal responsibility is addressed, typically during Article 32 hearings and special and general

courts-martial. For example, in accordance with Rule for Court-Martial (RCM) 706, if it appears to any commander who considers the disposition of charges, or to any investigating officer, trial or defense counsel, military judge, or court member that there is reason to believe that the accused lacked mental responsibility for any offense, the fact and basis of the belief is transmitted ultimately to the officer authorized to order such an inquiry [5].

Determinations of mental or criminal responsibility are referred to a board, commonly referred to as a "sanity board," consisting of one or more persons. Each member of the board shall be either a physician or a clinical psychologist. Normally, at least one member of the board is either a psychiatrist or a clinical psychologist [5]. Although RCM 706 does not require the participation of a forensic psychiatrist on the board, a military forensic psychiatrist is in many cases best qualified to serve as a member [2,5].

Military lawyers have acknowledged the specialized training and experience that a military forensic psychiatrist applies during sanity boards, and they have increasingly requested that convening authorities and military judges request such specialists to participate on the board during these assessments of criminal responsibility [2]. Sanity boards also make determinations about the accused's capacity to stand trial and address any other questions requested by the convening authorities.

According to Article 50a of the UCMJ [6], "It is an affirmative defense in a trial by court-martial that, at the time of the commission of the acts constituting the offense, the accused, as a result of a severe mental disease or defect, was unable to appreciate the nature and quality or wrongfulness of the acts." There is no volitional prong to this military standard. The burden of proving the defense of lack of mental responsibility falls to the accused, who must prove this defense by clear and convincing evidence. The accused then shall be found guilty, not guilty, or not guilty by reason of lack of mental responsibility [6].

The full report of the board is furnished to the defense counsel and, upon request, to the commanding officer of the accused. The full report may be released by the board or other medical personnel only to other medical personnel for medical purposes. Release of the full report to any person not authorized to receive it is only possible pursuant to an order by the military judge. A report consisting only of the board's ultimate conclusions as to all questions specified in the order is forwarded to the officer ordering the examination, the accused's commanding officer, the investigating officer, if any, appointed pursuant to Article 32, and to all counsel in the case, the convening authority or military judge [5].

Court-Martial Expert Consultants and Expert Witnesses

Case Example 1 (continued)

The psychiatrist believed that most of the soldier's symptoms were consistent with posttraumatic stress disorder and mild traumatic brain injury (TBI). However, he thought the soldier was malingering his auditory hallucinations. His report also said that he thought the soldier was competent and criminally responsible. He was asked to testify to that effect.

The soldier was convicted, but received only 10 years in prison, perhaps because of the PTSD and TBI.

In accordance with MRE 706, "The trial counsel, the defense counsel, and the court-martial have equal opportunity to obtain expert witnesses under Article 46 of the UCMJ" [5]. MRE 706 also allows for the accused to select his own expert witnesses at his own expense. MRE 702 states that "if scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education, may testify thereto in the form of an opinion or otherwise." MRE 703 addresses the bases of opinion testimony by experts. It states that "the facts or data in the particular case upon which an expert bases an opinion or inference may be those perceived by or made known to the expert, at or before the hearing. If of a type reasonably relied upon by experts in the particular field in forming opinions or inferences upon the subject, the facts or data need not be admissible in evidence." Sources for these facts and data include stipulations of fact, investigative and police reports, medical and service records, testimony heard during a court-martial, and personal and professional knowledge [5]. However, MRE 403 states that an expert's reliable and relevant testimony "may be excluded if its probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issues, or misleading the members, or by considerations of undue delay, waste of time, or needless presentation of cumulative evidence" [2,5].

MRE 704 allows experts to testify on the ultimate issue, stating that the expert's "opinion or inference otherwise admissible is not objectionable because it embraces an ultimate issue to be decided by the trier of fact." MRE 705 allows the expert to testify "in terms of opinion or inference and give the expert's reasons therefore without prior disclosure of the underlying facts or data, unless the military judge requires otherwise. The expert may in any event be required to disclose the underlying facts or data on cross-examination" [5].

The defense may request an expert consultant if a sanity board's opinions are deemed favorable to the prosecution or to investigate mitigating factors for sentencing, or both [2]. In accordance with a seminal military case, United States v Toledo, the defense must specifically request appointment of a confidential expert consultant for the consultant to be protected by attorney-client privilege. Such requests are often subject to intense scrutiny during pretrial motions [2]. If this appointment is not granted, the military forensic psychiatrist may still function as an expert within limitations of privilege.

The defense may request a military forensic psychiatrist to testify during the merits phase or sentencing phase. For example, the military forensic psychiatrist may be asked to provide expert testimony about the impact of combat-related posttraumatic stress disorder (PTSD), Gulf War syndrome, or Vietnam syndrome on the accused's mental state, behaviors, or both [7]. The military forensic psychiatrist may be asked to provide expert testimony regarding mitigating factors during the sentencing phase of the court-martial. Recent issues addressed by military forensic psychiatrists include the cumulative effects of

sleep deprivation secondary to combat stress or combat-related PTSD and operational tempo on judgment and decision-making capacity.

The trial counsel may request expert consultation if a sanity board reaches a conclusion that is not favorable to the prosecution. For example, sanity boards have been successfully challenged on the basis of thoroughness, accuracy, and the misapplication of the proper military standard for criminal responsibility.

The DoD has recently implemented new policies regarding sexual assaults [8]. The military forensic psychiatrist may be asked to provide expert testimony for the prosecutions during the merits phase regarding counterintuitive behaviors of an alleged victim. Examples include testimony about rape trauma syndrome and battered spouse syndrome. Because an accused may not be compelled to submit to any psychiatric evaluation beyond that of a sanity board, any testimony regarding aggravating factors at sentencing would likely be limited to a review of collateral documents and observation of the accused during the court-martial, which requires the military forensic psychiatrist to testify to this limitation.

Former and current fellows from the National Capital Consortium's (NCCs) Military Forensic Psychiatry Fellowship Program located in Washington, DC, have served as consultants and expert witnesses in courts-martial involving military-specific offenses. For example, three military forensic psychiatrists who were fellows of this program served as defense consultants during the Abu Ghraib general courts-marital involving charges of maltreatment of detainees (violation of UCMJ Article 93) and dereliction of duty (violation of UCMJ Article 92). The current program director of the NCCs forensic fellowship program served as a prosecution consultant during a general court-martial case involving the charge of aiding the enemy (violation of UCMJ Article 104). One of the former program directors of this forensic fellowship program and two former fellows served as consultants during two general courts-martial involving soldiers charged with "mercy killings" of Iraqis. Additionally, former and current fellows have also testified during courts-martial involving charges of malingering (violation of UCMJ Article 115) [6].

Malingering has always presented a special challenge for forensic psychiatrists, especially in the armed forces where it can also be a specific criminal offense under the UCMJ. Malingering has a longstanding history of recognition in the military, highlighted by the inclusion of avoidance of military duty at the top of the list of external incentives in its description in the DSM-IV [9]. This text also points out that malingering may be viewed as adaptive behavior under extreme circumstances (eg, when a prisoner of war feigns illness to escape maltreatment). This issue has predictably come to the forefront of clinical practice during a time of war. Malingering has again surfaced in an attempt to avoid combat duty by service members who otherwise lack the antisocial tendencies we usually associate with this behavior.

In this context, malingering can also be seen as a maladaptive response in a stressful situation [10]. Clinicians may be tempted to insulate the patient

from the natural consequences of this behavior through alternate diagnoses, with the shortsighted view that either the benefits accrued by a successful deception or avoidance of the penalties associated with fraud would be in the patient's best interest. However, this would inevitably promote a dysfunctional psychosocial developmental process and foster longer-term negative effects. The art in military psychiatry is to find a way to make our ethical and fiduciary responsibility to act in the best interest of the patient to coincide with the needs of the system. For forensic psychiatrists, the judicial consequences of their objective opinions often coincide with the patient's longer-term best interest in this regard. Such dual agency issues, of course, are not limited to the military, as therapeutic practice often requires balancing the individual needs of the patient with broader social obligations, as in the assessment of disability.

FITNESS-FOR-DUTY AND PHYSICAL DISABILITY EVALUATIONS IN THE UNITED STATES MILITARY

Case Example 2

A wounded soldier was treated for his severe injuries at Walter Reed Army Medical Center. He was referred for a medical board and received 60% disability for his wounds and 10% for posttraumatic stress disorder.

Case Example 3

Another soldier was evacuated from Afghanistan to Walter Reed with a diagnosis of acute stress disorder. His symptoms responded only partially to treatment, and his diagnosis was later amended to posttraumatic stress disorder on Axis I and a personality disorder, not otherwise specified on Axis II. He was also referred for a medical board, but received no disability from the board, as they said his personality disorder had existed before service.

Title 10, USC 61 grants the secretaries of the military departments the authority to retire or separate service members of all branches of the military for physical or mental impairments (either disease or injury) if conditions render the member physically unfit for duty [11]. DoD Directive 1332.18 and DoD Instructions 1332.38 and 1332.39 and specific branch regulations (eg, Army Regulation 635-40) and related branch specific regulations set forth the policies and procedures for implementing the federal statute and referring service members into the Physical Disability Evaluation System (PDES) [12–15].

Entry into the Fitness/Disability Evaluation System

In the US Army, soldiers may be referred into the Physical Disability Evaluation System (PDES) by way of several mechanisms. Under the provisions of Army Regulation 600-20, paragraph 5-4, if a commander believes a soldier is unable to perform military occupational specialty duties because of a medical condition, he may refer the soldier to a military medical treatment facility for a fitness-for-duty evaluation [16]. DoD Regulation 6490.1, Command Directed Mental Health Evaluations and related instructions, set forth the procedures for such a referral when the commander believes a mental condition may be resulting in inability to perform these duties [17]. The evaluation conducted at the treatment facility may result in a finding of fitness, a finding

that the service member's inability to perform duties results from a condition that existed before service entry (eg, ADHD or personality disorder) and therefore necessitates administrative separation, or a determination that the service member has a medical or mental condition, resulting in the service member's falling below medical retention standards. If the latter conclusion is reached, then a further evaluation and disability determination by way of the Medical Evaluation Board/Physical Evaluation Board (MEB/PEB) process is initiated.

Service members voluntarily seeking treatment for medical or mental conditions may be referred into the MEB/PEB process by their treating physicians within 1 year of diagnosis of a medical condition if they have received maximum benefit of medical care for a condition that may render them unfit for further military duty [18]. The Medical Evaluation Board determines whether the service member's condition causes him to fall below the retention standards and, if so, refers the service member to the PEB for a final determination of fitness or disability rating.

Treating physicians may also provide service members with duty profiles limiting specific activities on a temporary or permanent basis as part of treatment for medical or mental conditions. If these profiles are highly restrictive, precluding a service member from performing occupation-specific duties on a worldwide basis in a field environment, and granted on a permanent basis, a Specialty/Medical Retention Board (MMRB) may direct that a service member be trained for service in a less demanding military occupational specialty or refer the service member into the MEB/PEB process [19].

The Medical Evaluation Board

The MEB Narrative Summary is perhaps the most important document in the disability evaluation process. This is a narrative summary of history of present illness; past medical and surgical history; social and occupational history; history of hospitalization(s) and course of treatment; laboratory radiological assessment; mental status evaluation; and assessment of extent of impairment in military-specific, social, and industrial impairment resulting from medical or mental conditions. It results in a recommendation to the Physical Disability Board as to whether the service member's condition meets medical retention standards, and an estimate of the degree of impairment resulting from this condition or conditions. The medical evaluation board report is generated by the service member's primary treating physician but may contain consultation evaluations from other specialists.

The development of an accurate and comprehensive medical evaluation board is particularly challenging in times of war. Then service members may receive definitive treatment for conditions caused or aggravated by wartime service at tertiary military medical facilities far removed from their usual treatment location, their chain of command, or other sources of information (eg, family members or friends) who might provide information to evaluators as to premorbid functioning.

Although certain conditions, such as psychotic illnesses involving response to command hallucinations or paranoid delusions, do impair almost all military duties, the degree to which depressive symptoms or intrusive recollections or avoidance from PTSD would do so depends on required duties. Because the decision of the board requires determination based on the degree to which the illness or disorder precludes performance of military-specific duties, collateral information regarding the service member's duty performance is a prerequisite in some circumstances. Moreover, the extent to which preexistent personality disorder or traits might contribute psychiatric presentation at the time of MEB evaluation may not be readily apparent or accurately represented by the service members personal reports of his condition, particularly if he has prior knowledge of the military disability evaluation system.

Although some service members might deliberately embellish or malinger symptoms, in the authors' clinical experience, this is the exception rather than the rule. However, the extent to which reported symptoms result from specific exposure may be obfuscated by the "fog of war" or the complexity of multiple illnesses, regardless of the service member's intentions having entered a treatment facility.

The Physical Evaluation Board and the Fitness Standard

The standard for determining fitness is whether the condition precludes the service member from reasonably performing the duties of her office, grade, rank, or rating. The standard is performance based. Whereas the medical treatment facility may make a determination that a service member has a condition resulting in a fall below retention standards, the PEB relies heavily on performance data provided by the service member's immediate commander in making the final factual determination of fitness. Thus, fitness determinations on two service members with the same rank and identical medical conditions and severity may be different based on the specific duty requirement of their occupational specialties and the degree to which their duty-specific performance is affected by their condition. Though inability to perform duties in every geographic location and under any conceivable circumstance may not be the sole basis for a finding of unfitness, the ability to deploy worldwide is a consideration in these determinations. If a determination of unfitness is made, the PEB is required by law to use the Department of Veteran's Affairs Schedule for Rating Disability (VASR-D) from 0% to 100% in 10% increments for all medical conditions contributing to this determination [20].

Disposition

Four factors determine whether the PEB will find a service member fit for duty or recommend administrative separation, temporary retirement, or permanent retirement: (1) whether the service member can perform in his occupational specialty; (2) the rating percentage of his disabling condition(s); (3) the stability of the condition(s); and (4) the duration of active duty service before disability.

Generally, separation without pay or benefits results when the unfitting disability existed before service, was not permanently aggravated by military

service, and the member had less than 8 years of active service at the time of determination, or if the disability occurred while the service member was absent without leave or engaged in an act of misconduct or willful negligence.

Temporary disability retirement occurs when a service member is found unfit, but her condition will likely change so as to warrant a different disability rating with the next 5 years. These service members receive periodic reevaluations and determinations by the PEB until conditions stabilize. Permanent disability retirement occurs if the condition or conditions are determined to be stable and rated at a minimum of 30%. Separation with severance pay is granted for service members with less than 20 years of active service and unfitting conditions rated at less than 30%. Disability pay is calculated as 2.5 times years of active service times retired base pay, whereas severance pay is 2 months' basic pay for each year of active service, not to exceed 12 years. If the PEB determines that a service member can reasonably perform the duties of his grade, rank, and military specialty, he is found fit and returned to duty.

Adjudication and Due Process

Though there is variance between the services in the functional proponents for the physical disability evaluation process, the physical evaluation board in each service makes initial (informal) findings and recommendations based on a review of the medical evaluation board and additional records (including commander's input) without the service members' presence. Service members found unfit who disagree with the findings are entitled to a formal hearing before the PEB. They may elect to appear or testify at this hearing, to be represented by appointed counsel or counsel of personal choice (at no expense to the government), or to call other essential witnesses (treating physicians or unit members) to testify on their behalf. Each service branch has an agency responsible for reviewing all determinations in which the service member disagrees with the formal board findings and considers any rebuttal submitted by the service member (or counsel) in rendering a final appellate determination.

The Medical Evaluation Board Summary and Disability Determinations

Within the Army, Navy, Marines, Air Force, and Coast Guard, federal statutes allow for the medical separation of service members and the conditions for which medical disability pay and benefits are granted. Service-specific regulations govern the exact processes by which service members may enter the fitness or disability evaluation process and the subsequent adjudication and appellate processes. Regardless of service branch, the physical evaluation disability system relies heavily on the Medical Evaluation Board in reaching ultimate determinations. Obstacles to accurate assessment in these boards include information deficits, which may occur when service members receive treatment for injuries sustained in remote locations; difficulties in quantifying interaction of physical and mental health impairment, which may occur when illness or injury results from combat-related exposures; and the uncertainty that may accompany any assessment of impairment rendered when a service member

is removed from an inherently stressful field environment to a treatment location far from usual sources of social and occupational support.

PSYCHOLOGICAL AUTOPSIES

Case Example 4

A soldier was found deceased in his quarters, when he did not show for work after a long weekend. An empty whisky bottle was found next to him. There were empty bottles of fluoxetine and zolpidem in his medicine cabinet. The solider had no known major romantic, legal, or occupational issues, and there was no suicide note. The civilian medical examiner, who had jurisdiction because the death was off-post, ruled it a suicide. His family disagreed and requested a second opinion. The medical examiner requested a psychological autopsy to opine whether it was an accidental overdose resulting in death or a suicide. At the time of the request, alcohol toxicology levels had returned but other toxicology were pending (case to be continued).

Before 2001, a report known as a "psychological autopsy" was required on every suicide in the Army, and upon completion was submitted to the Army surgeon general and the Walter Reed Army Institute of Research. These retrospective investigations of a soldier's suicide were designed to gather information from the soldier's units and their families to provide lessons learned. Although the intent of these psychological autopsies was to gather information from the soldier's units and their families that may be relevant to preventing future suicides, many of the analyses were performed by mental health officers who may or may not have had specific training in any form of death investigation. Long narrative reports were generated, which often produced little feedback or change to the system. In addition, the report format made data extraction and analysis difficult.

Another major issue with psychological autopsies was who had access to the information. In the past, psychological autopsies were accessible under the Freedom of Information Act. For example, a reporter from the *Fayetteville News-Observers* obtained details of over 50 psychological autopsies from Fort Bragg and published salacious and intimate details from these reports in the newspaper.

The requirements for doing psychological autopsies were changed within the DoD, first by a Health Affairs policy letter and later in a DoD directive [21,22]. The requirement changed so that a formal psychological autopsy was done only if the death was equivocal (eg, if it was not known if it was a suicide, homicide, or accident). All suicides still must be evaluated. An Army Suicide Event Report is now generated for attempted and completed suicides. If the soldier has been followed by a mental health professional, a quality assurance review should be conducted.

As part of the new requirement, practitioners must receive additional training in how to complete psychological autopsies. The additional training covers basics of crime scene investigation, physical autopsy procedures, toxicology, and understanding of suicidal behavior and determinants. If a psychiatrist is forensically trained, then she has usually received the additional training [23].

Cases that require psychological autopsies tend to cluster in the following categories: (1) a drug overdose, which may be accidental or deliberate; (2) a motor vehicle accident, which may be accidental or deliberate; or (3) a gunshot, which may be self-inflicted but accidental. The changed requirements for psychological autopsies are still new, and thus the successes and limitations of the new system are just now being made apparent.

Case Example 4 (continued)
Because of the decomposition of the body, the alcohol level of 0.3 was hard to interpret. Toxicology showed no traces of fluoxetine or zolpidem. However, there were high levels of barbiturates. A repeat search of his room by CID found trace evidence of barbiturates in the pill bottles. There were also traces of mefloquine, an antimalarial he had been taking while in Afghanistan. An interview with an ex-girlfriend revealed that the solider had been e-mailing her obsessively. This was corroborated by a search on his computer. His e-mails became increasingly bizarre, depressed, and desperate. Based on this additional informational, the death was ruled a suicide. The source of the barbiturates was never found.

SUMMARY

The United Sates has historically been concerned about the successful adjustment of its military members returning from war. These concerns are based on the recognition that war-zone exposures may have considerable negative emotional or behavior consequences [24,25]. As the global war on terror continues, the United States military medical system will be required to address issues at the interface of psychiatry and the law. Despite clinical advances within the theater of war and at tertiary facilities in the United States, some military members will develop chronic and disabling mental illness as a result of traumatic exposure and exacerbated by the demands of the austere and dangerous operational environment. The extent to which violent and aggressive behavior in the aftermath of deployment can be attributed to combat experience remains an area of debate and ongoing investigation [25–27]. However, experience suggests that a very small subgroup of the hundreds of thousands of war veterans deployed in conjunction with the current conflict in Iraq has already been involved in violent crimes. For this group, military forensic psychiatrists will be called on to make determinations of competency and criminal responsibility and to inform the courts about the potential contributions of war-related distress or disorder to criminal behavior.

Though the overwhelming majority of war veterans will not be involved in criminal proceedings, a minority will develop career-ending (and in rare instances, life-ending) disabilities as a result of mental illness. For those who are no longer fit for duty, the military Physical Disability Evaluation System must make determinations of the extent to which future military performance and future civilian social and occupational function have been compromised. For a small yet highly visible minority of returning veterans, questions about

the cause, precipitants, and manner of death will necessitate psychological autopsies.

This article highlighted recent updates in military forensic psychiatry and the mechanisms through which answers to questions of disability and criminal culpability, and motivation underpinning self-injurious behavior, are determined within the United States military. As the global war on terror progresses, further experience and study of our country's judicial processes, disability system, and the policies and procedures governing psychological autopsies must evolve to meet these increasing demands.

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