



Martyrdom Denied, by Elzie Golden, oil on canvas, Iraq, 2005.
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Chapter 1

INTRODUCTION: FORENSIC AND ETHICAL ISSUES IN MILITARY BEHAVIORAL HEALTH

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INTRODUCTION

This volume is a companion to *Combat and Operational Behavioral Health*, in the Textbooks of Military Medicine series, published in August 2011.¹ That volume covered military behavioral health service advances from Vietnam through Operation Enduring Freedom and Operation Iraqi Freedom. Two previous books in the Textbooks of Military Medicine series on psychiatry were published in 1994 and 1995, *War Psychiatry* and *Military Psychiatry: Preparing in Peace for War*, respectively.^{2,3} The only known volume on the specific subject of military forensic mental health, *Principles and Practice of Military Forensic Psychiatry*, by doctors R. Gregory Lande and David T. Armitage, was published in 1997.⁴ Since these publications in the 1990s, much has occurred including the September 11, 2001 attacks and the subsequent wars in Iraq and Afghanistan. These conflicts and numerous humanitarian operations advanced the understanding of the psychological effects of combat.

The title of *Combat and Operational Behavioral Health* was much debated. The book title from 20 years ago, *War Psychiatry*, was no longer applicable, as the subject included more than war and more than psychiatry. The editors considered various titles, including “Behavioral Medicine.” *Combat and Operational Behavioral Health* was eventually chosen to cover all combat and operations other than war and the many relevant disciplines.

Similar debates exist for this volume. The military forensic part is obvious. But should the title also include psychiatry, behavioral health, psychological health, or mental health? The authors are mainly psychiatrists and psychologists. In forensic psychiatry, “mental” health is still used more than “behavioral” or “psychological” health. In the civilian world, “mental” health is also still most often used, although the

Army prefers “behavioral” health and the Department of Defense prefers “psychological” health. Finally, *Forensic and Ethical Issues in Military Behavioral Health* was chosen.

Forensic mental health deals with the intersection of the legal system and the mental health system. This volume focuses on both traditional military forensic psychiatry and psychology, as well as the range of forensic issues that has emerged or been amplified from the years of war since September 11, 2001. Traditional forensic work covers legal and courtroom issues, such as competency and criminal responsibility. The military refers to the evaluations for competency and criminal responsibility boards as “706” boards or sanity boards.

Disability evaluations, suicide investigations, and correctional issues are some of the specialized areas in forensic mental health that have changed since September 11, 2001. Now, for example, far more service members are receiving disability evaluations for posttraumatic stress disorder (PTSD). Suicide rates have been extremely high since 2007. Correctional issues have been highlighted by the controversy over Guantanamo Bay and the scandals at Abu Ghraib.

Numerous ethical issues will be explored either directly or indirectly in this volume. Confidentiality of medical records and communication with commanders and providers are both perennial forensic issues. For military providers, the importance of understanding the rules is highlighted by the question of when and how to report possible war crimes that a patient may discuss in therapy. The principles of bioethics, which include patient autonomy, justice, beneficence, and nonmaleficence (first, do no harm), guide both civilian and military medicine. These principles will be covered further below.

POSTTRAUMATIC STRESS DISORDER, SUICIDE, AND VIOLENCE

This volume will highlight some of the topical issues arising from the recent conflicts. The focus is especially on the so-called “signature” wounds of the post-September 11, 2001 wars: PTSD and traumatic brain injury (TBI). Unlike physical trauma, mental wounds can take years to surface, and they are also often more difficult to diagnose or treat than typical physical wounds. Treating them will be a bigger challenge as the wars wind down and the 2.5 million young men and women who served in them return home.

The diagnosis for PTSD changed as of May 2013 with the publication of *Diagnostic and Statistical Manual of Mental Disorders: DSM-5*.⁵ Rather than revise all the

chapters in this book as it went to press, the *DSM-IV* definition is generally used. However, it is important to be aware of the new criteria. *DSM-5* has a wider definition of PTSD, including the elimination of so-called criterion A-2, which requires fear, hopelessness, and horror at the time of the event.⁵ It also adds criteria allowing somatic reactions to triggers, depressive symptoms, cognitive problems, sleep problems, and irritability.

Several chapters in this book focus on suicide and violence to explain the dynamics involved. Although the numbers and rates of suicide have been well documented, far less clear is how to reduce these

tragedies.^{6,7} Mitigation of risk for suicide needs more of a focus. The update on how and when to do psychological autopsies provided in this book should be useful to the field.

Violence is a less well understood phenomenon. The violence since September 11, 2001 includes the murder-suicides at Fort Bragg, North Carolina, in 2002; a still-rising suicide rate in the military, especially in the Army; the massacre at Haditha, Iraq; the murders at Fort Carson in 2009; the shootings of and by psy-

chiatrists at Camp Liberty in Baghdad, Iraq, and Fort Hood, Texas, in 2009; and the massacre of Afghani civilians in 2012.^{8,9}

The post-September 11, 2001 history also includes torture of detainees at Abu Ghraib and Guantanamo Bay and other facilities. Other war crimes include urination on dead Taliban members. The relationship between PTSD, exposure to violence, and commission of crimes is still poorly understood.

POSTTRAUMATIC STRESS DISORDER, SUBSTANCE ABUSE, AND MEDICAL BOARDS

Other forensic subjects are ongoing issues, but they have been heightened by the long wars. A medical board is the commonly used term for a combined fitness-for-duty evaluation and disability evaluation. Medical boards have always been contentious issues in military medicine, but the tumult at Joint Base Lewis-McChord in Washington in the spring of 2012 has drawn attention to them again.¹⁰

The chapter on the medical board process should be especially useful to providers who are new to the process. Even for seasoned clinicians, malingering and substance abuse add to the complexity of decision-making about how much certain symptoms are compensated. Training in forensic psychiatry and psychology, and the careful use of psychological testing, can benefit both diagnosis and disability evaluations.

TBI also complicates diagnosis and treatment (TBI was covered in more detail in *Combat and Operational Behavioral Health*). Many symptoms of PTSD and TBI overlap, and TBI increasingly is implicated in suicide.

Substance abuse is a common comorbid condition with both PTSD and TBI. Substance abuse contributes to the risk of head injury initially,¹¹ and people with a head injury often have increased irritability and impulsivity.¹²

The relationship among PTSD, sleep issues, pain, and substance abuse is more complicated, yet often all seen in the same service members. The new diagnosis of PTSD in *DSM-5* specifically includes sleep problems.⁵ Insomnia and sleep problems associated with PTSD often lead to self-medication with alcohol.

The pain and disability from musculoskeletal injuries has, unfortunately, led to an over-prescribing of opiates, in both civilians and military members. Numerous challenges with opiate tolerance or addiction exist.

A chapter on mefloquine and PTSD outlines the extensive connections between taking the antimalarial agent and psychological symptoms. Distinguishing among side effects of the medication, PTSD, and TBI is likewise problematic.

CORRECTIONAL AND SECURITY ISSUES

In every war, the US military will have to deal with captured enemy combatants. Military medical staff need to be trained on the complexities of providing care in the exceptionally challenging detainee environment. Specifically, mental health staff will need to understand the challenges of providing care to detainees, which was covered in the last volume, *Combat and Operational Behavioral Health*.¹³

Behavioral science consultation teams have been exceptionally controversial. The American Psychiatric Association and American Psychological

Association spent several years debating the ethics of psychiatrist and psychologist participation with the interrogation teams. This chapter covers guidelines for safe, legal, and ethical interrogation with detainees.

The chapter on secure psychiatric facilities contributes to an understanding of the many issues in setting up a facility that is both secure and conducive to providing care. It should be useful not only to those designing a new psychiatric facility, but also to those renovating existing ones.

CURRENT TOPICS IN MILITARY MEDICAL ETHICS

Medical ethics normally focus on four principles: (1) autonomy, (2) justice, (3) beneficence, and (4) nonmaleficence. In simple terms, they mean, respectively: the right of the individual to make his

or her own decisions; equal resources for all; do good for the patient; and do no harm. These same principles, of course, also apply to military medical ethics.

In the gray areas of ethical discussion there are no clear right and wrong answers. Often competing priorities exist, depending on one's viewpoint. *Military Medical Ethics*, in the Textbooks of Military Medicine series, was published in 2003.¹⁴ The following quote is from the press release announcing the two-volume set, but is still relevant today: "Our unifying theme is straightforward: There is a tension within the individual military physician between the profession of medicine and the profession of arms, and that tension is good. There is, also, an ethic to what the military physician does, especially on and off the battlefield."¹⁵ Thomas Beam, senior editor, added, "That is the ethic of conserving the fighting strength by providing excellent medical care to military personnel."¹⁵ According to Ronald F Bellamy, MD, FACS, military medical editor of the Textbooks of Military Medicine series and a retired US Army military surgeon with service in Vietnam, "It should not surprise observers that the ethics of military medicine is the source of more passionate debate than any other aspect of the philosophy of ethics. Nowhere else is there likely to be such a stark and ongoing conflict between what are radically different views of what constitutes the good."¹⁵

The five ethical areas listed below are interwoven throughout this volume:

1. dual agency of the psychologist or psychiatrist (working for both the military and the service member);
2. return to duty versus evacuation (whether to keep someone in the battlefield or send him or her home);
3. retaining a service member in the military versus recommending a medical board (medical discharge);
4. confidentiality versus what command needs to know; and
5. disability and compensation issues for those diagnosed with PTSD.

Dual Agency

By definition, military medical personnel serve many "masters:" the service member, the military organization, and the United States, including national security, Congress, and the taxpayer. Dual agency is a classic military ethical dilemma that should be discussed with military physicians early in their careers. The question of whether and how the needs of service members, the military, or the nation is prioritized specifically arises in all the following areas.

Return to Duty Versus Evacuation

A common decision for a military psychiatrist in the combat theater is how to balance the needs of the individual against those of the organization when deciding when to evacuate for psychiatric reasons. Lessons from World War I, World War II, and the Korean War taught the military that those evacuated for "shell shock" or "battle fatigue" did not do well after evacuation. If soldiers were sent home for psychiatric reasons, the shame and stigma persisted. They usually would be discharged from the military. However, if they could be maintained on the front line, they maintained their ties with their unit, and had the satisfaction of having served honorably.¹⁶

Beyond these problems, those sent home were lost to the fight, and the intent of the Army Medical Department—as reflected in its motto—is "To conserve fighting strength." Although both the soldier and the Army seemed to do better when the soldier stayed on the battlefield, as has been extensively discussed in earlier texts in the Textbooks of Military Medicine series,¹⁻³ the mortality rate of potential psychiatric evacuees who stayed in theater is not known.¹⁷

Retaining a Service Member

Retaining as many soldiers on duty as possible became part of the Army's combat stress control doctrine, with the associated mnemonic "PIES" (proximity, immediacy, expectancy, and simplicity): treat close to the front lines, quickly and simply, with an expectation of return to duty. Currently, every military behavioral health practitioner should know the basic principles of far-forward behavioral health treatment. Normally, the patient gets a trial of treatment in the war zone. If patients do not improve, or are too dangerous (suicidal or homicidal), they are evacuated. Variations exist in how patients present and the circumstances on the ground, which influence the evacuation decision.

The military followed this policy in Iraq and Afghanistan. It seemed to work well, at least in the beginning. But now as the Army has left Iraq and is withdrawing from Afghanistan and downsizing, is it still the right approach? Perhaps the Army should evacuate everyone having difficulties. However, the Army is still concerned about retaining skilled soldiers. In addition, to be sent home for behavioral health reasons still usually ends a career—perhaps not immediately—and the chances of promotion are poor.

In the past, usually soldiers deployed once, for either a year (Korea, Vietnam) or the duration of the conflict (World War I and World War II). Now, as

troops rotate back and forth, military psychiatrists have a new challenge. If soldiers have developed PTSD from combat, is it ethical to send them back into a war zone? Many say absolutely not. If these soldiers are sent back into combat, they likely will experience the same stressors that previously led to PTSD. But if they cannot deploy again, they are eventually discharged from the Army for being nondeployable. The discharge may be medical or administrative, but either way it means losing their jobs and military identity. Both have negative consequences, especially in a time with very high unemployment, especially for young veterans. Additionally, many service members deliberately keep PTSD symptoms hidden to return to combat. Unfortunately, data are lacking on how these modern combat veterans do in terms of overall mortality. Does their hypervigilance help keep them alive? Or do their vulnerabilities get them in trouble?

Confidentiality

There are dilemmas in deciding what health information should be shared with command, the commanding officer of a company (usually a captain in the Army), or others up the chain of command. Protected health information should not be shared with commanders, unless they need to know about it. Commanders need to know whether or not a service member is able to fulfill the mission, able to deploy, and fit for duty. Obviously, if a soldier has a broken leg, he or she cannot deploy. Likewise, command needs to know if a female soldier is pregnant because she cannot be exposed to petroleum or other potentially toxic fumes, will need modified physical fitness training, and cannot be allowed to deploy.

However, if a soldier has a history of PTSD or of suicidal ideation, does command need to know? Command usually says yes: "I want to care for my soldiers, and I need to know about their issues, so that I can look out for them." The soldier (almost) always says no: "I want to stay on active duty and get promoted." The last thing soldiers usually want is to have their command informed about their vulnerabilities, including PTSD, depression, and substance abuse.

The current reality is that if soldiers display these conditions, they are not likely to stay in the military. The Army is downsizing, and those who frequently visit physicians or cannot deploy because of emotional problems are not likely to be allowed to remain in uniform, at least on active duty. Although the Department of Defense states that seeking help is a sign of strength, this attitude does not resonate with young enlisted soldiers who want to be promoted.

The military has been grappling with how to balance the competing needs to preserve confidentiality and also protect the force for many years. Several policies and Department of Defense instructions have attempted to specify exactly what information the command needs to know,⁶ but these policies may still fail.¹⁹

Another topical issue is the obligation of military providers to report possible war crimes revealed in the therapeutic encounter. On the one hand, a provider wants to encourage care seeking and avoid revealing patient confidences. On the other hand, a military officer has an obligation to report war crimes. In practice, in the author's experience most providers err on the side of preserving confidentiality. (This dilemma is similar to the choice about whether to report homosexual behavior before the repeal of "Don't Ask, Don't Tell.")

Unequal Access to Care

Since approximately 2006, there has been a major focus on PTSD and TBI in the military. The armed services, Congress, and others have poured money into military behavioral health issues. Excellent programs are now available for service members with PTSD and TBI, often with a heavy emphasis on integrated care (also known as complementary and alternative medicine). However, these programs tend to serve a relatively small number of soldiers, Marines, and other service members. These small numbers mean access to such good care is highly unequal. For example, the National Intrepid Center of Excellence in Bethesda, Maryland, has an intensive evaluation and treatment program, as do the Warrior Resilience Center at Fort Bliss, Texas; the Warrior Reset Program at Fort Hood, Texas; and the TBI unit at Fort Campbell, Kentucky. These programs tend to last 3 weeks or longer and serve a few dozen patients at a time.

Likewise, evidence-based therapies such as prolonged exposure and cognitive-behavioral therapy require treatment at least once a week—optimally twice a week—for 8 to 13 weeks. But these intensive programs do not exist in many places, and even where they do, the programs are unavailable to most service members because of insufficient providers or a service member's inability to get to the clinic that often.

If a service member does not get better, he or she is referred for a medical board, all but inevitably resulting in a medical discharge from the Army. This situation again raises ethical questions of fairness. Is a discharge fair if the service member has not received adequate therapy? This issue refers back to the basic principles of bioethics: autonomy, justice, beneficence, and non-

maleficence. The problem is simply and fundamentally a lack of justice: service members today have unequal access to care. When recruits sign up for military service, they know they may become a combat casualty. But troops should not have to take a chance on getting the best medical care—mental or physical—once they are wounded.

The uneven availability of care means that some service members will get better and others will not. Those who do not get adequate care will be—most likely—separated from the Army. They may or may not enter the US Department of Veterans Affairs (VA) or a private or public mental health system.

Unintended Consequences of the 50% Disability for Posttraumatic Stress Disorder

The disability system has long been controversial. Questions of fairness for disability for veterans were a major issue in World War I, both in the United Kingdom and the United States, and in every war since then.²⁰

Before 2007, PTSD was not adequately compensated, receiving maybe a 5% or 10% disability rating. There would normally be a severance package and no medical retirement. But now soldiers with PTSD usually receive a 50% disability rating, regardless of symptom severity. There are positive and negative consequences of this policy. However, the current system of giving military members with a PTSD diagnosis a 50% disability has mixed effects because giving 50% for a particular diagnosis creates a major incentive to get it and keep it.

The process, which is covered in chapter 4 in this volume, is as follows. If a service member has a severe medical condition, he or she goes before a medical evaluation board, which makes a recommendation as to whether he or she is medically fit for duty. Then he or she goes to a physical evaluation board, which makes the determination of whether he or she is fit and assigns a disability rating.

If someone is medically discharged from the military, he or she may or may not receive compensation in the form of severance pay or ongoing financial support. If a service member receives a rating of 30% or more, then he or she is medically retired, which means that he or she essentially receives 30% (or more) of the base pay, plus retiree benefits.

The military and VA disability process used to be a totally separate one. First the service members were assigned rating from the military, and then from the VA. In general, that rating was higher. Now there is one disability process: the Integrated Disability Evaluation System. Some argue that the 50% automatic disability is not helpful because of the financial incentive to receive the PTSD diagnosis rather than depression or anxiety, and the financial disincentive to get better. In 2012 this question erupted into national attention when allegedly a psychiatrist at Madigan Army Medical Center estimated in a public meeting that this disability cost the taxpayers \$1.5 million over a soldier's lifetime.^{21,22}

This is not just an Army or VA issue: it is a national one. How should veterans who have served in combat be compensated, whether or not they meet the technical definition of having PTSD?

CONCLUSION

The forensic and ethical issues raised by recent wars will continue for many years into the future. This volume is not intended to mandate policy or decisions, but to discuss the various sides of each issue and help guide practitioners, attorneys, and others grapple with these complex issues.

This is an ambitious book that deliberately tackles some of the most challenging issues in military behavioral health including PTSD and violence, the disability

system, and the behavioral science consultation teams. Many of these topics have been very high profile in the media and halls of Congress. In some cases careers have ended, publicly or privately. Thus, this volume hopes to enlarge the discussions before the next generations of psychologists and psychiatrists and other behavioral health providers have to grapple with them. These topics are encouraged to be discussed during training programs, grand rounds, and in other forums.

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