

Chapter 43

MILITARY FORENSIC MENTAL HEALTH

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INTRODUCTION

As the wars in Iraq and Afghanistan continue, the US military medical system is required to address many issues at the interface of psychiatry and the law. Service members with mental health consequences from war impact not just the healthcare system, but also the military justice and disability systems. This chapter highlights some of the most topical forensic issues facing military providers, attorneys, and the courts.

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.¹⁻³ However, of the hundreds of thousands of veterans deployed in these wars, only a small subgroup has been involved in violent crimes. For this group, military forensic psychiatrists will be called upon 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.

Complicating the widespread occurrence of war-related psychological disorders is the “signature wound” of these wars: traumatic brain injury (TBI). The numerous causes of head trauma include blast exposure, gunshot wounds, motor vehicle injuries, and other accidents. The severely wounded are routinely screened for head trauma; however, some soldiers who experience periods of unconsciousness may not present for treatment. They may later develop difficulty concentrating or irritability but be misdiagnosed or receive no medical treatment. More recently, updates in screening for TBI have been widely implemented. Now all deployed soldiers receive screening for TBI, as well as posttraumatic stress disorder (PTSD), upon their return from an overseas deployment. PTSD, although a well-recognized and validated psychiatric disorder, has also long been associated with malingering, allegedly for the purposes of both avoiding prosecution or punishment, and/or

obtaining disability compensation.

Forensic psychiatry, psychology, and social work focus on the intersection of mental health issues and the law. Core topics include competency, criminal responsibility, sexual trauma, and disability. This chapter focuses on forensic psychiatry, rather than the other disciplines, as that is the best-developed discipline in the military; however, the concepts will apply across the disciplines.

Military forensic psychiatrists currently serve in the US Army, Navy, and Air Force. Forensic psychiatry in the military has many similarities to forensic psychiatry as practiced in the civilian world, but some key differences exist. This chapter will accentuate some of the differences. It opens with a description of military law, determination of competency and criminal responsibility, and the role of expert witnesses in the courts-martial system. The next sections discuss malingering and psychological autopsies. Numerous forensic issues also relate to detainees. Although the care of detainees is presented in another chapter in this volume, this chapter will briefly discuss sanity boards on detainees and the behavioral science consultation team policies. A full discussion of the military forensic psychiatry issues and the military legal system is beyond the chapter’s scope but may be found in other sources.⁴⁻⁸ Several case examples, which are composites, are presented and are meant to illustrate principles.

Case Study 43-1: A soldier was returned from Afghanistan in the early years of the global war on terror (GWOT). After serving a hard 6 months there, he received an e-mail from a neighbor, saying: “I have seen a red pick-up truck in your driveway overnight the last few nights. What’s up?” The soldier applied for emergency leave, saying his mother was dying. The day after he returned home, he and his wife had a fight over his perceptions that she had a lover. He pulled his personal gun out of the nightstand and shot and killed her. He then turned the gun on himself.

THE PSYCHIATRIST AND THE CRIMINAL JUSTICE SYSTEM

Military Law

The birth of American military law can be traced to the first American Articles of War, which consisted of 69 separate articles enacted by the Continental Congress on June 30, 1775, governing the conduct of the Continental Army.^{5,6} Congress enacted today’s Uniform Code of Military Justice (UCMJ) in 1950.⁸⁻¹⁰ The UCMJ combined the laws formerly governing the US Army, Navy, and Air Force into one uniform code. As a result, the US military has its own system of

criminal justice with hierarchical sources of rights. In addition to the UCMJ, military law is based on the US Constitution, federal statutes, 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 unless superseded by military or operational necessity.^{9,10}

The UCMJ established several levels of courts-martial. General courts-martial are analogous to felony trials, and special courts-martial are analogous to mis-

demeanor trials. The summary courts-martial, comparable to a justice-of-the-peace court, is a single-officer court with significantly limited authority.⁹ The Fifth Amendment of the Constitution specifically denies the right to grand jury indictment to service members.⁹ In place of the grand jury, the military states that no case may be referred to a general court-martial unless there has been a UCMJ Article 32 investigation.⁹

An Article 32 investigation is an open hearing designed to inquire into the facts of the case surrounding the charges. Although similar to both 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.⁹

Forensic Evaluations or “Sanity Boards”

The issue of criminal responsibility is addressed in many military settings, typically during Article 32 hearings and special and general courts-martial. In accordance with Rule for Courts-Martial 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 (or defendant in civilian legal proceedings) 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.¹⁰

Determinations of mental or criminal responsibility are referred to a board, commonly referred to as a “706 board” or “sanity board.” Sanity boards determine the capacity of the accused to stand trial and address any other questions requested by the convening authorities, usually related to the clinical diagnosis and criminal responsibility. The board officially consists of one or more persons who must be either a physician or a clinical psychologist. Normally, at least one board member is either a psychiatrist or a clinical psychologist.¹⁰

Although not specifically required by the rule, a military forensic psychiatrist or psychologist is in many cases best qualified to serve as a member of the board.^{7,10} This is especially true for cases with complicated mental health issues or those involving very serious crimes, when the potential for appellate scrutiny of the sanity board findings is high. Military lawyers usually acknowledge the specialized training and experience that a military forensic psychiatrist or psychologist brings to sanity boards, frequently asking convening authorities and military judges to request such specialists to participate during assessments of

criminal responsibility.⁷

According to Article 50a of the UCMJ,

[i]t 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.¹¹

The above is often called the cognitive prong of the insanity defense (ie, that the accused knows the difference between right and wrong). This military standard, like the federal standard since the Insanity Defense Reform Act of 1984, does not include a volitional prong (eg, the capacity of the accused to conform his conduct to the requirements of the law). The burden of proving lack of mental responsibility falls on the accused, who must prove the defense by clear and convincing evidence. The court can then find the accused guilty, not guilty, or not guilty by reason of lack of mental responsibility.¹¹

Because the accused is obligated to participate in the sanity board process, protections afforded to the defense limit discovery of the findings. Two reports are prepared: (1) a full report that includes all of the board’s findings and the basis for its opinions, and (2) an abbreviated report containing only the board’s ultimate conclusions on all questions specified in the order. The full report is furnished only 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 allowed only pursuant to an order by the military judge. The abbreviated report is provided to the officer ordering the examination, the commanding officer of the accused, the investigating officer (if any) appointed pursuant to Article 32, and to all counsel in the case.⁸ If the accused chooses to raise a mental health defense, the full report (redacted to exclude direct statements made by the accused) may become discoverable.

Case Study 43-1 (continued): The gunshots were heard by the neighbor who had previously sent the soldier the e-mail about his wife. The soldier survived, although with severe brain damage and hearing loss. The defense requested a sanity board, on the basis that the soldier had PTSD and traumatic brain injury, and therefore was neither competent to stand trial nor criminally responsible because of his PTSD.

Sanity Boards on Detainees

In July 2008, requests for “706 Boards” or sanity boards began to be made for the detainees at Guan-

tanamo Bay. This author did four sanity boards that fall, until the trials ceased. While no individual issues are discussed here, a few thorny questions will be reviewed. Issues of culture and coercion are central. If a detainee discusses “djin” or spirits, is that psychosis or cultural belief? If he says that Allah made him do it, is that religiosity or terrorism? If he goes on a hunger strike, is that depression or coercion from other detainees? If it seems he cannot understand the questions, is that poor education, language difficulties, or deliberate refusal to cooperate with the examiners?

Courts-Martial Expert Consultants and Expert Witnesses

In accordance with MRE 706, “[t]he trial counsel, the defense counsel, and the court-martial have equal opportunity to obtain expert witnesses under Article 46 [of the UCMJ].”^{10(p275)} MRE 706 also allows for accused individuals to select expert witnesses at their own expense. MRE 702 states that

[i]f 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 . . .^{10(p275)}

MRE 703 addresses the bases of opinion testimony by experts. It states that

[t]he 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 in order for the opinion or inference to be admitted.^{10(p275)}

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.¹⁰ 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.^{10(p255)}

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.”^{10(p275)} 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.^{10(p275)}

The defense may request an expert consultant if a sanity board’s opinions are deemed favorable to the prosecution, if mitigating factors might affect sentencing, or in both cases.⁶ The expert may be either civilian or military. 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 the attorney–client privilege. Such requests are often subject to intense scrutiny during pretrial motions.⁷ If the appointment is not granted, the military forensic psychiatrist may still function as an expert within the limitations of rules of discovery.

The defense may request a military forensic psychiatrist or psychologist to testify during the merits phase (or “guilt phase”) or after conviction during the sentencing phase. For example, the expert witness may be asked to provide expert testimony during the merits or sentencing phases about the impact of combat-related PTSD, “Gulf War syndrome,” or the “Vietnam syndrome” on the mental state or behavior of the accused.¹² In addition, the expert witness may be specifically asked to provide testimony on mitigating factors during the sentencing phase. For example, 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.

Either defense or trial counsel may request expert consultation if a sanity board reaches a conclusion that is not favorable to its side. In addition, sanity boards have been successfully challenged on the basis of thoroughness, accuracy, and misapplication of the proper military standard for criminal responsibility.

The military forensic psychiatrist may also be asked to provide expert testimony for the prosecution during the merits phase on counterintuitive behaviors of an alleged victim, such as “rape trauma syndrome” or “battered spouse syndrome.”¹³ Because the accused may not be compelled to submit to any psychiatric evaluation beyond that of a sanity board, any testimony on aggravating factors at sentencing is often limited to a review of collateral documents and obser-

vation of the accused during the court-martial, which requires the military forensic psychiatrist to testify to this limitation.

Case Study 43-1 (continued): The sanity board did an extensive evaluation, including reviewing interviews of numerous witnesses, and a week-long assessment of the accused, including psychological testing. Although they agreed that he had PTSD, they did not think it rendered him not criminally responsible. The damage from the head wound did interfere with some of his activities of daily living. However, he knew the functions of the judge and jury and the basic elements of the case. He was able to cooperate with the defense attorney and to behave in the courtroom. Therefore he was found both competent and criminally responsible. Perhaps because of his diagnoses of PTSD and organic brain

syndrome, he received a sentence of only 10 years.

Board certification in the subspecialty of forensic psychiatry now requires completion of an accredited 1-year fellowship program, and then a board examination in forensic psychiatry. Currently only one forensic psychiatry program exists in the DoD—the National Capital Consortium’s Military Forensic Psychiatry Fellowship Program (in existence since 1992), located in Washington, DC. Recently a forensic psychology program was started there as well. In addition to the training requirements specified by the Accreditation Council for Graduate Medical Education, fellows receive training to serve as consultants and expert witnesses in court-martial involving military-specific offenses.

MALINGERING

Case Study 43-2: A soldier presented to the combat stress control unit in Balad, Iraq. He had been in an improvised explosive device attack the day before. Two of his buddies had been severely wounded. He had hit his head against the hatch in the explosion, but was otherwise unhurt. His chief complaint was, “I just want to go home.” He said he might shoot himself if he could not. The brief screen for traumatic brain injury and for PTSD was negative. He also said he could not stop shaking. The junior psychologist thought he might have a factitious disorder (tremor).

Malingering has always presented a challenge for forensic psychiatrists, especially in the armed forces, where it can be a specific criminal offense under the UCMJ. Healthcare professionals are reluctant to label patients as malingerers for many reasons, including the perception that it is tantamount to accusing the individual of fraud and deceit. Clinicians, accustomed to using their skills to diagnose and treat those who seek help for problems, often feel uncomfortable when confronted with patients who seek not therapeutic assistance to improve their well-being, but rather “official” corroboration of an attempted deception. However, reluctance to diagnose an obvious case of malingering or, even worse, treating patients as if they had the feigned illness (perhaps seen as the path of least resistance), may actually violate the maxim of “*primum non nocere*” (first do no harm). Insulating the patient from the consequences of malingering might be tempting, with the shortsighted view that either the benefits accrued by a successful deception or avoiding the penalties associated with fraud would be in the patient’s best interest. This action may promote a dysfunctional psychosocial developmental process and foster longer-term negative effects. Military healthcare practitioners must find ways to make their ethical and fiduciary responsibility to act in the patient’s best

interest coincide with the needs of the system. Such dual responsibilities, of course, are not limited to the military; therapeutic practice often requires balancing the individual needs of the patient with broader social obligations.

Malingering has a longstanding history of recognition in the military, as highlighted by “avoidance of military duty” topping the list of external incentives in its description in the *Diagnostic and Statistical Manual of Mental Disorders*.¹⁴ This text describes malingering as

the intentional production of false or grossly exaggerated physical or psychological problems, motivated by external incentives such as avoiding military duty, avoiding work, obtaining financial compensation, evading criminal prosecution, or obtaining drugs.¹⁴

Malingering may be viewed as adaptive behavior under extreme circumstances, for example, when a prisoner of war feigns illness to escape maltreatment. This issue has predictably come to the forefront of clinical practice during wartime. Malingering might increase in the attempt to avoid combat duty by service members who otherwise lack the antisocial tendencies usually associated with this behavior. In this context, malingering can also be seen as a maladaptive response in an extremely stressful situation.^{15,16} However, because military service in the United States is now voluntary, recruits know they are going to a theater of operations. In the author’s experience, soldiers are more likely to deny symptoms than to exaggerate them, a phenomenon known as “negative malingering.”

The treatment of the malingering patient in combat is complicated by dual agency and ethical considerations. Although the motivation may appear as no

more than a superficial attempt to return home, it is often predicated by a primal fear for personal safety. In either sense, individual malingering creates a concern for an “epidemic” of malingering within the unit. Furthermore, malingerers’ actions create a danger to the lives of their fellow soldiers, which creates a need for discipline and a duty to third parties when such deception has been detected. Military psychiatrists are challenged with balancing these considerations and the employment of limited therapeutic resources, including their own time and energies. Often the adage of “greatest good for the greatest number” dictates the type of treatment that can be offered in the combat zone, with substantial pressures to treat “bona fide” combat stress reactions, rather than “misconduct stress behavior.”

A “diagnosis” of malingering does not necessarily equate to the crime of malingering. Article 115 of the UCMJ describes the criminal offense of malingering as follows:

Any person subject to this chapter who for the purpose of avoiding work, duty, or service (1) feigns illness, physical disablement, mental lapse or derangement; or (2) intentionally inflicts self-injury; shall be punished as a court may direct.^{10(p344)}

Military law recognizes the two distinct forms of malingering—feigning illness and intentional self-injury—with different punishments for each (greater

for self-injury than for feigning illness). If the offense was committed in time of war or in a hostile-fire pay zone, the more serious offense of malingering to avoid combat duty brings even stronger penalties. Maximum prison sentences may range from 1 year for feigning illness in a noncombat situation to a maximum of 10 years for intentional infliction of self-injury to avoid combat duty.

Again, although there is a perception that malingering is common, in today’s all-volunteer military malingering is probably much less common than believed. In actuality, it is the author’s belief that soldiers are far more likely to conceal psychiatric symptoms than to embellish.

Case Study 43-2 (continued): The combat stress team treating soldiers in Balad was presented with a common dilemma. Should the team send him home, and therefore potentially have an epidemic of soldiers who had the same complaint of “I just want to go home”? The team members consulted with the division psychiatrist, who diagnosed a conversion disorder, rather than a factitious disorder. They elected to try the classic principles of combat psychiatry (eg, immediate treatment with the expectation of recovery and return to his unit). Unfortunately, the soldier did not respond and eventually had to be evacuated to Landstuhl. He was then evacuated to Water Reed Army Medical Center in Washington, DC, where he received numerous diagnoses. When he learned that he was going to be discharged from the Army, he ended his life by jumping off a bridge in Washington, DC.

PSYCHOLOGICAL AUTOPSIES

Before 2001, a report known as a “psychological autopsy” was required on every suicide in the US Army. After completion, it was submitted to the Army Surgeon General and the Walter Reed Army Institute of Research. These retrospective suicide investigations were designed to gather information from the soldier’s unit and family to provide lessons learned that might prevent future suicides. However, many of these postmortem investigations were performed by mental health officers who may not have had any specific training in this particular task. Investigators generated long narrative reports that seldom produced any feedback or change to the system. Furthermore, the report format made data extraction and analysis difficult. Another major issue of the psychological autopsies was who had access to their information. Before 2001, psychological autopsies were accessible under the Freedom of Information Act, which resulted in violation of patient privacy. For example, a reporter from the *Raleigh News and Observer* published salacious and intimate details obtained from over 50 psychological autopsies from Fort Bragg, North Carolina.¹⁷

DoD changed the requirements for psychological autopsies first in a Health Affairs policy letter in 2001 and later in a DoD directive in 2003.^{1,18} The policy requires a formal psychological autopsy only if the death were equivocal, that is, it was not known whether the death was a suicide, homicide, or accident. All suicides still must be evaluated. A DoD suicide event report is now generated for both attempted and completed suicides. If mental health personnel had been following the soldier, a quality assurance review—known as a root cause analysis—should be conducted. As part of the new requirement, practitioners must receive additional training in conducting psychological autopsies. The additional training should cover basics of crime scene investigation, physical autopsy procedures, toxicology, and understanding of suicidal behavior and determinants. Forensically trained psychiatrists have usually already received this training.¹⁹

Cases that require psychological autopsies tend to cluster in the following categories:

- an accidental or deliberate drug overdose;

- an accidental or deliberate motor vehicle accident;
- a gunshot wound, which may have been self-inflicted, accidental, or a homicide; or
- a hanging, which may have resulted accidentally from autoerotic asphyxia or intentionally from suicide.

Case Study 43-3: A soldier in the Warrior Transition Unit was found deceased. In his room were found nu-

merous pill bottles and an empty bottle of whisky, but no suicide note. The investigation found that he had recently gotten a divorce, but had seemed upbeat in the past several days. He had told his therapist that he was glad the divorce was finalized and was excited about the future. His command did not think it was a suicide. His family thought it might be a homicide, with his ex-wife giving him the pills for an overdose. The medical examiner agreed to a psychological autopsy. The results eventually supported an accidental overdose, although suicidal intent was suspected.

BEHAVIORAL SCIENCE CONSULTATION TEAMS

Although psychologists have supported detention operations and interrogations for many years, the events of September 11, 2001 and the ongoing GWOT have required the unprecedented and sustained involvement of behavioral science consultants (BSCs) in support of both detention operations and intelligence interrogations/detainee debriefing operations. Prior to GWOT, support for these missions was provided by personnel organic to the intelligence and special operations communities. However, the expanded demand for BSCs to support these missions has required assignment of psychologists and forensic psychiatrists from other mission areas within the DoD.

The Army is the executive agent for the administration of DoD detainee policy. The GWOT has resulted in the detention of large numbers of detainees by US forces. The intelligence interrogation and debriefing of detainees is a vital and effective part of the GWOT. It is designed to obtain accurate and timely intelligence in a manner consistent with applicable US and international laws, regulations, and DoD policy. Behavioral science personnel provide expertise and consultation to commanders to directly support the detention and interrogation/debriefing operations.

BSCs are psychologists and forensic psychiatrists, not assigned to clinical practice functions, but to provide consultative services to support authorized law enforcement or intelligence activities, including detention and related intelligence, interrogation, and detainee debriefing operations. Because BSCs are not engaged exclusively in the provision of medical care, they may not qualify for special status accorded retained medical personnel or carry DoD-issued identification cards identifying themselves as engaged in the provision of healthcare services. Analogous to behavioral science unit personnel of a law enforcement organization or forensic psychiatry or psychology personnel supporting the criminal justice, parole, or corrections systems, BSCs employ their professional training not in a provider-patient

relationship but in relation to a person who is the subject of a lawful governmental inquiry, assessment, investigation, adjudication, or other proper action.

BSCs function as special staff to the commander in charge of both detention and interrogation operations (ie, the Commander, Detainee Operations). BSCs should be aligned to report directly to this commander, not to one charged solely with command of the detention facility or Joint Interrogation Debriefing Center. This arrangement enhances the BSC's ability to provide comprehensive consultation regarding all subjects within the BSC's area of expertise on combined aspects of detention operations, intelligence interrogations, and detainee debriefings. Often behavioral science consultation to detention operations, intelligence interrogations, and detainee debriefings is conducted by individual BSCs working alone.

"Behavioral drift"—the continual reestablishment of new, often unstated, and unofficial standards in an unintended direction—is commonly observed in detention and other settings in which individuals have relative control or power over others' activities of daily living or their general functioning. It often occurs when established official standards of behavior are not enforced. Ambiguous guidance, poor supervision, and lack of training and oversight contribute to this change in observed standards. Certain psychological and social pressures can greatly increase the likelihood of behavioral drift. Drift is detrimental to the mission and may occur very quickly without careful oversight mechanisms and training.

The mission of a BSC is to provide psychological expertise and consultation to assist the command in conducting safe, legal, ethical, and effective detention facility operations, intelligence interrogations, and detainee debriefing operations. This mission is composed of two complementary objectives:

1. To provide psychological expertise in monitoring, consultation, and feedback regarding

the whole of the detention environment to assist the command in ensuring the humane treatment of detainees, prevention of abuse, and safety of US personnel.

2. To provide psychological expertise to assess

individual detainees and their environment and provide recommendations to improve the effectiveness of intelligence interrogations, detainee debriefings, and detention facility operations.

SUMMARY

The United States has historically been concerned about the successful adjustment of its military members returning from war. Although the greater population of war veterans will not be involved in criminal proceedings, a substantial minority will develop career-ending disabilities as a result of mental illness. In rare instances, these will be life-ending events. For a very small yet highly visible minority of returning veterans, questions about the cause, precipitants, and manner of death will necessitate psychological

autopsies. This chapter highlighted recent updates in military forensic psychiatry and the mechanisms through which answers to questions of competency, criminal culpability, and motivation underpinning self-injurious behavior are determined within the US military. As the GWOT progresses, so, too, will the experience and study of combat-related mental health. Military judicial processes and the policies and procedures governing psychological autopsies must continue to evolve to meet increasing demands.

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