

**MILITARY LAW TASK FORCE
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**MILITARY PSYCHIATRIC
POLICIES**

**AN INTRODUCTION
FOR ATTORNEYS & COUNSELORS**

This memo includes a summary of the diagnostic and classification system used by the military, discussion of psychiatric criteria for medical discharge or retirement and administrative discharges, and some practical counseling suggestions for attorneys and counselors handling these cases. The memo does not offer a critique of the conservative psychiatric model and assumptions on which the policies are based, but the author does not mean to suggest such a critique is unwarranted.

Readers who trained or work with CCCO's excellent manual, [Helping Out: A Guide to Military Discharges and GI Rights](#), should note that the military services have made a number of changes to the Department of Defense (DoD) discharge category of Other Designated Physical and Mental Conditions since that manual was published. Because of this, each service's criteria for this administrative discharge are discussed in detail here, including non-psychiatric conditions.

During the course of the war in Iraq, counselors and attorneys have seen increasing numbers of clients with psychological problems. In many cases, their conditions have been ignored by their commands. All too often, soldiers with serious depression or other disorders, sometimes just beginning trials of anti-depressants or other psychiatric medications, are deployed to combat zones without adequate psychiatric evaluation or support. A recent study of increased suicide rates in Iraq cited, among other reasons, difficulties in obtaining psychiatric assistance, anti-depressants and sleeping pills in the field. Soldiers facing activation or deployment, and servicemembers in general, often receive little or no attention to obvious psychiatric problems, while many soldiers returning from combat with symptoms of post-traumatic stress disorder (PTSD) or depression are similarly ignored. In some cases, soldiers disclosing psychiatric problems or showing symptoms of them have been accused of malingering or cowardice. Finally, the common military practice of subjecting whistleblowers and dissenters to involuntary psychiatric evaluation and treatment continues, despite regulations designed to protect against such retaliatory action. Given these problems, a clear understanding of the military's psychiatric policies is essential for military counseling and the practice of military law.

Preliminary Warnings

The need for counseling and legal assistance in this area is increased by the military's tendency to misdiagnose and underdiagnose psychiatric conditions which might warrant discharge or retirement, or require treatment to prevent suicide or other harm. Observers have long noticed a tendency among military psychiatrists and psychologists to misdiagnose serious disorders such as major depression or schizophrenia (which may warrant medical retirement with a disability pension) as personality disorders (which warrant only administrative discharge without disability compensation from the military or the VA), or as adjustment disorders (which in the past were not grounds for discharge at all). This is not intended as a criticism of all military psychiatrists, but is a pattern that often requires increased assistance from counselors or attorneys.

In almost all cases involving military psychiatric issues, it is valuable for members to obtain an independent civilian evaluation, preferably at the outset of the case. This allows clients and counselor or attorney to weigh options before raising any issues with the military, and to consider the accuracy of military diagnoses. While the military is not bound by civilian reports, they can assist servicemembers in gaining access to military psychiatrists, and can be persuasive with commands, medical officers and military psychiatrists. Another advantage of civilian evaluations is that unhelpful reports need not be presented to the command or military doctors.

The absence of confidentiality in the military medical system deserves special emphasis. Soldiers and sailors often assume that their discussions with doctors and other mental health professionals will remain private. Unfortunately, reports of evaluations and treatment are routinely available to commands and may be used in virtually all military administrative and disciplinary proceedings. Statements or misstatements in psychiatric reports can lead to accusations of fraudulent enlistment (as for concealment of pre-enlistment psychiatric treatment), accusations of malingering or making false statements, and disciplinary action or involuntary discharge for violation of military regulations or the UCMJ. For example, soldiers who reveal their homosexuality to military psychiatrists normally face involuntary discharge for homosexual conduct. In one Navy case, statements made during a psychiatric evaluation were treated as threats against superior officers, leading to court-martial and a bad conduct discharge.

In working with military clients, it is important to discuss the impact of psychiatric diagnoses and discharges on military service and civilian careers. Soldiers and sailors sometimes find that commands view emotional distress as an indication of weakness and unreliability. This may affect performance evaluations, promotions, desirable assignments and career prospects. In addition, information or misinformation about psychiatric problems often becomes a matter of common knowledge within commands. Informal harassment of members with obvious emotional problems or with known psychiatric diagnoses is widespread; such abuse is, of course, all the more difficult to handle when members are trying to cope with emotional distress in the first place.

While military records are considered private outside the military setting, and are unavailable to civilians and to many government agencies, nothing prevents potential employers from asking job applicants about military service and medical history, then requiring applicants to authorize release of records to the employer. Veterans are routinely asked to provide copies of their DD-214 discharge documents when applying for jobs. Even if this does not lead to requests for medical records, the DD-214 can be problematic in itself. When a DD-214 notes medical discharge or retirement, the diagnosis is not normally given, but employers can be expected to ask. In personality disorder discharges, those words are normally used as the narrative reason for discharge on the form.

Diagnosis and Classification of Psychiatric Conditions

Military policies regarding psychiatric conditions are based on standards and diagnoses adopted by the American Psychiatric Association (APA), and reflect the views and assumptions of the mainstream psychiatric establishment in this country. Non-traditional psychiatric diagnoses and therapy are normally treated with contempt. The military uses the classifications, definitions and criteria set out in the Diagnostic and Statistical Manual of Mental Disorders of the APA, Fourth Edition (DSM-IV). This manual attempts to define individual psychiatric disorders, listing specific symptoms and criteria for each, with sometimes detailed discussion of conditions which may be related to or mistaken for others. DSM-IV also attempts to consider gender, racial and cultural differences which may affect diagnosis, including behavior which may be entirely appropriate in one culture or religion and considered symptoms of illness in another.

A few military regulations, which have not been recently updated, refer to prior versions of the DSM, usually DSM-III or DSM-III-R (revised), but military evaluations and decisions should be based on DSM-IV. Some of the changes from III-R to IV are significant. For example, under DSM-III and III-R, one of the most commonly diagnosed personality disorders in the military was passive aggressive personality disorder. DSM-IV relegates it to “Criteria Sets and Axes Provided for Further Study.” Servicemembers with symptoms of the old passive-aggressive personality disorder should now be diagnosed with personality disorder not otherwise specified (NOS), often considered a catch-all for atypical personality disorders or conditions that don’t meet all of the criteria for any specific personality disorder.

Changes have also been made in the criteria for PTSD. Unlike III-R, DSM-IV does not require that the stressor which gives rise to the disorder be “outside the range of normal human experience,” since that was determined to be “unreliable and inaccurate.” DSM-IV requires instead that the person’s response to the stressor “must involve intense fear, helplessness, or horror.” This gives greater latitude in the range and type of traumatic experience required for a diagnosis of PTSD; in the past, individuals traumatized by more common but equally horrible experiences faced problems in establishing the diagnosis.

DSM-IV, like its predecessors, uses “Axes” to divide groupings of mental, medical and social problems, and military psychiatric reports should use this system. Axis I is used to report the vast majority of psychiatric conditions, from schizophrenia and PTSD to short-term adjustment disorders and sleep disorders. Axis II includes personality disorders and mental retardation. Diagnoses given under these two Axes are usually described as mild, moderate or severe. Axis III is used for physical illnesses and injuries; Axis IV for psychosocial and environmental issues such as occupational problems or problems with the legal system; and Axis V for a global assessment of functioning on a scale of 1 to 100. Military psychiatric evaluations normally include diagnoses, or a notation that there is no diagnosis, under Axes I and II, but do not always include Axes III to IV.

Under this classification system, a military psychiatric report might include the following:

Diagnosis:

Axis I: Adjustment disorder with depressed mood

Axis II: Narcissistic personality disorder, severe

Or

Axis I: Post-traumatic stress disorder

R/O major depressive disorder

Axis II: Diagnosis deferred

Or

Axis I: No diagnosis

Axis II: Obsessive-compulsive personality disorder

DSM-IV suggests that some diagnostic decisions be deferred when a serious and acute disorder makes evaluation of other conditions difficult. Personality disorder diagnoses are sometimes deferred when a serious Axis I disorder requires immediate treatment, and considered later when the other disorder becomes stable or remits. A R/O, or rule out, diagnosis is provisional, usually a doctor’s initial guess but occasionally a final diagnosis after hospitalization or treatment.

DSM-IV describes the criteria, course, associated features and specific cultural, age and gender features of disorders, their prevalence, and differential diagnoses for each listed disorder. This provides the mental health practitioner and the military counselor or attorney with an important tool for gauging the validity and significance of particular diagnoses. This is not to suggest that counselors and attorneys should second-guess psychiatrists and attempt to make diagnoses, but rather that they can assist clients in considering whether to question a diagnosis, obtain independent evaluations, and deciding whether to seek or object to a discharge based on the diagnosis. By way of example, these efforts can help clients discover whether the diagnosis of an adjustment disorder with depressed mood is a misdiagnosis of a much more serious major depressive disorder, whether a diagnosis of schizophrenia is actually a less serious schizoid personality disorder, or whether a diagnosis of personality disorder not otherwise

specified may be based solely on religious or political differences with military policies and practices.

In the military's scheme of things, serious Axis I disorders may be grounds for medical discharge or retirement, usually depending on their severity and amenability to treatment. The personality disorders of Axis II, considered less serious and almost impossible to cure may be grounds for administrative discharge, but not medical discharge or retirement. Short-term or less serious Axis I conditions have not been grounds for administrative or medical discharge, largely because they are expected to have less effect on performance of duties and to improve with time or treatment.

However, commanders have discretion to discharge soldiers and sailors on the basis of these less significant conditions while they are in entry-level status (the first 180 days of active duty service). This is often done under the very broad discharge category of Entry Level Performance and Conduct. Some of the conditions may be grounds for discharge for failure to meet enlistment medical standards, if discovered in the first months of service. In addition, the various services have expanded and revised the DoD discharge of Other Designated Physical and Mental Conditions (ODPMC) to include some of these diagnoses, with variation from service to service.

Criteria for Disability Discharge and Retirement

Medical disability separations may result from serious Axis I disorders, such as major depressive disorders or PTSD. In very general terms, these warrant discharge or retirement if they are severe enough to interfere significantly with performance of duties, require continuing psychiatric support, seriously endanger the servicemember's health or well-being, or prejudice the best interests of the government.

The controlling regulation is DoD Instruction 1332.38; guidelines for psychiatric conditions warranting discharge or retirement are contained in Enclosure 4., section 13, and include the following general categories:

- Disorders with psychotic features (delusions or prominent hallucinations);
- Affective disorders (mood disorders);
- Anxiety, somatoform dissociative [sic] disorders (neurotic disorders);
- Organic mental disorders;

- Eating disorders.

The DSM-IV lists specific disorders in each of these categories. For example, anxiety disorders include panic disorder, obsessive-compulsive disorder, PTSD, generalized anxiety disorder and several others.

The Instruction, like the implementing service regulations, requires consideration of the illness' effects on members' functioning; in most cases, merely having a condition

listed in the regulation is not a basis for separation. Each category includes an explanation of the severity, lack of response to treatment and/or other factor(s) to be considered in determining whether members should be separated. With psychotic disorders, even a single episode may warrant separation, while affective disorders such as depression warrant disability processing “[w]hen the persistence or recurrence of symptoms requires extended or recurrent hospitalization, or the need for continuing psychiatric support.” (E4.13.3) For anxiety disorders such as PTSD, separation is considered “[w]hen symptoms are persistent, recurrent, unresponsive to treatment, require continuing psychiatric support, and/or are severe enough to interfere with satisfactory duty performance.” (E4.13.4) These are fairly loose measurements, and the Instruction is designed to allow some medical discretion in disability decisions.

The DoD Instruction specifically excludes “personality, sexual, or factitious disorders, disorders of impulse control not elsewhere classified, adjustment disorders, substance-related disorders, mental retardation (primary) or learning disabilities” as grounds for medical processing, noting that these may be the basis for administrative separation. (E4.13.1.4)

The service regulations include Army Regulation (AR) 40-501, Secretary of the Navy Instruction (SECNAVINST) 1850.4E, which covers the Marine Corps as well as the Navy, and Air Force Instruction (AFI) 36-2902. These regulations occasionally differ from the DoD Instruction in language, usually about severity and the like, so that it is always worth reviewing both the Instruction and the service regulation when considering individual cases.

The increased use of anti-depressants and other medications for psychiatric conditions has affected the military’s handling of these cases. Servicemembers are frequently given medication (not always accompanied by therapy) in an effort to stabilize or improve the condition and permit retention in the service. Refusing psychiatric medication can be very difficult, as a practical matter, and may affect entitlement to disability benefits or even the reason for discharge. Under current wartime conditions, monitoring of medication use is often sporadic at best, making it difficult to determine whether there is really sufficient improvement to retain a servicemember, or whether side-effects may exacerbate the psychiatric condition or create other medical problems.

When medical problems are noticed within the first few months of service, soldiers and sailors are sometimes discharged with abbreviated medical proceedings under the medical standards for enlistment or procurement. These are generally stricter than retention standards, so that members with less serious disorders may obtain discharge much more easily at the beginning of their enlistment.

Criteria for Administrative Discharges

In the very old days, prior to 1982, less serious psychiatric conditions could lead to discharge for Unsuitability, a catch-all which included personality disorders, inability

to adapt to military life, performance problems, etc. In 1982, DoD overhauled its administrative discharge system and added, under Convenience of the Government discharges, the new category of ODPMC. Along with Unsatisfactory Performance and Entry Level Performance and Conduct discharges, this replaced the old category of Unsuitability in all of the services. DoD 1332.14, Encl. (3), Part E3.A1.1.3.4.8) allows discharge for:

“other designated physical or mental conditions, not amounting to Disability...that potentially interfere with assignment to or performance of duty.... Such conditions may include but are not limited to chronic seasickness, enuresis, and personality disorder.”

This DoD category has remained unchanged since 1982, but the individual services have made a number of changes. Most have designated personality disorder as a separate discharge category and all have added various other grounds for this discharge.

Personality disorder discharges:

Personality disorders continue to be a common reason for discharge. DSM-IV describes the disorder as:

“an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual’s culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment.”

They are considered conditions of character or personality rather than mood or cognition, extremely resistant to treatment, and likely to cause difficulties in occupational functioning and interpersonal interactions. The DSM currently lists ten specific personality disorders in addition to personality disorder not otherwise specified. A diagnosis of personality disorder is insufficient without the specific type.

The DoD Directive states that:

“separation on the basis of a personality disorder is authorized only if a diagnosis by a psychiatrist or psychologist, completed in accordance with procedures established by the military Department concerned, concludes that the disorder is so severe that the member’s ability to function effectively in the military environment is significantly impaired.” (Enc. 3, Part E3.A1.1.3.4.8.3)

Under this requirement, an opinion about severity and interference must be made by a military psychiatrist or psychologist. A commander’s conclusion that the condition is so severe that it interferes with duty is insufficient, and in fact is not required in the Directive. A psychiatrist’s opinion that a personality disorder is severe should not require discharge unless he or she finds that this severity causes interference with performance. These points are sometimes lost on military psychiatrists and commands.

The Army has placed personality disorders in a separate discharge section, AR 635-200, Chapter 5, Section 5-13. The regulation gives a detailed explanation of personality disorders, and distinguishes combat exhaustion and other “acute situational maladjustments,” which are not bases for this discharge. The requirement of a psychiatric opinion on severity and interference with duty parallels the DoD language. There is no stated requirement for other evidence of performance problems.

Navy and Marine Corps standards are found in SECNAVINST 1910.4B, but the services tend to rely on their individual regulations in discharge proceedings. Navy commands use Naval Military Personnel Manual (MILPERSMAN) Section 1910-122 for personality disorders. This section does not follow the DoD and SECNAV Instruction carefully on the requirement of severity. Section 1910-122, Para. 2.a, is vague, so that it is not clear that the determination must come from a mental health professional rather than the command. Para. 6.b states that discharge processing is appropriate when a mental health practitioner makes the required determination about severity and impairment (6.b. (1)) or “where there is documented evidence that the diagnosed personality disorder interferes with the member’s performance of duty (6.b.(2)).” Subsection (1) states that the psychiatric evaluation is for command use in determining the proper course of action, and is not in itself justification for discharge. Subsection (2) does not make any reference to severity at all. Since this is not in keeping with the controlling DoD Directive and Navy Instruction, it raises useful arguments for sailors whose diagnoses are “light” and who wish to be retained as well as those whose doctors diagnose disorders so severe that ability to function effectively is significantly impaired, but whose commands wish to retain them because of prior good performance.

The Marine Corps has also separated personality disorder discharge from other conditions, in Marine Corps Separation and Retirement Manual (MARCORSEPMAN) Section 6203.3. This more closely matches the language of the DoD Directive, but requires two forms of documentation: a psychiatrist’s or psychologist’s opinion that “the disorder is so severe that the Marine’s ability to function effectively in the military environment is significantly impaired” and “written nonmedical evidence....to show specific examples of how the Marine is unable to function in the Marine Corps.” (6203.3.b.(2))

The Air Force has come up with its own grouping of discharge categories. AFI 36-3208, Section 5.11 includes a discharge category of Conditions that Interfere with Military Service. Subsection 5.11.9 lists mental disorders, and 5.11.9.1 covers personality disorders. The Air Force makes the need for a psychiatric finding on severity quite clear for personality disorders and the other mental disorders in 5.11.9, but normally requires other evidence of performance problems:

“This [psychiatric or psychological] report must state that the member’s ability to function effectively in the military environment is significantly prepared. This report may not be used as, or substituted for, the explanation of the adverse effect of the condition on assignment or duty performance.”

The Air Force stands alone in requiring some oversight where commands fail to act on appropriate psychiatric findings about personality disorders or other mental disorders:

“When a psychiatrist or psychologist confirms a diagnosis of a mental disorder, under paragraph 5.11.1 [sic], that is so severe that the member’s ability to function effectively in the military environment is impaired and the commander chooses not to initiate separation action, the commander must have that decision reviewed by the discharge authority.” (Section 5.11)

Although the DoD Directive makes no mention of this, the services generally omit or simply ignore requirements of actual interference with performance, or counseling regarding performance, where mental health professionals conclude that the personality disorder is a danger to the member or others.

Many observers believe that personality disorders are diagnosed too frequently in the military. The diagnosis may be made when more serious disorders are missed, when command exaggerates performance and behavioral problems in referrals to psychiatrists, when servicemembers’ anger and frustration with the military are mistaken for the disorders, or when psychiatrists use the category to help soldiers get out or make soldiers go away.

For servicemembers seeking discharge, this is sometimes a convenient option, often requiring less time and documentation than, for example, conscientious objection or family hardship. At the same time, counselors and attorneys should assist clients in determining whether they are comfortable with the presence of a psychiatric diagnosis in their records, the possible effects on employment, and the absence of medical benefits for the condition.

The other designated conditions:

DoD 1332.14 gives the services discretion to make their own additions to ODPMC, and all have done so. Because a number of changes and additions have been made since Helping Out was published, they are listed here in detail, including those which are not psychiatric in nature. The most recent and notable changes have occurred in the Navy, which in September, 2004, expanded its list of other conditions from six to twenty five. All of the services except the Marine Corps have added specific psychiatric conditions which were not previously grounds for discharge, and the Marine Corps has recently added general phrasing which may be a prelude to such additions.

These changes may be in part a reflection of psychiatry’s and society’s increasing attention to psychiatric conditions such as sleep disorders, learning disorders, adjustment disorders, etc. To some extent, they may be a response to successful challenges to military attempts to discharge members for personality disorders on the basis of entirely different disorders and conditions which did not warrant this discharge. The changes certainly give

commands greater latitude in eliminating problem soldiers or sailors. At the same time, strict language about interference with performance allows commands to retain many members with these conditions so long as they can be made to do their jobs.

AR 635-200, Chapter 5, part 5-17, covers other designated physical or mental conditions, separate from personality disorders and from conditions which would have precluded enlistment. They may include but are not limited to:

- (1) Chronic airsickness.
- (2) Chronic seasickness.
- (3) Enuresis.
- (4) Sleepwalking.
- (5) Dyslexia.
- (6) Severe nightmares.
- (7) Claustrophobia.
- (8) Other disorders manifesting disturbances of perception, thinking, emotional control or behavior sufficiently severe that the soldier's ability to effectively perform military duties is significantly impaired."

A medical or mental status evaluation is required in each of these conditions. This may suffice for the "documentation confirming the existence" of the condition, required by 5-17.b. Only conditions in item (8) require a showing of severity. In all other cases, it seems to be sufficient for commanders and separation authorities to determine that the condition "potentially interferes with assignment to or performance of duty." Even in item (8), there is no requirement that the opinion about severity be made by a doctor, psychologist, or commander.

MILPERSMAN 1910-120 was revised effective 23 September 2004 as part of Change 8 to the Manual. It now includes a number of new conditions (parentheses below are from the text; brackets show this author's comments):

- (1) Enuresis (bedwetting). [listed in the prior version]
- (2) Sleepwalking and/or somnambulism. [treated as one condition in the prior version]
- (3) Dyslexia and other learning disorders.
- (4) Attention deficit hyperactivity disorder.
- (5) Stammering or stuttering.
- (6) Incapacitating fear of flying confirmed by psychiatric evaluation.
- (7) Airsickness, motion sickness, and/or travel sickness. [prior version had only the first two]
- (8) Phobic fear of air, sea, and submarine modes of transportation.
- (9) Uncomplicated alcoholism or other substance use disorder. [unless other sections are revised, this will be available in addition to drug or alcohol rehab failure and misconduct/drug abuse]
- (10) Personality disorders (not meeting criteria to justify separation under MILPERSMAN 1910-122). [there no specific requirement of severity]

- (11)Mental retardation.
- (12)Adjustment disorder.
- (13)Impulse control disorders.
- (14)Sexual gender and identity disorders paraphilias. [sic] [in the past these were processed under the Secretarial plenary authority of the Best Interests of the Service discharge, where they were not specifically listed]
- (15)Factitious disorders. [intentional manifestation of physical or psychological signs or symptoms in order to assume the sick role—not for purposes of malingering or other gain]
- (16)Obesity. [listed elsewhere in the prior version]
- (17)Overheight [in the prior version]
- (18)Pseudofolliculitis barbae of the face and/or neck. [an inflammation of the beard follicles caused by ingrown hairs, usually preventing shaving; found most often among African-American men]
- (19)Medical contraindication to the administration of required immunizations.
- (20)Significant allergic reaction to stinging insect venom. [prior version just mentioned allergies]
- (21)Unsanitary habits. [venerable Navy euphemism for repeated venereal disease, not recently in the regs]
- (22)Certain anemias – in the absence of unfitting sequelae—including G6PD deficiency, other inherited anemia trait, and Von Willebrand’s Disease.
- (23)Allergy to uniform clothing or wool. [prior version mentioned only allergies]
- (24)Long sleeper syndrome.
- (25)Hyperlipidemia. [excess lipids in the blood]

Anorexia and bolimia nervosa, eating disorders mentioned in the prior version, have been removed, but are found in the SECNAV Instruction on medical standards for retention, as in the DoD Instruction.

The MILPERSMAN does not require that these conditions be diagnosed as so severe as to interfere with performance of duties, but only that they “affect potential for continued naval service” and “impair a member’s performance.” (para. 2.a) However, discharges are not to be approved unless there is documentation from a medical officer that the condition prevents members from completing their service, even in another job or location. In member-initiated discharges, there must also be a showing that all medical avenues of relief have been exhausted.

The Marine Corps has recently renamed this discharge category. MARCORSEPMAN 6203.2 was titled Physical Conditions Not a Disability; and is now simply Conditions Not a Disability. No specific psychiatric conditions are listed. The general language now mentions physical “or mental” conditions which are apparently beyond the members’ control but do not constitute a disability. The language here is very general, not tied to psychiatric diagnosis or to a specific determination that the condition is so severe as to interfere with effective functioning. The only listed conditions are:

- (1) Obesity, where due to pathological factors, not of a temporary nature, and apparently beyond the Marine’s control.

- (2) Bed wetting (enuresis)
- (3) Sleepwalking
- (4) Chronic air sickness
- (5) Chronic motion sickness
- (6) Pseudofolliculitis barbae
- (7) Allergy, including but not limited to allergy to clothing, boots, bedding and bee stings, or illness such as asthma or hay fever
- (8) Disqualifying height “when, after a proper enlistment, a Marine cannot be assigned duties appropriate to grade and MOS due to increased height.”
[Commands are encouraged to explore reassignment options in these cases.]
- (9) “Any additional physical condition which interferes with duty, as determined by the commanding officer and medical officer, that is not considered a physical disability.”

Although no specific mental conditions have been added, and the language of item (9) has not been expanded to include mental conditions in general, the change in title and introductory language raise the possibility that other conditions may be added in the future.

Unlike 6203.3, personality disorders, 6303.2 does not discuss non-medical documentation of the effect on performance.

Interestingly, MARCORSEPMAN 6203.2.b lists another Condition Not a Disability, refusal of medical treatment, when the refusal interferes with duty. The language is fairly complex, allowing for several different approaches to discharge, depending in part on the reasonableness of the refusal. This reason for discharge is distinguished from refusal of inoculations, which may be a basis for disciplinary action and/or misconduct discharge.

The Air Force combines personality disorder and other conditions in AFI 36-3208, section 5-11, Conditions that Interfere with Military Service. Reasons for discharge include:

- 5.11.1 Enuresis, if there is no underlying pathology.
- 5.11.2 Sleepwalking.
- 5.11.3 Dyslexia.
- 5.11.4 Severe nightmares
- 5.11.5 Stammering or stuttering of such a degree that the airman is normally unable to communicate adequately.
- 5.11.6 Incapacitating fear of flying confirmed by a psychiatric evaluation.
- 5.11.7 Airsickness.
- 5.11.8 Claustrophobia
- 5.11.9 Mental disorders. ...
 - 5.11.9.1 Personality disorders.
 - 5.11.9.2 Disruptive behavior disorders.
 - 5.11.9.3 Impulse control disorders.

5.11.9.4 Other disorders, as defined in DSM-IV that interfere with duty performance and are not within the purview of the medical disability process.

5.11.10 Transgender or gender identity disorder of adolescence or adulthood, nontranssexual type.

5.11.11

Discharge for any of these conditions normally requires a commander's determination that the condition interferes with assignment or duty performance and, with the exception of enuresis and sleepwalking, an explanation of adverse, an explanation of why the condition interferes. This must be supported by documentation, though there is no general explanation of the type of documentation. Presumably medical diagnoses or assessments would be needed for some of the conditions. The subcategory of mental disorders also requires a psychiatrist's or psychologist's report confirming the diagnosis and stating that the disorder is so severe as to significantly impair the member's effective functioning in the military environment, expanding this requirement to mental conditions other than personality disorders. (5.11.9) It is noteworthy that transsexualism and gender identity disorder are not subsumed under the mental disorders. They require psychiatric or psychological confirmation, but no medical opinion about "severity." Section 5.11's introductory paragraph also states that psychiatric reports may not be used as or substituted for an explanation of the condition's adverse effect on assignment or performance.

The expansion of these categories give all of the services except the Marine Corps wide latitude in discharge servicemembers with conditions which may not be severe in themselves, but which interfere with duty performance. In addition to increased numbers of specified conditions, the Air Force and Army allow discharge for unspecified mental conditions which meet the overall criteria for effect on performance. The Navy reg makes it clear that conditions warranting discharge are not limited to those listed.

Perhaps the most striking development is the inclusion of adjustment disorders, which are considered transient and usually responsive to therapy. While impact on performance or potential performance must still be shown, this basis for discharge in the Navy and Air Force (and the possibility of its use under the broad language about psychiatric disorders in the Army regulations) may allow discharge for many who would not otherwise be eligible. In addition, this and other relatively mild psychiatric diagnoses may carry less social stigma than diagnoses of personality disorders or more serious Axis I disorders.

Discussion with other counselors and with attorneys suggests that many of these conditions are seldom used. While this may be in part a matter of the number of people affected by such conditions, it seems likely that some of this is a matter of unfamiliarity. Commands are often unaware of the possibility of discharge on new grounds or on grounds not in use for some time. Servicemembers are less likely than their commands to know the details of the regs and the specific conditions warranting discharge. In addition, the less common grounds for discharge are not widely known among military counselors and civilian or military attorneys, so that they are not always mentioned in the course of discharge counseling, or argued as a basis for discharge when diagnosed. Because this is a

significant area in which military regulations and practice appear to be changing, readers are encouraged to assist in gathering and sharing information about the availability and use of these discharges through the Military Law Task Force and the GI Rights Network.

This memo was first written for the Winter, 2004, issue of the MLTF newsletter, On Watch, and is intended as the first in a series on military psychiatric issues. The author is Kathleen Gilberd, a legal worker in San Diego, California, and co-chair of the MLTF.

ABOUT THE MILITARY LAW TASK FORCE

The NLG Military Law Task Force includes attorneys, legal workers, law students and "Barracks lawyers" interested in draft, military and veterans issues. The Task Force publishes *ON WATCH*, produces interim mailings on legal and political issues for Task Force members, sponsors seminars and workshops on draft, military and veterans law, produces educational materials on these issues, and provides support for members on particular cases or projects. It sponsors legal and educational work on military dissent, the rights of servicemembers, and challenges to oppressive military policies.

The Task Force encourages comments, criticisms, assistance and membership from Guild members and others interested in military, draft or veterans law. If you would like to become a member of the Task Force, or simply want more information about our work, please write the Task Force or call us at 619-233-1701 or 415-566-3732.