



MILITARY PSYCHIATRIC POLICIES AND DISCHARGES

AN INTRODUCTION FOR ATTORNEYS AND COUNSELORS

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This memo includes a summary of the psychiatric diagnostic system used by the military, discussion of psychiatric criteria for medical discharge or retirement and for administrative discharges and some practical counseling suggestions for attorneys and counselors handling such 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 with CCCO's 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 (now called Conditions and Circumstances Not Constituting a Disability) 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 wars in Iraq and Afghanistan, counselors and attorneys have seen increasing numbers of clients with psychological symptoms or diagnoses. In many cases, their conditions have been ignored by commands. All too often, soldiers with serious depression or other disorders are deployed to combat zones without adequate psychiatric evaluation or support. 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), traumatic brain injury (TBI) or depression are similarly ignored. In some cases, soldiers disclosing psychiatric problems or showing symptoms of them have been accused of malingering or cowardice. Servicemembers may face unwarranted discharge for psychiatric problems when none are present, while those seeking medical or administrative discharge on that basis often run into intransigence from commands and military doctors. 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 noted a tendency among military psychiatrists and psychologists to misdiagnose serious disorders such as major depression, PTSD 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 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 it 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 counselors or attorneys 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 medical care and can be persuasive with commands, medical officers and military psychiatrists or psychologists. Another advantage of civilian evaluations is that unhelpful reports need not be presented to the command or military doctors, whereas military evaluations become part of members' permanent records.

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 often 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 preenlistment psychiatric conditions or 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 illegal drug use to military psychiatrists normally face involuntary discharge. In one Navy case, statements about symptoms made during a psychological 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 improperly affect performance evaluations, promotions, desirable assignments and career prospects. In addition, information or misinformation about psychiatric problems may become a matter of common knowledge within commands. Informal harassment of members with obvious emotional problems or with known psychiatric diagnoses is common; such abuse is, of course, all the more difficult to handle when members are trying to cope with emotional distress in the first place. Conversely, commands may ignore the information provided by the members' medical professionals, including temporary profiles, and so put members at risk. In many of these cases, counselors or attorneys can assist clients in seeking redress of their problems, often through complaints under Article 138 of the UCMJ (see MLTF's memo, "[Article 138 Complaints](http://nlgmltf.org/military-law-library/publications/article-138/)" at <<http://nlgmltf.org/military-law-library/publications/article-138/>>) or through Congressional inquiries.

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 inquiring about military service. Veterans are routinely asked to provide copies of their DD-214 discharge documents when applying for jobs. When a DD-214 notes medical discharge or retirement or Conditions and Circumstances Not Constituting a Disability, the diagnosis is not normally given, but employers commonly ask, despite the protections of federal law. In personality disorder discharges, those words are normally used as the narrative reason for discharge on the DD-214.

In recent years, Congress has become increasingly critical of the military's mistreatment of members with psychiatric problems, and particularly the tendency to treat the symptoms of such problems as misconduct warranting punishment or involuntary discharge. As a result, Congress has required changes to military regulations to ensure that servicemembers facing misconduct discharges and the like (particularly those who have served in combat areas) have mental health evaluations to determine whether psychiatric problems contributed to, mitigated, or caused the alleged misconduct. While these changes are beyond the scope of this memo, counselors and attorney are encouraged to follow the changes in MLTF's newsletter, *On Watch*.

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. Nontraditional psychiatric diagnoses and therapy are normally treated with contempt in the military setting. The military uses the classifications, definitions and criteria set out in the *Diagnostic and Statistical Manual of Mental Disorders of the APA, Fifth Edition (DSM-5)*. This manual attempts to define individual psychiatric disorders, listing specific symptoms and criteria for each and often including detailed discussion of conditions which may be related to or mistaken for others. DSM-5 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 but considered symptomatic of illness in another. A few military regulations, which have not been recently updated, refer to prior versions of the DSM, usually DSM-IV-TR (revised), but military evaluations and decisions should be based on DSM-5.

DSM-5, unlike its predecessors, does not use “Axes” to divide groupings of mental, medical and social problems, though older military regulations and psychiatric reports may use this system. Axis I was used to report the vast majority of psychiatric conditions, from schizophrenia and PTSD to sleep disorders and short-term adjustment disorders. Axis II included personality disorders and mental retardation. Axis III was 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.

DSM-5 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 disorder such as anxiety or panic disorder requires immediate treatment, and considered later when the other disorder becomes stable or remits. An R/O, or rule out, diagnosis is provisional, usually a doctor’s initial guess but occasionally a final diagnosis after hospitalization or treatment.

The DSM 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 mental health practitioners and military counselors or attorneys 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 diagnoses, obtain independent evaluations, and seek or object to discharge based on the military diagnoses. 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 disorders such as major depression, anxiety or schizophrenia may be grounds for medical discharge or retirement, usually depending on their severity and amenability to treatment. Personality disorders, 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 conditions such as adjustment disorders were not grounds for administrative or medical discharge in the past, largely because they are expected to have less effect on performance of duties and to improve with time or treatment. However, such conditions have more recently become common grounds for administrative discharge.

Commanders may discharge soldiers and sailors fairly easily 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, including more serious ones, 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 Conditions and Circumstances Not Constituting a Disability to include some of these diagnoses, with variation from service to service; this discharge is more commonly used after the first six months of service.

Criteria for Disability Discharge and Retirement

For a general introduction to the military medical discharge/retirement system, readers are referred to MLTF's "[Military Medical Policies](http://nlgmtf.org/military-law-library/publications/military-medical-policies/)" memo, available at <http://nlgmtf.org/military-law-library/publications/military-medical-policies/>, with an update in the [October, 2015, issue of MLTF's newsletter, On Watch](http://nlgmtf.org/wp/wp-content/uploads/2015/10/2015xxvi1.pdf), at <http://nlgmtf.org/wp/wp-content/uploads/2015/10/2015xxvi1.pdf>. Major changes in procedures for medical discharge and retirement have occurred in the last several years, and an understanding of the system is essential for servicemembers trying to navigate it, and for counselors and attorneys assisting them. Relatively few changes have been made in the medical conditions warranting medical discharge/retirement.

Medical disability separations may result from serious psychiatric disorders such as major depressive disorders, PTSD, other anxiety disorders, schizophrenia and the like. In very broad 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 1332.18; this Instruction sets out, in Enclosure 3, Appendix 2, very general standards for determining whether medical conditions render a servicemember unfit for military service:

- a. A Service member will be considered unfit when the evidence establishes that the member, due to disability, is unable to reasonably perform duties of his or her office, grade, rank, or rating, including those during a remaining period of Reserve obligation.
- b. A Service member may also be considered unfit when the evidence establishes that:
 - (1) The Service member's disability represents a decided medical risk to the health of the member or to the welfare or safety of other members; or
 - (2) The Service member's disability imposes unreasonable requirements on the military to maintain or protect the Service member.

More specific guidelines for psychiatric conditions warranting discharge or retirement are left to the individual services and their regulations. These 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) 48-123. The service regulations occasionally differ in language so that it is always worth reviewing the specific service regulation when considering individual cases.

AR 40-501, Chapter 3, lists these conditions:

3-31. Disorders with psychotic features

The causes for referral to an MEB [medical evaluation board, normally the first step in military discharge or retirement] are as follows:

- a. Diagnosed psychiatric conditions that fail to respond to treatment or restore the Soldier to full function within 1 year of onset of treatment.
- b. Mental disorders not secondary to intoxication, infections, toxic, or other organic causes, with gross impairment in reality testing, resulting in interference with social adjustment or with duty performance.

3-32. Mood disorders

The causes for referral to an MEB are as follows:

- a. Persistence or recurrence of symptoms sufficient to require extended or recurrent hospitalization; or
- b. Persistence or recurrence of symptoms necessitating limitations of duty or duty in protected environment; or
- c. Persistence or recurrence of symptoms resulting in interference with effective military performance.

3-33. Anxiety, somatoform, or dissociative disorders

The causes for referral to an MEB are as follows:

- a. Persistence or recurrence of symptoms sufficient to require extended or recurrent hospitalization; or
- b. Persistence or recurrence of symptoms necessitating limitations of duty or duty in protected environment; or
- c. Persistence or recurrence of symptoms resulting in interference with effective military performance.

3-34. Dementia and other cognitive disorders due to general medical condition

The causes for referral to an MEB include persistence of symptoms or associated personality change sufficient to interfere with the performance of duty or social adjustment.

3-37. Eating disorders

The causes for referral to an MEB are eating disorders that are unresponsive to treatment or that interfere with the satisfactory performance of duty.

SECNAVINST 1850.4E lists unfitting psychiatric conditions in Enclosure (8), Section 8013. These include:

- b. Disorders with Psychotic Features (Delusions or prominent Hallucinations). One or more psychotic episodes, existing symptoms or residuals thereof, or a recent history of a psychotic disorder.
- c. Affective Disorders (Mood Disorders). When the persistence or recurrence of symptoms requires extended or recurrent hospitalization, or the need for continuing psychiatric support.
- d. Anxiety, Somatoform, Dissociative Disorders (Neurotic Disorders). When symptoms are persistent, recurrent, unresponsive to treatment, require continuing psychiatric support, and/or are severe enough to interfere with satisfactory duty performance.
- e. Organic Mental Disorders. Dementia or organic personality disorders that significantly impair duty performance.
- f. Eating Disorders. When unresponsive to a reasonable trial of therapy or interferes with the satisfactory performance of duty.

AFI 48-123, Chapter 5, includes:

5.3.12.1. Any psychotic episode other than those with a brief duration, good prognosis and clearly identifiable and reversible cause must meet MEB.

5.3.12.2. Mental conditions requiring MEB:

5.3.12.2.1. Conditions that are expected to have persistent duty impairment (more than 1 year despite treatment).

5.3.12.2.2. Conditions associated with recurrent duty impairment (2 or more episodes of impairment in 12 months).

5.3.12.2.3. Conditions which require continuing psychiatric support (e.g. weekly psychotherapy in order to function) beyond one year.

5.3.12.2.4. Conditions requiring use of lithium, anticonvulsants, or antipsychotics for mood stabilization.

5.3.12.2.5. Individuals who experience recurrent depression or anxiety disorders, require psychiatric medication for greater than one year, who have been hospitalized for a psychiatric condition, require an evaluation by a military mental health provider.

These cases warrant careful consideration of fitness for duty, worldwide assignability and deployability, given that adequate mental health support may not be available in all locations. Serious psychiatric illnesses (refer to criteria in 5.3.12.2.1-4 above) that result in hospitalization require a MEB. For ANG members on long-term antidepressant maintenance therapy even if asymptomatic or in remission, a WWD [worldwide deployability] evaluation must still be forwarded to ANG/SGPA for consideration.

The DSM-5 lists specific disorders in each of these categories. For example, anxiety disorders include panic disorder, obsessive-compulsive disorder, generalized anxiety disorder and several others.

The disability regulations exclude personality disorders, most sexual disorders, disorders of impulse control, adjustment disorders, substance-related disorders, learning disabilities and the like as grounds for medical processing. Instead, these form the basis for administrative discharges authorized by the command structure.

The Instruction and the implementing service regulations require consideration of an illness' effects on members' functioning; in most cases, merely having a condition listed in the service regulation is not a basis for a finding of unfitness and medical retirement or 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 mood disorders such as depression generally require resistance to treatment, a need for very long-term treatment, or significant interference with duty performance. These are fairly loose measurements, and the regulations are designed to allow some medical discretion in disability decisions.

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. While members are entitled to refuse medical treatment, in some cases it may affect entitlement to disability benefits or even the reason for discharge. Under current wartime conditions, monitoring of medication use is often sporadic, 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. (See, for example, AR 40-501, Chapter 2.) 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. Unless the condition has been "aggravated" by military service, medical retirement and its benefits are not available in these cases.

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 Other Designated Physical and Mental Conditions (later changed to Conditions and Circumstances Not Constituting a Disability). Along with Unsatisfactory Performance and Entry Level Performance and Conduct discharges, this replaced the old category of Unsuitability in all of the services. DoD Instruction 1332.14, which governs

administrative discharges, uses this separation category for physical or mental conditions which do not amount to an unfitting disability, but actually or potentially interfere with assignment to or performance of duties. With the 1982 change, DoD 1332.14 said that these conditions included but were not limited to chronic seasickness, enuresis, and personality disorder. While the service regulations initially followed this general language, they have more recently expanded the list of conditions significantly. Most have designated personality disorder as a separate discharge category and all have added various other grounds for this discharge.

DoD 1332.14, Enclosure 3, Part (8).c.1. states that discharge is only authorized for mental disorders if:

A diagnosis by an authorized mental health provider as defined in DoDI 6490.04 (Reference (i)) utilizing the Diagnostic and Statistical Manual of Mental Disorders (Reference (j)) and, 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.

Thus, as with disability discharge or retirement, the existence of a psychiatric condition alone is theoretically insufficient to warrant discharge. A psychiatrist or psychologist must make a determination not only of severity, but of impairment of functioning in the military. In some services, the command must also conclude that performance is impaired. The DoD Instruction and the services require that members be formally counseled, in writing, about performance deficiencies, and given an opportunity to overcome these deficiencies, before discharge may be initiated. Command failure to do so is common, and may be used to challenge involuntary administrative discharges under these regulations.

Administrative discharge procedures for Conditions and Circumstances Not Constituting a Disability are discussed in some detail in MLTF's memo, "[Representing Servicemembers in Involuntary Discharge Proceedings](http://nlgmtf.org/military-law-library/publications/involuntary-discharge/)," available at <<http://nlgmtf.org/military-law-library/publications/involuntary-discharge/>>.

Personality Disorder Discharges

For many years, personality disorders were a common reason for both voluntary and involuntary discharge. In many cases, servicemembers with PTSD, depression, anxiety or other serious disorders were under-diagnosed with personality disorders and so administratively discharged rather than medically retired with benefits. In other cases, the diagnosis was given on the basis of non-conformist behavior, whistleblowing, or other actions disliked by commands. To make matters worse, personality disorders were and are the only psychiatric-related discharge in which the diagnosis is listed on DD-214 discharge documents, rather than general language such as Conditions and Circumstances Not Constituting a Disability or Other Designated Physical and Mental Conditions.

After significant attention to these problems by national media and then by Congress, the military was forced to revise its policies. The regulations were changed to require psychiatrists and psychologists to look at a member's long-term behavior, including pre-enlistment behavior, when making a personality disorder diagnosis, to see if that behavior reflected the normally long-standing pattern of a personality disorder. In addition, for servicemembers who were in combat areas, or had been within the previous 24 months, personality disorder discharges could not be given without consideration of the possibility that PTSD or "other mental illness co-morbidity" were present. For such members who had been previously diagnosed with PTSD or TBI, or reasonably asserted that they had one of these conditions, DoD 1332.14 now requires a second opinion by an equivalent-level mental health professional on the personality disorder diagnosis, and a review at the service's surgeon general's office, before members could be discharged.

To no one's great surprise, the number of personality disorder diagnoses and discharges decreased dramatically almost immediately after these changes were made. This was, however, matched by a significant increase in discharges based on the relatively mild psychiatric diagnosis of adjustment disorder (see below). Nevertheless, some servicemembers are still discharged on the basis of personality disorders, and the category deserves attention from attorneys and counselors.

DSM-V describes personality disorder generally 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.

Personality disorders 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 eleven specific personality disorders in addition to other specified and unspecified personality disorders, commonly noted as "not otherwise specified." These include paranoid, schizoid, schizotypal, antisocial, borderline, histrionic, narcissistic, avoidant, dependent, and obsessive-compulsive personality disorders and personality change due to another medical condition. A diagnosis of personality disorder is insufficient without the specific type.

The DoD Instruction states at Enclosure 3, Part 8.c.1, that discharge for personality disorder is warranted when:

1. A diagnosis by an authorized mental health provider as defined in DoDI 6490.04 (Reference (i)) utilizing the Diagnostic and Statistical Manual of Mental Disorders (Reference (j)) and, 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.

a. The onset of personality disorder is frequently manifested in the early adult years and may reflect an inability to adapt to the military environment as opposed to an inability to perform the requirements of specific jobs or tasks or both.

b. Observed behavior of specific deficiencies should be documented in appropriate counseling or personnel records. Documentation will include history from supervisors, peers, and others, as necessary to establish that the behavior is persistent, interferes with assignment to or performance of duty, and has continued after the enlisted Service member was counseled and afforded an opportunity to overcome the deficiencies.

Under the DoD and service regulations, an opinion about severity and interference with duties 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 Instruction. A psychiatrist's opinion that a personality disorder is severe should not, in theory, require discharge unless he or she finds that this severity causes interference with performance. At the same time, it should be supported by command documentation of actual performance problems. These points are sometimes lost on military psychiatrists and commands.

The Army has placed personality disorders in a separate Convenience of the Government 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. The regulation states that evidence of actual performance problems should be documented. Unlike the other services, the Army discharges soldiers for personality disorders only if they have served less than 24 months when discharge proceedings are initiated; those who have served longer may be discharged under Section 5-17, which technically does not include personality disorders.

The Navy uses Naval Military Personnel Manual (MILPERSMAN) Section 1910-122 for personality disorders. This section does not follow the DoD 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 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 Instruction, 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 impaired. 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)

For servicemembers seeking discharge, this may sometimes be 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 ensure clients are comfortable with the presence of a psychiatric diagnosis on their DD-214s, the possible effects on employment, and the absence of medical benefits for the condition.

Adjustment Disorder Discharges

As noted above, the constraints placed on personality disorder discharges led to a sharp decrease in these discharges and an equally sharp increase in administrative discharges based on adjustment disorders, as medical personnel and commands looked for other methods to discharge unwanted members who had previously been separated for personality disorders. Here, too, the discharge has often been an under-diagnosis of PTSD or other more serious conditions, or a diagnosis for members whose problems were not psychiatric, but rather issues of conformity to military culture, whistleblowing, dissent and the like.

Because of the dramatic increase in adjustment disorder discharges and their frequent role as an under-diagnosis of PTSD or other unfitting conditions, Congress soon required the same consideration for adjustment disorders as for personality disorder discharges for members who had served in a combat area within the previous two years—a second opinion by an equivalent mental health professional and surgeon general level review of the diagnosis. In doing so, Congress expanded these requirements to all mental disorders included in Conditions and Circumstances Not Constituting a Disability, and the DoD Instruction was amended accordingly. These requirements are not as well known as the parallel requirements for personality disorders, and so are not uniformly carried out.

DSM-5 includes adjustment disorders under a general category of “Trauma- and Stressor-Related Disorders.” The diagnostic criteria include:

- A. The development of emotional or behavioral symptoms in response to an identifiable stressor(s) occurring within 3 months of the onset of the stressor(s).
- B. These symptoms or behaviors are clinically significant, as evidenced by one or both of the following:
 - 1. Marked distress that is out of proportion to the severity or intensity of the stressor, taking into account the external context and the cultural factors that might influence symptom severity and presentation.
 - 2. Significant impairment in social, occupational, or other important areas of functioning.
- C. The stress-related disturbance does not meet the criteria for another mental disorder and is not merely an exacerbation of a preexisting mental disorder.
- D. The symptoms do not represent normal bereavement.
- E. Once the stressor or its consequences have terminated, the symptoms do not persist for more than an additional six months.

DoD has recognized that adjustment disorders are occasionally chronic rather than short-term; in such cases, the condition is regarded as unfitting, warranting referral to a medical evaluation board and medical discharge or retirement.

Adjustment disorder discharges have become a common route for servicemembers seeking discharge. Although some of the services consider it only an involuntary (command initiated) discharge, members wanting separation can start the discharge process by obtaining a medical diagnosis of adjustment

disorder with a doctor's recommendation for administrative discharge. While commands are not bound by these recommendations, they commonly follow them. Unlike personality disorder discharges, separations based on adjustment disorder do not result in DD-214 discharge documents stating the diagnosis.

The other designated conditions

DoD 1332.14 gives the services discretion to make their own decisions regarding the specific conditions included in Conditions and Circumstances Not Constituting a Disability, and all have done so. At the same time, each service regulation includes broad language allowing separation for other conditions not included in the listings. Because a number of changes and additions have been made since *Helping Out* was published, the listed conditions are set out here in detail, including those which are not psychiatric in nature. All of the services except the Army have added specific psychiatric conditions which were not previously grounds for discharge, and the Army regulation includes general phrasing which leaves room for such conditions.

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 for discharge for 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. Now titled Convenience of the Government—Physical or Mental Conditions, it includes a number of conditions not previously considered a basis for discharge. The section lists:

- (1) Enuresis (bedwetting).
- (2) Sleepwalking and/or somnambulism.
- (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.
- (8) Phobic fear of air, sea, and submarine modes of transportation.
- (9) Uncomplicated alcoholism or other substance use disorder.
- (10) Mental retardation.
- (11) Adjustment disorder.
- (12) Impulse control disorders.
- (13) Sexual gender and identity disorders paraphilias.
- (14) 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]
- (15) Obesity.
- (16) Overheight.
- (17) 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]
- (18) Medical contraindication to the administration of required immunizations.
- (19) Significant allergic reaction to stinging insect venom.
- (20) Unsanitary habits. [venerable Navy euphemism for repeated venereal disease]
- (21) Certain anemias – in the absence of unfitting sequelae—including G6PD deficiency, other inherited anemia trait, and Von Willebrand’s Disease.
- (22) Allergy to uniform clothing or wool.
- (23) Long sleeper syndrome.
- (24) Hyperlipidemia. [excess lipids in the blood]

The MILPERSMAN does not require that these conditions be diagnosed as so severe as to interfere with performance of duties, but only that they “can 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 renamed this discharge category as the other services began adding new conditions. MARCORSEPMAN 6203.2 was titled Physical Conditions Not a Disability; and is now simply Conditions Not a Disability. The listed conditions are:

- (1) Enuresis
- (2) Sleepwalking and/or Somnambulism
- (3) Dyslexia and Other Learning Disorders
- (4) Attention Deficit Hyperactivity Disorder
- (5) Stammering or Stuttering
- (6) Incapacitating fear of flying confirmed by a psychiatric evaluation
- (7) airsickness, Motion, and/or Travel Sickness
- (8) Phobic fear of Air, Sea and Submarine Modes of Transportation
- (9) Certain Mental Disorders including:
 - (a) Uncomplicated Alcoholism or other Substance Use Disorder
 - (b) Personality Disorders
 - (c) Mental Retardation
 - (d) Adjustment Disorders (except Chronic Adjustment Disorders which are a ratable disability effective 10 April 2013)
 - (e) Impulse Control Disorders
 - (f) Sexual Gender and Identity Disorders and Paraphilias
 - (g) Sexual Dysfunction
 - (h) Factitious Disorder
- (10) Obesity
- (11) Overheight
- (12) Psuedofolliculitis barbae of the face and/or neck MCO 1900.16 26 Nov 2013 6-22 Enclosure (1)
- (13) Medical Contraindication to the Administration of Required Immunizations
- (14) Significant allergic reaction to stinging insect venom
- (15) Unsanitary habits
- (16) Certain Anemias (in the absence of unfitting sequelae) including Glucose-6-Phosphate Dehydrogenase Deficiency (G6PD), other inherited Anemia Trait, and Von Willebrand's Disease.
- (17) Allergy to uniformed clothing or wool
- (18) Long sleeper syndrome
- (19) Hyperlipidemia

Unlike 6203.3, which covered personality disorders, Section 6303.2 does not discuss non-medical documentation of the effect on performance, though the initial referral for psychiatric evaluation is to be done when a Marine's "performance deteriorates or has an adverse effect on others in the unit."

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 and/or severe nightmares.
- 5.11.3 Dyslexia and other learning disorders.
- 5.11.4 Attention deficit hyperactivity disorder.
- 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, or phobic fear of air, sea and submarine modes of transportation.
- 5.11.7 Airsickness, motion and/or travel sickness.
- 5.11.8 Other conditions as outlined in DODI 1332.38, *Physical Disability Evaluation*, Enclosure 5, that interfere with duty performance and are not within the purview of the AFI 36-3212, *Physical Evaluation for Retention, Retirement, and Separation*, disability evaluation system and provided a basis for separation is not addressed elsewhere in this instruction.
- 5.11.9 Mental disorders. ...
 - 5.11.9.1 Personality disorders....
 - 5.11.9.2 Disruptive behavior disorders.
 - 5.11.9.3 Adjustment disorders.
 - 5.11.9.4 Impulse control disorders.
 - 5.11.9.5 Transsexualism or Gender Identity Disorder of Adolescence or Adulthood, Nontranssexual Type (GIDAANT).
 - 5.11.9.6 Other disorders, as defined in DSM that interfere with duty performance or failure to adapt to military environment and are not within the purview of the AFI 36-3212, *Physical Evaluation for Retention, Retirement, and Separation*, and provided a basis for separation is not addressed elsewhere in this instruction.

For the mental disorders, the AFI requires a psychiatric determination that the condition is “so severe the member's ability to function effectively in the military environment is significantly impaired.” It also notes that the psychiatric report “may not be used as, or substituted for, the explanation of the adverse effect of the condition on assignment or duty performance.” All of the listed conditions normally require a commander’s determination that the condition interferes with assignment or duty performance and, with the exception of enuresis and sleepwalking, an explanation of why the condition interferes. This must be supported by documentation of the effect on performance.

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 it is a matter of unfamiliarity. Commands are often unaware of the possibility of discharge on relatively 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 have been 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 was updated in April, 2017. The author is Kathleen Gilberd, a legal worker in San Diego, California, and the executive director 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 military, draft and veterans issues. The Task Force publishes *On Watch*, 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 at 730 N. First Street, San Jose, CA 95112, email us at email@nlgmltf.org or call us at 619-463-2369.