

Caring for Active Duty Military Personnel in the Civilian Sector

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Abstract

Due to the wars in Iraq and Afghanistan, the unmet medical and psychological needs of military personnel are creating major challenges. Increasingly, active duty military personnel are seeking physical and mental health services from civilian professionals. The Civilian Medical Resources Network attempts to address these unmet needs. Participants in the Network include primary care and mental health practitioners in all regions of the country. Network professionals provide independent assessments, clinical interventions in acute situations, and documentation that assists GIs in obtaining reassignment or discharge. Most clients who use Network services come from low-income backgrounds and manifest psychological rather than physical disorders. Qualitative themes in professional-client encounters have focused on ethical conflicts, the impact of violence without meaning (especially violence against civilians), and perceived problems in military health and mental health policies. Unmet needs of active duty military personnel deserve more concerted attention from medical professionals and policy makers.

Key Words: behavioral medicine, health policy, health policy research, mental health, social factors in health and health care, injury, violence

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Combat operations in Iraq, Afghanistan, and elsewhere not only take the lives of US service personnel but also damage the physical and mental health of many who survive. Even though military officials may strive to implement high-quality military health-care,¹ reports originating both inside and outside the military have called attention to the unmet medical and psychological needs of service personnel.²⁻⁸ Some analysts have projected that physical and emotional injuries sustained by US soldiers will become a public health epidemic that will continue to stress the already over-extended U.S. health and mental health systems.⁹⁻¹¹

Several factors may lead active duty GIs* to request independent medical evaluation and treatment outside of the military system. GIs experience a command system and a medical care system where illness and injury may be viewed as obstacles to the military mission, inconveniences to local commands, or malingering.¹² GIs may face deployment to combat zones before full evaluation of physical illnesses. Those GIs with mental health problems such as depression or post-traumatic stress disorder may re-enter combat when newly diagnosed or just beginning a trial of medication.

In addition, the problem of double agency pervades the provision of health and mental health services in the military. Personnel shortages and pressure to deploy and re-deploy troops rapidly to Iraq and Afghanistan place increasing pressure on military physicians. As they encounter GIs with health and mental health problems, military professionals must consider the goals of maintaining the numbers

*The term GI here refers to active duty personnel of any U.S. military services and military reserves. This term historically referred to low-ranked members of the U.S. Army. "GI" originally derived from equipment issued to military personnel ("galvanized iron," later misinterpreted as "government issue" or "general issue").

Table 1. Professional Participants in the Civilian Medical Network (n=51)

Region						
	East	South	West	Central	Mid-West	Southwest
Total	14	3	25	1	4	4
(Percent)	(27)	(6)	(49)	(2)	(8)	(8)
Specialty						
	Primary care	Psychiatry	Psychology/social work/ counseling	Medical/ surgical subspecialties		
Total *	24	11	16	5		
(Percent)	(43)	(20)	(29)	(8)		

Note: Specialties total more than 51 because some participants have more than 1 specialty.

and readiness of combat forces.¹³ These military goals tend to contradict the goal of helping the individual patient. The dual role of military professionals raises inherent tensions that increase GIs' expressed needs for services in the civilian sector.

The Civilian Medical Resources Network is a small, national network of professionals that was established in 2006 to offer GIs an alternative to the military health and mental health care system. The Network consists of professionals in primary care medicine, psychiatry, psychology, social work, and public health who strive to address the needs of active duty US military personnel when they seek medical and psychological care in the civilian sector. Because other civilian resources at least partly address the needs of veterans, the Network focuses on active duty GIs who need medical or psychological help.

In this article, we describe the experiences of the Network and analyze some key policy issues related to the unmet health needs of US GIs. We do not consider the health impact of war on Iraqis and Afghans, a topic that has been reviewed elsewhere.^{14,15}

History, Structure and Activities of the Network

Although individual civilian practitioners had assisted active duty GIs informally since shortly after the onset of the Afghanistan War in late 2001, the Network began coordinated activities in 2006. The creators of the Network had gained experience

in similar support activities during the Vietnam War in the late 1960s and early 1970s,¹⁶ as well as during and after the Persian Gulf War in the 1990s. During those conflicts, groups such as the Medical Committee for Human Rights and the Medical Resistance Union organized efforts to provide physical and mental health services for individuals who sought medical exemption from the military draft and for GIs who requested care in the civilian sector. Due to the lack of a compulsory draft, efforts during more recent years have targeted active duty GIs.

Recruitment of clinicians for the Network occurred initially through personal outreach to professional colleagues. In addition, two national organizations, Physicians for Social Responsibility (with a focus on peace) and Physicians for a National Health Program (with a focus on health care access) announced the program to their members. As of late 2008, 51 professionals were participating in the Network. Participants are predominantly primary care and mental health practitioners and are based in all regions of the country. (Table 1) Professionals receive a brief training in the types of support and documentation that the GIs require.

Patients are referred to the Network from the GI Rights Hotline, a national effort maintained by 25 religious and peace organizations, as well as the Military Law Task Force of the National Lawyers Guild. Legal professionals provide advice to the Network and assist clinicians with documentation

of GIs' medical and mental health problems as needed in support of their requests for discharge or reassignment.^{17,18} During 2008, the Hotline received approximately 3,000 calls per month from active duty GIs and their families. When a GI or family member calls the Hotline and describes unmet needs for physical or mental health services, the Hotline counselor may, at his or her discretion, contact the Network, which then sets up a referral to one or more participating professionals.

Demand for services by the Network has increased steadily. As of late 2008, Network professionals had worked with approximately 200 GIs, and the Network was receiving approximately four new referrals per week. However, due to lack of sufficient outreach at military bases, many military personnel remain unaware of the Network. In addition, the limited number of participating professionals has not allowed the Network to increase substantially the number of referrals.

GIs generally have limited financial resources and insurance coverage for civilian services. Network professionals provide care free or at greatly

reduced cost. When possible, GIs visit Network professionals in person; if a face to face visit proves unfeasible due to geographical distance, Network professionals assist GIs through telephone consultations. Unpaid volunteers coordinate the referral procedures and relationships with the Hotline and Military Law Task Force.

The Network provides independent evaluation and treatment for both medical and psychological problems. In some cases GIs suffering from acute and life-threatening conditions, typically suicidal or homicidal ideation, have been referred to local health or mental health facilities. Network professionals have intervened in these situations to assure adequate physical and/or psychological treatment.

For less acute situations, GIs seek independent assessment of diagnoses made by military medics or physicians, or advice about treatment options and the impact of military service on their illnesses or injuries. Other GIs request independent evaluations for their own peace of mind, or independent treatment because of concerns about the adequacy of services in military clinics. Actions by civilian

Table 2. Clients in the Civilian Medical Resources Network (n = 70)

Gender						
	Male			Female		
Total	62			8		
(Percent)	(89)			(11)		

Region						
	East	South	West	Central	Mid-West	Southwest
Total	11	6	7	5	25	16
(Percent)	(16)	(9)	(10)	(7)	(36)	(22)

Primary Diagnostic Category *						
	Psychiatric				Medical/ Surgical	Don't Ask/ Don't Tell
	Depression		PTSD	Other		
	w/o suicidal or homicidal idea- tion	w/ suicidal or homicidal idea- tion				
Total	13	12	11	19	14	1
(Percent)	(19)	(17)	(16)	(27)	(20)	(1)

* Comorbidities, which occurred frequently, are not indicated. "Don't ask, don't tell" refers to issues regarding lesbian or gay sexual orientation.

professionals may assist GIs in gaining access to military physicians, particularly specialists, and reduce the likelihood that commanding personnel will block or oppose visits to sick call or military hospitals.

Overview of Civilian Medical and Mental Health Services

Coordinators of the Network collected anonymous data concerning 70 consecutive clients who received services from the Network during the years 2007 and 2008 (Table 2). These data were collected during the intake process, through information provided by the GI Rights Hotline counselors and/or an initial conversation between the GI and a Network coordinator. For some clients, clinicians providing care in the Network provided additional qualitative data to the authors via telephone or email.

Regarding patient privacy and informed consent, this report complies fully with the Uniform Requirements of the International Committee of Medical Journal Editors.¹⁹ Although our work does not involve research with human subjects as customarily defined, for the Network we have implemented more than the usual measures to protect our clients, including procedures pertaining to informed consent and protection of anonymity through the de-linking of all identifying data. Because many of our clients are Absent Without Leave (AWOL) and therefore subject to military prosecution, we do not maintain identifying data in hard copy or electronic form that could be subject to subpoena or similar attempts by the US Government or other entities to obtain information about the clients. We have communicated on multiple occasions with legal counsel and with our Institutional Review Board in assuring the ethical dimensions of our work with these clients, who seek civilian-sector services having tried and failed to obtain needed services within the military.

Description of the clients

Eighty-nine percent of the clients were men, although women comprised a similar proportion of clients (11 percent) as their overall proportion among active duty military personnel (15 percent).²⁰ Clients from all regions of the country have

sought services. All but one client reported that they and their families were low-income. About half of the patients were AWOL (absent without leave).

Reasons for consultation

Physical problems comprised 20 percent of referrals to the Network. Seventy-nine percent suffered from psychological conditions. Some typical case histories are presented on the next page.

Certain physical disorders appeared relatively minor, while others proved potentially life threatening. Minor physical disorders included musculoskeletal symptoms, such as back pain and foot pain, and rashes. Potentially life threatening problems involved unexplained seizures, numbness following fractured vertebrae, double vision following fracture of the eye socket in a shrapnel injury, and persistent bleeding from an ear after head injury.

Among mental health diagnoses, post-traumatic stress disorder, anxiety, depression, and substance abuse predominated. Occasionally GIs presented with acute psychiatric emergencies, most often linked to traumatic events. Most GIs with the latter problems feared redeployment to Iraq. Approximately one-fifth of clients reported suicidal ideation and/or suicide attempts, and three GIs reported homicidal ideation. Adverse childhood experiences such as abuse or neglect, a history of sexual assault, and female gender tended to increase the likelihood of GIs' post-traumatic stress disorder and depression. Military professionals have made similar observations.²¹⁻²³

Several features of clients' distress pertained to families. These problems occurred both while GIs remained in combat zones and after they returned home. The problems involved stress focusing on challenges of care-taking responsibilities for non-military family members, intimate partner violence, and marital or partnership dissolution. Studies of combat personnel from the United Kingdom and Canada reached similar findings, especially among reservists.²⁴⁻²⁷

Specific services provided by the Network

Based on their assessment, civilian professionals prepare reports with diagnoses, prognosis, and treatment recommendations. Typical documents

Sidebar. Illustrative Case Summaries*

This Army soldier served in Iraq, where he was assigned to observation points as part of a patrol searching for weapons caches and informants. He was regularly exposed to the dangers of snipers and improvised explosive devices. In January, within a five-day period, two close friends and an acquaintance were killed by roadside bombs. Frequent nightmares followed these incidents. The mission of his unit became devoid of meaning for him. He lost hope in what he was doing and questioned why his unit was in Iraq. Anger occurred for no apparent reason. He began to hate the Iraqi people and to view them as the source of his anguish. The Iraqi children he once loved to see now annoyed him. He had difficulty comprehending instructions and felt that his performance became inadequate. Upon returning to the United States, he made the decision not to return to Iraq. He did not want to pull a trigger ever again. This soldier was suffering from post-traumatic stress disorder, major depressive disorder, and panic disorder.

This young man, a native of a country in sub-Saharan Africa, enlisted in the Army and completed a one-year tour of duty in Iraq. During this time, he witnessed numerous injuries to civilians. Several friends were killed. Upon returning from this tour of duty, he learned quickly that he was to be redeployed to Iraq. In desperation, he left his base and became AWOL. This individual met criteria for post-traumatic stress disorder as well as severe depression.

A GI fell in basic training and injured his right leg and ankle. Then he was thrown on his right side during armed combat practice. With back pain radiating to the right lower extremity and numbness of the right foot, he needed use crutches. At sick call, he was given ibuprofen and tramadol. He felt hassled when he tried to use sick call. He had seen military doctors only but felt uncomfortable with his evaluation and treatment, so he sought civilian medical assessment.

During his tour in Iraq, a GI witnessed the violent deaths of several close friends as well as Iraqi civilians. One of his assignments involved removal

of blood and body parts from military vehicles. After he returned to the United States, he suffered from depression, post-traumatic stress disorder, and generalized anxiety. He entered a psychiatric hospital temporarily after one of four suicide attempts. When he learned that his unit was to be redeployed to Iraq, he went AWOL. When he contacted the GI Rights Hotline, he was living with his wife and infant son in a rural area and was working in odd jobs. He learned that military police and the local sheriff's department were trying to find him. During a phone interview, the GI expressed suicidal ideation, as well as an intent to kill specific officers if he were returned to his original unit.

A GI with two fractured vertebrae experienced severe numbness in his legs. When he wore a flack jacket, he could not move his legs. He previously fractured an eye socket, after which surgeons inserted a metal plate; he still experienced double vision and could not focus. Other problems included rectal bleeding and renal insufficiency. When he contacted the GI Rights Hotline, he was scheduled to be deployed to Iraq in about two weeks. Seeking a medical discharge, he went to sick call. He stated that a medic told him that he was in bad shape but that the Army needed him and so would not discharge him. Instead, he was told that he could get physical therapy in Iraq. He had a hard time seeing a doctor because his sergeant kept telling him that he shouldn't go to sick call. The GI requested documentation in connection with his request for discharge and secondarily also sought care for his problems.

A woman called on behalf of her fiancé, who was having seizures, possibly due to a brain lesion. She and the GI were dissatisfied with the military medical evaluation and asked to consult with a civilian physician.

*The authors selected these case summaries because they represent the spectrum of problems that the Network addresses.

are presented in an appendix to this article. When appropriate, Network professionals recommend reduced duties, reassignment, or medical discharge. They also assist patients in interpreting military medical conclusions and recommendations. Civilian professionals' reports contribute to a resolution of difficulties when GIs face court-martial for misconduct such as Absence Without Leave, or in disability proceedings when the military attempts to deny medical or financial benefits to GIs no longer able to perform their duties.

Themes emerging from discussion with clinicians

The following themes emerged from the authors' categorization of clinicians' reports. To be included, each theme arose in reports concerning at least 5 clients.

The Economic Draft: Most GIs enlisted due to economic challenges or lack of employment opportunities. In addition to low-income financial conditions, many GIs came from ethnic/racial minority backgrounds or were born in third world countries.

Deception: Psychological problems among GIs and reservists included perceived deception in recruiting processes, as well as longer and more frequent tours of duty than promised. Reservists usually did not expect combat duty.

Ethical Dilemmas and Violence Without Meaning: Physical and emotional problems derived from the witnessing or perpetrating violence without a sense that the violence led to progress in meeting military, political, or social goals. GIs frequently reported that they did not understand the purpose of military involvement in Afghanistan or Iraq. Many of the violent acts perpetrated against civilians, especially children, generated guilt, depression, and post-traumatic stress disorder. Such violence frequently involved intentional actions, some ordered by GIs' superior officers and some resulting from GIs' suspicions of armed attacks by combatants presenting themselves as civilians.

Concerns about Military Health Care: GIs re-

ported that military medical professionals frequently diminished the importance of their physical problems. These GIs sought confirmation of their physical problems by civilian professionals as a route to discharge or reassignment to non-combat positions.

Status in the Military: GIs who remained with their units experienced barriers in attempts to contact the Hotline and to receive evaluations through the Network. These barriers resulted primarily from the geographic isolation of military bases. In addition, scheduling problems due to work demands inhibited appointments with civilian professionals. Those GIs who were AWOL encountered fewer difficulties in travel or scheduling problems; however, they experienced deep fears about capture and return to their units.

Privatization of Services: Many clients contacting the Network reported difficulties that they or their families had experienced in obtaining privatized services from managed care organizations contracting with the military. Inconvenience in obtaining services and managed care practitioners' diminishing the importance of clinical problems motivated GIs and their families to seek services in the civilian sector.

The Context of Torture and Publicized Human Rights Abuses: This context has shaped GIs' experiences. Although most GIs using the Network did not engage in torture or other forms of abuse, they expressed awareness of these practices as part of military operations.^{28,29} In their training, GIs learned that such practices contradict historical rules of war such as the Geneva Convention, as well as specific regulations that govern actions by U.S. military forces. In practice, many GIs also learned that officers tolerated and sometimes encouraged the use of torture and similar abuses. This contradiction created stress, stigma, and shame about unethical actions perpetrated by military colleagues. Professionals working with GIs in the Network have noted high levels of shame, a situation that inhibits GIs from seeking help.

Conclusions

The Network has encountered GIs who, along with their families, experience a profound need for supportive services. Professionals in the Network have documented the unmet needs of active duty US GIs as well as some of the contextual problems both creating and sustaining those unmet needs. These contextual problems speak to the larger social issues of an all volunteer Army in an increasingly militarized society.

During the Vietnam War, a military draft led to induction of young people from a broad range of social positions; the current volunteer army depends on men and women predominantly from low-income and minority backgrounds. Although military and veterans' medical care periodically enters public consciousness, especially after scandals (as in the case of Walter Reed Army Hospital³⁰), the predominantly working-class origins of those suffering from the war limits the attention that this issue receives from policy makers and other leaders in the society.

Not surprisingly, mental health problems predominated among our patients. As others also have observed,³¹⁻³³ some GIs reported suicidal ideation that went unrecognized or unacknowledged when they sought care in the military system. Military statistics indicate rapid increases in suicides, suicide attempts, and self injuries among active duty GIs.^{34,35} For 2007, the U.S. Army reported approximately 2,100 suicide attempts and self-injuries, a rate of more than five per day, increased from less than 1,500 the previous year and less than 500 in 2002; these data do not include events involving Marines or other combat forces. The probability of suicide increases with the number of deployments and time spent in Afghanistan or Iraq. Suicides committed outside combat zones may remain underreported.

The epidemic of mental health problems in the military coincides with an unprecedented privatization of medical and mental health services for active duty GIs and their families. Although the military previously offered such services within its own facilities, private corporations more recently have received large contracts from the military to provide these services. As a result, the chief executive

officer who has benefited the most financially from the Iraq War heads not a corporation traditionally considered part of the military-industrial complex, but rather a large managed care organization (Health Net), whose contractor (ValueOptions) provides mental health services for GIs and their families.³⁶

For GIs who seek help within the military sector for post-traumatic stress disorder, depression, and other mental health problems, military psychologists increasingly have diagnosed personality disorder. Because military policy considers personality disorder as a pre-existing condition that antedated military service, GIs who receive this diagnosis lose financial and health benefits after discharge, creating major concern for the GIs and their families.³⁷ This policy applies even though military officials did not diagnose personality disorder during GIs' mental health evaluation when inducted into the armed forces; military researchers have documented the limitations of screening for mental disorders before entry into military service.^{38,39}

During the wars in Afghanistan and Iraq, military leaders have implemented strategies that involve less combat engagement with identified combatants and more violence involving civilians. Recent reports from GIs, including those using the Network, have emphasized violence committed against civilian non-combatants.⁴⁰ In a context where both torture and systematic human rights abuse occur, it is not surprising that soldiers suffer from high levels of psychological distress and even pathology. Resistance to the war then becomes medicalized. With accumulated injuries—both physical and psychological—GIs turn to professionals in the civilian sector as a route to less dangerous assignments or to discharge.

The unmet needs of active duty GIs deserve concerted attention among medical professionals and policy makers. We suspect that, in addition to our Network, many individual clinicians also face similar issues among their patients.⁴¹ We believe that professional organizations should address concerns regarding the quality of military medical care and the impact of the war upon soldiers and their families in the US. In addition, the Network welcomes interested clinicians to become part of its

referral system. Finally, any work to repair the damage caused by the Iraq and Afghanistan Wars also must address strategies to promote peace and to prevent war.

Additional Resources: Information about the Civilian Medical Resources can be found at their website: <http://www.civilianmedicalresources.net/index.html>

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References

1. Winkenwerder W, Galvin R. The complex world of military medicine. *Health Affairs*. 2005;W5(Suppl Web Exclusives):353-360.
2. President's Commission on Care for America's Returning Wounded Warriors. *Serve, support, simplify: final report*. Washington, DC: The Commission; 2007. <http://www.pccww.gov>. Accessed Aug 9, 2008.
3. Institute of Medicine. *PTSD compensation and military service*. Washington, DC: National Academies Press; 2007. http://www.nap.edu/catalog.php?record_id=11870. Accessed Aug 9, 2008.
4. Hoge CW, Castro CA, Messer SC, McGurk D, Cotting DI, Koffman RL. Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. *N Engl J Med*. 2004;1(1):13-22.
5. Hoge CW, Terhakopian A, Castro CA, Messer SC, Engel CC. Association of posttraumatic stress disorder with somatic symptoms, health care visits, and absenteeism among Iraq war veterans. *Am J Psychiatry*. 2007;164(1):150-153.
6. Milliken CS, Auchterlonie JL, Hoge CW. Longitudinal assessment of mental health problems among active and reserve component soldiers returning from the Iraq war. *JAMA*. 2007;298(18):2141-2148.
7. Seal KH, Bertenthal D, Miner CR, Sen S, Marmar

- C. Bringing the war back home: mental health disorders among 103 788 US veterans returning from Iraq and Afghanistan seen at Department of Veterans Affairs facilities. *Arch Intern Med*. 2007;167(5):476-482.
8. Hoge CW, McGurk D, Thomas JL, Cox AL, Engel CC, Castro CA. Mild traumatic brain injury in U.S. soldiers returning from Iraq. *N Engl J Med*. 2008;358(5):453-463.
9. Lieberman J, Boxer B. Make mental health a priority: when service members go untreated, the entire military suffers. *Army Times*. 2007;68(3):42. http://www.armytimes.com/community/opinion/marine_opinion_tnsbacktalk_070806/. Accessed Aug 9, 2008.
10. Friedman MJ. Veterans' mental health in the wake of war. *N Engl J Med*. 2005;352(13):1287-1290.
11. Friedman MJ. Posttraumatic stress disorder among military returnees from Afghanistan and Iraq. *Am J Psychiatry*. 2006;163(4):586-593.
12. Westphal RJ. *A discourse analysis of Navy leaders' attitudes about mental health problems*. Charlottesville, VA: Department of Nursing, PhD Dissertation, 2004. <http://stinet.dtic.mil/oai/oai?verb=getRecord&metadataPrefix=html&identifier=ADA429820>. Accessed January 19, 2008.
13. Sidel VW, Levy BS. The roles and ethics of military medical care workers. In: Levy BS, Sidel VW, eds. *War and Public Health*. New York: Oxford University Press; 2008.
14. Burnham G, Lafta R, Doocy S, Roberts L. Mortality after the 2003 invasion of Iraq: a cross-sectional cluster sample survey. *Lancet*. 2006;368(9545):1421-1428.
15. American Civil Liberties Union. *The Human Cost - Civilian Casualties in Iraq & Afghanistan*. <http://www.aclu.org/natsec/foia/29316prs20070412.html>. Accessed January 19, 2009.
16. Waitzkin H. Latent functions of the sick role in various institutional settings. *Soc Sci Med*. 1971;5(1):45-75.
17. GI Rights Hotline. <http://www.girightshotline.org/>. Accessed January 19, 2009.
18. Military Law Task Force, National Lawyers Guild. <http://www.nlgmlf.org/>. Accessed January 19, 2009.
19. International Committee of Medical Journal Editors. *Uniform requirements for manuscripts submitted to biomedical journals*. www.icmje.org/index.html. Accessed January 19, 2009.
20. U.S. Census Bureau. *Statistical Abstract of the United States, 2006*. www.census.gov/prod/2005pubs/06statab/defense.pdf. Accessed Aug 9, 2008.
21. Cabrera OA, Hoge CW, Bliese PD, Castro CA, Messer SC. Childhood adversity and combat as predictors of depression and post-traumatic stress in

- deployed troops. *Am J Prev Med.* 2007;33(2):77-8
22. Kimerling R, Gima K, Smith MW, Street A, Frayne S, The Veterans Health Administration and military sexual trauma. *Am J Public Health.* 2007;97(12):2160-2166.
 23. Smith TC, Wingard DL, Ryan MAK, Kritz-Silverstein D, Slymen DJ, Sallis JF. Prior assault and posttraumatic stress disorder after combat deployment. *Epidemiology.* 2008;19(3):505-512.
 24. Browne T, Hull L, Horn O, et al. Explanations for the increase in mental health problems in UK reserve forces who have served in Iraq. *Br J Psychiatry.* 2007;190(June):484-489.
 25. Rona RJ, Fear NT, Hull L. Mental health consequences of overstretch in the UK armed forces: first phase of a cohort study. *BMJ.* 2007;335(7620):603. Epub Jul 30, 2007.
 26. Hotopf M, Hull L, Fear NT, et al. The health of UK military personnel who deployed to the 2003 Iraq war: a cohort study. *Lancet.* 2006;367(9524):1731-1741.
 27. Sareen J, Cox BJ, Afifi TO, et al. Combat and peacekeeping operations in relation to prevalence of mental disorders and perceived need for mental health care. *Arch Gen Psychiatry.* 2007;64(7):843-852.
 28. Miles SH. *Oath Betrayed: Torture, Medical Complicity, and the War on Terror.* New York: Random House; 2006.
 29. Marks JH, Bloche MG. The ethics of interrogation - the U.S. military's ongoing use of psychiatrists. *N Engl J Med* 2008;359(11):1090-1092.
 30. Priest D, Hall A. Soldiers face neglect, frustration at Army's top medical facility. *Washington Post.* (February 18, 2008):A01. www.washingtonpost.com/wp-dyn/content/article/2007/02/17/AR2007021701172.html. Accessed January 19, 2009.
 31. Eaton KM, Messer SC, Garvey Wilson AL, Hoge CW. Strengthening the validity of population-based suicide rate comparisons: an illustration using U.S. military and civilian data. *Suicide Life Threat Behav.* 2006;36(2):182-191.
 32. Carr JR, Hoge CW, Gardner J, Potter R. Suicide surveillance in the U.S. military -reporting and classification biases in rate calculations. *Suicide Life Threat Behav.* 2004;34(3):233-241.
 33. Hill JV, Johnson RC, Barton RA. Suicidal and homicidal soldiers in deployment environments. *Milit Med.* 2006;171(3):228-232.
 34. Tyson AS. Soldiers' suicide rate on pace to set record. *Washington Post.* (September 5, 2008). Available at: <http://www.washingtonpost.com/wp-dyn/content/article/2008/09/04/AR2008090403333.html>. Accessed January 19, 2009.
 35. Army suicide rate jumps In 2007. *CBS News.* (January 31, 2008). <http://cbs3.com/national/army.suicide.rate.2.642286.html>. Accessed January 19, 2009.
 36. Anderson S, Cavanagh J, Collins C, Benjamin E. Executive excess 2006: 13th annual CEO compensation survey. Washington, DC, and Boston, MA: Institute for Policy Studies and United for a Fair Economy; 2007: 8-9. www.ips-dc.org/getfile.php?id=155. Accessed Aug 9, 2008.
 37. Kors J. How Specialist Town lost his benefits. *The Nation.* 2007 (April 9);284(14):11-21.
 38. Hoge CW, Toboni HE, Messer SC, Bell N, Amoroso P, Orman DT. The occupational burden of mental disorders in the U.S. military: psychiatric hospitalizations, involuntary separations, and disability. *Am J Psychiatry.* 2005;162(3):585-591.
 39. Pols H, Oak S. War and military mental health: the US psychiatric response in the twentieth century. *Am J Public Health.* 2007;97(12):2132-2142.
 40. Winter Soldier. Iraq and Afghanistan. <http://ivaw.org/wintersoldier>. Accessed January 19, 2009.
 41. Anderson MR. The war comes to our waiting room. *Social Medicine.* 2006; 1(2):104-106.



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Appendix:
Illustrative Documentation Provided by Network Professionals

The authors have selected these letters as typical of those that the Network professionals submit on behalf of clients.

DATE

CONFIDENTIAL

Re: NAME

To the Commanding Officer of NAME:

As a practitioner of PROFESSIONAL DETAILS HERE.

In this connection, I received a referral requesting assistance for Sgt. NAME. I have corresponded with him a number of times by e-mail and also have held several extended phone conversations with him and his wife, NAME. To assist them, I have tried to set up some local referrals to civilian mental health professionals near Fort NAME.

Based on this information, I can attest that NAME and NAME are both suffering from severe mental health disorders. Although I cannot tell with certainty the underlying causes of these problems, I do know that NAME's deployment leading to separation from his wife has exacerbated their mental health problems substantially.

In brief, NAME suffers from depression probably linked to bipolar disorder. She frequently becomes suicidal, and this tendency increases in severity when NAME is not present to provide emotional support in person. NAME does have a history of suicide gestures and attempts. Partly in response to the stress of his military responsibilities coupled with his marital responsibilities, NAME has been suffering from depression and recently has been prescribed a psychotropic medication by a military mental health professional.

Under the circumstances, I strongly recommend that you grant NAME a compassionate discharge. I believe that the situation otherwise may become quite dangerous. NAME is in a position where suicide is a realistic possibility, and NAME's depression has become more serious as the stress associated with his military responsibilities has deepened. I feel that you should be aware of the potential harm to life that the current situation entails.

Please don't hesitate to contact me if I can provide further information.

Sincerely yours,

NAME

TITLE

DATE

CONFIDENTIAL; URGENT

Military Police

Fort NAME, NAME OF STATE

Attention: Staff Sergeant NAME

BY ELECTRONIC MAIL

Re: NAME

DOB:

Dear Colleagues:

I am writing to request your urgent attention and review of a potentially life-threatening set of conditions that are affecting NAME.

My report of DATE, provides further details. In brief, Mr. NAME suffers from several serious mental disorders related to his military service. During recent meetings with me, he expressed both suicidal and homicidal ideation. I believe that he has serious plans and is at extremely high risk (as are others with whom he interacts) if he is returned to Fort NAME, which he identifies as a source of his perceived prior emotional injuries.

Mr. NAME suffers from several severe psychiatric disorders that create grave current disability. Based on suicidal and homicidal ideation and plans, I believe that he is at high risk of harming himself and/or others. The likelihood of such violent behavior will increase greatly if he is returned to Fort NAME, which he associates with prior harm to himself and others. If he is returned to Fort NAME, my legal and ethical responsibilities as a medical professional would lead me to seek his confinement in a psychiatric inpatient hospital facility, even if he does not consent to such confinement.

I should emphasize that, holding this knowledge of Mr. NAME's high risk of suicide and/or homicide, I am legally and ethically required to try to prevent those events from occurring.

I believe that major problems and potential loss of life (of both Mr. NAME and others) can be avoided if you respond to my recommendation.

Please contact me so that we can discuss how to protect the safety of Mr. NAME and persons at Ft. NAME (beeper NUMBER; home NUMBER; work NUMBER). I will be glad to collaborate with you to prevent injury and loss of life. Don't hesitate to contact me if I can provide additional assistance.

This letter serves as a formal professional warning required under law. Thanks very much for considering this information.

Sincerely,

NAME

TITLE

DATE

Re: NAME

DOB:

Dear Sir/ Madam:

I am writing regarding my evaluation of Mr. NAME's psychiatric condition and his need for ongoing treatment.

A brief summary of my background may provide a context for this letter. PROFESSIONAL DETAILS HERE.

In this letter, I provide my assessment of Mr. NAME, based on review of his medical records, four phone meetings, and a longer meeting of 1½ hours which occurred on DATE. I will focus mainly on information that supplements that in his medical records.

Current danger to self and others. In my interview with Mr. NAME on DATE, he stated a willingness to return to Fort NAME [a base different from his own] but also expressed both suicidal and homicidal ideation in the event that he is sent back to Fort NAME. In brief, he stated that - based on his prior experiences at Fort NAME - he would likely try to commit suicide there and also might try to kill one of several people who he feels are responsible for his mistreatment. He made these statements several times and was very concrete and specific. If he is returned to Fort NAME, I believe that the risk of suicide and/or homicide is very high - so high that ethically and legally I would need to contact authorities so that he could be held for psychiatric observation at a non-military hospital, even if such hospitalization were against his will. As you know, making such arrangements is an ethical and legal responsibility of medical professionals who believe that a client is at high risk of harm to himself or others.

Risk factors for post-traumatic stress disorder and depression. Mr. NAME has experienced severe stressors that predispose to psychiatric disorders. First, he was the victim of abuse within his family during his childhood and adolescence. He reported emotional and verbal abuse from his mother, as well as physical and sexual abuse by his mother's boyfriend.

Second, he has experienced tremendously aversive experiences in combat. As he described these experiences, three episodes stood out as events that would lead to lasting psychological injury. First, during a battle in Ramadi, Iraq, Mr. NAME tried to rescue U.S. military personnel who had been severely injured after a large explosion. Injured personnel remained on top of a large truck. When he tried to remove a GI by the legs, he was shocked to discover that only the pelvis and legs remained from the waist down; the upper part of the body had been separated. During that episode, he encountered many other body parts in the process of trying to rescue the injured. On a second occasion, he was ordered to clean the top of a truck that was covered with blood and body parts. During a third episode, he held the hand of an Iraqi soldier, who was dying after the lower part of his body had been blown off in an explosion. Mr. NAME reports frequent flashbacks and nightmares about these experiences, as well as deep guilt and remorse for his own actions in combat; he started crying as he stated, "I wonder how many orphans over there that I've created by killing their dad."

Recent psychiatric research in the military has shown that abuse in childhood and adverse combat experiences like those Mr. NAME endured constitute the two strongest predictors of PTSD and depression in deployed troops: Cabrera OA, Hoge CW, Bliese PD, Castro CA, Messer SC. Childhood adversity and combat as predictors of depression and post-traumatic stress in deployed troops. *American Journal of Preventive Medicine*. 2007; 33(2): 77-82.

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Violence, suicidality, and homicidal ideation. Mr. NAME described a specific episode of violent behavior and four separate suicide attempts since he returned from combat. Shortly after arriving home, his 13-year-old niece tried to wake him up; startled and experiencing a flashback to combat, he threw her against a wall. As his first suicide attempt, he tried wrecking his car while driving at 120-130 miles per hour. In a second attempt, he tried to hurt himself while driving a 4-wheel drive vehicle; he hit a tree, and the vehicle burned up. Third, while intoxicated, he offered another person in a dune buggy \$1,400 cash to run over him. Fourth, he drank a half gallon of vodka and a fifth of Jim Beam whisky and then took 12 Xanax tablets, in an attempt to kill himself. The next morning, when he woke up, he threatened to kill a “cop” who was present and everyone else in the room (including family members and his best friend, as well as himself).

Regarding current suicidal ideation, he stated that he experiences suicidal thoughts at least every two weeks. When asked about a plan, he responded that he has access to guns and has experience in using them. He mentioned a scenario in which he could take a gun from a “cop” if he wanted to obtain one.

Mr. NAME also reported frequent homicidal ideation. He stated, “If I could, given a chance, I would go to Ft. NAME and kill some people there because of the way they treated me at Ft. NAME and Iraq.”

Current social situation and health services. In my opinion, although he seems a devoted husband and father, Mr. NAME’s wife and 6-month-old son are at some degree of risk if Mr. NAME were provoked into violence – for instance, by an attempt to return him to Fort NAME. He did report some sources of social support in the local area where he is residing. However, he does not have a regular source of primary medical care, does not receive regular mental health services, and is taking no medications.

Physical symptoms. Mr. NAME reported a variety of physical symptoms: abdominal pain, frequent bowel movements (3-4 per day), muscle pains, headaches, shortness of breath, and rapid heart rate. Based on my assessment, although further diagnostic procedures might lead to one or more physical abnormalities, these symptoms did not appear related to a physiological or pathological disorder. As a result, I conclude that he suffers from somatoform symptoms and probable somatization disorder.

Testing. I administered the Patient Health Questionnaire (PHQ), a brief instrument widely used in psychiatry and primary care. Many research studies have confirmed the PHQ’s validity as a sensitive and specific diagnostic instrument for psychiatric and behavioral health disorders (references available on request). I am attaching the PHQ instrument, with Mr. NAME’s responses. Based on the recommended scoring procedure, Mr. NAME suffers from the following disorders: somatization disorder, major depression syndrome, panic syndrome, anxiety syndrome, alcohol abuse, PTSD, stress syndrome, and target of abusive behavior.

Diagnostic and Statistical Manual IV diagnoses.

Axis I, clinical disorders: PTSD (309.81), depressive disorder NOS (311), alcohol abuse (303.9), somatoform disorder (300.8), anxiety disorder (300.0), panic disorder (300.01)

Axis II, underlying conditions: None noted.

Axis III, acute medical conditions and physical disorders: None noted.

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Axis IV, contributing psychosocial and environmental factors: combat, loss of friends in war, AWOL charges, history of physical and sexual abuse, family problems

Axis V, Global Assessment of Functioning (GAF): 15 (“some danger of hurting self or others OR occasionally fails to maintain minimal personal hygiene OR gross impairment in communication”)

Treatment. In addition to follow-up appointments with me and mental health professionals, I have prescribed an antidepressant (paroxetine 20 mg. daily) and a minor tranquilizer/ sedative (buspirone 10 mg. daily as needed for panic and/or anxiety).

Summary. Mr. NAME suffers from several severe psychiatric disorders that create grave current disability. Based on suicidal and homicidal ideation and plans, I believe that he is at high risk of harming himself and/or others. The likelihood of such violent behavior will increase greatly if he is returned to Fort NAME, which he associates with prior harm to himself and others. If an attempt were made to return him to Fort NAME, my legal and ethical responsibilities as a medical professional would lead me to seek his confinement in a civilian hospital, even if he does not consent to such confinement.

Recommendation. Based on his adverse combat experiences, his multiple psychiatric disorders, his suicidal ideation, his homicidal ideation, and the lack of intensive medical care and psychiatric care that he clearly needs, I strongly recommend prompt discharge from military service. After discharge, other colleagues and I can assist in obtaining appropriate care for him. Should he remain in the military, he would be at risk to himself and his fellow soldiers.

Please don't hesitate to contact me if I can provide additional information.

Sincerely,
NAME
TITLE