

## COMMENT

### In Need of Correction: How the Army Board for Correction of Military Records Is Failing Veterans with PTSD

After completing two honorable tours of duty, fighting in four separate campaigns in Vietnam, and earning an Air Medal with Valor Device for heroism, John Doe<sup>1</sup> was given an Undesirable Discharge after he began threatening and striking other soldiers in 1973.<sup>2</sup> He was later diagnosed with Post-Traumatic Stress Disorder (PTSD). As a result of his Undesirable Discharge, he can be denied government employment and cut off from benefits, such as disability compensation, health benefits, education benefits, a military burial, and benefits for surviving family members.<sup>3</sup> Veterans like Mr.

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1. The record does not identify the veteran by name.
  2. *In re* [Redacted], No. AR20090005061 (Army Bd. for Corr. of Military Records Aug. 11, 2009), <http://boards.law.af.mil/ARMY/BCMR/CY2009/20090005061.txt>.
  3. See GERALD NICOSIA, *HOME TO WAR: A HISTORY OF THE VIETNAM VETERANS' MOVEMENT* 300 (2001); *Veterans Discharge Upgrade Manual*, CONN. VETERANS LEGAL CTR. 8-9 (2011), <http://ctveteranslegal.org/wp-content/uploads/2012/12/Connecticut-Veterans-Legal-Center-Discharge-Upgrade-Manual-November-2011.pdf>. Undesirable Discharges, also termed Other than Honorable Discharges, and Bad Conduct Discharges issued by special courts-martial are, with limited exceptions, bars to benefits if the Department of Veterans Affairs (VA) determines that the conduct falls into certain broad categories, including “[a]cceptance of an undesirable discharge to escape trial by general-court martial” and “[w]illful and persistent misconduct.” 38 C.F.R. § 3.12(d) (2013). One important exception is for healthcare, specifically for issues that the VA deems service-connected. See *Other than Honorable Discharges: Impact on Eligibility for VA Health Care Benefits*, U.S. DEP’T VETERANS AFF. (June 18, 2013), [http://www.va.gov/healthbenefits/resources/publications/IB10-448\\_other\\_than\\_honorable\\_discharges\\_0613.pdf](http://www.va.gov/healthbenefits/resources/publications/IB10-448_other_than_honorable_discharges_0613.pdf). Both Dishonorable Discharges and Bad Conduct Discharges issued by general courts-martial are, also with limited exceptions,

Doe have struggled to cope not only with their war wounds but also with the shame of a bad discharge. As one journalist observed, “Bad paper’ vets will not be honored on Veterans Day . . . . [They] have been largely forgotten and ignored by the military and veterans organizations.”<sup>4</sup>

In 2009, Mr. Doe applied to the Army Board for Correction of Military Records (ABCMR) for a discharge upgrade.<sup>5</sup> He argued that his sudden violence had been caused by undiagnosed PTSD, the symptoms of which include “[i]rritable behavior and angry outbursts” and an “[e]xaggerated startle response.”<sup>6</sup> Mr. Doe’s VA clinical records from 1968 show that upon returning from his first tour of duty in Vietnam, he was admitted to a hospital for “transient stress reaction . . . manifested by anxiety, insomnia and fear of death” and that a cause of these symptoms was “severe, combat duty in Vietnam.”<sup>7</sup> Despite the fact that Mr. Doe had served honorably during two other tours, had been hospitalized for a stress reaction, and had a sudden change in behavior consistent with the symptoms of PTSD, the ABCMR denied his application for a discharge upgrade.<sup>8</sup>

Mr. Doe is not alone. At least 560,000 Vietnam veterans were given discharges under conditions that were less than Honorable.<sup>9</sup> Three hundred thousand of these were General Discharges, which have no effect on most benefits but carry a grave stigma and often have adverse effects on employment.<sup>10</sup> The remaining 260,000 were “bad paper” discharges—either Other than Honorable (also sometimes termed Undesirable), Bad Conduct, or Dishonorable Discharges.<sup>11</sup> These veterans “were simply cut off from any government help at all, and not even eligible for a civil service job.”<sup>12</sup>

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automatic bars to all benefits, including service-connected healthcare benefits. See 38 U.S.C. § 5303(a) (2006); 38 C.F.R. § 3.12(c)(2).

4. L.P. Harvey, *‘Bad Paper’ Vets – America’s Discarded Warriors*, CHRISTIAN SCI. MONITOR, Nov. 10, 1986, <http://www.csmonitor.com/1986/1110/evets.html>.
5. *In re* [Redacted], No. AR20090005061, *supra* note 2.
6. AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS § 309.81(E) (5th ed. 2013) [hereinafter DSM-5].
7. *In re* [Redacted], No. AR20090005061, *supra* note 2.
8. *Id.*
9. NICOSIA, *supra* note 3, at 299-300.
10. *Id.* at 300; *Veterans Discharge Upgrade Manual*, *supra* note 3, at 9.
11. See *Veterans Discharge Upgrade Manual*, *supra* note 3, at 7.
12. NICOSIA, *supra* note 3, at 300.

Many of these “bad paper” veterans suffer from PTSD. The 1990 National Vietnam Veterans Readjustment Study (NVVRS) found that “30.6 percent . . . of male Vietnam theater veterans (over 960,000 men) and over one-fourth (26.9 percent) of women serving in the Vietnam theater (over 1,900 women) had the full-blown disorder [PTSD] at some time during their lives.”<sup>13</sup> NVVRS reported that 15.2 percent of male veterans and 8.5 percent of female veterans were “current cases of PTSD,”<sup>14</sup> but a later study found that in most cases, veterans’ PTSD is chronic: “Among Vietnam veterans who had ever developed full or partial PTSD, only one in five reported no symptoms in the prior 3 months when assessed 20-25 years after their Vietnam service.”<sup>15</sup>

Statistically, this would suggest that tens of thousands of veterans with bad discharges have suffered from PTSD. As Jonathan Shay, a psychiatrist with extensive experience working with Vietnam veterans with PTSD, wrote in a *New York Times* op-ed with Congresswoman Maxine Waters:

Many bad-paper veterans are among the 250,000 ex-combat soldiers who suffer from post-traumatic stress disorder. They have a higher incidence of unemployment, violent behavior, alcohol and drug abuse, family problems and homelessness than other veterans. Yet we won’t give them the treatment that could help them heal. They served their country and deserve treatment for their war wounds, physical and mental. . . . These ex-soldiers fill prisons and homeless shelters in disproportionate numbers around the country. The New England Shelter for Homeless Veterans, a 225-bed treatment center in Boston, is typical: 25 percent of . . . those who use it are bad-paper combat veterans.<sup>16</sup>

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13. Richard A. Kulka et al., *Contractual Report of Findings from the National Vietnam Veterans Readjustment Study, Volume 1: Executive Summary, Description of Findings, and Technical Appendices*, RES. TRIANGLE INST. 2 (Nov. 7, 1988), [http://www.ptsd.va.gov/professional/articles/article-pdf/nvvrs\\_vol1.pdf](http://www.ptsd.va.gov/professional/articles/article-pdf/nvvrs_vol1.pdf).
  14. *Id.*
  15. Paula P. Schnurr et al., *A Descriptive Analysis of PTSD Chronicity in Vietnam Veterans*, 16 J. TRAUMATIC STRESS 545, 551 (2003).
  16. Maxine Waters & Jonathan Shay, Op-Ed, *Heal the ‘Bad Paper’ Veterans*, N.Y. TIMES, July 30, 1994, <http://www.nytimes.com/1994/07/30/opinion/heal-the-bad-paper-veterans.html>. For a comprehensive study of the challenges facing veterans with PTSD upon returning to society, see JONATHAN SHAY, *ODYSSEUS IN AMERICA: COMBAT TRAUMA AND THE TRIALS OF HOMECOMING* (2002).

Waters was the sponsor of a bill to “establish a procedure for combat veterans to automatically upgrade their bad-paper discharges,” which she argued would be “a major step toward insuring that those who risked their lives in battle are not abandoned to the streets, prisons and margins of our society.”<sup>17</sup> Almost twenty years later, the proposed bill has faded into history and nothing has changed.<sup>18</sup>

Over the last several decades, medical research has illuminated the causes and severe consequences of PTSD. In 1980, PTSD was for the first time recognized by the *Diagnostic & Statistical Manual of Mental Disorders*.<sup>19</sup> Today, before being given a discharge that is not Honorable, “[a] Service member must receive a medical examination to assess whether the effects of post-traumatic stress disorder . . . or traumatic brain injury (TBI) constitute matters in extenuation that relate to the basis for administrative separation” if he or she “reasonably alleges the influence of PTSD or TBI based on deployed service to a contingency operation during the previous 24 months.”<sup>20</sup>

Yet there is evidence that the military is still not appropriately diagnosing PTSD. In 2009, there were reports of thousands of veterans with PTSD getting bad discharges based on abuse of alcohol, which they used to self-medicate.<sup>21</sup> Around the same time, *Salon* published an article revealing that an Army psychologist had been recorded saying to a sergeant who came in for an evaluation: “Not only myself, but all the clinicians up here are being pressured to not diagnose PTSD and diagnose [A]nxiety [D]isorder [Not Otherwise

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17. Waters & Shay, *supra* note 16.

18. See e.g., Phillip Carter, *The Vets We Reject and Ignore*, N.Y. TIMES, Nov. 10, 2013, <http://www.nytimes.com/2013/11/11/opinion/the-vets-we-reject-and-ignore.html>. (“Their discharges, which include overly broad categories encompassing everything from administrative discharges for minor misconduct to dishonorable discharges following a court-martial, nevertheless make them ineligible for the health care, employment, housing and education benefits offered by the Department of Veterans Affairs.”).

19. JUDITH LEWIS HERMAN, *TRAUMA AND RECOVERY* 27-28 (1st ed. 1992).

20. *Instruction Number 1332.14: Enlisted Administrative Separations*, U.S. DEP’T DEF. 8-9 (Sept. 30, 2011), [www.dtic.mil/whs/directives/corres/pdf/133214p.pdf](http://www.dtic.mil/whs/directives/corres/pdf/133214p.pdf).

21. Gordon Duff, *Army Gives Bad Discharges to Thousands of PTSD Vets*, SALEM-NEWS.COM (Sept. 19, 2009), [http://www.salem-news.com/articles/september192009/ptsd\\_discharges\\_gd\\_9-19-09.php](http://www.salem-news.com/articles/september192009/ptsd_discharges_gd_9-19-09.php); see also Jeremy Schwartz, *‘Bad Paper’ Discharges Can Stymie Veterans’ Health Care*, AUSTIN AMERICAN-STATESMAN (Oct. 3, 2010), <http://www.statesman.com/news/news/state-regional-govt-politics/bad-paper-discharges-can-stymie-veterans-health--1/nRyPr> (describing one veteran’s story).

Specified]” instead.<sup>22</sup> Similarly, a recently retired Army psychiatrist told *Salon* that “commanders at another Army hospital instructed him to misdiagnose soldiers suffering from war-related PTSD, recommending instead that he diagnose them with other disorders that would reduce their benefits.”<sup>23</sup> Additionally, there have been numerous recent reports of the military wrongly diagnosing veterans with Personality Disorder rather than PTSD, preventing them from receiving benefits.<sup>24</sup>

The ABCMR’s failure to take meaningful account of PTSD in applications by Vietnam veterans is the subject of recent litigation.<sup>25</sup> Army veteran and Bronze Star with Valor Device recipient John Shepherd, Jr., together with a proposed class of Vietnam veterans with Other than Honorable Discharges and PTSD, filed suit in 2012. The lawsuit claimed that “[t]he United States military has failed to correct the wrongful discharges of thousands of Vietnam War Era veterans suffering from Post-Traumatic Stress Disorder . . . undiagnosed while they were in service.”<sup>26</sup> Moreover, the lawsuit contends that “[s]ince 2003, of approximately 145 applications for upgrades of other-than-honorable

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22. Michael de Yoanna & Mark Benjamin, “*I Am Under a Lot of Pressure to Not Diagnose PTSD*,” *SALON* (Apr. 8, 2009), <http://www.salon.com/2009/04/08/tape>.
  23. *Id.* Note that even if a veteran gets an Honorable Discharge, he or she still cannot get retirement disability benefits for PTSD without a diagnosis at the time of discharge. See Thomas J. Reed, *Parallel Lines Never Meet: Why the Military Disability Retirement System and Veterans Affairs Department Claim Adjudication Systems Are a Failure*, 19 *WIDENER L.J.* 57, 111-23 (2009) (critiquing the disconnect between the VA system and the disability retirement system and noting that veterans later diagnosed with conditions, including PTSD, who were not diagnosed at the time of discharge have trouble getting disability retirement pay).
  24. See, e.g., James Dao, *Branding a Soldier with ‘Personality Disorder,’* *N.Y. TIMES*, Feb. 24, 2012, <http://www.nytimes.com/2012/02/25/us/a-military-diagnosis-personality-disorder-is-challenged.html>; Joshua Kors, *Disposable Soldiers: How the Pentagon Is Cheating Wounded Vets*, *NATION*, Apr. 26, 2010, <http://www.thenation.com/article/disposable-soldiers>; Joshua Kors, *How Specialist Town Lost His Benefits*, *NATION*, Apr. 9, 2007, <http://www.thenation.com/article/how-specialist-town-lost-his-benefits>; Melissa Ader et al., *Casting Troops Aside: The United States Military’s Illegal Personality Disorder Discharge Problem*, *VIET. VETERANS AM.* (2012), <http://www.vva.org/PPD-Documents/WhitePaper.pdf> (summarizing evidence that the military has been wrongfully diagnosing Personality Disorder).
  25. See Plaintiff’s Proposed Second Amended Complaint, *Shepherd v. McHugh*, No. 3:11-cv-00641 (D. Conn. Dec. 3, 2012) (proposed class action suit by Vietnam veterans with Other than Honorable Discharges and PTSD); see also James Dao, *Vietnam Veterans, Discharged Under Cloud, File Suit Saying Trauma Was Cause*, *N.Y. TIMES*, Dec. 3, 2012, <http://www.nytimes.com/2012/12/03/us/vietnam-veterans-claiming-ptsd-sue-for-better-discharges.html>. The author of this Comment worked on this case as a member of Yale Law School’s Veterans Legal Services Clinic.
  26. Plaintiff’s Proposed Second Amended Complaint, *supra* note 25, at 1.

discharges submitted by Vietnam veterans claiming PTSD, the ABCMR has approved two—a 1.4 percent approval rate,<sup>27</sup> a significantly lower rate than the 46% of all discharge upgrade applications granted by the ABCMR.<sup>28</sup> In November 2013, the Army agreed to upgrade Mr. Shepherd's discharge status and pay \$37,000 in attorney's fees in exchange for the dismissal of the case.<sup>29</sup> "Good thing I'm a fighter," Mr. Shepherd said, "because it took years of fighting to receive recognition of my sacrifices and service in Vietnam. But there are thousands of guys like me who also deserve better from the DoD. Their fight is still going."<sup>30</sup>

The ABCMR has the power to change any Army record when it is "necessary to correct an error or remove an injustice."<sup>31</sup> However, the ABCMR's policies make it nearly impossible for a veteran with a bad discharge caused by undiagnosed PTSD to obtain a discharge upgrade.<sup>32</sup> The Board refuses to accept any evidence that a diagnosis or lack thereof at the time of discharge was incorrect, even when applicants present substantial later medical evidence.

This Comment will first explain the history and diagnostic criteria of PTSD. It will then detail the failures of the ABCMR in adjudicating the applications of veterans claiming PTSD as the reason for a discharge upgrade. Finally, it will offer suggestions for policy changes that would make it possible for applicants whose discharge was due to PTSD to attain discharge upgrades without opening the floodgates to fraudulent claims.

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27. *Id.* at 12.

28. BARTON F. STICHMAN ET AL., VETERANS BENEFITS MANUAL § 21.4.8 & n.40 (2012).

29. *Veterans Clinic Settles Federal Lawsuit on Behalf of Vietnam Veteran*, YALE L. SCH. (Nov. 4, 2013), <http://www.law.yale.edu/news/17619.htm>.

30. *Id.*

31. 10 U.S.C. § 1552(a)(1) (2012) (This decision is based on whether or not "the Secretary considers it necessary.").

32. The other branches of service also have correction boards, which are an excellent topic for further research. Additionally, each service has a Discharge Review Board (DRB) that specifically reviews discharges, but only within fifteen years of discharge. The DRB's treatment of PTSD claims would also be a good topic for further research. This Comment will focus solely on the Army's BCMR because it is the largest service branch. The ABCMR rather than the Army's DRB is the focus for several reasons. First, most Vietnam veterans must now apply to the ABCMR because discharge review boards have non-waivable fifteen year statutes of limitations. Second, all veterans whose discharge was based on a general court-martial must apply to the ABCMR rather than the ADRB.

## I. BACKGROUND ON PTSD

### A. History of PTSD

The formal diagnosis of PTSD has only existed for a few decades, but the idea of combat stress is nothing new. Over time, there have been a number of different conceptions of the condition, and public and military support for those suffering from the condition has waxed and waned.<sup>33</sup> While traumatic stress from combat is as old as war itself,<sup>34</sup> the concept of combat neurosis or “shell shock” first came into focus during World War I.<sup>35</sup> One source estimates that forty percent of British casualties during the First World War were psychiatric.<sup>36</sup> Similarly, it is estimated that one-third of all World War II casualties were psychiatric.<sup>37</sup> However, when the first edition of the *Diagnostic & Statistical Manual of Mental Disorders (DSM-I)* was published in 1952, it did not include combat neurosis.<sup>38</sup> PTSD did not become an official diagnosis until the publication of the third edition (*DSM-III*) in 1980.<sup>39</sup>

In contrast to those reported in the First and Second World Wars, less than five percent of Vietnam War casualties were officially deemed psychiatric.<sup>40</sup> However, as psychiatrist Jonathan Shay explains, “[w]e now know that this low rate did not reflect the true incidence of major psychological injury, but instead reflected a multilayered institutional illusion, denial, and fiat.”<sup>41</sup> The military assumed that “[s]omeone who broke down was damaged goods to begin with and should be discharged as unfit or undesirable.”<sup>42</sup> Because of this attitude, many veterans who broke down in battle were given bad discharges

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33. HERMAN, *supra* note 19, at 20-28.

34. See JONATHAN SHAY, *ACHILLES IN VIETNAM: COMBAT TRAUMA AND THE UNDOING OF CHARACTER*, at xiii (1994) (noting “the similarity of [Vietnam combat veterans’] experiences to Homer’s account of Achilles in the *Iliad*” and arguing that “Homer has seen things that we in psychiatry and psychology have more or less missed”).

35. HERMAN, *supra* note 19, at 20.

36. *Id.*

37. SHAY, *supra* note 34, at 203.

38. AM. PSYCHIATRIC ASS’N, *DIAGNOSTIC & STATISTICAL MANUAL: MENTAL DISORDERS* (1st ed. 1952).

39. HERMAN, *supra* note 19, at 27-28.

40. SHAY, *supra* note 34, at 203.

41. *Id.*

42. *Id.* at 204.

rather than being considered psychiatric casualties. The striking difference between the rates of recorded psychiatric casualties in Vietnam compared with World Wars I and II, as well as the subsequent research on PTSD in Vietnam veterans, also suggests that the military was not recognizing combat stress and treating it appropriately.

In recent years, there has been considerable debate over the diagnostic criteria of PTSD and whether it is being over- or under-diagnosed. Harvard psychiatrist Richard McNally argues that “PTSD has become so flabby and overstretched, so much a part of the culture, that we are almost certainly mistaking other problems for PTSD, and thus mistreating them.”<sup>43</sup> Still, McNally acknowledges that “PTSD is a real thing, without a doubt.”<sup>44</sup> Even PTSD’s harshest critics generally recognize that the disorder exists; the debate instead centers around the specific criteria used to diagnose it. In May 2013, the much-anticipated fifth edition of the *Diagnostic & Statistical Manual of Mental Disorders (DSM-5)* made several changes to the diagnostic criteria, which will be discussed in the next Section.

### *B. Diagnostic Criteria of PTSD*

According to the *DSM-5*, PTSD is a psychiatric disorder caused by “[e]xposure to actual or threatened death, serious injury, or sexual violence.”<sup>45</sup> The symptoms of PTSD are intrusive thoughts or nightmares, avoidance of triggers of the trauma, negative changes in cognitions and mood, and heightened arousal and reactivity.<sup>46</sup> The symptoms must last for more than one month and must cause “significant distress or impairment in social, occupational, or other important areas of functioning.”<sup>47</sup>

The *DSM-5* eliminated the *DSM-IV*’s subjective requirement that the person experience “intense fear, helplessness, or horror” associated with the traumatic event.<sup>48</sup> Instead, the *DSM-5* more specifically describes what

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43. David Dobbs, *The Post-Traumatic Stress Trap*, SCI. AM., Apr. 13, 2009, at 64, 65, <http://www.nature.com/scientificamerican/journal/v300/n4/pdf/scientificamerican0409-64.pdf>.

44. *Id.*

45. *DSM-5*, *supra* note 6, § 309.81(A).

46. *Id.* § 309.81(B)-(E).

47. *Id.* § 309.81(G).

48. Compare *id.* § 309.81, with AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS § 309.81(A)(2) (4th ed. 2000) [hereinafter *DSM-IV*].



objectively qualifies as exposure to a traumatic event.<sup>49</sup> Additionally, the *DSM-5* separates the *DSM-IV*'s symptom of "avoidance of stimuli associated with the trauma and numbing of general responsiveness"<sup>50</sup> into two separate symptoms of "avoidance" and "negative alterations in cognitions and mood," now requiring that a person exhibit both types of symptoms in order to be diagnosed with PTSD.<sup>51</sup>

Former Army psychiatrist Elspeth Cameron Ritchie predicts that the elimination of the "fear and helplessness" requirement will make it easier to diagnose PTSD in soldiers.<sup>52</sup> Ritchie explains that "[w]hen the bomb goes off or they are shot at, most well-trained service members do not experience helplessness or horror. They are well-trained; they drag their wounded buddies to safety, lay down suppressing fire, and continue with the mission."<sup>53</sup> This reaction at the time of an incident, however, does not make them immune to effects after they get to safety: "[T]hey still may have intrusive memories," Ritchie explains, "seeing their friend's head[] blown off, or the dead children in the vicinity of the bomb blast."<sup>54</sup>

The symptoms of "avoidance" and "alterations in arousal and reactivity" are of particular importance for veterans given bad discharges who were later diagnosed with PTSD. To be diagnosed with PTSD, one must show "[p]ersistent avoidance of stimuli associated with the traumatic event(s)."<sup>55</sup> For soldiers, this can mean an effort to avoid battle by refusing orders, which will surely lead to a bad discharge. Similarly, two of the ways alterations in arousal and reactivity can manifest are "[i]rritable behavior and angry outbursts" and an "[e]xaggerated startle response."<sup>56</sup> These symptoms can cause a soldier with PTSD to overreact to noises or "instinctively strike[] or throw[] [someone] to the ground" when startled,<sup>57</sup> actions that could easily result in a bad discharge.

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49. *DSM-5*, *supra* note 6, § 309.81(A).

50. *DSM-IV*, *supra* note 48, § 309.81(C).

51. *DSM-5*, *supra* note 6, § 309.81(C)-(D).

52. Elspeth Cameron Ritchie, *An Easier PTSD Diagnosis*, *TIME*, May 14, 2013, <http://nation.time.com/2013/05/14/an-easier-ptsd-diagnosis>.

53. *Id.*

54. *Id.*

55. *DSM-5*, *supra* note 6, § 309.81(C).

56. *Id.* § 309.81(E).

57. *SHAY*, *supra* note 34, at 178.

## II. THE FAILINGS OF THE ABCMR

Congress has authorized the Secretary of the Army, acting through the ABCMR, to make changes to any Army record when doing so is “necessary to correct an error or remove an injustice.”<sup>58</sup> The Board regularly exercises this power to upgrade the discharge status of former service members. It has “the power, and the duty, to remove injustices and correct errors in servicemen’s records.”<sup>59</sup> Yet the ABCMR has refused to accept any evidence that a diagnosis or lack thereof at the time of discharge was incorrect, even when applicants present substantial later medical evidence. This policy makes it virtually impossible for a veteran whose bad discharge was due to undiagnosed PTSD to secure a discharge upgrade. These practices do not accord with the Board’s “abiding moral sanction to determine, insofar as possible, the true nature of an alleged injustice and to take steps to grant thorough and fitting relief.”<sup>60</sup>

### A. *The ABCMR’s Failure to Recognize the Medical Impossibility of a Pre-1980 PTSD Diagnosis*

In its recent decisions, the ABCMR has repeatedly explained the denial of Vietnam veterans’ applications by noting that their records did not show that they were *diagnosed* with PTSD before discharge. Such statements in Vietnam veterans’ cases fail to recognize, however, that it was medically impossible to have a PTSD diagnosis before 1980. Consider, for example, these recent explanations for denials of discharge upgrades:

1. “No evidence shows” that the applicant, who had honorably completed two previous tours of duty, “was diagnosed with PTSD or any mental condition prior to his discharge on 17 February 1976.”<sup>61</sup>
2. “Although the applicant,” who previously served an honorable tour of duty and was later treated for PTSD at a VA facility, “contends he suffers from PTSD, his record contains insufficient military

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58. 10 U.S.C. § 1552(a)(1) (2012).

59. *Yee v. United States*, 512 F.2d 1383, 1387 (Ct. Cl. 1975).

60. *Id.* at 1387-88 (quoting *Duhon v. United States*, 461 F.2d 1278, 1281 (Ct. Cl. 1972)).

61. *In re* [Redacted], No. AR20100026173 (Army Bd. for Corr. of Military Records May 19, 2011), <http://boards.law.af.mil/ARMY/BCMR/CY2010/20100026173.txt>.

treatment records showing a diagnosis of PTSD or any other mental condition while in the Army.”<sup>62</sup>

3. “[T]here is no evidence the applicant,” who previously served an honorable tour of duty and was ordered to be hospitalized for mental illness between tours of duty, “was diagnosed as having PTSD while he served on active duty.”<sup>63</sup>

Even when there is significant evidence that the veteran was suffering from PTSD at the time of discharge, the Board refuses to accept it unless the evidence itself also dates back to the discharge. One applicant, who had previously served one honorable tour of duty, was discharged for going absent without leave (AWOL) and for dereliction of duty in 1967.<sup>64</sup> He submitted six letters from VA medical personnel to the ABCMR in support of his claim for a discharge upgrade based on PTSD.<sup>65</sup> The ABCMR concluded that

[a]lthough a medical official at the [VA] contends the applicant’s second military discharge was likely in part due to his PTSD related issues, *no evidence* shows the applicant was having mental problems in 1967 that interfered with his ability to perform his military duties or that were the underlying cause for the misconduct that led to his discharge.<sup>66</sup>

In another case, the Board conceded that “[t]he applicant’s military records indicate he did suffer some type of traumatic event while in Vietnam which required a full psychiatric evaluation on 25 September 1969 and a two-day hospital stay,” but concluded that the fact that the veteran was then “returned to duty, albeit without a weapon,” “directly conflicts with the November 2009 statement that the applicant had an acute stress disorder or PTSD.”<sup>67</sup> The Board took the fact that the psychiatric evaluation done in 1969 did not

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62. *In re* [Redacted], No. AR20110019371 (Army Bd. for Corr. of Military Records Apr. 17, 2012), <http://boards.law.af.mil/ARMY/BCMR/CY2011/20110019371.txt>.

63. *In re* [Redacted], No. AR20070008956 (Army Bd. for Corr. of Military Records Nov. 15, 2007), <http://boards.law.af.mil/ARMY/BCMR/CY2007/20070008956.txt>.

64. *In re* [Redacted], No. AR20110013885 (Army Bd. for Corr. of Military Records Jan. 24, 2012), <http://boards.law.af.mil/ARMY/BCMR/CY2011/20110013885.txt>.

65. *Id.*

66. *Id.* (emphasis added).

67. *In re* [Redacted], No. AR20100011237 (Army Bd. for Corr. of Military Records Oct. 20, 2010), <http://boards.law.af.mil/ARMY/BCMR/CY2010/20100011237.txt>.

diagnose PTSD and allowed the veteran to return to duty as conclusive evidence that he did not have PTSD at that time. Further, the Board acknowledged that the veteran returned to duty without a weapon, but did not consider that as indicative of a mental disorder at the time. Also troubling in this case was the fact that the Board initially stated that partial relief should be granted “as a matter of justice,” but then voted to deny relief stating that “[n]otwithstanding the staff discussions and conclusions above to grant partial relief . . . the Board determined that there was insufficient evidence to show the applicant suffered from a mental disorder significant enough to excuse his misconduct.”<sup>68</sup>

Throughout these cases, the fact that the Board repeatedly states that there is a lack of a PTSD diagnosis in the record pre-1980 shows its complete disregard for the history of the diagnosis. Moreover, while the Board also sometimes notes the absence of a contemporary diagnosis for an “other mental condition,” the lack of such a diagnosis does not prove that the veteran was not suffering from PTSD. PTSD has a specific cluster of symptoms that need to be seen together for a correct diagnosis. Taken alone, symptoms such as nightmares, avoidance of situations reminiscent of the trauma, sudden impulsive actions, and reclusive behavior could be ignored or, worse yet, easily attributed to simply being a “bad soldier.” Indeed, Mr. Doe was hospitalized for “transient stress reaction . . . manifested by anxiety, insomnia and fear of death” as a result of “severe, combat duty in Vietnam” – and that was still not enough to prove a sufficient mental condition at the time of discharge.<sup>69</sup> As explained in Section I.A, the prevailing attitude at the time was that “[s]omeone who broke down was damaged goods to begin with and should be discharged as unfit or undesirable.”<sup>70</sup>

### *B. The ABCMR’s Refusal to Consider Evidence of an Incorrect Initial Diagnosis*

In addition to its failure to recognize that the lack of a PTSD diagnosis at the time of discharge is not dispositive – particularly before 1980, when such a

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68. *Id.* (capitalization altered). Staff analysts at the ABCMR prepare cases for review and draft opinions for the Board’s consideration. *Army Board for Correction of Military Records*, ARMY REVIEW BOARDS AGENCY, <http://arba.army.pentagon.mil/abcmr-overview.cfm> (last visited Jan. 28, 2014) (“If the application cannot be resolve[d] administratively, the Board staff will prepare a brief for the Board’s consideration. The Board will render a decision which is final and binding on all Army officials and government organizations.”).

69. *In re* [Redacted], No. AR20090005061, *supra* note 2.

70. SHAY, *supra* note 34, at 204.

diagnosis was medically impossible—the ABCMR also refuses to consider the possibility that a different psychiatric diagnosis made at discharge was incorrect, even if the weight of the evidence suggests that it was. As explained in Section I.B, PTSD cannot be diagnosed until at least a month has passed since the traumatic event. Everyone has a stress reaction; it becomes a disorder when it does not go away. Therefore, if a veteran’s discharge proceeding was less than a month after he or she began showing symptoms, the doctor could not definitively diagnose PTSD.

Further, some of the symptoms of PTSD are similar to those of other psychiatric disorders, such as Adjustment Disorder (AD). PTSD and AD have overlapping symptoms: the *DSM-IV* criteria for AD include “marked distress that is in excess of what would be expected given the nature of the stressor or . . . significant impairment in social or occupational (academic) functioning.”<sup>71</sup> However, one distinguishing factor is that “[b]y definition, an Adjustment Disorder must resolve within 6 months of the termination of the stressor (or its consequences).”<sup>72</sup> Therefore, if a patient’s symptoms last longer than six months after the stressor is taken away, the AD diagnosis is not accurate.

For example, in one recent case, a veteran was diagnosed with AD at the time of his discharge because “[h]e had severe difficulties adjusting to the stress associated with deployment.”<sup>73</sup> During his deployment, he experienced “multiple instances of killing.”<sup>74</sup> After his discharge, the VA diagnosed him with PTSD and awarded him service-connected disability compensation. The ABCMR decision in this case notes that “an award of a rating by another agency does not establish error by the Army” and that “the VA does not have the authority or the responsibility for determining medical unfitness for military service.”<sup>75</sup> It is true that a VA diagnosis should not bind the Board. However, it should be considered as evidence, and in this case, if the Board’s decision reflected even a basic understanding of how these diagnoses worked, it would have concluded that the first diagnosis was incorrect. The problem is that the Board refuses to consider medical opinions that the diagnosis at the time of discharge was incorrect. The ABCMR’s refusal to accept evidence of a

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71. *DSM-IV*, *supra* note 48. The *DSM-IV* was the governing manual at the time of the case discussed immediately below.

72. *Id.*

73. *In re* [Redacted], No. AR20120011895 (Army Bd. for Corr. of Military Records Nov. 1, 2012), <http://boards.law.af.mil/ARMY/BCMR/CY2012/20120011895.txt>.

74. *Id.*

75. *Id.*

later diagnosis is particularly troubling given the evidence that some military doctors have failed to properly diagnose PTSD.<sup>76</sup>

*C. The ABCMR's Dereliction in Discrediting Veterans' Narratives of Wartime Events*

John Shepherd, Jr.'s discharge upgrade application stated that he had witnessed the death of his lieutenant from Connecticut.<sup>77</sup> The ABCMR was not able to find a record of the death of a lieutenant from Connecticut in Mr. Shepherd's unit during that time period and concluded that "the event to which [Mr. Shepherd] alludes as being most stressful and disturbing, and which led directly to his refusal to participate in combat, is not supported by the facts."<sup>78</sup> Not only did the ABCMR "rel[y] on records and evidence to which Mr. Shepherd and his counsel did not have access, denying Mr. Shepherd notice of critical evidence and any opportunity to be heard as to that evidence,"<sup>79</sup> but the Complaint alleged that there had in fact been an officer holding the rank of second lieutenant in Mr. Shepherd's company who had been killed during the timeframe he was in combat.<sup>80</sup> Also troubling was the fact that the ABCMR initially sent Mr. Shepherd a decision with a page missing, and later sent him a different version, claiming that the one Mr. Shepherd had received was only a draft.<sup>81</sup>

The ABCMR gave no indication of having considered that Mr. Shepherd might have been credible, even if mistaken on one minor detail: where the officer was from. Nor did the Board consider that because people mean different things when they say where they are "from," they may state places other than those reflected in their records. This inattentive practice is particularly damaging for trauma survivors, who "often tell their stories in a highly emotional, contradictory, and fragmented manner which undermines their credibility."<sup>82</sup> After an interview with Joanne Archambault, who was in charge of the special victims unit at the San Diego Police Department for ten

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76. See *supra* notes 21-24 and accompanying text.

77. *In re* [Redacted], No. AR20120006241 (Army Bd. for Corr. of Military Records June 7, 2012), <http://boards.law.af.mil/ARMY/BCMR/CY2012/20120006241.txt>.

78. *Id.*

79. Plaintiff's Proposed Second Amended Complaint, *supra* note 25, ¶ 28.

80. *Id.* ¶ 15.

81. *Id.* ¶¶ 23-25.

82. HERMAN, *supra* note 19, at 1.

years and who trains police officers nationwide, journalist Melinda Henneberger explained that “because of the way the brain processes information in traumatic situations, victims almost always get some details wrong. Only the phony reports are perfect.”<sup>83</sup>

Similarly, another applicant described an event in which “a rocket exploded in a tent next to his and killed numerous Soldiers.”<sup>84</sup> The applicant stated that “he was unable to get any substantial sleep for the next 3 months which made him unable to do his job.”<sup>85</sup> He was discharged in 1971 after he refused to go back into the field. Before his discharge he stated, “I get flashbacks and I am not going to endanger anyone’s life because of it.”<sup>86</sup> The ABCMR denied his application, stating that “[h]is record is void of any evidence and he has not provided any evidence showing that he was ever in the vicinity of an exploding rocket which resulted in the loss of numerous Soldiers or that he experienced any other traumatic event while serving in the Army.”<sup>87</sup> It is unfair for the ABCMR to put the burden on the veteran to produce evidence of particular war events.

### III. SUGGESTED CHANGES

The challenge for the ABCMR in reforming the way it treats PTSD cases will be developing a system that understands and accommodates veterans with PTSD without giving them a blanket excuse. This Part will provide several concrete suggestions that address this delicate balance.

#### *A. Later Expert Medical Opinions Should Rebut the ABCMR’s Presumption that the Medical Assessment at Discharge Was Correct*

The first major challenge for veterans who were not diagnosed with PTSD at the time of discharge—whether because they were discharged before the diagnosis existed or because they were erroneously diagnosed with the wrong

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83. Melinda Henneberger, *Why I Won’t Be Cheering for Old Notre Dame*, WASH. POST: SHE THE PEOPLE (Dec. 4, 2012, 11:02 PM), <http://www.washingtonpost.com/blogs/she-the-people/wp/2012/12/04/why-i-wont-be-cheering-for-old-notre-dame>.

84. *In re* [Redacted], No. AR20100015023 (Army Bd. for Corr. of Military Records Jan. 4, 2011), <http://boards.law.af.mil/ARMY/BCMR/CY2010/20100015023.txt>.

85. *Id.*

86. *Id.*

87. *Id.*

mental disorder—is proving that they in fact had PTSD at that time. If an Army doctor misdiagnoses a veteran at discharge or fails to make any psychiatric diagnosis, most of the time the only way the veteran can prove that conclusion was incorrect is with later medical evidence. The Board has a sensible presumption that the medical assessment at discharge is correct, but a later doctor’s expert opinion should rebut this presumption and flip the burden. Unless there is strong evidence that the discharge at the time was correct, the new opinion should control.

There are several reasons why the later doctor’s diagnosis should be given more weight. First, as time goes by, there is the benefit of additional development of information from which to draw conclusions. For example, the amount of time that the symptoms persist might be relevant to distinguishing PTSD from AD. Second, diagnostic methods and criteria change and become more precise over time. As described in Section I.B, the advent of the new *DSM-5* diagnostic criteria may make it easier for some soldiers to get an appropriate diagnosis as “fear and helplessness” is no longer required. If a soldier is diagnosed based on this new set of criteria, it does not mean that he or she just developed PTSD, just that it was not recognized until now. Therefore, it is important that the ABCMR accept the new diagnosis as powerful evidence.

*B. In Appropriate Circumstances, the ABCMR Should Presume Causation*

Another challenge for veterans with PTSD applying to the ABCMR is that it is impossible to prove the nexus between an action leading to discharge and PTSD. Veterans who have submitted expert medical opinions saying that their conduct was likely caused by PTSD have been rebuffed by the Board for lack of evidence.<sup>88</sup> The ABCMR should adopt a procedure by which a veteran can establish a presumption that actions leading to discharge were caused by PTSD by showing that (1) he or she has been diagnosed with PTSD caused by his or her military service, (2) he or she was discharged based on actions that correspond to symptoms of PTSD, and (3) the actions leading to discharge represent a change in behavior. For example, a veteran with PTSD who earned service awards for heroism in combat and then suddenly refused to go back out

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88. See, e.g., *In re* [Redacted], No. AR20110013885, *supra* note 64; *In re* [Redacted] AR20120006241 (Army Bd. for Corr. of Military Records date unavailable), <http://boards.law.af.mil/ARMY/BCMR/CY2012/20120006241.txt>.



into the field should get the benefit of the doubt that this action was a result of PTSD.

*C. The ABCMR Should Accept the Veteran's Testimony of Combat Events*

In 2010, VA changed its regulations so that if a veteran has served in a war zone and has PTSD, the agency will presume that the veteran's account of the events leading to his or her PTSD is accurate.<sup>89</sup> As President Obama stated in his Weekly Address announcing the change, "for years, many veterans with PTSD who have tried to seek benefits—veterans of today's wars and earlier wars—have often found themselves stymied. They've been required to produce evidence proving that a specific event caused their PTSD."<sup>90</sup> He added, "I don't think our troops on the battlefield should have to take notes to keep for a claims application."<sup>91</sup> The VA regulation now provides that

[i]f the evidence establishes that the veteran engaged in combat with the enemy and the claimed stressor is related to that combat, in the absence of clear and convincing evidence to the contrary, and provided that the claimed stressor is consistent with the circumstances, conditions, or hardships of the veteran's service, the veteran's lay testimony alone may establish the occurrence of the claimed in-service stressor.<sup>92</sup>

This change recognizes both the reality of war—during the chaos of combat, soldiers are not able to, nor should they attempt to, spend effort trying to record particular details to help in a later claim—and the reality of the way PTSD affects memory. The ABCMR should adopt this same approach. If a veteran offers medical evidence that he or she has PTSD and that it was caused by an event to which he or she has testified, the ABCMR should not require additional proof of the event and should certainly not seek out minor details to discredit the veteran.

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89. 38 C.F.R. § 3.304(f) (2013).

90. Office of the Press Sec'y, *Weekly Address: President Obama Announces Changes to Help Veterans with PTSD Receive the Benefits They Need*, WHITE HOUSE (July 10, 2010), <http://www.whitehouse.gov/the-press-office/weekly-address-president-obama-announces-changes-help-veterans-with-ptsd-receive-be>.

91. *Id.*

92. 38 C.F.R. § 3.304(f)(2).

*D. These Proposed Changes Would Not Open the Floodgates for Fraudulent Discharge Upgrade Claims*

As discussed in Section I.A, there is considerable debate about the prevalence and diagnostic criteria of PTSD. While some might argue that this debate counsels against adopting more liberal standards for awarding discharge upgrades on the basis of PTSD, this argument is misguided.

First, the debate is far from settled. Many people argue that PTSD is actually under-diagnosed, particularly in the military where many have shown that doctors have failed to diagnose the disorder.<sup>93</sup> Second, the debate does not revolve around whether or not PTSD is a real condition or whether or not it exists, but rather around how it is diagnosed. That debate will continue to occur in the medical community, and the experts who design the *DSM* will make changes as they see fit. Meanwhile, the legal community should respond in its area of expertise.

This Comment does not suggest that every veteran with PTSD and a bad discharge deserves an upgrade. However, under current practice, the ABCMR consistently disregards later evidence of PTSD, making it nearly impossible for veterans with bad discharges arising from conduct due to undiagnosed PTSD to get discharge upgrades. That is unacceptable, and the ABCMR should adopt the procedures outlined in this Part to more fairly adjudicate these claims.

## CONCLUSION

The ABCMR is often Army veterans' last stop for a discharge upgrade,<sup>94</sup> which affects their benefits, employment prospects, educational opportunities, burial rights, and societal recognition. The ABCMR is authorized not only to "correct an error," but also to make changes necessary to "remove an injustice."<sup>95</sup> In order to do justice to the veterans who fought for this country, the ABCMR should reform its procedures. Its current practice of disregarding evidence of an incorrect diagnosis at the time of discharge makes it virtually impossible for a veteran with PTSD to contest his or her discharge on that basis, denying countless veterans the honor and benefits they deserve. This

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93. See *supra* notes 21-24 and accompanying text.

94. See *supra* note 32.

95. 10 U.S.C. § 1552(a)(1) (2012).

cannot accord with the Board's "abiding moral sanction"<sup>96</sup> to serve the interest of justice.

REBECCA IZZO\*

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96. *Yee v. United States*, 512 F.2d 1383, 1387 (Ct. Cl. 1975).

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