Information Paper on the Relationship Between PTSD, TBI, and Criminal Behavior

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This information paper highlights the current state of knowledge about the relationship between criminal behavior and mental illnesses that are common among servicemembers who have experienced combat and situations in which their lives were threatened or in which they were forced to harm others in the course of their duties, particularly noncombatants. Although each person can—and many do—react very differently to the events which cause Posttraumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI), and there are incentives for persons facing charges to fake a disorder or exaggerate its symptoms in attempts to reduce potential punishment, countless real experiences have led to a consensus among experts that *some portion* of combat veterans engage in criminal conduct as a result of untreated mental health conditions related to combat. Excluding cases in which individuals have malingered a disorder or its symptoms, the following paragraphs discuss lessons from actual cases.[*]

Criminal Conduct Related to Mental Health Conditions

Traumatic Brain Injury is a signature injury of the wars in Iraq and Afghanistan, and one estimate projects that 300,000, or nearly 20%, of veterans of these wars may suffer from PTSD.[1] Posttraumatic Stress Disorder and TBI often underlie criminal behavior because both conditions, together or independently, influence one's judgment and ability to respond to stressful triggering events. This information paper does not seek to suggest that there is an excuse for the criminal misconduct stemming from PTSD or TBI. Rather, the below examples, drawn from research and observations from Vietnam to the present, are intended to highlight conditions that can be prevented or minimized with a proper course of treatment if intervention occurs early enough during the life-course of the disorder.

For practical purposes, PTSD is a disorder that arises from a significant threatening event that leads to specific types of responses based on unwanted reminders of the real trauma or attempts to avoid similar trauma from happening again. One shorthand description of combat PTSD is "the persistence into civilian life or life in garrison of the valid physiological, psychological, and social adaptations that promote survival when other human beings are trying to kill you."[2] Traumatic Brain Injury is injury to the brain which results from physical impact. Based on the nature of the trauma inflicted and the parts of the brain damaged by the physical impact, physiological responses can influence the brain's processing of information and the ability to regulate emotion. In some cases, TBI impairs judgment to the point where a person perceives nonexistent threats or lacks the ability to express rage, shock or grief in a socially acceptable manner.[3] Those individuals who suffer from both PTSD and TBI, often stemming from injuries inflicted during the same combat events, may experience symptoms of greater or extended severity than they would if they only suffered from one.

While the true incidence of trauma-related criminal behavior remains unknown due to non-reporting, lack of mental health diagnoses, and lack of evaluation of circumstances or history by military or civilian authorities, criminal behavior more commonly associated with, and often "stemming directly from," untreated PTSD includes:

[*] For ease of reading, references are kept to a minimum and appear in endnotes following the text.

- "AWOL or desertion after return to U.S.";

- "Use of illicit drugs to self-medicate symptoms of PTSD"; and

- "Impulsive assaults during explosive rages . . . after return to the U.S."[4]

Army Field Manual 22-51, the *Leader's Manual for Combat Stress Control*, includes these and other criminal behaviors as "misconduct stress behaviors" originating from experiences in combat and emerging over time following such exposure.[5] While the former sources date to 1994 and lessons from Vietnam era combat veterans, a 2007 Department of Defense mental health task force report similarly linked PTSD to "[d]ifficulty controlling one's emotions, including irritability and anger . . . , [s]elf-medication with . . . illicit drugs in an attempt to return to normalcy [and] reckless/high risk behaviors."[6] Overall, many violations of the *Uniform Code of Military Justice* may be further explained by the specific symptom clusters, stress triggers, or environmental stimuli addressed below:

Self-Medication. The persistent reminders of original trauma that repeat over time in an unwanted way and hypervigilence, a state in which an individual is constantly on alert expecting a threat to guard against, are PTSD symptoms that can lead one to become exhausted and constantly on edge. A very common response to these conditions is misuse and abuse of alcohol, prescription medication, or illicit narcotics to relieve such symptoms. Although servicemembers have choices and their mental conditions do not force them to engage in this activity, this "self-medication" is often for the purpose of relaxing or sleeping. Depending on the facts of an individual case, one who might have recreationally used alcohol prior to the trauma may begin abusing it for its benefits without knowing he or she has a mental health disorder and failing to notice abuse of alcohol until an event or a witness makes this clear.

A **dissociative episode** is an experience in which a person detaches from reality and believes himself or herself to be in an environment similar to the one in which actual trauma occurred, mistakenly anticipating or believing that a similar threat will be or is present. Sometimes described as a "flashback," the dissociative episode can be triggered by sights, smells, situations of high emotion, or other reminders of actual trauma. Witnesses often describe individuals as "going on autopilot" when they are in dissociative states in part because the trauma-survivor, overcome by events, will resort back to survival behavior that they had learned through repetition during training or that they actually relied upon to survive in extremely dangerous situations.

Behaviors based on a **shattered assumption of moral order**. When an event is traumatizing enough to result in PTSD, which is currently diagnosed in part based on the duration of a person's symptoms lasting more than one month,[7] the causal event challenges a number of core assumptions necessary for social survival. One key assumption that is often "shattered" by the trauma is the notion that "a moral order exists in the universe that discriminates right from wrong."[8] After the traumatic event, the survivor may find certain behaviors to be acceptable that he or she considered as morally wrong or criminal prior to the event, essentially reasoning that life operates according to fewer rules in a far more haphazard manner.

Thrill or sensation-seeking behavior, which arises from sustained periods living in dangerous environments where the veteran expected threats at any moment, can occur when the trauma-survivor returns to civilian roles that he or she perceives to be boring and uneventful. In some cases, combat veterans perceive such uneventful roles as an exception to the norm and extremely distressful. In an effort to return to a similar sense of routine, some veterans try to recreate the common adrenaline rush by engaging in dangerous behavior behind the wheel of a car or handlebar of a motorcycle, starting fights at

bars, or undertaking more deliberate acts involving the possibility of capture by the authorities or persons capable of retaliating with force.[9]

Self-punishment. In a different response to traumatic experiences, particularly ones in which the combat veteran felt responsible for injury or death to fellow servicemembers or civilians, the veteran may resort to criminal activity hoping to be caught and punished with the belief "I deserve to suffer,"[10] viewing incarceration and its resulting discomfort as methods of evening the score or making right the situation. In an extreme variation, "Depression-Suicide Syndrome," the veteran may hope for law enforcement to respond to his or her criminal behavior with lethal force as a means of suicide.[11] As opposed to this "unconscious" or "survivor's" guilt,[12] a combat veteran may also use extreme forms of self-punishment in an effort to protect society from his or her own threat of unpredictable violence.[13] In either case, because the object of the behavior is in law enforcement's response to it, the crimes often appear to be illogical, "bizarre," and "poorly planned."[14]

"Moral injury" results from a traumatic event in which a veteran felt authorized or required by the circumstances in combat to act in conflict with his or her conscience and sense of values.[15] A common example used by the psychiatrist who coined the term is the Marine who acted on orders to shoot a sniper who was using an infant serving as a human shield.[16] Although the situation and the rules of engagement may have permitted such conduct, the nature of the behavior can create a major conflict within the servicemember on a deeper moral level. Moral injury can result in criminal offenses, especially those involving domestic violence, through the veteran's effort to "strike first," one of three common maladaptive responses to the lack of ability to trust others.[17]

Revenge. It is sometimes the case that individuals suffering from symptoms of combat-related mental conditions will engage in criminal behavior as a form of retaliation. After being plagued by recurring readjustment difficulties, criminal behavior may be an attempt to "prove their abilities, for they perceive society as viewing them to be incapable.[18] Alternatively, these veterans may direct such rage toward "any figures or symbols of authority" as a result of feeling used and exploited during combat service.[19]

Decrease in duty performance due to lack of ability to concentrate or cognitively organize information. Failures to show up to work call or physical fitness on time, outbursts, and inability to meet deadlines are often explained by PTSD and TBI symptoms. These symptoms, when left undiagnosed, may give leaders the misleading impression of a lazy or unmotivated servicemember who has chosen to disregard significant responsibilities within his or her military unit.

Violent behavior occurring during a sleep-state in response to vivid nightmares. Within family advocacy committees it is not uncommon to encounter a spouse assaulted by the military member during sleep or as he or she awoke from a nightmare. In some cases, veterans have killed their spouses in such states.[20]

Adverse reactions to psychotropic medications during the course of treatment for mental conditions. The treatment of PTSD and other mental health conditions resulting from combat trauma often involves prescription narcotics to regulate behavior and emotion. When physicians replace drug types, add new ones, or experiment with different dosages of the same drug over time to overcome the body and brain's resistance, these changes or combinations can result in adverse reactions that impair judgment or induce stress responses.[21]

Recognition of the Criminal Connection

Although the mental health community is learning more about PTSD and TBI with each passing day and has much more to learn, its members have recognized a significant relationship between combat trauma and later criminal conduct by a significant proportion of the total population of combat veterans:

- The Department of Justice's study of incarcerated veterans in 2004 revealed that "over 200,000 veterans are in U.S. jails and prisons, and more than half have been incarcerated for violent offenses."[22] Such statistics do not reflect more recent trends in the wake of intensified combat operations since that time.

- The majority of the incarcerated veteran population (54% in state and 64% in federal prison) "served during a wartime period."[23]

- The National Vietnam Readjustment Study, "the largest study of Vietnam veterans," revealed that "nearly half of [the] male Vietnam combat veterans afflicted with PTSD had been arrested or incarcerated in jail one or more times."[24]

- A study of veterans of Operation Iraqi Freedom who had seen "violent combat" revealed common experiences of "aggressive behaviors following deployment, including angry outbursts, destroying property, and threatening others with violence."[25] Combat veterans have an increased likelihood of using handguns or other weapons in the perpetration of such threats.[26]

- In 2005, Marines who had deployed, including service in Operations Enduring and Iraqi Freedom, were up to twice as likely to use illegal narcotics as their peers who had never deployed.[27]

- In 2010, a key study of 77,998 Marines who deployed in Operation Enduring Freedom or Operation Iraqi Freedom revealed that those who were diagnosed with PTSD were "11.1 times more likely to have a misconduct discharge compared with their peers who did not have a psychiatric diagnosis."[28]

- More recently, in 2012, research with a sample of 1,388 Iraq and Afghanistan veterans revealed that a diagnosis of PTSD or TBI increases the risk of criminal conduct and subsequent arrest for those who experience anger and irritability linked to their symptoms.[29]

Systemic Responses

Outside the DoD, many state legislatures have created diversionary programs specifically for veterans to allow them to obtain mental health treatment in lieu of arrest, conviction, or incarceration. Nearly 100 special court dockets devoted to veterans, called "veterans treatment courts," are functioning throughout the nation with hundreds more in the planning stages.[30] While these courts differ, state by state, and sometimes jurisdiction by jurisdiction, they all exist in recognition that a common manifestation of untreated mental health disorders is criminal conduct. They further understand that traditional punitive responses involving conviction and incarceration largely fail to address the underlying cause of the misconduct, sometimes counterproductively leading symptoms to worsen.[31]

The DoD has begun to realize the value of mental health treatment in a number of ways. In the introduction to the 2012 *Goldbook*, the Army's Vice Chief of Staff underscored the fact that military leaders "cannot simply deal with health or discipline in isolation," and that "these issues are interrelated and will require interdisciplinary solutions."[32] Aside from the efforts of individual commanders to create options for offenders in need of treatment, institutional responses exist for individuals who qualify for Disability Evaluation System processing for a mental health condition. If they are simultaneously facing separation for misconduct, the commander acting as the separation authority must evaluate the circumstances surrounding the misconduct and address whether the mental health condition was the "direct or substantial contributing cause of the conduct that led to the recommendation for administrative separation."[33] While it is unknown how many punitive actions have been terminated to allow for medical separation of those qualifying for mental health treatment, the requirement to address such circumstances suggests special sensitivity toward and recognition of the connection between mental health conditions and criminal conduct.

A second sign of institutional response within DoD occurred in October 2009 when Department of Defense mental health providers met with Department of Veterans Affairs (VA) professionals and identified the objective to provide targeted mental health services for active duty servicemembers facing disciplinary action.[34] Modeled off of VA's Veterans Justice Outreach program now operating in jails and prisons throughout the Nation as well as most Veterans Treatment Courts,[35] a pilot program is now underway at Army, Navy, and Air Force installations to determine the effectiveness of an intervention program with the input of Veterans Justice Outreach personnel in the same communities.[36] Although the success of the program has not been evaluated and the program's focus is on obtaining treatment during the servicemember's interaction with the military justice system and planning for the servicemember's transition to the civilian community, its genesis lies in the fact that many servicemembers who are involved in the military justice system have mental health conditions and related needs not currently met by the military disciplinary system.

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[10] Harvey J. Schwartz, *Unconscious Guilt: Its Origin, Manifestations, and Treatment*, *in* PSYCHOTHERAPY OF THE COMBAT VETERAN 47, 52 (Harvey J. Schwartz ed. 1984).
[11] Wilson & Zigelbaum, *supra* note 9, at 74–75 (describing "Depression-Suicide Syndrome"). *See also* Burgess et al., *supra* note 9, at 68 (providing actual examples of these symptoms from reported cases).
[12] Schwartz, *supra* note 10, at 47, 52.

[13] Pentland & Dwyer, *supra* note 9, at 403, 409.
[14] *Id*. at 409.
[15] Brett T. Litz et al., *Moral Injury and Moral Repair in War Veterans: A Preliminary Model and Intervention Strategy*, 29 CLINICAL PSYCHOL. REV. 695 (2009).
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