14.1 ADJUSTMENT DISORDERS

AEROMEDICAL CONCERNS: Adjustment disorders are often associated with decreased concentration, depression, anxiety, impairment of occupational or social functioning, inattention, indecisiveness, fatigue, and insomnia, all of which are incompatible with aviation duties. This is one of the most common psychiatric diagnoses among aviators.

WAIVER: Adjustment disorder is temporarily considered disqualifying (CD) for aviation until resolved. Once fully resolved, the patient is PQ with no waiver required. In cases where medication has been prescribed, the grounding period should include the time required for full metabolism and clearance of the specific medication(s) used; an Aeromedical Clearance should not be issued until the member is completely asymptomatic and free of medication effect.

INFORMATION REQUIRED: Upon return to an up status, FS must submit:

1. A brief summary of pertinent symptoms and treatment
2. All any mental health records or Medical Board reports (if applicable)

TREATMENT: Neither medication use nor psychotherapy during the symptomatic period is compatible with aviation duties. All treatment must be completed, and adequate time must be allowed for full metabolism and clearance of medication(s) prior to issuance of Aeromedical Clearance.

FOLLOW-UP REQUIREMENTS: Psychiatric follow-up is at the discretion of the mental health provider. *Adjustment disorders diagnosed by mental health personnel are not considered resolved until a mental health provider makes that statement in the patient's health record.*

DISCUSSION: The subjective distress or impairment in functioning associated with adjustment disorders is frequently manifested as decreased performance at work or school and temporary changes in social relationships. Adjustment disorders are also associated with an increased risk of suicide attempts and suicide.

14.2 ALCOHOL ABUSE OR DEPENDENCE

AEROMEDICAL CONCERNS: Alcohol has both acute and chronic effects on cognitive and physical performance. Cognitive effects include impairment of short-term memory, degradation of reasoning and decision-making, and inattentiveness. Psychomotor dysfunction includes an increase in reaction time and procedural errors. These damaging effects can occur at low blood alcohol levels (0.02 mg/dl). In addition, after moderate alcohol consumption, these effects can persist for many hours even after the blood alcohol level has returned to zero. Alcohol can also cause problems with visual acuity, oculovestibular dysfunction (positional alcohol nystagmus), and vertigo. This susceptibility exists long into the "hangover" period. In addition, alcohol reduces Gz tolerance by 0.1-0.4 G. Acute alcohol intoxication can also produce ataxia, vertigo, nausea, and dysrhythmias that usually disappear quickly but can leave moderate conduction delays for up to one week (the "holiday heart" syndrome). Acute alcohol intoxication is implicated in about 16% of general aviation fatal accidents.

HISTORY OF ALCOHOL ABUSE OR DEPENDENCE TREATMENT: To properly identify and follow all aviation personnel with a history of alcohol abuse or dependence, all aviation physical exams shall include the following question on the appropriate medical history questionnaire (SF 93 or 6120/2): *"Have you ever been diagnosed or had any level of treatment for alcohol abuse or dependence?"* Treatment must have been provided at a Sustance Abuse Rehabilitation Program (SARP) or other free-standing facility authorized to provide such treatment to USN personnel. Waiver requests documenting treatment other than that described will be reviewed on a case by case basis to assess standard of care. Civilian education programs, shipboard aftercare programs and IMPACT / PREVENT education programs are inadequate treatment for aviation personnel diagnosed with alcohol abuse/dependence requesting a waiver.

- **Former** Treatment Levels
  Level I - PREVENT/IMPACT for an alcohol related incident or prevention.
  Level II - OUTPATIENT for a diagnosis of alcohol abuse.
  Level III - INPATIENT for a diagnosis of alcohol dependence.

- **Current** Treatment Levels
  Level 0.5 -IMPACT for an alcohol related illness or mild alcohol abuse.*****
  Level 1 - OUTPATIENT for a diagnosis of alcohol abuse.
  Level 2 - INTENSIVE OUTPATIENT for a diagnosis of alcohol dependence.
  Level 3 - DORMITORY for junior enlisted assigned to a barracks with a "buddy" system will
  attend level 1 or 2 outpatient treatment and live in the barracks at night.
  Level 4 - INPATIENT (medical ward) for those at risk for withdrawal prior to treatment.

** Please note Level 0.5 IMPACT is NOT adequate treatment for aviation personnel diagnosed with alcohol abuse requesting a waiver. They MUST receive at least OUTPATIENT treatment for alcohol abuse.*

An alcohol related incident is not considered disqualifying (NCD). Alcohol abuse and/or dependence are considered disqualifying (CD) and require a waiver.

PREVIOUS DIAGNOSIS OF ALCOHOL ABUSE OR DEPENDENCE: If the member has a previous diagnosis of alcohol abuse or dependence and a waiver has not been granted, follow the guidelines for New Diagnosis of Alcohol Abuse or Dependence. If the member has a previous diagnosis of alcohol abuse or dependence and has been granted a waiver, follow the guidelines for Annual Waiver Continuance Process (outlined below).
Applicants to the aviation programs for duty involving flight will be evaluated in accordance with these standards. Diagnosis of either alcohol abuse or alcohol dependence will require treatment. Records of court-ordered "counseling/treatment/education" programs for alcohol-related incidents should be obtained and reviewed to assess whether a substance use or any other psychiatric diagnosis was made that would require waiver.

ABSTINENCE: Abstinence is required of all aeronautically designated personnel or students (aviators, aircrew, air traffic controllers, hypobaric chamber inside observers, and instructors) diagnosed with alcohol dependence or abuse per BUMEDINST 5300.8 as follows:

- Navy/Marine Corps active/reserve serving in a flying status involving operational or training flights (DIFOT)
- Duty in a flying status not involving flying (DIFDEN) orders
- Personnel serving as hypobaric chamber inside observers
- Instructors under hazardous duty incentive pay (HDIP) orders
- Civilian DON employees including nonappropriated fund employees and contract employees involved with frequent aerial flights or air traffic control duties

NEW DIAGNOSIS OF ALCOHOL ABUSE OR DEPENDENCE: Flight Surgeon must submit grounding physical to NAMI Code 342. Waiver is possible 90 days after the patient has:

1. Successfully completed OUTPATIENT or INTENSIVE OUTPATIENT treatment.
2. Maintained a positive attitude and an unqualified acknowledgment of his alcohol disorder.
3. Remained abstinent without the need for Antabuse-type medications.
4. Complied with aftercare requirements post-treatment during the 90 days (see below).

AFTERCARE REQUIREMENTS: The member must document participation in an organized alcohol recovery program (Alcoholics Anonymous (AA)), and meet with designated professionals for the following specified timeframes:

Aftercare Timeframe

Professional /Meetings	**First Year**	**Second / Third Year**	**Fourth Year**
Flight Surgeon	Monthly	Quarterly	Annually
DAPA /SACO	Monthly	Monthly	N/A
Psychiatrist/Psychologist	Annually	Annually	N/A

Alcoholics Anonymous	3x weekly	1x weekly	recommended not required

INITIAL WAIVER PROCESS: As with any other waiver, the member should initiate the request. *In the waiver request letter, the member must acknowledge the specific aftercare requirements listed above.* Further, the member must provide specific evidence of current compliance. This will avoid claims that the member was never advised of all the requirements for requesting and maintaining an alcohol-related waiver. The following paragraph must be included in the member's request:

"I have read and received a copy of BUMEDINST 5300.8 series. I understand that I must remain abstinent. I must meet with my flight surgeon monthly for the first year, then quarterly for the next two years of aftercare. I must meet with the DAPA monthly and receive an annual mental health evaluation for the first three years of aftercare. And I must document required attendance at alcoholics anonymous (AA)."

Information required:

1. Complete flight physical, including Mental Status Exam (SF 88 and SF 93 or 6120/2).
2. Flight Surgeon's narrative (Flight Surgeon's waiver endorsement) to include:
    a. Detailed review of all factors pertaining to the diagnosis, including events preceding and after the initial clinical presentation.
    b. Statements concerning safety of flight, performance of duties, potential for recovery, and any symptoms of comorbid diseases or significant stressors.
    c. Documentation of compliance with aftercare requirements including abstinence and AA attendance.
3. Outpatient/Intensive Outpatient treatment summary.
4. DAPA's statement documenting aftercare including AA attendance.
5. Psychiatric evaluation by a privileged psychiatrist or clinical psychologist. (SECNAVINST 6320.24 (Boxer Law) does not apply in these cases)
6. Internal Medicine evaluation (if indicated).
7. Command endorsement
8. Local Board of Flight Surgeons (if convened) must reference BUMEDINST 5300.8 series.

ANNUAL WAIVER CONTINUANCE PROCESS:

1. During first three years of aftercare
    a) Complete long-form flight physical (SF 88 and SF 93 or DD2807/2808).
    b) Flight Surgeon's statement (must address the following)
        i. Safety of flight, performance of duties, potential for sustained recovery, and any symptoms of comorbid diseases
        ii. Documentation of compliance with aftercare requirements including abstinence and AA attendance.
    c) DAPA's statement documenting aftercare including AA attendance.
    d) Psychiatric evaluation by a privileged psychiatrist or clinical psychologist (SECNAVINST 6320.24 (Boxer Law) does not apply in these cases).

2. After three years of aftercare
    a) Short-form flight physical (NAVMED 6410/10)
    b) Flight Surgeon's statement (must address the following)
        i. Safety of flight, performance of duties, potential for sustained recovery, and any symptoms of comorbid diseases.
        ii. Documentation of member's continued abstinence

NONCOMPLIANCE OR AFTERCARE FAILURE: The following pertain to any member in denial of an alcohol problem, failing to abstain, or not compliant with all aftercare requirements of BUMEDINST 5300.8 series. These member's are to be considered NPQ and the following actions shall be performed:

1. Ground the member immediately! Grounding period is a minimum of 6-12 months.
2. Submit grounding physical to NAMI Code 342 (MED-236).
3. Re-evaluation by Flight Surgeon, DAPA, and Alcohol Treatment Facility to determine potential for re-treatment.

NOTE: The member's command must recommend a revocation of the current waiver in accordance with BUMEDINST 5300.8 series. If member requests waiver after the 6-12 month grounding period, please follow the Initial Waiver Process (above). Please discuss these waiver requests with NAMI Psychiatry Department Code-321 before submission. NAMI will review these waiver requests only on a case by case basis.

DISCUSSION: Use the current American Psychiatric Association's Diagnostic Statistics Manual (DSM-IV-TR) criteria to diagnose alcohol-related disorders. No difference exists in the waiver process or aftercare requirements for a member diagnosed with alcohol abuse versus alcohol dependence. The evidenced-based aftercare requirements (above) will help a member diagnosed with alcohol dependence maintain long-term sobriety/abstinence. According to Fiorentine 1999, weekly or more frequent AA participation is associated with drug and alcohol abstinence. Also, less than weekly AA participation is not associated with favorable drug and alcohol outcomes. According to Trent 1998, in his study of the Navy's alcohol treatment programs, the single best predictor of success at one-year is the number of months of aftercare participation. In addition, the best predictor of long-term success is one-year of sobriety/abstinence. Physicians often do not recognize the disease or ignore it. Alcohol related disorders should be considered in any patient with trauma, mood disorders, anxiety, sexual dysfunction, hypertension, gastritis, or current infections. In the United States, there are at least 12 million alcoholics and 76 million adults who have been exposed to alcoholism in the family. 64% of high school seniors have been drunk and alcohol is a factor in 41% of automobile fatalities and up to 50% of suicides. Surveys of United States pilots concerning use of alcohol reported that 22% would fly within one hour of drinking and 50% after 4 hours. In addition, a study in 1990 reported that 50% of pilots underestimate the deleterious effects of acute alcohol use.

REFERENCES

-BUMED INSTRUCTION 5300.8 (20 Mar 92) DISPOSITION OF REHABILITATED ALCOHOL DEPENDENT OR ABUSER AIRCREW, AIR CONTROLLERS, HYPOBARIC CHAMBER INSIDE OBSERVERS AND INSTRUCTORS with 2 MSG changes/updates **(see below)**

Paragraph 6b:
-MSG 1813002 JAN 94 (Aviation personnel diagnosed as alcohol dependent prior to 1987 or as alcohol abusers prior to 20 MAR 92 need to be identified and shall be subject to this instruction.

Paragraph 6g:
-MSG 021300Z FEB 94 (Submit grounding P.E. upon diagnosis of alcohol dependence or abuse. A complete P.E. should be submitted with initial waiver request. Thereafter P.E. for endorsement is required annually for continuance.
DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS Fourth Edition TEXT REVISION (DSM-IV-TR)

ICD-9 CODES
303.90 Alcohol Dependence (specify either with Psychological Dependence or without psychological dependence)

NOTE: May Specify **Early Partial Remission** Between 1 and 12 months if 1 or more criteria for abuse/dependence are met, but not all criteria for dependence; **Early Full Remission** Between 1 and 12 months, no criteria for abuse/dependence met; **Sustained Partial Remission** 12 months or longer with 1 or more criteria for abuse/dependence met, but not full criteria for dependence; **Sustained Full Remission** 12 months or longer with no criteria for abuse/dependence met
305.00 Alcohol Abuse

14.3 ANXIETY DISORDERS

AEROMEDICAL CONCERNS: The symptoms may produce distraction in flight with autonomic symptoms as well. Panic attacks can produce sudden incapacitation.

WAIVER:

- **Panic Disorder**
- **PTSD**
- **Generalized Anxiety Disorder**
- **Obsessive Compulsive Disorder**
- **Acute Stress Disorder**

The above diagnoses are all CD for aviation. Treatment should occur under the auspices of a Limited Duty Medical Board. Waiver may be requested when the member is asymptomatic, off medications, and out of active treatment for one year. A waiver may be considered for Acute Stress Disorder if the patient has remained asymptomatic and off medications for six months.

Specific Phobias: NPQ only if they impact on performance or flight safety. Refer package to NOMI for departmental review.

Social Phobias: NPQ if the behavior impacts on flight performance. Refer package to NOMI for departmental review.

INFORMATION REQUIRED:

1. Psychiatric evaluation and treatment summary
2. Medical Board reports (if indicated)

TREATMENT: The medications used to treat these disorders are incompatible with flying status. Behavioral therapy, including relaxation, biofeedback, and anxiety management, is permitted in a flying status if the symptoms are so mild that it does not meet the criteria for Panic Disorder, PTSD, Generalized Anxiety Disorder, or Obsessive Compulsive Disorder. Medication and behavioral therapy may certainly be used while the patient is on a Limited Duty Board.

FOLLOW-UP REQUIREMENTS: Psychiatric follow-up for the anxiety disorders is at the discretion of the treating mental health provider. Patients on Limited Duty status are generally seen at least monthly in follow-up. After one year off medications and symptom-free in a Full Duty status, the patient should receive a psychiatric evaluation to verify that there has been no recurrence. This evaluation must be included with the waiver request.

DISCUSSION: Patients with PTSD, Panic Disorder, and GAD may complain of palpitations, dizziness, headaches, shortness of breath, tremulousness, and impaired concentration and memory. OCD patients complain of obsessional thoughts and/or compulsive rituals which interfere with functioning. Long term prognosis is controversial, however over 50% may

recover within a year with appropriate treatment. Panic disorder has a high rate of recurrence, and is associated with increased mortality from cardiovascular disease and suicide.

ICD-9 CODES:
300 Anxiety Disorders
300.00 Anxiety Disorder NOS
300.01 Panic Disorder without Agoraphobia
300.02 Generalized Anxiety Disorder
300.21 Panic Disorder with Agoraphobia
300.23 Social Phobia
300.29 Specific Phobia
300.3 Obsessive Compulsive Disorder
309.81Post Traumatic Stress Disorder

14.4 ATTEMPTED SUICIDE

AEROMEDICAL CONCERNS: There is a risk that a person may make an attempt which would compromise the safety of others (pilots sometimes use their aircraft as the instrument of suicide).

WAIVER: "Suicide attempt" by itself is a behavior, not a DSM-IV psychiatric diagnosis. Waivers are based on the psychiatric diagnosis of which the suicide attempt is a manifestation. If the suicide attempt was the manifestation of a Personality Disorder, the patient is NAA. If the suicide attempt was a manifestation of an Adjustment Disorder, the patient would be PQ when the Adjustment Disorder is fully resolved. Recurrent suicide attempts, however, may be disqualifying regardless of the diagnosis.

INFORMATION REQUIRED:

1. Psychiatric evaluation
2. Psychiatric hospitalization (if warranted).
3. Submission of a brief summary of pertinent details and any available records

TREATMENT: Treatment is based on the individual's psychiatric diagnosis. However, suicide attempts associated with most Axis I and Axis II diagnoses other than Adjustment Disorder or V codes are incompatible with aviation duty.

FOLLOW-UP REQUIREMENTS: Follow-up psychiatric care is at the discretion of the treating mental health provider, and the frequency should be clearly stated in the psychiatric evaluation or hospital discharge summary.

DISCUSSION: Of those who make a suicidal gesture, 66% are involved in an acute personal crisis and many will have ingested alcohol within 6 hours of the attempt. Within one year, 20% will repeat the attempt and 2% will be successful. There is an underlying personality disorder in 20-25% of cases.

ICD-9 CODE:
958.9 Attempted Suicide

14.5 EATING DISORDERS

AEROMEDICAL CONCERNS. Eating disorders can cause potentially life-threatening metabolic alkalosis, hypochloremia, and hypokalemia, which can have drastic implications for aviation safety. Anxiety and depressive symptoms are common, and suicide is also a risk.

WAIVER: Eating Disorders (Anorexia, Bulimia, and Eating Disorders NOS) are CD for aviation. Currently these cases are handled by Administrative Separation if the symptoms interfere with duty. These cases may be treated under the auspices of a Medical Board if the member has another primary psychiatric diagnosis, such as depression or dysthymia. Waiver may be considered on a case-by-case basis if the patient is off medication, asymptomatic, and out of active treatment for one year. A NOMI Psychiatry evaluation is required prior to waiver consideration. These patients must meet the minimum aviation weight standards.

INFORMATION REQUIRED:

1. Psychiatric evaluation
2. Copy of Medical Board (if applicable)
3. Flight surgeon's narrative (Aeromedical Summary) outlining any social, occupational, administrative, or legal problems of the patient

TREATMENT: Treatment is very difficult and involves intensive long term therapy, group therapy, and possibly pharmacotherapy, all of which are incompatible with aviation duty.

FOLLOW-UP REQUIREMENTS: Follow-up psychiatric care for those patients retained on Limited Duty is at the discretion of the treating mental health provider, but should involve at least monthly follow-up.

DISCUSSION: Relapse rate is high. In long term follow-up of anorexia, 40% recover, 30% improve, and 30% are chronic. Anorexia is potentially fatal in 5-12% of cases. Bulimia is often associated with alcohol abuse.

ICD-9 CODES:
307.50 Eating Disorder NOS
307.51 Bulimia
307.1 Anorexia Nervosa

14.6 IMPULSE CONTROL DISORDERS

AEROMEDICAL CONCERNS: Stereotyped or impulsive behavior may lead to aviation safety problems. These disorders involve an inability to resist acting on an impulse that is dangerous to the patient or others, and that is characterized by a sense of pleasure when gratified.

WAIVER: Impulse Control Disorders (intermittent explosive disorder, kleptomania, pathological gambling, pyromania, trichotillomania) are CD for aviation. Waiver requests are handled on a case-by-case basis, and questions should be referred to NOMI Psychiatry via telephone consultation or referral for formal evaluation.

INFORMATION REQUIRED:

1. Psychiatric evaluation
2. Flight surgeon's narrative (Aeromedical Summary) outlining any social, occupational, administrative, or legal problems of the patient.

TREATMENT: Psychotropic medications used with Intermittent Explosive Disorder and trichotillomania are incompatible with aviation duty. Pathological gambling and kleptomania are generally treated with behavior therapy.

FOLLOW-UP REQUIREMENTS: Follow-up psychiatric care is at the discretion of the mental health provider in those cases in which it is deemed necessary.

DISCUSSION: Differential diagnosis should include substance abuse, temporal lobe epilepsy, head trauma, bipolar disorder (manic), and antisocial personality disorder. The diagnosis is usually not made if the behavior occurs only in the context of another Axis I or Axis II disorder such as schizophrenia, bipolar disorder, or adjustment disorder.

ICD-9 CODES:
312.3 Impulse Control Disorder, NOS
312.31 Pathological Gambling
312.32 Kleptomania
312.33 Pyromania
312.34 Intermittent Explosive Disorder
312.39 Trichotillomania

14.7 LEARNING DISORDERS/ATTENTION-DEFICIT/HYPERACTIVITY DISORDER

AEROMEDICAL CONCERNS: Learning disorders may be associated with underlying abnormalities in cognitive processes, including deficits in visual perception, attention, memory, or linguistic processes. Depending on the severity of the disorder, these deficits could pose both safety and mission execution problems in the fast-paced aviation environment. Attention Deficit/Hyperactivity Disorder (ADD or ADHD) involves a persistent pattern since early childhood of inattention and/or hyperactivity/impulsivity. Depending on the severity of the disorder, there may be difficulties with sustained attention, concentration, distractibility, impatience, and impulsiveness that would have a negative impact within the aviation environment.

WAIVER:

Learning Disorder: History of a learning disorder is not necessarily disqualifying. The severity and nature of the disorder should be documented. Any residual problems or history of a persistent learning disorder requires a neuropsychological evaluation. Depending on the results, the member may be found NPQ.

Attention Deficit/Hyperactivity Disorder: A diagnosis of ADD/ADHD meeting DSM criteria is considered disqualifying. Applicants or designated aircrew with ADD/ADHD who have not taken medication for 12 months and who remain symptom free may be considered for waiver.

NOTE: If a flight surgeon reviewing all available medical records determines that the diagnosis of ADHD was erroneous or does not meet DSM criteria, the flight surgeon's interview reveals no persistent ADHD features, there has been no medication use for at least 12 months, and there is evidence of satisfactory academic performance, the record may be referred to NAMI Psychiatry for consultation to recommend a waiver or to find the candidate physically qualified.

INFORMATION REQUIRED:

1. All prior medical and mental health records documenting how the diagnosis of ADHD was initially determined and any subsequent assessments. Records should encompass all periods of medication use.
2. Flight surgeon narrative summary (Aeromedical Summary) documenting all prior symptoms, absence of persistent features, when medication was discontinued, and evidence of current academic performance.
3. Current neuropsychological evaluation (obtained after discontinuing all ADHD medications)

TREATMENT: Stimulant medication to maintain attention and decrease hyperactivity is incompatible with aviation duty.

FOLLOW UP REQUIREMENTS: None

DISCUSSION: Many studies suggest the diagnosis of ADHD is frequently assigned inappropriately and that ADHD medication is frequently prescribed to children and adolescents who do not satisfy DSM criteria for ADHD. Recent research of ADHD suggests that 30-70% of children diagnosed with ADHD continue to exhibit symptoms into adulthood. Children with ADHD frequently outgrow impulsivity and hyperactivity, but often have problems with inattention and distractibility throughout adulthood.

References:

Silver, L.B. Attention-deficit disorder in adult life. Child and Adolescent Psychiatric Clinics of North America, 2000(9)3: 411-523.

ICD-9 CODES:
314.00 Attention deficit disorder without hyperactivity
314.01 Attention deficit disorder with hyperactivity

14.8 MOOD DISORDERS (DEPRESSION, MANIA)

AEROMEDICAL CONCERNS: Mood disorders are associated with decreased concentration, inattention, indecisiveness, fatigue, insomnia, agitation, and psychosis, all of which are incompatible with aviation duties. Risk of suicide is 15%, the highest of all mental disorders. There is a strong association with substance abuse.

WAIVER:

- Major Depression
- Dysthymia
- Depressive disorder NOS

The above diagnoses are disqualifying for aviation. Treatment should be considered under the auspices of a Limited Duty Medical Evaluation Board. Waiver may be requested when the member has been completely asymptomatic in a "Fit for Full Duty" status for a minimum of six months after completion of all treatment, including both medication and psychotherapy. A current psychiatric evaluation is required to document complete, sustained remission of all symptoms, and shall be included with the waiver request. Further recurrences are CD, waiver not recommend.

- Bipolar Disorder:

The above diagnosis is disqualifying for aviation, and the member is not eligible for a waiver. The member should be referred to central Physical Evaluation Board for determination of fitness for general duty / retention.

INFORMATION REQUIRED.

1. Psychiatric evaluation and treatment summary
2. Medical Board reports (if applicable)

TREATMENT: Psychotropic medications and psychotherapy for depressive/manic symptoms are not compatible with aviation duties.

FOLLOW-UP REQUIREMENTS: Psychiatric follow-up is at the discretion of the mental health provider. Mood disorders are generally seen at least monthly early in therapy or while on limited duty. After the member has been completely asymptomatic in a "Fit for Full Duty" status for a minimum of six months after completion of all treatment, including both medication and psychotherapy, a waiver can be requested. A current psychiatric evaluation is required to document complete, sustained remission of all symptoms and shall be included with the waiver request.

DISCUSSION: 15% of depressed patients eventually commit suicide. 50-75% of affected

patients have a recurrent episode. Acute major depression is treatable in 80% of patients. 20-30% of dysthymic patients develop subsequent depression or mania.

ICD-9 CODES:
296.2 Major Depressive Disorder, Single Episode
296.3 Major Depressive Disorder, Recurrent
296.0 Bipolar Disorder
300.4 Dysthymic Disorder
311 Depressive Disorder, not otherwise specified

14.9 PERSONALITY DISORDERS

AEROMEDICAL CONCERNS: Maladaptive personality traits may lead to flight safety problems. Aeronautical adaptability involves a person's coping mechanisms, personality style, and defense mechanisms. These may impact on the member's ability to undergo training, safety in aviation environments, and the ability to interact in a harmonious way with other crew members. Certain personality traits may produce thrill seeking behavior, conflicts with authority, emotional lability, questionable judgment and poor impulse control, or inflexibility incompatible with the rigors of aviation duty.

WAIVER: Personality disorders result in the member being found to be NAA. Maladaptive traits which impact on aeronautical performance also result in the member being found to be NAA. Once an individual is found NAA, it is unlikely that they will be found AA at a later date. Therefore, no waivers can be considered for aeronautical adaptability. If, however, the patient demonstrates over a period of 2-3 years a substantial personality maturation in terms of their ability to sustain the stressors of the aviation environment, work in harmony with other members, and stabilize their personal life and turmoil, they may then be considered for reevaluation by a Psychiatrist or Psychologist. This evaluation shall preferably be done at NAMI Psychiatry provided both the patient and his/her command have a strong desire to return to flight status. Questions regarding the aeronautical adaptation of designated aviation personnel should be referred to NAMI Psychiatry by telephone consultation. Designated pilots and NFOs should be referred to NAMI Psychiatry for evaluation.

INFORMATION REQUIRED:

1. Psychiatric evaluation (must also clarify suitability for general and special duty)

TREATMENT: Treatment of personality disorders requires long term intensive psychotherapy, which is incompatible with aviation duty.

DISCUSSION: The diagnosis is largely based on the history of pervasive behaviors or traits that are characteristic of the person's recent and long term functioning (since early adulthood) which cause social or occupational impairment or subjective distress. Psychometric testing such as the MMPI may be abnormal in Class 2 personnel, but is frequently normal in SG I and SG II personnel. The stress of military life frequently exacerbates maladaptive behavior and the diagnosis becomes apparent in the operational environment.

ICD-9 CODES:
301.0 Paranoid PD
301.20 Schizoid PD
301.22 Schizotypal PD
301.83 Borderline PD
301.81 Narcissistic PD

301.50 Histrionic PD
301.60 Dependent PD
301.7 Antisocial PD
301.82 Avoidant PD
301.40 Obsessive Compulsive PD
301.9 Personality Disorder NOS

14.10 PSYCHOTIC DISORDERS

AEROMEDICAL CONCERNS: Symptoms of aeromedical concern include eccentric behavior, illogical thinking, hallucinations, social withdrawal, and the risk of suicide. Recurrence is abrupt, unpredictable and incapacitating in aviation.

WAIVER:

- Schizophrenia
- Schizophreniform Disorder
- Schizoaffective Disorder
- Delusional Disorder
- Brief Psychotic Disorder Without Marked Stressors
- Psychotic Disorder NOS

The above diagnoses are CD for aviation, with no waiver considered. Patients should be referred to Central Physical Evaluation Board for determination of fitness for general duty/retention.

- **Brief Psychotic Disorder with Marked Stressors (Brief Reactive Psychosis):** CD for aviation. Treatment should occur under the auspices of a Limited Duty Board. Waiver may be requested when the member is asymptomatic and off medications for one year in a full duty status. These cases are handled on a case-by-case basis depending on the prognostic factors of the case.
- **Substance-Induced Psychotic Disorder:** Substance-induced Psychotic Disorder with clear evidence from the history, physical examination, or laboratory findings that the disturbance is etiologically related to medication use is PQ when resolved, as long as the "substance" inducing psychosis was not alcohol or illicit drugs. Submit a summary of pertinent details and appropriate records to NAMI for review.
- **Psychotic Disorder Due To General Medical Condition:** NCD when resolved if the precipitating organic factors are identified and considered not likely to recur. Submit a summary of pertinent details and appropriate records to NAMI for review. Physical illness or other disorders causing persistent delirium are permanently disqualifying and should be referred to a medical board.

INFORMATION REQUIRED:

1. Psychiatric evaluation
2. Copy of Medical Board (if applicable)

TREATMENT: Antipsychotic medications and close psychiatric follow-up care are incompatible with aviation duty.

FOLLOW-UP REQUIREMENTS: Psychiatric follow-up is at the discretion of the treating psychiatrist. The majority of these disorders require Physical Evaluation Boards due to their incompatibility with general duty.

DISCUSSION: Increased vulnerability to stress is considered lifelong in these disorders. In schizophrenia, 1/3 will lead somewhat normal lives, 1/3 will continue to have significant symptoms, and 1/3 require frequent hospitalization and chronic care. 50% of schizophrenics make a suicide attempt, and 10% will succeed.

ICD-9 CODES
295.40 Schizophreniform Disorder
295.70 Schizoaffective Disorder
296.24 Major Depressive Disorder, single episode, with psychotic features
297.1 Delusional Disorder
298.8 Brief Psychotic Disorder
298.9 Psychotic Disorder NOS

14.11 SEXUAL DISORDERS

AEROMEDICAL CONCERNS: Generally, sexual dysfunctions such as sexual desire/arousal/orgasm disorders do not impact on a person's aviation performance. The paraphilias, however, such as exhibitionism and transvestic fetishism, may impact aviation performance. Such patients exhibit compulsive behavior and poor impulse control, and certain legal ramifications may cause the person to be inattentive to detail and a safety risk.

WAIVER: Paraphilias are generally CD. Waiver requests are handled on a case-by-case basis by NAMI Psychiatry after the patient has completed treatment and been asymptomatic for one year. Factors that will be considered in waiver requests include the type of paraphilia, duration and frequency, type of treatment required, and the adequacy of follow-up care. However, many cases are handled by administrative disposition due to the legal implications and impact on good order and discipline. Sexual Dysfunctions may be NCD if they do not impact aviation performance.

INFORMATION REQUIRED:

1. Psychiatric evaluation and treatment summary
2. Flight surgeon statement (aeromedical summary) documenting any social, occupational, administrative, or legal problems of the patient.

TREATMENT: The treatment of sexual desire/aversion/arousal/pain/orgasm disorders generally involves behavioral techniques which should not preclude aviation duty. Use of medication is incompatible with aviation duty. Treatment of paraphilias is less successful and generally requires intensive long-term treatment.

FOLLOW-UP REQUIREMENTS: Psychiatric follow-up is at the discretion of the mental health provider in those cases in which treatment is deemed necessary.

DISCUSSION: Paraphilic activity often has a compulsive/impulsive quality. Patients may repeatedly engage in risk-taking behavior, and this behavior increases when the patient feels stressed, anxious, or depressed. The legal consequences generally preclude treatment within the military.

ICD-9 CODES:
302 Sexual Disorders
302.4 Exhibitionism
302.2 Pedophilia
302.9 Paraphilia NOS
302.81 Fetishism
302.89 Frotteurism

14.12 SOMATOFORM AND FACTITIOUS DISORDERS

AEROMEDICAL CONCERNS: These disorders have a chronic course and patients make repeated visits to physicians due to multiple physical or somatic complaints. Patients with factitious disorders may seriously injure themselves (injecting feces, swallowing ground glass, injecting insulin) and are at extreme risk in the aviation environment.

WAIVER: These disorders are CD. They should be referred to a Medical Board for treatment. Waivers may be considered for those rare cases that are successfully treated on a Limited Duty Board and remain asymptomatic and off medications for one year in a full duty status.

INFORMATION REQUIRED:

1. Psychiatric evaluation
2. Copy of Medical Board (if applicable)
3. Flight surgeon's narrative (aeromedical summary) outlining any social, occupational, administrative, or legal problems of the patient.

TREATMENT: Treatment offers little hope of return to flight status in factitious disorders. These patients are rarely motivated for psychotherapy, and generally change physicians when confronted. The psychotropic medications used in somatoform disorders are incompatible with aviation status.

FOLLOW-UP REQUIREMENTS: Follow-up psychiatric care is at the discretion of the treating mental health provider. Patients are generally seen at least monthly while on Limited Duty.

DISCUSSION: 15-30% of patients with hypochondriacal disorders have physical problems. 30% of conversion disorder patients have associated physical illness. Patients with factitious disorders also have a high risk of substance abuse over time.

ICD-9 CODES:
300.16 Factitious illness with psychiatric symptoms
300.19 Other/unspecified factitious illness
301.51 Chronic factitious illness with physical symptoms
300.11 Conversion Disorder
300.7 Hypochondriasis
300.81 Somatization Disorder