PRINCIPLES AND PRACTICE OF MILITARY FORENSIC PSYCHIATRY

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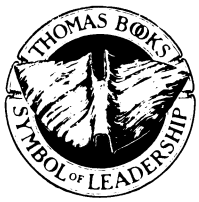

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To my family: My mother, Anne, who modeled compassion, my father, Maurice, who taught objectivity, my wife, Brenda, who tirelessly supports our relationship and the radiant light of my life, my son, Galen.

R.G.L.

To Barri, my love and my law, and our cherished ones—Nancy, David and Alice.

D.T.A.

FOREWORD

I am honored to pen the foreword to this book. Forensic psychiatry is an interesting and important subject for our society as a whole. Military forensic psychiatry occupies a significant segment of that subject. Serious literature focusing on forensic psychiatry in the military community is lacking. Thus, this superb book fills a void and will be essential reading for all of those involved in the complex areas where law and medicine converge.

The chapters of this book were written by a number of highly qualified authors, all of whom have the requisite training and rich experience to speak with authority. The authors include practicing military and civilian psychiatrists, a practicing civilian attorney, Assistant United States Attorneys, and the Chief Judge of the United States Court of Appeals for the Armed Forces. The authors include professionals from all branches of the military services.

The book includes a wide range of topics, including an introductory chapter on the history of forensic psychiatry in the United States military. Some of the other subjects covered are defense counsel strategies, malingering, syndrome testimony, disposition of those acquitted by reason of insanity, military child forensic psychiatry, counter intuitive principles in child abuse cases, military medical malpractice, ethics and regulation of military psychiatry. My not mentioning some covered subjects in no ways diminishes their importance.

It is my hope that military personnel in the medical and legal communities will read and study this book. It will surely be a standard text at military educational institutions. I also hope that military personnel not in the medical and legal professions, especially commanders and leaders, read this book to acquaint themselves with serious matters that affect the members of our armed forces and their families.

Lastly, I am confident that this text will be quite useful for professionals in the civilian community. It will provide them with valuable insight into the complex world of military medicolegal issues and their resolution. This text will greatly assist civilians practicing forensics in the military system by

increasing their knowledge and contributing to the quality of their finished products.

WILLIAM K. SUTER, J.D.
Major General, USA (Ret.)
Clerk of the Supreme Court of the United States

PREFACE

Military forensic psychiatry represents an intersection of three cultures: medicine, law, and the military. Each brings an impressive heritage to the amalgam that creates the new. The serious study of military forensic psychiatry is a relatively recent development, although scrutiny identifies historical antecedents. This book is designed to advance the profession by filling a void long neglected. The reader will gain familiarity with the various tensions that exist at this professional intersection and the never ceasing accommodations. For some outside observers the pace of change no doubt appears glacial, but years of wisdom gathered through experience, tradition, and history act as a prudent brake. Change does occur but only after a collective reflection from a large, complex organization.

Preparing this text for publication highlighted the dynamic nature of military forensic psychiatry. The U.S. Supreme Court opinion in *Jaffee v. Redmond,* 1996 WL 315&41 (1996) is one example where the Court has recognized a privilege protecting confidential statements made to psychotherapists. To ensure that the reader benefited from this new development, the editors sought counsel from the United States Court of Appeals for the Armed Forces. John B. Holt, J.D., in collaboration with colleagues at the Court, provided an expeditious review.

As a result of the *Jaffee* decision, the psychotherapist privilege is now recognized. The military courts, accordingly, must recognize the privilege under Mil.R.Evid. 501(a)(4) unless the prohibition in Mil.R.Evid 501(d) that prevents the application of a doctor-patient privilege is construed to apply to the new psychotherapist privilege.

The narrow issue is the scope of Military Rule of Evidence 501(a)(4) and the limitation in 501(d). The courts have held that this rule precludes recognition of a privilege for statements made to medical officers, including both psychiatrists and psychologists, during mental health treatment, or to civilian physicians or psychiatrists during treatment. *See United States v. Mansfield,* 38 MJ 415 (1993), *affirming* 33 MJ 972 (AFCMR 1991); *United States v. Toledo,* 25 MJ 270 (CMA 1987). Because of the Rule 501(d) exclusion, these decisions probably remain valid even after *Jaffee.*

There is now debate among lawyers whether Mil.R.Evid. 501(d) precludes

recognition of a more narrow common law privilege for communications made to social workers and civilian psychologists. At issue is whether a social worker or a psychologist is "a medical officer and civilian physician" and therefore is within the ambit of the exclusionary rule. If communications made to social workers and civilian psychologists are protected, but communications made to medical officers and civilian physicians are not privileged, the result makes little sense as a matter of public policy.

Perhaps the President of the United States will amend the Military Rules of Evidence either to create some form of psychotherapist-patient privilege or unequivocally to reject this privilege. Alternatively or additionally, the courts most certainly will be tasked to address the present legal imbroglio. Until there is further guidance on both the legal and policy issues, both the clinician and the patient are in a tenuous position— uncertain of legal protection of the confidentiality of the professional relationship. This uncertainty continues to cloud the atmosphere of confidence and trust and thwarts a patient's frank and complete disclosure of facts, emotions, memories, and fears.

Other significant recent changes in the law, incorporated in the text, contribute to the excitement, uncertainty, and debate that accompany the practice of military forensic psychiatry.

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Preparing a new multicontributor text for publication requires the assistance of many more people than is apparent from perusing the list of authors. Among the "unseen" essential participants are secretaries, fact researchers, proofreaders, and copyright holders. Although each chapter contributor doubtlessly could acknowledge a variety of helpers, the editors determined that the assistance provided by several persons and publishers was of special significance to completion of the text.

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Two talented and dedicated professionals labored over the many chapter drafts, offering not only technical advice but also suggestions on improving the communicative value of the text. Many thanks to Barri J. Armitage, M.A., and Brenda N. Lande, M.L.S., for their tireless efforts.

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The challenge of maintaining consistency in format and word usage fell to Mimi Mullen who devoted long, long hours to retooling the enormous number of references. Mimi also offered helpful suggestions on wording changes that improved the readability of the text. Her unfading cheerfulness and enthusiasm were highly valued accouterments. Much thanks is given to Charles A. Peck, Jr., M.D., who sacrificed his own administrative support by detailing Mimi to the publishing project.

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CONTENTS

PRINCIPLES AND PRACTICE OF MILITARY FORENSIC PSYCHIATRY

Chapter 1

THE HISTORY OF FORENSIC PSYCHIATRY IN THE U.S. MILITARY

R. GREGORY LANDE, D.O.

INTRODUCTION

Modern military forensic psychiatry has a rich medical heritage. The barely discernible historical roots were first planted during the American Revolution. During this turbulent period, the American colonies were forging a political government while pursuing a war of independence. Despite the absence of an organized military and a ideologically united populace, the war was prosecuted. British political traditions and military principles provided a transitional footing. The British military system was eventually adopted to serve emerging American interests. As America pursued the War of Independence, certain practices developed. These ideas arose from military service, medical care, and the deprivations of war. Over two hundred years ago alcohol abuse, homesickness, malingering, psychosomatic illness, and crime depleted the military ranks of battle ready soldiers.

The inexperienced colonial medical and legal professions each sought, in different ways, to preserve the military fighting strength. Military law accomplished this by advancing command authority. The British rules of war were adopted early but were rapidly modified. Military medicine at the time was primitive. Throughout the American War for Independence the medical system heroically struggled to keep pace with the casualties. Early lessons learned emphasized prevention, sanitation, and attention to the human spirit.

Colonial observations and theories, forged from the heat of battle, formed links in an unbroken chain to modern day military forensic psychiatry. The story of military forensic psychiatry historically unfolds from the general to the specific. The modern day subspecialty continues to honor, through practical application, those early observations. Timeless themes of prevention, education, command consultation, medicolegal liaisons, and personal readiness proficiency are the cornerstones of modern military forensic psychiatry.

COLONIAL AMERICA

The outbreak of hostilities commencing the American War of Independence demanded a military-political mobilization. The initial structure necessary to field an army, and run a government, borrowed heavily from British traditions. When George Washington took command there were about fourteen-thousand soldiers.[1] Military training, logistics, and a unified command structure were goals, not realities. Washington was impressed "that their spirit has exceeded their strength."[1] The numbers of regulars of the Continental probably never exceeded seventeen-thousand men.[1] Although this number was supplemented by as many as three-hundred-thousand who served shorter hitches, Washington relied primarily on his regulars.[1]

The organization of the Continental Army required support from both medicine and law. Responding to the call to arms, colonial medical students in Edinburgh and London quit their studies and returned home. This elite cadre of the academically trained was joined by patriot physicians and apothecaries who had learned their art through apprenticeships.[2]

American medicine in the period immediately preceding the war was very slowly transitioning to a more scientific understanding.[3] Bloodletting was still a common treatment for a number of conditions such as pleurisy and rheumatism. Inoculations for smallpox were recognized, but irregularly practiced. The colonial pharmacy included wine as a medicine for fever, mercury for inflammations, various emetic preparations, and diverse questionably efficacious compounds derived from oils, acids, and powders.

One contemporary medical authority believed that "the physical practice in our colonies is so perniciously bad, that excepting surgery, and some very acute cases, it is better to let nature, under a proper regimen, take her course . . . "[3]

Given the state of the colonial art, "the military medical phase of the revolution was frequently chaotic, chronically discouraging, and sometimes calamitous to the point of threatening the whole war effort."[2]

There was a desperate need to establish a medical structure for the war effort. This required hospitals, doctors, and a reliable way to secure medical supplies. The Continental Congress, responded by issuing an order establishing a military hospital on July 17, 1775.[4] This order created the Army Medical Department. Eventually 1,700 physicians would be recruited, of which about one-hundred had medical degrees.[4]

From the outset the Revolutionary Medical Department was mired in controversy.[4] Military surgeons were selected for important assignments based less on medical experience than on personal relationships. The first three directors general of the young medical department were an embarrassment. All three left office following various political and legal accusations.

Significant enmity existed between the field surgeons and the directors general. The bickering escalated and threatened to undermine the entire medical organization. George Washington actively campaigned for change to the Continental Congress, but his pleas were ignored.

The entire war effort was characterized by medical inexperience, congressional intrusions, and endless authority conflicts. During battles, only minor injuries were treated. Major surgery lacked anesthesia. Camp sanitation was dreadful and infections took a horrible toll.[1] About a year after the war began there were roughly 2,200 killed and wounded in action. Five times that number were dead from illnesses. Other problems included overcrowded barracks, limited recreational opportunities, polluted water, insufficient food, and a British Naval Blockade that severely impeded medical supplies.[1] A dispirited Army seemed inevitable. That this was not entirely decisive for the war effort is a tribute to George Washington's leadership. Washington routinely inspected camps and hospitals and tirelessly pressed the Continental Congress for support.[5]

The miserable conditions of war exacted an emotional cost which affected military readiness. These costs were measured in terms of homesickness, alcohol abuse, psychosomatic illness, malingering, desertions, and other crimes.

Army doctors mobilized available resources and knowledge to minimize these conditions. The contemporary thoughts of Benjamin Rush, who briefly served as the physician general of the middle department's medical service, are illuminating.[6] Rush's brief tenure was marred by internecine political struggles that led to his departure.

Rush emphasized prevention. To support his campaign, Rush published a field pamphlet titled "Directions." Subdivided into five headings of dress, diet, cleanliness, encampments, and excise, this small publication distilled Rush's creative medical thinking.[6]

The blend of discipline and medicine that military life fosters are evident in Rush's writings. Concerning a crowded colonial military hospital, Rush comments that "the physicians and surgeons of the hospital possess no power to prevent or punish . . . misconduct.[6] In a later section of the same commentary, Rush further argues that "A soldier should never be suffered to exist a single hour without a sense of his having a master being impressed upon his mind, nor the fear of military punishments."[6]

Rush's punitive approach in part arose from a fervent belief in temperance, shaped by his religious beliefs but reinforced through sober-minded observations.[7]

Rush's moral-medical crusade against drunkenness was particularly strong in the military. A one-time friend, and revolutionary general, was dismissed from service following repeated episodes of drunken misconduct. Rush