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# Post-Traumatic Stress Disorder & the Military Justice System

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ABSTRACT: This article, in the main, addresses how the Military Justice system deals -- and ought to deal -- with military members who are suffering from post-traumatic stress disorder (PTSD), and commit crimes. It begins with a thorough overview of PTSD in the current military, and then moves on to analyze the topic through three particular lenses: punishing versus treating military members who suffer from PTSD in light of Retributivst theory; psychotherapist-patient privilege in the military as affected by the recent restructuring of military psychiatry; and how military courts' own oft-ignored tradition of rights protection affects these issues. The paper concludes provisionally that, due to the nature of military society, the military must both punish and treat its members who commit crimes in order to have the best chance of reintegrating those members into the community; and that, while Department of Defense directives and other military law has arguably eliminated the psychotherapist-patient privilege in the military, military courts have an opportunity to restore and maintain the privilege in light of those courts' tradition of protecting the interests and rights of military members.

> I remember about myself a loneliness and poverty of spirit; mental collapse; brief jovial moments after weeks of exhaustion; discomfiting bodily pain; constant ringing in my ears; sleeplessness and drunkenness and desperation; fits of rage and despondency; mutiny of the self; lovers to whom I lied; lovers who lied to me. I remember going in one end and coming out the other. I remember being told I must remember and then for many years forgetting.
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> -- Anthony Swofford, from "Jarhead: A Marine's Chronicle of the Gulf War and Other Battles"[1]

## I. Introduction

Combat causes Post-Traumatic Stress Disorder (PTSD). Modern psychiatrists have identified its symptoms as early as the Trojan War.[2] The military, when it fights wars, both performs a vital national function, and, in doing so, contributes to a diagnosable

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[1] At 3 (Simon & Schuester 2003)

[2] Brotherton, *Post-Traumatic Stress Disorder – Opening Pandora's Box?*, 17 New Eng. L. Rev. 91, 92 (1981)

psychological malady in its warriors (the enemy is of course primarily responsible). The military has started to recognize both the severity of PTSD, and its obligations to troops sent into combat. As a nation, we ought to commend the military for taking these steps, especially in light of the military's traditional prejudice against psychiatric treatment.[3]

But it is a sad fact that these same steps create major problems for the Military Justice system. First, they raise issues as to how the military ought to punish offenders, whether for disciplinary offenses with no counterpart in civilian law, or for more traditional criminal offenses. And, second, these steps change the relationship between psychotherapist, patient, and commanding officer, and so directly raise questions about how military personnel relate to both their superiors and to the military as a whole.

First they raise questions of discipline, rehabilitation and punishment. The effects of PTSD make it very hard to maintain military discipline, and so lead directly to the commission of more disciplinary offenses. Yet in punishing disciplinary offenses the military explicitly seeks not only to punish but to rehabilitate the offender[4] -- which is to say, to restore and improve discipline. This creates a dilemma: the military first contributes to a condition that leads to disciplinary offenses, then must both punish and rehabilitate those who have committed the offenses. Such a dilemma, however, lends itself to legal and philosophical discussions on the nature of punishment, which this paper starts to address.

Second, as psychotherapists become more and more integrated (and important) in the military, their independence and ability to preserve confidentiality starts to disappear. They start to become an arm of the command, and cease being independent caregivers. So while the military's reforms may reap benefits (an optimistic conclusion this paper questions), they will certainly create problems -- and possibly detriments -- in the Military Justice system. This is especially true for Military Justice's psychotherapist-patient privilege.[5]

As if to illustrate just this problem, in 2006 the Court of Appeals for the Armed Forces (CAAF) reserved the question on how the duties of military psychiatry relate to psychotherapist-patient privilege.[6] From the text of the relevant Military Rules of Evidence,

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[3] MHAT-I at IV.

[4] *See infra* note 76

[5] Military Rule of Evidence 513.

[6] United States v. Jenkins, 63 M.J. 426, 429 (CAAF 2006).

service Instructions, Department of Defense Directives, and military justice precedents the answer to that question -- and to other questions of military psychiatry and military justice -- are simply unclear. On the one hand, the relevant texts, read in a straightforward manner, seem to vitiate the privilege. On the other hand, the purpose behind those texts and the traditions of military justice (not to mention precedents in military case law) seem to uphold it. This paper does not propose to offer final, Platonically perfect answers. It, however, does seek to outline a number of the relevant problems, and contribute to reaching reasonable solutions. Indeed, the current issues of PTSD and psychotherapist-patient privilege in the military can profitably serve as a "hook" for discussing a number of far larger issues, such as the relationship between commanding officers and enlisted military members, the effects of warfare on the minds of soldiers, sailors and airmen, and what place, if any, confidentiality can have in a modern military.

This paper's argument thus proceeds in three parts. The first part addresses PTSD as a psychiatric disease, and especially its close relationship to combat. This part concludes by addressing the changed doctor-patient-commander relationship in the military.

The second part of the paper seeks to establish a framework for analyzing and discussing the Military Justice System, and how PTSD relates to punishment of minor disciplinary offenses. Special attention is paid to the impact of military members' mental health, and how it both leads to, and provides a defense for, infractions against the Uniform Code of Military Justice.[7] Finally, it offers philosophical (which is to say, Kantian) and legal rationales for treating PTSD *concurrently with* meting out punishment.

As alluded above, the paper's third part is also its longest. It deals with the problems PTSD raises in more serious offenses, particularly psychotherapist-patient privilege in courts-martial. The paper further examines how recent military rules, regulations, and reforms have changed the relationship between psychotherapists, patients, and commanding offers. It then goes into a specific example of this changed relationship, psychotherapist-patient privilege in the armed forces. This paper contends that recent Department of Defense Directives and other Military Justice materials have probably eliminated psychotherapist-patient privilege in the military, without, however, intending to do so. Yet there are arguments beyond the facial meaning of the rules. In particular, courts-martial have developed a robust, independent tradition of rights-protection -- almost entirely

[7] 10 USC §§801-946 (2000).

ignored in the scholarly literature -- that provides a powerful justification for maintaining the privilege.

## II. The Nature of Post-Traumatic Stress Disorder Stemming from Combat: Characteristics and Current Prevalence in Military Members Deployed to Iraq.

### a. The Characteristics of PTSD, and Its Relationship to Combat

The essential feature of Post-Traumatic Stress Disorder is the development of

> characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury . . . [Characteristic symptoms are ] persistent rexperiencing of the traumatic event. . . persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness ["psychic numbing"] . . . and persistent symptoms of increased arousal. . . . These symptoms may include difficulty falling or staying asleep that may be due to recurrent nightmares during which the traumatic event is relived . . . hypervigilance . . .and exaggerated startle response. . . Some individuals report irritability or outbursts of anger. [8]

Suffering from PTSD also correlates highly with "Panic Disorder, Agoraphobia, Obsessive-Compulsive Disorder, Social Phobia, Specific Phobia, Major Depressive Disorder, Somatization [sleep-related] Disorder, and Substance-Related Disorders."[9] Military combat is one of the classic causes of PTSD.[10] The DSMV-IV goes on to say, "The disorder may be especially severe or long-lasting when the stressor is of human design (e.g. torture, rape). The likelihood of developing this disorder may increase as the intensity and physical proximity of the stressor increase."[11] So one would expect combat with these features to increase the incidence of PTSD. Indeed, other studies have indicated that specific combat experiences worsen both the prevalence and severity of PTSD. Combat

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[8] DSMV-IV 309.81 (1994).

[9] *Id.*

[10] *Id.*

[11] *Id.*

injury, even if relatively minor, precipitously increases both the serviceman's likelihood of developing PTSD (by a factor of about eight to one), and his or her likelihood of developing the most severe forms of PTSD.[12] Seeing or Handling human remains also dramatically increases the severity of any PTSD the service member may experience.[13]

And PTSD may strike months, or even years, after a soldier's combat exposure. In a study of Persian Gulf War veterans, service members were screened for PTSD at 1, 6, and 24 months after returning home and were found to have "progressive increases in PTSD symptoms."[14] Moreover, "those cases that screened positive at one month continued to screen positive for PTSD at 2 years."[15] PTSD symptoms may come and go for an even larger group. Currently 15.2 % of male Vietnam theater veterans are diagnosed with PTSD, while more than twice as many, 30.9%, have experienced PTSD at some point during their lifetimes.[16]

### b. The Prevalence of PTSD in Operation Iraqi Freedom (OIF) Military Members

The Office of the Surgeon Multinational Force-Iraq, Office of the Surgeon General, and United States Army Medical Command have, since the inception of Operation Iraqi Freedom, issued four Mental Health Advisory Team (MHAT) reports, the latest being MHAT-IV, published in 2007, and covering the period from 2005-2007 (OIF 05-07). The study found that 17% of OIF 05-07 soldiers, and 14% of marines screened positive for acute stress.[17] Additionally, in the previous MHAT report (OIF 04-06) 17% of respondents screened positive for a combination of depression, anxiety and acute stress, symptoms that correlate very highly,

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[12] D. Koren et al., *Increased PTSD Risk with Combat-Related Injury: A Matched Comparison Study of Injured and Uninjured Soldiers Experiencing the Same Combat Events*, 162 AMER. J. PSYCH., 276-282 (2005).

[13] McCarroll et al., *Symptoms of PTSD Following Recovery of War Dead: 13-15 Month Follow-Up*, 152 AMER. J. PSYCH., 939-941 (1995)

[14] Stephen J. Cozza, *Combat Exposure and PTSD*, PTSD RESEARCH QUART., vol. 16, no. 1, at 3.

[15] *Id.*

[16] United States Department for Veterans Affairs (National Center for PTSD), "Epidemiological Facts about PTSD", http://www.ncptsd.va.gov/ncmain/ncdocs/fact_shts/fs_epidemiological.html.

[17] Mental Health Advisory Team (MHAT-IV) Operation Iraqi Freedom 05-07: Report (17 November 2007) at 19=23. ("MHAT-IV")

and indeed nearly define, PTSD [18] (respondents in OIF 05-07 were not screened for this combination of symptoms, although those screenings that were repeated tended to show slight increases in stress, depression, etc.[19]). Military members who had undergone multiple deployments evinced higher levels of acute stress, notably 24%.[20] The RAND corporation has also recently released a report on psychiatric disorders in the military which broadly agrees with the MHAT findings.[21]

Because of the nature of the conflict, military members were also exposed to the combat conditions most likely to cause the most severe forms of PTSD (those factors being, as above, where the "stressor is of a human design", where the soldier has been injured, where the soldier has experienced close physical proximity to a life-threatening situation, and where the soldier has seen or handled human remains).[22] During OIF 05-07, 62% of marines and 66% of soldiers knew someone who was seriously injured or killed; 52% and 53% respectively had a member of his or her own unit become a casualty; 41% and 42% had seen dead or seriously injured Americans [23]; 45% and 46% were in threatening situations where they did not know how to respond under the Rules of Engagement; and 58% and 62% had been exposed to an Improvised Explosive Device (IED) or other booby trap (which, by their very nature, must be set off in close physical proximity to their intended targets)[24]. Given the indiscriminate nature of the enemy's tactics[25], and that the enemy often targets civilians[26], and not military personnel, one can also assume that a high percentage of American service members would have

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[18] Mental Health Advisory Team (MHAT-III) Operation Iraqi Freedom 04-06: Report (29 May, 2006) at 15.

[19] MHAT-IV at 20.

[20] *Id.* at 23

[21] Terri Tanilian and Lisa H. Jaycox, eds., "Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery" (RAND Corporation 2008). ("RAND Study")(For instance, RAND found that 14% of those deployed in Operation Iraqi Freedom screened positive for PTSD, using RAND's test. RAND Study 96 et seq.)

[22] See supra, n. 8, 12.

[23] Id. At 15

[24] Id. at 14

[25] See, e.g., Richard A. Oppal and Qais Mizher, "At Least w130 Die as Blast Levels Baghdad Market", N.Y. Times, Feb. 4, 2007, http://www.nytimes.com/2007/02/04/world/middleeast/04iraq.html?ref=world (Last visited January 27, 2009).

[26] Id. (all killed in the bombing, the single worst since the American occupation began, were civilians)

seen and handled dead or mutilated Iraqi noncombatants, and their body parts. Once again, the RAND study basically concurred with these results.[27]

Given the above statistics, a tragically high percentage of Americans serving in Operation Iraqi Freedom will probably develop the most severe forms of PTSD, those most disruptive to normal life, and most likely to cause traumatic flashbacks, an exaggerated startle response, and violent outbursts. The implications for military discipline and military justice will be profound.

## III. The Deepening Relationship Between Commanding Officers, Enlisted Personnel, and Military Psychotherapists

Thus, both today and in the past, PTSD has afflicted our military. Over the years, the military has developed a well-established treatment regime -- which has not, however, traditionally included modern psychiatric care. The military has started to address this problem, and formal psychiatric care has become a much larger part of its treatment regimen. Yet the military's new approach has also created new problems.

To wit, the military has traditionally put the commanding officer in the role of primary psychiatric caregiver. Such a position gave the commanding officer both access to a great deal of power over the personnel he commands, and a great deal of information about them. Today, even though trained psychotherapists are now more involved in treatment, the commanding officer has maintained the traditional prerogatives in the psychiatric care of those under his or her command. So, paradoxically, as the psychiatric evaluation of military members increases, their privacy and confidentiality decrease. Such a process puts both the rights of service members, and the existence of psychotherapist-patient privilege, in serious doubt.

### a. The Current (Modified-Traditional) Approach to PTSD Treatment

The military's basic approach to treating PTSD developed long before the disorder was recognized as such. Due to the huge number of soldiers who had to be evacuated due to combat stress during World War I,

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[27] See RAND Study at 5 ("The day-to-day activities of troops in combat vary widely, but some common stressors in the current conflicts have been identified as roadside bombs, IEDs, suicide bombers, the handling of human remains, killing an enemy, seeing fellow soldiers and friends dead or injured, and the helplessness of not being able to stop violent situations"); at 25-27 (Discussing the use and spread of IED's in the Iraqi conflict"); at 97 (reporting that: 49.6% of military members surveyed reported "Having a friend who was seriously injured or killed"; 45.2% "Seeing dead or seriously injured noncombatants", etc.)

the military developed the concept of "forward psychiatry", as exemplified by the acronym with which it is constantly intertwined, PIE, standing for: "proximity (treatment close to the battlefield), immediacy (rapid and readily available intervention), and expectancy (belief that the soldier would return to combat)."[28] There is some evidence to support this system's effectiveness. For instance, an Israeli study showed that soldiers treated under principles similar to PIE had a higher return-to-duty rate than those treated at base hospitals. However, evidence also exists that the military has over-stated the positive results from PIE, and, as the same article put it, "It remains uncertain who is being served by the intervention . . . the individual soldier or the needs of the military."[29]

Forward Psychiatry finds its incarnation in today's American military under another acronym, BICEPS, which stands for:

> Brevity ([return the soldier to duty in] usually less than 72 hours); Immediacy (as soon as symptoms are evident); Centrality of management (in a centralized CSC [Combat Stress Control] unit separate from, but proximal to, a medical unit); Expectancy (CSC unit personnel expectation that casualties will recover); Proximity (of treatment at or near the front as possible); and Simplicity (the use of simple measures such as rest, food, hygiene, and reassurance).[30]

In this system, the front line in the battle against combat stress is not CSC mental health personnel, but commanding officers, who are tasked with "primary prevention [of combat stress]" through "leadership, communication, unit cohesion, and morale."[31] And commanders are to receive training before, during, and after deployment that focuses on "leadership, communication with troops, unit morale and cohesion, and individual psychosocial stressors"[32] (this is known as BATTLEMIND training[33]). On the one hand, this approach makes a great deal of intuitive

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[28] Stephen J. Cozza, Combat Exposure and PTSD, 16 PTSD Research Quart., Winter 2005, at 1.

[29] Jones & Wessely, "Forward Psychiatry" in the military: Its Origins and Effectiveness, 16 J. Traumatic Stress, 2003, at 411-419.

[30] Department of Defense Directive 6490.5, Combat Stress Control (CSC) Programs, issued February 23, 1999 (certified current as of November 24, 2003), at Enclosure 1: Definitions.

[31] Id. at 4.9.2.2.

[32] Id. at 4.9.1.

[33] See, e.g., Col. Carl A. Castro & Maj. Dennis McGurk, "The Goal of Battlemind Psychological Debriefings", in "Battlemind Psychological Debriefing" (at http:/

sense. Of course a soldier will be in better psychological health in an environment of high morale and cohesion, and with a communicative leadership in whom he or she has trust. Moreover, it is doubtful that the military would have for so long employed PIE-like principles if they were not effective in returning a soldier to combat readiness in the short term.

On the other hand, these programs raise at least two major objections. First, a military officer, no matter how effective a leader and communicator, is not a psychiatrist. Except by acquiring real-world experience, he or she will probably not be able to accurately and consistently identify significant PTSD symptoms such as "psychic numbing"; and hence will not be able to address these symptoms in a timely fashion. Second, and more importantly, PIE-like treatments make little or no provision for the soldier's long-term mental health. The worst symptoms of PTSD may delay onset for months[34], and require both the attention of a professional therapist, and the prescription of medication (It is worth noting, in this context, that the "Iraq War Clinician Guide" recommends a course of treatment far more intimate and long-term than would be possible under BICEPS).[35]

However, effectiveness aside, PIE, BICEPS, and the principles they embody unequivocally put the commanding officer in charge of the enlisted person's mental health care. As long as the commanding officer remains in his or her traditional role, few problems result. But, as psychiatric care increases in importance in the military -- as the next section will discuss -- so will the role, and power, of the commanding officer.

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[34] Stephen J. Cozza, Combat Exposure and PTSD, 16 PTSD Research Quart, Number 1, 2003, at 3.

[35] For instance, the Department of Veterans Affairs, in its "Iraq War Clinician Guide" recommends a course of treatment for PTSD far different than BICEPS. It recommends intensive therapy and deep clinician involvement in the patient's readjustment to life away from a war zone; exposure therapy where the patient re-experiences a simulation of his or her trauma in a safe environment; "cognitive restructuring" where the patient systematically learns to associate new responses to the negative thoughts associated with the trauma; and family counseling. More importantly, the "Iraq War Clinician Guide" asserts that "If Iraq War veterans arrive at VA Medical Centers very soon (i.e. within several days or several weeks) following their trauma exposure, it is possible to use an early intervention to try to prevent development of PTSD. "Such recommendations directly contradict the BICEPS goals, most notably the goal of returning the soldier to combat duty within 72 hours. Even more worrisome, this same contradiction suggests that, by returning the soldier to combat duty within 72 hours instead of evacuating him or her to a VA facility for early intervention, the military will cause some cases of PTSD that could have been prevented.

b. Two (Possible) Recent Improvements in Military Mental Health Care . . .

While BICEPS remains the primary treatment approach, and officers the primary caregivers, the military has, as above, announced policies that will increase the importance -- and, one hopes, the effectiveness -- of military psychiatric care. First, the military has announced a policy of medically screening all troops before deployment to Iraq and Afghanistan, and at least once upon return.[36] Second, MHAT III, at least, has reported both an increase in the ease with which soldiers could receive mental health services, and a decline in the traditional prejudice of military members against psychiatric treatment (for fears that seeking treatment it would make them seem "weak" or "unfit for service").[37] As a result, the report concluded, 30% of OIF 04-06 soldiers received behavioral health care while deployed, as opposed to only 23% during OIF 02-04.[38]

MHAT-IV did not duplicate these results, but there can be no doubt of the increasing prominence of military psychiatric care. Most importantly, the military has instituted what is known as the RESPECT-MIL program, designed to increase awareness of PTSD and related psychological ailments among, and provide treatment through, the military's primary care physicians.[39] Of course, only those active-duty soldiers who report to primary care physicians are screened[40], meaning those who do not report at all receive no screening (RAND estimates that only half of those who *do* report for treatment receive adequate care[41]; and only 30 percent of those needing care receive it[42]). Nevertheless, this program will hugely expand psychiatric screening of military members,

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[36] Sgt. Sara Wood, "Military Health Care Making Advances", American Forces Information Service: News Articles, Dec. 13, 2006,http://www.veteransadvantage.com/news/archive/MilitaryHealthCareMakingAdvances.html (Last visited January 27, 2009).

[37] MHAT-IV at 25.

[38] Id.

[39] MEDCOM Operational Order 07-34 (Re-engineering Systems of the Primary Care Treatment (of Depression and PTSD) in the Military - RESPECT MIL) ("MEDCOM Order 07-34");See also http://www.pdhealth.mil/respect-mil.asp (Last visited January 27, 2009).

[40] MEDCOM Order 07-34 at (d)(2)(a). ("All AD [Active Duty] patients are screened for depression and PTSD . . . as part of the clinic check-in and vital signs assessment at designated primary care facilities.")

[41] RAND Study at 108.

[42] RAND Study at 101.

and the statements and announcements coming from senior military leadership only confirm this new emphasis.[43]

c. . . . And the Problems They Create

Yet these increased screenings come with a problem: the soldier's commander receives the results of all mental health screenings of his or her troops.[44] On the one hand, a screening, if kept confidential, is incapable of aiding either a commander in unit management, or an army in evaluating the mental health of its troops. In short, a confidential screening is useless. On the other hand, revealing the results of the screening destroys doctor-patient confidentiality, at least in the practical sense; the relevant DoD Instruction even requires the mental health provider to inform the soldiers that the consultation will not be confidential.[45] Thus, at least some soldiers will not give candid statements to the mental health provider, and, consequently, the mental health provider will inevitably give a somewhat inaccurate evaluation to the unit commander.

And, more importantly, this changes the relationship of the commanding officer, patient, and psychotherapist. Put simply, if the psychotherapist must report the results of mental health evaluations to commanding officers, this action might destroy psychotherapist-patient confidentiality (as will be discussed at length below). Moreover, not only are psychotherapists required to report their findings to commanding officers[46], but the military has identified commanding officers as (at least initially) in charge of the mental health of the troops.[47] So these two positions -- commanding officer and psychotherapist -- have become increasingly blended, as the first assumes the role of the second, and the second must report his or her findings to the first.

Yet, as alluded above, each of these positions has distinct legal duties to, and power over, troops under his or her care. In theory, separation between them should help protect the soldier from arbitrary or (unjustly) punitive actions based on his or her supposed mental health. Again, in theory, giving both treating physicians and military commanders

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[43] *See, e.g.,* Virginia Reza, "Chief says Army needs to replicate Bliss PTSD program", Army.Mil/News, July 18, 2008, http://www.army.mil/-news/2008/07/18/11001-chief-says-army-needs-to-replicate-bliss-ptsd-program/ (Last visited January 27, 2009).

[44] Department of Defense Instruction 6490.4: Requirements for Mental Health Evaluations of Members of the Armed Forces, issued August 28, 1997 at 6.1.3.3, 6.1.3.5.

[45] Id. at 6.1.3.3.

[46] *Supra* note

[47] *Supra* note

some say over the soldier's mental health care should provide the soldier with two "levels" of process. But this overlooks the extent to which the psychotherapist is subservient to the military commander: the psychotherapist must report to the commander, not the other way around.[48] And to the extent commanding officers and psychotherapists merge, commanding officers can assume the powers of military psychotherapists, and hence assume a set of powers and degree of control over service members which neither the Congress (which issues rules governing the armed forces[49]) nor the Executive (who is Commander-in-Chief[50]) has contemplated. (Psychotherapists might also expand their powers, but given the hierarchical nature of the military -- and that commanding officers occupy the top of that hierarchy -- this seems less likely). The military's recent focus on improving mental health care might have inadvertently expanded commanding officers' power beyond its legal limits. This certainly does not look pretty: while not significantly expanding access to mental health care, the military has nevertheless created new legal problems for both itself and its members.

It is difficult, however, to determine the precise content of a military member's rights, especially Constitutional rights. This paper, therefore, will confine itself to military members in the military justice system in general, and those seeking to invoke psychotherapist-patient privilege in particular. With this in mind, this paper will move on to a brief overview of the former topic, and then on to an analysis of the latter topics.

## IV. PTSD and Minor Military Justice Infractions: Between Rehabilitation and Punishment

Because of the nature of military society and the needs of military discipline, the armed forces have established several levels of infraction and punishment. This section primarily addresses those UCMJ infractions that one could describe as "disciplinary", which is to say, those infractions against the maintenance of military discipline -- infractions with no precise analogs in the civilian justice system.[51] As the following parts will outline, PTSD, because of its symptoms, can greatly disrupt military discipline. As a result, this paper recommends a disciplinary system that,

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[48] *Supra* n. 41.

[49] U.S. Const., Art. I, § 8, cl. 14

[50] U.S. Const., Art. II, § 2

[51] *See infra*, fns. 62-69, for an explanation of the term "disciplinary" and a list of such offenses.

for reasons both philosophical and practical, combines separate elements of rehabilitation and punishment.

But, in order to both contextualize these disciplinary offenses, and lay some groundwork for subsequent arguments, this section begins with an overview of the military justice system in both its disciplinary and criminal components.

a. Preliminary Overview of the Military Justice System

The military justice system operates on essentially three levels: nonjudicial punishment (NJP); Special Courts Martial (SCM); and General Courts Martial (GCM).[52] The first two serve to reprimand military members for what would generally be misdemeanor offenses (in the civilian world) or breaches of military discipline, while the latter addresses what civilians would think of as felonies.[53] In either case, it is, by custom as much as law, the accused's commanding officer who files ("prefers" in military terminology) charges.[54] He, not the Staff Judge Advocate, possesses "prosecutorial discretion."[55] [56] These three levels of the system are described in greater detail below.

Article 15, UCMJ delegates to commanders (officers) the authority to impose NJP on soldiers serving under them, as long as the soldier so consents. Soldiers always have the right to demand a Court Martial, where the standard of proof is "beyond a reasonable doubt."[57] As David A. Schlueter writes in his treatise *Military Justice: Practice and Procedure*, "The nonjudicial punishment option is one of those always available to a commander in exercising his prosecutorial discretion. The seriousness of the offense . . . reduces the likelihood that nonjudicial punishment will be offered."[58] The service branches strictly regulate what punishment the commander may give, based on both the commander's rank, and the rank of the accused. To use an example from the Air Force, if a low-ranking

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[52] *See Generally*, Major Michael W. Goldman, ed., "The Military Commander and the Law", Chaps. 2, 4 (Air Force Judge Advocate General School, 2004)

[53] Id.

[54] Id. at 52.

[55] David A. Schlueter, "Military Criminal Justice: Practice and Procedure," ed. 6 (Lexis Nexis 2004), §3-3(A), fn 4

[56] Technically, any person subject to the UCMJ may prefer charges against any other person subject to the UCMJ. "The Military Commander and the Law" at 52.

[57] Id. at 92.

[58] Schlueter, at §3-3(A), fn 4.

airman were caught pilfering a video game from the base store, his commanding Lieutenant could impose a punishment of forfeiture of seven days pay, but no more.[59]

However, as above, the accused may always demand a Court Martial, either Special or General, depending on the gravity of the offense. As above, Special Courts Martial handle those minor issues that could also be dealt with by NJP[60], while General Courts Martial handle more serious offenses.[61] I will use the term "disciplinary" to refer to those minor matters handled either by NJP or Special Court Martial. I have chosen the term because the stated goal of the Military Justice system in handling these offenses is not to punish the soldier, but to rehabilitate him and maintain unit discipline.[62]

b. A Brief Overview of Disciplinary Offenses

Schlueter divides disciplinary offenses into nine general categories: Absence offenses[63]; disrespect offenses[64]; disobedience offenses[65]; conduct unbecoming an officer[66]; the general article [67]; drug offenses[68]; fraternization (generally, consensual sexual contact between

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[59] Michael W. Goldman, ed., "The Military Commander and the Law", at 96.

[60] Schlueter at § 4-3(B)

[61] Id. at § 4-3(A)

[62] Schlueter at § 3-2; "The Military Commander and the Law" at 92.

[63] Arts. 85-87, UCMJ

[64] Art. 89, UCMJ; Art. 91, UCMJ

[65] Art. 90, UCMJ (disobedience of a superior's orders); Art. 91, UCMJ (disobedience of orders of warrant, petty or noncommissioned officer); Art. 92, UCMJ (disobedience of orders or regulations)

[66] Art. 133, UCMJ; See, e.g., United States v. Page, 43 M.J. 804 (A.F.Ct.Crim.App. 1995) (denigrating the marital relationship of an enlisted subordinate erodes confidence in command and is thus conduct unbecoming an officer)

[67] Art. 134, UCMJ. There are three subsections to the article: 1) conduct to the prejudice of good order and discipline in the armed forces; 2) conduct of a nature to bring discredit upon the armed forces; 3) conduct violating federal or state laws.

[68] Art. 112(a) UCMJ. Traditionally, drug offenses were charged under either Art. 92 (disobedience), or Art. 134 (the general article), and offenses not covered by Art. 112(a), such as the possession of drug paraphernalia, are still so charged. Schlueter § 2-7(A).

officers and enlisted members[69]) ; and AIDS and HIV-Related offenses (violating "safe sex" orders[70]).

c. The Impact of PTSD on Disciplinary Offenses

In theory, a military member suffering from PTSD would find complying with the laws relating to disciplinary offenses to be extremely burdensome.[71] PTSD's comorbidity with agoraphobia and major depression[72] [73] would lead to an increase in absence offenses.[74] The combination of major depression, increased startle response, "psychic numbing", and violent outbursts[75] would make it exponentially more difficult for the soldier to avoid (depending on his rank) disrespect offenses, disobedience offenses, conduct unbecoming an officer, or offenses under the general article.[76] Most dramatically, with a combination of "psychic numbing" (often leading to an increase in high-risk behavior), and the direct correlation between PTSD and substance abuse[77], one might think it virtually inevitable that a soldier suffering from PTSD would fall

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[69] Charged under either Art. 133, UCMJ (conduct unbecoming an officer), or Art. 134, UCMJ (the general article). Schlueter § 2-8(B).

[70] The military screens all applicants for HIV/AIDS when they enter the service. When a military member tests positive, he or she receives a mandatory order to refrain from unsafe sexual practices that might spread the disease. Hence, offenses are charged under Art. 90, UCMJ (disobedience to a superior's orders). Schlueter 2-9(B).

[71] The RAND Study notes "there may be significant costs stemming from the downstream consequences of these illnesses, including increased non–mental health related medical costs, caregiver burden, strain on family relationships, domestic violence, substance abuse, crime, and homelessness." RAND Study at 176.

[72] DSMV-IV 309.81

[73] PTSD-induced major depressive disorder is particularly troubling in the military context, for three reasons. First, roughly 15% of those with major depressive disorder will commit suicide, a rate which can only be heightened in an environment with ready access to weapons. Second, major depressive disorder is itself associated with substance-related disorders and panic disorder, both of which would be highly prejudicial to military discipline, and possibly violative of the UCMJ. And third, major depressive disorder is also associated with borderline personality disorder, itself associated with intense, uncontrollable outbursts of anger – leading inevitably to more episodes of murder, assault, and the violation of the laws of war among members of our armed forces. DSMV-IV 300 (Major Depressive Disorder); DSMV-IV 301.83 (Borderline Personality Disorder).

[74] Arts. 85-87, UCMJ

[75] DSMV-IV 309.81.

[76] Art. 89-92, UCMJ (disrespect and disobedience offenses); Art. 133 (conduct unbecoming an officer); Art. 134, UCMJ (the general article).

[77] DSMV-IV 309.81.

afoul of the fraternization, drug, and, in the worst case scenario, HIV/AIDS offenses.[78]

PTSD is, in short, highly prejudicial to the maintenance of good discipline, and highly likely to increase violations of the UCMJ. To the extent that discipline requires a clear mind, predictable and reasonable response to stimuli, and freedom from the burdens of major depression and substance abuse, PTSD is discipline's mortal enemy. As the Supreme Court itself famously noted, "[A]n army is not a deliberative body. It is the executive arm. Its law is that of obedience. No question can be left open as to the right to command in the officer, or the duty of obedience in the soldier."[79] Can an officer or a soldier suffering from severe PTSD really be expected to live up to this ideal? Unfortunately, when he does not do so, he becomes the target of the Military Justice System.

### d. The Preferring Commander's Response to PTSD: Is There a Right Answer?

To say it plainly, the problem PTSD poses for the preferring commander in disciplinary cases may be insoluble. The unfortunate commander faces two sets of considerations, diametrically opposed. First, as above, disciplinary action is "intended to improve, correct and instruct subordinates who depart from standards of performance, conduct, bearing and integrity, on or off duty."[80] It is rehabilitative, not punitive.[81] Moreover, in deciding to offer NJP, the military commander is counseled to consider a wide range of factors such as "the nature of the offense and the circumstances surrounding its commission; [and] the member's age, rank, duty assignment, record, and experience."[82] By logical extension, the commander must also consider these same issues in deciding whether to prefer Special or General Court Martial charges. These factors all counsel toward leniency in deciding the case of a military member suffering from PTSD. The Supreme Court itself has recognized some sort of special

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[78] Arts. 133-134, UCMJ (fraternization); Arts. 112(a), 133-134, UCMJ (drug offenses); Art 90, UCMJ (disobeying a "safe-sex" order).

[79] Parker v. Levy, 417 US 733, 733 (1974).

[80] "The Military Commander and the Law", at 108.

[81] Schlueter at § 3-2; "The Military Commander and the Law" at 92

[82] "The Military Commander and the Law" at 92.

relationship between military commanders and their subordinates[83], even though the legal effects of that relationship are extremely limited. [84] Even without a legal obligation, the military arguably has some moral obligation in the case of PTSD: notably, by exposing the soldier to the combat that has indirectly caused his or her condition.

But, second, the military, while concerned for its members, also undertakes a broader mission. As the Air Force states quite plainly, "The importance of the Air Force's mission and inherent responsibility to the Nation requires its members to adhere to higher standards than normally found in civilian life."[85] As detailed above, PTSD undercuts just these qualities – it can cause the sufferer to become agoraphobic, easily startled, depressed, more likely to abuse drugs and alcohol, numb to the world around him, forgetful of everyday duties, violent, and, in short, a bad soldier.[86] These disabilities will lead to increased infractions of the UCMJ, and hence will demand command attention, and punishment.[87] Multiple infractions, especially those dealing with substance abuse, will lead, ultimately, to imprisonment pursuant to a Court Martial, forced separation from the military, or, at worst, imprisonment followed by a dishonorable discharge.[88] Given that, for instance, many employment applications ask for both record of military service and criminal record, the military will have done much to burden this hypothetical soldier's life – the precise opposite of its stated goal, and "quasi-parental duty."

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[83] See Feres v. United States, 340 U.S. 135 (1950) (Holding soldiers may not sue their superiors under the Federal Tort Claims Act), as interpreted by United States v. Muniz, 374 US 150, 162 (1963) ("[in] the last analysis Feres seems best explained by the peculiar and special relationship of the soldier to his superiors").

[84] Some litigants have alleged a "quasi-parental" duty on the part of the military to its members. Courts have expressed some sympathy for this characterization, but it has not yet given rise to any liability for the military. See, e.g., Corrigan v. United States, 815 F. 2d 954 (4th. Cir. 1987)(Court held that the military could not be held liable when an under-age soldier became intoxicated and visibly inebriated at an on-base club, was allowed to drive off base, and then caused a serious traffic accident. The court also noted, regarding the "quasi-parental" duty, that parents and children could generally not be held liable for each others' actions at common law)

[85] Air Force Policy Directive 36-29, "Military Standards", issued 1 June 1996, at 1.

[86] See DSMV-IV 309.81 (1994)

[87] See § IV(c), supra

[88] See AFI 36-2308, Administrative Separation of Airmen, issued 28 May 2003: separation appropriate for, e.g., "conditions that interfere with military service", "unsatisfactory conduct", "minor disciplinary infractions", "a pattern of misconduct." Additionally, commanders MUST discharge an airman, or seek a special waiver, if the reason is "Civil court conviction for an offense for which a punitive discharge and confinement for one year or more would be authorized by the UCMJ", or "drug abuse."

So, to speak broadly, PTSD raises acutely a question common to all justice systems: is punishment ever really rehabilitation? The goal of NJP and Special Court Martial proceedings may be rehabilitation, but they also leave a black mark on the soldier's record – in the form of an "Unfavorable Information File" that "provides commanders with an official repository of substantiated derogatory data concerning "[a] member's personal conduct and duty performance"[89] – that could dog that soldier for his entire time in the military, limiting his opportunities for advancement and reenlistment. And, needless to say, those same infractions that go in an "Unfavorable Information File" can also end a military career.[90] So let us put the matter starkly: should the Military Justice System attempt to deal with PTSD at all?

### e: PTSD and Disciplinary Offenses: Between Rehabilitation and Punishment

The relationship between rehabilitation and punishment is one of the most complex in the philosophy of law. Nevertheless, exploring this relationship gives the contours of an answer to how the military justice system ought to treat PTSD. It explores the contours between psychiatric rehabilitation and punishment for disciplinary breaches.

In the relationship between rehabilitation and punishment, at one extreme is the position that punishment should have no rehabilitative aspect; rather punishment should, first, act as a deterrent, and, second, segregate law-breakers from the rest of society. At the other extreme is the position that punishment can only be justified if it is rehabilitative. So if the law-breaker will not repeat his malfeasance, or if punishment will not rehabilitate him or her, no punishment should be carried out. A middle ground -- and the one that helps most for present purposes -- is the Kantian position. To wit, punishment is rehabilitation because the lawbreaker can only rejoin the community after he has done his penance.[91] To expand on Kant's point slightly, one might say that punishment is justified when not

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[89] See "AFI 36-2907, Unfavorable Information File (UIF) Program, issued 1 May 1997. For enlisted personnel, NJP and Court Martial convictions must be placed in the Unfavorable Information File.

[90] See Fns. 71, 72, supra.

[91] Immanuel Kant, "The Philosophy of Law: An Exposition of the Fundamental Principles of Jurisprudence As the Science of Right" (The Lawbook Exchange, Ltd., 2002) at 196

only does the lawbreaker do his penance, but he can (both in the eyes of the community and in fact) rejoin the law-abiding community afterward.[92]

When the proposition is put that way, it allows us to break down a "punishment" into two parts -- that part which is punitive, and that part which is rehabilitative. This analysis lends itself to literal application in the PTSD context.[93] If a service member commits a disciplinary offense, and that service member has previously screened positive for PTSD, his sentence ought to combine not only the punishment the service member would normally receive, but a mandatory course of PTSD treatment. Such a course of punishment nicely fulfills Kant's objectives. First, the service member will do his penance, allowing the service member to re-join military society without that member being accused of escaping justice. And, second, the recommended course of punishment would also allow the service member to be literally rehabilitated. He or she would receive treatment to address the psychological condition from which he or she is suffering. Ideally, the military member could then re-enter military society, and that society would welcome him or her back.

## V. Commanders, Psychotherapists, and Courts-martial

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[92] Id. Kant actually spoke to the issue of medical care vs. punishment specifically (although Kant was referring to the criminal undergoing medical experimentation as a replacement for punishment. The author of the present paper, however, believes Kant's point applies with even greater force when the alternative to punishment is rehabilitative care):

> What, then, is to be said of such a proposal as to keep a criminal alive who has been condemned to death on his being given to understand that if he agreed to certain dangerous experiments being performed upon him, he would be allowed to survive if he came happily through them? It is argued that physicians might thus obtain new information that would be of value to the commonweal. But a court of justice would repudiate with scorn any proposal of this kind of made to it by a medical faculty; for justice would cease to be justice, if it were bartered away for any consideration whatever. . . . [Public justice]j is the principle of equality, by which the pointer of the scale of justice is made to incline no more to the one side than the other. It may be rendered by saying that the undeserved evil which any one commits on another, is to be regarded as perpetrated on himself. [And so to achieve "public justice" the criminal must be punished in the same measure as he has harmed others. [Then the "scale of justice" would be re-balanced]

[93] This paper will not address the far thornier issue of the balance between rehabilitation and punishment when the service member has committed a serious general court-martial crime. The issue is "thornier" because the instinct to punish, the need to segregate the perpetrator from society, and the hostility of the society to the perpetrator are all much greater than when dealing with disciplinary offenses. The author will only note Congress's constitutional power to pass laws for the governance of military forces -- and hope that the "wisdom of crowds" will prevail when Congress does the balancing.

As established above, even as professional psychotherapists have taken on a role in the military that was traditionally the province of commanding officers, officers have not relinquished their traditional power and prerogatives. More specifically, they still remain intimately involved in the psychiatric care of those under them. This is particularly troubling in the case of the military justice system, where courts-martial (as opposed to the NJP used for minor offenses) supposedly protect the privilege.

The Court of Appeals for the Armed Forces has reserved the question as to whether disclosures from psychotherapists to commanding officers destroys psychotherapist-patient privilege.[94] Since psychotherapy is becoming a much more significant part of our military, these questions will only grow more important.

This section, then, examines the existing rules and procedures relating to military psychotherapy and the military psychotherapist-patient privilege. Given the plain language of the current rules, psychotherapist-patient privilege probably has been destroyed. But that does not end the inquiry. Rather, this section goes through several arguments, both policy and legal, that the policy ought to be preserved.

In particular, this section uncovers a little-known but very important tradition of rights-protection in the military courts. Over the years, these courts have often extended protections to military members even when civilian courts would seem to have limited those protections or taken them away. The section thus ends by arguing that, in the case of psychotherapist-patient privilege, military courts ought to act in conformity with this tradition, and preserve psychotherapist-patient privilege in the military justice system.

### a. Why Psychotherapist-Patient Confidentiality Probably No Longer Exists in Courts-Martial

It should be noted, that, as above, at least 30%[95] of military members in the regular course of their duties receive mental health evaluations, either at their own behest, or at the order of their

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[94] Jenkins, 67 M.J. 429.

[95] MHAT-III at 7. This amount will have increased somewhat, due to the efforts to expand access to mental health treatment (and screening) outlined above. However, MHAT-IV did not provide data on the percentage of soldiers receiving care.

commander.[96] And, given the frequency of deployments to Iraq, soon close to 100% of military members will have been screened for PTSD.[97]

The question then becomes: what is the status of these evaluations at trial and during regular military operations – are they confidential and privileged or not? Because the psychotherapist-patient privilege covers only confidential communications[98], the issues of confidentiality and privilege are inextricably intertwined, and this section will discuss them as a piece. Additionally, discussing privilege along with confidentiality brings the latter problem into much sharper focus.

Here, the military rules, on the surface, mirror the federal ones almost entirely. However, this section will argue that DoD Directive 6490.1 and DoD Instruction 6490.4 have made it impossible for a service member to have a "confidential" mental health evaluation, and so the theoretically robust protection of psychotherapist-patient confidentiality outlined below in fact is mere words on paper. Nevertheless, that being the case, this section will conclude by arguing that profound reasons of judicial doctrine and method might allow military judges to maintain the psychotherapist-patient privilege in the military justice system.

Nevertheless, according to the Military Rules of Evidence, once the accused is subject to a court-martial under the UCMJ, he enjoys a psychotherapist-patient privilege:

> A patient has a privilege to refuse to disclose and to prevent any other person from disclosing a confidential communication made between the patient and a psychotherapist or an assistant to the psychotherapist, in a case arising under the UCMJ, if such communication was made for the purpose of facilitating diagnosis or treatment of the patient's mental or emotional condition.[99]

As in the federal system, certain exceptions apply, only a few of which need concern us here: the psychotherapist may reveal information when he believes the patient to be a danger to any person[100]; "when necessary to ensure the safety and security of military personnel, military dependents, military property, classified information, or the accomplishment of a military mission"[101]; and, most importantly,

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[96] See DoD Instruction 6490.4.

[97] See note 31, supra.

[98] Military Rule of Evidence 513

[99] Id. at § (a).

[100] Id. at (d)(4)

[101] Id. at (d)(6)

> when an accused offers statements or other evidence concerning his mental condition in defense, extenuation, or mitigation, under circumstances not covered by R.C.M. 706 or Mil. R. Evid. 302. In such situations, the military judge may, upon motion, order disclosure of any statement made by the accused to a psychotherapist as may be necessary in the interests of justice.[102]

The first few might apply particularly in cases of patients suffering from severe PTSD, when, as discussed above, there is a heightened tendency to violent behavior.[103] And the last would obviously come into play were the defendant to make a PTSD defense, that subject being discussed below.

In theory, then, this system provides the accused broad protection against the disclosure of psychiatric information, consistent with the protections he would enjoy in federal court. But there is one major problem. DoD Instruction 6490.4, at §§ 6.1.3.3 and 6.1.3.5 instructs any mental health provider (MHP) seeing the soldier to report the results of the mental health evaluation, whether voluntary or involuntary, to that soldier's commander. The Instruction even informs the MHP explicitly to say that the session is "not confidential"[104], and to instruct the service member on the "conflict of duties" the psychotherapist faces, as between a duty to the patient and a duty to the commander.[105] Thus it would seem that there are NO mental health evaluations that would meet the Rule 513 standard, as none would be confidential.[106]

Language in other Department of Defense Directives and Instructions strengthens this suspicion. DoD Directive 6490.1, of which 6490.4 is an implementation[107], has a savings clause, which reads, "The policy of making referrals for mental health evaluations . . . does not modify any authorities or responsibilities about the prevention, investigation, or prosecution of offenses under the UCMJ."[108] First, this language obviously makes no mention of the rights of the defendant, confidentiality, or evidentiary privileges. Second, and more importantly, it is arguable that the Rules do not fall under the UCMJ, per se, but under

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[102] Id. at (d)(7)

[103] DSMV-IV 309.81

[104] DoD Instruction 6490.4, at 6.1.3.3

[105] Id. at 6.1.3.4.

[106] Id. at 6.1.3.3, 6.1.3.5.

[107] See Id. at 1: References

[108] DoD Directive 6490.1, at 4.9.

the *Manual for Courts-Martial*.[109] The UCMJ is a legislative document, created by Congress[110], while the *Manual for Courts-Martial* is an executive document, created by executive order[111] (albeit pursuant to a grant of authority from Congress[112]). The practical difference is that the executive may not modify or circumvent the UCMJ -- rather it is an executive-constraining statute[113] -- while he may modify the *Manual* and the Rules. Thus 6490.1's savings clause is necessary when applied to the UCMJ, but inappropriate (indeed inexplicable) when applied to the *Manual* or the Rules.

Hence, by the plain language of the text, and the differing histories and sources of authority for the UCMJ and *Manual for Courts Martial*[114] the saving clause of 6490.1 does not apply to the Military Rules of Evidence, and hence not to Rule of Evidence 513. As a result, DoD Instruction 6490.4 has effectively removed the psychotherapist-patient privilege from all routine mental evaluations of service members by eliminating confidentiality in mental evaluations.[115] [116]

b. A Limited Procedural Privilege under the *Manual for Courts-Martial*

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[109] Manual for Courts-Martial, Part III: Military Rules of Evidence (2005 ed.)

[110] 64 Stat. 198 (1950),

[111] Executive Order 12473 (1984)(creation of the modern Manual. Of course, for as long as there have been courts-martial there have been procedural rules governing them) .

[112] 10 USCS 836(a).

[113] Posner & Sunstein, Chevronizing Foreign Affairs Law 116 Yale L.J. 1170, 1198, 1224 (2007)(suggesting that the UCMJ is a statute meant to constrain the executive, rather than a general statute meant to be given specific implementation by the executive)

[114] See notes 138, 139, supra.

[115] DoD Instruction 6490.4, at 6.1.1.3, 6.1.1.5.

[116] Far more protection exists for non-routine referrals and psychiatric treatment. If a service member is involuntarily admitted to a psychiatric facility, DoD 6490.4, at 6.2.2.3 that, when involuntarily hospitalized "The Service member shall be evaluated by the attending privileged psychiatrist". And, if the hospitalization continues for more than 24 hours, 6.2.3.1 states that, "Within 72 hours of admission, an independent, privileged, psychiatrist, or other medical officer . . . shall review the factors that led to the involuntary admission." [emphasis added]. Although the psychiatrist is to "coordinate" with the commanding officer who referred the member for involuntary hospitalization at the admissions stage, 6.2.2.1, afterwards it is the job of the reviewing psychiatrist to ensure that the commanding officer did not refer the member improperly, 6.2.3.6. Moreover, in these situations, mental health providers do not report their findings to the member's commanding officer. Similar protections exist for military whistleblowers. See DoD Directive 7050.6, "Military Whistleblower Protection", issued August 12, 1995.

So it has been established that psychotherapist-patient privilege should not cover any mental health evaluations that the soldier would receive during the regular course of his duty.[117] However, once the trial proceeding has begun some limited protections begin to apply, although they are procedural, not evidentiary.[118] If questions of competence or capacity are raised during trial, the military judge may order the defendant to appear before a "sanity board", consisting of at least one clinical psychologist (independent of any experts the prosecution or defense may retain).[119] Unlike the results of regular mental evaluations, if the sanity board convenes during trial, "No person, other than the defense counsel, accused, or, after referral of charges, the military judge may disclose to the trial counsel any statement made by the accused to the board or any evidence derived from such statement."[120]

However, even here a loophole exists, although it is only a partial one. If the issue of competency or capacity is raised while the commander is considering preferring charges, or during the preferral of charges[121], and the sanity board is so convened[122], no confidentiality protections apply to the *conclusion* of the board – everyone even conceivably involved gets a copy of the conclusion.[123] Yet the full findings of the sanity board may be disclosed only to the judge, defense counsel, accused, and commanding officer.[124] So even though such a report would not be confidential under the meaning of Rule of Evidence 513[125], the prosecutor could not see it because of protection under RCM 706.

c. The Twin Problems a Lack of Confidentiality Poses for Military Justice

This paper has already alluded to the first and most obvious problem a lack of confidentiality in military psychiatry poses: it throws up

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[117] See note 141, supra.

[118] See RCM 706: Inquiry into the mental capacity or mental responsibility of the accused.

[119] Id. at (c)(1)

[120] Id. at (c)(4)

[121] See RCM 601: Referral

[122] RCM 706(b)(1)-(2)

[123] RCM 706 at (c)(3)(A)

[124] Id. at (C)(3)(B)

[125] See DoD Instruction 6490.4 at 6.1.1.3, 6.1.1.5.

a barrier to effective PTSD treatment. The "Iraq War Clinician Guide" instructs MHP's to

> Connect with the returning veteran: Practitioners should work from a patient-centered perspective, and take care to find out the current concerns of the patient (e.g. fear of returning to the war zone, concerns about having been evacuated and what this means worries about reactions of unit, fear of career ramifications, concerns about reactions of family, concerns about returning to active duty)[126]

The Department of Defense has itself established that such fears are widespread among military members[127] (although they may be decreasing[128]). Moreover, as above, the Guide instructs MHP's to undertake what must be, by its very nature, a long-term, intimate course of treatment, including "Education about post-traumatic stress reactions", "Training in Coping Skills", "Exposure Therapy, "Cognitive Restructuring", and "Family Counseling."[129] If, however, MHP's must provide reports to the soldier's commanding officer about every therapy session[130], then not only will the soldier's likely fears about unit and career stigma be immeasurably strengthened,[131] but effective, intimate treatment itself may become an impossibility. As a result, both the instances and severity of PTSD in the military will increase, leading, as discussed above, to not only more disciplinary offenses[132], but, quite likely, to more murders, assaults, and rapes.[133]

The second, more acute problem (from the service member's perspective) with the lack of confidentiality in military psychiatry emerges with respect to the latter group of charges. PTSD results not in a single

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[126] "Iraq War Clinician Guide" at 36.

[127] MHAT-I at A-4.

[128] MHAT-III at 7. For an argument that this improvement may be overstated, see § IV(b), supra.

[129] Id. at 37-38.

[130] DoD Instruction 6490.4 at 6.1.3.3, 6.1.3.5.

[131] MHAT-III at 25: "individuals who met the criteria for acute stress symptoms, depression and anxiety reported significantly higher levels of stigma than did those who did not meet any of the criteria." Unsurprising, but nevertheless a problem: those who need help fear the stigma most.

[132] See § IV(c), supra.

[133] See § V, supra.

instance, but in a pattern[134], over many years[135], of behavior destructive to self and to others. If the military member develops a close bond, effective for treatment, with his MHP, reveals such a pattern of behavior, and that revelation is not confidential, but, indeed, reported regularly to commanding officers[136], then nothing will stop a military prosecutor from using that information in a court-martial.

Now, one should note that while this second problem is certainly a major problem for any military member subject to prosecution, it constitutes a far lesser problem for the military as a whole. The military operates like both a society and a business. Like any society, it needs effective mechanisms to maintain law and order, including mechanisms to prosecute, and segregate, those society members who have already, or are most likely, to harm others.[137] And like any business, it needs to manage its personnel – thus the explicitly stated goal of military psychiatry of "managing human resources."[138] In some ways, the Department of Defense has decided to strike a balance quite like that in *Tarasoff*[139], in explicitly requiring military psychiatrists to alert authorities of any potentially dangerous military members.[140] And, certainly, the psychiatric profession has survived that case. Yet, in other ways, the different, world-apart nature of the military increases the problem. The dissent in *Tarasoff* discussed both its desire for effective (and thus intimate) psychiatric care, and its fear that imposing a duty to warn would deter those who most needed care from seeking it.[141] The nature of the military environment, and the relevant policy on psychiatric care, takes these worries from the theoretical to the incarnate.

First, military members already worry more than the general population about career and personal stigma attached to mental health

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[134] DSMV-IV 309.81; Department of Veterans Affairs, National Center for PTSD, "Epidemiological Facts about PTSD", at http://www.ncptsd.va.gov/ncmain/ncdocs/fact_shts/fs_epidemiological.html?printable=true.

[135] Id.

[136] DoD Instruction 6094.4 at 6.1.3.5.

[137] See DoD Directive 6490.1 at 1.2.3 ("Requirement that commanding officers be alert to potentially dangerous Service members and take actions aimed at reducing danger to both the Service member and the general public")

[138] See DoD Directive 6490.1 at 1.2.3; AFI 44-109 at 6.1 ("Appropriate communications between MHPs and commanders aid in managing human resources")

[139] 551 P.2d 344 (1976)(psychiatrist had duty to warn third party when he could confidently predict high potential of harm against her)

[140] 6490.1 at 4.7.

[141] Tarasoff, 551 P.2d at 359.

care.[142] And, second, the issue before us is not an occasional duty to report an especially violent patient, but the regular reporting of even the most routine psychiatric care[143] (exponentially increasing the service member's aversion to seeking care) and the complete destruction of psychotherapist-patient privilege in litigation.[144] Universal PTSD screening[145], and the authority of commanders to order members to seek psychiatric care[146], address the first of these problems to an extent. But, in this author's view, they do not solve the problem – they only make it more complex. And besides, they do nothing to address the second problem. In point of fact, they create it.

d. Maintaining Psycotherapist-Patient Privilege in the Military Justice Ssytem

i. A Word of Caution: Does the Real World Conform to the Theory?

It is not clear how these many rules are operating in practice. On balance, the evidence indicates that the issues outlined in parts i and ii above remain simply unresolved. The military may be the largest and most complex bureaucracy in the federal government.[147] And, certainly, not every Staff Judge Advocate or Military Judge will have read every DoD Directive and Instruction, of which, by this author's rough count there are over a thousand[148], with new ones issued every year, not to mention the equally numerous complementary and implementing instructions in the Service branches.[149] And some good evidence exists that, whatever the actual legal rules may be, Rule of Evidence 513 still protects psychotherapist-patient privilege in practice.

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[142] MHAT-I at A-4.

[143] DoD Instruction 6490.4 at 6.1.3.5.

[144] See Id.; Military Rule of Evidence 513 (requirement of confidentiality)

[145] Sgt. Sara Wood, "Military Health Care Making Advances", American Forces Information Service: News Articles, Dec. 13, 2006, http://www.defenselink.mil/Utility/PrintItem.aspx?print=http://www.defenselink.mil/news/NewsArticle.aspx?ID=2408

[146] DoD Instruction 6490.4 at § 6.

[147] Philip Carter, "What about the Grunts?" at http://www.slate.com/id/2155105/ (the author, a lawyer and former army officer, actually writes the American military is "the largest and most lethargic bureaucracy in world history")

[148] See "DoD Issuances and OSD Administrative Instructions", at http://www.dtic.mil/whs/directives/search.html (this government service was also used in obtaining many of the Department of Defense documents used in this paper.)

[149] See http://www.e-publishing.af.mil (the same sort of site as that in fn 121, but exclusively for Air Force documents)

For instance, DoD Directive 6490.1 and DoD Instruction 6490.4 were both issued in 1997.[150] Even though 6490.4 should have more or less eliminated psychotherapist-patient privilege for regular mental health evaluations, Air Force Instruction 44-109, "Mental Health, Confidentiality, and Military Law", issued 1 March 2000, and which references both 6490.1 and 6490.4[151], does not treat the issue in this way. Rather, it characterizes psychotherapist-patient privilege as broad, with only limited exceptions. But the Instruction is itself confusing, and requires some explication.

It states that the general rule is that communications between a patient and a psychotherapist are privileged, but that "confidential communications will be disclosed to persons or agencies with a proper and legitimate need for the information and who are authorized by law or regulation to receive it."[152] Because of this drafting, it is not clear if these communications remain otherwise confidential despite their disclosure, or if the disclosure destroys that confidentiality.

A similar problem arises when the Instruction discusses the evidentiary privilege in particular. It quotes Rule of Evidence 513 verbatim[153] but then goes on to say "There is no privilege under this rule . . . when federal law, state law, or service regulation imposes a *duty* to report information contained in the communication."[154] [emphasis added] The question thus becomes, do psychotherapists have a legally cognizable "duty" to report the results of mental health evaluations to commanding officers? On the one hand, 6490.4 clearly understands routine mental health evaluations as being "not confidential"[155] and says that "the mental healthcare provider *shall* forward a memorandum to the Service member's commanding officer."[156][emphasis added] These clauses clearly create a duty for Mental Health Providers to report their findings to commanding officers.

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[150] 6490.1 at 1 (October 1, 1997); 6490.4 at 1(August 28, 1997)(6490.4 is an implementing Instruction of 6490.1. For an indication of the density of the military bureaucracy, please note that the implementing Instruction was issued more than a month before the Directive it was implementing)

[151] AFI 44-109 at 1.

[152] AFI 44-109 at 2.1

[153] Id. at 2.2.

[154] Id. at 2.2.3

[155] DoD 6490.4 at 6.1.1.3.

[156] Id. at 6.1.3.5.

On the other hand, AFI 44-109, which is fully cognizant of 6490.4 and references it multiple times[157], interprets that same DoD Instruction quite differently. Regarding communications between Mental Health Providers and Commanders, it states

> Appropriate communications between MHPs and commanders aid in managing human resources and can improve therapeutic results for service members. MHPs are encouraged to discuss the beneficial effects of command involvement with members and, whenever possible, to obtain the member's prior consent to the communication with the commander. Some situations may, however, justify contacting the commander without the member's knowledge.[158]

Moreover, the Instruction provides a list of situations in which the MHP is required to contact the commander[159], for example "[When] in the MHP's opinion, the member is a danger to self or others"[160] – thus, by negative implication, the MHP need not contact the Commander in other situations. The Instruction goes on to state that, "In fulfilling the requirements of Paragraph 6, MHPs will provide the commander the information required for informed decision-making, but should, to the extent possible, maintain the confidentiality of communications from the patient."[161] The Instruction does not say whether this limited disclosure destroys legal confidentiality, i.e. the psychotherapist-patient privilege, in which case "confidentiality" would be referring to the patient's personal confidentiality; or whether legal confidentiality is maintained, despite the limited disclosure.

Nevertheless, the Air Force legal system clearly believes 6490.4 to make communication between an MHP and Commander optional in all but a limited class of cases[162], and additionally seeks to preserve patient confidentiality even in the communication with the commander.[163] Thus, under the Air Force's interpretation of 6490.4, there would probably not be a legally cognizable "duty"[164] on the part of MHP's to report the results of

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[157] See, e.g., AFI 44-109 at 4.9.1.

[158] Id. at 6.1.

[159] Id. at 6.2.

[160] Id. at 6.2.1.

[161] Id. at 6.4

[162] Id. at 6.2.

[163] Id. at 6.4

[164] Id. at 2.2.3.

a mental health evaluation to a commander, and the effect of Rule 513 is preserved.

Thus, to put it politely, psychotherapist-patient privilege under military law remains "unresolved."[165] Perhaps the vast bureaucracy that is the Department of Defense never meant to eliminate psychotherapist-patient privilege in the first place, so the Air Force's interpretation[166] is a proper one. Perhaps, in psychotherapist-patient privilege, the left hand simply did not know what the right hand was doing. Or perhaps the Air Force, seeing the danger that 6490.1[167] and 6490.4[168] might pose to Military Justice, and equally aware that the Pentagon does not have time to read and monitor every AFI, deliberately chose to embark on its own creative interpretation of the Pentagon's rule.

e. The Textual Case for Maintaining the Privilege

The President derives authority to promulgate military rules of evidence from section 836 of the UCMJ.[169] The only salient restriction on his power to do so is that the military rules must mirror those in federal courts as far "as he [the President] considers practicable" (836(a))[170], and they must be uniform from one military court to another, "so far as practicable."(836(b))[171] In construing the term "practicable" in 836(b), the Supreme Court has, in *Hamdan v. Rumsfeld*, said that the President, before departing from 836(b)'s uniformity requirement, must make a showing that maintaining uniformity would be impracticable.[172] There are no Supreme Court decisions construing 836(a), but, if the word "practicable" is to have the same meaning in both sections of 836, then departing from the requirements of 836(a) would also demand a showing of impracticability. That showing is obviously absent regarding psychotherapist-patient privilege. That is, the military rules of evidence

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[165] Compare Dod Instruction 6490.4 at 6 with AFI 44-109 at 6.

[166] AFI 44-109 at 6.

[167] DoD Directive 6490.1 at 4.9. (not including the Rules of Evidence in the savings clause)

[168] DoD Instruction 6490.4 at 6.1.1.3, 6.1.1.5 (eliminating psychotherapist-patient privilege)

[169] 10 USCS 836 (2006).

[170] Id. at (a).

[171] Id. at (b).

[172] 126 S. Ct. 2749, 2791 (2006).

recognize the privilege[173], while it is only other executive instruments which undermine it.[174] Almost by definition there can be no showing of impracticability if the President has not changed the rule of evidence itself in the first place.

The obvious counter-argument -- itself voiced in *Hamdan*[175] -- is that the wording of 836(a) and 836(b) are respectively different, the former employing the phrase "so far as he [the President] considers practicable", while the latter simply says "insofar as practicable." The Supreme Court's dicta aside, this is a distinction without a difference. In either case, the President (and the executive branch more generally) promulgates the military rules of evidence and runs courts-martial. The additional phrase "as he considers" in section (a) doesn't materially change the meaning of "practicable" in both sections, since under both sections it is necessarily the President who considers, and then determines, practicability in the first instance. Moreover, in the instant case, the official "determination" of the President is found in MRE 513. At the least, before 513 could be gutted, it would require the President to make a comparable "determination" (likely in the form of a new rule of evidence), which, as above, he has not done. The official "determination" in this (courts-martial) context is MRE 513, which provides the privilege.

The theoretical advantage of such a method is that it leaves both sets of rules mostly intact. Obviously, the privilege rules receive their full effect, the effect they would be given if the required disclosure rules did not exist. Moreover, even the required disclosure rules are given effect in either all or the vast majority of situations to which they apply. If the above speculation is correct -- that psychotherapist-patient privilege in the military was eliminated, in effect, "by mistake"[176] -- then the required disclosure rules were never intended to destroy psychotherapist-patient privilege in the first place. Moreover, even without this assumption, the required disclosure rules would continue to apply in all cases, in that all disclosures to commanding officers would continue to occur, fulfilling the rules' goal of more effective personnel management. The effect of the proposed canon would be to simply eliminate one of the collateral effects

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[173] MRE 513.

[174] See, e.g., DoD Directive 6490.1.

[175] 126 S. Ct. at 2791.

[176] Supra, §V(b)(i)

of this personnel management protocol.[177] And, of course, in the vast majority of cases, where courts-martial are not involved, privilege issues would never arise in the first place.

Which is not to say that the proposed construction would carry the day in litigation or future rules' revision. The most serious -- perhaps fatal -- argument against it is very simple: it goes against the plain meaning of the relevant texts. That is, the existing privilege rule protects "confidential communications", and communications disclosed to a third party, in this case a commanding officer, are simply not confidential. The relevant DoD instructions state as much.[178] Thus, under any ordinary interpretation, the communication would not be privilege in litigation.

Yet reason exists to think that military judges would not -- and should not -- choose such a route. First, the relationship between the relevant texts is unclear, and is itself open to multiple interpretations. If each text is read separately, and given its plain meaning, then the psychotherapist-patient privilege could be read not to survive. However, if the texts are read together, a different reading might result. If we assume, *arguendo,* that psychotherapist-patient privilege exists in the military by virtue of MRE 513, but that disclosure to commanders is required under DoD Directive 6490.1, then privilege must continue to exist despite disclosure. To put it another way, if the service member's therapeutic sessions are *inevitably and unavoidably* disclosed to a third-party (the commander), then one could argue that the commander also falls within the "zone of protection" of the privilege. This reading makes sense given that the basic goals of the psychotherapist and commander are the same -- effective psychiatric treatment leading to improved performance and personnel management. In this way the commander can be analogized to a specialist whom the psychotherapist consults in the course of treatment. If disclosure is part of treatment, then disclosure would not break the privilege. These reasons are rooted in the military justice system's long and proud tradition of according its people more rights than the civilians in charge see fit to.

## VI. Military Justice's Native Tradition of Rights-Protection and Psychotherapist-Patient Privilege

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[177] An obvious problem with the above construction is that it would not per se stop the prosecution from simply asking the accused's commanding officer to relate the results of any psychiatric evaluation. The author, however, believes the hearsay rule would eliminate many such situations in actual litigation.

[178] DoD Instruction 6490.4, at 6.1.3.3

In recent decades military courts have developed a robust tradition of protecting the rights of service members. They have done so, at least in part, in response to developments in how the civilian courts have handled cases either arising in the military or originating in the military justice system. These shifts in the civilian justice system have led to an independent military tradition of rights protection, not tethered to developments in the civilian courts, and largely unappreciated by the wider world. Yet this under-studied tradition provides both a framework in which to analyze issues of psychotherapist-patient privilege, and a possible way to resolve the issue of the privilege's dubious existence. Which is to say, courts-martial have repeatedly stood up for the rights and privileges of military members against commanding officers and military bureaucracy. And military justice should do so here.

a. The Civilian Courts' Shifting Deference Standard toward the Military

Over the two centuries that the Supreme Court has addressed the Constitutional rights of military members, its jurisprudence has twice shifted dramatically. This section will detail both of those shifts, the first from general deference to the military to a far more skeptical judicial posture; and the second away from this posture, and back toward deference (although how much this second period of deference resembles the first one is open to debate). It will also point out some of the obvious deficiencies in the Court's current jurisprudence.

Until the late 1950's, the Court adopted a general policy of "non-interference" in military affairs. Rather than enunciating a positive doctrine, deferential or not, by which to evaluate military claims of right, it simply refused to "interfere" in the military justice system.[179] Practically, this meant that then-existing military policy prevailed, and so the military won nearly all its cases.[180] The first shift occurred during the tenure of Chief Justice Warren, as the Court began to aggressively evaluate the jurisdiction, procedures, and rights protections of the military

[179] Stephen B. Lichtman, The Justices and the Generals: A Critical Examination of the U.S. Supreme Court's Tradition of Deference to the Military, 1918-2004, 65 Md. L. Rev. 907, 915 (2006) (describing the Court's military jurisprudence prior to the 1950's as the "era of noninterference") (hereinafter "Lichtman")

[180] Under Chief Justice Vinson, for instance, Prof. Lichtman's analysis reveals that the military "won" 75.9% of the time.

justice system.[181] Indeed, during this period, the Bretheren were sometimes openly skeptical -- even hostile -- to courts-martial. To take the most glaring example, in one case Justice Douglas opined,

> Courts-martial as an institution are singularly inept in dealing with the nice subtleties of constitutional law . . . A civilian trial, in other words, is held in an atmosphere conducive to the protection of individual rights, while a military trial is marked by the age-old manifest destiny of retributive justice.[182]

In the years following this 1955 decision, the Court seems to have often acted on this assumption, dramatically limiting the jurisdiction of courts-martial, and dramatically challenging military policy, on constitutional grounds, both in and out of the courtroom.

I will give just three examples. In *United States ex re. Toth v. Quarles*, from which the above language regarding the competence of courts-martial was quoted. Here, an active-duty serviceman murdered a civilian while on active duty deployment in Korea. Charges were only preferred, however, several months after the accused had been discharged from the military and returned to the United States. The Court ruled that, because of the accused's discharge, a court-martial did not have jurisdiction to try him[183] -- the result being that, absent an act of Congress, no court outside of Korea could prosecute the accused.

A few years later, the Court extended this line of reasoning somewhat, in *Reid v. Covert*. Here the Court ruled that a court-martial did not have jurisdiction to try an Army wife who had murdered her husband while he was on active duty in the United Kingdom.[184] Finally, the Court extended its reasoning from former servicemen and military spouses to military members themselves, in *O'Callahan v. Parker.* Here the Court again held that a court-martial did not have jurisdiction, this time to try an active-duty serviceman for an assault and attempted rape that he had committed in the United States, while off-base on permitted leave. The

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[181] Prof. Lichtman asserts that the proper classification of military cases is not by era, but by subject-matter. John F. O'Connor disputes Prof. Lichtman's approach, and gets the better of the argument, by pointing out that both the military's success rate and the purported reasoning of the Court vary far more by era than by subject-matter. See John F. O'Connor, Statistics and the Military Deference Doctrine: A Response to Prof. Lichtman, 66 Md. L. Rev. 668 (2006). This debate, though interesting, is not central to this paper. Rather, for purposes of this paper, the author simply accepts Mr. O'Connor's analysis, while making use of the raw data that Prof. Lichtman produced.

[182] United States ex rel. Toth v. Quarles, 350 U.S. 11, 22 (1955)

[183] 350 U.S. 11, 22-23 (1955)

[184] 354 U.S. 1, 15-19 (1957)

Court reasoned that the charges against the accused lacked the requisite "service connection" go give a court-martial jurisdiction.[185]

With such lacunae of justice obviously in mind, the Court's jurisprudence shifted again -- just as seismically -- starting in the mid-1970's. The Court began to routinely defer to the military in virtually every litigation before it (by Prof. Lichtman's calculation, the military, in these years, has gotten a favorable outcome before the Court about 85% of the time). In this area, however, the Court has not developed a satisfying jurisprudence. As Prof. Diane Mazur has argued, convincingly if not always coherently, the Court's current military jurisprudence is little more than *ipse dixit*, and the repetition of "magic words" about the uniqueness and importance of the military.[186] The Court, while saying repeatedly that the Bill of Rights and other protections generally apply in courts-martial, has not provided any principled basis on which to withhold or extend rights to servicemen. As Justice Brennan put it in *Goldman v. Weinberger,* "If a branch of the military declares one of its rules sufficiently important to outweigh a service person's constitutional rights, it seems the Court will accept that conclusion, no matter how absurd or unsupported it may be."[187]

One does not have to agree with Justice Brennan's judicial or political philosophy to see the unfortunate truth in his statement. *Goldman,* that is, should have been a hard case. It involved a reasonable military regulation (service members may not wear head gear that is not part of their uniforms) applied in an unreasonable fashion (only after the plaintiff had testified against the government in a court-martial). Chief Justice Rehnquist, writing for the Court, spends no more than a few sentences outlining the basis for the decision against the plaintiff (and those sentences are mostly the rote repetition of quotes from previous cases, none of which are directly on point).[188] The opinion itself is quite short, and almost all of its few pages are devoted to arguing against various propositions in the dissent. Or, as Justice O'Connor pointed out in her separate dissent, "No test for free exercise claims in the military context is even articulated, much less applied. It is entirely sufficient for the Court if the military perceives the need for [its policy]."[189]

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[185] 395 U.S. 258, 300-303 (1969).

[186] Diane H. Mazur, "Rehnquist's Vietnam: Constitutional Separation and the Stealth Advance of Martial Law", 77 Ind. L. J. 701 (arguing that Justice Rehnquist's political preference for the military gave birth to the Court's modern military jurisprudence).

[187] 475 U.S. 503, 515 (1986)(Brennan, J., dissenting).

[188] Id. at 508

[189] Id. at 528 (O'Connor, J., dissenting).

The functional result of this combination of "because we say so" jurisprudence and deference to the military has meant that one cannot say what, if any, protections servicemen before courts-martial *are* required to have. The obvious temptation, then, would be for the military to treat servicemen as if they had no rights. Fortunately, this is not what it has done. Rather it has pushed back, extending more rights to servicemen than the civilian authorities see fit to mandate.

### b. The Development of Judicial Rights-Protection in the Military

Which is to say, the military courts put their own interpretations on the Supreme Court's precedents as they applied to the military. And these interpretations have consistently extended to service members more rights than would follow naturally from the Supreme Court's language and reasoning.

I will give two examples. To begin with, in *United States v. Tempia*, the then-Court of Military Appeals (now the Court of Appeals for the Armed Forces), when faced with the question of whether military police had to give *Miranda*[190] warning when performing searches, answered in the affirmative.[191] There is nothing particularly remarkable in that result -- except that it is somewhat inconsistent with the *Miranda* opinion itself. That is, in *Miranda,* the Court itself gave the military justice system as an example of a system that *already* gave adequate constitutional protections to defendants.[192] Although that portion of the opinion is dicta, a plain reading of that dicta and of the Court's more-central observation that the *Miranda* warnings are only one possible way to fulfill the defendant's Constitutional guarantees[193], yields the result that military police could safely ignore *Miranda* as long as they maintained their then-existing protections. And even if MP's could not "safely" ignore *Miranda*, they at least had the luxury of waiting for the Supreme Court to disqualify the more-than-plausible reading of *Miranda* mentioned above. Indeed, the dissent in *Tempia* made exactly these points.[194]

The majority, however, disagreed. They relied on the particular facts of *Tempia* to extend *Miranda* to military defendants. In *Tempia*, one

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[190] 384 U.S. 436 (1966)

[191] United States v. Tempia, 16 USCMA 629, 642 (1967).

[192] Miranda, 384 U.S. at 489.

[193] Id. at 478-479.

[194] Tempia, 16 USCMA at 643 et seq. (Quinn, C.J, dissenting).

plausible reading of the facts was that the defendant, although apprised in a general way of his right to counsel, did not actually realize that he had a "right" that was related to other rights that would protect him during questioning, and so he both declined counsel and declined to exercise other Constitutional rights.[195] Using these facts as a springboard, the Court of Military Appeals extended *Miranda* warnings to all military defendants[196], despite the *Miranda* Court's positive treatment of the protections already afforded in the military justice system.[197]

*Miranda*, of course, is a landmark of individual-rights jurisprudence, a high water mark of sorts. Yet even hear the Court of Military Appeals decided to go higher than the high water mark, and mandate *Miranda* warnings, even though they certainly did not need to do so, on either one of two bases. Either, as above, they did not need to do so because *Miranda* warnings were not mandatory, or they did not need to do so because the military justice system already fulfilled *Miranda*'s requirements.

*Middendorf v. Henry*[198] stands as a different sort of landmark than *Miranda*. *Middendorf* and several other cases from the mid-1970's signaled the second major shift in the Supreme Court's military jurisprudence, discussed above. Instead of applying the close scrutiny that had characterized its jurisprudence in the 1950's and 1960's, the Court began to apply a far more deferential standard based on the "separate" nature of military society and the importance and uniqueness of the military mission.[199] More specifically, it ruled that the accused had no right to counsel in summary court-martial proceedings.[200] Three things are remarkable about *Middenforf*, two of which are directly pertinent to this paper.

To begin with, as already stated, *Middendorf* marked the beginning of the Court's modern military jurisprudence. Other writers have already

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[195] Id. at 631-32.

[196] Id. at 639 ("In sum, we are not persuaded by our [dissenting] brother's views that we [the military] have anticipated the Supreme Court in this area . . . We must effectuate the mandate by holding Miranda v. Arizona applicable in military prosecutions")

[197] Miranda, 384 U.S. at 489.

[198] 425 U.S. 25 (1976)

[199] Ironically, the Court, in discussing the "separateness" and "uniqueness" of the military cited Toth v. Quarles to justify the proposition. The irony is that the Toth Court was anything but deferential to courts-martial and the military, while the Middendorf Court based its deference, in large part, on the military's separate and unique nature.

[200] 425 U.S. at 48.

documented this sea-change.[201] What is remarkable about *Middendorf*, for present purposes, is what the Court of Military Appeals did before *Middendorf*, and what it did afterwards. In *United States v. Aldernman*, decided two years before *Middendorf*, the CMA held that the defendant *did* have a right to counsel at summary courts-martial.[202] The Supreme Court, while noting the *Alderman* decision, and that substantial deference is "normally" due to the CMA's resolution of military justice issues[203], held the opposite.[204]

The CMA would not be galled, however. Two years after *Middendorf*, in *United States v. Booker*[205], it pushed back again. Of course, the CMA could not outright overrule *Middendorf*, but the majority clearly disagreed with it. What they did instead -- in obviously specious fealty to *Middendorf*'s reasoning -- was to sharply reduce the scope of offenses for which summary court-martial was possible.[206] That is, the CMA reasoned that, since *Middendorf* based its denial of the right to counsel (in part) on the summary court-martial's disciplinary nature, summary courts-martial could thenceforth only hear disciplinary offenses, and not the full range of disciplinary and minor military justice offenses they had heard to that point.[207] The CMA put the firmest possible limit on the Supreme Court's ruling by sharply limiting the number and type of cases to which it would be applicable.[208]

### c. How These Competing Tradition Apply to Psychotherapist-Patient Privilege.

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[201] See, e.g., O'Connor, supra, n. 189 (and accompanying text); Mazur, supra, n. 194; but see Lichtman, supra, n. 189 (arguing, in part, that the Court's military jurisprudence is better classified by subject-matter than time period).

[202] 22 USCMA 298 (1973).

[203] Middendorf 425 U.S. at 43.

[204] Id. at 48.

[205] 5 M.J. 238 (1977).

[206] Id. at 244.

[207] Id. at 240-42.

[208] In Middendorf, Justice Rehnquist justified his lack of deference to the CMA, in part, on the fact that Judge Quinn had authored the opinion below, the Judge being broadly and publicly in favor of extending servicemen's rights. 425 U.S. at 44 n.20. In this context, it is surely important to note that Judge Quinn was not involved in the Booker decision. 5 M.J. at 238 (noting the judges who disposed of the case, none of whom was Judge Quinn).

All of which is to make a rather simple point -- the CMA/CAAF has often been more solicitous of service members' rights than have the civilian courts. Valid reasons exist for this discrepancy. Military courts (even those, like the CAAF, that are staffed by civilian appointees) are doubtless more sensitive to the peculiar needs of military society than their civilian counterparts. To give an obvious example, the Supreme Court's *O'Callahan* service-connection approach proved famously hard for military authorities to implement[209], while there is no indication that the military courts' rights-extending opinions have thrown up the same difficulties. Even though the Supreme Court's military deference doctrine is deeply unsatisfying, it exists for a good reason.

But, given the existence and independence of military courts, civilian jurisprudence provides not an end-point for analysis, but a starting point. In the instant case, the author hopes the military courts will continue their tradition of protecting the rights of servicemen, and save psychotherapist-patient privilege from DoD Directive 6490.1. The civilian courts certainly can't be expected to.

## VII. Conclusion: The Goals, and Necessity, of Military Psychiatry

Finally, let us turn from the particular to the general. First, as above, about 17% of OIF 04-06 members currently screen positive for symptoms consistent with PTSD.[210] Second, if history is any guide, an even larger percentage will experience PTSD in the months and years to come.[211] And, third, PTSD is bound to be highly prejudicial to both military discipline and military justice, in that it both makes it more difficult for a military member to operate with the sort of everyday discipline the military requires, and leads to increased likelihood of certain crimes.

Thus the necessity of military psychiatry. As the Iraq War Clinician Guide states, restoring an affected military member to mental health will likely take both an aggressive intervention by the psychiatrist, and an open, trusting relationship between psychiatrist and patient[212] (Indeed, the success of the former probably depends in large part on the existence of the latter). Yet if the psychoterapist-patient relationship is "not confidential", and the psychotherapist must tell the patient as much[213],

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[209] For example, the military courts of appeals repeatedly reversed themselves in deciding whether or not drug use was service-connected.

[210] Supra note 14.

[211] Supra note 12.

[212] Supra notes 25-29.

[213] Supra note 117.

then it is difficult to see how aggressive psychiatric intervention would be either successful or possible. If the doctor-patient relationship is not as successful as it could be, then one can conclude that cases of PTSD will essentially go untreated, with adverse effects for both military discipline and military justice.

This paper has suggested some ways, based on both statutory construction and military precedent, that military courts might preserve the psychotherapist-patient privilege. These, of course, are not the only solutions, nor are they even necessarily the best solutions. Indeed, the best solution would probably come from re-writing the relevant DoD directives, the military rules of evidence, or both. Yet, in the short term, working through the courts probably has the advantage of speed, in that military courts deal with military justice issues every day, while the larger DoD and executive bureaucracy only deals with them sporadically. Moreover, if the courts construe the DoD directives or rules of evidence in a way the military or executive chain of command finds unworkable or unwise, then the relevant authorities can almost certainly simply re-write the rules to undo the work of the courts (there not being, in the author's estimation, any colorable constitutional issues involved).

However, this paper does not presume to tell the political branches exactly where or how to draw these lines. Military justice and military regulation are, after all, core areas of political branch competence.[214] That being said, this paper has sought to outline the necessity of military psychiatry, the problems it poses for military discipline and military justice and, finally, the more specific dangers current policy poses to psychotherapist-patient confidentiality in the military.

It would be inapposite to end on so prosaic a note, however. Psychotherapist-patient privilege is first of all a human issue -- one stemming from the very real and very horrific traumas our soldiers undergo. We must keep in mind statements like the following, from a soldier suffering from PTSD: "I didn't answer the phone, I didn't go to the door, I didn't even want to see my kids. I just lay on the couch rolled up in an orange caftan. It got so bad my father started coming over every day and forcing me to get up. He would just walk me around the neighborhood to get some fresh air."[215] Or even to the quote from Swofford that opened this paper – "loneliness and poverty of spirit;

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[214] See, e.g., Solorio v. United States 483 U.S. 435, 443 (""The constitutional grant of power to Congress to regulate the Armed Forces, Art. I, § 8, cl. 14, appears in the same section as do the provisions granting Congress authority, inter alia, to regulate commerce among the several States, to coin money, and to declare war. On its face there is no indication that the grant of power in Clause 14 was any less plenary than the grants of other authority to Congress in the same section")

[215] Scott Anderson, "Bringing It All Back Home", May 28, 2006, at Section 6, pg. 36.

mental collapse; brief jovial moments after weeks of exhaustion . . . sleeplessness and drunkenness and desperation; fits of rage and despondency; mutiny of the self; . . . being told I must remember and then for many years forgetting."[216]

In such statements, the person suffering emerges as a full human being – unable to escape the traumas life has inflicted upon him, rolled up in an orange caftan on the couch, in mutiny against himself. And remember that PTSD is that disorder where "the victim gropes in the dark terror of insecurity, perpetually geared up for action."[217] The disorder stalks its victim, rendering him helpless, or making him into a killer.[218] And do not forget either that although the enemy always bears primary responsibility for creating trauma in our veterans, the military sends its warriors into war zones, and then asks them to come back to civilian life, and pick up where they left off.[219] Some can not[220], and some, even though suffering themselves, commit horrible, unforgivable crimes.[221]

Yet the problem here is both wide and deep. It extends not only to horrible crimes but to disciplinary offenses, where goals of rehabilitation and punishment inextricably intertwine. And where this paper has attempted to provide a Kantian solution to the legal problem. It further extends to a problem both very significant and somewhat specific -- psychotherapist-patient privilege in courts-martial. But, even in these discrete areas, the background considerations do not go away. It is not just legal rules that are on the line, but military members, their minds, and their futures. The military justice system, most of all, ought never forget this.

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[216] Swofford at 3.

[217] The Encyclopedia of Psychiatry, Psychology, and Psychoanalysis" at 409. (quoting Ursano et al., 1992)

[218] Id.

[219] As one returning veteran put it, "I mean, it's great being back with my wife, spending time with my kids, but in other ways . . . well, I guess I kind of miss it. I miss my fellow soldiers. I miss the camaraderie. And I don't mean to sound arrogant when I say this, but I miss the power . . . And now you're back here, and you ain't king of nothing. That's very hard to explain to anyone else, but it's why I try to avoid these situations that set me off – like being in crowds or people doing stupid things on the road – because when that happens, I get hyper, and I don't like being hyper because there's nothing I can do about it." Anderson, "Bringing It All Back Home" at 6

[220] Id.; MHAT-III at 7-8 (deployments causing increased family stress)

[221] See, e.g., Dobson 63 M.J. 1. (brutal murder of husband by wife who claimed to be suffering from PTSD).