

## Investigating the Psychiatric Lessons of War and Pattern of Preventable Wartime Behavioral Health Crises

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### Abstract

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**Background:** After extensive review of official military records, government investigations, and news media accounts, the authors provide the first-ever examination of repetitive mental health crises after every major American war since the 20<sup>th</sup> century. **Method:** Compelling evidence of generational crises is established using direct testimony from credible first-hand sources, clearly indicating that over the past century American society has continued to replicate preventable mental health crises. **Results:** This has largely been caused by repetitive failure to learn from and improve upon lessons learned about the psychiatric effects of war. The authors identify ten super ordinate “foundational lessons” essential to meeting wartime needs. **Conclusion:** Antiquated medical dualism, dysfunctional organizational structure, and leadership ambivalence toward mental health services are believed to promulgate a culture of mental health stigma, discrimination, and disparity. The key to transforming military mental healthcare and ending the cycle is to adopt a contemporary holistic mind-body approach emphasizing full-parity with medical services.

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**Keywords:** Military; Veterans; War Stress; PTSD

The iconic American film “Groundhog Day” (1993), starring comedians Bill Murray and Andie MacDowell, depicts a self-centered disengaged weather man who awakens and finds himself trapped to re-live the same Groundhog Day over and again. Desperate attempts are made to deal with a vexing recurrent problem by denial, avoidance, prevention, resignation, and superficial changes-all failing to alter the inevitable outcome. Murray’s character finally succeeds in ending the cycle by recognizing culpability of his self-defeating paradigm and consequent failure to learn fundamental lessons of caring that proved harmful to self and others.

### National Groundhog Day

On an infinitely broader and more solemn note, American society has been trapped reliving a pattern of self-inflicted mental health crises following every major American war since the 20<sup>th</sup> century. Awareness of this vicious self-perpetuating cycle motivated Second World War (WWII; 1939-1945) military leaders to painfully reflect on their failure to learn from previous generations of hard-won war trauma lessons, “Further, and most important, there was the documented history of World War I, as well as accounts from other previous wars, which provided abundant evidence that combat would produce large numbers of psychiatric casualties” (Glass, 1966a; p. 17), however the authors conclude “Despite the foregoing data that were available to responsible authorities, there was no effective plan or real preparation for the utilization of psychiatry by the Army in World War II. Facilities for the care and treatment of psychiatric cases were only barely sufficient for the small peacetime Army (Glass, 1966a; p. 18).”

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Recognizing its culpability in replicating a generational crisis of unmet mental health and social needs of its warrior class, U.S. Army Surgeon General, Leonard D. Heaton (1966) gave this stern warning in the massive two-volume Army Medical Department compilation of psychiatric lessons since the First World War (WWI; 1914-1918): "With this information so readily available, there can be little excuse for repetition of error in future wars, should they occur" (cited in Glass & Bernucci, 1966; p. xiv).

### **16 June 2007 – National Groundhog Day in the 21st Century**

Invisible to the national consciousness-on 16 June, 2007, nearly six years into the first major American war of the 21st century, a congressionally-mandated Department of Defense (DoD) Task Force on Mental Health publicly unveils its greatly delayed findings depicting an urgent mental health crisis that Institutional Military Medicine [Military Medicine and Department of Veterans Health Affairs (VA)] had steadfastly denied as late as May 2007 (e.g., Kilpatrick, 2007; Zoroya, 2007). The Task Force was mandated by Congress two years earlier amid gross discordance between Institutional Military Medicine's (IMM) reassurances and numerous reports of a major mental health crisis including the filing of 28 December 2005 and 5 January 2006 Navy and DoD Inspector's General grievances from a military whistleblower describing IMM's failure to avert a predictable crisis (Russell, 2006a; Zoroya, 2007). Echoing an all too familiar verdict on military mental healthcare, "The Task Force arrived at a single finding underpinning all others: The Military Health System lacks the fiscal resources and the fully-trained personnel to fulfill its mission to support psychological health in peacetime (our emphasis) or fulfill the enhanced requirements imposed during times of conflict (DoD Task Force, 2007; p.ES.2)." Indistinguishable from generations of other post-war analyses, the military Task Force report climaxes with a fervent appeal to end the cycle of failure to learn so-called "psychiatric lessons of war" pontificating "The time for action is now. The human and financial costs of un-addressed problems will rise dramatically over time. Our nation learned this lesson, at a tragic cost, in the years following the Vietnam War. Fully investing in prevention, early intervention, and effective treatment are responsibilities incumbent upon us as we endeavor to fulfill our obligation to our military service members" (DoD Task Force, 2007; p. 63). Despite the obvious circularity, we find no investigations into the apparent pattern of preventable wartime mental health and social crises, and more importantly, no prior queries of the proverbial "elephant in the room"— Why each generation repeatedly ignores essential, common-sense war trauma lessons such as the fundamental need for adequate planning, preparation, and training for inevitable war stress casualties?

### **Purpose of the Study**

The current study represents our preliminary findings of the first known analysis of repetitive wartime public health crises. The primary aim is three-fold: (1) generate critical public awareness of a previously invisible pattern of costly mental health crises, (2) demonstrate linkage between generational crises and repetitive failure to properly learn basic lessons of war trauma (e.g., the need to plan, prepare, and train for inevitable psychiatric war stress casualties, etc.) that might prevent or at least significantly diminish harm, and (3) provide the rationale for investigating the causes of the present crisis. In regards to the latter, it is imperative to refrain from reflexive finger pointing. This generational problem is complex and organizationally entrenched. Meaningful inquiry into the root causes of the present crisis requires leaders to openly reflect upon what was, or wasn't done, and why, without fear of repercussions.

### **Importance of the Study**

This national form of Groundhog Day is readily distinguishable from the cinema version by the sheer scope, magnitude, and potentially life ruining consequences of repetitive crises literally impacting millions of veterans and family members across generations. The price for failing to recognize and end the vicious cycle is staggering.

### **Benefits to the Private Sector**

Throughout history the military has often been a trendsetter when it comes to changing societal cultural norms. WWII would not have been won without the integration of American Women and racial minorities integrated into the workforce, including military. Consequently, after WWII in 1946, women, racial minorities, and mental health professionals were given permanent status in the American military, whereas in previous generations they were summarily dismissed at wars end (Craighill, 1996). The military's post WWII integration policies served as an invaluable (albeit imperfect) model, which paved the way towards correcting culturally entrenched social injustice toward women and people of color. Decades later, the military is again at the forefront of eliminating another social injustice-discrimination of sexual orientation.

Conversely, we believe the current ambivalence toward mental healthcare on the national stage is largely shaped by how well the military (and society) regards mental health and the lessons learned from war trauma. For instance, the U.S. Army's WWII Chief of Staff, General George C. Marshall (1943) retorts, "To the specialists, the psychoneurotic is a hospital patient. To the average line officer, he is a malingerer. Actually, he is a man who is either unwilling, unable, or slow to adjust himself to some or all phases of military life, and in consequence, he develops an imaginary ailment which in time becomes so fixed in his mind as to bring about mental pain and sickness" (cited in Menninger, 1966b; p. 132). In contrast, WWII-era U.S. Army Chief Neuropsychiatry Consultant, Brigadier General William Menninger (1948) opines, "If medical practice is ever to progress to the ideal of psychosomatic medicine, it will require the reorientation of medical training and of all practitioners so that equal emphasis is placed upon the roles of the psyche and of the soma in all illness (p. 163). The two differing viewpoints reflect lingering antiquated debates over dualistic versus holistic nature of mind-body interaction and health, legitimacy of mental health services, and authenticity of traumatic (war) stress "injury." Far from mere academic musing, dualistic, inauthentic paradigms of mental illness in general, and war stress injury in particular, continue to plague contemporary society as evidenced by persistent harmful bias, mental health stigma, and gross inequality with medical science that in turn creates the conditions for systemic neglect and crisis during times of war (e.g., Marlowe, 2001). Whether and how 21<sup>st</sup> century America addresses the cycle of crisis will impact every individual and family touched by mental illness, as well as their healers for generations to come. Thus, public acknowledgment of generational failure to learn war trauma lessons is critical not only for ending the tragic betrayal of war veterans, but to serve as a crucial blueprint for transforming the national healthcare system.

### **Methodology and Limitations**

We conducted an extensive review of the American experience in managing war stress casualties in every major armed conflict since the 20<sup>th</sup> century: First World War (WWI: 1917-1918); Second World War (WWII: 1941-1945); Korean War (1950-1953); Vietnam War (1961-1973); Persian Gulf War (1990-1991); and the 21<sup>st</sup> century wars [Operational Enduring Freedom (OEF: 2001-present); Operation Iraqi Freedom (OIF: 2003-2010); and Operation New Dawn (OND: 2010-2011)]. To be certain, pre-20<sup>th</sup> century war trauma lessons were readily available before WWI as exemplified by "There is a strong suspicion that the high insanity rate in the Spanish-American War and the Boer War, and perhaps in earlier conflicts, was due, in part at least, to failure to recognize the real nature of the severe neuroses, which are grouped under the term "shell shock" in this war. This may account for the remarkable recovery rate among insane soldiers in other wars" (Salmon, 1917; p. 14). Additionally, repetitive wartime mental health crises are also evident in the United Kingdom (e.g., Holden, 1998), Germany (e.g., Lerner, 2003), Russia (e.g., Wanke, 2005), and Israel (Solomon, 1993), with analyses citing similar failure to learn psychiatric lessons from previous generations. In all, we examined recurring themes from over 100 primary and 30 secondary sources, emphasizing official primary source material such as military medical department records, books, and reports; transcripts of congressional hearings; official memoirs by first-hand military witnesses; and government commissioned studies, task forces, or other investigatory reports; as well as secondary sources from credible military historians and cohort news archives from *The New York Times* and *Washington Post*. Where possible, we preserve the historical narrative by citing directly from primary sources.

### **Limitations**

We felt it important to mention up front the inherent limitations of this study to properly explain and support every possible assertion, nuance, and contradiction that may arise. It is impractical to adequately describe, display, or compare generations of historical material in a single review article, thus what is presented should be considered a "snap shot." Similarly, estimating the actual scope and costs of generational crises is heavily dependent upon the availability, access, and accuracy of such documentation, as well as its interpretation. The literature on war and traumatic stress injuries is replete with confirmatory bias on every side of every issue. We have done our best to acknowledge divergent views, while striving to stake common or middle ground. In sum, the analysis should be interpreted as preliminary and incomplete-however, immediate, relevant action items are readily apparent.

### **Definition of “Mental Health Crisis”**

For our purposes, we define a “Military Mental Health Crisis” as “a sentinel public health event whereby mental health demand of the military population (e.g., active-duty military, reservists, national guard, veterans separated from the military, retirees, DoD/VA civilian personnel, family members, embedded journalists, DoD-contractors, embedded intelligence and law enforcement officials), greatly exceeds the mental health system’s capacity to provide adequate access to timely, effective mental health and social support services typically caused and/or greatly exacerbated by a series of decisive omissions, commissions, and organizational dysfunction resulting in escalating unmet needs that potentially endangers the health and safety of large numbers of individuals, families, and society.” We describe a “Mental Health Catastrophe” as the enduring serious public health consequences caused by protracted mental health crisis resulting in significant individual harm and societal costs due to long-term suffering, disability, impaired health, suicide, and social disruption.

### **What is meant by “Preventable” Crisis?**

Appel and Beebe’s (1946) WWII refrain that “Each moment of combat imposes a strain so great that men will break down in direct relation to the intensity and duration of their exposure. Thus psychiatric casualties are as inevitable as gunshot and shrapnel wounds in warfare” (Appel & Beebe, 1946; p. 185), serves a profound reminder of the inherent tragedy of war. The earliest written recordings 3,000 years B.C.E., depicts warring humans (Chandler, 2000). In every war, people are killed, medically wounded, and/or afflicted with war stress injury. Figley and Nash (2007) describe the evolution of “weaponizing combat stress,” as the intentional development of weapons, tactics, and war-fighting strategies aimed primarily to demoralize, terrorize, and debilitate the enemy with stress casualties. This is especially salient in “low-intensity” guerilla or anti-insurgent wars (Jones, 1995a). In short, war stress injuries cannot be fully prevented any more than the deaths and maiming of those exposed to warzones. That said, until the 20th century, significantly more combatants died from disease and infection than killed in actual battle (Gabriel, 2013). For instance, according to the U.S. Army (1888), disease was responsible for the deaths of three-fourths of the estimated 200,000 Confederate army casualties. Thus, learning medical lessons of war (e.g., sterilization of surgical equipment, ensuring adequate supply of well-trained medical specialists, etc.) has prevented millions of veterans from unnecessary suffering and premature death. The overall success from the military’s investment in learning from post-war medical analyses and research is best exemplified by the stunning evolution of survivability rates whereby 97% of severely wounded 21<sup>st</sup> century combatants survive in contrast to 3% in the armies of Alexander (Gabriel, 2013). We posit that wartime mental health “crises,” just as epidemics of avoidable medical disease and infection, are preventable or least can be greatly mitigated, by actual learning basic war trauma lessons-which has never been tried.

### **Learning the Psychiatric Lessons of War**

According to the U.S. Army, military psychiatry is “the study of the recognition of stressors that lead to psychiatric breakdown and the development of preventive and treatment measures to alleviate their effects” (Jones, 1995a; p. 6). Military medicine acknowledges the immense value of knowing the history of war stress injuries in that “the past can enable mental health professionals to avoid mistakes made earlier and to devise new ways to deal with modern stress” (Jones, 1995a; p. 6). Each of the military medical departments (Air Force, Army, and Navy/Marine Corps) are responsible for provision of mental health services to their respective service personnel and family members during times of peace and war. Evidence of learning war trauma lessons is relatively straightforward. The clearest proof of actual lessons learned is the absence of forgetting or ignoring basic tenets for meeting wartime mental health needs and preventing crisis. Literally hundreds of psychiatric lessons of war are available through numerous retrospective analyses and official reports conducted by the military, historians, commissioned investigations, and memoirs by senior military leaders. Aside from a single book chapter on “The Psychiatric Lessons of War” in the Army’s *Textbook of Military Medicine: War Psychiatry* (Jones, 1995a), there is no identifiable resource describing what are the lessons of war trauma, nor evidence of their successful learning-in fact, the opposite is true. For example, within the military’s psychiatry textbook, the history of managing war stress casualties is aptly summarized under the table header “Lessons Learned/Relearned, Lessons Available but Not Learned” (Jones, 1995a; p. 5). It is highly uncharacteristic for sophisticated armed forces like the United States to blatantly and repeatedly neglect the lessons of war. In stark contrast to well-defined military policies and dedicated “lessons learned” centers for incorporating tactical and medical lessons, there is no official policy or central repository wherein psychiatric lessons are explicitly collected, identified, reported, regularly incorporated into training, or monitored for compliance throughout military medicine.

Instead, each of the armed services relies upon an ill-defined, fragmented patchwork of reports and Internet postings of “war trauma lessons” embedded within its extensive medical lessons learned systems (e.g., Department of the Navy, 2005). The absence of dedicated policies and systems for learning war trauma lessons creates the high probability that psychiatric lessons will again be overshadowed by medical lessons, thus perpetuating generational crises. For example, post-WWII analyses commentary that “In contrast to the endeavors of The Surgeon General in planning for the medical and surgical problems of mobilization, there was no comparable effort in the sphere of military psychiatry,” leading to the conclusion “Such an omission is all the more surprising because the experience of even the peacetime Army after World War I had demonstrated the prevalence of psychiatric disorders of such magnitude as to be the subject of repeated comment in the Annual Reports of The Surgeon General since 1920” (Glass, 1966a; p. 17-18). Every war generation similarly describes problems associated with the gross disparity between medical and mental health. For instance, during the Persian Gulf War, military authors cite “Operation Desert Storm demonstrated marked differences between policies and practice for managing physical casualties and those for managing stress casualties” (Kirkland, 1996; p. xxx), and from WWII-era Army’s Chief Neuropsychiatric Consultant, “In spite of the fact that the number of psychiatric casualties created a problem of such size that it could not be ignored, in too many instances psychiatrists were only tolerated very reluctantly; often they were resisted” (Menninger, 1948; p. 20-21).

### **The Need for a “Behavioral Health Corps”**

An effective “lessons learned” system whether in the military or private sector, requires a set of coherent policies and devoted personnel responsible and accountable to ensure lessons are truly learned. A good example is NASA’s response to the 1986 Space Shuttle Challenger tragedy, or safety investigations following airline disasters. Failure to learn potentially life-endangering lessons is generally unacceptable by civilized society. Within DoD, each service branch (Air Force, Army, Navy/Marine Corps) appoints Flag (Admiral) or General staff officers accountable for managing specific professional disciplines or “Corps” including incorporating lessons learned. These Corps consists of the “Medical Corps” (including neurology, psychiatry)” “Nursing Corps” (including psychiatric nursing) “Dental Corps,” “Legal Corps,” “Chaplain Corps,” “Supply Corps,” “Veterinary Corps,” and “Civil Engineering Corps.” However, there is no “Behavioral (Mental) Health Corps” (Russell, 2006b). Instead, military psychologists, social workers, and occupational therapists compete with twenty or more other clinical (e.g., pharmacists, industrial hygienists) and administrative fields (e.g., accountants, hospital administrators, public affairs) in a “Medical Service Corps.” Consequently, military psychotherapists (clinical psychologists and social workers) are unable to promote to Flag and General staff levels, therefore psychotherapy provisions become lower-ranked priorities, which may help explain the 2007 DoD Task Force finding “A thorough review of available staffing data...clearly established that current mental health staff are unable to provide services to active members and their families in a timely manner; do not have sufficient resources to provide newer evidence-based interventions in the manner prescribed; and do not have the resources to provide prevention and training for service members or leaders that could build resilience and ameliorate the long-term adverse effects of extreme stress [American Psychological Association Task Force (APATF, 2007)]” (p. 43).

### **Additional Fragmentation of Mental Health Services**

It is important to appreciate the inherent role of organization structural learning barriers across IMM (VA/DoD) in perpetuating mental health crises. For instance, each non-medical military service (Air Force, Army, Navy, Marine Corps) operates “community counseling centers” staffed by thousands of licensed civilian social workers, counselors, and occasionally psychologists, each operating under separate policies and procedures that are entirely independent from military medicine and its electronic records. For example, the Air Force and Army routinely permit their community counseling personnel to treat clientele with PTSD, depression, suicide ideation, etc., whereas the Navy and Marine Corps erect barriers (e.g., Department of the Navy, 2005). Moreover, chaplains and contracted civilian mental health practitioners called “military life consultants,” also offer mental health services independent of military medicine and thus are not tracked via DoD’s electronic record or databases (e.g., AHLTA-II). Therefore, research reports relying upon DoD statistics on prevalence of war stress injuries and utilization of mental health services vastly underestimate actual mental health demand (e.g., Armed Forces Health Surveillance Center, 2012).

To further complicate matters, a recent National Council for Community Behavioral Healthcare (2012) study reports 23% (630,000) of veterans and active-military are currently seeking mental healthcare within the community-based sector, which is estimated to increase to 40% by 2014-further challenging official estimates of a crisis. In dire contrast to extensive tracking, coordination, and reporting of nation-wide medical epidemics by government agencies like Centers of Disease and Control (CDC), there is no single government entity within or outside IMM, responsible or accountable for ensuring mental health needs are met, or the proper monitoring of wartime mental healthcare (e.g., Weinick, Beckjord, Farmer, Martin, Gillen, et al., 2011). Consequently, every major investigation into military mental healthcare reports inherent fragmentation, lack of coordination, and disorganization both within and between military service branches, between IMM agencies (VA and DoD), and the private sector (e.g., DoD Task Force, 2007; GAO, 2006; Weinick, et. al., 2011). Concerns over a deeply flawed organizational structure of military mental healthcare is far from new as WWII-era's Chief Army Neuropsychiatric Consultant asserts "Certain factors within the Army-its organizations and system-further added to the difficulty for psychiatry. Each of these contributed directly to the production of psychiatric casualties. All of this could be changed so that they would be much less of a menace to mental health" (Menninger, 1948; p.516). The General's candid appraisal is collaborated by, "A frequent comment by frustrated and harassed psychiatrists during World War II was that responsible authorities failed to heed the lessons learned by psychiatry in World War I" (Glass, 1966b; p. 735), thus giving credence to the proposed solution "Some (clinical psychology) officers believe that a separate corps within the Medical Department should have been created" (Seidenfeld, 1966; p. 586)-we concur.

### Types of War Trauma Lessons

We posit three types of psychiatric lessons: (a) explicit, (b) direct, and (c) implicit.

**Explicit lessons.** Many psychiatric lessons are explicitly labeled in official sources as "lessons," "lessons learned" or "recommendations." For example, after WWII, "Lessons Learned-The marked shortage of psychiatrists in World War II has been the subject of much comment in several chapters of this volume. Attempts to overcome this shortage were only partially successful, but from the experiences of these efforts was derived an enduring lesson of military psychiatry" (Glass, 1966a; p. 757), repeated during the Persian Gulf War "It was noted in the subsequent lessons-learned process that the forward deployment of most of the OM team assets did mean that there were not sufficient CSC (combat stress control) resources in the corps rear and echelon above corps to fully cover the combat stress threat generated by the Scud missiles. It is also becoming increasingly evident that more CSC resources in theater could have been used in demobilization and pre-homecoming debriefings, to minimize posttraumatic or deployment distress" (Stokes, 1996; p. 18). As for the 21<sup>st</sup> century wars, "Recommendation 5.3.2 Provide Sufficient Staff and Allocate Them Properly. Mental health services housed within DOD's MTFs (military treatment facilities) or assigned to combat units currently lack the resources required to provide a full continuum of clinical care for active duty members and their families, and to provide crucial preventive and resilience-building services for service members (DoD Task Force, 2007; p. 42). "Recommendation 5.1.3.4: Develop and implement a core curriculum to train all mental health personnel on current and emerging clinical practice guidelines...DOD's mental health providers require additional training regarding current and new state-of-the-art practice guidelines. DOD and the DVA (2000; 2004) have combined to create evidence-based clinical practice guidelines (CPGs) for depression and the management of post-traumatic stress. The recent MHAT-IV report noted that few mental health professionals had attended Combat and Operational Stress Control training (OMNF-I & OTSG, 2006), and in another study 90% of the providers indicated they had received no training or supervision in clinical practice guidelines for PTSD (Russell, 2006a, 2006b)" (DoD Task Force, 2007; p.20).

**Directlessons.** Other psychiatric lessons are framed by authoritative statements that clearly describe a critical deficiency or necessary corrective actions, but are not explicitly labeled as "lessons learned." For instance, the lesson to ensure early identification and ready access to definitive treatment of war stress injuries prior to military separation is transparent in post-WWI analysis, "First, that it is not only in accordance with the best scientific practice to treat soldiers suffering with war neuroses as early and as effectively as possible but to do so is an important contribution toward the conservation of manpower and military morale" (Salmon, 1929a; p. i). In the 21<sup>st</sup> century "Accessibility Care is easily accessible with minimal delays and minimal unmet need. While dire emergencies are seen immediately, patients may wait up to 30 days for a mental health appointment. The policy of tolerating long waits for initial mental health clinic appointments is inconsistent with the frequency and magnitude of mental health problems in the military.

The stressors inherent in military life make basic mental health services as critical and time-sensitive as basic medical care. For individuals under stress, psychological health problems may quickly deteriorate. Stigma may cause active duty members to delay seeking help. As such, timely intervention is crucial" (DoD Task Force, 2007; p.43).

**Implicit lessons.** Still other lessons are available only through implication or inference, or what we refer as "connecting the dots." For example, the available, albeit implicit psychiatric lessons for (1) military leadership must implement "top-down" change of its antiquated dualistic beliefs about mental versus physical health, and (2) the military must eliminate organizational mental health stigma and barriers to care, appears in the official memoir of Army Brigadier General William C. Menninger, Chief Consultant of Neuropsychiatry during WWII. He opines, "When one combines this state of affairs with a prevailing ignorance of and prejudice against psychiatry, it is not surprising that there was a staggering number of psychiatric casualties" (Menninger, 1948; p. 516), and that "Stigmatization of patients. There was a tendency to stigmatize the neuropsychiatric patient as being a failure. When the case was not physical, then the individual was variously regarded as perverse, subversive, unwilling, weak, dumb. He was likely to be labeled as a "quitter," "an eight-ball," "gold brick," or any of numerous other vernaculars disparaging terms (Menninger, 1948; p. 20)." He also notes this WWI-era observation, "The greatest obstacle to neuropsychiatry in both civil and military practice has been the barrier that tends to separate nervous and mental diseases from all other diseases, and it was thought by some that, in so far as the Military Establishment was concerned, the greatest good, both to the practice of neuropsychiatry and to the patients who were dependent upon it, would be accomplished if a determined effort were made to break through this barrier and to place the mental patient on a par with patients incapacitated by reason of other diseases" (Bailey, 1929; pp. 42-43). As for the 21<sup>st</sup> century, "In the military, stigma represents a critical failure of the community that prevents service members and their families from getting the help they need just when they may need it most. Every military leader bears responsibility for addressing stigma; leaders who fail to do so reduce the effectiveness of the service members they lead (DoD Task Force, 2007; p. 15), followed by "Evidence of stigma in the military is overwhelming. Results from the MHAT-IV report indicate that 59 percent of the Soldiers and 48 percent of the Marines surveyed thought they would be treated differently by leadership if they sought counseling" (DoD Task Force, 2007; p. 15). Taken together, the implication is that failure to enact cultural change in paradigms of mental health, including zero tolerance of harmful bias and stigma, will likely lead to crisis.

### **Preliminary Findings on Classifying Psychiatric Lessons of War**

We define foundational war trauma lessons as broad, inter-related, super ordinate lessons encompassing fundamental obligations that significantly impact capacity to meet basic mental health and social needs. Foundational lessons apply during times of war and peace, across type of warfare (e.g., low or high intensity, symmetrical or asymmetrical; see Jones, 1995b), and historical era. These super ordinate lessons represent broad, critical mental health-related domains, comprised of multiple empirically or historically supported explicit, direct, and/or implicit subcomponent lessons that proscribe what specifically must be accounted for in learning a particular lesson. To the degree there is evidence that each subcomponent lesson has been properly "learned" (e.g., incorporated into everyday policy and practice; or clearly implemented during pre-war preparation), will determine whether foundational lessons are truly learned.

### **Ten Foundational War Trauma Lessons**

Below we list ten foundational lessons most commonly either cited or implied over the past century, but due to space limitations have left out subcomponent lessons for all but the first lesson in order to illustrate the super ordinate nature of foundational lessons:

1. War inevitably causes a legitimate spectrum of war stress injury (e.g., Berlein & Waggoner, 1966; Glass, 1966a; Glass & Jones, 2005; Hoge et al., 2004; IOM, 2008; Kulka, Schlenger, Fairbank, Hough, Jordan, Marmar, & Weiss, 1990; Menninger, 1948; Salmon & Fenton, 1929; Sobel, 1949; etc.).
2. Adequate research, planning, and preparation are indispensable during war and peace (e.g., Bailey, 1923; Glass, 1966b; Glass & Jones, 2005; IOM, 2008; Kulka et al., 1990; Martin, 1992; Martin & Cline, 1996; Salmon, 1917; Salmon & Fenton, 1929; etc.).

3. A large cadre of well-trained mental health specialists is compulsory during peace and war (e.g., Farrell, & Berlien, 1966; Glass, 1966b; IOM, 2008; Jones, 1995a; Kulka et al., 1990; Martin & Cline, 1996; Menninger, 1966a; Salmon & Fenton, 1929; Stokes, 1996; etc.).
4. A holistic public health approach to war stress injuries necessitate close collaboration with the private sector along with full parity between medical and mental health services (e.g., IOM, 2008; Menninger, 1948, 1966b; Russell, 2006b; Weinick, et al., 2011; etc.).
5. Effective mental health services demands empowered leadership of an independent, unified, organizational structure (e.g., "Behavioral Health Corps") providing integrated, well-coordinated continuity of care equal to medical services (e.g., DoD Task Force, 2007; Martin & Cline, 1996; Menninger, 1948; Russell, 2006b; Weinick, et al., 2011; etc.).
6. Elimination of mental health stigma, barriers of care, and disparity is a priority leadership issue at all levels directly impacting individual, family, and military readiness (e.g., DoD Task Force, 2007; Menninger, 1948; Salmon, 1917; etc.).
7. Ensure ready access to high quality mental health services including definitive care prior to military separation or discharge (e.g., DoD Task Force, 2007; Brill 1966a, 1966b; Glass, 1966b; Glass & Jones, 2005; Kulka et al., 1990; Quinn, 1966; VA/DoD, 2010; etc.).
8. Families must receive adequate mental health and social support during and after military service (e.g., DoD Task Force, 2007; Figley, 1978; IOM, 2010; Kulka et al., 1990; Peebles-Kleiger, & Kleiger, 1994; etc.).
9. Accurate, regular monitoring and reporting are crucial for timely, effective management of mental health needs (e.g., DoD Task Force 2007; Dean, 1997; Menninger, 1966b; Russell, 2007).
10. Robust dedicated mental health "lessons learned" policy and programs are integral to meeting present and future needs and prevent crisis (e.g., DoD Task Force, 2007; Glass, 1966b; Glass, 1973; Glass & Jones, 2005; Iverson, Chalder, & Wessely, 2007; Jones, 1995a; Kulka et al., 1990; Martin & Cline, 1996; Salmon & Fenton, 1929; Scurfield, 2006; etc.).

### **Consequences for Ignoring Foundational War Trauma Lessons**

Given the inherent inter-relatedness between super ordinate lessons, failure to implement a single foundational lesson can have a cascading effect that significantly erodes capability to meet basic needs. Predictable outcomes include high incidence of unmet mental health and social needs, social reintegration difficulty, suicide spikes, chronic co-morbid injuries and disability in the context of clear erosion of system capacity to meet needs (e.g., staffing shortages, attrition, delayed access to care, etc.). Sustained neglect, prolonged warfare, delayed recognition, and continued disregarding of foundational psychiatric lessons will always devolve into costly mental health catastrophes, posing significant long-term harm, costs, and public health risks. Herculean efforts by Congress to deal with the effects of crisis cannot overcome the damage from inordinate delay and decades of neglected war lessons, therefore the crisis deepens as greater numbers of the military population with untreated war stress injuries exit the military and chronicity of problems escalate in co-morbidity (e.g., relationship strain, suicide, unemployment, etc.). For instance, "400 Ex-Soldiers New York Suicides (The New York Times, 1921), and late WWII headlines "Bradley Demands Aid for Veterans: Say Community Must Help or Create Conditions That Can Breed Psycho-Neurotics" (The New York Times, 1944b) and "Communities Held Failing Veterans: Social Service Experts Find a Lack of Help in Solving Readjustment Problems" (The New York Times, 1945c), all reflect real-world consequences of delayed action and failure to learn war trauma lessons. Similar reports were available late in the Vietnam War, "Veterans Battle Emotional Strain: Vietnam Returnees Discuss Problems of Dislocation" (The New York Times, 1973); and repeated by 21st century news media "Military Update: VA fails to meet vets PTSD needs" (Philpott, 2011) and "The Army's Continuing Dearth of Mental-Health Workers" (Thompson, 2012).

### **Conclusion**

Generations of preventable wartime crises from failure to learn lessons of war, demand a long overdue paradigm shift-one that fully integrates and equally values mental and physical health in order to end stigma, disparity, and National Groundhog Day. Addressing the reasons "why" psychiatric lessons are blatantly unheeded offers the best chance to propel mental healthcare into the 21st century.



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