

Mental Weakness and the Failures of Military Psychiatry

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Psychiatric Casualties: How and Why the Military Ignores the Full Cost of War. Mark C. Russell and Charles Figley. New York: Columbia University Press, 2021, 464 pages, \$40.00 paperback, \$160.00 hardcover.

Throughout the past decade, there has been a growing awareness of the high rate of suicide among veterans of the United States Armed Forces. Suicide is only the most visible facet of a complex of mental health problems facing multiple generations of war veterans. Psychiatric casualties since World War II (WWII) have surpassed the combined numbers of personnel both killed and wounded in action. Here at the end of major US Military activity in Iraq and Afghanistan, these problems are receiving some attention from national and military policy makers. But has anything substantial actually been done to fix the problem? Why is there so much unmet mental health need amongst war veterans in the first place? What could have been done to mitigate the problem? Mark C. Russell and Charles Figley provide answers to these important questions in *Psychiatric Casualties: How and Why the Military Ignores the Full Cost of War*. They find a pattern of recurring failures on the part of the military and those who oversee it. Primarily, Russell and Figley show that the military has repeatedly failed to act on the lessons that should have been learned many times over from each successive conflict in US history. Further, the authors argue that while proper action has been abdicated, harmful “dark-side strategies” have been used to eliminate, minimize, or conceal the problem of unmet mental health needs.

In their book, Russell and Figley present history, data, and policy analyses from disparate sources, never before compiled in a coherent examination of military

I would like to thank Raymond Russ for helpful feedback on the natural experiment herein discussed, and for guidance on the construction of this critical notice. Correspondence concerning this article should be addressed to Stuart T. Doyle, 3rd Force Recon Co, 1630 S Broad Street, Mobile, Alabama 36605. Email: stuartdoyle1@gmail.com

shortcomings in mental health. They conclude with specific policy recommendations which address the presented deficiencies. Overall, this book provides a much needed picture of the past and present state of the military mental health system, and a vision of a possible brighter future. The general conclusions are mostly supported by the extensive base of cited facts and data. However, one of the main points made in the book is incorrect, and is not supported by the cited data when properly understood. Chapter 7, titled “Purging Weakness: The Fifth Dark-Side Strategy,” is dedicated to condemning the previous military practice of screening out recruits judged to be predisposed to mental breakdown. This condemnation is poorly supported, and leads to an erroneous theoretical perspective. A main point of this paper will be to argue against this perspective, using a natural experiment. But first I will provide more context by way of further summary of Russell and Figley’s work.

A History Lesson Left Unlearned

The book makes the case that the military is currently in a wartime mental health crisis, that it has failed to learn from repetitive past mental health crises, and that it employs harmful strategies to compensate for this lack of learning. Russell and Figley define a wartime mental health crisis as a public health event where “mental health demand of the military population demonstrably exceeds the mental health system’s capacity to provide adequate access to timely, effective mental health and social support services during and/or after a period of war resulting in escalating unmet needs that endangers the health and safety of large numbers of individual members, families, and society” (p. 6). Avoiding such mental health crises is said by Russell and Figley to depend on learning and acting on the following lessons from history:

1. War inevitably causes a legitimate spectrum of war stress injury.
2. Adequate research, planning, and preparation are indispensable during war and peace.
3. A large cadre of well-trained mental health specialists is compulsory.
4. A holistic public health approach to war stress injuries necessitates close collaboration with the private sector along with full parity between medical and mental health services.
5. Effective mental health services demand empowered leadership of an independent, unified, organizational structure (e.g., “Behavioral Health Corps”) providing integrated, well-coordinated continuity of care equal to medical services.
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.

7. Ensure ready access to high-quality mental health services including definitive care prior to military separation or discharge.
8. Families must receive adequate mental health and social support during and after military service.
9. Accurate, regular monitoring and reporting are crucial for timely, effective management of mental health needs.
10. Robust dedicated mental health “lessons learned” policy and programs are integral to meeting present and future needs to prevent a crisis.

It was known at the end of World War I that American psychiatric patients could not be cared for in the base hospitals throughout France. Many of the hospitals lacked personnel who had experience in the care and treatment of patients suffering from acute mental disorders. And no special neuropsychiatric military facilities existed at the time. Despite this knowledge, no special preparations were made in WWII for the incoming flood of psychiatric casualties which should have been expected. Over 60 years later, the 2007 congressionally mandated Department of Defense (DoD) Task Force on Mental Health found that the military health system lacks the resources and trained personnel to fulfill its mission to support psychological health even in peacetime, let alone in war. Russell and Figley argue that since the lessons of history have remained largely unlearned, the military has instead resorted to a suite of harmful practices to compensate for its failure. The book details ten such “dark-side strategies,” each given its own chapter.

1. *Cruel and inhumane handling.* Historical examples include the treatment of WWII Marines and soldiers diagnosed with war stress injuries in the Pacific. On returning ships, thousands were confined in cages which were poorly ventilated and too small for the confined Marines and soldiers to even sit up. Nineteen died in transport.
2. *Legal prosecution, incarceration, and executions of mental illness.* This refers to the punishment of misconduct which is associated with, and, in a sense, caused by war stress injury. The book cites a study which showed that deployed Marines with PTSD were eleven times more likely to be discharged for misconduct than their peers without PTSD.
3. *Humiliate, ridicule, and shame into submission.* This strategy describes the stigma against mental injury. Historically, and even in the present, mental injury has been seen as a moral failing and indicative of contemptible weakness. Russell and Figley cite a 2004 study in which 77 percent of Soldiers returning from Iraq reported that they would not seek mental healthcare for fear of being seen as weak.
4. *Denying the psychiatric reality of war.* Denial here refers to both the perpetual surprise at the high number of psychiatric casualties in each successive war,

and inaction in properly treating the casualties. For example, service members found to be at high risk of PTSD in post deployment health assessments are not referred to specialists, but instead must themselves take the initiative to seek treatment.

5. *Purging weakness.* This refers to the practice of screening out potential recruits who may be predisposed to mental injury. This was the practice during WWII. Russell and Figley dispute the notion that some individuals are predisposed, as that is akin to the notion that some individuals are mentally weak; a notion which could reinforce stigma against psychiatric casualties. But as I will argue below, an excellent natural experiment shows that some individuals are predisposed to mental injury, and that screening can be effective.
6. *Delay, deceive, and delay again.* This category includes all the ways in which the military presents a misleading minimized image of the mental health problem. One example is that aggregate numbers and prevalence of deployment-related mental conditions such as PTSD are not recorded or tracked. Unflattering data can not be reported as long as they do not exist.
7. *Faulty diagnosis and backdoor discharges.* Here Russell and Figley document the ways in which war stress injuries are misdiagnosed, allowing the military to quickly get rid of problematic service members. For example, PTSD can be misdiagnosed as a personality disorder, which is classified as a preexisting condition rather than a condition caused by war. This opens an administrative path for separation of the service member without benefits.
8. *Avoiding responsibility and accountability.* The lack of accountability is largely a function of organizational structure. The military has no Mental Health Corps or Behavioral Health Corps. This means that no one in particular is in charge of ensuring proper mental healthcare. Thus proper accountability is not possible.
9. *Inadequate, experimental, or harmful treatment.* Studies are reported showing that military psychologists lack specific training for treatment of PTSD, and that the majority of service members diagnosed with PTSD do not receive an adequate number of psychotherapy sessions. This section of the book also argues that there is no scientific support for the military's practice of "frontline psychiatry," which returns neuropsychiatric evacuees to combat duty within a few days. In the opinion of Russell and Figley, this practice is harmful.
10. *Perpetuating neglect, indifference, and self-inflicted crises.* This section reiterates the claim that many of the problems in the military mental health system have been observed, forgotten, observed again, and forgotten again without ever having been adequately addressed.

After extensively describing the scope and depth of mental healthcare deficiency in the military, Russell and Figley propose specific corrective actions

which could be taken by military leaders or mandated by congress. Perhaps most importantly, they recommend organizational restructuring. Establishment of a Mental Health Corps would make resources more available, would make the use of resources more trackable, would make accurate reporting of mental health outcomes more feasible, and would make accountability for failures possible.

Now that Russell and Figley's project has been summarized, its scientific merits can be evaluated. Though the broad picture of the mental health crisis is informative, and the goal of improving the situation is commendable, not all of Russell and Figley's claims are empirically or theoretically sound.

A Critique of Russell and Figley and a Natural Experiment

In the chapter on "purging weakness," Russell and Figley contrast two views of mental breakdown in reaction to traumatic experience: stress injury versus mental weakness. Stress injury, a medicalized category, is presented as the correct conception. The concept of mental weakness is described by Russell and Figley as a fallacious denial of the fact that the neuroses seen in war veterans are caused by trauma. Tied up in this conception of mental weakness are both the military's cultural stigma against mental injury (discussed in chapter 5 of Russell and Figley), and the scientific perspective of predisposition.

Because traumatic experience is the primary cause of stress injuries such as PTSD, Russell and Figley advocate for abandonment of the attempt to understand predispositions (p. 159), and especially of attempts by the military to screen out recruits who are predisposed to mental breakdown. Russell and Figley want to eliminate stigma, and it seems to them that eliminating the mental weakness paradigm would go a long way towards that goal. And if those individuals who are affected by war induced neuroses are absolutely not to be seen as weak, then as Russell and Figley would have it, they can not be seen as having been predisposed to their neuroses. "The evidence is overwhelmingly clear: *predisposed weakness theory* is a myth with no substantial evidence to support it" (p. 184). But this assessment of the evidence is flawed, as is the false dichotomy between predisposed weakness and the primacy of the trauma itself as the cause of neurosis.

Trauma causes stress injury; more so in those individuals who are predisposed. This should not be a controversial statement. It is unsurprising that disorders such as PTSD should have predispositions, given that nearly all human ailments have predispositions. For example, consider lung cancer. It is now obvious that smoking is "the" cause of lung cancer. But even with that established, it is also true that the heritability of lung cancer is estimated to be 18 percent, and various specific mutations have been identified as genetic predispositions (Benusiglio et al., 2021, p. 1). Likewise, PTSD has been shown to be significantly heritable, meaning that some people are more predisposed to develop PTSD in response to trauma than are others.

Not all those exposed to severe trauma develop PTSD, and twin studies show that 40 to 50 percent of the variance in PTSD following trauma is heritable (Sharma and Ressler, 2019, p. 197). There has not been much success in identifying specific genetic variations which would explain the heritability of PTSD (Nievergelt et al., 2021, p. 2). But that merely suggests that predisposition to PTSD is a result of complex interactions between polygenic traits and pre-trauma environment. Studies using the identical co-twin control design make it possible to distinguish risk from sequelae. Abnormalities that are present in both the twin with PTSD and the unaffected co-twin suggest pre-existing vulnerability indicators. These include smaller hippocampal volume, large cavum septum pellucidum, more neurological soft signs, lower general intellectual ability, and poorer performance in the specific cognitive abilities of executive function, attention, declarative memory, and processing of contextual cues (Kremen et al., 2011, pp. 649–650).

Aside from these identified predispositional factors, there are data from WWII reported by Russell and Figley which should lead them to conclude that there are individuals predisposed to mental breakdown in war, and further, that it is plausible to screen a significant proportion of these individuals out of military service. Unfortunately, Russell and Figley misinterpret the data. In WWII, the Selective Service utilized neuropsychiatric screenings to disqualify from service anyone judged likely to break under the stress of war or to develop a neuropsychiatric disorder. Russell and Figley characterize the WWII screening program as “nothing short of a colossal failure” (p. 168). Their reason for this characterization is primarily that there was a large absolute number of neuropsychiatric casualties not prevented by the program. Despite screening out 1,846,000 potentially vulnerable recruits, WWII still saw the discharge of 600,000 neuropsychiatric casualties.

But Russell and Figley fail to ask and answer the perennial question of social science: Compared to what? With a total of 16,112,566 Americans (U.S. Department of Veterans Affairs, 2017, p. 1) having served in the United States Armed Forces during WWII, Russell and Figley cite a figure of 600,000 or 3.7 percent neuropsychiatric discharges. The natural question should be: How many would have been neuropsychiatrically discharged if not for the screening program? We can actually answer this question because, as Russell and Figley are aware, a few thousand men who were initially rejected by the Selective Service were subsequently inducted into the military when manpower needs necessitated it. An analysis by Egan and colleagues followed up 2054 men rejected on psychiatric grounds, but later inducted into the army. They found that 18 percent of these initially rejected service members ended up as neuropsychiatric discharges (Egan et al., 1951, p. 468). That is five times greater than the baseline rate ($p < 10^{-64}$). Figure 1 shows the differing neuropsychiatric discharge rates. This suggests that had all 1,846,000 rejected recruits been enlisted, the total number of neuropsychiatric

discharges would have been roughly 930,000; 55 percent more than the 600,000 which Russell and Figley frame as an unacceptably high number.

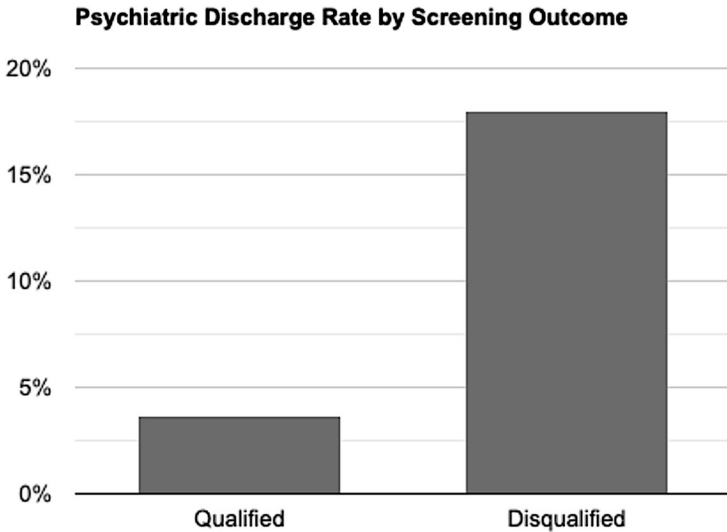


Figure 1: Psychiatric Discharge Rate by Screening Outcome. There is a large difference in discharge rate between the experimental group (initially disqualified, $n = 2,054$) and the control group (initially qualified, $n = 16,110,512$). The difference is statistically significant with a p value $< 10^{-64}$.

Since the initially disqualified recruits (experimental group) were only enlisted when needs were greatest, one might think that they may have entered the military during the most intense combat, creating the confound of exposing this experimental group to more severe battle conditions, thus greater trauma than the control group. However, this is not the case. The control group on average must have been exposed to more war trauma than the experimental group. Service members in WWII remained deployed for the duration of the war, or until they became casualties. So those who passed the initial neuropsychiatric screening and enlisted early in the war were also present in the combat which resulted in stress injuries amongst the initially rejected recruits. Thus those in the control group had more cumulative time during which attrition by mental breakdown could happen, and the trauma they experienced in the later battles was added to trauma already experienced in battles which preceded the enlistment of the experimental group. Russell and Figley argue that exposure to war stress “is the single-best explanation for war-stress injury” (p. 169). And they note an additive effect of

war stress, which increases with time spent deployed, resulting in increased rate of stress injury (p. 176). This means that all else being equal, the WWII service members in the control group, who on average spent more time in war, should be expected to exhibit more stress injuries than those in the experimental group who on average spent less time in war. So the 500 percent greater rate of neuropsychiatric discharge amongst the initially disqualified group actually paints a very conservative picture of their greater predisposition to stress injury.

Thus, compared to the realistic alternative, the WWII screening program was in fact a success. Of course it did not completely eliminate the problem of neuropsychiatric injury, but it significantly reduced the problem. And of course it came at the cost of shrinking the pool from which to draw military manpower. But it is not simple to judge whether more manpower is better in war when the additional men come with at least a five times greater probability of mental breakdown. Mental breakdown in critical moments of battle could be disastrous enough that the military may be better off with a shortage of men.

Curiously, Egan et al., who performed the follow up of initially rejected recruits in 1951, did not focus on comparing that group to a control group, but rather on descriptive statistics. The researchers, along with later authors of reviews such as Jones et al. (2003) and Helmus and Glenn (2005), all failed to perform the arithmetic to directly compare the initially rejected group to the group which passed the initial screening. Egan et al., Jones et al., Helmus and Glenn, and Russell and Figley all focus on the fact that the simple majority of initially rejected service members ended up performing satisfactorily, as if that statistic speaks for itself and needs no point of comparison.

Used as a natural experiment, the WWII data are precious. But this only works as an experiment if the experimental group is held in comparison to a control group, which surprisingly has not been done up until now. Unlike mere correlational studies, this comparison allows for direct causal inference. And unlike an IRB approved laboratory experiment, these real-world data are applicable to — the real world. Because of the external validity, colossal effect size, and high statistical power, it is safe to make some clear conclusions:

1. People differ in their predisposition to mentally break in the face of severe trauma (today this mental breakdown is mostly labeled as acute stress disorder, progressing into post-traumatic stress disorder).
2. Those with greater predisposition can be identified with considerable success, even using techniques available in 1941.

These conclusions are consistent with the twin studies mentioned above which show that PTSD is heritable and made more likely by certain anatomical, physiological, and cognitive abnormalities. These conclusions also complicate matters for the military and those within it.

Russell and Figley want to avoid blaming service members with stress injuries such as PTSD for their own injuries. It is hardly a moral failing to take personal risk for the cause of the nation, experience trauma, and deal with extended suffering as a consequence. For this reason, they want to deny predisposition; they see that predisposition is akin to fragility, that fragility is akin to weakness, and that weakness is a moral failing when seen through the lens of military virtue. So it is. And yet, predisposition theory is true. Insofar as any institution has any values at all, the military must value strength and resilience, or at least its direct combat elements must. Predisposition to mental breakdown is not compatible with strength and resilience, and therefore can not be accepted in the military any more than physical weakness can be accepted.

So what can be done about the injustice of blaming the casualty for his own injury? Although the truth of predisposed weakness theory should not be denied, and thus screening for predisposition should not be ruled out, one of the stated goals of Russell and Figley can help here. They advocate for bolstering the military's mental and behavioral health system until it reaches parity with the military's medical system (pp. 8, 69, 300). They see parity with the medical system as a reasonable goal because the medical system is an example of the general effectiveness which is possible in a context where injuries will never be eliminated and some degree of bureaucratic friction will always exist. The military medical system is imperfect but generally better than the military mental health system. So rather than targeting unrealistic perfection, Russell and Figley take parity with the medical system as their standard for the mental health system. But if mental and physical health really were treated comparably, recruits would be screened for predisposition to stress injury. Such a screening may reduce the stigma faced by those service members who do develop stress injuries.

A recruit's first encounter with military medicine is a screening examination which determines whether the recruit is medically qualified to serve. One may be disqualified for any of dozens of minor medical conditions which make physical breakdown in military service more likely. Passing this examination serves as a sort of proof to all concerned that the recruit is not physically fragile. Thus when that recruit becomes physically injured, it can not be due to a contemptible personal shortcoming, but to bad luck and circumstance. Though not part of the medical system, the physical fitness requirements in each military branch perform much the same function of stigma prevention. If one member of a unit becomes physically injured, whether in war or by mundane accident, the others around him know that he is not especially fragile, they know that he recently performed to a standard of physical strength, and thus it is logically difficult to see his injury as a result of personal deficiency. If all recruits were subject to a comparable initial mental screening to determine resilience, a logically analogous signal would be sent. It would be somewhat more difficult to attribute stress injury to personal mental weakness when all those involved have already been officially tested as mentally strong.

So although Russell and Figley are quite opposed to initial mental screenings, such a program would, ironically, be a step toward achieving their goal of ending the disparity between mental and physical health in the military. And such a program may also be the most effective way to achieve another of Russell and Figley's goals: reducing stigma against those who become mentally injured in war. Russell and Figley recommend creating policies that would make mental health stigma effectively illegal in the military (p. 298). But since stigma consists mainly of negative attitudes and beliefs, these proposed policies would amount to an unenforceable ban on thoughtcrime, which may lead more to backlash than compliance. It would be better to create a structural reason for military members to stop forming negative attitudes and beliefs about those among them who develop stress injuries. Screening out "mental weakness" would achieve this.

Conclusion and Endorsement

Despite the above critique and despite some editorial failures,¹ the book is well worth reading. It validly argues an important main point: that the failure of military mental health has been historically repetitive but can be fixed with specific policies, especially organizational restructuring. This point should be vigorously brought to the attention of ranking DoD officials and lawmakers. Russell and Figley's book provides an informational foundation on which this task can be accomplished. But contrary to their seventh chapter, psychological screening should be considered as one of many tools to fix the mental health crisis, since its effectiveness is supported by an eminently applicable and extremely powerful experiment.

References

- Benusiglio, P. R., Fallet V., Sanchis-Borja M. et al. (2021). Lung cancer is also a hereditary disease. *European Respiratory Review*, 30, 210045.
- Clark, J. (2021). These stock photos supposedly portraying service members are all kinds of fail. *Task & Purpose*. <https://taskandpurpose.com/popular/god-awful-military-stock-photos-ever/>
- Egan, J. R., Jackson, L., and Eanes, R. H. (1951). A study of neuropsychiatric rejectees. *Journal of the American Medical Association*, 145, 466–469.
- Helmus, T. C., and Glenn, R.W. (2005). *Steeling the mind: Combat stress reactions and their implications for urban warfare*. Santa Monica: RAND Corporation.
- Jones, E., Hyams, K.C., and Wessely, S. (2003). Screening for vulnerability to psychological disorders in the military: An historical survey. *Journal of Medical Screening*, 10(1), 40–46.
- Kremen, W. S., Koenen, K. C., Afari, N., and Lyons, M. J. (2012). Twin studies of posttraumatic stress disorder: Differentiating vulnerability factors from sequelae. *Neuropharmacology*, 62(2), 647–653.

¹ Without carefully searching, I noticed 31 typos. For example, p. 305 refers to "War World II," instead of World War II. The book also sports an unfortunate cover design by Elliott S. Cairns, featuring a stock photo of a man wearing protective gear which does not resemble real military equipment. Such stock photos are often objects of derision from actual military members. For examples of such derision see O'Donnell, 2020, Clark, 2021, and Stilwell, 2021.

- Nievergelt, C. M., Maihofer, A.X., Klengel, T. et al. (2019). International meta-analysis of PTSD genome-wide association studies identifies sex- and ancestry-specific genetic risk loci. *Nature Communications*, 10, 4558.
- O'Donnell, W. (2020). Authenticity matters — the truth behind terrible stock military photos. *Medium*. <https://medium.com/swlh/authenticity-matters-the-truth-behind-terrible-stock-military-photos-38991d74cd1a>
- Sharma, S., and Ressler, K. J. (2019). Genomic updates in understanding PTSD. *Progress in Neuro-Psychopharmacology and Biological Psychiatry*, 90, 197–203.
- Stilwell, B. (2021). 15 terrible military stock photos we can point and laugh at. *We Are the Mighty*. <https://www.wearethemighty.com/mighty-trending/15-terrible-military-stock-photos-we-can-point-and-laugh-at/>
- U.S. Department of Veterans Affairs. (2017). *America's wars fact sheet*. Washington, D.C. http://www.va.gov/opa/publications/factsheets/fs_americas_wars.pdf