Combat Psychiatry in Afghanistan

Experiences, Challenges, and Lessons Learned

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Disclosure

• Everything I say up here is mine, mine, mine and is in no way endorsed or representative of official US Government policy, beliefs, etc...

• The patients and events I discuss have had details changed.

• More generally, assume everything I say is a fiction and don’t you dare quote me.
Psychiatry and the Military

• Long, substantial history
  – Freud and the Death Instinct
  – Menninger and WWII
  – Surgeon General’s Report
Psychiatry and the Military

The key to an understanding of the psychiatric problem is that in combat the danger of being killed 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 just as inevitable as gun shot and shrapnel wounds in warfare. Prevention can be thought of only in terms of preventing needless waste of manpower.
Psychiatry and the Military

Extent of Manpower Loss From Psychiatric Disorders. Of all branches, the infantry is most affected by danger. Battle casualty rates in no other branch even approach the same levels. For this reason loss of manpower from psychiatric cases is greatest in infantry units.

(1) In general 15-25% of the total nonfatal battle casualties are neuropsychiatric.

(2) Of more significance, however, is that in the North African theater practically all men in rifle battalions, not otherwise disabled, ultimately became psychiatric casualties. Just as a 2 1/2 ton truck becomes worn out after 14-15000 miles, it appears that the doughboy became worn out. The point at which this occurred appears to have been in the region of 200-240 aggregate combat days. The number of men on duty after this is small and their value to the unit negligible... (SGO Central File, 1943-1945, "710-Psychoneurosis", Record Group 112. Records of the Surgeon General. National Archives, Washington, D.C.)
Combat Stress Control Units

• Approx 50 Soldiers
• 2-4 psychiatrists / nurse practitioners
• 4-8 therapists
• Command element
• 20 or so mental health technicians/medics.
• Ancillary staff
Combat Stress Control Units

- HQ
- Rest and Restoration
- FOB #1
- FOB #2
- FOB #3
- CONUS

FOB = Forward Operating Base
CONUS = Continental United States

Safe
Very unsafe
AFGHANISTAN
ISAF RC AND PRT LOCATIONS

Regional Command Capital (RCC)
Lead nation: France
Regional Command North
Lead nation: Germany
Regional Command West
Lead nation: Italy
Regional Command South
Lead nation: Netherlands (rotates: GBR, CAN)
Regional Command East
Lead nation: United States

ISAF

Afghanistan
Horn of Panjwayi
From the Air
From the Air
Housing unit: “Chu”
Housing unit: “Chu”
From the Ground
From the Ground
From the Ground
Irrigation Ditches
Irrigation Ditches
Cash Crop
On the Ground
On the Ground
On the Ground
On the Battlefield
On the Battlefield
On the Battlefield
In the Clinic
In the Clinic
Surrealism
### Rules for Using the Toilet

<table>
<thead>
<tr>
<th>Rules</th>
<th>हिन्दी</th>
<th>Српски</th>
<th>Swahili</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do not Stand on the Toilet</td>
<td>शौचालय पर खड़े न रखें</td>
<td>Не стој на тоалетот</td>
<td>Sheria ya kutumia choo</td>
</tr>
<tr>
<td>Don't Keep Water Bottles inside the toilet</td>
<td>शौचालय के अंदर झाड़ा न रखना</td>
<td>Не оставажте шишиња со вода во тоалетот</td>
<td>Je, si Simama juu ya choo</td>
</tr>
</tbody>
</table>

**Incorrect!**

**Correct!**

[Image of a person using the toilet correctly and incorrectly with a no water bottle symbol]
Combat Stress Control Units

FOB = Forward Operating Base

CONUS = Continental United States
Surrealism
Surrealism
Clinical Cases: Themes

- Mission vs. Patient Care
- Psychosis
- Forensic
- Personality Disorder
- PTSD
- Grieving
Clinical Cases: Mission vs. Patient Care

• 28 yo E5, WM, 3\textsuperscript{rd} deployment, 1 & 3 yo in CONUS, 10 yrs in.
  – Wife abusing meth
  – Children left with parents
  – Serious SA
  – Return to COP?
  – What if he walks to COP on his own?
Clinical Cases: Mission vs. Patient Care

• 25 yo E4, WF, 3rd deployment, “a hero”, 3 yo daughter at home.
  – Presents to “check in”: pre-condition of deployment. Husband on nearby FOB.
  – On:
    • quetiapine 300 QHS,
    • alprazolam 1.0 TID (800+ pills on hand),
    • fluoxetine 80 QD.
  – Self-cutting, anorexia nervosa, purging,
  – 2 prior SA
Psychosis

- 24 yo E5, 1st psych presentation
  - Two Article 15s: No “cover” and AWOL
  - New onset x 3 weeks of vivid dreams
    - Ninja
    - Dragon
  - New onset VHs 1 week ago
  - Started mefloquine 3 weeks ago
Psychosis
Forensic

- 19 yo E3 SWM. Brought in by MPs w “she loves me / loves me not” knife
  - Got intoxicated and broke into chu
  - Destroyed property, defected on bed, and vomited
  - Went to work. MPs arrest him.
- Erotomania. Describes past relationship.
- Female denies (appears false due to photo evid.)
- COL presses charges, retains Soldier (in affair himself)
Personality Disorder

• 19 yo E2, 1st deployment. Presents for excessive force.
  – Disrupted childhood
  – HI?
    • “Of course. Everyone wants to kill somebody. I think it would be fun – to bury a hatchet in somebody’s head and put the body under the floorboards. We just don’t do it because we’d probably get caught.”
Personality Disorder

• 26 yo WM, recently demoted, told to get evaluated but w/o proper paperwork. Voluntarily stays.
• Reports that he:
  – personally saved a President’s life due to intel,
  – that he can hack into the Russian IT network
  – That he hates everyone in his command
  – That he was framed for the loss of sensitive items.
• He is isolated and only uses the computer.
PTSD

• 38 yo E8, BM, 3 children.
  – Iraq: Blown up and tossed into the remains of the convoy driver.
  – Iraq: Witnessed aircraft crashing. Located missing body from smell of neural tissue – “a sweet, sickly smell”
  – Afghan: Rocket attacks, experiences terror.
Grief

- 19 yo E3 and a 22 yo E4 are blown up by an IED. One passes away, the other loses three extremities. Unit strength diminishes by 10%.
- The remaining Soldiers are either in the blast or on patrol elsewhere. Over next two days they collect at base.
- Confusion regarding fallen Soldier ceremony. 3 different units, 3 different ceremonies?
Problems

- Delays getting Soldiers out
  - Requires healthy escorts
  - Paperwork and consents
- Lack of utox screens
- Highly distributed troops w difficulties accessing care
- Stigma:
  - Correct dx can lead to termination from army
  - Incorrect dx leads to bad outcomes
The tradition and ceremony of the Military does an excellent job at containing aggression. Upon leaving the military, Soldiers experience a tremendous loss of structure and support.

This problem will increase immensely as we downsize the military and involuntarily dismiss career Soldiers.
Heroism