

Achilles in Iraq Part I

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In 1969, a few months after I was discharged from the U.S. Navy, I got a panicked call from an emergency room physician in San Francisco. He asked whether I knew a gunnery sergeant, Sean Donovan (not his real name). I said, "Yes, I treated him for several months at the Chelsea Naval Hospital upon his return from Vietnam. What's up?" "Well, *he's* breaking up our emergency room right now" (I could hear a lot of noise in the background, crashing glass, etc.). I said, "I don't understand. When I knew Sergeant Donovan, he was a 'gentle giant' of a man, never prone to violence. What did you do?" He said, "Well, sir, he was complaining of 'flashbacks' and we decided to give him an Amytal interview to help him re-live his war experiences." I said, "I see the problem. My suggestion is that you give him IV Thorazine until he can't even blink for about three days. I'm sure when he recovers and re-integrates, he will be just fine. And please, don't help him re-live any more of his combat experiences."

Sean Donovan had been part of a Marine rifle squad that had walked into a nasty ambush near Hue, South Vietnam, and every man in the squad except him had been killed.

Although we now know that descriptions of the lingering psychological effects of combat literally go back to Homer, the first reporting in relatively modern times occurred during the Civil War, when palpitations and chest pains in combat soldiers were felt to be a functional cardiac disorder known as "soldier's heart". Initially, combat anxiety during World War I, known as "shell shock", was attributed to neurological lesions.

However, psychoanalysis had been given a great boost during and after World War II because of the success in using psychodynamic methods in treating what came to known as "combat fatigue." Psychoanalyst Abram Kardiner's seminal "Traumatic Neuroses of War" anticipated most of the elements of what we much later came to know as "Post-traumatic Stress Disorder". Another analyst, Mardi J. Horowitz, also made key contributions in his 1976, "*Stress Response Syndromes*".

At the time of the Viet Nam conflict, I was a "Berry Planner." This was a plan in which every physician was obligated to serve two years in the military. My two years fell between 1967 and 1969, the height of the Vietnam War. I was stationed at Chelsea Naval Hospital, one of the two naval hospitals (the other being San Diego) designated to receive direct Marine and Naval casualties from Vietnam. After a one night layover in Guam, physical and psychiatric casualties would be air-evaced daily into Chelsea Naval Hospital, the oldest continuously operating naval hospital in the country.

I ran both a locked and an open neuropsychiatric ward, evaluating and treating combat casualties, as well as screening military personnel for sensitive posts, such as missile bases and cruisers, nuclear submarine duty, etc.

The concept of "Post-traumatic Stress Disorder" did not begin to evolve until the latter stages of Vietnam War. The incidence of psychiatric casualties from World War I, World War II, and even the Korean War, did not reach anywhere near the monumental

numbers that resulted from the Vietnam conflict. It seemed clear that we were seeing some kind of new phenomenon, and we did not know how to effectively treat it.

The above clinical example clearly states how little most medical personnel knew about treating what we now know as PTSD. The so-called "Amytal interview" to encourage the "re-living" of combat experiences was the popular and prevailing wisdom of the time, beginning with its use in World War I and II. Far from helping, it often simply re-created the trauma. It seems to have been based on a profound misunderstanding and misapplication of psychoanalytic theory, i.e. the need to undo repression.

These theories of treatment seemed to have evolved initially from medical personnel who did not have military experience or who had not worked with military post-combat soldiers. Those of us with accumulating experience in this field gradually began to move toward what later became the official American Psychiatric Association recognized diagnosis of Post-traumatic Stress Disorder. Major contributors to this field included John Krystal, and Bessel Van der Kolk. Of special note is "*The Trauma of War: Stress and Recovery in Viet Nam Veterans*", edited by Stephen Sonnenberg and Arthur Blank, both analysts. What has evolved is a much more sophisticated understanding of trauma, which includes psychodynamic, neurophysiological, group and social factors, a true biopsychosocial phenomenon.

The experience of our soldiers involved in Afghanistan, but especially Iraq, is much more similar to the experiences in Vietnam than those in World War II. While the rates of psychological trauma in World War II were relatively low, they were quite high in Vietnam and extremely high in Iraq and Afghanistan. To quote a few statistics from the Rand Corporation, more than one in five suffer from major depression or traumatic stress; more than 300,000 have suffered traumatic brain injury; the number seeking assistance for homelessness is up 600% in the past year. While the VA had been reporting that there were fewer than 800 suicide attempts per year by veterans in its care; other sources report that the number was closer to 12,000. Much has been said about the VA's attempts to conceal these statistics. What does seem clear is that the ability of the VA and the military to deal with such massive and unanticipated numbers has been overwhelmed.

What is far from clear is why there is a higher proportion of our soldiers who suffer from PTSD, depression, and other forms of mental illness, in wars such as Viet Nam, Iraq, and Afghanistan, compared to a popularly supported and a much more severe conflict, such as World War II.

And, based on our best understanding, what can we as an organization and as individuals do to help? In my next column, I will address these issues.