FOREWORD

COMBAT STRESSES

A tremendous lack of understanding about the nature and power of combat stresses (psychosocial, traumatic, and environmental) still persists today, despite the massive amount of data and work done to elucidate the cause and effect of these stresses in this century. Much of our knowledge about psychophysiological processes is new and is either not understood or not disseminated widely. Therefore, there is even less knowledge outside of the military and scientific communities about the nature of the effects of such stresses and their psychological, immunological, and psychophysiological consequences. Data accumulated in recent years have shaped the ultimate perspective of this report. Simply put, a scratch on the mind is a scratch on the body as well. As we now understand, the mind is a function of the brain. Brain and body represent a single system; however, it is not a closed system operating solely in terms of phenomena that take place within. Rather, it is an open system articulated to the events of the external world. These events are then transposed or translated by mind/brain into physical events within the body that will ultimately have lesser or greater physiological consequences for an individual experiencing them. There is a vast scientific literature supporting this perspective, and some of it will be cited during the course of this report. While there is still much in terms of mechanisms that we do not yet fully comprehend or understand—the outlines of the biological, psychological, and physiological processes involved have begun to take form. Yet the power and capacity of many events appear to be significantly controlled by cultural beliefs and perceptions that not only alter from human group to human group but also over time. Acknowledging these factors means acknowledging or accepting that the outcomes of exposure to certain events are the result of a complex interaction among person, social group, and event. For some, this is less comforting to accept than simple notions of direct causality.

Throughout history, persistent cultural biases have attempted to deny various aspects of human psychological vulnerability, labeling them as not applicable
or demeaning if stated about “people like us,” for example. To some extent these cultural biases remain today. This said, it is important to keep in mind that, with the exception of panic and certain other events that involve the massive physical and psychological erosion of a military organization, the proximate and long-term acute stress of combat, and the subacute stress of dangerous deployment, combined with prolonged physical and psychological hardships appear to have dysfunctional effects on only a small to moderate number of soldiers. The majority, enduring the horrors of the battlefield, recover from their initial shock, continue on, do their job, and perform well. McFeely (1981), in his biography of U.S. Grant, described the carnage of the first day at Shiloh when the immense new firepower of the rifled musket worked its shattering effects upon men who had been used to Napoleonic tactics, asking, “How was it that Grant’s bewildered, bloody troops rallied so strongly the next day that they drove the Confederates into retreat to Corinth?” Just as McFeely gropes for an answer, so do we.

We can say that deployment and combat will leave, at a minimum, “scratches on the mind”—long-term memories for some who participated. The loss of comrades, the experience of pain, and the memories of fear, deprivation, hunger, thirst, and killing will remain. For most soldiers, the psychic wounds close; they themselves endure and go on. After the wars throughout history, including and after the Gulf War, most soldiers have, on balance, viewed their experience as a positive one. Soldiers saw their service as contributing to their own growth and their capacity to understand others and the world, and as enhancing their senses of self-worth and identity. Above all, in any war perceived as a “just” one, in which victory is achieved over some perceived evil, the stresses and sacrifices are not seen as exactions that have injured the service member’s sense of self and negatively altered his or her life course. Participation is recalled as a necessary and important contribution to human decency, the common wealth, and the maintenance of one’s cultural integrity, personal values, and liberties.

In this report, we focus on the patterns of breakdown, symptoms, and long-term sequelae caused by combat in a minority of soldiers. We must remember that we try to understand the “victim” in a context in which many who had the same experiences and who participated directly with him or her did not develop the same patterns of symptoms. Perhaps the greatest danger, both explicit and implicit, is the temptation to build our measuring instruments for “normalcy” out of the parameters of either the pathological or the ideal.
HEALTH AND MENTAL HEALTH

There appears to be a widespread contemporary American vision of normalcy: a life that is free of physical symptoms, in which there has been neither exposure to nor memory (repressed, suppressed, or otherwise) of traumatic events, or at a minimum such memories were cleared and detoxified through some mechanism of positive closure. In this popular definition, normalcy appears to mean being continually satisfied with one's health status, almost always happy, productive, and fulfilled.

The controversy about how health is defined (which has many diagnostic consequences) dates to the World Health Organization (WHO) battles of the 1950s about the definitions of “health” and “mental health.” This followed the adoption of the ideal WHO definition of 1946: “A state of complete physical, mental and social well being and not merely the absence of disease or infirmity.” Do we adopt “ideal standards” or popular standards? It impresses me that in the last two decades a large segment of our population appears to have moved, in its cultural beliefs, to the use of an “ideal” measuring implement, based particularly on the individual’s self-assessment of what “one’s life should be like,” e.g., essentially symptom free. This has moved us radically away from the reality of the human condition in which most of us have some nagging physical and mental symptoms for much of our lives. If one looks at history, developing countries, the poor, or soldiers (engaged in a highly stressful, physically and psychologically demanding and always potentially dangerous profession), this reality is clear. One recognizes that such culturally espoused ideal states of health are at best illusory. Life is filled with traumas, fears, apprehensions, hunger, aches, pains, illnesses, failures, unfulfilling work, and memories of pain. It is balanced by moments of happiness and pleasure, memories of positive events, doing one’s duty, and enduring. The evolutionary history of our species is one in which those individuals who have survived to continue the human line have done so in the face of extreme violence, hunger, drought, flood, diseases, and war.

If we conceive that the expected outcomes of exposure to stress, pain, and life events should not deviate from ideal standards of health, there is the danger that some will allocate all the negative phenomena to which body and brain are normally heir to dark and powerful pathogens where none may exist. In that case, we will not only fail the test of realistic measurement of looking at health status as based on normative criteria, but we may also disallow the possibilities of realistic treatment and symptom amelioration.