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Operational Stress Injury in CF- Need for Change in Culture

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ABSTRACT

Operational Stress Injury (OSI) is considered to be an occupational hazard of modern military missions. It has a prevalence of up to 20 per cent of those Canadian Forces members returning from operational deployments. Canadian Forces members seem to be poorly informed about mental health issues and the link between physical and mental health. The senior leadership of the Canadian Forces has repeatedly claimed total commitment to doing what needs to be done to see that CF members are provided with a standard of care comparable to that available to the majority of Canadians. Indeed, progress has been made in the implementation of a number of initiatives designed to deal with OSI. This paper argues that problems still exist with leadership approach, inappropriate labeling and ostracizing attitudes amongst the peers and supervisors of the members afflicted with OSI. It also makes recommendations for designing an integrated system to deter and mitigate the negative effects of the stress of operations on military personnel.

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INTRODUCTION

Canadian veterans of various recent deployments suffer from certain stress-related illnesses at rates at least three times higher than those found in the Canadian population.[1] The types of stress-related illness found among veterans are similar in nature whether it was the Gulf War, Somalia, Bosnia or Rwanda deployment.[2] Research shows that these wide-ranging and varied symptoms are consistent with those exposed to operational stress since at least the First World War.[3]

According to the military's ombudsman Andre Marin's Special Report, "PTSD is an operational hazard that is a fact of modern military missions." To support this conclusion, he provides survey numbers and anecdotal opinion suggesting that the prevalence of PTSD is nearly 20 per cent of those in uniform and 50 per cent of Reservists returning from operational deployments. He adds that this is "only the tip of the iceberg" because many sufferers don't realize or won't admit that they're casualties.[4]

When the Board of Inquiry- Croatia presented its findings and recommendations, it became apparent that illnesses reported by veterans of Operation Harmony had something more than what could be expected to result from environmental contamination. There were reports of "a lot of mental illness" during Operation Harmony, and some cases of mental breakdown in theatre similar to that observed in previous wars or operations.[5] Finally, veterans of other operations are now reporting delayed symptoms (up to five years or more after their deployments), comparable to past conflicts.[6] It was postulated that some of the symptoms resulted from high level of chronic stress experienced

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[1]Greg Passey and David Crockett, "*Psychological Consequences of Canadian UN Peacekeeping*," unpublished paper, Department of Psychiatry, University of British Columbia, (revised 18 Aug 1997), Exhibit No. 51 BOI, p. 8.
[2]Goss Gilroy Inc., "*Health Study of Canadian Personnel Involved in the 1991 Conflict in the Persian Gulf*," (20 April 1998), p.5, 7, 8-9, "Canadian Gulf War vets report similar symptoms as same frequency says study," (22 Nov 1999), GulfLINK, Office of the Special Assistant for Gulf War Illnesses [USA], website http://www.gulflink.osd.mil/news/na_canadian_study.html accessed 04 April 2003.
[3]Zahava Solomon, *Combat Stress Reaction: The Enduring Toll of War* (New York and London: Plenum Press, 1993), pp. 31-38; Dr Wolter de Loos, Central Militair Hospitaal, Netherlands, cited in Engel testimony, pp. 9-10.
[4] André Marin, Ombudsman, Canadian Forces, " *Special Report: Systemic treatment of CF members with PTSD" 4 February 2002, p. vi.*
[5]Dr Theodore J. Bachynski, testimony before the Croatia BOI, 23 Sep 1999, 16; and Brett testimony, p. 23.
[6] Cook testimony, pp. 7, 8-10, 12, 15-18, 27.

during these operations. The BOI-Croatia also found, among other things, that "Canadian Forces members are poorly informed about mental health issues and the link between physical and mental health." It therefore recommended that attitudes and procedures concerning mental and physical health issues be changed in the CF.[7] In response to the Board's recommendations, the ex-Chief of the Defence Staff (CDS), General Maurice Baril indicated that he was "totally committed to doing what needs to be done to see that CF members are provided with the right guidance to conduct operations and a standard of care that is comparable to that available to the majority of Canadians."[8]

Overall, the Canadian Forces (CF) has indeed made progress in the implementation of a number of initiatives designed to deal with operational stress injuries (OSIs) and the level of awareness of stress-related injuries in the CF has improved markedly.[9] For example, with Rotation 9 and 10 of OP PALLADIUM deployed to Bosnia in 2001 and 2002, changes in the level of psychological support for the Battle Group drawn largely from personnel at Canadian Forces Base (CFB) Valcartier were beginning to become evident. The decision to deploy a Canadian Battalion Group to Afghanistan to help combat terrorism provided a further opportunity for the CF to demonstrate a commitment to deal with the issue of stress reduction during operations and on redeployment in a number of ways — such as the decompression time in Guam and the gradual reintegration of members with their families.[10]

Apparently, therefore, the issues relating to stress on operations have been identified and are in the process of being addressed. The leadership of the CF appears to be committed to providing whatever resources are required to effectively address this problem. An "Action Plan" was published to deal with recommendations from the Board of Inquiry–Croatia and policies and procedures are

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[7] Operation "Harmony" was the name given to the Canadian portion of the United Nations peacekeeping mission in Croatia, *Final Report -Board of Inquiry-Croatia*. pp. 1, 2, 27.
[8] General (Retd.) Maurice Baril, "Final Report of the Croatia Board of Inquiry and the Thomas Report," letter dated March 2000.
[9] Marin, André , Ombudsman, Canadian Forces, "*Follow-up Report: Review of DND/CF actions on operational stress injuries*", December 2002.
[10] http://www.dnd.ca/hr/cfpn/engraph/06_02_reintegration_e.asp accessed 12 February 2003.

being put in place to respond to the Special report of the military Ombudsman. Five Operational Trauma and Stress Support Centres (OTSSC's) have been established across the country to assist CF members and their families in dealing with the effects of operational stress.[11] This paper will argue that there still exist problems with leadership approach, inappropriate nomenclature and ostracizing attitude amongst the peers and supervisors of the members afflicted with the OSI. It will put forward recommendations for devising a broad and integrated system to reduce the effects of the stress of operations on military personnel. As the stress affects its victims in a non-discriminatory fashion, both the combat-induced stress and other forms of operational stress will be discussed as one single entity.[12] Therefore, the term "Operational Stress Injury (OSI)" is used in this paper to include all types of stress-induced disorders encountered by CF members as a result of deployment on combat or Operations Other Than War (OOTW) missions.

DEFINITIONS

Operational Stress Injury, if managed inappropriately can lead to Post Traumatic Stress Disorder (PTSD) and other psychiatric conditions. These disorders are caused by the reaction of the brain to a very severe psychological stress such as feeling one's life is threatened and are genuine and legitimate medical conditions, like any other physical malady affecting the human body.[13] Illnesses or injuries affecting brain function are not a matter of personal will. Fortunately, most CF members exposed to these stresses will not develop these problems. The exact percentage of CF members, who are suffering from ill effects of OSI, is not accurately known. Current estimates are that from 2 to 15 % of people returning from a stressful mission may be affected in some way.[14] It is often

[11] "*Fact Sheet on PTSD for CF Members"* , CF Health Services, http://www.dnd.ca/health/information/engraph/fact_sheet_ptsd_e.asp accessed 10 Mar 2003.
[12] Tomi S. MacDonough, "Noncombat Stress in Soldiers," in *Handbook of MilitaryPsychology*, Reuven Gal and A. David Mangelsdorff, eds. (Chichester: John Wiley, 1991), pp. 548-549; and Franklin C. Pinch, "Lessons from Canadian Peacekeeping Experience," unpublished report prepared for the Department of National Defence (DND), (November 1994), pp. viii-xiv.
[13] "*Fact Sheet on PTSD for CF Members"* , CF Health Services.
[14] *Ibid.*

compounded by other personal, social, spiritual and mental health difficulties. PTSD is defined as a psychiatric disorder characterized by symptoms resulting from exposure to extreme psychological trauma. These symptoms include persistent re-experiencing of the traumatic event, persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness and persistent symptoms of increased arousal. The full symptom picture must be present for more than one month and the disturbance must cause clinically significant distress or impairment in social, occupational or other important areas of functioning.[15]

In a documentary on CBC, "Peacekeeping: Invisible Wounds" it was said, "that there's a cost of peacekeeping that can't be measured"; a cost that has driven Lieutenant General (retd.) Romeo Dallaire, the U.N. Commander in Rwanda, to the edge of suicide and left many others deeply scarred. Dallaire recounts:

> [I]t took nearly two years to all of a sudden not being able to cope; not being able to hide it; not being able to forget it or to put it in, keep it in a drawer…I became suicidal because there was no other solution… You couldn't live with the pain and the sounds and the smell and the sights. I couldn't sleep. I couldn't stand the loudness of silence…and sometimes I wish I had lost a leg instead of having all those brain cells screwed up. You lose a leg; it's obvious; you've got therapy, all kinds of stuff. You lose your marbles; very very difficult to explain, very difficult to gain that support that you need. But those who don't recognize it and don't go to get the help are going to be at risk to themselves and to us.[16]

Trauma is often heightened by a sense of helplessness. Maj. Phil Lancaster, another veteran watched mothers and their children murdered by mobs. Lancaster says:

> [t]here we were… there I was, wearing a blue beret, supposedly as a member of a world body with credibility and force and power…and interest from the nation's people, all the best-thinking in the world, went into construction of the UN, and it didn't mean a damn thing at that time and place…the next day I got up with the intention of going back down to the troubled area and found I just couldn't move, just

[15] "*Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition (DSM-IV)",* (American Psychiatric Association, Washington D.C)., 1994, section: 309.81.
[16] CBC documentary, "*Peacekeeping: Invisible Wounds",* http://www.tv.cbc.ca/national/pgminfo/ptsd/wounds.html accessed 18 Apr 2003.

> couldn't get myself out the door…and I realized then that I'd had it. I just could not go on.[17]

McGill University anthropology professor Allan Young, who did field research in the United States from 1986 to 1988 commenting on PTSD explains, "It is a disease of time."[18] The disorder's distinctive pathology is that it permits the past (memory) to relive in the present, in the form of intrusive images and thoughts and in the patient's compulsion to replay old events. Such factors as physical ill health, retirement, loneliness, anniversaries, service reunions and the use of psychotropic medications increase the risk of reactivation.[19]

HISTORICAL REVIEW

Psychological evils of war are nothing new. From the First World War, when medics struggled to get shell-shocked soldiers back to the front line, to the treatment of battle fatigue and combat stress along the battlefronts of the Second World War and the Korean War, the military has been dealing with the emotional toll on soldiers.[20]

It was American war veterans who politicized shell shock. Before the 1970s, doctors treating the emotional disturbance, even in soldiers never exposed to gunfire, found shell shock (or war hysteria, as it was sometimes called) extremely difficult to distinguish from cowardice, historians say.[21] Then, activists and psychiatric workers concerned about the lack of recognition of the effects of the Vietnam War on returning veterans' psychological health revived interest in U.S. combat psychiatrist Abram Kardiner's largely forgotten book dealing with subject of psychological trauma of war.[22] Dr. Kardiner, now credited with defining PTSD for the remainder of the 20th century, characterized chronic irritability, startle reactions, explosive aggression and an atypical dream life as

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[17] *Ibid.*
[18] Allan Young, "*The Harmony Of Illusions: Inventing Post-Traumatic Stress Disorder*", (Princeton University Press, Princeton, NJ, USA), 1997, p. 112.
[19] A.D. Macleod, "*The reactivation of post-traumatic stress disorder in later life*". *Aust NZ J Psychiatry* 1994;28:, p. 625.
[20] Tana Dineen**, "** *Manufacturing Victims: What the Psychology Industry is Doing to People",* Vancouver Sun**,** February 24, 2003; p. A13.
[21] Sarah Jane Growe, "*PTSD*", TORONTO STAR September 24, 2000.

war-related trauma, even though such phobic behaviour made the veterans in his care look as if they were suffering from long-standing neuroses. But it was not until 1980 that the American Psychiatric Association accepted PTSD - including "rape trauma syndrome," "battered woman syndrome," "Vietnam veterans' syndrome" and "abused child syndrome" - as a bona fide medical diagnosis in its Diagnostic And Statistical Manual Of Mental Disorders (DSM).

Historical review shows that Canadian forces have gone through three stages with regard to the treatment of operational stress.[23] During the first and most ineffective stage of treating operational stress at the beginning of the Second World War, there was a lack of any organized system to deal with operational stress. This resulted in large numbers of stress-related cases, which were called shell shock, neurosis or lack of moral fibre.[24] The second stage between the first and second World Wars consisted of a multiplicity of haphazard efforts by various groups such as healthcare workers and military officers in the chain of command, to address the problem, but preventable stress casualties were still plentiful. The third stage, which was achieved at the end of the First and Second World Wars, was distinguished by an integrated and comprehensive system for dealing with operational stress and a significant reduction in the number of preventable operational stress casualties. What is notable is that in the third stage, the development and implementation of policies was under the direct supervision of military commanders who received advice from various experts, including operations researchers, behavioural scientists and various members of the health care community.[25]

At the beginning of WWI, those who were unable to cope with the mental strain of combat in the British and Canadian armies were labeled as suffering from hysteria, a disease believed to be

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[22] Abram Kardiner, "*The Traumatic Neuroses Of War*", (Paul B. Hoeber, Inc., New York, USA), 1941.

[23] Allan English, "Leadership and Operational Stress in the Canadian Forces", Canadian Military Journal, Autumn 2000, p. 34.

[24] *Ibid*., p.

[25] Allan English, "*Historical and Contemporary Interpretations of Combat Stress Reaction*," prepared for the Board of Inquiry-Croatia and presented at the 1999 Conference on Defence Ethics, Ottawa, 2 November 1999, published on the Board of Inquiry-Croatia website http://www.forces.gc.ca/hr/boi/engraph/home_e.asp accessed 04 April 2003, pp.1-4, 7-14.

caused by a lack of will power, laziness or moral depravity.[26] They were sent back to Britain where, after being provided with 'rest and sympathy', some had their symptoms resolved, but most ended up becoming chronic cases.[27] They were treated with psychotherapy sessions and anti-anxiety medications including tranquilizers with limited success. These losses took their toll on both armies but became critical when, after the first battle of the Somme in July 1916, several thousand soldiers had to be withdrawn from battle due to nervous disorders. A new treatment regime was quickly instituted that, by 1918, had evolved to the point where it was very similar to the present-day treatment for operational stress near the front line, emphasizing the principles of immediacy, proximity and expectancy.[28] Neglecting many of the lessons of the First World War after 1918 resulted in regression to the first and most ineffective stage of treating operational stress at the beginning of the Second World War. During the US Army's initial operations in North Africa and Sicily, 35 percent of all nonfatal casualties were diagnosed as 'psychiatric'; however, because most of them were evacuated 90 miles or more from the front lines for treatment, no more than three percent were ever returned to combat.[29]

The manpower crisis of the North-West Europe campaign (1944-45), with combat units suffering an average ratio of 25 percent of casualties classified 'neuropsychiatric', finally forced the Allied armies to return to the proven forward treatment methods of the First World War.[30] The modern Israeli experience echoes the experience of the Allies in the Second World War. During the disastrous early days of the Yom Kippur War in October 1973, the Israeli Defence Forces suffered operational stress (the Israeli's referred to this as Combat Stress Reaction (CSR)) casualties at a

[26] Michael J. Clark, "The Rejection of Psychological Approaches to Mental Disorder in Late Nineteenth-Century British Psychiatry," in *Madhouses, Mad-Doctors, and Madmen,* Andrew Scull, ed. (London: Athlone, 1981), pp. 293-7.
[27] Sidney I. Schwab, "*The War Neuroses as Physiologic Conversions*," *Archives of Neurology and Psychiatry* 1 (1919), p. 593; and Arthur F. Hurst, "Hysteria in Light of the War Experience," *Archives of Neurology and Psychiatry* 2 (1919), p. 565.
[28] Colin K. Russell, "War Neurosis," *Archives of Neurology and Psychiatry* 1 (1919), pp. 34-35. A current Canadian approach to dealing with operational stress is outlined in "Stress Management in Operations".
[29] Richard Gabriel, *No More Heroes: Madness and Psychiatry in War* (New York: Hill and Wang, 1987), pp. 117-118.

whopping rate of 60 percent of total casualties. Treating them by evacuation to civilian hospitals in the rear meant that only 16 percent were returned to combat duty. After implementing the proven First World War methods of treating casualties by providing forward treatment near the front line, emphasizing the principles of immediacy, proximity and expectancy return rates improved dramatically with 70 percent of soldiers returning to combat.[31]

PROBLEMS WITH CURRENT APPROACH

The current missions of the CF, including operations other than war, such as peacekeeping or peacemaking, may actually be more stressful than combat in war. A study by the Walter Reed Army Institute of Research of a US battalion deployed in the Sinai in 1982 with the Multinational Force and Observers (MFO), noted that the lack of action and the defensive posture of the peacekeeping mission was partially responsible for having a more stressful effect than active operations for elite troops. The study concluded that the health of the battalion was worse in theatre than it had been in the US, and that a number of physical illnesses were probably a result of psycho-social stress.[32] The experience of Canadian peacekeepers has been consistent with those of the US MFO battalion. A recent study concluded that those going on peacekeeping missions needed to be carefully screened based on their past and present history of psychiatric problems or ongoing family social life issues to avoid taking those who could not cope with the stress of the mission; that maintenance of cohesion and morale in theatre requires more attention; and that while improvements have been made to the personnel support system there is still dissatisfaction among those surveyed with the support they

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[30] Terry Copp and Bill McAndrew, *Battle Exhaustion: Soldiers and Psychiatrists in the Canadian Army, 1939-1945* (Montreal and Kingston: McGill-Queen's Univ. Press, 1990), pp. 58, 81, 114,135, 149-50; and Gabriel, p. 46.
[31] Stasiu Labuc, "Cultural and Societal Factors in Military Organizations," in *Handbook of Military Psychology*, Reuven Gal and A. David Mangelsdorff, eds. (Chichester: John Wiley, 1991), pp. 484-5; and Shabtai Noy,"Combat Stress Reactions," in *Handbook of Military Psychology*, p. 520.
[32] Joseph M. Rothberg, et al., "Illness and Health of the US Battalion in the Sinai MFO Deployment," *Armed Forces and Society* 11, No. 3 (Spring 1985), pp. 413-4, 421-2.

have received if they fell victim to an OSI.[33] The current method of dealing with operational stress in the CF lacks co-ordination and does not appear to be capable of dealing with some of the fundamental causes of operational stress casualties.[34]

The CF does deserve some credit for various initiatives to address the issue of OSI. Operational Stress Injury Social Support (OSISS) is a project, which is one of such initiatives. It has been a tremendous success. OSISS has a mandate to provide peer counselling and support for members who may have an OSI, and to conduct education and training about OSIs for CF members and others. Its success owes not only to the dedication of its staff but also to the championing it has received from the highest levels of the chain of command.[35] Notwithstanding this praise, military has been criticized for ignoring the problem.[36] It is argued that following three problems remain unresolved to its potential and deserve serious re-thinking on the part of military leadership and policy makers to effectively deal with issues surrounding OSI.

PROBLEM# 1: LEADERSHIP ISSUES

Leadership at all levels is the key to reducing the effects of operational stress. There has been very little empirical research done in this area in the CF; however, the small number of studies that have been published indicate that there is a "definite association" between certain stress-related illnesses on deployments and the confidence that personnel had in unit leaders.[37] Dr. Jacques Gouws, a psychologist with considerable experience in the field of stress injuries says:

[I]t is important that soldiers should know what they will be

[33] André Marin, Ombudsman, Canadian Forces, " *Special Report: Systemic treatment of CF members with PTSD"4 February 2002.*
[34] *Ibid*., "Executive Summary".
[35] Marin, André , Ombudsman, Canadian Forces, "*Follow-up Report: Review of DND/CF actions on operational stress injuries*", December 2002.
[36] *Ibid*.
[37] Passey and Crockett, Exhibit No.51, p. 9; and Pinch, pp. 133-35, 139-43.

> facing...the most important factor that has been shown to prevent combat stress reaction from developing is leadership, and the confidence that soldiers have in their leadership and the cohesion within the unit…and the one thing that has been shown that should not happen is units should not break up at all.[38]

These results are consistent with the findings of other studies done on the effects of leadership in reducing preventable operational stress casualties.[39] One of the few empirical studies on the subject of leadership and operational stress in the CF, revealed that as many as 41 percent of unit personnel expressed "low confidence" in the leadership of junior officers and that up to 33.8 percent of unit personnel expressed "low confidence" in the leadership of senior officers.[40] This reflects that there are potentially serious shortcomings in leadership in the CF. However, more research is needed to put these figures in context yet it reminds the CF of a situation that requires attention. A Chief of Staff of the US Army's Leadership Survey in which 760 mid-career Students (Majors with a Few Lieutenant Colonels) at the Command and General Staff College participated, also revealed that army's senior leadership had a definite credibility problem. There is a lack of trust. Officers question how much the senior leaders really care – "riding the status quo" versus standing up and sounding off. To hear a general officer make the statement that something is "above my pay grade" generates massive cynicism.[41]

PROBLEM# 2: INAPPROPRIATE NOMENCLATURE

Operational Stress injuries are not a new phenomenon. The military has been dealing with the emotional toll on soldiers from WW I. But what is disturbing now is the effort to sensationalize and exaggerate the psychiatric illness the military, the effect of which is to turn such problems into illnesses and soldiers into patients. Last November, in an update to his report, military ombudsman,

[38] http://www.tv.cbc.ca/national/pgminfo/ptsd/wounds.html accessed 18 April 2003.
[39] Noy, pp. 517, 519, 520.
[40] Passey and Crockett, Exhibit No. 52.

Andre Marin went so far as to declare, "PTSD is one of the most significant enemies of the soldier that there is."[42]

Many mental breakdowns are short-term responses to transient operational conditions rather than the result of some weakness or defect on the part of the soldier. We must be careful not to make stress unreasonably pathological. Colonel Boddam says, "Not everyone exposed to catastrophe reacts in the same way…some may have no stress…others may have post-traumatic stress."[43] But simply feeling upset after a trauma is not a disorder. Terms such as 'battle exhaustion,' 'combat fatigue', and 'combat reaction' have been used since the Second World War to avoid the stigma attached to such terms as war neurosis, psychoneurotic etc.[44] The current widespread use of the Post-Traumatic Stress Disorder (PTSD) label to include many of those who have experienced operational stress is a regression to inadequate pre-1944 methods, which contributed to high rates of operational stress casualties, and of inappropriately labelling stress casualties with terms usually reserved for mental illnesses with clearly defined symptoms. Canadian Psychologist, Tana Dineen is troubled by the ethics of stigmatizing what she believes is normal human suffering. Labelling normal human reactions as an illness might actually create one, she says. People, who might normally cope with haunting memories in all sorts of routine ways, are now being told they are mentally ill and need treatment.[45]

It is suggested that terms like 'operational stress' that reflect non-judgmental ways of describing the problem be used instead of labels like PTSD which is associated with illness and

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[41] "Chief of Staff of the Army's Leadership Survey", http://www.d-n-i.net/fcs/leadership_comments.htm accessed 20 April 2003.
[42] Tana Dineen, "*Dire warnings of post-traumatic stress disorder are no help to Canadian soldiers",* Vancouver Sun, February 24, 2003, p. A13.

[43] Sarah Jane Growe, "*PTSD*", TORONTO STAR September 24, 2000.
[44] Zahava Solomon, *Combat Stress Reaction: The Enduring Toll of War* (New York and London: Plenum Press, 1993), pp. 29-30.

disease. Some limited progress in dealing with these issues has been made, but the current system is still based on a model of stress as a disease, and it emphasizes treatment over proven methods of prevention.[46]

PROBLEM# 3: OSTRACIZING ATTITIDES

In his report, the military ombudsman, Andre Marin added: "There was a distressingly common belief among both the peers and leaders that those diagnosed with OSI were fakers, malingerers or simply poor soldiers."[47] Mr. Marin quoted psychologically scarred soldiers who failed to get appropriate treatment because of fear of retribution or ridicule. One soldier said of the fact that news leaked out about his condition. "The time I went back to the unit, everyone was looking at me sideways and tiptoeing around me, just sort of whispering, "There he goes, there goes the crazy boy."[48] Those succumbing to PTSD resulting from OSI face a classic military Catch 22. Seek help, and perhaps the nightmares; the chronic anxiety and the unchecked anger will be treated. But asking for help raises questions from fellow soldiers, suspicion of dereliction of duty.[49] Some critics go as far as saying that PTSD is a fiction - a creation of a society obsessed with psychology and psychological labels. This cult of victimhood, they claim, allows malingerers to always blame something or someone for their suffering, instead of taking responsibility for their own behaviour and happiness.[50]

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[45] Scott McKeen,, "*Damned if they do, damned if they don't: Experts divided on validity of Post-Traumatic Stress Disorder*", Edmonton Journal, April 14, 2001

[46] Franklin C. Pinch, "*Lessons from Canadian Peacekeeping Experience*," unpublished report prepared for the Department of National Defence (DND),November 1994, p. 128.

[47] André Marin, Ombudsman, Canadian Forces, " *Special Report: Systemic treatment of CF members with PTSD" 4 February 2002.*

[48] *Ibid.*

[49] Scott McKeen,, "*Damned if they do, damned if they don't: Experts divided on validity of Post-Traumatic Stress Disorder*", Edmonton Journal, April 14, 2001.

[50] Vancouver Sun, "*Dire warnings of post-traumatic stress disorder are no help to Canadian soldiers"* February 24, 2003, p. A13.

The next section will propose some steps that could be taken to move towards a comprehensive and coordinated approach for dealing with operational stress in the CF.

RECOMMENDATIONS FOR CULTURAL CHANGE

Review of literature on the subject of OSI confirms that the most successful way to decrease preventable stress-related casualties was through cultural change brought on by a broad and integrated system planned to diminish the effects of the inevitable stress of operations on military personnel. The central theme for success in designing and running this type of system has always been that military leaders must bear the ultimate responsibility for the system. Whenever they have attempted to relegate this responsibility to others, the results have been unnecessary operational stress casualties.[51] It is well known that strength of leadership and unit cohesion are the key factors that have had a consistent impact on reducing operational stress casualties.[52] "I think it is probably valid, at least from the standpoint of unit cohesiveness…the more cohesive a unit is, the more likely they are to recognize problems among their peers and be willing to talk about them" said Col Boddam, senior CF psychiatrist and advisor to the Surgeon General on OSI. Data on the risk of reactivation and the appropriate long-term follow-up of patients are lacking and have been identified by a consensus group on the management of operational stress injuries as outstanding research questions. In the absence of data, experts agree that veterans have unique issues that are best ameliorated through peer counselling and active engagement in family and community.[53] These factors are under the command and control of commanders at all levels. Therefore, those in the operational chain of command should regulate a new way of thinking and a new system for dealing with operational stress. A team approach where there are a number of officers with operational

[51] Allan D. English, *The Cream of the Crop: Canadian Aircrew 1939-1945* (Montreal and Kingston: McGill-Queen's University Press, 1996), pp. 145-154.
[52] Shabtai Noy, "Combat Stress Reactions," in *Handbook of Military Psychology*, pp. 517, 519, 520.
[53] M. Friedman, P. Schnurr , A. McDonagh-Coyle , "*Post-traumatic stress disorder in the military veteran*" *Psychiatry Clin North Am* 1994;17:268.

experience and formal education in behavioural sciences to provide opinions based on field experience coupled with scholastic background. The team leader should be a representative of the upper echelons of the operational chain of command, which in the final analysis is accountable for the success or failure of the system. The CSR doctrine of the Israeli Defence Forces (IDF) is a sound model to emulate in this regard. It focuses on improving leadership practices, strengthening unit cohesion and providing forward treatment. It has successfully reduced the effects of operational stress in the IDF. It would, however, require major modifications to be acceptable to the CF.[54] The officers in the operational chain of command should be leading the charge as they bear the final responsibility for the system. There is a need for research to put the lessons of the past in a context that can be useful to those confronting today's challenges, and to analyze the strengths and weaknesses of past systems so that we can build on their strengths while avoiding their mistakes. Insights into individual and group performance through psychological analysis, including leadership and cohesion, will play a pivotal role in devising new strategies to combat operational stress injuries.[55]

CONCLUSION

Operational Stress Injury has obviously become a key factor in many Canadian Forces operational deployments. Its effects have been obvious during numerous peacekeeping and peace support operations, in addition to international deployments to the Balkans, the Adriatic, Somalia, Rwanda, Kosovo and East Timor. It is encouraging to see that the CF leadership is taking serious interest in dealing with the problem of operational stress injuries. Mr. Eggleton, ex-Minister of National Defence said that the health and well being of troops was his foremost concern. He stated:

[54] Stasiu Labuc, "Cultural and Societal Factors in Military Organizations," in *Handbook of Military Psychology*, Reuven Gal and A. David Mangelsdorff, eds. (Chichester: John Wiley, 1991), pp. 484-5; and Noy, pp. 510, 522.
[55] Allan English, "*Leadership and Operational Stress in the Canadian Forces*", Canadian Military Journal, Autumn 2000, p. 38.

> [w]e need to effect a cultural change to eliminate the stigma associated with PTSD , or any type of mental injury…failure to respect and properly treat our members who are suffering from these illnesses will not be tolerated.[56]

Notwithstanding the claims of the military decision makers that it is doing its best to tackle the issue of OSI, there remains room for improvement in the domain of leadership practices and attitudinal changes amongst the peers and supervisors of members affected by OSI. It is vitally important to pay special attention to the mental health needs of soldiers who return from peacekeeping missions, particularly ones that entail unforeseen escalation in hostilities. Soldiers should be systematically evaluated for signs of psychological distress and other mental problems and given opportunities by the military leaders for rest and unrestrained expression of their feelings about the mission.[57] It is recognized that changes in an organization as large as the Department of National Defence (DND) will take a long time to become effective. While there is no doubt that medical and quality of life issues are an important part of preventing operational stress casualties, they are only parts of what should be an integrated system that is focused on cultural change with the help of commanders at all levels. To accomplish this task a comprehensive leadership education program will need to be designed based on research relevant to the Canadian situation. However, until problems of operational stress are viewed as leadership issues, and addressed by military professionals in a systematic and integrated way, there is little hope for any real progress.[58]

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[56] Daniel Leblanc, "*Shell shock to be given priority*", The Globe and Mail, February 6, 2002, p. A6.
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