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MASTER OF DEFENCE STUDIES RESEARCH PROJECT

LEADERSHIP AND POST TRAUMATIC STRESS: ARE THE CF LEADERS OF TODAY DOING EVERYTHING THEY CAN?

By /par LCdr/Capc Bisson

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ABSTRACT

In this day and age, media portrayal of the Canadian Forces leads one to believe that the military leadership is not dealing with Post Traumatic Stress Disorder (PTSD). With changing technology influencing modern day warfare, world nations are concentrating much of their efforts and militaries towards maintaining peace. It is difficult to imagine how these peacekeeping operations could compete with the Great Wars of the 20th century, which resulted in countless psychological casualties. However, the hostile environments of these conflicts are having detrimental effects on soldiers who are being exposed to unforgettable atrocities that are having lasting impressions.

With the arrival of the new millennium, the CF leadership has seen a dramatic rise in the number of PTSD cases. This combined with the knowledge that societal views are preventing many more from coming forward is one of the many challenges of the 21st century facing the CF leadership. More specifically the CF leadership plays an important role in the manner in which the challenges of the 21st century including peacekeeping, training, personnel rotation, personnel reduction and stigma associated with PTSD are addressed.

The framework of this paper reflects but a small segment of the complexity of PTSD. The historical information provided combined with the clinical perspective of PTSD will facilitate the understanding of how the challenges of the 21st century are having an effect on this condition. This established foundation will assist in the critical assessment regarding the military's actions, more specifically, it will show that although there is still much work to be done, the CF leadership is taking an effective and proactive role in dealing with PTSD.

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INTRODUCTION

> *[L]ong after our troops have left the fighting, the killing, the humanitarian disasters behind, they are still waging private battles; battles with the memories of all they have seen and experienced.*[1]
>
> *Casualties of Peace – Judy Piercey*

With the beginning of the 21st century, it is difficult to believe that with the evolution of humanity, wars and conflicts are still an integral part of our lives. Whether the War on Terrorism, another offensive on Iraq or sending more Canadian troops to Afghanistan, Canada's military's continued effort in world peace is not going unnoticed. World tensions are once again rising. More than ever, a greater dichotomy exists among the world's nations that could lead to the demise of the United Nations (UN), an organization in place "to promote social progress and better standards of life in larger freedom."[2] At the time of the UN's creation, many thought that the Great Wars of the early 20th century would be the last conflicts of such immense devastation. However, it has become apparent that such thinking was both inaccurate and short sighted.

The evolution of warfare continues to be influenced by both technological advancements and society. During the Agrarian stage of human history, warfare was strongly influenced by the minerals and agriculture of the time. The weapons were fabricated from the available raw materials and wars were fought only when they did not interfere with the harvest. Leaders were cognisant of the importance of cultivating their fields in order to ensure their survivability. The battles themselves, barbaric in nature, saw man pitted against man in an effort to gain little ground.

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[1] "Casualties of Peace," Judy Piercey, CBC National – Magazine, 2002, [http:cbc.ca/national.magazine/ptsd].
[2] "Charter of the United Nation," [http//www.un.org/aboutun/charter/index.html].

In the late 19th century, the industrial age further influenced warfare. During the industrial revolution, the cheap labour and mass production enabled nations to develop weapons that could inflict injury from a greater distance. Hence, the war machines and weapons became more developed resulting in an expanded battlefield. Greater accuracy was possible and this had a direct impact on the soldiers' level of stress. In addition, these technological advancements resulted in the development of chemical and biological weapons that posed a greater risk to the soldiers and the population as a whole. As such, the soldier on the battlefield was now vulnerable all the time.

> The unfortunate infantryman who finds himself facing a truly modern army may be fully justified in believing not only that he has no hope of survival but, still more stressfully, that he and his comrades will have no means of fighting back.[3]

The growing technological changes of the 20th century have significantly impacted on the way wars are now conducted. The advancement in computers has resulted in more accurate long-range weapon systems that have the capability to inflict more damage and deliver both chemical and biological agents inflicting mass destruction. Hence, it is not surprising that nations have been concentrating much of their efforts in preventing wars for fear of catastrophic outcomes. This was especially evident post WWII and into the 1990's. These decades saw many UN and North Atlantic Treaty Organization (NATO) troops sent to assist in providing a peaceful resolution to various areas of conflict throughout the world. It is hard to anticipate what the future technology will bring, however, if the pace of change seen in the 20th century is any indication, the results could be devastating.

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[3] Paddy Griffith, "Fighting Spirit: Leadership and Morale on the 'Empty Battlefield' of the Future," in *The Human Face of Warfare: Killing, Fear & Chaos in Battle*, ed by Michael Evans and Alan Ryan (Australia: National Library of Australia, 2000), p 117.

Walking through the many war cemeteries in France and seeing the thousands upon thousands of graves, one quickly realizes that despite the changes in technology and the influence this has had on warfare, there remains one factor that has not changed. Regardless of the era, there has been and will always be the casualties of war. Not only those resting in peace, but also the survivors, many of who are reliving their horrific experiences day after day. When considering these casualties, one often looks for physical signs, whether a dead body, a missing limb or a permanent scar that shows one's involvement in the conflict. However, it is important that one not forget the other casualties of war, those affected with psychological injuries. In WWII alone, it is estimated that there were 1,339,000 such casualties.[4] In the late 20th century, the American Psychiatric Association coined the term Post Traumatic Stress (PTS), also referred to as Post Traumatic Stress Disorder (PTSD), to clarify and clinically identify the condition suffered by individuals, often during times of conflicts and wars, after they had experienced a traumatic event.

In the last few years, it has not been uncommon for news headlines to read, "Soldiers suffering from stress don't get the help they need"[5] or "Military blamed for not treating stress disorder properly."[6] Canadian society is now being exposed to the effects of PTSD on its military members. The story of Corporal McEachern, a sufferer of PTSD, who was charged with driving his sport utility vehicle (SUV) into the Garrison Headquarter building in Edmonton, is but one of the many stories that has inundated the

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[4] Colonel J.G.J.C. Barabé, "The Invisible Scars of the Peace Field: The Operational Commander's" (unpublished, Advanced Military Studies Course 2, 1999), p 6.
[5] John Ward, "Soldiers suffering From Stress Don't Get the Help They Need: Ombudsman," [http://ca.news.yahoo.com/020205/6/ihm7.html], 5 February 2002.
[6] CBC News Online Staff, "Military Blamed for not Treating Stress Disorder Properly," [http://cbc.ca/storyview/CBC.2003/02/04/ptsd030204], 4 February 2003.

news.[7] The public is being made aware of the travesties experienced by our soldiers who are being sent abroad to act as peacekeepers in often hostile environments. The atrocities of Rwanda, the single most devastating genocide of the 20th century, and their effects on our peacekeepers are being publicized, "between early April and mid-July, 1994, members of the Hutu majority in the tiny central African nation of Rwanda systematically gunned down or hacked to death with machetes up to 800,000 fellow citizens of Tutsi descent."[8] Lieutenant General Romeo Dallaire, who headed the UN mission to Rwanda (UNAMIR) and who is now among the many who are suffering from this devastating condition has brought this illness to light. Society is now questioning whether or not the Government and more specifically the Canadian Forces (CF) leadership is taking a proactive approach in addressing this problem. Through the many studies that have taken place, it has been proven that leadership plays a crucial role when it comes to PTSD. It has been determined that the level of leadership present has an impact on how troops deal with the situation at hand before, during and after a deployment, regardless of its nature, whether it be a war, a civil conflict or a peacekeeping mission. Everybody from the media to the general public and Ombudsman's Office have publicly criticized the CF leadership for not taking appropriate steps in dealing with the individuals afflicted with PTSD.

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[7] Darcy Henton, "Edmonton Soldier Found Guilty of Criminal Conduct in Ramming SUV Into Office," *The Halifax Herald Limited*, 4 February 2003, [http://www.herald.ns. Ca/stores/2003/02/04/fCanada186.raw.htm].

[8] D'Arcy Jenish, "Canada and the World: 'Preventable Genocide'," *Maclean's Archive*, 17 July 2000, [http://www.macleans.ca/xta-asp/storyview.asp?viewtype=search&tpl =search_frame&edate=2000/07/17&vpath=/xta-doc1/2000/07/17/canada/36991. shtml&maxrec=15&recnum=9&searchtype=BASIC&pg=1&rankbase=144&searchstring=POST+TRAUM ATIC+STRESS].

This paper will show that the CF leadership of today, faced with the multifaceted challenges of the 21st century, is taking an effective and a proactive role in dealing with PTSD. To substantiate this thesis and considering the vast amount of material available on this subject, it is imperative that the scope of this essay be limited to four specific areas. First and foremost to put things into context, a historical review of warfare stress will be provided. This will cover the many acronyms used to describe the condition including the actions taken by both the leadership and the medical professionals to deal with the soldiers inflicted with psychological injuries. The focus will then shift to what PTSD is in terms of a clinical definition. It will clarify the factors behind acute and chronic stress including the symptoms that are commonly observed. It will also identify the possible mediators to this illness. The challenges of the 21st century and how they are linked to PTSD will be highlighted. The evolution of warfare, force reduction and stigmas behind mental illness will be but a few of the issues that will be addressed. Finally, the focus will shift towards how the leadership of today is taking an effective and proactive role in dealing with these challenges.

The framework of this paper reflects but a very small segment of the parameters surrounding the complex issue regarding PTSD. Since the release of the Ombudsman's report, *Systemic Treatment of CF Members with PTSD*,[9] much of the media's attention has been focussed on how the CF leadership is dealing with its members afflicted with PTSD, the premise of this paper. Prior to addressing this, it was important to establish a common ground for the readers. Although many are cognisant of this mental condition

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[9] André Marin, *Systemic Treatment of CF Members with PTSD*, Report to the Minister of National Defence Pursuant to the Ministerial Directives, September, 2001 (Ottawa: DND Canada, 2001), pp 29-30. This report was promulgated as a result of a complaint submitted by Christian McEachern to the Ombudsman's Office.

very few are aware of its origin. Hence to establish the foundation it is important to provide the readers with a general understanding of the historical context regarding combat related stress. It is hoped that this will emphasize that this mental condition has existed for centuries. Furthermore to set the stage and considering that the majority of society classifies all mental conditions resulting from stressful events as PTSD, it is critical to demonstrate, from a clinical perspective, where PTSD falls within the medical environment.

The recent rise in the number of PTSD cases being reported, leads one to question what is different in this century that would fuel such a rise. As such, this essay will address some of the many challenges of the 21st century that are faced by the leadership and how they are linked to PTSD. With this established foundation, the reader will be in a better position to critically assess the principal part of this essay regarding whether or not the CF leadership is taking appropriate steps to deal with PTSD.

HISTORY OF TRAUMATIC STRESS

O my good lord, why are you thus alone?
For what offence have I this fortnight been
A banish'd woman from my Harry's bed?
Tell me, sweet lord, what is't that takes from thee
Thy stomach, pleasure, and thy golden sleep?
Why dost thou bend thine eyes upon the earth,
And start so often when thou sit'st alone?
Why hast thou lost the fresh blood in thy cheeks,
And given my treasures and my rights of thee
To thick-ey'd musing and curs'd melancholy?
In thy faint slumbers I by thee have watch'd,
And heard thee murmur tales of iron wars,
Speak terms of manage to thy bounding steed;,
Cry 'Courage! To the field!' …
Thy spirit within thee hath been so at war,
And thus hath so bestirr'd thee in thy sleep,
That beads of sweat have stood upon thy brow
Like bubbles in a late-disturbed stream;
And in thy face strange motions have appear'd,
Such as we see when men restrain their breath
On some great sudden hest. O, what portents are these? …[10]

- William Shakespeare – *Henry IV, Part I,* 1597

This exert from William Shakespeare's *Henry IV*, written in the late 16th century, depicts Lady Percy expressing her trepidation over Harry's recent behaviour. She uses words that "eloquently depicts a number of classic symptoms of war-related PTSD, including (in order) estrangement from others, restricted range of affect, difficulty sleeping, exaggerated startle, dysphoria, nightmares and strong anxiety."[11] Although the term PTSD was not officially coined until 1980, when it was included in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM)[12], referred to as DSM III, as an

[10] Peter Alexander, ed, *Complete Works of William Shakespeare* (London: Collins Clear-Type Press, 1951), pp 489-490.
[11] H. Hendin and A. Haas, *Wounds of War* (New York: Basic Books, Inc., 1984), p 104.
[12] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed.; Washington: American Psychiatric Association, 1980).

official diagnostic category and thus viewed as a war-related stress reaction,[13] it has been a known fact that "as long as there have been wars, individual have suffered from the after-effects of traumatic experiences."[14] Throughout the ages, different terms have been used to describe this traumatic experience. Everything from nostalgia, shell shock, traumatic war neurosis, combat exhaustion, and gross stress syndrome were used to describe the condition later to be known as PTSD.

In the early 19th century, the medical profession initially ignored the psychological impact that war had on the soldiers. Although both the leadership and the medical professionals saw the direct affects of these consequences, no due consideration was given to determine ways to treat those afflicted, let alone try to understand why they were affected in such a manner. Instead, emphasis was placed on the control of infectious diseases, which at the time was the biggest contributor to the loss of life.[15]

It was not until the American Civil War of 1861, that the medical profession started to closely observe the psychological impact of war on the soldiers. This was influenced by the emergence of psychiatry and psychology. Initially, it was thought that the severe depression and loneliness were caused by the soldiers' extended absence from home. As such, the term "nostalgia" was used to describe their condition.[16]

During the initial stages of WWI, the Allied armies were inundated with a large number of psychiatric casualties. At the end of the war it was estimated that of the over 2 million men and women in uniform that crossed the Atlantic, "106,000 were treated for

[13] H. Hendin and A. Haas, *Wounds of War…*, p 103.
[14] André Marin, *Systemic Treatment of...*, pp 29-30.
[15] Lars Weisaeth, "The European History of Psychotraumalogy," *Journal of Traumatic Stress Studies*, Vol 15, No. 6 (December, 2002), p 446.
[16] H. Hendin and A. Haas, *Wounds of War…*, p 105.

psychiatric reasons."[17] The British reported that up to 40% of their battle casualties were psychological in nature.[18] It is important to remember that prior to WWI, "military psychiatry was not considered a legitimate field of study."[19] As such, limited efforts were spent on understanding the psychological impact of war. Therefore, it was not surprising that during WWI, the medical profession was ignorant of the psychological impact that war could cause and as such shared the opinion that, "the present war is the first in which the functional nervous disease (shell shock) have constituted a major medico-military problem."[20] Hence, it was felt that the large calibre artillery that was first introduced during this war caused this new symptom. In 1915, British psychologist, Charles Myers, was the first to coin the term "shell shock" and explained that the symptoms were attributed to "the concussive effects of exploding shells."[21] As the war progressed, it became apparent that not all soldiers who were experiencing shell shock had been exposed to the physical trauma of the exploding shells. As a result, the military psychiatrists had to concede that shell shock was linked to psychological and not physical trauma.[22] This resulted in the syndrome being viewed as a form of neurosis.[23]

Although they were able to characterize the syndrome as neurosis, there still remained the issue of how to treat the victims and return them to the frontlines. The Russian Army's approach to this was to use valerian, a mild and effective tranquilizer, combined with a shot of vodka to help calm their soldiers.[24] The French, on the other

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[17] Colonel J.G.J.C. Barabé, "The Invisible Scars…", p 6.
[18] Arthur Anderson, "Anxiety-Panic History: Anxiety, Disorders and Treatments Throughout the Ages," [http://www.anxiety-panic.com/history/h-1900.htm].
[19] *Ibid*.
[20] *Ibid*.
[21] *Ibid*.
[22] *Ibid*.
[23] H. Hendin and A. Haas, *Wounds of War*…, p 105.
[24] Arthur Anderson, "Anxiety-Panic…".

hand, used the technique of "torporlage" which involved administering electrical current to the paralysed limb.[25] The British's initial approach was much more humane and involved soothing baths, massages and rest. However, it quickly became apparent that this method was not returning the troops to the front lines in a timely manner. As such, a more proactive tactic was employed which involved a number of persuasive actions. Everything from hypnosis, deceptive cures, and phoney wonder drugs were used.[26] In addition it was found that if the psychological casualties were treated closer to the front lines, they responded more quickly to the treatment and thus could resume full duties. Another lesson which was soon forgotten after this war.

In the initial stages of the war, the senior leadership often questioned these casualties' moral character. It was felt that these soldiers were "at best, a constitutional inferior human being, at worst a malingerer and a coward."[27] They were often referred to as "moral invalids"[28] and many leaders felt that these individuals should be court-martial and dishonourably discharged.[29] However, as the war progressed, the medical professionals started to accept combat neurosis as a legitimate psychiatric condition, which could occur even in the soldiers with the highest moral character. W.H.P. Rivers, a physician during WWI who was also a professor of neurophysiology, psychology and anthropology, had established the concept that "men of unquestioned bravery could succumb to overwhelming fear and, second, that the mo

of the enemy. It was the love of soldiers for one another."[30] The American military psychiatrists later accepted these principles and applied them during the subsequent war.

After WWI, much of the insights that had been gained with respect to military combat neurosis or traumatic stress were pursued to some extent but with limited success. Although valuable knowledge was gained, the psychiatrists that had played a significant role during WWI were unable to influence their profession into developing new services to assist the mental casualties of the war. As such, there was little accomplished with respect to institutional changes.[31] Psychiatry concentrated on issues, such as psychoanalytical theory and psychological testing, which had a direct impact on society and could positively be used to influence daily activities. Consequently, the valuable lessons of WWI were soon forgotten.

In 1939, with the commencement of WWII, attempts were made to use psychological testing to screen for potential stress casualties.[32] At this point, combat stress was referred to as traumatic war neurosis or combat exhaustion. The failure of the test was evident during the North African campaign. As a result of the faith placed in this psychological screening, it was felt that the soldiers that were selected to fight this campaign would not succumb to the effects of the battle and as such, no contingency plan was put into place to deal with possible stress casualties. Subsequently, although tested, soldiers still suffered and became stress casualties and unfortunately had to be sent to distant treatment facilities, far away from their units and the frontline, to receive

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[30] Arthur Anderson, "Anxiety-Panic…".

[31] Lars Weisaeth, "The European History…" , pp 448-449.

[32] Major Michael E. Doyle, "Combat Stress Control Detachment: A Commander's Tool," *Military Review*, Vol LXXX, No. 3 (May-June, 2000), p 80. This screening was based on "20th century theories of human behavior and development to screen out soldiers who would crack under the stress of battle." The American Army after WWI decided to concentrate their efforts on these theories vice implementing the lessons that had been learned. They hoped that this screening would prevent psychiatric casualties.

treatment.[33] By September 1943, the psychological tests screened out more army candidates then they were recruiting. These psychological tests were merely an IQ test. Since it has not been proven that intelligence is related to an individual's capacity to resist stress, the testing itself did not accomplish its original mandate. This was unacceptable and thus forced commanders and psychiatrists to accept the fact that "every soldier has a point at which he will become a psychiatric casualty."[34] Initially, the psychiatrists attempted to treat their patients away from the battlefield and completely ignored the important lessons of WWI regarding the principles behind the PIE concept.[35] During WWII, it has been reported "[that] more than 1,393,000 men and women in uniform manifested serious psychological deficiencies."[36] Unfortunately, even with the advancement of psychiatry, many leaders and the general population felt that the soldiers were "affronts to traditional attitudes about proper soldierly behaviour."[37] In one particular instance, Sir Andrew McPhail, a historian of the Canadian Medical Service went as far as to make the following comments, "Shell-shock is a manifestation of childishness and feminity; men who were liable to such condition were not fit for the hard business of war."[38]

However, similar to the events after WWI, post WWII did little to advance the cause regarding treatment of combat stress.

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[33] Major Michael E. Doyle, "Combat Stress Control Detachment…," p 80.
[34] Lieutenant Colonel Faris R. Kirkland, "Confronting Psychological Trauma," *Military Review*, Vol LXXVIII, No. 1 (January – February, 1998), p 76.
[35] In all cases, it was apparent that the battlefield psychiatrists "learned much about the phenomenology of war-related stress reactions and discovered the ingredients of effective intervention that became codified as the principles of proximity, immediacy, and expectancy." These principles have been quantified as PIE and have enabled psychiatrists to effectively treat their patients and return them to the frontlines. H. Hendin and A. Haas, *Wounds of War*…, p 105.
[36] Colonel J.G.J.C. Barabé, "The Invisible Scars…", p 6.
[37] Bill McAndrew, "Traumatic and Post-Traumatic Stress Disorder," National Network News, Vol 7, No. 1 (Spring 2000), [http://www.sfu.ca/dann/Backissues/nn7-1_6.htm], p 1.
[38] *Ibid*, pp 1-2.

> [T]he Services made tremendous efforts in the treatment of mental illness. It was recognised that there were thousands of sick personnel who were casualties of battle, or of prisoner of war camps, or who had witnessed atrocities. But suddenly it was all abandoned.[39]

Once again, it was important for society to view their returning soldiers as heroes. It was not difficult for them to "regard their postwar difficulties as weaknesses interfering with our idealized picture of them, caused us not to notice that even heroes pay a high price for their wartime actions."[40] Although this was the last of the Great Wars, the subsequent Cold War and overall tensions throughout the world did not eliminate the traumatic stress caused by battles.

Conflicts such as Korea, saw history repeat itself again, however it was not until the 1960's, with the Vietnam War, that the next significant milestone in history of traumatic stress took place. During this war, "there were few soldiers who fell victim to combat stress during the conflict."[41] Many leading psychiatrists believed that combat stress had been brought under control. However, this was not the case and it was not until after this war that it became apparent that "combat in Vietnam heightened our awareness of the frequent delay between traumatic events and the development of stress."[42] This war was unlike any of the previous wars in that throughout the campaign it was apparent that "in no prior war fought by the US has the actual combat experience of our fighting men been less understood by the public than in the Vietnam War."[43] The

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[39] Roy Brook, *The Stress of Combat – The Combat of Stress: Caring Strategies Towards Ex-Service Men and Women* (Portland, Oregon: The Alpha Press, 1999), pp 93-94.
[40] H. Hendin and A. Haas, *Wounds of War…*, p 6.
[41] Hans Binneveld, *From Shellshock to Combat Stress: A Comparative History of Military Psychiatry* (Amsterdam: Amsterdam University Press, 1997), p 179.
[42] H. Hendin and A. Haas, *Wounds of War…*, p 7.
[43] *Ibid*, p 3.

lack of public support and the absence of a clear objective combined to make it difficult for the soldiers to justify their presence and the death surrounding them. They were faced with insurmountable challenges including having to deal with an enemy that was often made up of women, children and elderly who did not hesitate to pull the trigger.[44] Brought up in a society where their roles were to protect these individuals it was a challenge for them to justify their retaliation. In a war that saw 16% death rate, it is difficult to imagine that the psychiatric casualties amounted to 12.6% of the total troops.[45]

Since the Vietnam conflict, the issue of delayed traumatic stress has been a major issue in much of the literature on the subject.[46] In the case of the Vietnam veterans they "were denied a heroes' welcome and came back to a United States that had disowned them, to massive antiwar demonstrations and cries of 'baby killer'."[47] Studies have shown that this combined with an accumulation of stress have "eventually led to the delayed onset of latent disorders among survivors who had initially been able to contain their traumatization."[48] As a result, there have been a large number of latent combat stress symptoms, now referred to as PTSD, which are being reported.[49] It is abundantly clear that PTSD is viewed as "a long-term reaction to war-zone exposure that may linger, reactivate or even present as late as 50 years after exposure."[50]

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[44] H. Hendin and A. Haas, *Wounds of War…*, p 4.
[45] Colonel J.G.J.C. Barabé, "The Invisible Scars…", p 6.
[46] Zahava Solomon, *Combat Stress Reaction: The Enduring Toll of War* (New York: Plenum Press, 1993), p 212.
[47] *Ibid*, p 224.
[48] *Ibid*, p 224.
[49] Lieutenant Colonel Faris R. Kirkland, "Confronting Psychological…", p 76.
[50] Erica Weir, "Veterans and post Traumatic Stress-Disorders," *News and Analysis* (31 October 2000), p 187.

The Canadian military has followed a similar trend with respect to its treatment of soldiers suffering from traumatic stress. Basically, the military's method of dealing with traumatic stress has undergone a three stage repetitive approach.[51] Initially, like many other nations, the military lacked "any organized system to deal with operational stress."[52] Secondly, once confronted with these casualties, there was an uncoordinated approach by various groups including the leadership, medical doctors, psychologists and psychiatrists to attempt to deal with these individuals. Finally, in some cases, a proactive approach was taken and an "integrated and comprehensive system for dealing with operational stress"[53] was established. This was done under the leadership of the military commander with advice from the experts in the medical fields. This approach was positive and resulted in a decrease in the number of stress casualties. Similar to other militaries' approach to traumatic stress, the CF did not continue to follow through with this third stage after the war. The important lessons of how to identify and deal with such casualties were soon forgotten. As such, at the beginning of any new conflict the process of dealing with those with combat related stress always started from stage one and the cycle was once again repeated.

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[51] Dr Allan D. English, "Leadership and Operational Stress in the Canadian Forces," *Canadian Military Journal*, Vol 1 No. 3 (Autumn 2000), p 3.
[52] Dr Allan D. English, "Leadership and Operational …", p 3.
[53] *Ibid*, p 3.

WHAT IS POST TRAUMATIC STRESS DISORDER (PTSD)

> *Sometimes, I wished I'd loose a leg instead of having all these grey cells screwed up. You loose a leg, it's obvious, you've got therapy, and all kinds of stuff. You loose your marbles, very difficult to explain, very different to recognize it and gain that support that you need. But those who don't recognize it and don't go out to get the help are going to be a risk to themselves and to us. Had I not gone to get help, I would have never been promoted because I probably wouldn't be alive.*[54]
>
> *Major General R.A. Dallaire*
> *On Rwanda – UNAMIR*

As seen in the preceding section, emphasis was placed on the fact that many terms have been used to describe the traumatic stress experienced by soldiers during and after the many conflicts that have been fought in the last century. Before continuing any study of PTSD, it is important to understand where it falls within the clinical parameters of traumatic stress and to comprehend the relationship that exists between PTSD, Combat Stress Reaction (CSR) and Critical Incident Stress (CIS). Furthermore, a brief synopsis of the stress related triggers also known, as mediators will be identified. These emphasize the method in which social conditions can influence or trigger the onset of PTSD. These mediators are grouped into the various stages of a deployment cycle (pre-deployment, deployment and post deployment).

Traumatic stress can effectively be divided into two categories, acute and chronic[55]. It is important to comprehend that "acute stress reactions occur during combat or shortly after, whereas chronic reactions persist over time."[56] Both CSR and CIS fall under acute stress reactions. Many definitions regarding CSR can be found in the literature pertaining to traumatic stress. Among these definitions is one provided by H.R.

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[54] Canada, Department of National Defence. *Witness the Evil* – A Canadian Forces Video, 1998.
[55] The Concise Oxford Dictionary defines Acute as "coming sharply to a crisis" and Chronic as "lingering, lasting".
[56] H. Hendin and A. Haas, *Wounds of War*…, p 112.

Kormos, known for his writings on the Vietnam War, who describes CSR as "consist[ing] of behaviour by a soldier under conditions of combat, invariably interpreted by those around him as signalling that the soldier, although expected to be a combatant, has ceased to function as such."[57] Dr Allan English, a Canadian historian who has written many articles on traumatic stress and leadership including *Historical and Contemporary Interpretations of Combat Stress Reaction*, supports the definition provided by Shabtai Noy of Israel. This definition details CSR as "all soldiers who negotiate evacuation with a reason other than being hit by a direct enemy projectile or explosive are CSR casualties."[58] Captain (Navy) Richard R. Town in his paper on *The Effect on Sustainment of Stress in Operations* goes as far as to say "Allan English lent his support to the definition provided by Noy because it represented 'the definition most often used in the psychological literature… and common in the CF'."[59]

Throughout the years, many different terms have been used to describe CSR including but not limited to nostalgia, shell shock, and combat neurosis. In the majority of the cases, CSR was characterized by "a reduction of the person's capacity to function as a soldier and by the subjective experience of overwhelming distress and inescapable anxiety."[60] By its very nature, CSR is a reaction resulting from combat. However, it is clearly apparent that traumatic stress can be caused by other events, which are viewed as non-combatant or critical incident (CI). This is defined as "an event outside the range of normal experience that is sudden, unusual, and unexpected, disrupts one's sense of

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[57] H.R. Kormos, "The Nature of Combat Stress" in Stress Disorders Among Vietnam Veterans, C.R. Figley, ed. (New York: Brunner and Mazel, Inc., 1978), pp. 3-22 as cited in Solomon, op cit., p. 30

[58] Shabtai Noy, "Combat Stress Reactions" in Handbook of Military Psychology, Reuven Gal and a. David Mangelsdorff, eds. (Chichester: John Wiley, 1991), p 508.

[59] Captain(Navy) Richard R. Town, "The Effect on Sustainment of Stress in Operations" (unpubrre C

control, involves the perception of a threat of life, and may include elements of physical or emotional loss."[61] As such, the next acute traumatic stress, CIS covers the areas of stress that are non-combatant in nature.

CIS is defined as "the unusually strong physical and emotional reaction that may be experienced in the face of a CI, and that could interfere with one's ability to function during or after the critical incident."[62] It is important to remember that few will be unaffected when they experience a CI and thus "a strong reaction is a normal reaction."[63] This type of response can be physical (nausea, muscle tremors, sweating), cognitive (confusion, difficulty in making decisions) or emotional (anxiety, anger, fear).[64] In some of these cases, the reactions can be delayed, however, the majority of the symptoms will be similar. When these CIS symptoms persist and become chronic, the condition of PTSD will result.

PTSD is defined in the Defence Ethics Report published in 1999 as, "[a] severe form of stress or trauma reaction [sic]. The extreme case is often the result of stressors that are beyond [the] normal range of human experience. [It is] also categorized as an anxiety disorder, which can make a person physically sick and dysfunctional."[65] In 1980, PTSD finally received official recognition by the American Psychiatric Association

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[61] Department of National Defence, A-MD-007-144/JD-004 *Preparing For Critical Incident Stress* (Ottawa: DND Canada, 2000).
[62] Department of National Defence, CFAO 34-55 *Management of Critical Incident Stress in the Canadian Forces* (Ottawa: DND Canada, 1994). Examples of Critical Incidents can include "Natural disaster, bombing of buildings, multiple casualty accidents, mining of roads, sexual or other assault, attacks on vehicles or convoys, death or serious injury of a child, armed attacks, hostage-taking, suicide, being a powerless spectator of violence, large-scale massacres, epidemics and fames, traumatic death in family, duty-related death of co-worker, sever physical harm or injury, and war-related civilian deaths".
[63] Department of National Defence, A-MD-007-144/JD-004 *Preparing For* Critical…
[64] *Ibid*.
[65] Department of National Defence, Chief Review Services, *Defence Ethics Programme, Extract of the Ethics and Operations Project, Interim Project Report*, 13 October, 1999, p 5.

(APA) in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III). The following criteria were adopted:

- Existence of a recognizable stressor that would evoke significant symptoms of distress in almost everyone.

- Re-experiencing the trauma
  - Recurrent and intrusive recollections of the event
  - Recurrent dreams of the event
  - Sudden acting or feeling as if the traumatic event were reoccurring, because of association with an environmental or idealistic stimulus

- Numbing of responsiveness to or reduced involvement with the external world, beginning some time after the trauma.
  - Markedly diminished interest in one or more significant activities
  - Feeling of detachment or estrangement from others
  - Constricted effect

- Two of the following symptoms that were not present before the trauma:
  - Hyperalertness or exaggerated startle response
  - Sleep disturbance
  - Guilt about surviving when others have not, or about behaviour required for survival
  - Memory impairment or trouble concentrating
  - Avoidance of activities that arouse recollection of the traumatic event
  - Intensification of symptoms by exposure to events that symbolize or resemble the traumatic event[66]

This recognition legitimized PTSD as a "distinct diagnostic entity."[67] The fourth edition of the DSM (DSM-IV) maintained the same norms as DSM-III, however, the stressor criteria was expanded to include the following specific information.

> [A] subjective component – experiencing trauma with helplessness and horror – and include traumas that are witnessed or occur to loved ones or are personally

As such, since 1980, the medical profession has been able to provide a concrete medical diagnosis for PTSD.

To understand the stressors that lead to this condition, it is important to remember the following.

> PTSD can follow a distressing event which is far outside the normal range of human expectation. It can be brought on by a serious threat to one's life or body, a serious threat to one's family, the sudden destruction of one's home or community, seeing another person being killed by an accident or by some physical violence, or learning about a serious threat to a close friend.[69]

In accordance with DSM IV, stressors are defined in a clinical context as follows.

> The person has been exposed to a traumatic event in which both of the following were present:
>
> (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
> (2) the person's response involved intense fear, helplessness, or horror[70]

The symptoms of PTSD vary, however, in accordance with DSM-IV the symptoms will usually involve "persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness"[71] and "persistent symptoms of increased arousal including difficulty falling or staying asleep, irritability or outbursts of anger, difficulty concentrating, hypervigilance, exaggerated startle response."[72] In many of the cases, one of the predominant symptoms, "one that relives the event and won't go away. The victim relives sights, sounds or even smells. A 'reminder' incident can start the process off all

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[69] Roy Brook, *The Stress of Combat…*, p 229.
[70] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, (4th ed., Washington: American Psychiatric Association, 1994). As described in the lecture presented by Colonel Boddam to the Canadian Forces Staff College Course 29 on 6 September 2002.
[71] *Ibid*.
[72] *Ibid*.

over again."[73] Dr Jacques Gouws, a military psychologist, has carried out extensive studies in combat stress. He supports the research that shows PTSD as a physiological injury to the brain.[74] This research has gone as far as to show by magnetic resonance imaging (MRI) scan that the brain of someone with PTSD has similar structural changes to someone with a brain injury. Dr Gouws proposes the following explanation behind these structural changes.

> When you go into combat, you pump adrenaline at levels that you can never imagine, which means that the body is flooded. It's totally flooded with a hormone that does one thing and one thing only, it prepares you to fight or flee. And you are fighting. So everything is focused on just this one thing. So whatever comes in stays. It is so well entrenched that you almost can't remove it. It's burned into memory. The experience, the smell, the sight, the feel, it's all there.[75]

Corporal Chris Cassavoy, a member of the Canadian contingent to Rwanda (UNAMIR) described this best.

> There are foods I can't eat anymore. Grilled chicken; can't eat it, looks like a dead body. There are vehicles that I see, like rusted out vehicles – I can't go near them… Children, I have a hell of a time – all the time looking at kids. Especially new-borns, because they were a plaything for the Hutus. They really liked killing kids.[76]

From a social context, there have been specific mediators[77] that have been found to increase the likelihood or influence the onset of PTSD during peacekeeping missions. A number of studies including those carried out by Dr Megan Thompson, a social

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[73] Roy Brook, *The Stress of Combat…*, p 229.
[74] "Broken Soldiers: Combating Military Stress," CTV W5, 7 March 2003, [http://www.Ctv.ca/servlet/ArticleNews/story/CTVNews/1047060032429_37111?hub=wfive].
[75] *Ibid*.
[76] Canada. Department of National Defence. *Witness the Evil…*
[77] Defined in the Concise Oxford Dictionary as "one who forms connecting link between; be the medium for bringing about or conveying".

psychologist with the Defence Research and Development Canada[78], have identified such stress related factors and have broken them down into three categories reflective of the current phases of a CF deployment: pre-deployment, deployment, and post-deployment.[79]

The mediators associated with the pre-deployment phase are those that are linked to a member's vulnerability to peacekeeping stress. An individual's personality, more specifically, his[80] state of mind and his expectation regarding the upcoming mission are key factors that could influence the level of stress being experienced. Applicable training during this phase will assist the member to understand the mission's objective. This will clarify what is expected and as such remove much of the stress that an individual may be experiencing before a deployment.[81]

The mediators grouped within the deployment phase are those that "immediately impact stress – e.g., perception of risk, violence/intensity of events during deployment, group cohesion and leadership."[82] In such cases, the stronger the group cohesion and leadership are the lower the chances are of developing PTSD. The ability to rely on others and realizing that these individuals are present to assist in accomplishing the task or in providing moral support has a significant impact on how an individual deals with stress. Similarly, a strong leader will usually have a clear vision of his mandate and will provide accurate direction as to how to proceed to attain these goals. The knowledge of what is expected can often eliminate the stress of the unknown. Another factor that falls

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[78] This organization was formerly known as DCIEM, Defence and Civil Institute of Environmental Medicine.
[79] Carol McCann, "DCIEM, Comments on Peacekeeper's Stress Article," *The Bulletin For Soldiers By Soldiers*, Vol 7, No. 2 (October, 2000), p 7.
[80] It is to be understood that the term "his" refers to both "his and/or hers".
[81] Carol McCann, "DCIEM, Comments…, p 7.
[82] *Ibid*, p 7.

under the deployment category, of which the member has the least control over, is the nature of the trauma that can be faced during the operation. Factors such as the amount of fear experienced, duration of the exposure, continued threat, and perception of lack of control can all add to the possibility of developing PTSD during or after the deployment.

The stress related factors associated with the post-deployment phase are those that rely on the social support that is provided to the members upon their return to Canada. One of the most significant mediators during this phase relates to the recognition by society of the efforts that were put forward by the members who deployed on behalf of the government. A positive recognition provides the soldier with a purpose and regardless of the atrocities experienced he is cognisant that society supports his actions. The emotional support provided by family and friends provides a conduit for members to alleviate the stress that they may have experienced. The information support provided by professionals whether in the medical field or in the chain of command, help the member cope with his experiences. Finally, one of the most important areas of support is that provided by peers who have shared similar experiences and who are able to relate first hand to the stress that have been experienced.

Although the definition of PTSD has undergone numerous modifications and is still considered to be in its infancy, it is safe to state, "over the last 10 or so years, however, the validity of PTSD has become well established and is currently considered one of the most prevalent and disabling psychiatric disorders in civilian and military populations."[83] It is indeed one of today's "most commonly encountered mental disorder amongst Servicemen, and civilians, who have encountered a very serious or sudden shock

[83] Charles Moreau MD and Sidney Ziscook MD, "Rationale For…", p 776.

to their system."[84] This is an illness that will be with society well within the 21st century and that will need to be better understood in order to help those suffering from it.

[84] Roy Brook, *The Stress of Combat*…, p 1.

21ST CENTURY CHALLENGES

Badge of Dishonour and Stairway of Shame.[85]

During the last decade there has been an increase in the number of PTSD cases reported. It is estimated that up to one in every five soldiers will develop some form of combat stress after returning from an overseas deployment.[86] This is surprising considering the fact that the world in the last few decades has not experienced any conflicts of the magnitude seen during the Great Wars. Obviously the nature of warfare has changed and has a direct impact on PTSD.

As previously discussed, the manner in which wars are fought has changed drastically. Everything from the physical attributes of the battlefield to the weapons used to the soldiers themselves has metamorphosed. This is primarily as a result of the many technological advancements that have taken place in the past and which continue to make significant progress in the new millennium. From the creation of gunpowder, to the development of artillery, to the invention of nuclear weapons and smart bombs, the world has seen drastic advancements in weapons with the capacity for mass destruction. With such weaponry, world leaders have altered their attitudes regarding the tensions that have arisen since WWII. Many nations are now providing their militaries to help alleviate many of the rising tensions and are using military forces as peacekeepers vice war fighters. A more proactive approach to settling these problems has taken on greater importance as the 21st century approached. This section will concentrate on the

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[85] Oliver Moore, “Badge of Dishonour Suffered in Silence,” Globe and Mail, 17 December 2002, [http://www.globeandmail.com/servlet/ArticleNews/front/RTGAM/20021217/wptsd1217/Front/homeBN/breakingnews].
[86] “Broken Soldiers…”.

challenges of the 21st century and how these have acted as mediators for PTSD. Among such challenges are the military's increased participation in peacekeeping, training for military troops, rotation of deployed forces, personnel reduction and the stigma associated with mental health.

PEACEKEEPING

Since the creation of the UN, Canada has played an important role in peacekeeping missions throughout the world. Since 1947, Canada has deployed more than 100,000 troops in over 40 UN observer and peacekeeping operations.[87] This tempo drastically increased during the 1990's, where Canadian troops were involved in 23 different UN observer and peacekeeping deployments.

Throughout the years, peacekeeping operations have evolved from their conventional roles. Originally, it was not uncommon for the missions to be peaceful operations with willing adversaries wanting the international organizations to resolve their conflicts. However, this traditional role has indeed changed.

> [P]eace operations arguably not peacekeeping at all, at least in the traditional sense. They entail an increased risk of casualties, of death even. A distinct peace operations continuum or "spectrum of conflict" has developed.[88]

Conventional peacekeeping operations involved very limited exposure to traumatic events. Unfortunately, this standard no longer exists and the current missions are now

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[87] Rae Corelli, Stefan Lovgren, and Luke Fisher, "Early In, Early Out," *Maclean's Archive*, 25 June 2001, [http://www.macleans.ca/xta- asp/storyview.asp?viewtype= search&tpl=search_frame&edate=2001/06/25&vpath=/xta-doc1/2001/06/25/world/ 53105.shtml&maxrec=15&recnum=6&searchtype=BASIC&pg=1&rankbase=144&searchstring=POST+TRAUMATIC+STRESS]. Attached at Annex A is a table of all the UN observer and peacekeeping missions that Canada has participated in since 1947.

[88] Colonel J.G.J.C. Barabé, "The Invisible Scars…", p 10.

experiencing traumatic events at a prolonged and alarming rate.[89] In many cases, the peacekeepers are sent to areas where there is no effective peace or nation-states. As a result, "[p]eacekeepers, too, face enormous stresses, associated not only with combat but with rapid transitions from quiet situations into fighting ones."[90] An excellent example of this was seen in 1993 with the deployment of Canadian troops to Croatia. The UN placed the Canadian PPCLI contingent in Vojna Krajina, where it was feared that the Croatians would try to slaughter the 500,000 Serb inhabitants. Unbeknownst to the public back home,[91] in September 1993, the Canadian troops were engaged in a vicious 15-hour battle with the Croatian forces. Under such circumstances, the Canadians were fortunate not to suffer any losses. Although their actions resulted in a truce the incident was indicative of the new age of peacekeeping.[92]

Changes in the nature of these missions have also led to ambiguity regarding a number of critical issues surrounding a peacekeeping mission.

> Ambiguities during peacekeeping operations: unclear rules of engagement for defense, lack of proper training for mission, restricted ability to act in the face of threat or abuse, unclear standards to judge if a mission is successful, questions about the relevance of peacekeeping missions to a "soldier identity", soldier doubts about their ability truly alter the stalemate, concerns about having to switch from being a peacekeeper to being a warrior, questions about whether the

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[89] Colonel J.G.J.C. Barabé, "The Invisible Scars…", p 11.

[90] Michael G. Wessells, "Humanitarian Intervention, Psychosocial Assistance, and Peacekeeping," in *The Psychology of Peacekeeping*, ed by Harvey J. Langholtz (Westport, Connecticut: Praeger Publishers, 1998), p 140.

[91] "Canadians were focused on the disturbing revelations that a teenager named Shidan Arone had been tortured and killed by Canadian peacekeepers in Somalia. Kim Campbell's conservative government was also facing a federal election and didn't want the increasing dangers Canadian troops were facing in the Balkans raised as an issue." Michael Snider and Sean M. Maloney, "Firefight at the Medak Pocket," *Maclean's Archive*, 2 September 2002, [http://www.macleans.ca/xta-asp/storyview.asp?viewtype =search&tpl=search_frame&edate=2002/09/02&vpath=/xta-doc1/2002/09/02/world/ 71190.shtml&maxrec=15&recnum=2&searchtype=BASIC&pg=1&rankbase=144&searchstring=POST+TRAUMATIC+STRESS].

[92] *Ibid*.

> military will reward participation in peacekeeping operations, and questions about the overall importance of peacekeeping operations.[93]

These uncertainties combined with the public's continual struggle to grasp and understand their military's involvement in peacekeeping add to the stresses that present day soldiers are facing.[94]

The increased operational tempo has resulted in more troops having to redeploy. This heightened frequency combined with the potential for greater exposure to trauma and the lack of mission guidance defines peacekeeping in the 21st century. As previously discussed, these factors are all mediators for PTSD. Consequently, unless preventive measures are put into place, participation in peacekeeping in the 21st century could result in greater PTSD manifestation.

TRAINING

Training is defined in the Concise Oxford dictionary as "bring or come to desired state or standard of efficiency [sic] by instruction and practice." In that context it plays a significant role in all aspects of life. Whether learning how to walk, ride a bike, or fire a weapon, there will be some form of training that will take place in order to help meet the objectives. In both civilian and military life, "many problems in organization occur when rules or regulations are too complex, non-existent, or are not clearly communicated to workers."[95]

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[93] Thomas W. Britt, "Psychological Ambiguities in Peacekeeping," in *The Psychology of Peacekeeping*, ed by Harvey J. Langholtz (Westport, Connecticut: Praeger Publishers, 1998), p 112.
[94] *Ibid*, p 115. In 1993, Eure et al. conducted an analysis of the social construction of peacekeeping from the US perspective and found that most people agree that the military's primary goal is to protect national interests. However, using the military as peacekeepers was not "institutionalized as a proper role of the armed forces."
[95] Thomas W. Britt, "Psychological Ambiguities…", p 119.

> The military trains its troops to meet the Government's objectives.
>
> They are sent by their governments, who employ them as instruments in some national goal. Whether that goal is defined as defense, the protection or pursuit of a vital interest, or the maintenance of the nation's values or principles, the soldier fights for purposed larger than his own, for others as well as himself.[96]

Military training revolves around meeting these goals, as such, the soldiers are trained for combat. As a profession of arms and in accordance with General Douglas Macarthur, "the sure knowledge that in war there is no substitute for victory. That if you fail, the nation will be destroyed."[97] These strong words still hold true to this day.

The challenges of the 21st century revolve around the fact that troops are currently deploying on peacekeeping missions. It is important to remember that our soldiers have been trained for combat and it is not surprising that they experience internal conflicts adapting their roles as soldiers to an environment where their combat actions are restricted to only self-defence and they are therefore left feeling helpless when incidents occur around them.[98] Corporal McEachern, reliving his experiences in Uganda, vividly described such a feeling to the Ombudsman team who were investigating on the *Systemic Treatment of CF Members with PTSD*.

> I think the one that bothered me the most was the night the woman got raped right beside our compound, we could see the whole thing and hear her screaming. I called in about three times and asked if I could interfere, fire a shot or do something and I wasn't allowed to do anything because security for the division compound could not be compromised [sic] the act was pretty bad but not being able to do anything … you trained hard to go over there and be able to make a difference and then they tie your hands like that …[99]

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[96] Zahava Solomon, *Combat Stress Reaction…*, p 251.
[97] General Dennis J. Reimer, "Developing Great Leaders in Turbulent Times," *Military Review*, Vol LXXVII, No. 1 (January-February, 1998), p 110.
[98] Michael G. Wessells, "Humanitarian Intervention…", p 141.
[99] André Marin, *Systemic Treatment* of…, p 12.

Many studies have been conducted on the effects of these situations on soldiers. In 1997, Litz et al. conducted a study on the predictors and effects on soldiers to "suppress their natural tendency to respond aggressively to threats during peacekeeping operations."[100] They found that among the US soldiers who deployed to Somalia, these individuals reported greater "negative aspects of peacekeeping [which] was associated with greater pressure of having to uphold restraint in the face of threat."[101] It is no surprise that soldiers in peacekeeping missions may "develop a fear of their own aggression, a situation that differs from soldiers in wartime operations."[102]

With the changes in warfare, the soldiers have had to adapt to a new enemy. Their training and society's influence has revolved around an enemy that was equal.[103] Conflicts of late have seen a new enemy including women, children and elderly, groups that society has spent centuries protecting. In Vietnam, it was not uncommon for the civilians to participate in the battles and ambushes, which created "rampant feeling that the whole country was the enemy and blurred the distinction between combatants and noncombatants."[104] During the conflict in Lebannon, it was not unusual for Israelis to be shot at by kids carrying RPGs.[105] These types of experiences added to the soldiers stress due to the fact that they were now dealing with "not only the inherent threat of injury and death but also the moral conflict it evoked in these soldiers, who were trained not to harm

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[100] Thomas W. Britt, "Psychological Ambiguities…", p 122.
[101] *Ibid*, p 122.
[102] Peter Warfe, "Post-Traumatic Stress and the Australian Defence Force: Lessons From Peace Operations in Rwanda and Lebannon," in *The Human Face of Warfare: Killing, Fear & Chaos in Battle*, ed by Michael Evans and Alan Ryan (Australia: National Library of Australia, 2000), p 86.
[103] In the Israel army "one of the key concepts of military training and indoctrination in the Israeli army is the concept of "purity of arms" which refers to the preservation of humane conduct in war." Zahava Solomon, *Combat Stress Reaction…*, p 83.
[104] *Ibid*, p 82.
[105] *Ibid*, p 76. The 10-year old kids were often referred to as "RPG kids", named after the automatic weapons that they carried.

children."[106] From another perspective, Israel soldiers are trained in the concept of "purity of arms" which revolves around the principle of humane treatment in the conduct of war.[107] During the Lebanon war it was very difficult for the soldiers to live by this principle considering, "the terrorists knew all of this and deliberately mingled with civilians; and there was nothing we could do because of the strict instructions."[108] Such conditions place undue stress on soldiers.

As previously discussed, training has been identified as a pre-deployment mediator of PTSD. In an ideal world, the soldiers would have the time to train for all eventualities. However, realistically, the military does not have that luxury. Although there has been an increase in peacekeeping missions, national security will always be at the forefront of any military's objectives. As such, soldiers will continue to be trained for combat. With ongoing participation in peacekeeping, the government will be relying on these soldiers to adapt and accept the stresses of assuming roles for which their training may not be suited.

PERSONNEL ROTATION

It is difficult to comprehend how troop rotation can impact on PTSD. The thought of moving troops in and out of theatres of operations appears to be straightforward. One would expect that the only problem that would be encountered would involve coordinating a military flight or chartering a civilian aircraft to accommodate the movement of a group or individuals. However, the amount of time it now takes to get someone from the frontlines to their homes and the rotation of

[106] Zahava Solomon, *Combat Stress Reaction…*, p 76.
[107] *Ibid*, p 83.
[108] *Ibid*, p 84.

individuals in and out of theatre could surprisingly have a significant impact on the development of PTSD.

Through the 20th century, increased technology has significantly improved transportation. The development of faster trains, more efficient ships, automobiles and aircrafts has tremendously improved society's transportation and as such has decreased the time it takes to get to one's destination. During WWI and WWII, the mode of transportation primarily used by troops to and from the area of operations was by ships, on lengthy transAtlantic/Pacific transits. Often members of a unit travelled together from the battlefield and spent hours together on the voyage home. It has been proven that these long transits enabled the soldiers to decompress, "detoxify the fear, horror, guilt and shame they were feeling by talking their experiences through with the most effective source of validation – the men who had shared those experiences."[109] They were able to rely on group cohesion and morale to help them through their experiences.

During the Korean conflict, the US military attempted to minimize the development of combat related stress by using fixed terms of service. It was felt that if the members knew how long they would be in theatre fighting, it would assist them in getting through this stressful period of time. As such, personnel were continually being rotated in and out of units as individuals and sent back home alone. This had a detrimental affect on group cohesion and morale and resulted in a weakened social support.[110]

Throughout the Vietnam War, a similar approach was used. In this particular case, there was the application of the DERO, "Date of Estimated Return from

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[109] Lieutenant Colonel Faris R. Kirkland, "Confronting Psychological…", p 37.
[110] *Ibid*, p 77.

Overseas"[111] which was given to each soldier prior to departing overseas. Again, it was felt that the knowledge of their return would alleviate much of the stress of combat. However, similar to Korea, movement of personnel were done as individuals making each tour a "solitary, individual experience."[112] One veteran put it best when he relayed his feelings of isolation while in Vietnam.

> For the first six months nobody talked to me because I was the FNG, the 'fucking new guy', and I was going to get them killed; for the second six months I didn't talk to anyone cause now they were the FNG and liable to get me killed.[113]

With the use of aircrafts to fly soldiers back to their nations it was not uncommon for members to be home within days. In one particular case, a Canadian veteran who served in Vietnam recalls his experience of being in the jungle when he received his order. He proceeded by getting onto a helicopter with the dead and the wounded and within forty-eight hours was in Vancouver in his mother's kitchen.[114] The affects of such occurrence can be viewed, as unnerving at best and their detrimental impact are still unknown to this date.

Conflicts that have since followed have seen Canadian units deploy as a group to and from the theatre. However, in an attempt to return troops home, aircrafts have been used resulting in the quick reunification of soldiers with their families and friends. As such, very little time is available for the soldier to decompress before reintegrating back into society.

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[111] "War, Wounds and Memory," directed by Brian McKeown, Passionate Eye, CBC Newsworld, 12 August 2002, [http://cbc.ca/cgi- bin/newsworld/viewer.cgi?FILE=P120020812.Html&TEMPLATE =pe2.ssi&SC=PI].
[112] *Ibid*.
[113] *Ibid*.
[114] *Ibid*.

All aspects of troop rotation factor into the challenges of the 21st century. They have a direct impact on group cohesion and morale, which are two factors that have been shown to mediate PTSD. The dilemma now faced is weighing the options of getting soldiers home quickly or giving them the time to adapt.

PERSONNEL REDUCTION

It is a known fact that in this day and age, there is an expectation that people should do more with less. The same principles hold true for the CF. During the last decade, the Canadian military has gone from a total strength of 85,000 to 60,000 in an effort to streamline the organization. At the same time, Canada has increased its peacekeeping commitments and has deployed its limited troops to over 23 different missions overseas, the highest number of troops deployed since the Korean War. This fact alone is having a significant impact on the CF's welfare. The increased number of deployments has resulted in many soldiers deploying on numerous missions, often within a year of one another. This has placed a tremendous toll on the members and their families. In addition, it has increased the chances of being exposed to CIs or traumas. Furthermore, the reduction in troops has created an atmosphere where many of the deployments are being augmented with personnel from other units including the reserves. This creates a problem because these soldiers are often brought into the unit at the last moment and as such have a very difficult time integrating within the unit. The lack of group support often adds undue stress on these augmentees who often feel that they are not part of the group. The outcome has been an increase in stress related illnesses.

Ironically, personnel reductions also equate to less medical professionals available to deal with these individuals.

It is a given fact that when the forces were reduced and the overseas commitment were increased, more soldiers would be called upon to deploy. However, the trend in the last decade has seen the number of missions increase dramatically resulting in members being deployed on multiple missions. During the last decade, the recurring commitments to both Bosnia and Haiti combined with new missions in Kosovo and Central Africa resulted in many units being deployed for 6 months, returning to Canada for one year and then redeploying for another 6-month mission. The crew of HMCS WINNIPEG deployed to the Arabian Sea in September 2002 after only being home for one year. In addition, after returning from OPERATION APOLLO, HMCS IROQUOIS spent only 10 months in Halifax before redeploying to the Arabian Sea. Many could argue that this is the price one must pay to wear the uniform. That is a valid point, however, as previously indicated these missions have changed drastically and the deployed troops are being exposed to greater traumas than ever experienced in earlier peacekeeping operations. Although removed from the atrocities witnessed on land, the ships' companies in recent time have experienced their own level of stress. The bombing of USS COLE has emphasized that even our ships at sea face a greater threat.

Recurring exposures to trauma does increase the chances of developing PTSD. In the Israel military, it is not unlikely for reservists to be called up for service during increased tensions. In one particular situation it was demonstrated that frequent reserve service impacted on inducing PTSD, "Moshe's initially mild symptoms became increasingly severe with each call-up until he finally asked for help during his third

period of reserve duty following the war."[115] Unfortunately this is the reality for members of the CF in the 21st century.

> Force reductions compound these problems: the increased demand for peacekeepers coupled with the reduced supply of available personnel combine to increase the tempo of operations, with all the problems prolonged exposures to operational and psychological demands have on them and their immediate families.[116]

With a decrease in overall strength and an increase in the number of people unable to deploy for various reasons, units have had to rely on augmentees to help support them. Often these individuals come from the Regular Force support trades and from the Reserve Force. These soldiers will often join the unit prior to the deployment and in some cases will be lucky enough to take part in the pre-deployment training with the unit. Then upon return to Canada, they will be quickly returned to their units.

Studies have shown that these individuals are at a greater risk of developing PTSD.[117] Colonel Marsha Quinn has indicated that the main reason behind this is that "Reserve soldiers or augmentees who are sent on deployment with a Regular Force unit are more susceptible to stress because they are not part of the unit's 'family' of closely banded soldiers."[118] It is important to remember that prior to spending six months on deployment, these soldiers have worked as a team for a number of years and in some cases, have previously deployed as a group. It is difficult for an individual to break into this tightly knit family. Although it is an unfortunate fact, it does illustrate that group cohesion is an important factor and the lack of it may mediate PTSD.

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[115] Zahava Solomon, *Combat Stress Reaction…*, p 215.
[116] Colonel J.G.J.C. Barabé, "The Invisible Scars…", p 12.
[117] André Marin, *Systemic Treatment of…*, p 36. LCdr (Ret'd) Passey, a former psychiatrist with the CF, has done extensive research with Canadian soldiers returning from overseas deployments and has medically treated many of these individuals that suffer from PTSD. His research has shown that there is a higher rate of PTSD in Reserve Force personnel.
[118] *Ibid*, p 37.

The increase number of people placed on sick leave combined with the original reduction places the CF at a strength well below 60,000. To make matters worst, as a result of the initial reductions, the CF now has fewer medical personnel to deal with those individual that are on sick leave. This vicious cycle will continue unless our overseas' commitment decrease or our recruiting efforts increase to meet our current personnel deficiencies.

STIGMA BEHIND MENTAL ILLNESS

Another challenge of the 21st century is society's views concerning mental illness. Although technology has made many changes in people's lives, perception of mental illnesses has not been affected.

> A prejudicial attitude towards mental illness is certainly not unique to the military. The CF appears to have had no more success than civilian organizations in accepting and dealing with mental illness as a legitimate health issue.[119]

It is true that this stigma is not a mediator for PTSD, however, it is a significant dilemma for the military leadership as emphasized by Mr André Marin, Ombudsman, in his report to the Minister of National Defence on the *Systemic Treatment of CF Members with PTSD*. The response of the CF leadership can indeed, whether during a deployment or not, act as a mediator for PTSD. More importantly, they can influence the environment to encourage the afflicted soldier to get help. It is important to remember that the troops' welfare should be their top priority.

> Mental distress still carries a stigma of shame, and in many cases the most difficult task is to persuade the patient that he is ill, or to persuade his family that their loved one is not about to be put away somewhere unpleasant.[120]

[119] André Marin, *Systemic Treatment of...*, p 56.
[120] Roy Brook, *The Stress of Combat…*, p 2.

Basically there are two major dilemmas that face the soldier and often prevent him from getting the help he needs. The first has to deal with his personal pride and the second with societal views.

The personal conflict that an individual with PTSD must confront has to deal with the society in which he was raised. In many cases, individuals are taught to be strong and to not express any true feelings or concerns for fear of being considered as weak. For example, in Israel the "masculine self-image is closely associated with military prowess."[121] Here a man is encouraged not to be "introspective or open about their weaknesses"[122] as such if he seeks help for mental stress he does so at a high price. Society will view him as not being able to solve his own problems and therefore "it forces him to admit that he could not cope 'like a man' with the task of defending home and country."[123] Unfortunately this attitude is shared by many societies and provides an explanation as to why so many individuals who are suffering with this illness have not come forward.

The second major obstacle that has been around for years is the challenge of dealing with society's and the military's views on mental illness. This problem is not only common within the CF but also in many other militaries throughout the world. For example, in Israel where, "the Israeli soldier has been regarded as the 'silver platter' on which the Jewish state was given,"[124] there are some dilemmas with respect to mental illnesses. Although their government has implemented rehabilitation policy for the war

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casualties, compensation for mental disabilities is much more difficulty to obtain.[125] Even in Israel, where the public is very supportive of their war casualties they have a difficult time accepting soldiers suffering from mental illnesses.

> All too often, battle-traumatized soldier is treated to blame and condemnation, to the usually unspoken but potent accusation that if he had done his job as he should have, he would have been injured physically and not mentally, as he claims.[126]

Indeed the stigma associated with mental illnesses has prevented the soldiers from obtaining appropriate medical help. Fuelled by personal pride and society's influence, soldiers prefer to live with their psychological problems rather then admit that they need help. Unfortunately society has made it very difficult for them to seek the medical assistance they require. The CF leadership indeed plays an important role with respect to this social stigma and the many other challenges that are present in the 21st century.

[125] Zahava Solomon, *Combat Stress Reaction…*, p 253.
[126] *Ibid*, p 253.

LEADERSHIP

> *PTSD is not a new problem, nor is it one that can be avoided. It is the cost of Canada's continued involvement on the world stage as a nation committed to preserving peace. The cost of this commitment should not be borne by the men and women of the CF. It is a national responsibility, one that the leadership of the CF and DND must make a priority.*[127]

It is not uncommon for the CF to be scrutinized by the media for its actions. As a reflection of society, the military and thus its leadership are held accountable to maintain the highest of standards that are set by society and envisioned for the general population. Right or wrong, this has become mainstream for the CF leadership. When an issue comes to light, especially in the press, it is expected to be resolved immediately, regardless of the programs that have to be implemented. Since the release of the Ombudsman report in February 2001, the media's attention has focussed on how the CF leadership is dealing with PTSD.

According to the press, the CF is not addressing PTSD. However, one has to realize that the media's views only reflect one small segment of the problem. To determine whether or not the CF leadership is taking an effective and proactive role in dealing with PTSD, parameters must be established in order that a logical assessment can be made. In the preceding section, the challenges of the 21st century were identified. These challenges were shown to be mediators for the onset of PTSD. Therefore, by demonstrating how the CF leadership is addressing these challenges, one can determine whether the CF leadership is being proactive and effective in this role.

[127] André Marin, *Systemic Treatment of…*, p ix.

PEACEKEEPING

One of the many challenges of the 21st century revolves around the frequency and changing nature of peacekeeping missions. In the 1990's, at the height of these deployments, the CF had reached a pinnacle of the number of soldiers deployed since the Korean War. Government's foreign policies were and remain at the base of these deployments and are reflective of Canada's willingness to play an active role in peacekeeping missions throughout the world. Unfortunately, politicians are unaware or unwilling to accept that the nature of these missions has drastically changed.

> Politicians think peacekeeping doesn't put soldiers under the same stresses as war, but we're dealing with a Government still stuck in Trudeau-era think [sic] and is anti-military. In the 1990's, we were involved in suppressing hot spots around the world, not peacekeeping. Canadian society has to accept that these guys are fighting wars on our behalf over there. We need to understand that as people.[128]

Although, the military is at the mercy of the Government, the CF leadership is not limited in what it can do. It was not until the military had cycled a number of soldiers through Bosnia and Croatia, where they were exposed to the increased tensions of peacekeeping missions, that the side effects became noticed. It is clearly apparent now, that the military was not prepared and did not have the appropriate mechanisms in place to deal with the psychological effects on the soldiers.[129] It was not until Colonel G.E. (Joe) Sharpe convened the Croatia Board of Inquiry in the summer of 1999, that the CF

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[128] "Battling Trauma," *Maclean's Archive*, 12 August 2002, [http://www.macleans.ca/xta-asp/storyview.asp?viewtype=search&tpl=search_frame&edate=2002/08/12&vpath=/xta-doc1/2002/08/12/qa/70166.shtml&maxrec=15&recnum=3&searchtype=basic&pg=1&rankbase=144&searchstring=POST+TRAUMATIC+STRESS]. This quote is from an interview that Sean M. Maloney, who teaches at the Royal Military College of Canada in Kingston, had with Tom Fennell from Maclean's World Editor on post-battlefield trauma. Maloney has written many books on the Canadian military.
[129] *Ibid*.

leadership realized that they had a problem on their hands and could not ignore PTSD.[130] Unfortunately, many soldiers, especially the Gulf War veterans were unable to convince the military that they had legitimate medical problems resulting from the war. There are over 150 Canadians, like Louise Richard, who served in the Persian Gulf War and are suffering from debilitating medical problems as a result of this deployment. Initially these members were told that the symptoms were "all in their heads" and for years the views of both the victims and the military drastically differed. It was not until July 1998, that the military concluded, "that the symptoms of Gulf War syndrome are related to the psychological stresses of war."[131] Finally, the military realized and admitted to the tolls that peacekeeping missions were having on their soldiers.

This position still holds true to this date. In his recent address to the Annual General Meeting of the Conference of Defence Associations in February 2003, it was apparent that the Chief of Defence Staff (CDS), General Ray Henault was cognisant of this impact when he emphasized "the ongoing challenge of our high operational tempo, and the stress it places on our people."[132] He also discussed the number of operations in which the military was currently involved including the deployment to Afghanistan to which he concluded, "our new mission to Afghanistan will likely necessitate a review of

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[130] Brigadier General G.E. Sharpe, *Croatia Board of Inquiry Leadership (and other) Lessons Learned* (Ottawa: DND Canada, 2002), p vii. The Board was ordered by General Maurice Baril, the Chief of Defence Staff, due to the publicity that was mounting as a result of allegations by retired Warrant Officer Matt Stopford regarding the possible environmental exposures that the soldiers may have suffered as a result of their tour of duty in Croatia. The BOI, through its investigation found that "the Canadian Forces were unprepared to deal with either the number or the type of casualties that resulted from operations in the region."

[131] Barbara Wickens, "The Mysterious Gulf War Illness," *Maclean's Archive*, 21 February 2000, [http://www.macleans.ca/xta-asp/storyview.asp?viewtype=search&tpl=search_frame&edate=2000/07/17&vpath=/xta-doc1/2000/07/17/canada/36991.shtml&maxrec=15&recnum=9&searchtype=BASIC&pg=1&rankbase=144&searchstring=POST+TRAUMATIC+STRESS].

[132] General Ray Henault, "CDS Speaking Notes," Annual General Meeting of the Conference of Defence Association, Ottawa, Ontario, 27 February 2003, [http://www.cds.forces.gc.ca/pubs/speeches/27-Feb-03-e.as].

our participation in some of these operations, particularly Bosnia."[133] Statements such as these are signs that the CF leadership is trying to address the problem of increased overseas deployments.

One could argue that these comments are just hearsay and in the long run, the CF leadership will succumb to Government pressures. To address such arguments, one simply has to refer to the decision that was reached regarding rotating the land troops in Afghanistan in the summer of 2002. In an unprecedented case, the CDS informed the Government, who was under a great deal of pressure from the United States, that the CF did not have the personnel required to maintain the long list of current operations, in addition to providing replacements for those in Afghanistan. The CF leadership, regardless of the consequences and realizing the toll that these missions were having on their members, maintained their position. As a result, the Government did not pursue a rotation of troops into Afghanistan.

Unfortunately this approach does not always work as apparent in the recent decision to deploy troops back to Afghanistan in the summer of 2003. When considering this case, it is important to remember two things. First of all, it will have been one year since the CF has embarked on any new missions, the time frame that conforms to current mandates regarding the minimum time that a member must stay at home before redeploying. Secondly, it signifies that regardless of the military's position on the issue, Government's agendas will always be the overriding factor and these are often beyond the military's control.

Since 1998, the CF leadership has implemented a number of initiatives to help alleviate the frequency of deployments. Among these, they have adopted a one-year

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[133] General Ray Henault, "CDS Speaking…".

waiver policy, which guarantees that a soldier will not be redeployed within one year of his last mission. This would enable soldiers to have sufficient time at home with their families. In addition, the post deployment leave which is based on the number of months that a member is deployed is but another initiative that strives to give members an opportunity to rest and reintegrate themselves within society prior to resuming their normal work routines.

Another challenge surrounding peacekeeping missions deal with the atrocities that are often associated with international conflicts. Since non-participation is not an option that the current Government will entertain, CF leadership can only ensure their soldiers are provided with the tools to cope with the possible atrocities they may encounter. This leads to the next challenge of the 21st century, that of training.

TRAINING

The numerous deployments have provided the CF with individuals possessing extensive experiences in a variety of peacekeeping missions. As previously stated, the CF trains its soldiers for combat in order to protect country and self. As such, peacekeeping training, which varies significantly with respect to the rules and regulations, is limited to unit level training prior to deploying. Therefore, this vast peacekeeping expertise at all levels of command has enabled units on the verge of deploying, to better prepare themselves both physically and mentally for the upcoming deployment. This experience enables one to understand and pass on to subordinate the very nature of peacekeeping missions. In addition, they are better able to explain how the missions are carried out and the ambiguity that are found within this milieu especially

when under the UN control. This was clearly apparent when one of the worst atrocities took place in Rwanda. Prior to the devastation, Lieutenant General Dallaire warned the UN that "the Hutu-led Rwandan government appeared to be planning the slaughter of Tutsis."[134] Unfortunately, the UN did not provide neither the authority nor the resources to Lieutenant General Dallaire in order to prevent this atrocity. These are but some of the challenges that the CF has to deal with in attempting to provide the best training to prepare their troops for overseas deployments. To the CF leadership's credit they have revamped the training to address some of these obstacles that will present themselves in these missions. Steps such as establishing the rotation schedule well in advance for units deploying to Bosnia enables the units to carry out mission specific training including rules of engagement. Furthermore, training centres such as those in Kingston and Cornwallis, specifically address peacekeeping and delve into the societal climates that surrounds the mission.

Regarding stress related training, units have revamped their pre-deployment procedures to take this into consideration. In particular three avenues are addressed. First and foremost, each member of the unit undergoes a detailed pre-deployment screening process. Regardless of the rank or position, each member is seen by a social worker or padre and medical officer to ensure that the member is emotionally and physically able to deploy. Secondly, members are provided with literature concerning deployment related stress. This includes the various CF pamphlets on signs and symptoms of deployment related stress.[135] Finally, a senior officer is assigned as the unit

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[134] D'Arcy Jenish, "Canada and the World…".
[135] These pamphlets are as follows: *Preparing for Critical Incident Stress; Preparing for Deployment Stress; Preparing for Reunion Stress*. Department of National Defence, A-MD-007-144/JD-004 *Preparing For Critical Incident…* Department of National Defence, A-MD-007-144/JD-005 *Preparing*

administrative stress co-ordinator. As part of his responsibilities he ensures that the selected peer counsellors are trained in areas regarding dealing with and helping others deal with CIs. In addition, along with the medical officer and the unit chaplain, a mental health nurse deploys with the unit. Together this trio provides ongoing training throughout the deployments and with assistance from the peer counsellors, they provide the necessary guidance and encouragement during stressful periods or after CIs.[136] Prior to returning to Canada, the members receive reintegration and stress management briefings by the chaplain, BPSO and the mental health nurse. Among other topics, these briefing address the issue of PTSD. In addition, the peer counsellors identify possible individuals that might need further assistance to deal with stress. Considering the delayed reaction of PTSD, it is difficult to validate the current initiatives that have been incorporated within the deployment cycle. However, the approach taken by the CF leadership is in line with current findings regarding dealing with individuals that have been exposed to traumatic experiences.

Steps are also being taken by the CF leadership to incorporate this important training within the curriculum of the various leadership and basic training courses at both the officer and non-commissioned levels. The Basic Officer Training Course (BOTC) has incorporated stress training within the Enhanced Leadership Model (ELM), which includes a segment on signs and symptoms of PTSD. As of July 2001, the Basic Military Qualification (BMQ), teaches four 40-minute periods on stress including CIS, PTSD,

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For Deployment Stress (Ottawa: DND Canada, 2000). Department of National Defence, A-MD-007-144/JD-006 *Preparing For*

stress management and recognizing suicide risks have been added to the curriculum. At the Senior Leadership Academy, which is the stepping-stone for future senior NCOs, two periods on operational stress are provided to the students.[137] The training is also being provided to middle management, the Lieutenant Colonels and Majors, two groups for which the Ombudsman feels is one of the problem areas within the military. Within the Canadian Forces Command and Staff College Course, which is attended by this specific rank level, the students receive a lecture on Combat Stress and the important role that the leadership must play with respect to this issue.

Some may express concerns that specific peacekeeping stress related training is not provided to members proceeding on these deployments. In a recent report on PTSD aired on CTV's W5, the question was asked why the CF did not incorporate the training that has been adopted by the US Special Forces Delta Forces at West Point. This training concentrates on training the soldiers' mind to help them avoid PTSD. However, in accordance with Lieutenant Colonel Dave Grossman who provides this training to the US Forces, there is no indication whether this training would work with peacekeepers, the principal "unofficial" role of the CF. As he emphasized, "We've put them in an impossible situation. We gave them weapons; we gave them training; we put them in a distant land and then we told them do nothing while innocent people were murdered."[138] To address this, Dr Megan Thompson, a social psychologist with Defence Research and Development Canada in consultation with the military, is involved with a long-term

[137] André Marin, *Systemic Treatment of…*, p 93.
[138] "Broken Soldiers…".

Deployment Stress Project, which is looking into the causes of stress in peacekeeping missions.[139]

The CF leadership has to approach the issue of training with caution. The current benefits that training provides are still unknown. In some instances, the post trauma incident training could be more detrimental. In one study published in the Canadian Journal of Diagnosis, researchers analyzed the results from a number of studies that addressed the effectiveness of this training. The results concluded that the briefings, "did not contribute to preventing or reducing symptoms of PTSD. In fact, outcomes appeared better among control subjects then among the people that attended [this training]."[140] This further justifies the CF leadership's methodical approach regarding stress training. It is important to remember that their priorities are to the well being of the troops. Without them, they cannot meet their objectives of having a fighting force.

PERSONNEL ROTATION

Regarding personnel rotation, the military is implementing some effective steps to provide their soldiers with the opportunity to decompress before being re-integrated back into society. During the recent redeployment of the troops from Afghanistan, the soldiers were sent through Guam. The majority of the unit remained in Guam for three to five days where they received the necessary post deployment training including CI debriefings.[141] Here they were given the opportunity to slowly re-integrate within society without the pressures from family and friends. In addition, upon their arrival back in

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[139] Carol McCann, "DCIEM, Comments…", p 7.
[140] A.A. van Emmerik, J.H. Kamphuis, and A.M. Hulsbosch, "Post-Traumatic Stress Disorder One Day's Rest Enough?," *The Canadian Journal of Diagnosis* (December, 2002), p 19.
[141] CTV News Staff, "Soldiers Face Stigma Dealing With Stress: Marin," [http:www.ctv.ca/servlet/ArticleNews/story/CTVNews/1040151901495_13//], 18 December 2002.

Canada, they were not immediately sent off on leave. Instead for the first couple of weeks they continued to work part time. This helped to ease them back into a normal routine with their families and in addition, gave them an outlet to discuss the deployment with peers who had experienced similar tensions. This enabled them to become accustom to their daily routine, prior to deploying. As such, the soldiers did not have to deal with the pressures of being away from their families and then the shock of being with them on a 24-hour basis.

PERSONNEL REDUCTIONS

The CF leadership is currently addressing the dilemma surrounding personnel reductions. Presently, there are a number of initiatives in place for recruiting and money is being put into these projects in an attempt to increase the total number of soldiers, especially in those trades that are deficient. Although the CF leadership is doing everything it can, it is being faced with stiff competition from the high tech industries. Unfortunately in this day and age, this will continue to be an ongoing problem.

With these shortages, units are relying on augmentees, including reservists, to bring them up to strength. At the present, all efforts are being exhausted to try to get these individuals into the unit early enough to involve them in the training thus integrate them within the unit and the group cohesion. In addition, every effort has been implemented to ensure that appropriate follow-up actions are carried out at the member's unit. In this particular case, COs are sending letters to both the augmentees' COs and medical officers to ensure that appropriate follow-up actions are implemented.

One could argue that if the military is suffering from a shortage of personnel why are they releasing those individuals that are trained but suffering from PTSD. Some feel that these individuals could be retrained in another classification. In one Edmonton newspaper article, Mike Hogan who is responsible for the soldiers on the Service Personnel Holding List was quoted as saying, "they can be trained for other trades, and would repay the second chance with a lot of loyalty, and they would also bring a lot of maturity and wisdom to their new job."[142] This statement goes without saying, however, to what trade could they be reclassified? During the past decade all environments within the CF have deployed and been exposed to the new age of peacekeeping. In the navy alone, since September 11th, over 4,500 sailors out of strength of 9,000 have been deployed on OPERATION APOLLO.[143] There would be no trades that could guarantee that these individuals would not be deployed. As harsh as this may sound, the military leadership cannot take such a chance with a member's well being.

STIGMA

The stigma surrounding PTSD is not only prevalent within the military but society as a whole. The general public is still unable to deal with injuries that are not visible to the human eye. Mental illness, is still viewed with scepticism and unfortunately, this perception has not changed. Although this stigma is not a mediator for PTSD, it is a significant dilemma for the leadership. The reason for this is twofold. The first is with respect to the attitudes held within the military and second with societies' opinions. It is

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[142] Paul Cowan, "Stress? Get outta here! Forces Discharging PTSD Soldiers Instead of Working With Them Says Specialists" *The Edmonton Sun*, 23 March 2003, [wysiwyg://7/http://www.canoe.ca/EdmontonNews/es.es-03-23-0015.htm].

[143] Vice Admiral R.D. Buck, "Chief of Maritime Staff Issues and Challenges," Command and Staff Course 29 – Naval Component, Toronto, Ontario, 1 April 2003.

clearly apparent that the CF leadership cannot address the perception of a nation. However, its influence cannot go unnoticed especially with the impact that it has on that part of the society found within the military. It is important to remember, "[a] soldier is a mirror of the society from which he comes."[144]

On several occasions and especially recently as a result of his investigation into the *Crazy Train* incident[145] in Winnipeg, the Ombudsman has chastised the military for not eliminating this stigma. He has indicated that there is a requirement for zero tolerance against those affected.[146] In his report, Mr Marin once again re-emphasized that the problem exists at the regional and unit levels of command.

> There is no doubt that at National Defence headquarters (NDHQ) in Ottawa, there is a full and mature appreciation of the problem and efforts are being made. I fear that there is a disconnect, however, between the commitment at the top , and the sensitization of those in position of command in the regions. This must be addressed.[147]

This level of command, primarily made up of the Lieutenant Colonels and Majors, has a significant influence over subordinates. It is clearly apparent that the senior leadership is cognisant of PTSD and are aware of the steps that need to be taken with respect to accepting and dealing with it. However, the problem arises in getting the middle management to perceive it in the same manner. It is clear that attitude at this level need to change before the stigma that currently exists can be eliminated. The senior CF leadership have taken steps in attempting to educate this group of officers.

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[144] Richard E. Cavazos, "The Moral Effect of Combat" in *Leadership on the Future Battlefield*, ed by James G. Hunt and John D. Blair (Virginia: Pergamon-Brassey's International Defence Publishers, 1985), p 17.
[145] The report was as a result of "a complaint that a parade float entered in the Grey Cup celebration on November 22, 2002, mocked soldiers who have been diagnosed with operational stress injuries." André Marin, *Off the Rails: Crazy Train Float Mocks Operational Stress Injury Sufferers*, Report to the Minister of National Defence Pursuant to the Ministerial Directives, March 2003 (Ottawa: DND Canada, 2003).
[146] CTV News Staff, "Soldiers Face Stigma…".
[147] André Marin, *Off the Rails*…, p 4.

In the document *Officership 2020* the former CDS, General Maurice Baril stated, "undeniably, the 1990's represented the first strong test of the contemporary CF officer corps and we found that part of it was broken."[148] As such, efforts were put towards analyzing the future officer professional development. The various internal and external studies that took place identified the requirement to establish a leadership institute as "the central point for the CF's effort to continually research, evaluate historical and contemporary knowledge and alternative points of view on leadership."[149]

In September 2001, the Canadian Force Leadership Institute (CFLI) was established. As the centre of excellence for leadership research and development in the CF, this group's mandate is to "strengthen the foundation of CF leadership, capitalize on the wealth of experience in our Officers and NCMs and articulate enduring military principles."[150] Since being established, this organization has sponsored a number of research pertaining to leadership. Cognisant of the importance to determine the correlation between leadership and stress, the CFLI sponsored Dr Kelloway and Dr Francis from Saint Mary's University to research stress and the role played by leaders. Findings from their papers emphasized the critical role that the leadership lays with respect to the well being, both physical and mental of their subordinates. More specifically it revealed that, "leaders can be seen as a source of stress, a source of social support and a resource."[151] The importance of such research enables CFLI to implement changes to further strengthen the foundation of CF leadership. Such initiative by the CF

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[148] Captain (Navy) A.C. Okros, "Development of the Canadian Forces Leadership Institute" (paper presented at the Center for Hemispheric Defense Studies Research and Education in Defense and Security Studies, Washington, DC, May 22-25, 2001), p 3.
[149] *Ibid*, p 8.
[150] Department of National Defence, *Canadian Forces Leadership Institute Mandate* (Ottawa: DND Canada, 2001).
[151] E. Kevin Kelloway, Ph.D. and Lori Francis, Ph.D, "Stress: Definitions, Interventions and the Role of Leaders," Saint Mary's University, Halifax, NS, 2003, p 42.

senior leadership emphasizes the fact that they are aware of the requirement to educate their middle management. This has been further strengthened in the revised *CDS Guidance to Commanding Officers*. In this document, the CDS has dedicated a specific chapter on Stress Management.[152]

Within the military there is a "macho atmosphere that is slow to modernize its attitude."[153] These feelings will continue to prevail regardless of how the leadership addresses this stigma. To be able to fight, a military cannot show any signs of weakness even though "emotion[s] cannot be far below the surface, even in an army that rejects the modern fad for showing feelings."[154] These types of feelings are unlikely to change. However, they do not necessarily obstruct changes in attitudes. This was clearly apparent in the early 1990's when the CF leadership was addressing and taking actions against sexual harassment.

> In the mid-1990's, amid a series of scandals over sexual harassment in the military, the generals decided to crack down. They ordered military police to hunt down and prosecute harassers. There were high-profile courts martial, including one of a colonel decorated during the Gulf War.[155]

With this belief, the CDS, Gen Henault is cognisant of the problem and has often reiterated this position.

> We are working vigorously to change the culture within the Canadian Forces to eliminate the stigma that is sometimes attached to operational stress injuries… or any type of mental injury. Failure to respect our people and treat them properly will not be tolerated.[156]

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[152] General Ray Henault, "CDS Guidance to Commanding Officers," [http://www.forces.gc.ca/health/engraph/home_e.asp.], 2003.
[153] Oliver Moore, "Badge of Dishonour…".
[154] John, Keegan, "Soldiers Don't Like War, but When It Comes, They Want To Be There," *The Daily Telegraph*, 20 March 2003, [wysiwyg//31http://potal.telegraph.co….jhtml?xml=/opinion/2003/03/20/do2001.xr].
[155] John Ward, "Dealing With Post-Traumatic Stress Needs Tough Actions," [http//www.ottawalynx.com/Health0202/13_stress-cp.html], 13 February 2002.
[156] CBC News Online Staff, "'Culture of Shame' Surrounds Military Stress, Says Ombudsman," [http://cbc.ca/storyview/CBC/2002/12/18/stress_military021218], 18 December 2002.

With a firm stance and acceptance of responsibility, the CF leadership has set the stage for addressing the issue regarding this stigma. They are well aware that it will take more then just stating their position. Consequently, programs such as the Operational Stress Injury Social Support (OSISS) were established to "provide the best possible peer support to the men and women of the Canadian Forces, who continue to participate in an ever-demanding operations around the world."[157] However, many including the Ombudsman have publicly criticized the military for not making these centres available off base so that the members will not be reluctant to attend and not fear being seen entering those buildings located on the bases. The CF leadership, is still investigating this possibility, however, to date appear to be somewhat hesitant to make this project happen. LGen Couture, the Associate Deputy Minister for Human Resource – Military (ADM (HR Mil)) in response to these queries fears that such centres will further ostracize the inflicted members. "What I do not want to create is reinforcing the stigma that you do not belong anymore to the military family and that's the reason why we'd be treating you off base."[158]

Another important tactic that must be employed by the CF leadership is educating their troops. It has been demonstrated that this is ongoing. Key courses attended by all members of the military at some stage of their careers have incorporated stress and PTSD training into their curriculum. In addition, this training is also part of the deployment cycle and the soldiers are closely monitored by qualified individuals to ensure that they are cognisant of the signs and symptoms. Finally and to some extent ironically, the media is helping the military. The continual coverage of stress related cases resulting

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[157] "Operational Stress Help Available," *The Lookout (Vol. 47, No. 45),* 12 November 2002.
[158] CBC News Online Staff, "Culture of Shame…".

from operational deployment combined with outcries over the outcome of the Ombudsman report are paying huge dividends. Although the military may not always be well portrayed, they are not fighting these news stories because they realize that these are educating the general public and thus their subordinates. In such cases, the CF leaderships' reputation is paying a small price for the overall good that this press is doing in changing attitudes and thus helping to eliminate the stigma. As Mr Marin has conceded, "the culture of shame surrounding operational stress injuries has to be changed – something he admitted would take time."[159] Dr John Service, the Executive Director of the Canadian Psychological Association, has emphasized that the military has taken steps forward and "[t]hey just need to do a better job of it and they need to do it probably with more resources but to say they haven't been concerned and attentive to it is incorrect in my opinion."[160]

Leadership plays a significant role and has the sole responsibility for dealing with the issues surrounding PTSD. Although it is a medical problem, the CF leadership has to ensure that the proper steps are taken to deal with it. For the first time between conflicts, the CF leadership has been proactive. They are cognisant of this critical condition that affects between 15-30% of the CF.[161] The issues addressed in this section are but a few of the initiatives that the CF leadership has been busy addressing and implementing. It is clearly evident that their actions to date will have a direct impact on helping those afflicted with PTSD. Is there more work to be done? That goes without saying,

[159] CBC News Online Staff, "Culture of Shame…".
[160] John Ward, "Dealing With Post-Traumatic…".
[161] CTV News Staff, "Military Ombudsman Releases Report on Stress," [http:www.ctv.ca/servlet/ArticleNews/story/CTVNews/10248948790954_20303990//], 5 February 2002. The figures quoted are provided by Dr Diane MacIntosh who is based out of Edmonton and has worked with soldiers like Christain McEachern.

however, it is obvious that this will be an ongoing issue especially considering that PTSD can remain dormant for years before it manifests itself.

CONCLUSION

A warrior I have been … A hard time I have now[162]

Chief Sitting Bull

For centuries soldiers have been living with the demons brought on by the horrors of war. These psychological casualties were willing to surrender their lives for that of their countries and as a result paid dearly for their ultimate sacrifice. Not only are they suffering the medical and mental problems associated with PTSD, they have also had to live with being ignored by a society that is unable to accept a casualty for which the injury is not visible. With the start of the new millennium one would have hoped that technological advances and changes in the overall quality of life would have modified society's views regarding mental illnesses. Unfortunately, this has not materialized and these casualties are living with this knowledge and questioning why.

The CF has been guilty of not being more proactive regarding the mental condition now referred to as PTSD. Although by the end of most major wars, the CF leadership and medical professional were proactive regarding dealing with psychological casualties. These important lessons were soon forgotten one the conflict was over and follow-up actions were never pursued. Towards the end of the 20th century, the CF leadership was still fighting the issue regarding the possibility that their soldiers could be suffering from psychological injuries as a result of their participation in conflicts sanctioned by the country. The battles that were fought with the Gulf War Veterans are clear indications of the CF leaderships' denial that such injuries could be happening and at such a latent stage. Had it not been for the Croatian report, media pressures and for

[162] "War, Wounds…".

that matter the 2002 Ombudsman report, it is difficult to assess whether or not the military would have become as proactive with respect to PTSD. Regardless of how the CF leadership was coerced into addressing this the fact remains that they have accepted their shortfalls and are facing the challenge presented to them.

Since the late 1990's, the CF leadership has been faced with a number of challenges including peacekeeping, training, personnel reductions, personnel rotation and stigma, that have been found to act as mediators for the onset of PTSD. In an attempt to deal with PTSD, the CF leadership has placed an inordinate amount of effort and resources towards addressing these challenges. The last few decades has seen the CF deploy on countless peacekeeping missions, which have metamorphosis. The once peaceful missions are now inundated with increase tensions, lack of direction and above all, atrocities that have seen our soldiers exposed to sights and sounds that have had lasting impressions. Cognisant of these changes, the CF leadership is closely monitoring the operational tempo and has taken a firm stance on the feasibility of deploying its troops. They are finally realizing that as a result of decreases in personnel and increases in number of deployments that apart from maintaining the number of deployed personnel, these folks are also being called upon to redeploy on more than one mission therefore increasing their chances of being exposed to CIs. The CF leadership has implemented a number of initiatives including waivers whereby members cannot redeploy prior to be home for one year, post deployment leave to help the member re-integrate back into society and screening processes to ensure that a member is both physically and mentally fit to proceed on operations. Over and above these initiatives, the CF leadership has also made some significant changes regarding training.

Although soldiers will continue to be trained for combat in order to protect country and self, pre-deployment training has been revamped to make it more conducive to the mission. Relying on the peacekeeping experience that their subordinates have gained as a result of the increased number of deployments, the CF leadership has used this pool of knowledge to help prepare the troops for their upcoming deployments. These preparations have included stress related training to prepare the members for the possible CIs they or their peers may encounter and how to address and deal with these occurrences. In consultation with the CF leadership, DRDC is involved in a long-term Deployment Stress Project, which hopes to determine the cause of stress in peacekeeping missions.

Aware that not everybody will be receiving such predeployment training, the CF leadership has mandated changes to some of the core CF courses including basic training for both NCMs and officers and the various leadership courses that are offered later in their careers. By incorporating such training early in their career, the CF leadership hopes to educate their soldiers and thus help them understand that PTSD is a legitimate illness and therefore try to alleviate the stigma associated with it.

The stigma, present both within the military and society, proves to be the biggest obstacle being faced by the CF leadership. Not only is the CF leadership trying to change attitudes within the CF, especially at the middle management level where unit level COs have a significant influence with subordinates, but they are also trying to accomplish this task faced with the obstacle that society's views have not changed. Continued efforts by the CF leadership and such agencies, as CFLI will eventually break through these barriers.

For the first time in history, the CF leadership is taking responsibility for leading the campaign to address PTSD during a post-conflict era. Is there more work to be done? That goes without saying, however, the CF leadership is showing that it is taking an effective and proactive role in dealing with PTSD.

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