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CANADIAN FORCES COLLEGE / COLLÈGE DES FORCES CANADIENNES
CSC 33 / CCEM 33

EXERCISE/EXERCICE NEW HORIZONS

**Understanding the Contingent Components to Aid in PTSD Reduction Among Augmentees
and Reservists – A Commander’s Broadening Responsibilities**

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Introduction

Operational stress injuries (OSI) of Canadian soldiers are currently receiving a renewed amount of interest. Be it concerns of the incidence of Post Traumatic Stress Disorder (PTSD) correlated to gender¹, or the increase of PTSD following intense combat in Afghanistan², we must remind ourselves that OSIs are not a new phenomenon. Historically, described as shell shock, combat fatigue, combat stress reaction or post traumatic stress disorder, OSIs have been around for a long time and have often mystified those attempting to treat them. History has unfortunately also demonstrated that an inability to recover may cause a previously fruitful member of the community to return from combat as an ineffective shell of their former self, having their health and interpersonal relationships with loved ones negatively impacted.

It must be acknowledged that people will not readily admit the effects of stressors or their importance. It is neither socially desirable to do so nor likely to make a positive contribution to self-image. However, to willfully ignore the significance of these pressures for command is to court inefficiency if not disaster. It is far more beneficial to identify the stressors, analyse their causes, and eradicate or, at least, control them and their impact.³

What has, thankfully, evolved over time are the observations that certain treatments aid in the prevention of OSIs as well as the recovery of the member and assist in a return to effective functioning. For combat-related stressors, the community support and effective integration of soldiers returning from operations into their units or homes appears to have the greatest influence on the development of long-term psychiatric sequelae.⁴ In addition, of particular concern to

¹ Naomi Breslau, et al., "Sex differences in posttraumatic stress disorder," *Archives of General Psychiatry*, 54, no.11 (November 1997): 1044.

² Bruce Campion-Smith, "When war returns with the soldier," *Toronto Star*, 17 February 2007, F5.

³ Glynis Breakwell, and Keith Spacie, "Pressures Facing Commanders," *The Strategic and Combat Studies Institute*, Occasional Paper, no. 29, 1997, 27.

⁴ Ronald J. Koshes, et al., "Debriefing Following Combat," in *War Psychiatry* (Office of the Surgeon General: TMM Publications, 1995), 273.

current Canadian operations is the growing percentage of augmentees, and in particular reservists, in the deploying contingents. Evidence is pointing to the fact that the support mechanisms available for Regular Force personnel are not there for Reservists.⁵ Commanders must be cognizant of this fact as it behooves them to care for OSIs among their troops.

It is these observations and subsequent guidelines for commanders that will be examined in this paper to assess the value of a relatively recent introduction to the Canadian Forces operational doctrine, that of Third Location Decompression (TLD). Of particular importance will be the utility of these intervention measures to program the transition between theatre and home. TLD will be demonstrated to afford the soldiers the time to adapt back to a westernized culture and home life role and it will also provide health care specialists with a teachable moment to convey aspects of a healthy lifestyle.

This report will conclude with recommendations to commanders regarding the requirement for TLD following operational deployments – recommendations that may assist in reducing the prevalence of OSI in their troops.

History

Since Johannes Hofer first published an article in 1678 in the medical literature, the recognition that stress affects those who serve in combat has been well documented and studied. Observations were first made of soldiers returning with a ‘disease’ exhibiting symptoms of dejection, melancholy, incessant thinking of home, insomnia, weakness, loss of appetite, anxiety,

⁵ Ombudsman National Defence and Canadian Forces, “News Release – Ombudsman Launches New Investigation into the Treatment of Injured Reservists In Releasing his 2005-2006 Annual Report,” http://www.ombudsman.forces.gc.ca/mediaRoom/newsReleases/2006/06-06_e.asp; Internet; accessed 16 December 2006.

etc. Hofer's case descriptions led the medical profession to diagnose this disease as 'nostalgia', based on the most prevalent symptom.⁶

During the First World War, however, casualties that could not cope with the strain of combat were diagnosed as suffering from 'hysteria', a disease believed caused by lack of will, laziness or moral depravity.⁷ While they still exhibited the same symptoms of 'nostalgia', they were now viewed as being weak or lazy. They were largely evacuated to Britain and given rest and sympathy. Most ended up institutionalized and became chronic cases.⁸ Something had to be done, however, when the first Battle of the Somme in July 1916 demonstrated that losses due to mental strain took a terrible toll on troop strength. Several thousand soldiers had to be withdrawn from this battle due to nervous disorders. Consequently, by 1918, out of necessity for troop numbers, some patients were treated in a manner similar to modern treatment using principles of proximity, immediacy, expectancy, and simplicity (commonly referred to as PIES) and some progress was made.⁹ Unfortunately, many were still being repatriated to Britain and Canada and were subject to a range of treatments from forceful counseling to electric shock therapy.¹⁰ The rationale for this type of care was that the soldiers must have afflictions of a physical cause or organic injury. There were strong, unconsciously determined resistances to "the idea that the

⁶ Department of National Defence. "Historical and Contemporary Interpretations of Combat Stress Reaction." *Reports and Studies: Board of Inquiry* – Croatia, Ottawa, ON: Department of National Defence, 2000, pg 2.

⁷ Department of National Defence. "Historical and Contemporary Interpretations of Combat Stress Reaction." . . . , 3.

⁸ *Ibid.*, 3.

⁹ Center for the Study of Traumatic Stress, Department of Psychiatry, Uniformed Services University of the Health Sciences, "War Psychiatry Today: From the Battle Front to The Home Front." <http://www.centerforthestudyoftraumaticstress.org/downloads/WarPsychiatryExecSumUrsano-2005.pdf>; Internet; accessed 10 April 2007.

¹⁰ Department of National Defence. "Historical and Contemporary Interpretations of Combat Stress Reaction." . . . , 3.

British soldier or ‘hero’ would show “mental’ symptoms”, as these psychoneurotic disorders would be an evasion of duty and “shameful evidence of ‘moral weakness’.”¹¹ Therefore, the new and more palatable diagnosis of “shell shock” was used to describe what was thought to be physical damage to the nervous system caused by the concussive force of exploding shells. Being sustained in the course of actual fighting, shell shock was, therefore, morally justified.¹²

During the Second World War, similar types of stress-induced illnesses were seen but attitudes regarding these newly termed neuropsychiatric disorders had changed. One of the problems was in the selection of soldiers. With no pre-deployment assessment of psychological fitness, many unfit soldiers ended up in uniform.¹³ Long psychotherapeutic modalities were employed, frequently preceded by heavy sedation. Consequently low return rates were once again experienced. For example, the US Army’s campaigns in North Africa and Sicily saw 35 percent of all non-fatal casualties diagnosed as ‘psychiatric’, but no more than three percent were ever returned to combat following evacuation for care¹⁴. With an average ratio of 25 percent of casualties suffering from neuropsychiatric disorder, the Allied armies resorted to methods introduced during the First World War involving forward treatments and more positive response rates ensued.

¹¹ Robert H. Ahrenfeldt, *Psychiatry in the British Army in the Second World War* (London: Routledge and Kegan Paul, 1958), 6.

¹² Robert H. Ahrenfeldt, *Psychiatry in the British Army in the Second World War*. . . , 6.

¹³ Department of National Defence. “Historical and Contemporary Interpretations of Combat Stress Reaction.” . . .,4.

¹⁴ Richard Gabriel, *No More Heroes: Madness and Psychiatry in War* (New York: Hill and Wang, 1987), 117.

Recent Insights

As successive campaigns evolved, more information regarding neuropsychiatric disorders was experienced and studied. The Korean conflict validated the concept that unit cohesion and morale were key supporters that permitted soldiers to deal effectively with combat related stress.¹⁵ Additional information came from the Yom Kippur War in October 1973, in which early Israeli Defence Force (IDF) reports indicated Combat Stress Reaction (CSR – a contemporary term describing stress caused by combat exposure or intensive operations) casualties comprised 60 percent of total casualties, however once the IDF regained the upper hand in the conflict, CSR casualties dropped to 30 percent of total casualties. The opposite occurred in the 1982 Lebanon conflict wherein early Israeli successes and the conviction that they were fighting for a just cause saw the IDF suffering few CSR casualties. With mounting doubts about the righteousness of the Israeli action and the advance becoming slowed, CSR casualties of 23 percent were reported.¹⁶ Clearly, both the intensity/nature of the operation and the societal attitudes were becoming identified as significant contributing factors.

Therefore, an evolution in causality has emerged from one equating CSR symptoms with a psychological disorder of physical weakness to that of social psychology. CSR casualties were now being tied to a group phenomenon whereby the collapse of the social network of support was the cause of the symptoms. The social psychological model views CSR as a perfectly normal reaction to the loss of a group support system designed to help the individual survive in combat.

¹⁵ Richard Gabriel, *No More Heroes* . . . , 121.

¹⁶ Department of National Defence. “Historical and Contemporary Interpretations of Combat Stress Reaction.” . . . , 5.

Consequently, the approach is to restore the support systems that permit the member to function effectively.¹⁷

Being a reaction to trauma, CSR is not static, and instead evolves over time. The stages have been described as being acute and chronic.¹⁸ The acute stage crystallizes the initial emotional and behavioural manifestations into defensive structures. In the chronic stage, commencing a few months or more after the incident, many of the symptoms diminish, but there may remain a nucleus of post-traumatic syndrome, usually in the form of PTSD. It is important to understand, however, that PTSD is not necessarily an undiagnosed or untreated extension of CSR. PTSD may result from inappropriate treatment of CSR, but the development of PTSD is not dependant on CSR.¹⁹ PTSD, as a clinical condition, is predicated on the experience of an overwhelming trauma and consequent biopsychosocial adaptation. The Diagnostic and Statistical Manual of Mental Disorders, 4th ed. establishes criteria whereby the individual must re-experience the event, such as through intrusive recollections, distressing dreams, and avoidance procedures and may display such symptoms as hyperalertness, vigilance and irritable behaviour. The symptoms must last for at least one month and must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.²⁰ The stress of

¹⁷ *Ibid.*, 5.

¹⁸ Shabtai Noy, "Combat Stress Reactions," in Handbook of Military Psychology, Reuven Gal and A. David Mangelsdorff, eds. (Chichester: John Wiley, 1991), 515.

¹⁹ The Army Lessons Learned Centre, "Stress Injury and Operational Deployments." *Dispatches: Lessons Learned for Soldiers* 10, no. 1 (February 2004): 6.

²⁰ Merck Source, Resource Library, "Posttraumatic Stress d. (PTSD)," http://www.mercksource.com/pp/us/cns/cns_hl_dorlands.jspzQzpgzEzzSzppdocszSzuszSzcommonzSzdorlandzSzorlandzSzmd_d_24zPzhtm#12308074; Internet; accessed 11 January 2007.

combat does not inevitably result in PTSD, but early intervention appears to assist in interrupting the connection.²¹

Non-intervention Concerns

PTSD has been identified as a serious health problem after the soldiers have returned home.²² While the individuals may have been an immediate concern to the commander in the field, they eventually, if not successfully treated, represent a loss not only to the armed forces but also to society as a whole. Instead of being a productive and contributing member, they may be unable to work and must eventually depend upon social assistance or a military pension after their military service is concluded.

Symptoms of PTSD are often categorized into two areas of physical symptoms and mental or emotional symptoms. Physical symptoms include such things as aches, pains, easy startling, cold sweats, upset stomach, vomiting, feeling tired, drained, distant or haunted look, substance abuse, motor disturbances, visual problems, auditory symptoms, tactile sensory changes, speech changes, and more. Mental or emotional disorders encompass such things as anxiety, increased irritability, disturbing easily, difficulty in remembering details or paying attention, troubled sleep, grief, anger, and others. Changes in behaviour are often a natural reaction to military deployment, and may not be abnormal or problematic. It is often helpful, in fact, for unit members to hear that others are experiencing similar reactions and that these

²¹ Ronald J. Koshes, et al., "Debriefing Following Combat," . . . , 273.

²² Department of National Defence, "Historical and Contemporary Interpretations of Combat Stress Reaction." . . . , 11.

reactions often improve over time. However, when the reactions become extreme, and/or prolonged, this may be the indication for the need of psychological intervention.²³

Treatment Objectives

Prevention of CSR and PTSD has been most cost-effectively aimed at the indirect and preventive avenue. In the pre-trauma and acute stages, treatment has focused on strengthening the organization in order for it to support its members. Of utmost importance is consultation with the leadership because of the central role of the commander in the soldier's chances for survival. Indeed, while the responsibility for stress management lies with the individual soldier, management of CSR is a leadership function.²⁴ Instilling trust in one's soldiers appears paramount in reducing the incidence of PTSD and this is most easily achieved through ongoing combat drills, thereby promoting skill and confidence. Also introduced at this time would be a regular physical fitness training routine, shown to increase tolerance and reduce the impact of combat stress²⁵ The aim is directed at reducing the level of anxiety before and during combat. Commanders may also be instrumental in the healing process by understanding the importance of ordering soldiers to stay together as a group after experiencing massive stress and that reaction not be labeled as an illness, but rather a normal abreactive process of healing.²⁶

There is, however, no way to prevent combat casualties including those experiencing CSR and PTSD.²⁷ Anxiety on the battlefield is a normal reaction to the threatening experience

²³ NATO Task Group HFM 081/RTG, *A Leader's Guide to Psychological Support Across the Deployment Cycle*, Pre-release of NATO Task Group Human Factors and Medicine Panel of the Research & Technology Organisation (RTO-TR-HFM-081) 2007, 24.

²⁴ The Army Lessons Learned Centre, "Stress Injury and Operational Deployments," . . . , 4.

²⁵ *Ibid.*, 19.

²⁶ Shabtai Noy, "Combat Stress Reactions," . . . , 521.

²⁷ *Ibid.*, 520.

and as long as the soldier feels able to continue coping, the anxiety is quite normative. A failure to adapt is the commencement of the acute stage of CSR and the possible beginning of PTSD.²⁸

Modern treatment modalities focus on adaptive coping rather than on the symptoms. It adapts the discomfort of the intrusions of thoughts, images, or dreams as a part of the healing process.²⁹ The overall goal, therefore, is to pause the loss of equilibrium and assist the individual's spontaneous inner forces that are trying to regain homeostasis, an essential for preventing exacerbation and chronicity. The debriefing process is one method that has proved particularly instrumental in reducing these untoward effects of trauma.³⁰ It is a structured meeting designed to permit the ventilation of feelings, fears and stories about the traumatic event. It is viewed as the beginning of the healing process, ultimately aimed at facilitating the member's reentry into the community.³¹

The comprehension of these facts is required information for all soldiers deploying on and returning from operations. Seminars regarding CSR are built into the pre-deployment schedule of present day deployments. While the efficacy of seminars, as opposed to more in-depth discussions, may be questioned and may require more study, the hope is that it will assist members to identify symptoms of CSR within themselves or others, thereby prompting assistance. At the conclusion of an operation, however, there are additional stressors involved with the reintegration procedure. For example, the social support and unit cohesion that was so important while in theatre is now lost, and the home support network has, in their absence, learned to adapt without them. Additionally, those who have avoided needed intervention or who

²⁸ *Ibid.*, 522.

²⁹ *Ibid.*, 517.

³⁰ Ronald J. Koshes, et al., "Debriefing Following Combat," . . . , 273.

may develop latent symptoms may require a reminder of the aspects of their behaviour of which they should be aware. This is the rationale behind post-deployment briefings, with one of the possible venues being that of third location decompression (TLD).

Third Location Decompression

Third Location Decompression is an opportunity for members who have undergone a period of prolonged and/or intense stress during an operational deployment to experience rest, relaxation, education and possible intervention at a location away from the theatre prior to returning home to the potential reintegration stresses associated with families and friends.³² Historically, decompression-like activities took place through the use of ship transport of troops. During the voyage the time aboard ship allowed for a clean break from theatre, permitting an opportunity for post-deployment medical examinations, peer discussions about experiences, and relaxation and unwinding before rejoining family and friends.³³ Following present-day conflicts, however, modern air travel can have troops returning home from theatre within hours, leaving little time for decompression and readjustment. One particularly disturbing recount had a CF soldier standing in his driveway with his children a mere twenty four hours after having left the theatre, and looking down only to discover that his boots were still covered with blood.³⁴ Decompression permits the member the opportunity to minimize family reintegration stress and ensure early identification of any potential health problems by permitting time for reflection on

³¹ *Ibid.*, 273.

³² Ombudsman National Defence and Canadian Forces, "From Tents to Sheets," http://www.ombudsman.forces.gc.ca/reports/special/decomp/decomp_e.asp; Internet; accessed 07 December 2006, 4.

³³ Ombudsman National Defence and Canadian Forces, "From Tents to Sheets," . . . , 4.

³⁴ *Ibid.*, 5.

the mission accomplishments, gain a sense of closure and facilitate a smooth reintegration into Canadian society.³⁵

The aim of modern day TLD is to assist the member through this somewhat difficult transition to normal life. The evidence supporting the benefit of TLD to assist in the prevention of OSI emergence, however, is not conclusive. National Defence Medical Staff have been unable to uncover any definitive scientific evidence indicating benefits, either short or long-term, of TLD, in reducing operational stress injuries or reintegration stress.³⁶ Indeed, there is a largely silent disagreement between the operators and mental health specialists regarding the purpose and likely outcomes of TLD. Many of the operators harbour an expectation that TLD will prevent the emergence of OSIs or other deployment-related psychosocial problems. In contrast, nearly all of the mental health specialists believe that TLD is unlikely to have such benefits.³⁷ The difficulty is determining how TLD might be studied to assess its benefit in reducing OSI incidence. The only way to create a suitable control group would be to randomly allocate a large group of members to receive TLD and another to undergo usual care (that being decompression at home with family and friends).³⁸ Failing that, the best indication of the value of the experience must come from the participant's own opinion of whether the experience was valuable for them. In this area, considerable information has come from the Guam TLD for Operation APOLLO and the Cyprus TLD following Operation ATHENA.

OP APOLLO

³⁵ *Ibid.*, 6.

³⁶ *Ibid.*, 4.

³⁷ Major Mark Zamorski, e-mail communication with author, 26 September 2006.

³⁸ Major Mark Zamorski, e-mail communication with author, 26 September 2006.

The CF first used TLD in 2002 following Operation APOLLO, Canada's initial military contribution to the international campaign against terrorism. The decompression period involved scheduled activities including physical fitness, lectures, cultural and sightseeing events and some private time. Debriefings included such topics as the home front, work reintegration, anger management and suicide awareness.³⁹ The commander of Op APOLLO believed the TLD would assist his troops in the transition to the physical comforts of life, ease the move from the highly structured operational tempo to the less rigid/threatening home environment, and afford the members an opportunity to build upon the formal reintegration process that occurred during pre-deployment training.⁴⁰

The Special Ombudsman Response Team conducted a feedback and evaluation investigation and, following interviews with members and a number of deployed members' spouses, the report concluded that there were four main benefits arising from the decompression - members appreciated the recognition for their efforts, the decompression was conducted in a very comfortable environment, there was an ability to unwind mentally, and the experience afforded them the opportunity to have access to education and training.

Op ATHENA

Despite the apparent success of the TLD in Guam, the following operation, Op ATHENA, did not undergo a TLD. A CANFORGEN and accompanying Deputy Chief of Defence Staff (DCDS) Directions for International Operations had been issued outlining the four phases of reintegration, and made it clear that TLD would only be exercised if Comd TFK, with

³⁹ Ombudsman National Defence and Canadian Forces, "From Tents to Sheets," . . . , 8.

⁴⁰ *Ibid.*, 7.

DCDS concurrence, deemed a third location necessary for decompression.⁴¹ DCDS Directions for International Operations, Chapter Twelve: Post Deployment Requirements Paragraph 1220 (Appendix 2), refers to the four phases of reintegration as:

Phase One: Preparation of Deployed Personnel and their Families at Home;

Phase Two: Decompression in a Third Location “if the requirement has been identified”;

Phase Three: Reintegration in Canada at Garrison Locations; and

Phase Four: Post Mission Follow-up.

The criteria needed to assess the requirement for TLD were lacking at the time of Op ATHENA, as the reintegration plan shifted from directing all members to be held at CFB Petawawa for reintegration purposes to the eventual one day program at the CFB Trenton Airport of Departure, with subsequent three day reintegration procedures at the member’s home unit.⁴² The commander believed TLD was not required because, based on his team’s advice, his troops had experienced significantly improved living conditions over those of Op APOLLO, all members had a substantial block of leave from theatre during the tour and the relatively stable threat environment and absence of large-scale casualties created an atmosphere from which he believed extensive decompression was not required.⁴³

With a lack of concrete guidance to assist commanders in making their decision, yet an increased need to gain a greater appreciation for the value of TLD, the Ombudsman launched an analysis of the CF TLD experience. The results of this analysis generated several guidelines.

TLD Guidelines

⁴¹ CANFORGEN 154/03 DCDS 280 311515Z DEC 03

⁴² Ombudsman National Defence and Canadian Forces, “From Tents to Sheets,” . . . , 11.

⁴³ *Ibid.*, 12

The Ombudsman's report "From tents to sheets" discussed the criteria that commanders might utilize to facilitate the decision making process of whether or not a TLD should proceed and the intensity and duration of the TLD should it occur.⁴⁴ The ultimate responsibility and accountability regarding the conduct of a TLD rests with the theatre commander, because no two operations are exactly alike. The Ombudsman's guiding principles were designed to help facilitate the commander's decision and encourage consistency, credibility, predictability and relevancy, among others. The report identified fourteen significant criteria that commanders should consider including such issues as threat levels, casualty occurrences, mission tempo, living conditions, opportunities for leave during the tour, professional community intervention, and others. While the report will invariably assist commanders in deciding whether or not to conduct a TLD, what was not considered a factor for commanders to entertain was the growing change in troop demographics in which increasing numbers of Reserve Force personnel are being operationally deployed.⁴⁵ The report did comment on the need to train and educate both Reserve and Regular personnel prior to their return home, but the recent significant increase in reserve force members makes it imperative that their welfare becomes a growing priority for a commander's consideration.

Op ATHENA, Rotation 3

Following Operation ATHENA, Rotation 3, the operational tempo had changed and the results of the Ombudsman's report had provided commanders with guidelines for their consideration. The commander believed a TLD was required, and consequently the location of Cyprus was selected. Surveys following this TLD evaluated many aspects of the TLD and some of the results revealed the following statistics: 95% of the participants indicated that they agreed

⁴⁴ *Ibid.*, 3.

⁴⁵ *Ibid.*, 3

or strongly agreed that they were satisfied with the training, 93% agreed or strongly agreed that they found the training useful, and they agreed or strongly agreed that they were satisfied with presentations regarding anger management (83%), Bouncing Back (88%), Critical Incident Stress Debriefing (100%) and Healthy Relationships (94%).⁴⁶

Further analysis is currently being conducted on the Cyprus decompression, but the anecdotal evidence suggests that “it assisted the members in readapting to the normalcy of the home front and introduced some important considerations regarding their mental well being that they should keep in mind.”⁴⁷

Evolving Concerns

Traditionally, the complement of troops has been taken from one geographic location for a particular deployment. The troops for Operation APOLLO, for example, were largely deployed from 3PPCLI in Edmonton, Alberta. As deployments have progressed and a suitable number of troops from one location have been strained, the CF has relied upon augmentees, including reservists, from other locations across the country to fill in the gaps and help the CF deliver on its mandate. Reservists have been deploying on operations in significant numbers since the early 1990s. Missions like UNPROFOR in the former Yugoslavia, IFOR and SFOR in Bosnia, KFOR in Kosovo and now ISAF in Afghanistan have deployed a significant percentage of reservists. Generally, the number of reservists increases as theatres of operation mature, but in Afghanistan the numbers have increased at a more rapid rate than in Bosnia. Primary Reserves amounted to 364 personnel in Task Force (TF) Afghanistan Roto 2, but increased to 400 in Roto 3 and

⁴⁶ After Action Report (AAR) Decompression Centre Cyprus

⁴⁷ Dr. Don McCreary, personal discussion with author, 06 February, 2007.

planning is underway for TF3-08 projecting more than 500 positions, or almost one-quarter of the TF, to be filled by the Primary Reserve.⁴⁸

The concern about increasing numbers of reservists revolves around their proximity to post-deployment intervention. Facilities and knowledgeable caregiver access is readily available for regular force members who return to large garrison centres. Reservists, however, often return to smaller centres that are remote from the bases and their corresponding medical facilities. As Brigadier-General (Ret'd) Joe Sharp commented,

If you are a young reservist from northern Saskatchewan, you are a long way from the peer support network. Resources become a challenge, particularly dealing with reserve members and with families of reserve members.⁴⁹

While it is anticipated that reserve personnel will eventually be provided better access to medical support measures, currently deployed troops must be kept in the forefront of our minds. Consequently, should there be an issue of mental illness, current intervention techniques must be readily available for all deployed individuals, but also all deployed individuals must be cognizant regarding warning symptoms that they should be aware of in themselves.

This has added another dimension to the complexities of the decision making process for the commander. The opportunities for medical intervention and counseling during the decompression period that may not otherwise be available to the growing numbers of augmentees and reservists on current deployments must figure in the commander's decision for the necessity of TLD. If their access to appropriate post-deployment medical intervention is presently limited, the TLD becomes the last opportunity to comprehensively discuss aspects of

⁴⁸ Major T. Lourie, J5 PSYOPS, via e-mail to author, 22 Jan 07.

⁴⁹ Proceedings of the Subcommittee on Veterans Affairs, http://www.parl.gc.ca/39/1/parlbus/commbus/senate/Com-e/vete-e/02evb-e.htm?Language=E&Parl=39&Ses=1&comm_id=79; Internet; accessed 07 December 2006.

OSI in a relaxed environment and afford the members easy, available access to mental health professionals prior to reintegration.

Concerns regarding the incidence of PTSD in reservists have been a growing issue. The 2001 Annual Report to the Standing Committee on National Defence and Veteran's Affairs (SCONDVA) on Quality of Life in the Canadian Forces addressed the issue. The report discussed the reservist's needs for assistance in dealing with the effects of PTSD and other OSIs. Initiatives included the requirement for timely and responsive services by VAC and interventions to clients suffering from these illnesses.⁵⁰ The necessity for improved services surfaced again four years later, this time through the CF Ombudsman.⁵¹

Augmentee and Reserve Force Issues

In his 2005-2006 annual report, the Department of National Defence and Canadian Forces Ombudsman indicated concern regarding the treatment afforded to reservists who are increasingly called upon for operations.⁵² The report sited the launching of an investigation into the apparent disparity between the treatment of reservists and regular force personnel. The Ombudsman noted,

The Canadian Forces cannot have one standard for all military members when it comes to risking your life but different standards of care for those that are injured serving their country.⁵³

⁵⁰ SCONDVA Annual Report, http://www.forces.gc.ca/hr/scondva/engraph/2001inj_e.asp?cat=1#inj; Internet; accessed 07 December 2006.

⁵¹ Ombudsman National Defence and Canadian Forces, "News Release," http://www.ombudsman.forces.gc.ca/mediaRoom/newsReleases/2006/06-06_e.asp; Internet; accessed 16 December 2006.

⁵² Ombudsman National Defence and Canadian Forces, "News Release," . . . , 2.

⁵³ *Ibid.*, 2.

On 6 December 2006, the Subcommittee on Veterans Affairs of the Standing Senate Committee on National Security and Defence met to study the services and benefits provided to members of the Canadian Forces, veterans of war and peacekeeping missions and members of their families. The concern is that the Reservist's Class B or C service while on operations is reverted to Class A upon return to Canada. Consequently they move from the coordinated and established treatment team approach of the CF to that of VAC, which appears more bureaucratic, less organized and less experienced at dealing with issues of PTSD. As Major J. Fisher, Regimental Major, Grey and Simcoe Foresters, stated, "The growing number of reservists are left with a system of red tape and jumping through hoops to access care. They often don't get to see a specialist for years."⁵⁴ From this, we have an appreciation of the complexities and frustrations of the process of caring for reserve members. While progress is being initiated, the current dilemma is that reservists are, in increasingly larger numbers, returning from theatre to a system that is ill prepared to care for their potential OSIs.

Considerations for Commanders

The growing number of reservists on operational tours combined with the understandably difficult challenge of providing post-deployment medical intervention makes it prudent for commanders to consider the makeup of their troops in their deliberations pertaining to the necessity of TLD. The TLD provides a unique opportunity for the entire contingent to undergo decompressive training together. Indeed, "[p]ost-deployment assessment is required by some NATO nations in order to link service personnel to psychological support professionals back

⁵⁴ Major J. Fisher, personal conversation with author, 23 Jan 07.

home.”⁵⁵ While there is no statistically significant data to indicate that TLD reduces the incidence of PTSD, perhaps the most important impact is that all members, regular force and reserve, receive this training which outlines avenues for intervention – avenues that reservists may have to access on their own upon their return to Canada.

Discussion

It is intuitively understandable that those most vulnerable would be those that return home from a deployment to a location where the support mechanisms identified as effective to remedy CSR are cumbersome and frustrating to access. The Israeli experience in the Lebanese war identified that reservists are at greater risk for stress related injuries than their regular counterparts.⁵⁶ This was related to the fact that reservists lack the normal confidence and bonds that develop from training as a unit; they don’t become one of the family. In the Canadian context, this was elaborated upon by the Reserve Advisor to the Director General Health Services from the Ombudsman’s Report in stating that,

[a] lot has to do with the whole augmentee thing. Desperately trying to fit in with the family, finally making it into the family, being dropped like a hot potato out of the family, and then having to regroup and join the other family which you left, whether it’s your own personal family or your unit family.⁵⁷

Reservists would, in this scenario, be devoid of a commander’s personal leadership, the social network of friendship with peers, and readily available support networks that are thoroughly versed with issues related to PTSD and commensurate treatments. Ironically, the 2003 CF Mental Health Survey found that reservists, including those who had served on

⁵⁵ NATO Task Group HFM 081/RTG, *A Leader’s Guide to Psychological Support Across the Deployment Cycle*, Pre-release of NATO Task Group Human Factors and Medicine Panel of the Research & Technology Organisation (RTO-TR-HFM-081) 2007, 25.

⁵⁶ The Army Lessons Learned Centre, “Stress Injury and Operational Deployments,” . . . , 14.

⁵⁷ *Ibid.*, 14.

operations, suffered less from mental illness, including PTSD than their regular force counterparts.⁵⁸ This may, unfortunately, change as greater numbers of reservists deploy.

TLD Potential Drawbacks

There are three potential drawbacks regarding TLD following operational deployments. The first is cost. TLD has a significant monetary price tag that must be covered. As an example, the office of ADM Finance/Corporate Services indicated that the total cost for the Guam decompression was \$1.636 million. The entire cost for Operation APOLLO was \$396.5 million.⁵⁹ While the cost of TLD to some may be significant, its value in terms of education and therapeutic intervention must be appreciated. Combined with the ability to address reserve and other augmentee issues, and potentially avert more costly therapy, the cost of TLD soon becomes money well spent. Commanders must, however, support these operations with a view to demonstrating fiscal adeptness, consequently, if the benefits of TLD are not clearly enunciated, commanders will be reticent to recommend the spending of the additionally required funds.

The second drawback is the belief of the additional days added to the length of the tour. It has been argued that members could be home approximately five days earlier were it not for the TLD interventions. In reality, decompressive interventions form a part of the matrix of care, being performed either by TLD or Phase Three, being conducted post-deployment at the home base. The complications and concerns revolve around the type of dilemma associated with such things as the Op ATHENA return point to the fact that TLD may be the most effective mechanism to instill the required information and offer required counseling services. The solution to the timeline concern, therefore, is twofold – announce the requirement for

⁵⁸ *Ibid.*, 15.

⁵⁹ Ombudsman National Defence and Canadian Forces, "From Tents to Sheets," . . . , 8.

decompression training early in the mission, preferably as a component of the pre-deployment training, and ensure the value of having the training conducted at a third location is explained.

Thirdly, one of the prominent features of the decompression is the concern with alcohol and other related trauma. During the Cyprus TLD, there were eleven incidences of alcohol-related injuries.⁶⁰ Mitigating strategies, i.e., meal hours, buddy systems, etc., have since been initiated to help prevent such a recurrence. While it is somewhat understandable that these types of incidences may occur, commanders must initiate preventive strategies and also caution their troops to demonstrate prudence when going out on town.

While these factors certainly need to be taken into consideration, prudent leadership, as indicated, will remedy these concerns. Foremost in the commander's mind must be the understanding that TLD remains a unique opportunity for intervention that may save peoples lives and should there be a concern, provide the soldiers with the knowledge regarding the avenues that should be taken to seek assistance.

Conclusions

Of particular importance to any discussion of mental illness including PTSD is that no one is immune. Each of us has a breaking point at which trauma-related stress overwhelms our system, resulting in involuntary reactions. While they may vary in intensity, it is critical that their identification prompts appropriate treatment. Failure to seek assistance can potentially be fatal.

This paper reviewed the history of OSIs and identified the value of TLD in reducing trauma-related stress reactions. It identified that TLD assisted in several areas including enhancing unit cohesion, encouraging abreactive legitimacy and, perhaps most importantly, regaining the soldier's self-perception as healthy and coping, rejecting the illness label.

The paper also helped identify the unique concerns involving augmentees and reserve members. With their unique post-deployment concerns, commanders must take reservists into consideration when deciding upon the manner in which to deliver post-deployment decompressive reintegration information. The changing compositions of deploying contingents as operations mature make it imperative for commanders to seriously consider TLD as the most cost effective avenue available for ensuring a smooth transition into the home environment and potentially lessening OSI numbers through improved education and prompt intervention.

Bibliography

After Action Report (AAR) Decompression Centre Cyprus, Annex C to 3350-1 (TLC CYPRUS), 4 Sep 06.

⁶⁰ After Action Report (AAR) Decompression Centre Cyprus, Annex C to 3350-1 (TLC CYPRUS), 4 Sep 06.

- Ahrenfeldt, Robert H. *Psychiatry in the British Army in the Second World War*. London: Routledge and Kegan Paul, Ltd., 1958.
- Breakwell, Glynis and Spacie, Keith. "Pressures Facing Commanders." *The Strategic and Combat Studies Institute Occasional Paper*, no. 29, 1997: 27.
- Campion-Smith, Bruce. "When war returns with the soldier." *Toronto Star*, 17 February 2007.
- Canada, Department of National Defence. "Historical and Contemporary Interpretations of Combat Stress Reaction." *Reports and Studies: Board of Inquiry – Croatia*. Ottawa, On: Department of National Defence, 2000.
- Canada, The Army Lessons Learned Centre. "Stress Injury and Operational Deployments." *Dispatches: Lessons Learned for Soldiers* 10, no. 1 (February 2004): 3.
- CANFORGEN 154/03 DCDS 280 311515Z DEC 03
- Center for the Study of Traumatic Stress, Department of Psychiatry, Uniformed Services University of the Health Sciences, "War Psychiatry Today: From the Battle Front to The Home Front."
<http://www.centerforthestudyoftraumaticstress.org/downloads/WarPsychiatryExecSumUrsano-2005.pdf>;
Internet; accessed 10 April 2007.
- Gabriel, Richard. *No More Heroes: Madness and Psychiatry in War*. New York: Hill and Wang, 1987.
- Indian Psychiatry. "Abreaction." <http://www.indianpsychiatry.com/Glossary.htm>;
Internet; accessed 07 January 2007.
- Koshes, Ronald J, et al. "Debriefing Following Combat," Chap. 11 in *War Psychiatry*. Office of the Surgeon General, United States Army, Falls Church, Virginia, 1995.
- Major Zamorski, M., e-mail communication with author, 26 September 2006.
- Major Lourie, T., e-mail communication with author, 22 January 2007.
- Merck Source, Resource Library. "Posttraumatic Stress d. (PTSD)."
http://www.mercksource.com/pp/us/cns/cns_hl_dorlands.jspzQzpgzEzzSzppdocszSzuszS_zcommonzSzdorlandzSzdorlandzSzdmd_d_24zPzhtm#12308074;
Internet; accessed 11 January 2007.

NATO Task Group HFM 081/RTG. *A Leader's Guide to Psychological Support Across the Deployment Cycle*. Pre-release of NATO Task Group Human Factors and Medicine Panel of the Research & Technology Organisation (RTO-TR-HFM-081) 2007, 24.

Noy, Shabtai. "Combat Stress Reactions," in *Handbook of Military Psychology*. Reuven Gal and A. David Mangelsdorff, eds. Chichester: John Wiley, 1991.

Ombudsman National Defence and Canadian Forces. "From Tents to Sheets."
http://www.ombudsman.forces.gc.ca/reports/special/decomp/decomp_e.asp;
Internet; accessed 07 December 2006.

Ombudsman National Defence and Canadian Forces. "News Release."
http://www.ombudsman.forces.gc.ca/mediaRoom/newsReleases/2006/06-06_e.asp;
Internet; accessed 16 December 2006.

Proceedings of the Subcommittee on Veterans Affairs. "Issue 2 – Evidence – Meeting of December 6, 2006." http://www.parl.gc.ca/39/1/parlbus/commbus/senate/Com-e/vete-e/02evb-e.htm?Language=E&Parl=39&Ses=1&comm_id=79; Internet; accessed 07 December 2006.

SCONDVA – Standing Committee on National Defence and Veteran Affairs. "2001 Annual Report to the Standing Committee on National Defence and Veterans Affairs on Quality of Life in the Canadian Forces The Injured, Retirees and Veterans (Care of Injured personnel)."
http://www.forces.gc.ca/hr/scondva/engraph/2001inj_e.asp?cat=1#inj; Internet; accessed 07 December 2006.