

HEALING THE INVISIBLE WOUNDS OF WAR

Introduction

Focus

This *News in Review* story is about post-traumatic stress disorder (PTSD) in the Canadian military. PTSD is now recognized as the most common form of mental illness to affect Canada's soldiers. In this story we look at the symptoms and treatment of the illness, how the Canadian Forces are dealing with the problem, and the economic and social costs of PTSD for Canada.

*You smug-faced crowds with kindling eye
Who cheer when soldier lads march by,
Sneak home and pray you'll never know
The hell where youth and laughter go.*
— Siegfried Sassoon, "Suicide in the Trenches" (1918)

For many people, mental illness is still a condition that is best kept secret. Unlike most other illnesses, it has a real stigma attached to it—a suspicion that somehow the person with mental illness has somehow failed and is really responsible for his or her condition.

This attitude has—and continues to be—a special problem in the Canadian military. Soldiers have always been expected to suck it up when they find themselves under extreme stress. Any other behaviour is considered to be a sign of weakness, a proof of inadequacy, or a failure to make the grade.

It is only since 2000 that coping with post-traumatic stress disorder (PTSD), the most common form of mental illness to which soldiers are subject, has been a priority for the Canadian military. As will become apparent in both the *News in Review* video and guide, significant steps have been taken to identify and treat those showing symptoms of PTSD and to assist the families of sufferers. PTSD has also been recognized as a pensionable

disability; more than 5 000 soldiers with PTSD are now receiving veterans' disability payments.

Senior members of the military have thrown their support behind programs to change the culture of the Canadian Forces and its attitude toward mental illness. One such program—It's All Right to Hurt—has seen officers and enlisted personnel alike share their stories of PTSD with other members of the forces to encourage victims to come forward for treatment when they experience symptoms. Coping with stress and mental illness is now a basic component of military training.

But for many the stigma remains. Part of the problem is that no soldier wishes to appear weak in the eyes of others. Equally significant, however, is a long-standing rule that requires all personnel to be fit for deployment for any duty, including combat, or leave the military.

With recent news stories revealing Canadian Forces' policy of redeploying personnel who have received treatment for PTSD, it is likely that the Canadian military and its handling of PTSD will remain a controversial topic for some time. And, if as predicted, more veterans of the Afghanistan conflict develop symptoms of PTSD, the real costs of war will become more significant.

To Consider

Siegfried Sassoon's poem was written during the First World War and is about a young soldier, likely suffering from PTSD, who commits suicide. It can easily be applied to any modern conflict.

1. What images come to mind when you re-read the lines from the poem?
2. Do you think we glorify war in our culture? If so, in what ways?
3. Search for Sassoon's poem on the Web and read the rest of it. Which parts of the poem still apply to soldiers serving in armed conflict today? Which parts do not?

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Video Review

Further Research

A video, "PTSD: Stress and Resilience," about a recent (U.S.) National Institute of Mental Health study of PTSD is available at www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd/index.shtml.

Quote

"When one mother said her son was on the verge of committing suicide, she went to his supervising officer in Petawawa, who told her to suck it up."
— CBC *News in Review* video, December 2011

Pre-viewing Activity

Post-traumatic stress disorder is a mental illness that is an extreme anxiety disorder. We would likely all agree that being part of a military operation is likely to cause considerable anxiety in anyone. Based on what you know about Canada's mission in Afghanistan, what would you consider to be some of the most stressful activities performed by Canada's soldiers? Make a short list and compare it with those of other members of the class.

Viewing Questions

Answer the questions in the spaces provided.

1. How many Canadian soldiers were killed during the Afghanistan combat mission? How many were wounded?

2. What Canadian military policy especially worries Steve Lively, former soldier and PTSD patient?

3. What does the term *redeployment* mean?

4. How does psychologist Ken Welburn describe the effects of redeployment?

5. What does the universality-of-service rule mean for Canadian soldiers?

6. According to Dr. Rakesh Jetly, how long is the military's predeployment training before a soldier with PTSD is redeployed on a combat mission?

7. Briefly describe how virtual reality (VR) therapy is used to treat PTSD.

8. How does exposure therapy help a PTSD patient?

9. Why is VR therapy not being used by the Canadian military to treat PTSD?

10. How does U.S. soldier Jason Skinner describe his current condition after undergoing extensive VR therapy?

Post-viewing Discussion

Make notes on the following questions and then join with a partner or small group to discuss.

1. Is the universality-of-service rule unfair to members of the Canadian military? Must all members of the Canadian military be able to serve on combat missions? Why or why not?

2. With 20 per cent or more of Canadian soldiers leaving Afghanistan with PTSD and other mental disorders, is it realistic to expect that most of them could be redeployed on a combat mission in six to nine months? Note that most psychiatrists expect the average treatment for civilian PTSD to take about two years. Should we expect soldiers to be treatable in a shorter period of time?

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PTSD

Further Research

A good one-page summary of the causes, symptoms, and usual treatment of PTSD is available from the U.S. National Library of Medicine at www.ncbi.nlm.nih.gov/pubmedhealth/PMH0001923/.

Reading Prompt

As you read this section, make a list in your notebook of the causes and symptoms of and usual treatment procedures for PTSD.

Post-traumatic stress disorder (PTSD) is an anxiety disorder. The symptoms of this form of mental illness have been recognized for centuries, but it is only since 1980 that PTSD has been classified as a specific form of mental illness by the medical profession, appearing as such in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders*.

The symptoms of PTSD result from situations of extreme trauma, such as abuse or episodes of violence. The names used to describe PTSD before 1980 include shell shock, war neurosis, battle fatigue, and post-Vietnam syndrome. Clearly PTSD is not a recent occurrence in the military.

Defining a Mental Illness

PTSD is not limited to soldiers. Modern definitions recognize that anyone is a potential victim of PTSD.

“PTSD is an anxiety disorder that some people get after seeing or living through a dangerous event. When in danger, it’s natural to feel afraid. This fear triggers many split-second changes in the body to prepare to defend against the danger or to avoid it. This ‘fight-or-flight’ response is a healthy reaction meant to protect a person from harm. But in PTSD, this reaction is changed or damaged. People who have PTSD may feel stressed or frightened even when they’re no longer in danger” (www.nimh.nih.gov/health/publications/post-traumatic-stress-disorder-ptsd).

The extreme events that might trigger PTSD include accidents;

natural disasters; acute illnesses; acts of terrorism; physical, sexual, or psychological abuse; and wartime stressors. PTSD often occurs in persons who provide care to trauma victims, such as police officers, fire fighters, and health-care personnel.

According to the Canadian Medical Association, about one in 10 people has PTSD. With treatment, recovery on average takes about two years.

Symptoms

PTSD symptoms are grouped into three categories:

- **Re-experiencing.** Patients relive the original trauma, often experiencing physical distress such as racing heartbeats. They react intensely to visual or auditory cues that symbolize the event. Nightmares are frequent and especially distressing.
- **Avoidance.** Patients often try to avoid anything that reminds them of the traumatic event—people, places, and activities. They may lose interest in things that once were enjoyable. Reminders of the event may result in feelings of guilt or depression. Amnesia may be present—patients may have real trouble remembering some of the event. Patients are often emotionally numb.
- **Hyper-arousal.** Patients tend to be constantly tense and irritable. They may have trouble sleeping or concentrating on a task. They often startle easily and react to surprises in a way that is totally inappropriate.

Quote

"If you're the spouse and you're sleeping in the same bed, the person might be screaming out at night, may be drenched in sweat, may be tossing and turning, may be striking out at somebody that they feel are a threat. So quite often people end up sleeping in separate rooms, in separate beds."

— Lt.-Col. Rakesh Jetley, *Esprit de Corps*, February 2010

Diagnosis

Only an experienced psychiatrist or psychologist can diagnose PTSD. The diagnosis is very specific. The patient must have all of the following for at least one month:

- One or more re-experiencing symptoms
- Three or more avoidance symptoms
- Two or more hyper-arousal symptoms

Treatment

Treatment for PTSD involves psychotherapy and medication, often working together.

Psychotherapy treats a mental illness by encouraging patients to talk about their condition. This is especially helpful with PTSD patients. "By encouraging talk about the experience and listening attentively, the psychotherapist demonstrates that the event can be dealt with and that the patient can safely relate details. The healing process comes from communicating the memory of the trauma to another person and experiencing the memories and emotions together" (*Patient Care*, October 15, 1999).

As part of their psychotherapy, patients learn to deal with their special needs. They may be taught ways of relaxing, controlling anger, or dealing with guilt feelings.

Medication—including antidepressants—also has a role to play in treatment of PTSD. Drug treatments help in many ways: providing relief from flashbacks and nightmares, alleviating depression, and reducing hyper-arousal symptoms.

On its own, medication is rarely a solution for PTSD sufferers. It is most effective in providing relief in combination with psychotherapy. Often selective medication is used to prepare a patient for psychotherapy.

Collateral Damage

People suffering from PTSD often suffer from alcohol or drug addiction. A study of Vietnam veterans with PTSD in the United States showed that 60 to 80 per cent of them exhibit substance abuse or dependence. Studies also indicate that PTSD develops first; alcohol or drug addiction follows and may develop as a form of self-medication.

Often, the families of PTSD sufferers also require assistance to deal with the effects of the condition. One study reported by the *Hamilton Spectator* (October 16, 2010) looked at how PTSD can affect teenagers. Sociology professor Deborah Harrison found that adolescents living with parents with PTSD could face physical abuse, emotional neglect, and unpredictable rage.

The stress on spouses trying to care for both their partner with PTSD and their family makes it critical that they, too, seek assistance. This is necessary because they need to be educated to understand that PTSD is an illness that requires proper treatment and time to heal. There is every indication that a united and understanding family contributes to a sufferer's recovery.

Helpguide.org offers the following suggestions for those dealing with a loved one with PTSD (http://helpguide.org/mental/post_traumatic_stress_disorder_symptoms_treatment.htm):

- Be patient and understanding. Getting better takes time, even when a person is committed to treatment for PTSD. Be patient with the pace of recovery and offer a sympathetic ear. A person with PTSD may need to talk about the traumatic event over and over again. This is part of the healing process, so avoid the temptation to tell your loved one to stop rehashing the past and move on.

- Try to anticipate and prepare for PTSD triggers. Common triggers include anniversary dates; people or places associated with the trauma; and certain sights, sounds, or smells. If you are aware of what triggers may cause an upsetting reaction, you'll be in a better position to offer your support and help your loved one calm down.
- Don't take the symptoms of PTSD personally. Common symptoms of post-traumatic stress disorder include emotional numbness, anger, and withdrawal. If your loved one seems distant, irritable, or closed off, remember that this may not have anything to do with you or your relationship.
- Don't pressure your loved one into talking. It is very difficult for people with PTSD to talk about their traumatic experiences. For some, it can even make things worse. Never try to force your loved one to open up. Let the person know, however, that you're there when and if he or she wants to talk.

Follow-up

1. Using your notes, prepare a chart showing a typical patient diagnosis of PTSD with a complete list of required symptoms.
2. Write a short treatment plan for the PTSD sufferer and his/her family.

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Mental Illness and the Military

Quote

“For a lot of soldiers especially, to have a mental health disorder is self-perceived as a failure as a soldier and as a person. You’re not allowed to be sick, and to have a mental health illness is even worse. So often the person with PTSD is caught up in the shame of being a failure and therefore is not even really thinking about help, they’re thinking, ‘how can I hide this from everybody?’”
— Psychiatrist Ken Welburn, *Esprit de Corps*, February 2010

Focus for Reading

The military’s official attitude toward mental illness in general, and post-traumatic stress disorder in particular, has changed considerably in recent years. As you read through this *News in Review* section, makes notes on how the official attitude compares with that of the average soldier. After completing this section, write a one- or two-paragraph report describing these attitudes.

While the symptoms of PTSD have been recognized for centuries, many in the military have questioned its reality as a medical condition. Many doubted PTSD’s very existence; any problems associated with soldiering in wartime were something that just had to be sucked up. It was only with the First World War that the true nature of PTSD began to become apparent, with thousands of soldiers suffering what was known at the time as shell shock.

“For the British High Command, such exhibitions were symptoms of mass malingering and cowardice—signs, perhaps, of the corruption of the British character brought on by the years of relative affluence and leisure that preceded the war. But the numbers were too great and the conditions too bizarre to completely ignore, so psychiatrists and neurologists were hastily commandeered, hospitals were set up, and the field of military psychiatry was born” (www.walrusmagazine.com/articles/2010.07-health-the-enemy-inside/).

By the end of the Second World War most of the symptoms were well understood, and various therapies to assist its victims were being developed. But many in the military still believed that most of the psychiatric casualties were either malingerers or cowards trying to avoid active service on the front lines. The true face of PTSD and the havoc it wreaked only began to be recognized after the return of many damaged individuals to the U.S. during and after the Vietnam War.

PTSD and Canada’s Military, Round One

It was 1980 before the American Medical Association recognized PTSD as a specific mental illness. It took another 20 years for the Canadian military to recognize it as a disability. In 2000 the Veterans Affairs table of disabilities—in its first update since 1919—added a section on stress and anxiety disorders (PTSD is defined as an anxiety disorder). It was hoped that this classification would help the many soldiers who suffered with PTSD as a result of service in places like Croatia, Bosnia, and Rwanda.

But in 2002, André Marin, the military’s ombudsman, issued a report on the medical services offered to Canadian soldiers with PTSD. The report indicated that support staff for dealing with PTSD was inadequate. It also pointed to an even bigger problem for soldiers with PTSD: the military culture.

According to Marin, many soldiers were afraid to state publicly that they were suffering from PTSD because it could end their careers. He wrote: “There was a distressingly common belief among both peers and leaders that those diagnosed with PTSD were fakers, malingerers, or simply poor soldiers” (*The Globe and Mail*, February 6, 2002). In a news conference he stated: “PTSD is seen as a professional death sentence.”

At the time of the report, Canada was beginning its involvement in the Afghanistan conflict, and 2 500 military

Further Research

The 2008 ombudsman's report, "A Long Road to Recovery: Battling Operational Stress Injuries," is available at www.ombudsman.forces.gc.ca/rep-rap/sr-rs/osi-tso-3/index-eng.asp.

personnel were posted abroad. The number who might be affected by PTSD was believed to be as high as 20 per cent.

Both the government of the day and the military appeared to embrace the report. Defence Minister Art Eggleton released a statement that said: "We need to effect a cultural change to eliminate the stigma associated with PTSD, or any type of mental injury. Failure to respect and properly treat our members who are suffering from these illnesses will not be tolerated" (*The Globe and Mail*, February 6, 2002). Lieutenant-General Christian Couture said that soldiers needed to recognize that PTSD is as real an injury as a broken leg.

PTSD and Canada's Military, Round Two

Fast forward to 2008, and a new military ombudsman's report by Mary McFadyen. The report stated that the "strong commitment" by senior military leaders to deal with PTSD had yet to reach the community level.

Some progress had been made, including improved screening before soldiers are sent into conflict, support groups for families of PTSD sufferers, and a commitment to hire more mental health professionals by March 2009. But the negative stigma, myths, and stereotypes of PTSD remain a real problem in most military establishments.

The ombudsman's report was released at a time when more than 20 per cent of Canadian soldiers and police officers sent to Afghanistan were leaving the force with PTSD or other psychiatric problems.

Partly in response to the ombudsman's report, the House of Commons Defence Committee in June 2009 asked the Minister of Defence and the Chief of the Defence Staff to speak up and debunk the myths surrounding PTSD. General Walter Natynczyk responded by

launching a campaign called "All Right to Hurt," an attempt to lessen the stigma associated with mental illness in the military. During the campaign, members of the military publicly shared their struggle with mental illness.

The CBC interviewed Lieutenant-Colonel Stephane Grenier, who had served in Rwanda with the United Nations forces during the genocide. He returned from there with a new perspective on the military and mental illness.

"What happened to us in Rwanda really shocked my own belief systems, my own values, my own morals. The military tends to be a 'very macho, very stoic culture,' so getting support within that workplace from superiors is key to recovery," which is what happened for him, Grenier said. "That's what this campaign is all about—to change that culture of ours and make it acceptable that the mind can also be injured" (www.cbc.ca/news/canada/story/2009/06/25/military-campaign025.html).

Institutional Support

National Defence and the Canadian Forces (NDCF) provide mental health services for members of Canada's military. Those services are outlined on the NDCF website at www.forces.gc.ca/health-sante/ps/mh-sm/default-eng.asp.

Services include the Road to Mental Readiness (R2MR) program that includes special training before, during, and after deployment. It includes training components not only for military personnel, but also for their families.

NDCF also provides a number of psychosocial services—like crisis intervention or addiction counselling—as well as mental health programs. Special programs at major military bases treat patients with PTSD.

Veterans Affairs Canada (www.veterans.gc.ca/eng/mental-health) also

provides mental health services for veterans, members of the Canadian Forces, members of the RCMP, and families of those with mental health problems. Of special significance for those suffering from PTSD is the Operational Stress Injury Social

Support (OSISS) Program. It provides peer support co-ordinators who are themselves victims of operational stress to assist PTSD sufferers. Family peer support co-ordinators are also available to assist families affected by PTSD or other operational injuries.

Follow-up

Lieutenant-General Roméo Dallaire suffered PTSD as a result of being commander of the United Nations Assistance Mission for Rwanda. He has worked to promote awareness of PTSD among the military and the general public. Use the CBC website (www.cbc.ca/news/background/dallaire/), the CBC Archives (http://archives.cbc.ca/war_conflict/peacekeeping/clips/11660/), and other sources to research and write a brief account of how PTSD affected his life.

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The Ongoing Costs of War

Further Research

Search for the CBC news story "Domestic violence up in Canadian military families" online at www.cbc.ca/news. The page also provides access to video and audio reports on the same topic from *The National* and *The Current*.

The direct costs of Canada's combat missions are relatively easy to predict and to quantify. What can be far more difficult to evaluate are the auxiliary costs, both economic and social, that result from participation in foreign conflicts. In this section we look at some of those ongoing costs—costs that continue long after the mission is complete. We begin with economic considerations.

Disability Pensions and Veteran Care

It may have taken years for post-traumatic stress disorder (PTSD) to come to the attention of the Canadian Forces, but by 2005 it certainly was having an acknowledged impact. More than 5 000 ex-soldiers were receiving disability pensions for PTSD. Half of those pensions were awarded once combat began in Afghanistan.

In 1995 only 25 pensions were awarded to veterans diagnosed with PTSD. In 2004 the number was 1 141. PTSD disability pensions make up more than half the pensions paid out to ex-soldiers with psychiatric disorders. In 2005 that number was over 9 000.

Not all the veterans applying for PTSD disability pensions served in Afghanistan. Many served in peacekeeping roles in countries like Bosnia, Kosovo, and Rwanda. The number of applications has been growing rapidly.

On the other hand, in 2005 Veterans Affairs was administering a total of 170 000 disability pensions payable to ex-soldiers or their widowed partners. The total cost to Canadian taxpayers was \$1.5-billion.

PTSD's contribution to the ongoing

costs of war will likely continue for some time even after the conclusion of our military role in Afghanistan. By 2009 more than 20 per cent of our soldiers and police officers deployed to Afghanistan were leaving the forces with psychiatric problems. The number in the year preceding April 2009 was 1 053; the year before that it was 700.

It's not easy to predict the total residual costs of a conflict like Afghanistan, but David Perry, a researcher at Carleton University, has made an educated estimate. Canada now has about 41 000 veterans of the Afghanistan conflict, about 9 000 of whom will likely suffer some kind of mental health problems. Working with U.S. estimates on the cost of veterans' care, Perry determined that the lifetime care for 41 000 Canadian Afghanistan veterans could cost around \$11.5-billion (theyee.ca/News/2009/03/26/AfghanStress/).

Social Costs

One of the most powerful examples of the ongoing social cost of war is its effect on military families.

In March 2011 the CBC obtained a copy of a military police domestic violence report completed in 2008 but not publicly released. It reported that domestic violence on military bases rose steadily as soldiers returned from deployment in Afghanistan.

The report indicated that the problem was especially acute at Canadian Forces Base Petawawa. In fact, after troops returned to base following Operation Athena, there was a five-fold jump in reported cases of domestic violence. Psychologists believe the rise in domestic violence is directly linked to

physical and emotional trauma suffered by soldiers in Afghanistan, especially PTSD. The Canadian Forces believe that that correlation is possible but unproven.

The U.S. military has found a four-fold higher risk of violent behaviour among PTSD sufferers. The likeliest victims of that violence are family members.

Domestic violence is not the only social problem faced by families of PTSD sufferers. Lieutenant-Colonel Rakesh Jetley, a psychiatrist with the Canadian Forces, describes living with a PTSD victim. “Suddenly you may have somebody that no longer wants to go out to dinner, no longer wants to go to a concert, no longer wants to go to a mall, no longer wants to go to movies, anywhere with a lot of people. They may not want to watch the same TV shows because, perhaps, *CSI* or *Criminal Minds*, the favourite family, sit-around-

the-table-in-the-evening-having-popcorn type of thing is no longer enjoyable. The spouse ends up giving up a lot of things that they were able to enjoy” (*Esprit de Corps*, February 2010).

Ultimately, however, no one pays a higher social price than the PTSD sufferer him- or herself. Soldiers tell of returning to Canada completely alienated from civilian society. Many turn to drugs and alcohol in an attempt to self-medicate to try to cope with the worst effects of their illness. Several, in despair, attempt suicide. Most never regain 100 per cent of their health.

Canada’s soldiers are highly trained, capable individuals. The failure to fully reintegrate them into civilian society and to make full use of their skills and abilities is a tremendous loss to the country and a significant ongoing cost of war.

For Discussion

According to many psychiatrists, children are especially vulnerable to the secondary effects of PTSD on the family. What might be some of these effects, and how would they affect young people?

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Activity: Breaking the Silence

Quote

“As many as 20 per cent of Canadian soldiers serving in Afghanistan are likely to suffer from mental illness upon their return home.”
— Lieutenant-Colonel Stephane Grenier (www.cbc.ca/news/canada/story/2009/06/25/military-campaign025.html)

As we have seen, mental illness remains a difficult topic for many people. Here is your opportunity to open a dialogue on the topic.

Your Task

Part I

In small groups, you will investigate some of the stigmas associated with mental illness. You may wish to use information in the video or guide to inform your discussion.

Use the following questions to get you started:

Why is it so difficult to talk about mental illness?

What do we perceive as the significant differences between mental and physical illness?

Why are feelings of shame and guilt so often associated with mental illness?

Are there different types of mental illness that especially promote those feelings?

Do men and women approach a discussion of mental illness differently? Is it easier for one or the other to discuss mental illness?

How does the casual use of pejoratives like “crazy,” “nut case” or “loony” affect the way people think of mental illness? Is there a need for us to be more careful with our language?

Who needs to take the lead in promoting frank discussion of mental illness?

How can we as a society make people comfortable when they want to discuss mental illness?

Part II

Make a list of the main points that result from your discussion and present them graphically, perhaps as a Wordle, or in some type of graphic organizer, to the class. You may also choose to represent the results of your discussion artistically.