

THE HIDDEN WOUNDS OF WAR

Introduction

Quote

This *News in Review* story focuses on Canadian soldiers returning from Afghanistan with post-traumatic stress disorder (PTSD). It examines the challenges these soldiers face in coming forward and asking for help from an institution that has traditionally looked down on mental illness as a sign of weakness.

The news was chilling. In 2002, in the United States, four military wives were shot, strangled, or burned to death by their soldier husbands at the Fort Bragg military base (www.bragg.army.mil) in North Carolina. Three of the soldiers had recently returned from a tour in Afghanistan. Even before all of the details of the cases were known, the U.S. military was being criticized for not doing enough to help soldiers adjust to normal life following a tour of duty.

In Canada, military officials were quick to point out that no one knew whether or not the soldiers were suffering from a mental illness as a result of combat, or whether the deaths were tragic cases of domestic violence. As well, officials like retired Major-General Lewis Mackenzie stressed that a direct comparison between U.S. and Canadian soldiers should not necessarily be made. He noted that the military base at Fort Bragg alone is about five times the size of the total Canadian army. Thus our military institutions are quite different.

Nonetheless, a few weeks later it was revealed that a former Canadian soldier had been charged with plotting the death of his wife after he attacked her with an axe. The soldier's lawyer confirmed that the man had been diagnosed with post-traumatic stress disorder (PTSD), a serious mental illness that affects soldiers more often than people in the general population. The symptoms of PTSD are frightening and disabling; they include nightmares, panic attacks, paranoia, and violent outbursts.

News about PTSD continued. In July 2003, a U.S. marine, Jeffrey Lucey, returned from a tour of duty in Iraq and sank into a deep depression. He began drinking heavily and isolating himself

from family and friends. By the spring of 2004 he had dropped out of college and was barely eating or sleeping. He talked constantly about the terrible things he'd seen and done. His family had him committed to a psychiatric hospital, but he was released a short time later. He crashed the family car, and a month later a neighbour found him wandering the neighbourhood in full camouflage, carrying two battle knives he'd been issued in Iraq. In June 2004, Lucey hanged himself in the basement of his family home.

Then, in 2006, a report was released about the mental health of Indian soldiers fighting in the Kashmir region. The Kashmir region—situated on the northern border between India and Pakistan—has been in dispute since 1947, but the latest fighting broke out in 1989. Since then, 44 000 lives have been lost in the region. The mental stress on soldiers has been acute, mostly because they never know when they will be attacked and because Kashmiri rebels will use suicide bombers to carry out their mission. The report concluded that the Indian soldiers are on high-alert for most of their duty, and that this hyper-vigilance was having negative health effects on them.

Alarming, the report noted increasing numbers of "fragging" incidents.

Fragging is the term used to describe acts where one soldier deliberately kills a colleague. In one incident, Santosh Kumar, a soldier who occupied the lowest rank in the army, shot three of his officers before killing himself. Thirty incidents of fragging have been reported to officers, but soldiers say the numbers are actually much higher. Most fragging incidents are covered up for insurance

Further Research

The Web site of Veterans Affairs Canada has an excellent overview on PTSD and war-related stress. Check it out at www.vac-acc.gc.ca/clients/sub_fm?source=mhealth/ptsd_warstress#Item3-1.

reasons and out of respect for the dead soldiers' families.

Also of concern is the rising number of military suicides. In 2005, 106 Kashmiri-based soldiers killed themselves, compared with 96 in 2003. The stress that leads to such deaths is evident in the following soldier's letters home to his family.

"I no longer want to continue the service. I am getting tired. We are trained in conventional war to guard our country against a foreign army. But here we are forced to fight an unconventional war against the insurgents who are sneaking in quietly and can strike at any place, any moment. Courage does not work here and it is heavily stressful. My tension is getting unbearable. For weeks I go without sleep . . ." ("What to do when stress really is a killer: How well will Canadian soldiers bear up in Afghanistan? Ask India's troops fighting the rebels in Kashmir," *Newsweek*, August 29, 2005).

By 2006, an alarming number of Canadian soldiers who had returned from Afghanistan were suffering from PTSD. Some of these soldiers, like Travis Scouten—featured in this *News in Review* story—told of the challenges they faced while trying to get treatment for their mental-health problems. In Scouten's case, shortly after he returned from Afghanistan he started

having nightmares and flashbacks. He was drinking heavily and engaging in dangerous activities. As he got sicker and sicker, Scouten's family grew desperate. At one point, Scouten's parents marched into an office at the Petawawa military base and demanded treatment for their son. According to the Scoutens, the officer there looked directly at Travis and said: "I was in Afghanistan too. Suck it up."

In some ways, the officer's attitude is not surprising. The military prides itself on toughness. Mental illness has always been seen as a sign of weakness. But knowledge and attitudes toward mental illness have changed. We know that mental illness is not the result of weakness, but rather stress, trauma, heredity, and chemical imbalances in the brain. We also know that mental illnesses improve with treatment. Without treatment people often get sicker and sicker.

The military has started to change its attitude toward mental illness and now acknowledges that about 20 per cent of troops fighting in Afghanistan will suffer from some type of stress-related mental illness. The military is hiring more psychiatrists, psychologists, and therapists, and is trying to change the negative stereotypes associated with mental illness that may prevent some soldiers from coming forward for help.

To Consider

1. Why is it not surprising that a certain number of soldiers suffer from PTSD after serving in combat missions?
2. Why might returning soldiers feel reluctant to talk about their mental-health problems?
3. In your opinion, does Canada have any duty to these soldiers? Explain.

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Video Review

Respond to the following questions as you view the video.

1. Describe how Corporal Travis Scouten felt when he returned from Afghanistan.

2. What percentage of soldiers are believed to have a mental-health problem? _____%

3. What percentage of soldiers engage in heavy drinking? _____%

4. What incident made Scouten realize he was in trouble?

5. What is PTSD and what are some of its symptoms?

6. In the past, how has the military tended to view PTSD and other mental illnesses?

7. What steps did Scouten's family have to take to get Travis help?

8. What steps has the military taken to help soldiers deal with mental-health issues?

Post-Viewing Activity

In small groups, discuss and share your opinions on the following statements:

1. Because PTSD is so devastating, all families should be trained to spot the signs of this disorder before soldiers return from active duty.
2. Since the military is aware that 15 per cent of soldiers will experience mental-health problems, all returning soldiers should be monitored by psychiatrists or psychologists for a period of two years.
3. Soldiers are adults so they should be left alone when they return from duty. We should assume that they would come forward for help if they need it.

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What is PTSD?

Further Research

The Web site of the Canadian Mental Health Association contains excellent material about PTSD, including information on the mental health of children and youth. Visit the site at www.cmha.ca.

PTSD stands for post-traumatic stress disorder. It is a serious mental illness that can make it difficult for sufferers to cope with daily life. Anyone who has experienced a serious traumatic event can suffer from PTSD. The rate of PTSD among soldiers is higher than the general population, possibly because they are more likely to witness death or experience threats to their own lives while in combat.

What causes it?

PTSD is caused by a psychologically traumatic event. Seeing another person harmed or killed, suffering a violent personal assault—such as rape—or being involved in a serious accident are types of stressors that can trigger PTSD. Less frequently, learning that a close friend or family member is in serious danger can trigger the disorder.

PTSD appears to be the result of biological changes that occur in the brain in response to extreme stress. These changes alter the way memory is stored. It works like this: During a period of extreme stress the body produces massive levels of adrenaline. This adrenaline speeds up the heart, quickens reflexes, and burns vivid memories that are capable of activating the amygdala, or fear centre, in the brain. Instead of creating protective memories, the rush of adrenaline creates memories that intrude on everyday life. Without treatment, these negative memories can actually pose a threat to a person's life.

What are the symptoms?

The symptoms of PTSD often begin within three months of the traumatic event. Sometimes, however, the symptoms may appear years later. There are three categories of symptoms.

1. Re-experiencing the event

This is the main characteristic of PTSD, and it can happen in different ways. Most commonly, the person has powerful, recurrent memories, nightmares, or flashbacks where they relive the traumatic event. The anniversary of the traumatic event, or situations that remind them of the event, can unleash dreadful symptoms.

2. Avoidance and emotional numbing

People with PTSD may avoid encountering scenarios that remind them of the trauma. The person may withdraw from friends and family, may lose interest in activities they previously enjoyed, and have difficulty feeling emotions. Feelings of extreme guilt are also common. In rare cases, a person may enter a dissociative state (breakdown of memory, consciousness, or identity), lasting anywhere from a few minutes to several days, during which they believe they are reliving the episode and behave as if it is happening all over again.

3. Changes in sleeping patterns and hyper-vigilance

Insomnia is common among PTSD sufferers, as is hyper-vigilance. Hyper-vigilance can be described as never feeling at peace or safe—even in one's own home. Someone who is hyper-vigilant may have to check the locks on the door over and over, or may not be able to sit in a room that has windows without blinds or curtains. Insomnia and hyper-vigilance often result in difficulty concentrating and finishing tasks, and in increased aggression.

Did you know . . .

In the general population, women are more likely than men to develop PTSD. Why do you think that this may be true?

Other problems associated with PTSD

Many people who suffer from PTSD also develop other anxiety disorders. They may suffer from panic attacks, where they begin to sweat and develop a very rapid heartbeat and feel as though they are going to die. They may suffer from agoraphobia, which is a fear of being out in public.

PTSD sufferers also have higher than normal rates of drug or alcohol use.

Drug and alcohol use can make the PTSD symptoms more intense and may increase the chance that the sufferer will become aggressive or violent.

People with PTSD also may struggle with depression. Feelings of guilt or self-loathing are not uncommon, and these depressed feelings further complicate the treatment of PTSD. Depression may also increase the risk of suicide.

Apply What You Have Learned

Watch this *News in Review* story again and record the symptoms of PTSD experienced by Travis Scouten. Alternatively, locate an article about someone suffering from PTSD and analyze those symptoms. It may be helpful to create a checklist of symptoms before you begin.

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Mental Illness and the Military

Did you know . . .
Canadian military doctors were the leaders in recognizing shell shock as a legitimate health issue and not an example of cowardice.

We all know that war is horrible. Those who fight in wars have to live that horror. In some ways, it is remarkable that any soldier can return from battle and resume his or her former life without disruption. Understandably, some cannot. The extreme levels of stress during battle, the loss of friends, and the witnessing of death and destruction have a significant psychological impact on many soldiers. These are not new problems for soldiers, and the army has never made it easy for soldiers to talk about their psychological problems and seek help. But you will see in the following information that attitudes are beginning to change for the better.

Shell Shock in the First World War

During the First World War, the term *shell shock* was used to describe various mental problems experienced by soldiers. Following time in the trenches, some soldiers became paralyzed or panicky. At the time, the military believed that the soldiers' problems were caused by the sound waves of exploding shells. But the military also believed that soldiers who were paralyzed by those sounds were "cowards." Consequently, they were forced back into action. Soldiers who refused to carry out their duties could be imprisoned or face death by firing squad.

By the end of the war, the large number of soldiers suffering from psychiatric problems, and the lack of available soldiers to replace them, resulted in the military developing an efficient and effective treatment protocol. The soldiers were treated as close to the front lines as possible and as quickly as possible so they could return to active duty in the shortest time possible.

Combat Fatigue in the Second World War

Soldiers who "lost their nerve" and didn't want to continue fighting in the Second World War were said to have "combat fatigue." These soldiers shared an overpowering desire to escape from combat and showed signs of anxiety and memory loss. Unfortunately, the lessons learned about psychiatric disorders in the First World War were not initially part of standard operating procedure in the Second World War. As a result, many soldiers suffered as these lessons were relearned.

In the article "Wounds without scars: Treatment of battle fatigue in the U.S. armed forces in the Second World War," published in *Military Affairs* in 1985, Brian Chermol uses the U.S. campaign in North Africa to describe the huge strain that combat fatigue placed on the military's medical departments. In November 1942, three U.S. divisions were deployed in North Africa to assist British troops in driving German forces out of the region. Within months, the number of soldiers being evacuated for battle fatigue exceeded the number of soldiers available to replace them. As a result, cooks, mechanics, and other support personnel had to be pressed into service as infantrymen. Within the original infantry units, every soldier involved in the initial landings who was not killed, injured, or diseased eventually became unable to fight because of combat fatigue. This pattern continued until a neuropsychiatrist (a physician capable of understanding brain-behaviour relationships) was placed at the front and began to apply the principles and techniques developed during the First World War.

Did you know . . .

Some military units in the Second World War kept reported cases of combat fatigue artificially low by not counting soldiers sent to rest homes for short periods of time or discharged from service.

From PTSD to Personality Disorder

Although we are learning more about mental illness all the time, it seems that in some ways the military has been slow to respond to this new information. Or perhaps, it is just harder to change the attitudes that exist within a traditionally male-dominated institution like the military. Regardless of the reasons, it appears that the military is still not doing enough.

In an August 20, 2006, article entitled “Treating the trauma of war—fairly,” Judith Schwartz wrote that the United States military had started to give thousands of enlisted men and women a new diagnosis: “personality disorder” (*The Christian Science Monitor*). By changing the label from PTSD to personality disorder for a soldier suffering from the psychological effects of war, the government would not be held responsible for treating the ill soldier. That is because a personality disorder—defined as an ingrained, maladaptive way of orienting oneself to the world—would be considered a

pre-existing condition that predates a soldier’s tour of duty. And this would save the military the cost of medical treatment.

Schwartz believes that the new label of personality disorder is also terrible because it sends the message that the suffering is the soldier’s fault, not the fault of the war. It implies that a healthy person would be able to resist the psychological trauma of war.

“Someone who succumbs to the flashbacks, panic, and anger that haunt many former soldiers must have something inherently wrong with them. It’s the psychological side of warrior macho: If you’re tough, you can take it. Of course, we know this is not true” (Judith Schwartz, in *Christian Science Monitor*, August 20, 2006).

It will be necessary for the military to reconsider and stop imposing this label on recruits if there is ever to be the cultural shift required that both recognizes and destigmatizes the need for psychiatric care.

To Consider

Reflect on what you have learned about how the military has traditionally seen and treated mental illness. Based on that information, provide a response to the two men who made the following quotations:

1. A commanding officer, consulted about the suicidal behaviour of Travis Scouten: “I was in Afghanistan too. Suck it up.” — *News in Review*, February 2008
2. Alberta paratrooper and D-Day veteran: “We didn’t have a problem. We saw it all. The graves. We not only had to shoot [enemy soldiers in battle], we had to bury them afterward. We had to put the ropes on them. Arms came off. Legs came off. We saw it all. But after, we were all right.” — “Great stress upon stress: The Defence Department begins a proactive approach to combat post-traumatic stress disorder,” *The Report Newsmagazine*, March 18, 2002

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Helping Soldiers

Coming back from war is a very difficult transition. After all, a soldier goes from being involved in a dangerous mission one day to paying bills and taking out the trash the next. It is also a challenge for the families of returning soldiers. Spouses who have adjusted to being single parents in their partner's absence have to readjust to shared parenting and a modified routine around the house. Children who have adjusted to living without their mother or father now have a new parent back on the scene.

The Canadian military tries to make the adjustment back to civilian life an easier one for soldiers and their families. They do this through a program of decompression, reintegration, and post-deployment monitoring and treatment.

Decompression

When soldiers finish their tour of duty in Afghanistan their first stop is a decompression stay in Guam, an island in the Pacific Ocean. They are reintroduced to comfortable bedding and fast food—a big change after sleeping in tents or dormitories and eating army food. They also receive instruction on managing the stress, depression, burnout, and suicidal feelings that can result from time spent in a combat zone.

Reintegration

When soldiers first return to their own country, they get a two-day leave with their families. This family visit occurs outside the military base. After that, they return to the base for a one-week work

integration program. Then they get a 55-day leave. During the fourth week of that leave, the military checks in with the soldiers and gives them a complete medical examination. At the end of the leave, the soldiers return to duty. This program is designed to gradually reintegrate them into civilian life and to catch any problems they may be experiencing as quickly as possible.

Post-deployment monitoring and treatment

The transition process continues for a few months after the return to Canada. Medical and mental-health follow-up measures such as questionnaires and medical examinations continue for about six months after a deployment. These measures help to identify psychological and other types of injuries that were not immediately evident upon their return. Veterans and peer co-ordinators are available to provide social support during this time.

Dr. Mark Zamorski of the Canadian Forces Health Services (www.forces.gc.ca/health/engraph/home_e.asp) notes that while the majority of soldiers who return from a deployment will adjust well following the reintegration process, some soldiers requiring assistance will be missed. This is because post-deployment monitoring cannot identify every single soldier with mental-health issues. As well, some soldiers may be reluctant to admit having any symptoms for fear that they may be stigmatized within their families or among their colleagues.

Reflection

Based on what you have learned about PTSD in this *News in Review* story, are there any additional measures that you believe the Canadian Forces should take to assist returning soldiers?

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Treatment for PTSD

Obtaining appropriate treatment for PTSD is not always easy, particularly in the military. That is because negative attitudes and stereotypes about mental illness prevent some sufferers from coming forward, and because there are not enough psychologists and trained therapists to deal with the number of people suffering from the disorder. However, PTSD sufferers can be helped and can live a normal life again.

Treatment for PTSD often involves a number of stages. The most common include the following:

A) Crisis Stabilization and Engagement

- PTSD symptoms can flare up and plunge a sufferer into a crisis. If this happens, the person needs to access a 24-hour counselling service or be taken to a hospital emergency ward. During the time in hospital, medication will be administered to deal with the most severe symptoms, and a cooling-off period will occur for the patient and the family.
- Once referred to a psychologist or therapist the person will need to take some time to establish faith and trust in the counsellor. This can be very difficult for those who have suffered trauma, as it may have been a long time since they were able to trust anyone.

B) Education and Information

- Becoming informed about the disorder can help sufferers to understand that they aren't "crazy" and that they aren't alone.
- With greater information, sufferers can come to realize that the symptoms they have are the normal result of the trauma they suffered or witnessed. This is often

very reassuring for the person with frightening and disturbing symptoms.

- People who have been through a traumatic event often have trouble understanding what happened and why it happened. Therapists often help the sufferers to find out more about what happened during the event. A good understanding of exactly what happened and why it happened often facilitates recovery.

C) Symptom Management

The symptoms of PTSD often interfere with daily functioning, so it is very important to develop effective strategies to cope with the symptoms. Once people can recognize and cope better with the symptoms, they are able to function more effectively in their lives. Symptom management includes:

- Learning techniques to reduce levels of anxiety and arousal.
- Reducing levels of anger and irritability by learning how to identify early warning signs of stress, learning how to re-evaluate a situation to keep it in perspective, learning how to stay calm in difficult situations, and learning problem-solving strategies to deal with disagreements.
- Reducing and managing depression by identifying patterns of depressive thoughts and realistically evaluating and challenging negative beliefs and thoughts.
- Helping patients to reduce sleep disturbances.

D) Exposure Therapy – Confronting Feared Situations or Memories

- Anxiety causes people to want to escape or avoid situations, thoughts, memories, or feelings that are painful

Did you know. . .

In January 2008, a report noted that Toronto Transit Commission drivers suffered from a high incidence of PTSD. The drivers appear to be dealing with high levels of abuse and even violence from riders. What other non-military groups in Canada might you expect to suffer from PTSD? Why?

or distressing. However, this avoidance is one of the major impediments to recovery.

- Exposure therapy helps people to confront the feared situation in a very controlled and gradual fashion.
- By building upon repeated successes in facing these feared situations, people are eventually able to confront them without anxiety.

E) Cognitive Restructuring

- Cognitive restructuring is an important part of treatment because it helps to identify maladaptive (negative) thoughts and replace them with more realistic thoughts.
- This is particularly important for people who may feel they are bad or evil for acting the way they did during a crisis. Cognitive restructuring can relieve feelings of guilt, anger, or shame.

F) Psychodynamic Psychotherapy

- Some therapists use a psychodynamic approach to help patients with PTSD. This approach attempts to make connections between the traumatic experience and vulnerabilities in their

earlier life. In other words, they try to understand how current situations evoke traumatic responses even though the original trauma is past.

- For some people, disruptive and traumatic experiences early in life can make them more likely to respond negatively to trauma later in life. Therapists look for connections between such negative experiences to free individuals from excessive or unreasonable guilt.

G) Relapse Prevention

- For many people, PTSD is a chronic disorder that flares up from time to time even following treatment. Preventing or reducing the number of recurrences is important.
- Patients are taught how to recognize that times of stress may lead to flare-ups and but that the recurrence does not mean they are going to become extremely ill again. At the time of a flare up, patients need to practise the techniques they learned to help them manage their symptoms. They may also need to contact their doctor or therapist.

Activity

Based on what you have learned about the treatment for PTSD, work with a partner to draft a treatment plan for Travis Scouten. When you are finished, exchange your plan with another pair of students and compare the two documents.

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Letter-writing Activity

The Facts

- About 15 per cent of Canadian soldiers returning from Afghanistan will have mental-health problems.
- Their mental-health problems may include post-traumatic stress disorder, suicidal tendencies, or problem drinking.
- Mentally ill soldiers may suffer from night terrors, anxiety, and intrusive thoughts.
- The families of these soldiers suffer; some of them experience domestic violence.
- There are not enough trained mental-health practitioners within the Forces.
- Many soldiers are reluctant to admit they are having problems or come forward for help because of the negative stigma associated with mental illness within the military.

Frederic Couture was 21 when he stepped on a landmine while on patrol in the Panjwai district of Kandahar in December 2006. He lost part of his left leg and returned home to Quebec. He received a lot of media attention because of his positive attitude and determination. In an interview with CBC News in January 2007, Couture appeared unconcerned about his future:

"My life is not finished. I'm going to have a prosthesis (artificial substitute for a part of the body). And all the things that I was doing, I'm going to do it in the future. It's not because I lost a foot that I can't do anything" ("Coroner probing suicide of Quebec soldier wounded in Afghanistan." CBC broadcast transcript, November 16, 2007).

Couture's neighbours and family were shocked when he shot and killed himself in November 2007. Forces personnel were also upset and stated that they believed he had been recovering well, both mentally and physically.

Your Task

Write a letter to your local MP or the Minister of National Defence outlining the steps you feel the Canadian Forces should take to assist soldiers with mental-health problems. Remember mail may be sent postage-free to any member at the following address:

House of Commons
Parliament Buildings
Ottawa, Ontario, Canada K1A 0A6

Include the following elements:

- Date and return mailing address
- A formal greeting (Dear Mr. or Ms., Dear Minister)
- A short body paragraph outlining what you believe needs to be done
- A respectful salutation (Respectfully, Yours truly, Yours sincerely) followed by your name

You can send your letter to the Minister of National Defence electronically through the following Web site: www.dnd.ca/site/contact_e.asp

Or you can send the letter through the mail to:

Minister of National Defence
National Defence Headquarters
Major-General George R. Pearkes Building
101 Colonel By Drive
Ottawa, Ontario, Canada K1A 0K2