STRESS INJURY AND OPERATIONAL DEPLOYMENTS
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COMMANDER’S FOREWORD

This Dispatches is intended to be thought-provoking and to stimulate discussion. Stress injury is a controversial area for the simple reason that it cycles in and out of contemporary thought and, until recently, has almost been an uncomfortable subject to discuss. It is time to remove any remaining discomfort and properly set our soldiers up for success before, during and after missions.

From my perspective, there are three important axioms leaders at all levels should take to heart in their fight against stress injury:

First, **Know your soldiers!** Simple, but this remains the most effective way of determining what strengthens them, when they are having an adverse reaction to stress, and what are the most effective things to do to help them recover.

Second, **Create a work environment within your unit that fosters acceptance and open discussion.** Cohesion is probably the most important factor in the prevention of stress injury. Junior leaders need to create a working/fighting environment where group cohesion and support are present at all times. I know this sounds like a motherhood statement, but the reality is that traditional group cohesion works and is significant in the fight against stress injuries.

Finally, **Seek out appropriate medical expertise** and work with those experts for the benefit of your soldiers.

One final thought: this Dispatches, for the most part, stayed away from Post Traumatic Stress Disorder or PTSD. Not to minimize the problem, but the danger is that when we focus only upon PTSD, many of our soldiers who suffer psychological injury from their deployments and yet fall outside the rubric of PTSD, will be overlooked or ignored, thereby compounding that injury. Continuing to focus solely on PTSD vice stress injury in general will result in soldiers becoming angry when told that they do not have a diagnosis of PTSD, even though it is clear that they are suffering. Consequently, I am very happy that this document provides a broader ‘treatment’ to the area of stress injury, and in turn, should prove to be a more comprehensive reference tool in combating stress injury.

I encourage you to read through this Dispatches, and discuss it with your soldiers. I would also recommend discussing it with your mental health care team members. They form your resource experts: use them!

R.J. Hillier
Lieutenant-General
Chief of the Land Staff

DISPATCHES 1
PART 1—BACKGROUND

The survivor...cannot but wonder for the rest of his life how or why he did not go with the unfortunate instead of being a survivor of it all. When the fire is heavy, one forgets the danger and instinctively follows his call for duty. When he has time to think is the time of greatest danger of running away...in every campaign or rather every battle there comes a time when the bravest may say 'I can do no more'.

—Extract from an account of the War of 1861 by soldier Joseph Taylor Smith, from Shook over Hell: Post-Traumatic Stress, Vietnam, and the Civil War


Stress injury is not a new phenomenon. The terms above demonstrate the sad reality that stress injury has been around for a considerable period of time but has never quite been understood properly. Whatever terms are used to describe stress injury—rightly or wrongly, as the terms above are not all related to the same disorder—they all describe soldiers who for any number of reasons are unable to cope with the demands of battle at a certain point in time.

Dealing with stress reaction involves the ability to control stress not avoid it. Stress cannot and, indeed, should not be avoided as it can produce many positive benefits. At the same time, it is essential that soldiers learn to properly manage their stress, or give themselves a chance to properly recuperate from it. How they handle stress can make a huge difference in their response to a stressor and can help avoid reactions which, in the extreme, can lead to deliberate self-injury or suicide. We all need to recognize the reaction stress is having upon us and learn to control that reaction. We also need to learn when to ask for help in dealing with stress, whether that help is from our buddies or from health care professionals.

This Dispatches aims to examine stress and combat stress reactions in particular. The warning signs of stress reaction will be outlined, as will practical avoidance and remediation techniques for dealing with that reaction during the pre-deployment, deployment and post-deployment phases of any operational mission.

Mental illness carries with it a stigma that is not attached to those who suffer from demonstrably physical conditions.

—Extract from the Changing Mind, a recent information campaign by the UK Royal College of Psychiatrists
PART 2—DEFINING PSYCHOLOGICAL INJURY

The terminology of psychological injury has changed over the decades, keeping pace with the recognition of the problem and its effect on troops in combat. While not exhaustive, the following terminology will give the reader an understanding of the issues which will be explored within this Dispatches and will allow the lessons to be placed in context. Please note that terminology is constantly changing: as this Dispatches was being written, the author learned that the newest buzz word in the military community is "Operational Stress Injury," which has been included for edification.

- **Stress.** The first of the terms to be used is stress, defined by the *Concise Oxford English Dictionary of Current English* as a "demand on physical or mental energy." Stress is more familiarly looked upon as defining an adaptive process by which an individual interprets, consciously or unconsciously, a significant environmental event, either real or perceived, and reacts accordingly (i.e., the fight, freeze or flee response). Each person's interpretation of the event (often called a stressor) is unique and based upon that person's own experience and expectations. In its simplest form, stress is the wear and tear experienced as we adjust to a continually changing environment. Stress can be both positive and negative: it can compel us to learn and increase our awareness of our surroundings, or it can increase negative feelings like mistrust and anger and promote the development of health problems like ulcers, headaches and upset stomach.

- **Combat Stress Reaction (CSR).** CSR has come to encompass a number of older terms, including battle fatigue, battle shock, shell shock and combat exhaustion—the more general term neuropsychiatric casualty has been used in the past as well (World War II in particular). CSR refers to a number of reversible effects caused by the stresses associated with operations and can be the result of a critical incident or incidents. It usually involves temporary (although it can also be longer term) psychological injury that can render a soldier unable to function normally, to engage the enemy or even to survive. Whereas the onus for stress management is on the individual, management of CSR is a leadership function.

A World War II study done by two researchers, Swank and Marchand, included a determination that after 60 days of continuous combat, 98 percent of all surviving soldiers will have become psychiatric casualties of one kind or another. Swank and Marchand also found that the 2 percent who are able to endure sustained combat had as their most common trait a predisposition toward "aggressive psychopathic personalities."
CSR is related to a number of factors including the duration, type and intensity of battle. In Grozny, for example, Russian Major-General V.S. Novikov, a senior academic from the Russian Military Medical Academy, found from a sample of 1312 troops:

- 28% were healthy.
- 72% were stress casualties, more accurately broken into:
  - 46% exhibited symptoms like insomnia, lack of motivation, anxiety, neuro-emotional stress or tiredness; and
  - 26% exhibited psychotic reactions—high anxiety, aggressiveness, deterioration of moral values or interpersonal relations, excitement or depression.

More Statistics, Damned Statistics...

W.J. McAndrew, in an article entitled "Stress Casualties: Canadians in Italy 1943–45," claimed that for the infantry alone, Canadian stress casualties in the 1st Canadian Division amounted to some 507 soldiers between 28 November 1943 and 12 February 1944 and another 370 between 25 March 1944 and 17 June 1944.

Yet consider the stress casualty figures from the 15th Infantry Division during the period 08 February to 10 March 1945: as part of XXX (British) Corps, the division suffered the second highest battle casualties within the corps (just over 1000 casualties), yet had a psychiatric casualty rate that was half (about 10%) of the other infantry divisions within the corps—this during a period that included a number of hard battles, such as Operation VERITABLE, the Reichwald Line and the Siegfried Line. Analysis has attributed much of the success enjoyed by 15th Infantry Division in warding off combat stress casualties to the measures adopted by MGen F.M. Richardson, then the Divisional Assistant Director of Medical Services (ADMS). Two conclusions can be drawn from the division's experience: first, and most importantly, stress casualties can be reduced (measures that have proven effective in the past, including those adopted by this division, will be discussed later in this Dispatches); and second, statistics cannot be used to predict CSR casualties.

- **Post-Traumatic Stress Disorder (PTSD).** The *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition* (published in 2000 by the American Psychiatric Association) defines PTSD as follows:

  The development of characteristic symptoms following exposure to an extreme stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threats to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate. The person's response to the event must involve intense fear, helplessness, or horror. The characteristic symptoms resulting from the exposure to the extreme trauma include persistent re-experiencing of the traumatic event, persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness, and persistent symptoms of increased arousal. The full symptom picture must be present for more than one month and the disturbance must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

PTSD is a legitimate medical condition and manifests itself in a variety of symptoms and with a wide range of severity among individuals. Some PTSD sufferers may be...
able to continue functioning within a military environment, while others may not. As with any health problem, treatment is usually more effective if the condition is identified early.

The following figures are related to American Vietnam veterans suffering from PTSD and are taken from The National Vietnam Veterans Readjustment Survey (Kulka et al):

- Over 30% of male and 26% of female veterans are believed to have PTSD. Another 22% of male and 21% of female veterans have had partial PTSD at some point in their lives.
- 40% of male veterans with PTSD have been divorced at least once, 14% have high level of marital problems, and 23% have parental problems.
- Almost 50% of male veterans with PTSD have been arrested or jailed at least once. Over 30% have been jailed more than once. 11.5% have been convicted of a felony.
- Lifelong alcohol abuse is estimated at over 39% for male veterans with PTSD while alcohol dependence is estimated at 11%.

Tracking of PTSD in Canada is in its infancy. Nevertheless, the existing statistics do indicate the presence of a serious problem that merits attention. PTSD is often misunderstood, does not inspire a great deal of empathy with those afflicted and is often misdiagnosed. Unlike CSR, which—as the historic terms combat stress, combat or battle fatigue and shell shock—indicate, is often short term in nature, PTSD is a long-term condition that can result in permanent disability. It has the potential to affect anyone, regardless of rank, age or sex and is truly an equal-opportunity affliction. It is an impairment on a soldier's ability to function normally either in combat, in garrison or even in social situations outside the military. In its most extreme forms, PTSD can result in anger and violence, leading to self-destructive behaviour including suicide.

Compare those statistics with the recent findings from the 2003 CF Mental Health Survey conducted for the CF by Statistics Canada:

Current CF data shows that the 7.2% of the CF Regular Force has suffered from PTSD at some point in their lives, with 2.8% having suffered from this condition within the previous year. For those who have completed three or more operational tours, the figures rise to 10.3% in their lifetime, and 4.7% over the previous year.

So what is the relationship between CSR and PTSD? Or is there one?

PTSD can result from inappropriate treatment of CSR, although this is not universal. At least one source has suggested that even with the proper treatment of CSR, a percentage of such cases have developed into PTSD. The bottom line is that the development of PTSD is not dependent on CSR. In fact, soldiers who develop PTSD may not have suffered from CSR or acute stress disorder at all.

Other terms that don't relate specifically to stress injury but have been used or may be encountered include the following:

- **Operational Stress Injury (OSI)**. This is neither a medical nor a legal term, and it has limited utility in this Dispatches. Instead, it is a generic term used to identify any stress injury that develops from an operational deployment. Any number of stressors, including financial and family problems, can contribute to the overall stress experienced by the soldier while deployed operationally.
Traumatic Incident. Often labelled "critical incident", a traumatic incident is more narrowly defined as an event which causes feelings of intense fear, helplessness or horror and can cause serious psychological or physical injury. Examples of the type of incident which would provoke such reactions include:

- **Injury or Death.** The serious injury or death of a fellow soldier, a civilian or any such incident involving women or children, especially when it happens in a traumatic manner.

- **Near Miss.** A near miss with a projectile, shell or mine.

- **Handling of the Dead.** The handling or movement of a dead body or bodies—remember that for most people, the handling of even a single dead body, never mind exposure to a mass casualty or grave situation, may be sufficient to provoke a significant emotional response.

Note that the list above is not exhaustive: there are other events which most would not consider traumatic, but some would. As an example, driving along a coast road in Bosnia with a dramatic drop off on one side would be considered traumatic to some drivers. The bottom line: avoid being judgemental in applying your perception to what should be considered traumatic.

Critical Incident. This term encompasses any event which provokes a strong, unpleasant emotional response. It can include, as an example, bad news from home (e.g., a child taking ill) while deployed.

Critical Incident Stress Debriefing (CISD). CISD is but one form of debriefing that has, in the past, been used to debrief those involved in a critical incident as soon as possible after the incident. CISD follows a fairly rigid format, which is outlined later in this Dispatches. Note that CISD was under review as this Dispatches was written: some research has shown it to be a potentially harmful process for some people. Consider the following:

**Stress debriefings became routine after critical incidents involving deaths (military or civilian), mine strikes, intensive shelling or small arms firefights. Even so, the unit's overall stress level rose significantly after the 4–5 days of the Medak Pocket Operation. The unit asked for and received additional stress counsellors from LFWA HQ to assist the in-place teams for the period 26 Sep–4 Oct 93. This was very successful and when integrated with the 2 PPCLI counsellors already in place, also served to prepare the soldiers to reintegrate back to their family lives on arrival in Canada.**

—Extract from the Op HARMONY Roto 2 Post-Operation Report

Despite this, the Op HARMONY group experienced a large number of long-term stress injuries, more than has been typically experienced on like missions. While in the short term, CISD may have provided some relief, in the long term, CISD does not necessarily prevent PTSD or other stress injury, contrary to public mythology.
While there is some agreement that some form of debriefing is helpful in some situations, there is not universal agreement as to what form that debriefing should take. Leaders at all levels should seek out appropriate medical advice on the timing and format of an appropriate debriefing process. Participation in these debriefings must be understood to be voluntary, and those who choose to participate must be made aware of the limitations and possible consequences of this type of intervention.

PART 3—UNDERSTANDING COMBAT STRESS REACTION: THE FIRST STEP TO PREVENTION

Feedback from a number of American WWII battalion surgeons indicated that the psychosomatic form of battle fatigue was the most common form seen at battalion level and is believed to have accounted for a large percentage of the patients seen at battalion aid stations during the heaviest periods of fighting.

Examples of psychosomatic forms of battle fatigue include stomach aches, indigestion, diarrhoea, back or joint pain, rapid or irregular heartbeat, and headaches.

—Extract from American Field Manual 22-51 Leader’s Manual for Combat Stress Control

The first step in CSR prevention is understanding stress and recognizing the symptoms of stress. While defining stress and stress-related terminology gives a better understanding of stress, the key to recognizing stress and CSR is the presence of easily recognizable symptoms. There are both physical and emotional symptoms of stress injury. The indicators listed below are warning signs, which should be treated as quickly as possible. Non-treatment can lead to festering and eventually to more serious stress-related problems. As with all potential injury, consult your medical staff for advice and direction on how best to deal with these symptoms.

Physical Symptoms

- Aches, pains, shaking or trembling, weakness in the legs, fidgeting.
- Easily startled by sudden sounds or movement.
- Cold sweats, dry mouth and pale skin.
- Feeling dizzy or light-headed, pounding heart.
- Out of breath.
- Upset stomach, including possible vomiting.
- Diarrhoea or constipation, frequent urination.
- Emptying of bowels and/or bladder at instant of danger.
- Feeling tired, drained, movement becomes an effort.
- Distant or haunted look, the so-called "1000-yard Stare."
- Substance abuse.
Mental or Emotional Symptoms

- Anxiety.
- Increased irritability, swearing, complaining, easily disturbed.
- Difficulty in remembering details or paying attention.
- Difficulty in communicating with others.
- Troubled sleep, awakened by bad dreams.
- Grief, including crying for dead or wounded friends.
- Feeling bad about mistakes or about the consequences of actions taken.
- Anger towards leaders or others in the unit.

The problem for the leader is that often soldiers may attempt to either minimize their problems or will deny them outright (so-called "negative malingering" or "toughing it out"). Others will attempt to communicate when they feel unable to continue with their mission in a combat zone. That communication will be made in such a way as to allow the soldier to ensure his exit from the combat zone is made without generating feelings of hostility against him. Obviously, a leader must seek to support the affected soldier during his mission and will be working to ensure that he remains in combat. What becomes critical is the ability of the leader to recognize that the soldier's inability to continue in combat may not be communicated verbally, but more often through the appearance of the symptoms identified above.

In either case, a leader must be vigilant and recognize that those manifesting CSR symptoms will usually require some modification of their duties, perhaps something as simple as rotating front line troops and returning those affected to base camp.

There are a number of so-called physical function disturbances which manifest themselves in the absence of any physical injury. While the physical symptoms above may be indicative of stress, these "disturbances" should be considered the unconscious manifestation of CSR:

- Motor disturbances, including weakness or paralysis of limb or body, sustained contraction of muscles and gross tremors.

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It started to get difficult. Terror began to get the better of me. I was surrounded by the injured and the dead. I had to continue to fight, I was the best soldier… I couldn't be a disappointment. I began to think about death. I felt lonely, defenceless… The doctor and the platoon commander asked me what had happened. I couldn't disappoint them and destroy my image, so I told them I had a problem of conscience, of ideology.

—Extract from an account by a young Israeli paratrooper during the 1982 War in Lebanon
(sometimes including the loss of consciousness).

- **Visual problems**, including blurred or double vision, tunnel vision or total blindness.
- **Auditory symptoms**, including ringing of the ears, deafness or dizziness.
- **Tactile sensory changes**, including loss of sensations, or abnormal sensations like "pins and needles."
- **Speech changes**, including stuttering, hoarseness or muteness.

**Physical function disturbances** manifest themselves more often in so-called elite units or groups (such as the officers of airborne units) than in other units. Such units often have a culture of social pressure or heroic self-image which does not allow the expression of emotion.

The physical symptoms of combat stress also manifest themselves more often among soldiers who come from social and cultural groups that have not learned how to express their feelings in words.

—Extracted from FM 22-51 Leader's Manual for Combat Stress Control

OK, Now for the Theory of Fight, Flight or Freeze: The Role of the Adrenals.

*Man's troubles are rooted in extreme attention to senses, thoughts, and imagination. Attention should be focused internally to experience a quiet body and a calm mind.*

—Buddha

The next step in dealing with stress is to understand the role of your adrenal glands and the involuntary responses they can provoke in your body during a traumatic incident or a time of significant stress. **Note that this is theory and, while these theories have been postulated, none have yet been proven.** Nevertheless, there are still valuable messages that should be communicated by leaders to their soldiers (please see the recommendations at the end of each "theory" section).

Life-threatening situations will cause your adrenal glands to begin pumping either adrenaline or noradrenaline into your system. In the case of adrenaline, your body is placed in a state of hyperalertness: your heart rate, blood pressure, muscle tension and blood sugar level all increase. The adrenaline surge allows your body to become more capable of either fighting back against, or running away as powerfully as possible from, the threat. This is often referred to as the fight-or-flight response. Essentially, your body has been given a super boost of energy. The boost in energy also manifests itself in heightened sensory data. Sounds, smells and other sensory data become more acute and tend to be impressed upon our memory more fully than normal. This explains in part why trauma is sometimes played back over and over when triggered by certain stimuli.

On the other side of the equation is the noradrenaline surge. This will cause an involuntary freeze reaction. Moving or acting becomes difficult and, in some cases, impossible. It has been described as "moving or thinking in slow motion." At the
same time, as with an adrenaline rush, your body becomes hyper-aware of its surroundings and sensory data becomes very acute. As with the adrenaline rush, the memory is imprinted with the trauma and can be triggered by certain stimuli in a post-traumatic setting. One important difference, though, is that the noradrenaline experience can often result in feelings of massive guilt because individuals went limp, couldn't think or couldn't do anything in a specific situation. While difficult to overcome, it is important to remember that the noradrenaline response is not the result of a lack of courage or a lack of dedication: rather, it is a largely involuntary reaction, one over which we have little to no control.

The adrenaline response can also result in increased violence. Soldiers in battle have been tempted to use their adrenaline rush in forms of abusive behaviour, needless killings and other acts of violence. It is a leadership responsibility to channel the adrenaline surge constructively, to control the violence in combat, as strange as that concept may seem. Excessive and criminal adrenaline violence is not excusable and must be controlled.

Consider the recent examples of the effects of an unchecked adrenaline rush. Philip Caputo described a pursuit during the Vietnam War in which a Marine Company turned "savage": "This was especially true of 1st platoon; they had done the actual killing, and once men begin killing it is not easy to stop them." The dead included an executed Viet Cong wounded during the fighting. The massacre at My Lai by an American company of young and inexperienced soldiers who were demoralized by heavy casualties resulted in the murder of some 347 unarmed non-combatants. Anecdotal evidence from Grozny has indicated similar unchecked violence by both the Russians and Chechens.

A post-operation report (POR) comment which has surfaced more than once has indicated that too often pre-deployment training scenarios have been terminated after a significant or stressful event. This has resulted in leaders not being forced to deal with regaining control over adrenal-pumped soldiers. Anecdotal evidence has suggested that this has often been the case with Crowd Control training in particular.

**RECOMMENDATION**

When monitoring your soldiers' reaction to traumatic or stressful situations, be prepared for the adrenaline rush and be sensitive to the need to maintain control over that excessive energy. Good discipline based upon trusted leaders is the key to avoiding criminal behaviour. At the same time, soldiers need to be reassured that their response (or lack of response) is quite normal and not the result of a lack of courage or dedication.

More Theory on Prolonged Stress: I Need You; I Don't Need Anyone...

All of us are nicely balanced between courage and cowardice, and we find ourselves with anxiety controlled, expressing itself only through the autonomic nervous system; yet there must for many come a time when courage, however well cultivated and maintained, fails to operate... Broadly speaking, it is true that any man MAY break down, granted that there are sufficient predisposing causes... The man who has a high personal morale, and is well trained and happy in a well-disciplined group, will manage his fear better than the man who has not got those qualities or circumstances.

—Statement by Brigadier Rees, a British Army psychiatrist in 1945
Prolonged stress can subject the body to excesses it was not intended to handle. The result, simply put, is to overstress the body and subject it to permanent damage. One area of potential damage is to your neurotransmitters, which help the body regulate the intensity of emotions and moods. Repeated or intense stress can result in the depletion of the neurotransmitters and may lead to a number of reactions, including clinical depression, mood swings, explosive outbursts, over-reaction to subsequent stressors and the startle response.

Other reactions can include the over-dependence response ("I can't make it without you") or the unrealistic independence response ("I don't need anyone"). Consider this third theoretical reaction, the so-called Learned Helplessness Syndrome, put forward by Martin Seligman and defined in his own words as follows:

*When an organism has experienced trauma it cannot control, its motivation to respond in the face of later trauma wanes. Moreover, even if it does respond and the response succeeds in producing relief, it has trouble learning, perceiving, and believing that the response worked. Finally, its emotional balance is disturbed: depression and anxiety, measured in various ways, predominate.*

Prisoners of war, in particular, and other veterans of combat have struggled with this syndrome long after the imprisonment or combat is over, dealing with the passivity, anxiety and depression that come from having learned to be powerless.

It is important to understand that that there are a number of factors involved in the stress response, some of which we can't directly control. Nevertheless, we need to appreciate that we can learn to understand what is happening and eventually overcome stress response. It is not irreversible!

**Factors Contributing to Combat Stress Reaction**

From his studies of earlier wars (statistics are cited earlier in Part 1), Russian General Novikov found that two main lessons have become prominent:

- The longer a soldier was stationed in war zone, the more radical the change in his neuro-psychological condition.
The most stressful activities were house-clearing and booby-trap disarming.

**RECOMMENDATION**

Implement a regular rotation schedule for troops participating in combat or any stress-related activities (e.g. close quarter fighting in a built-up area, excavation of mass graves or explosive ordnance or improved explosive device disposal (EOD/IEDD work). Training programmes should be designed to expose troops to such combat or stress-related activities, the goal being to reduce their uncertainty in similar situations and improve their ability to deal with the unfamiliar. Establish a rest area in a secure location, far enough from the frontlines that troops are able to relax and unwind.

The Israeli Army has conducted studies on combat stress and has identified what they believe are the two key factors which are more likely to influence soldiers to become combat stress victims when coupled to a critical incident(s):

- **Lack of Unit Cohesion.** Soldiers who were newly attached to units were more likely to become stress casualties than those who had been with the unit for some period of time and had time to become identified as a member of the group. How long it takes for soldiers to become integrated into a unit is difficult to quantify.

> Commands must therefore resist turbulence in their units. Every effort must be made to keep companies, platoons, and sections together for lengthy periods so that the bonds so necessary in war can be forged in peace. It is horrifying, when one examines recent operations, to see how the ad hoc unit has become normal practice. In war such an organization is a potential mob. When we either hamper the build-up of company and regimental loyalty, or deliberately break it down, we throw away one of our major assets.

—Major General T.S. Hart

Downsizing in the Canadian Forces is likely contributing to the incidence of post-traumatic stress among peacekeepers, especially in the army, two retired generals contend...As the military cut its numbers, [General] MacKenzie said, battalions shrank to around 600 people. But most peacekeeping missions need around 1,000. Reservists and members of other units were dragooned in to flesh out the numbers, leaving patchwork battalions. The soldiers don't know and don't trust their comrades, they don't know the officers and the officers didn't know them.

The battalion MacKenzie took to Sarajevo...had soldiered together and lived together for years...and were a close-knit bunch...But such tight-knit units no longer exist.

—Extract from The Kitchener-Waterloo Record, dated 14 May 2001

It is important to recognize that there is a difference between *social cohesion* and *task cohesion*. The former refers to the emotional bonds that are formed through friendship and manifests itself in groups that are *socially cohesive*, spending their spare time together and enjoying each other's company. Some have gone as far as to suggest that social closeness indicates an emotional commitment to each other. The latter, *task cohesion*, refers to a shared commitment to the mission or task at
Members of the group share a common goal and are motivated towards achieving that goal.

However, it is important that leaders recognize that there is a difference: studies have indicated that task cohesion is less critical to successful group cohesion than is social cohesion. Fostering task cohesion is important, but fostering social cohesion becomes almost critical to success and the lowering of the impact of stressors. The recent CF Mental Health Survey confirmed the importance of social cohesion, showing that there is a correlation between the degree to which a soldier feels supported within the unit and within the CF, and the likelihood of them experiencing symptoms of stress injury.

Clearly the leader's role...is to ensure that everyone has a 'buddy.' I would add that this is why special thought should be given [not only] to 'loners' but also to those higher up the chain of command who may, by virtue of rank and responsibility, find it difficult to have a 'buddy.'

—Col Randy Boddam, Director of Mental Health Services

There are also indications that suggest that smaller groups are able to foster a higher social cohesion than larger groups and, therefore, are able to minimize the effects of stress better. While cliques can be problematic to leaders, there is a certain logic to encouraging the creation of smaller, more socially cohesive groups within a unit setting.

Interestingly, external stressors may promote cohesion, while internal stressors related to the group's structure and role or task can often decrease group cohesion.


The Israeli experience from the Lebanese War suggested that reservists in particular are at greater risk for stress related injuries than their regular counterparts.

This was believed to be the result of reservists and/or augmentees who are parachuted into the unit at the last minute, either missing the pre-deployment training entirely or missing a major amount of the training. In either case, the normal confidence and bonds that develop from training are not present: they don't become one of the “family.” Note the following comment from the Ombudsman's Report, which tends to reinforce this problem:

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.

—Attributed to the Reserve Advisor to the DG Health Services, from the Ombudsman's Report
Note that the following from the 2003 CF Mental Health Survey indicates that a CF Reserve Force soldier is not more likely to develop mental illness than a Regular Force soldier:

*Interestingly, data from the recent CF Mental Health Survey show that Reservists, including those who have served on operational tours, suffer from mental illness, including PTSD, at a rate lower than their Regular Force counterparts. Among Reservists who had completed one or more tours, the rate of PTSD over the year prior to the survey was 2.4%, as compared with 2.7% of Regular Force members who had completed one or more tours and 4.7% of Regular Force members who had completed three or more tours.*

Keep in mind, though, while it is clear is that CF reservists are not suffering from mental illness in any statistically greater numbers than their Regular Force counterparts, they have, at least in the past, not been as well served by post-deployment support mechanisms as the Regular Force.

High casualties can also have a profound effect on group discipline, as often the survivors become wary of making too profound an emotional investment in “the new guy.” Particularly at sub-unit and below, leaders must take active measures to ensure this self-preservation mechanism does not come into play, as it can contribute to a breakdown of unit cohesion and an increase in combat stress reaction both among the veterans and among the new members.

**RECOMMENDATION**

Assign a sponsor to all new arrivals to assist them in integrating into the unit and, if required, to assist with their family’s adjustment. After a brief orientation and sincere welcome to the unit, section/platoon leadership should continue regular follow-up contact with new arrivals to ensure their welcome is reinforced.

Although more study is required on the incident rates of CSR and PTSD among reservists and augmentees, a plan must be put in place to ensure that regular post-deployment contact is made with former members of the deployed unit. That contact should be made by former leaders and members from the reserve or augmentee member’s former deployed unit.

- Recent Changes on the Home Front. Both negative problems—Dear John letters, a sick child or debt—and positive—recent marriage or birth of a child—serve to distract soldiers from focusing on their psychological defences. Internal conflict is created over the need to perform well in combat and the need to resolve the home front problem or concern. Note that this is not confined to the soldier’s blood relatives: soldiers deployed on UN missions have also suffered from critical incident stress resulting from incidents involving their local extended families who have suffered a worsening in their situation.
RECOMMENDATION

Know your soldiers! Consider that those soldiers involved in the provision of humanitarian aid, as part of the mission effort or on their own initiative, may form deep-rooted relationships with locals, relationships which can be violently changed or severed overnight in war zones. That type of change in a relationship can cause severe trauma in some cases and should be treated as a stressor.

There are a host of other stressors that can influence the likelihood of combat stress manifesting itself in a unit. These are less likely to be immediately visible but have a very strong collective influence and need to be countered immediately:

- **Lack of Confidence in Leadership.** Confidence in leaders can be based upon their competence, whether the leader cares about the soldiers' welfare or whether the leader is candid or courageous enough. While we generally consider this to be a tactical stressor, this can also manifest itself as a strategic stressor when soldiers become disillusioned with missions that feature restrictive ROE and force soldiers to play the role of bystanders to the violence erupting around them as they are unable to take the necessary steps to stop the violence.

- **Lack of Confidence in Equipment.** Very often, a lack of understanding of supporting arms and equipment capabilities can lead to doubts in the effectiveness of one's own equipment versus that of the enemy.

- **Lack of Information.** Ignorance breeds fear. Keeping people informed about what is happening and what is being planned helps them focus on something tangible rather than wondering about the unknown.

- **Lack of Belief in the Justness of the War.** Loss of faith raises questions about whether the cause is worth suffering and possibly dying for.

- Finally, there are a number of **physical stressors**, such as:
  - Sleep loss.
  - Dehydration and/or malnutrition.
  - Chronic discomfort, including temperature extremes.
  - Poor hygiene.
  - Low-grade fevers, illnesses or infections.
  - Noise, vibration, blast, fumes.

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*DISPATCHES 15*

*We trained hard, but it seemed that every time we were beginning to form up into teams we would be reorganized. I was to learn later in life that we tend to meet any new situation by reorganizing: and a wonderful method it can be for creating the illusion of progress while producing confusion, inefficiency and demoralization.*

—*From the writings of Petronius Arbiter, 210 B.C.*

*It is fatal to enter any war without the will to win it.*

—*General Douglas MacArthur*
OPERATING WITHIN A CHEMICAL/BIOLOGICAL/RADIATION/NUCLEAR (CBRN) ENVIRONMENT.

**NOTE**

An *individual's personality type* is not a useful or accurate predictor of combat stress.

**PART 4—PREVENTION AND/OR REMEDIATION OF COMBAT STRESS**

*It is not stress that kills us, it is our reaction to it.*

—Hans Selye

At the strategic level, there are a number of ideas that can be undertaken to reduce the likelihood of combat stress reaction and, by extension, PTSD. Some are clearly not realistic in all circumstances, and others appear self-evident. Nonetheless, whenever possible, all should be considered for their effect on combat stress reaction.

- Ensure that the goals of a particular military operation are well communicated and are legitimate and moral. Soldiers and their families must be convinced that the goals are worthy of the risk to their lives.

- While it is important that the goals of a mission are moral, the mission itself must also be conducted in a relatively moralistic manner. The ends may justify the means, but witnessing or participating in atrocities or other immoral acts places soldier at very high risk for combat stress disorders.

- Dehumanizing one's enemy is considered counter-productive and often leads to self-destructive behaviour. Dehumanization raises internal conflict with ethical values and increases substantially the probability of combat stress disorders.

- Group cohesion is a major stress buffer and, at the same time, a major stress intensifier. On the one hand, group cohesion reduces the likelihood of succumbing to combat stress; on the other hand, the impact when a member of the group is killed or injured is that much greater and more intense. Nevertheless, conventional wisdom is that group cohesion allows for a more rapid recovery from combat stress and PTSD than in a non-group environment.

Consider also the role of religious or spiritual ritual and its importance in creating group cohesion:
The other aspect of group cohesion that needs to be emphasized is avoidance of fostering a we-they rift within a unit. Emphasizing the contributions of those in combat, for example, over those who occupy non-combat positions is counter-productive and leads to an increase in combat stress. Better to emphasize the contributions made by all parties in the unit.

Pre-Deployment Measures

It is important to be aware of, and have availability to, standardized and well proven personal rituals, such as those of a religious or spiritual nature, when a soldier finds themselves under various levels of stress.

—Maj R.E. Gilbert, 33 CBG Senior Chaplain and LFDTS HQ's first Chaplain

There are a number of measures which a unit preparing for deployment can adopt to minimize stress. Combat stress management recommends a three-part programme: training, detection, and treatment. During the pre-deployment period of any mission, the training part of the programme becomes critical and should encompass the following:

- **Realistic Training.** Realistic training is considered the best way to desensitize troops from potential combat stressors. Training during the pre-deployment period also serves to minimize boredom and time available to worry about real or imagined stressors.

The phenomenon [of combat stress reaction] is difficult, if not impossible, to simulate in training. Nevertheless, regiments can establish and practice procedures designed to minimize the risk of losing their soldiers from battle fatigue.

—Brigadier-General (Retired) E.A.C. Amy, DSO, OBE, MC, CD

You smug-faced crowd with kindling eyes,  
Who cheer when soldier lads march by,  
Sneak home and pray you'll never know,  
The hell where youth and slaughter go!

—Captain Siegfried Sassoon, MC, Company Commander, Royal Welsh Fusiliers
At the same time, the training should not be so realistic that the unit begins to experience combat stress casualties!

Many who experienced the long and thorough training given to the British armies in the 1940s will agree that their first experience of real battle was a somewhat dreamlike feeling that it was yet another exercise.

—Extract from Shelford Bidwell's Modern Warfare

One of the aims of any training must be to give the leaders and soldiers an understanding of the threat facing them, the nature of the battlefield environment in which they will be operating and the leadership requirements and demands that will be made on all within that environment. The aim is to reduce as much as possible the negative impact of combat stress on individual soldiers and unit level performance through realistic training. When successful, the eventual introduction to combat will echo in many ways the training environment, as indicated below:

There was a feeling of illusion about it, almost as if it had been only another in the great and bloodless schemes that had filled so many weeks in England. It left the men with an oddly discontented feeling, incongruously mixed with a superb self-confidence.

—From Farley Mowat's writings of the first day of the invasion of Sicily, where he served as a platoon commander in the Hastings and Prince Edward Regiment

- **Emphasize Physical Fitness Training.** Regular physical conditioning has been found to reduce the impact of combat stress by increasing tolerance. Include activities that emphasize team and unit cohesion building in addition to the physical benefits. Team sports like soccer or football provide tangible benefits in this regard.

- **Incorporate Stress Coping Training.** This includes deep breathing exercises, muscle tension relaxation exercises and cognitive exercises. The US Marines have developed an excellent programme, which incorporates these measures and has been found to greatly assist in relaxing personnel easily and quickly under even the most stressful of conditions. There are other coping mechanisms that may work for you: self-suggestion, meditation and stress inoculation among others. Speak to your local medical expert—the local social work officer, your unit's medical officer, a member of the local mental health team, someone from the Operational Trauma and Stress Support Centre (OTSSC) or Canadian Forces Personnel Support Agency (CFPSA), etc.—for more details.

There are also a number of techniques for coping with stress in others—again, any member of the health care team can provide more details. These include, but are by no means limited to:

- **Ventilation.** Very basically, one person listens while the other vents.

- **Stress Counselling.** This helps an individual identify his/her problem and focuses on how to deal with it.
✓ **Crisis Management.** This involves observing and calming the soldier, protecting him/her and others from imminent danger, collecting all relevant info on the situation and taking appropriate action. Crisis management takes place at the crisis scene.

✓ **Peer Feedback.** Two or more soldiers review and evaluate the action and behaviour of a soldier who is obviously not coping well with a stressful situation.

Another very effective coping mechanism that should be fostered during pre-deployment training is the appraisal approach. This involves matching the perception of the demand with the individual or group's ability to meet that demand. For example, if an individual becomes worried about being wounded, the appraisal method would see a fostering of confidence in one's own physical condition, the medical abilities of yourself and your buddies, and your own protective equipment by demonstrating it throughout the realistic pre-deployment training.

➢ **Enforce Sleep Discipline.** Fatigue and sleep loss during operations are major sources of stress. It is important that personnel be made aware of the impact that fatigue and sleep loss will have on their effectiveness.

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The importance of occasional enforced rest cannot be overstressed. If it is possible to have a rest centre near Company or Battalion HQ (especially when in a defensive role) to which men are sent periodically or when showing signs of strain, many breakdowns may be prevented.

—Extract from Major-General F.M. Richardson's *Fighting Spirit*

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✓ During pre-deployment training, introduce and practice a work-rest programme that provides for at least four hours of sleep per 24 hours and preferably during the period 2400–0600 hours. Bear in mind, though, four hours per night is far from the ideal and will eventually lead to decreased performance.

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**A British exercise, EARLY CALL I, conducted in June 1976, demonstrated that soldiers who slept three hours a night could remain militarily effective for nine days or more; soldiers who slept one-and-a-half hours a night, for five days; and soldiers who did not sleep at all became militarily ineffective after three days.**

In the follow-up exercise, EARLY CALL II (November–December, 1977), the men ceased to constitute an effective fighting force after 68 hours without sleep, primarily because of inappropriate and irrational behaviour, rather than because of loss of physical efficiency. Symptomatic of this deterioration was the fact that all of the subjects reported vivid visual hallucinations after 72 to 96 hours without sleep; these hallucinations disrupted behaviour and performance. They occurred only at night and when the men were alone or otherwise socially isolated, leading Dr. Belenky, of the Walter Reed Army Institute of Research, to conclude that social support and sensory stimulation are important in maintaining normal behaviour in men who are tired and stressed.

—Extract from ORAE Report Number 77, *Combat Motivation*
Prioritize sleep for those whose judgement and decision-making are essential to mission accomplishment. Ensure leaders adhere to this principle.

Use relaxation exercises either as a complement to sleep schedules or as an alternative when regular sleep is not possible.

Sleep cycles should be changed as a group, not as individuals.

Emphasize the importance of maximizing sleep prior to the commencement of an operation (up to 12 hours).

Adjust your diet to meet your energy needs.

American Colonel Gregory Belenky, a leading sleep expert, found that "brain function is degraded by prolonged waking." His high-tech brain images illustrate that sleep debt decreases the entire brain's ability to function—most importantly impairing the brain's areas responsible for attention, complex planning and mental operations and judgment.

He also found that even after giving research subjects 48 hours of sleep to recover from their sleep deprivation, they were still performing more errors than when they started.

—Extracted from Farrah Hassen, Sleep Deprivation: Effects on Safety, Health and the Quality of Life

RECOMMENDATION

Sleep is critical in the prevention of combat stress. A sleep discipline plan is essential to planning for any operational deployment. Sleep whenever possible. Six to Nine hours of sleep at night is optimal. Try to get a good sleep prior to working long hours. Catch up on your sleep after going without for any significant period of time. Remember, stress is always easier to cope with following rest.


The greater the stress, the greater the possibility that the riskiest alternative will be chosen by the decision-maker. Remind people that during times of stress, the resources are available to make what should be, in retrospect, the best choice.

The greater the stress, the more likely also that a premature decision will be made from alternatives judged to be available. The old adage "make a decision, any decision" is not necessarily borne out by history. Emphasize the need to pay attention to the recourses available, including the time necessary to make an informed decision.

During a crisis, the ability to devote intense and focused attention on a difficult task decreases dramatically.

The greater the stress, the less likely it is that a person will be able to tolerate ambiguity.

DISPATCHES 20
As stress increases, productive thoughts decrease and distracting thoughts increase.

As stress increases, so too does the distortion in the perception of the threat, often resulting in an increase in poor judgement.

The greater the fear, frustration and/or hostility aroused by a crisis, the greater the tendency towards aggression and escapist behaviours (fight or flight response).

REMEMBER

Long-range considerations are often sacrificed for immediate survival goals in cases of extreme stress (whether that stress is real or perceived).

- Undertake a Proper Screening Process. Screening prior to deployment is essential. The aim of screening should be to initially identify those who are obviously unfit to deploy for reasons of physical fitness, behaviour or because of serious family problems (marital, monetary or health problems). Pre-deployment training should be used to identify emotional and behavioural problems. This reinforces the requirement for leaders to know their soldiers!

Screening should also be used to ensure that family members are adequately prepared for the deployment and separation of the military member. While this is largely the responsibility of the individual soldier, the stand up of rear parties and the understanding that rear party members will check on spouses and families and will make emergency services available if required can reduce a major source of stress.

On the importance of the unit medical officer (UMO) and padres during the screening process...

The UMO must carefully assess the advisability of permitting individuals with longstanding medical problems to deploy into operational environments. Allowing soldiers with chronic or recurrent medical problems to undertake peacekeeping duties does no one any favours—the soldier is put at risk of exacerbating the problem, the CO may suffer manpower shortages, and the UMS [unit medical section] workload increases due to multiple visits by patients with chronic problems. I urge you to support your UMO in his decision to recommend such soldiers not deploy on operational tasking.

Soldiers with significant family problems must also be screened out and this is an area where your padres must be very attentive in their DAG questioning. However, even with the best screening by the padres, new family problems WILL occur during the deployment...

Remember also that social work officers and chaplains have an important role to play in the recognition of family situations that could predispose individuals to the development of combat stress.

**Deployment Measures**

*Battle fatigue has no favourites and all ranks in combat units are vulnerable from the Trooper to the Commanding Officer.*

—Brigadier-General (Retired) E.A.C. Amy, DSO, OBE, MC, CD

Measures undertaken on operations build upon the counter-measures identified in the pre-deployment phase of the operation. Continued attention to family situations remains a high priority, which is addressed in part by a responsive rear party. In addition, consider the following tips for reducing the likelihood of combat stress reaction:

- **With appropriate medical advice, be prepared to participate in a debriefing process** following a traumatic incident. Annex B outlines the purpose and conduct of the Critical Incident Stress Debriefing (CISD), which is but one of many potentially useful debriefing formats that can be employed. As noted previously, the issue of CISD is currently under review as there exists significant controversy about its utility and the potential for harm from its use. The key is to seek out medical advice on the best format to be undertaken for such a debriefing. Again, Annex B is but one such format, which is clearly not appropriate for every situation.

- **Welcome new members to the unit and get to know them quickly.** The faster they are incorporated into your group, the less likely they are to suffer from combat stress. If you are new, seek out new friends.

- **Maintain your physical fitness.** This should include adhering to the unit rest and relaxation plan, which is particularly important for those in leadership positions.
- **Practice rapid relaxation techniques.** This also includes the use of the stress coping mechanisms outlined in the pre-deployment phase measures.

- **Seek out information from your leaders/supervisors.** Ignore rumours. Uncertainty is a major source of stress and can be countered by participating in regular information sessions to keep all abreast of unit, friendly unit and enemy intent/operations.

  > Some unit leaders issued calling cards to soldiers with family problems back home. These calling cards were donated by veterans organizations for the benefit of deployed soldiers. This allowed soldiers to discuss family problems with loved ones without running up high long distance phone bills.

  —Extract from US CALL Newsletter 01-17, Return to Readiness!

On the home front, use of the unit rear party can help relieve stress associated with family concerns.

There are a number of stress aide-memoires that are available through the system—speak to your padre. There are three that have been identified from Bosnia deployments as particularly useful:

- **Combat Stress Reaction: What to do: Self and Buddies**

- **Combat Stress Reaction: A Normal Reaction to an Abnormal Situation: Leaders Action**

- **Combat Stress Reaction: Notes for Commanding Officer**

- **Don't overlook the importance of unit administration on reducing stress and improving morale.** We tend to marginalize logistics 'play' during training. However, General TS Hart notes in his paper, "Determination in Battle," that colloquial evidence suggests that even when the operational situation appears to be a shambles, soldiers are reassured when "their unit moved well and was fed, etc."
Peacekeeping brings with it a number of stressors that aren't usually present in combat; yet they have the potential to be just as destructive to one's mental health. In particular, the constraints of rules of engagement and the limits on one's activities based on the political requirements of deployments can lead to greater frustrations. Dr. Paul Bartone, a noted psychologist working with the US Army, has developed a model for psychological stress in peacekeeping missions that includes countermeasures that provides guidance for mission planning. See Annex E for details.

At the unit level, ensure that a combat stress management plan has been incorporated into the battle plan. The plan should be based upon the recognized principles of proximity, immediacy, expectancy and simplicity (PIES). The next section outlines a suggested system based on combat experience.

General TS Hart has advocated the implementation of a triage system of sorts for dealing with combat stress casualties, which has seen success in a number of wars and is recommended as an excellent start point:

*Men in early stages of psychiatric breakdown are highly suggestible and can still be retrieved, especially by a positive approach by a leader the man trusts and respects. I would suggest that there are three possible courses of action.*

*If it is still possible to communicate with the man, attempts should still be made to stir him into action by carrying messages, helping a comrade, etc. This activity could be carried out at a company aid post or company headquarters level.*

*If the man is incapable of such action, rest, sleep, food, etc., actually in the company aid post can often work wonders.*

*Lastly, there is the psychiatric casualty who, either by his position in the company hierarchy, by his symptoms is causing unrest amongst the others, or by the very seriousness of his symptoms cannot be treated within the company and therefore has to be evacuated.*

*Even in the case of the last group, I would suggest nearly all could, and should, be treated at the regimental level.*

*There is one final point I would like to make. A psychiatric casualty, in many cases, knows he has failed. Censure and mockery from a respected member of the group will do him more harm than good. He wants firm but understanding support. He needs firm direction and aid from a member of his group or a leader he respects. He does not need a shoulder to cry on, or in most cases, certainly not a psychiatrist.*

As General Hart notes, the so-called third stage of combat stress reaction requires evacuation from the frontlines for rest and food, etc. That evacuation is not to a rear-area, but rather to what has been termed a forward echelon system: Annex A explores the success rate of the forward echelon system versus evacuation to the rear area.

There are a number of principles to maintain when treating combat stress reaction:

- Remember the four key factors associated with successful treatment of combat stress: proximity, immediacy, expectancy and simplicity (PIES).
- In the words of General Hart:
Commanders at all levels must watch for the first signs of defeat in a soldier and come to the man’s rescue. Leaders, officers or NCOs who have been with their men for some time and know them well will quickly recognise the first signs. It is at this stage that a joke, asking the man to carry out a simple act, the odd word, or even a hand on the shoulder, will give him the support he needs. How many times have we read in descriptions of a battle, that, just before the action started, in that terrible short period of inactivity when the will begins to ebb away ‘The leader moved amongst his men.’ This sort of situation is the test of real leadership. If a man is causing concern to a leader, asking that man to accompany him as he moved about often gives the soldier the support he needs.

✓ Retention as close as possible to the soldier’s unit while removing the soldier from the worst effects of combat.

✓ Maintain the expectancy in the soldier’s mind that he will return to his unit and to battle.

➢ Health care personnel exposed to combat stress casualties for the first time tend to err on the side of pessimism. Anecdotal evidence suggests that personnel with experience in clinical psychiatry are often surprised at how quickly combat stress casualties recover.

➢ Combat stress reaction remains a chain of command issue, not a medical issue at this stage. Treat the stress casualty as a soldier, not a patient.

➢ Sleep and/or rest, both before battle and after trauma, are very useful tools in treating combat stress. Remember the role of food also during rest periods: a hot meal can work wonders for morale.

During World War 2, the German Commanding Officer of the 90th Armoured Infantry Division, Major General Baade, was reported to have halted the retreat of his Division by using the field kitchens. He was able to halt the general retreat which had become close to a route some 3 km from the frontlines, gave the men food and drink, allowed them to rest for about two hours and then was able to convince them to return to their abandoned positions in the line, without the use of violence.

—Extracted from Oberst Elmar Dinter’s article, "The Physical and Emotional Stresses in Wartime"

Post-Deployment Measures

The post-deployment phase of any operational deployment is dominated by the reintegration process, the intent of which is to ensure that all unit members reintegeate back into society, their families and their garrison units successfully. Annex F outlines the reintegration process employed for Op APOLLO and provides a useful model for future, like deployments.

From anecdotal evidence, it is clear that the reintegration of the soldiers returning from a deployment presents a major challenge to any unit. That reintegration must be considered not only from a military perspective but also from a societal and familial point of view. In fact, the latter two perspectives
may be more important than the former. The abrupt removal of a soldier from a high stress environment—be it combat or peace support operations—and the end of the resultant isolation from his society and family creates a stress of its own. The soldier is removed from his military family, many members of which have experienced the same stresses as he, and is left with no one who can relate to his experience while deployed. At the same time, the spouse may not feel that efforts undertaken on the home front are receiving the attention they deserve.

The reintegration process, then, has two main themes:

- The first is to understand that while his reactions to family reunion and reintroduction to normal Canadian society are themselves normal, they are often in conflict with reactions from spouses and friends. In the case of family, there is a requirement to ensure that both soldier and spouse are aware of likely reactions by both parties during the family reunion. Both must be made aware of the support mechanisms that are available should they be unable to work through the homecoming and re-establishment of the family unit (this includes health care workers, local military family resource centres, unit/base padres, family doctors, etc.).

  Anecdotal evidence from the Second World War clearly indicated that mail became a key lifeline back to "normal" life away from combat. While that mail became important in sustaining soldiers and the will to fight, it also creates problems for reintegration. Too often, the spouse and/or the family life was seen in idyllic circumstances and was placed upon the proverbial pedestal. When one or the other did not match up to that ideal, problems in re-adjustment occurred.

- The second is to ensure that units continue follow-up with members who have exhibited combat stress reaction in theatre, as they are at most risk for PTSD. The high-risk group-individual augmentees—must be specifically targeted by any follow-up programme. Coordination with home units is essential.

Our greatest concern [for monitoring and follow-up] is not with those soldiers continuing to serve within the formed units/sub-units that deployed, but...with those individual augmentees and soldiers posted out of the units that find themselves outside the Brigade in units that have limited or no knowledge of these soldiers and their experience.

—Extract from the 3PPCLI BG Op APOLLO POR (1 CMBG comment)
The key thing to take away from any discussion on combat stress reaction and PTSD is that no one is immune. Each of us has his or her breaking point at which stress and trauma-related stress overwhelms our systems and results in involuntary reactions.

Reactions differ in terms of intensity but are no less critical in the requirement to seek help in dealing with that reaction. Failure to seek out assistance can potentially be fatal.

Stress and its management are not new concepts. Much of the postulating on stress management can be confusing and conflicting. What appears to be best for one person has no effect for another. Yet, as we have attempted to point out, there are a number of strategies that can be pursued and are often helpful in dealing with stress. Again, though, it's important to remember that if these strategies do not result in a positive change, professional assistance should be sought out.

The current method of dealing with operational stress in the CF appears to be in the second stage as some steps have been taken to address operational stress issues, but they lack coordination and do not appear to be capable of dealing with some of the fundamental causes of operational stress casualties.

—Extract from Dr. Allan English, Leadership and Operational Stress in the CF
ANNEX A

The Forward-Echelon System

Compare the World War II experience towards the latter part of the war:

Some regiments assigned an NCO, with an outstanding record as a fighter and leader, to deal with this. His task was to look after these survivors and restore, by example and persuasion, their confidence and fighting spirit. These NCOs were rotated frequently because by nature they were usually impatient to rejoin their troops in action.

He set up a bivouac in B echelon and with the help of an assistant prepared to greet them. When they arrived, they were given as much medicinal rum as seemed appropriate, a hot meal and then to bed. On awakening, they were issued fresh kit and the assistant provided hot water and meals. They were encouraged to relax and after a period when the NCO felt they were ready, he started the rehabilitation process. There was no timetable to this and while not always successful, many were returned to their troops to fight again.

—Extract from Brigadier-General E.A.C. Amy, DSO, OBE, MC, CD—Commanding Officer of The Canadian Grenadier Guards in WWII

...with this new reality (?) from Chechnya:

During Chechnya, the Russian military inaugurated the so-called "psychological first aid tent", which featured a club-atmosphere mixing video with classical music. In one part of the tent, video screens show a fireplace burning logs, a view of the ocean or a tranquil mountain scene. Landscapes, flowers and waterfalls are also shown, while the works of Vivaldi, Schubert and Chopin are playing softly overhead. The intent is to soothe the wounded psyche of the soldier by offering the gentle method of music and pictures for ‘psychological correction’.

—Extracted from Timothy Thomas & Major Charles O’Hara, Combat Stress in Chechnya: “The Equal Opportunity Disorder”

Israeli studies of stress related injuries during the 1973 Yom Kippur War and the 1982 War in Lebanon have affirmed the requirement to treat such injuries in the forward area. During the 1973 war, large numbers of stress injured soldiers were evacuated from the front, given hospital pyjamas and housed at seaside resorts. Not surprisingly, the expectation was created that the injured personnel would not be returning to combat and was judged to be the critical factor which contributed to many graduating from combat stress reaction to post-traumatic stress disorder.
By contrast, the latter half of the 1982 war saw the Israelis adopt what they called forward-echelon treatment (ideally, this type of treatment centre should not be part of the hospital complex). This consisted of giving the stress injured an opportunity to rest, in uniform, at a centre close to the operations area, with the understanding that they would be returning to operations. In this case, the expectation was created that the men would be returning to battle, and did in fact result in that happening.

The 1982 War in Lebanon also highlighted the importance that the factor of expectation played: during the latter half of the war, a number of stress injuries were evacuated to Israel proper for treatment by mistake. The percentage of combat soldiers who were treated in forward areas and then returned to their units within a few days was four times greater than those treated by mistake in a rear setting in Israel proper.

What also became clear from this study was that of the three factors associated with treatment of combat stress reaction—immediacy, proximity and expectancy—expectancy was the most critical. During the 1982 war, treatment timings between the forward and rear areas was about equal, making this the least critical factor. Proximity was judged to be of importance only insofar as it reinforced the expectancy that the soldier would return to his/her unit. In point of fact, the Israelis had established two treatment centres within 200 metres of each other. One operated as a forward-echelon centre and the other as a second-echelon treatment centre. The former conveyed a greater expectancy of return to units than the latter and, in fact, had a higher rate of return to unit than the other. Proximity became important from a logistical point of view, in that the return of soldiers to their units following treatment was often logistically difficult to the extent that soldier were unable to return.

The Israeli experience also highlighted a number of important factors for psychiatric personnel who are involved in the treatment of combat stress reaction:

- Forward-echelon centre psychiatrists and psychologists identified with the unit needs to conserve manpower and not be undermined by having personnel with non-physical injuries leave the unit and fail to return.

- Forward-echelon centre orientation briefs focussed combat stress reaction as being attributable largely to situational reactions, which are often transient and temporary, unlike personnel in civilian medical settings, who viewed combat stress reaction as attributable to personal characteristics of the soldiers themselves.

- Forward-echelon centre personnel share the same experiences as the troops to some degree and tend to regard the symptoms with a good prognosis for rapid recovery.

- Forward-echelon centre personnel do not identify troops suffering from...
combat stress reaction as being ill, unlike civilian medical personnel. The difference in settings, coupled to the illness label, also influences expectancy. In the forward echelon, the presence of uniformed personnel, with weapons and other military kit in view at all times, reinforces the likelihood of return to one's unit. The quiet hospital setting in the rear, with none of the military cues present, reinforces the idea of illness and the probability of not returning to one's unit.

Based on the Israeli experience, which reinforces a number of lessons from the First and Second World Wars, there are a number of factors that should be considered when establishing a forward-echelon treatment programme:

- Proximity to the front allows for continued contact with the soldier's unit, allowing for visits from comrades-in-arms.
- The emphasis is on short stays, of a few days at most, rather than an extended stay of several weeks.
- Mental health officers function as both therapist and military commander. One of their critical duties is to ensure that each soldier is informed that after a short period of rest, he/she will again become an active soldier capable of returning to the front.
- Therapist-to-patient ratios are kept high, preferably one-to-one. Sessions should be frequent and include group sessions to confirm for soldiers that their reactions are normal and shared. The Israeli model included two one-on-one and two group sessions a day as a minimum.
- Soldiers continue to live in field conditions, taking their meals in a communal military dining hall, and are required to maintain a proper military appearance and participate in an active physical training programme.

The Bartemeier Commission, a post-World War II review of all cases of combat stress reaction treated at a forward-echelon centre, found that in 95% of all cases, the acute reactions subsided after a brief period of time away from combat and the soldiers were then able to return to their units. Other studies have found that the time in combat is also a major factor in success rates: those who had been in combat for a month or less showed an 80 to 90% recovery rate using the forward-echelon system, while those in intense, continuous combat for periods longer than a month had only a 30 to 35% recovery rate. In both cases though, studies have shown a fourfold increase over those with combat stress reaction who are treated in a rear area hospital location.

Studies of American combat stress reaction during the Korean War have also shown favourable rates of recovery using the forward-echelon system, with between 65 and 75% recovering and returning to active duty. The Vietnam War early years also showed comparable results, further validating the forward-echelon system.
ANNEX B

An Example of a Debriefing Technique: Critical Incident Stress Debriefing (CISD)

NOTE

CISD was under review as this Dispatches was written: some research has shown that it can be harmful to some people. While controversial, we have included this portion to provide ideas on the possible structure for a debriefing activity following a critical event. Once again, we reiterate the requirement to consult with medical authorities prior to undertaking a debriefing.

CISD—What is it?

A group discussion among those soldiers connected to the traumatic or critical incident. The structured discussion is guided by a trained debriefer and is intended to provide participants with an opportunity to:

- Share their thoughts and feelings with those who shared the experience. This often serves to reassure those involved in an event that others are experiencing similar reactions to the event, which in turn reassures all involved that their reactions are normal.
- An opportunity to review and discuss the event as they saw it. This serves to clarify what happened and why actions were taken, rightly or wrongly, and it provides everyone with an opportunity to provide their perspective on the event.
- Identifies those who may be able to provide help later if problems develop.

Experience is the hardest kind of teacher. It gives you the test first, and the lesson afterward.

—Anonymous

CISD—What is it not?

- A CISD is not mandatory. Participation in debriefings must be voluntary and individuals must be aware of the limitations and possible consequences of this type of intervention.
- It's not group therapy.
- It's not part of an investigative process, although admissions from the CISD could form the basis of an eventual criminal investigation.
- It's not open to anyone who was not connected in some way to the critical event.

Of critical importance is the training of a unit team, which can then, in turn, train the remainder of the unit and conduct/coordinate debriefings. Soldiers at all ranks are extremely unreceptive to outside agencies/non combat arms CIS debriefers and trainers.

—Extract from the Op HARMONY Roto 5 POR
That's not to say outside resources cannot be used, rather that such outside assistance should be the exception rather than the rule.

In Croatia, a CISD team was formed to handle debriefing and consisted of the Padres, UMO and the Administration Company Sergeant Major. The debriefing of personnel who were involved in any incident identified in the CISD policy was mandatory. The mandatory nature of CISD completely removed any stigma which might have been attached to the process and it became a drill.

—Extract from an article by Major S.M. Fisher, "3 PPCLI in Croatia—Lessons Learned"

How is a CISD conducted?

As indicated above, the CISD is normally and preferably conducted by a professional debriefer. It is also not to be considered or conducted as a mandatory activity, despite the excerpt above.

Having said that, CISD generally follows a model itinerary developed by Dr Jeffrey Mitchell:

- An **Introductory Phase**, which outlines what event is being discussed and what the CISD is and is not. This phase also lays out the ground rules for the CISD, emphasizing that personnel are treated equally during the CISD and may speak without fear of reprisal. Courtesy to all is expected.

- A "**Thinking Through**" or cognitive phase, in which the event is reviewed by examining the facts surrounding the incident. One popular method is the reconstruction of the timeline associated with the event, beginning before the incident and working through the event with views from all sides and perspectives.

- An Emotional Phase, in which the emotions surrounding the incident are explored. All participants should be encouraged to contribute. The transition from fact to emotion can result in a number of common themes, feelings and misperceptions. This phase aims at ensuring all understand their feelings and reactions are normal, through the use of judicious questioning, helps restore "true" perspective and prevents scape-goating and personal verbal or physical abuse.

- Another "**Thinking Through**" phase, in which participants re-examine the incident, keeping in mind any revelations from the emotional phase. This moves the emphasis back from the emotional to the factual and should include input from all members on their physical reactions to the incident(s). This phase demonstrates that the physical and emotional reactions suffered by members are a shared response and are therefore normal. This phase should conclude the CISD and have allowed the debriefing leader to identify members for follow-up.
Some Debriefing Observations

- Conducted in a similar manner to an after action review, except that it is expanded to include sharing and speaking out on emotional reactions to the event(s).

- Should be led by a specially trained team, which can include any of the following:
  - Area social work officer or equivalent.
  - Chaplains.
  - Physicians, nurses, medics, or other medical personnel.
  - Trained officers and/or senior NCOs.

- Best conducted with 24 hours of incident, although all involved should have time for rest and recovery to ensure members are alert and involved.

- Can take the form of a short “defusing” debriefing if time and tactical situation does not permit a full debriefing.

- Should take place in an emotionally neutral place, relatively safe from enemy action, distraction and observation (examples include the reserve position or assembly area). There must be sufficient light to see all participants.

- Establish ground rules for the CISD:
  - No repetition of any personal information, emotions or feelings that are shared during the CISD.
  - Ensure all understand that the CISD does not override moral and legal responsibility to report any criminal violations of the law that may have occurred during the incident(s).
  - Neither recordings nor notes are to be taken.
  - Encourage all to speak. Those who remain apart and do not participate should be approached after to see if they desire an individual debriefing or other assistance.

Remind all that the intent is not to conduct an operational critique nor is it a fault-finding mission, rather it is intended to clarify to all those involved in the incident what happened and restore confidence in all members. More importantly, it is a process that normalizes the emotional and physical reactions or stress responses that the participants experienced.
Suicide

It is important that the risk of suicide be considered when looking into psychological injury. While there exists the possibility of a stress casualty turning to violence against others as a result of his injury or disorder, the more likely possibility is the self-injury, with suicide being at the extreme end of that course of action. This annex seeks to identify some of the warning signs that have commonly preceded a person's decision to commit suicide. These warning signs should be taken as a call for intervention. In any case, the leader should strive to create an environment in which his soldiers feel secure or comfortable enough to seek out assistance well before they seriously consider suicide.

Suicide Warning Signs

Note that the presence of these warning signs is not necessarily related to an impending suicide but should be treated as reasons for intervention with the soldier. Keep in mind that these warning signs are often noted in retrospect:

- Appearing depressed
- Threatening suicide
- Talking about wanting to die
- Significant changes in behaviour, appearance or mood
- Drug or alcohol abuse
- Recently experienced significant relationship problems (a break-up or divorce)
- A significant financial problem (unresolvable debt, bankruptcy)
- Loss of social status, such as a demotion
- Deliberate self-injury
- Giving away personal possessions
- Withdrawal from social activities
- Apathetic appearance and loss of interest in those activities which are normally pleasurable
ANNEX D

Recognition of Victimization

Doctor Aphrodite Matsakis, in her book *I Can't Get Over It: A Handbook for Trauma Survivors*, identifies the three levels of victimization experienced by most people involved in any traumatic incident.

The first level is the "Shattering of Assumptions," which is the undermining of assumptions that all of us have about human nature and the nature of the world around us. This often leads to a re-examination of three basic assumptions: first, the loss of invulnerability; second, the loss of an orderly world; and third, the loss of a positive self-image. There are other reactions—feelings of helplessness, a desire to withdraw or isolate oneself, anger or rage—but these three are most likely to manifest themselves in PTSD.

The second level is that of "Secondary Wounding," which comes from our fellow comrades and other well meaning personnel around us. Very often this is an unintentional victimization based upon thoughtlessness or callous behaviour. It can also come from ignorance, cultural differences or from burnout in the case of professionals who deal with too many instances of stress injury. Secondary wounding can take many forms: disbelief, denial or discounting of the event; blame directed against the victim directly; or denial of assistance to the victim. It can also become a sort of "piling" onto the original trauma, becoming just as painful and wounding as the original trauma.

The third level is the "Victim Thinking," or the continued thinking and acting like a victim even though no longer in the original trauma situation. Trauma survivors typically adopt one of four mindsets: there are those that become intolerant of mistakes, either by themselves or by others; those that deny any personal difficulties for fear of being seen as weak, incompetent or otherwise unfit for work; those with an all-or-nothing attitude, viewing life situations and other people as either friends or enemies, without any in-betweens; and those who continue with the survival tactics which they found worked during the traumatic event.
### ANNEX E

**Stress and Peace Support Operations: Stressors and Counter-Measures**

Source: Paul T. Bartone, *A Model of Psychological Stress in Peacekeeping*

<table>
<thead>
<tr>
<th>Stressor</th>
<th>Counter-Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Isolation</strong></td>
<td>Activities, cohesion and communication are vital and include:</td>
</tr>
<tr>
<td>- physically remote</td>
<td>- prompt passage of information</td>
</tr>
<tr>
<td>- communications are</td>
<td>- use of newsletters or other media-</td>
</tr>
<tr>
<td>difficult</td>
<td>promotion of unit activities (sports, contests, etc.).</td>
</tr>
<tr>
<td>- cultural differences-</td>
<td></td>
</tr>
<tr>
<td>newly configured units</td>
<td></td>
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<tr>
<td>(unit cohesion not yet</td>
<td></td>
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<tr>
<td>formed)</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Ambiguity</strong></td>
</tr>
<tr>
<td>- mission definition</td>
<td>Communication becomes critical to identify mission, roles and command structure.</td>
</tr>
<tr>
<td>- command structure is</td>
<td></td>
</tr>
<tr>
<td>confused</td>
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</tr>
<tr>
<td>- role is confusing</td>
<td></td>
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<tr>
<td>(soldier versus</td>
<td></td>
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<tr>
<td>peacekeeper)</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Powerlessness</strong></td>
</tr>
<tr>
<td>- Restrictions on, or</td>
<td>Rules of Engagement must be clear, and unambiguous.</td>
</tr>
<tr>
<td>lack of clarity in,</td>
<td>Limited activity needs to be dealt with as per counter-measures for isolation (above).</td>
</tr>
<tr>
<td>Rules of Engagement</td>
<td>Promotion of small unit swaps or joint tasks with other mission units can overcome barriers. Consider local humanitarian projects.</td>
</tr>
<tr>
<td>- Activity limited due to</td>
<td>Continue with cultural and language classes in theatre.</td>
</tr>
<tr>
<td>operational environment</td>
<td>Standardize and publicize benefits given in response to mission deprivation. A well stocked kit shop is always a morale booster.</td>
</tr>
<tr>
<td>- Cultural and language</td>
<td></td>
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<tr>
<td>barriers both with</td>
<td></td>
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<td>locals and with other</td>
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<td>nations involved in the</td>
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<tr>
<td>mission</td>
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<tr>
<td>- Deprivation compared to</td>
<td></td>
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<tr>
<td>normal life</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Boredom and Tedium</strong></td>
</tr>
<tr>
<td>- Repetitive and</td>
<td>A creative in-theatre training plan is essential.</td>
</tr>
<tr>
<td>monotonous duty</td>
<td>Professional and educational development opportunities should be widely advertised and encouraged.</td>
</tr>
<tr>
<td>- Work is less than</td>
<td>Special events, including holiday celebrations, should be scheduled/planned.</td>
</tr>
<tr>
<td>professionally</td>
<td>Consider, if operationally feasible, troop rotations to new tasks.</td>
</tr>
<tr>
<td>rewarding</td>
<td></td>
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<tr>
<td>- Daily events lack a</td>
<td></td>
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<td>great deal of variety</td>
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</table>
ANNEX F

Post-Deployment Stress Measures and the Reintegration Process

The Op APOLLO post operational stress plan is provided as an example for consideration. Clearly, the effectiveness of this plan was still under study at the time this Dispatches was being written.

The Op APOLLO plan was broken down into five phases:

- Phase 1—Preparation—Kandahar.
- Phase 2—Decompression—Guam.
- Phase 3—Arrival in Canada.
- Phase 4—Life after Mission.
- Phase 5—Monitoring and Follow-up.

The plan was based upon an initial concept forwarded from the 3PPCLI BG, as outlined below:

"In general terms, it is suggested that the re-integration process take place in three phases:

a. **Phase One—Kandahar.** Before the soldiers leave Kandahar, they will participate in both an educational and a group process. The educational portion will be done at company level and will include basic instruction of stress/stressors, signs and symptoms of PTSD, and general information about the emotional process of 'going home.' The second stage will be a small group (probably section size) debriefing conducted by trained peers and professional Battle Group personnel working together to provide the best/safest debriefing for each group.

b. **Phase Two—Interim Location (TBD Editor’s note: location chosen was Guam).** During past global conflicts (World Wars and Korea) Canadian soldiers did not have the luxury of the plentiful air assets available to governments today—soldiers did not get on a plane one day and return home the next, thereby immediately severing themselves from their comrades and instantaneously forcing their way back into society and into their families. Sea and rail transport gave the soldiers the valuable opportunity to spend longer periods of time to de-stress, put their mission/experience into perspective, while sharing good times and stories with those who had become their family while deployed away. Air travel has taken away this opportunity. The rationale for staging the Battle Group home through a third location is to rebuild the interpersonal skills and coping strategies through a gradual return to a sense of normality. Therefore, it is recommended that the Battle Group spend a minimum of five days collectively at an interim location before returning to Canada. This will be the first transition to the physical comforts of life—'from tents to sheets.' Furthermore, it will be an opportunity to move from a highly structured theatre schedule to a less rigid and threatening environment; a time
for relaxation, participation in sports and social activities; but more importantly, it will be a juncture to build upon the formal re-integration process that occurred during Phase One. This is the location where the Battle Group’s Padres and PSO will engage in personal interviews with each soldier. These interviews will mirror the Pre-Deployment Screening Process and will give each soldier the opportunity to raise any concerns they might have before going home. This will enable the care-providers to pre-arrange any necessary support systems. In addition to personal interviews, there would be the opportunity for company level briefings on significant issues and personal counselling as required. This intermediate stop will also allow the Battle Group to re-group in order to transit back to Canada en masse.

c. Phase Three—Edmonton. Phase Three will be implemented upon the arrival of the BG in Edmonton. This phase will involve all members of the Battle Group, their families and the Rear Party support network. With the out of town families should also come a representative of the care-provider community, as well as the CO and RSM of major units that provided augmentation to the Battle Group. This would position the entire team together in one place to support our soldiers. It is critical that the BG arrive as a whole. In this manner, all soldiers receive the same welcoming and validation for the sacrifice they have made by participating in this mission. To reinforce success and assist in the smooth transition to family life, soldiers should not immediately proceed on leave, but remain as a formed unit for a period of no longer than two weeks. During this time, soldiers would participate in Post-Operation drills while at the same time attend family re-integration briefings and sessions with their spouses or significant others. These briefings should be conducted at the platoon level and utilize the care-providers from Edmonton, Winnipeg, Shilo and other places from which the Battle Group received augmentation. These briefings would give the soldiers and their families an opportunity to transition from the integral resources that were available in theatre to other available resources back in the community. For this to work, there are two significant hurdles to overcome. First, the spouses (or significant others) of members who are not from Edmonton would have to be brought to Edmonton for this time period. Second, there will need to be a mind-set change of the soldiers of the Battle Group, as well as those that are, and have been, supporting the Battle Group, in understanding that the tour does not end until Phase Three has been completed. This will be a function of the chain of command at all levels and will need to be supported by innovative initiatives; extending allowances until Phase Three has been completed is one.

4. A final consideration for the re-integration process is the re-integration of the Battle Group care-providers who are involved in supporting the process. It is recommended that they participate in an organized and professionally led retreat scheduled sometime after the re-deployment, custom tailored to deal with the issues specifically to a care-provider. This need not happen immediately but should be completed within the first six weeks of returning home.”

—Extract from 3PPCLI BG POR Phases 4–5
References / Suggested Reading List

Paul T. Bartone, Ph.D., *A Model of Psychological Stress in Peacekeeping Operations*
Dr. Allan English, RMC, *Leadership and Operational Stress in the Canadian Forces*
Major M.J. Farley, Ph.D., Thesis entitled *A Model of Unit Climate and Stress for Canadian Soldiers on Operations*.
Mr. Timothy L. Thomas, and Maj Charles P. O'Hara, *Combat Stress in Chechnya: "The Equal Opportunity Disorder".*

Additional Sources of Information:

Army Lessons Learned Centre's Lessons Learned Information Warehouse (LLIW) documents (available through the LLIW Version 10 CD) including:
- Combat Stress Special Library collection
- Canadian Army CLFCSC Realties of Battle—Battlefield Stress, dated October 1991
U.S. 528th Medical Detachment (Combat Stress Control)
Virtual Naval Hospital, online at www.vnh.org (Note: Internet sites are subject to change. Keyword searches are recommended.)

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