

Peacekeeping stress prompts new approaches to mental-health issues in Canadian military

Rhonda Birenbaum

Résumé : De nombreux changements se sont produits dans la façon dont les Forces armées canadiennes traitent les incidents stressants qui touchent le personnel militaire. Le stress éprouvé par les troupes canadiennes envoyées outre-mer dans des missions de maintien de la paix est l'une des raisons de ces changements. Selon un médecin militaire, les médecins civils devraient être au courant de la possibilité d'un stress post-traumatique chez les réservistes qui reviennent d'une mission de maintien de la paix. Cette façon d'envisager le traitement se démarque clairement des méthodes utilisées au cours des deux guerres mondiales.

Earlier this year, 11 Canadian soldiers serving as peacekeepers in Bosnia were the victims of a mock execution, via a firing squad, after they had been taken prisoner by Serbian troops. At the time, none of the Canadians knew it was a game.

When the soldiers were eventually returned to their base, each reacted differently. Some panicked, while others became withdrawn and were unable to relate to people

around them. A few became hyper-vigilant and irritable. For all 11, there was intense psychologic distress.

Within hours, the armed forces had dispatched a mental-health team comprising a social worker, nurse and psychiatrist to help the men deal with the stress. Within days, the 11 soldiers were in France, where they were reunited with their families for some rest and relaxation.

"Our goal," explained Lieutenant-Colonel Jim Jamieson, chief of social work for the Canadian Armed Forces, "is to deal with traumatized troops as quickly as possible and as close as possible to [the] event."

These are modern times for psychiatric care in the military. Eighty years ago, during World War I, armies — including Canada's — responded to battle stress by executing soldiers whose actions had been caused by battle fatigue. Today, these soldiers are treated.

In their book *Battle Exhaustion: Soldiers and Psychiatrists in the Canadian Army, 1939-1945* (McGill-Queen's University Press, Montreal and Kingston, 1990), Terry Copp and Bill McAndrew reported that 25 Canadians were executed for cowardice during World War I. The historians suggest that most were probably dysfunctional psychoneurotic patients. By World War II, the medical corps had begun to deal with stress, but commanding officers still asked whether "demoralized malin-

gering cases cropping up whilst in action should be shot on the spot as an example."

No Canadians were executed for cowardice in World War II, during which the army established its first overseas psychiatric service. However, the notion of providing psychiatric care for troops continued to provoke controversy. When the psychiatric service expanded in 1941, for example, the orders to psychiatrist Dr. Jack Griffin were categorical: "Under no circumstances will you treat anybody in the army for a psychiatric condition."

Jamieson insists this would not happen today because there has been a major shift in the way the armed forces helps personnel deal with personal, social and mental-health concerns. "In the last 20 years we've become much more dramatically committed to a supportive, caring role. We now say to people that good leadership includes making sure your people get to the health professionals they require. It is not a sign of weakness, or failure on an individual's part if they seek [professional] assistance."

Unlike earlier war veterans who had been branded cowards or malingerers, today's troops are treated as victims of critical incident stress [see sidebar]. And rather than face punishment, they will be rested and encouraged to express their feelings.

Much of this change occurred because of the Vietnam war. Even to-

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day, many Vietnam veterans are unable to put their experiences behind them, and Jamieson has no doubts that the number of psychologic casualties from the Vietnam war far outweighed the number of dead or wounded (58 000 Americans were killed in the conflict, and it is estimated that more than 15 000 American veterans have committed suicide since the war ended in 1975).

As a result of American, Israeli and British research, the current wisdom is that psychologic casualties can be returned to duty quickly if frontline treatment is carried out close to the battlefield soon after the trauma occurred.

When Canadian military personnel were sent to the Persian Gulf in 1991, they were accompanied by a psychiatric nurse, a social worker and a psychiatric resident, Lieutenant-Commander Greg Passey. En

route to the Gulf aboard HMCS *Huron*, Passey was responsible for predeployment education designed to teach personnel how to cope with battle stress and to understand that stress is normal.

But it's not just war that triggers psychologic distress. Three peacekeeping regiments returning from the former Yugoslavia reported no physical casualties, but data show that post-traumatic stress disorder (PTSD) and depression affected 20% of the returning troops.

The study of 1300 soldiers, conducted by Passey, is based on the results of a confidential questionnaire surveying combat engineers based in Chilliwack, BC, and troops from the Royal Canadian Regiment in Gagetown, NB, and Princess Patricia's Canadian Light Infantry (PPCLI) in Winnipeg.

"The study confirms my

thoughts that our people are under horrendous stress," Passey told *CMAJ*. "Peacekeeping is very stressful and very difficult."

Passey and a colleague, psychologist David Crockett, are the first to quantify the psychologic impact of peacekeeping. Symptoms they discovered included a combination of anxiety or panic attacks, irritability, difficulty in falling asleep or staying asleep, diminished interest in work, family or friends, and curtailed emotions. "Peacekeeping may not be more stressful than battle," Passey stated, "but it is certainly more stressful than anyone thought."

Peacekeepers are typically placed between warring factions that seldom appreciate their presence. They are often fired upon yet seldom fire back, and not only must they remain neutral, but also they must be perceived as neutral by every party involved.

AP/Canapress



Horrific scenes like this, of a British peacekeeper covering the mangled body of an elderly Croat killed in bitter fighting in Bosnia, have caused psychiatric problems for Canada's peacekeeping troops.

"In war," Passey explained, "one measures success by how many hills or towns are captured. In peace, one measures success by how many people got food or were not killed. That can be very stressful. Troops can't just come back [from peacekeeping duty] and get on with their lives unaffected."

There is no suggestion that psychologic trauma among soldiers is new. "Shell shock" claimed thousands of victims in World War I. Battle exhaustion, the euphemism used in the 1940s, also took a terrible toll, accounting for up to 30% of Canadian casualties in some battles.

Nevertheless, at the end of World War II the director general of medical services told the American Psychiatric Association that military psychiatrists were unnecessary because "the strain of battle no longer exists and it is probable that army life in peacetime is no more hazardous, from the psychiatric point of

view, than many civilian occupations."

Recent incidents suggest otherwise. A 26-year-old soldier from the Winnipeg-based PPCLI killed himself after returning from a peacekeeping mission in Croatia. A soldier from another peacekeeping unit is believed to have attempted suicide. And there are also stories of family and other types of violence, a high divorce rate and requests for transfers. (As this was being written, an American ex-serviceman allegedly shot and killed four people, including two physicians, at an air force base in Washington state.) Passey also found that peacekeepers exhibit up to three times the rate of depression found in the general population.

Colonel Robert Miller, chief of psychiatry at the National Defence Medical Centre (NDMC) in Ottawa, said "we're now recognizing that psychiatric illness overall is more common than we realized. At the

same time, psychiatric illness doesn't mean such horrific things as we thought."

"We don't see many major disorders such as schizophrenia, psychoses or bipolar depressions," said Passey. He described his principal role as sorting out personality defects from treatable disorders. Personnel with personality defects may not be effectively employed in the military, he said, but those with treatable disorders can be.

Miller said the defence department is currently revising the way it delivers mental-health care. The general-duty medical officer (GDMO), the military's general practitioner, is to assume more responsibility for such treatment, as are allied health professionals such as social workers. When required, psychiatrists will visit bases and work alongside GDMOs.

Canada has been studying the model used by Britain's Royal Air

Combat stress a legitimate symptom, military says

In World War I, they were shot. In World War II, they were stigmatized and called LMFs, because they showed a "lack of moral fibre." But today, Canadian military personnel who experience "shell shock" or "battle exhaustion" — it is generally called critical-incident stress (CIS) — receive psychiatric care and are taught coping skills.

"We don't consider combat stress a psychological problem that means a person is cowardly or crazy," declared Lieutenant-Colonel Jim Jamieson, the defence department's chief social worker. "We consider it a normal reaction to an abnormal situation."

Today, a new program prepares troops for overseas duty and helps them cope with stress while there and readjust when they return. "Without understanding this phenomenon [CIS]," said Jamieson, "many soldiers will think, 'Am I go-

ing crazy?' It just makes good sense to address critical-incident stress. People who suffer from stress are ineffective and unable to do their work."

CIS refers to the psychologic distress experienced in the face of an event that occurs suddenly and unexpectedly and is outside the range of normal experience. It disrupts one's sense of control, involves the perception of a life threat and may include elements of physical or emotional loss. For military personnel, the event could be combat, exposure to artillery fire, transport disasters, being personally threatened, or scenes involving people who have been killed, wounded or suffered serious injury.

According to Jamieson, a person can usually lessen the effects of the stress by talking the incident over with peers and awaiting the natural healing process. Sometimes,

however, CIS can lead to post-traumatic stress disorder (PTSD), a long-term and enduring illness whose symptoms include anxiety, depression, recurrent nightmares, insomnia, concentration problems, flashbacks, survivor guilt, misuse of alcohol or other drugs, uncharacteristic isolation, and other problems pointing to impaired functioning. Experiencing six of the symptoms together indicates the disorder.

CIS debriefings involve group sessions led by a social worker, nurse, medical officer or chaplain, during which soldiers are encouraged to talk about the incident and their feelings. The goal is to reduce stress and speed the return to a normal mental state. Equally important is preventing critical-incident stress from progressing to post-traumatic stress. Thus far, the military has sent CIS debriefing teams to both Somalia and the former Yugoslavia.

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Force (RAF). In the early 1970s, the RAF switched to a community model of care. Psychiatrists fan out from central psychiatric units to work with mental-health teams on every base. GDMOs have more frontline involvement, with psychiatrists visiting regularly.

Passey's work with victims of PTSD reflects this new strategy. The third-year psychiatric resident at the University of British Columbia and former GDMO travels weekly to the military base in Chilliwack, where he helps the base medical staff treat psychiatric patients. During these visits he uncovered the cluster of PTSD

cases that led him to begin his investigation of peacekeeping-related stress. In the last few months he has set up an outreach PTSD clinic.

Five years ago, Passey might not have been allowed to open such a clinic. Today, said Miller, the armed forces realizes it is a mistake to isolate psychiatric services from general medical care. It is more important to make care easily available and accessible, he said, and to keep patients close to their support systems and on the job.

“Proper psychological care,” Jamieson insisted, “means better performance from the troops.” Conse-

quently, satellite clinics like the one in Chilliwack are being set up around the country to bring more services to troops and their families.

Despite these changes, one very large issue remains: How does the military deal with the apparent stigma attached to psychiatric care? “It's never been easy to get soldiers to talk openly about their psychological health,” Miller said.

“Many believe no one understands the horrors they've seen,” Passey added. “Some believe that asking for help is a sign of weakness and a black mark on their careers. As far as I'm aware, there are no career im-

Reservists may fall victim to post-traumatic stress disorder, civilian doctors warned

Despite growing recognition that military duty is stressful and frequently requires professional intervention, a significant proportion of Canadian soldiers return from UN peacekeeping missions with no access to psychologic support.

Lieutenant-Commander Greg Passey, a family physician and psychiatric resident, told *CMAJ* he worries about the mental health of the ever-growing contingent of reservists serving on peacekeeping missions — soldiers who do not have access to the military's medical safety net upon their return to Canada.

Reservists now account for close to half the soldiers participating in Canada's major peacekeeping missions. While exposed to the same traumatic events as full-time personnel, reservists do not share

the same medical-support systems.

“We have a significant population of reservists going to civilian doctors,” Passey said, “and these doctors may not be aware of post-traumatic stress disorder [PTSD] and its prevalence among military personnel.”

PTSD, which is described in the *Diagnostic and Statistical Manual of Mental Disorders (DSM) III-R*, consists of a cluster of symptoms that fall into three main areas:

- intrusive symptoms, such as flashbacks, distressing recollections and dreams, and intense psychologic distress;
- avoidance symptoms, such as diminished interest in significant activities, feelings of detachment or estrangement from others, and a sense of a foreshortened future; and
- arousal symptoms, such as

hypervigilance, sleeping difficulties, irritability and exaggerated startle response.

“It is important that civilian primary care physicians be aware of PTSD and how patients may present,” Passey said. He suggested that they ask about military duty when patients present with any PTSD-type symptoms.

The rate of depression, panic disorder, generalized anxiety disorder, phobias (especially agoraphobia), alcohol abuse and drug abuse is higher among returning troops than in the general population. Passey said the symptoms may not appear until 6 months after the stress or trauma.

“One must be a detective and search for the clues,” he emphasized. “Unless the appropriate questions are asked, the PTSD will be missed.”

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plications linked to psychiatric care.”

Nevertheless, many military personnel try to deal with stress on their own — some may turn to alcohol, or leave the military. “We’ve got to remove the stigma and make help available to our troops,” said Passey.

Part of the stigma may involve the ties between military physicians, particularly psychiatrists, and commanding officers (COs), Miller explained. Regulations specify that the CO is entitled to receive information on the health of his troops; if physicians see someone who they believe is unfit — an alcoholic, for instance — they will report back to the CO.

“Military personnel have to be fit,” Miller said, but reporting is difficult for physicians who have to balance rules of confidentiality and the

rights of the individual with society’s rights to have functional military personnel. “We can’t afford to say half a regiment can’t go to Bosnia because of health problems.”

Historically, it was the task of military psychiatrists to screen out unfit personnel at the time of enlistment. Col. F.H. van Nostrand, an army neuropsychiatrist, wrote in *CMAJ* in 1942: “Although we are interested in rehabilitation . . . our primary function is early diagnosis, early treatment and, above, all, early disposal of the mentally unfit.”

Today, military psychiatrists are less apt to try and keep people out of the military through psychiatric screening — that could invite legal challenges. Rather, the rigours of basic training appear to provide, in effect, self-screening.

“Members are under a fair amount of stress during training,” said Passey. “This probably screens out a lot of [people with psychiatric] disorders.” This would include those who function only marginally, who have difficulty with authority, or who have difficulty putting group needs ahead of individual needs.

However, once someone has passed successfully from training into everyday military life, both Passey and Miller contend that mental health becomes an important aspect of overall health care provided by the military. Today the armed forces offers family or individual counselling to handle the marital discord and readjustment that seem to stem from the demands of military life.

These changes, Jamieson maintained, are being driven by a new appreciation of people’s needs and a larger social accountability: “We do have a responsibility to assist victims of violence and workplace traumatic stress, and to provide counselling services.”

And what about those 11 soldiers who were terrorized in Bosnia? After their debriefings, they all went back to their regiment — and back to work. ■

thromboplastin reagents and provide additional guidance for defining the appropriate therapeutic regimen. **Initial Dosage** - The administration of COUMADIN dosing must be individualized according to the patient’s sensitivity to the drug as indicated by the PT and/or INR. COUMADIN therapy is commonly started above anticipated maintenance dosage levels. A commonly used regimen for COUMADIN is 10 mg/day for 2 to 4 days, with daily dosage adjustments based on the results of PT/INR determinations. Use of a large loading dose may increase the incidence of haemorrhagic and other complications, does not offer more rapid protection against thrombi formation, and is not recommended.³ Lower initiation doses are recommended for elderly and/or debilitated patients and patients with increased sensitivity. (see PRECAUTIONS). **Maintenance** - Most patients are satisfactorily maintained at a dose of 2 to 10 mg daily. Flexibility of dosage is provided by breaking scored tablets in half. The individual dose and interval should be gauged by the patient’s prothrombin response. **Duration of therapy** - The duration of therapy in each patient should be individualized. In general, anticoagulant therapy should be continued until the danger of thrombosis and embolism has passed. **LABORATORY CONTROL** - The PT reflects the depression of vitamin K dependent Factors VII, IX, X and II. There are several modifications of the one-stage PT and the physician should become familiar with the specific method used in the laboratory. The degree of anticoagulation indicated by any range of PTs may be altered by the type of thromboplastin used, the appropriate therapeutic range must be based on the experience of each laboratory. The PT should be determined daily after the administration of the initial dose until PT results stabilize in the therapeutic range. Intervals between subsequent PT determinations should be based upon the physician’s judgement of the patient’s reliability and response to COUMADIN in order to maintain the individual within the therapeutic range. Acceptable intervals for PT determinations are normally within the range of one to four weeks. To ensure adequate control, it is recommended that additional PT tests are done when other warfarin products are interchanged with COUMADIN. **TREATMENT DURING DENTISTRY AND SURGERY** - The management of patients who undergo dental and surgical procedures requires close liaison between attending physicians, surgeons and dentists. In patients who must be anticoagulated prior to, during, or immediately following dental or surgical procedures,

adjusting the dosage of COUMADIN to maintain the PT at the low end of the therapeutic range, may safely allow for continued anticoagulation. The operative site should be sufficiently limited and accessible to permit the effective use of local procedures for haemostasis. Under these conditions, dental and surgical procedures may be performed without undue risk of haemorrhage. **CONVERSION FROM HEPARIN THERAPY** - Since the onset of warfarin’s effect is delayed, heparin is preferred initially for rapid anticoagulation. Conversion to COUMADIN may begin concomitantly with heparin therapy or may be delayed 3 to 6 days. As heparin may affect the PT, patients receiving both heparin and COUMADIN should have blood drawn for PT determination, at least 5 hours after the last IV bolus dose of heparin, or 4 hours after cessation of a continuous IV infusion of heparin, or 24 hours after last subcutaneous heparin injection. When COUMADIN has produced the desired therapeutic range or prothrombin activity, heparin may be discontinued.

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Strength	Imprint Side 1	Imprint Side 2	Colour
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2.0 mg	COUMADIN 2	Du Pont	Lavender
2.5 mg	COUMADIN 2.5	Du Pont	Green
4.0 mg	COUMADIN 4	Du Pont	Blue
5.0 mg	COUMADIN 5	Du Pont	Peach
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