**AS HEALTHY AS POSSIBLE UNDER THE CIRCUMSTANCES:
COPING WITH OPERATIONAL STRESS
IN THE CANADIAN ARMED FORCES**

by

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The Faculty of Graduate Studies and Research
in partial fulfillment of the requirements for the degree of

Master of Arts

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The undersigned hereby recommend to the Faculty
of Graduate Studies acceptance of this thesis submitted by
Roberta Abbott as partial fulfilment of the requirements for
the degree of Master of Arts.

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Abstract

The current emphasis, inside and outside of the military, on Post-Traumatic Stress Disorder is more a symptom of a social spill-over effect from a risk averse and fearful civilian culture, and the reality of new warfare, than of endemic mental health problems in the Canadian Armed Forces. There are fewer objective and different, and more complex, subjective risks involved in recent military operations than in previous decades. With the absence of grave physical risk, the risk of mental illness and physical illness has become more apparent. The Department of National Defence is responding to the public and media inspired impression that PTSD is a very serious problem in the Canadian Armed Forces, but in doing so it must approach the problem by reassessing its collective approach to risk, reaffirming its identity and challenging cultural norms within the military institution regarding mental illness in all its forms.¹

¹ Style Note: Inverted commas are used to connote words and phrases that are paraphrased, common usage or expressions, or in cases where the words have value or meaning beyond their usual definition. Quotation marks are used only in cases of directly quoted material.

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Introduction:**Warning: A career in the military may be hazardous to your health.**

We, in the ‘developed’ world, are now, more than ever before in human history, objectively safe in our surroundings—regardless of what one might argue about the ubiquity of terrorists. Those who live in the healthy, prosperous Western world face very few physical threats to their existence save those that are self-inflicted (i.e. fast cars, alcohol consumption, cigarettes), to the extent that we are creating risk in order to satisfy our natural inclination for excitement and identifying previously unnoticed risks in a fearful desire to live ever safer lives. In North America we live in a culture of fear (this is particularly true of the US where there is the highest rate of private ownership of firearms in the world²) in which we perceive danger lurking round every corner. We suspect contaminants in our water, air and food; we arm and increasingly guard ourselves against theft and violent crime; our children are watched over constantly as crimes against them are more widely publicised and become high tech and international; and we spend enormous amounts of money on attempting to achieve physical and mental ‘well being’ through fitness.

In our zeal for safer lives, we have done an unexpected thing; we have imposed upon our military the cult of safety, the unrealistic aim of making soldiers invulnerable, mentally and physically. We have exhorted our military organizations to take great measures to ensure the ‘well being’ of their personnel, sometimes with beneficial results as in the case of quality of life measures that ensure adequate housing and pay, but

² That is eight firearms for every 10 Americans, one per adult (15 years and older) or 2.1 per household.

sometimes to the detriment of their ability to train and to fight. We have turned the 'just warriors' of past centuries, those who we chose to send forth to kill and die in the defence of the nation, into soldier-scholars and soldier-statesmen whose expensively trained, professional existence is so valuable that they must no longer die (they also must no longer kill).

Much has been written about risk-averse Western governments being unwilling to use their militaries because the voting public of their democratic nations are unwilling to condone casualties. The assumption is that voters are excessively concerned, from a benevolent, caring perspective, with the well-being of military personnel and civilians in other societies and are imbued with a desire for peace. This argument has been criticized because it presumes that Western society is consistently and rationally concerned with the welfare of others. Rather, much of our casualty aversion is part of an irrational, fear-based construction of acceptable and unacceptable risk and real and perceived danger that can be overridden by political justification and media representation. In the battles of centuries and decades gone by, war and death were synonymous. When one went to war, casualties were expected. As we have changed our perception of what war is, and what peace is and the lines between them have blurred, our willingness to accept the risks of war and the casualties that result, has diminished. We are sometimes willing to put up with killing and dying in the pursuit of what we consider a 'just cause', although even this has its temporal limits. However, in most cases, if the military operations we engage in do not have a cause sufficiently just to raise personal and national ire to a fever pitch (as they now rarely do, Afghanistan being a recent exception), we expect those who we

send to attend to the business of conflict to return home physically and mentally unharmed.

A military in a democracy generally reflects the society from which it is drawn. Therefore, we have managed to convince the members of our military to join us in our health and safety obsession and the belief that risk-free war is achievable. This is not to suggest that military leaders relish risking the lives of their troops, quite the opposite is true. However, they generally understand and accept the risks of the job they have chosen far better than those who ask them to do it. When they deploy on a military operation, they understand that their lives may be on the line, they believe this is as it should be, they feel a guilty pleasure at the adrenalin rush they get from the dangers they're sent to encounter, but they also have a political and social *responsibility* to return home uninjured. Governments are expected to resist with all means the need to expend the lives of their citizens in violent pursuits, but loss of life can only be guaranteed if they're never asked to engage in such pursuits in the first place.

The Canadian Department of National Defence (DND) is working very hard to respond to the recent public outcry against what it has been told is an unprecedented epidemic of mental illness in the Canadian Forces (CF). It is having difficulty addressing this problem because most of its psychologists, psychiatrists and social workers (and other mental health practitioners) agree that much of what can be done, from a practical standpoint, is being done, albeit not with the efficiency and effectiveness they would prefer to be capable of. What can change and needs to change is more in the realm of culture and knowledge of mental health issues and mental illness, because DND is not facing anything new, simply a new response to a very old problem. 'Operational stress

injury' is just the latest name given to a complex of mental health problems, frequently with physical manifestations, that result from or are exacerbated by exposure to the stressful experience of military life.

DND and the CF are impelled in this pursuit by unprecedented media scrutiny of the problem and the recommendations of their own internal mechanisms for change, for example, the DND and CF Ombudsman³, and by other forces both within and without that seek a different kind of soldier. The new soldier should be an extremely intellectually and tactically complex individual: able to negotiate with all sides of a conflict without demonstrating bias; able to respond to quickly shifting rules of engagement, ever mindful of international law; able to work with myriad international governmental and non-governmental organizations, protecting them and assisting them; and, when necessary, able to exert lethal force.⁴ This may be possible, with a much higher level of training and education than currently exists, but the public perception is that he (or she⁵) should do this without getting injured, certainly without getting killed. However, it is increasingly expected that he may very likely succumb to operational stress. Such has been the press attention to this issue that it is assumed to be 'normal' for a member of the CF to be so

³ The DND and CF Ombudsman, Mr. André Marin, released a series of reports in 2000/2001 regarding a study conducted by his office on the affects of military deployments on the mental health of CF members, with specific focus on PTSD and the stigma associated with it.

⁴ Because of the connection in the press between 'peacekeeping' and 'PTSD', the Army is the primary focus for discussions of operational stress and the environment about which the most information is available, and, therefore, will figure prominently in this thesis. Navy and Air Force personnel also face extreme stressors, even in peace operations, in transporting personnel and supplies in and out of war zones, patrolling transportation routes, and other tasks. They are also potentially much more affected in complex operations where naval and air forces are more involved, but the sources and effects of stress would likely be different for them, e.g. from distant anti-aircraft or torpedo fire than from proximity to atrocities. Insufficient research has been done regarding stress and naval and air force personnel.

⁵ Although women are still only 6% (effective strength) of the combat arms in the CF, there are women present in the theatre of operations as soldiers, sailors, aviators and as support personnel and are as susceptible to operational stress. However, because of the lack of empirical data associated with mental

affected by the rigours of combat and the environment of lethal conflict, whether he is a participant or not, that he is mentally debilitated by it, an assumption that is neither incorrect nor dangerous if properly understood. However, it is being over estimated to the extent that if he does not succumb to this influence, he may question his own claim to being 'normal'. When he does succumb to operational stress, as we're told by the Ombudsman a very large, but undefined, number of troops have, he must be treated, in ways not yet clearly determined, and no one within the military or the Department should rest until a 'cure' is found.

It is important that anyone experiencing symptoms of operational stress, or any other psychological illness or disorder, is given any measure of appropriate support that the military can muster and that medical and social science can provide. It is desirable that the CF do everything in its power to prepare its members for whatever circumstances they may encounter throughout their careers and attempt to minimize mental health concerns. However, the present obsession with mental wellness that has gripped the media and is impelling some aspects of research and treatment currently being undertaken in DND may ultimately be harmful to members of the Canadian Forces. Mental health practitioners in DND are walking a knife-edge between being *seen* to 'do something', reacting to public pressure for the sake of action, taking on board the wide ranging recommendations of the organization, and accurately defining the parameters of the problem and devising prevention and treatment regimes that are sensitive to the needs of individual members. This thesis addresses the factors associated with this balance and

health outcomes there is no specific data with regard to whether operational stress affects men and women differently.

the attempts of DND professionals to achieve it, while working within the cultural boundaries of the Department and the CF.

Data for this thesis has been drawn from interviews with health and social science professionals within the Department of National Defence whose work is either directly or indirectly connected with mitigating operational stress injury in the Canadian Forces. They were asked a series of questions (see Appendix 1) relating to their work, the incidence of operational stress in the CF, how their work is received by the people it is intended to help, and how they work together within the Department to deliver mental health assistance. The respondents were numbered and their responses were coded and grouped based on the primary areas of argument in this study. Also interviewed were a small number of retired general officers who were chosen for their knowledge and experience of the pressures of command and the high degree of respect and credibility they enjoy within the profession.

Their responses had a dramatic impact upon the hypothesis of this study and on my knowledge and understanding of mental health. I had initially hypothesized that combat stress reaction (I was mostly concerned with the likelihood of combat stress arising from the intensity of post-Cold War missions) was the primary cause of lingering psychological malaise in the CF and that little was being done to address the issue. Rather, as a result of the interviews I have conducted and the literature research I have done, I have been persuaded that, while combat stress reaction is a problem and there are CF members who are diagnosed with mental health problems relating directly to traumatic incidents associated specifically with combat, or who suffer long term psychological problems as a result of combat, it is likely that the cumulative stressors of

general life in the military and pre-existing or mild but persistent mental health problems are as common within the CF.⁶

I was also, throughout the course of my research, struck by the increased media attention this problem is receiving. A substantial amount of this attention is due to the recent Ombudsman's Reports (2000/2001), regarding a complaint by Corporal Christian McEachern (a reservist turned regular force member of the PPCLI⁷ Regiment), that inadequate and inappropriate treatment for PTSD was the cause of his action when he drove his SUV through the front door of the Edmonton garrison headquarters. This is the sort of news story that is very appealing to the general public, it is medical and therefore scientific, but with human interest and a personal tragedy to relate. This kind of story creates sympathy and curiosity, but because of the need of reporters to proceed quickly through the research process, they are often rife with half-truths and pseudo-science and devoid of international comparison, which would clarify the issue considerably. Both within the military and outside of it, experts and hobbyists abound with an interest in Post-Traumatic Stress Disorder (PTSD)—the lingering psychological effects of experiencing or witnessing a traumatic event. Even those who have to struggle to remember what the acronym 'PTSD' means, have an opinion on what causes it and what the military ought to do about it. Frequently the Department's mismanagement of the issue is cited in the press, its callous disregard for soldiers, and the image of the tough,

⁶ A study currently being conducted by Statistics Canada, the results of which will be known within the coming few months, is likely to reveal the current state of mental wellness in the Canadian Armed Forces in comparison with those among the general public. DND health professionals believe this will give them concrete, quantifiable evidence with which to respond more directly to concerns raised by the Ombudsman.

⁷ Princess Patricia's Canadian Light Infantry. Details regarding this case will be discussed in later sections of the thesis.

unfeeling commanding officer is invoked, he who chides his troops for weakness if they dare come forward with complaints of psychological distress.

While more could be done to provide for troops who have psychological problems, and there are commanding officers (COs) who believe that psychological problems equate to weakness, it became apparent from my interviews and literature research that the hue and cry for more attention to the issue is akin to the kind of public attention that humanitarian disasters in other parts of the world receive. There is a sense that someone ought to 'do something', we're not sure exactly what, we feel a certain amount of personal guilt because of a vague awareness that their plight is something for which we are partly to blame, but it's easily forgotten when the next news story comes along. The arguments made in this thesis are not in all cases a direct empirical reflection of the statements of the interview subjects. They are frequently my interpretation of their collective opinions. The larger impression provided by their opinions was in fact quite different from what I expected.

Chapter 1 of this study will describe how risk theory, as articulated by cultural anthropologists, political scientists and psychologists provides a theoretical basis for increased risk perception in Canadian society and in the CF. Using international affairs literature, this chapter will introduce the argument that the current climate of risk-aversion in Western culture is largely responsible for a heightened sense of personal and professional risk in the CF.

Chapter 2 will address the issue of 'risk aversion' versus 'casualty aversion' at the institutional level and the misperception that governments and militaries have *become* casualty averse. Rather, it will be argued that militaries are, by necessity, averse to

recklessly incurring casualties, governments are selectively casualty averse, and civilians are averse to actions that do not represent their values and beliefs regarding risk. The data and DND analysis from the 2000/2001 study Meeting the Challenges of Peace Operations: The experiences of Canadian Forces Officers⁸, conducted by Maj. J.E. Adams-Roy, Dr. R. MacLennan, and L. Rossiter will contribute to the argument that CF officers perceive risks differently in the post-Cold War era because the threat environment and the skills required to respond to that environment have changed. Concurrent changes to civilian perceptions of risk have created a demand for hazard-free soldiering and an invulnerable military in which physical and/or mental injuries, including PTSD, are unacceptable. The civilian desire for and belief in the possibility of a life free of illness and death has led to the perception of any detected illness as epidemic and chronic and surely resulting from Departmental negligence.

Chapter 3 will move the analysis from the institution to the individual. The discussion of physical and mental health in the military will be expanded with a historical and contemporary examination of the prevalence, prevention and treatment of operational stress injury in the Canadian military and other forces. This chapter will also discuss how PTSD, as a result of media engagement and the determination of some parties to the debate to focus solely on a single cause, has become the primary self- and other-diagnosis in the attempts to remove 'at risk' elements from the CF. The relationship of these 'risky' personnel with their militaries and their place in the organization will also be explored. The primary research data for this thesis is used throughout the document, but contributes more extensively to Chapter 3 in the form of paraphrased quotations and tables.

⁸ This study will hereinafter be referred to as Meeting the Challenges.

Chapter 4 will further argue that in order for Canadian Forces personnel to be more effective in multinational operations, the Department and the CF must redefine the cultural parameters of acceptable and unacceptable risks and their associated responsibilities regarding mental health. Understanding that psychology and mental wellbeing are not the requisite domain of experts, but also of traditional aspects of military culture, will aid in reducing the fear of change systemic to the organization.

Chapter 5 will explore and critique the original hypothesis of this thesis: the efficacy of a 'health promotions framework' for managing operational stress in the CF, recognizing that aspects of this option might contain their own risks. This chapter will also suggest implications for international affairs arising from the research with regard to the willingness of political and military actors to take risks and create change. It is more likely that cultural change will have to come as the result of negotiations among social scientists, medical practitioners and senior officers regarding how to address mental health issues within the culture of the institution, insuring soldiers not against the war-front, but against misinformation from the home-front.

Chapter 1: Risk Theory, A Cultural Perspective

1.1 A culture of fear

In recent decades, Western society's interest in health and wellness has metamorphosed into an obsession. According to an Economist article on the phenomenal growth in the fitness business, the reason for so many millions to engage in the "boring and self-punitive pursuit" of 'working out' is a mystery because its benefits for most people do not match its costs in time and money. The article's author hypothesizes that the fitness obsession "like most popular religions, probably has something to do with fear of death and immortality" (Economist, 2003, 101). The Director of Oxford University's Social Issues Research Centre, Dr. Peter Marsh (2001), points out that we fear death more than ever in spite of the fact that "we live on average considerably longer than even our immediate progenitors."⁹ Our desire to escape death through obsessively good health has created a reverence for health that is akin to religiosity, making ill health a sin to an extent similar to 19th century Europe's Christian ideal of healthiness as a road to godliness. 'Healthism' is the new religion, marginalizing those who aren't willing or able to achieve perfect fitness or who eschew the healthy 'life-style'. One must choose a 'style' of living, either healthy or unhealthy, active or inactive, with value judgments attached to those labels. Marsh argues: "While previously ill-health had been seen as an unavoidable misfortune, it has now become (at least in part) the result of bad habits." In a

⁹ From a lecture to the Institute for Cultural Research, London, UK, delivered November 17, 2001. Available in full-text version on the SIRC website at: http://www.sirc.org/publik/bad_habits.shtml

vain and fearful attempt to achieve the new norm, modern Western societies are ever-alert to new risks and the symptoms of ill health. Alarmist stories in the media on every topic from pesticides to terrorism create a culture of fear where risks are perceived as ubiquitous. In the words of anthropologist Deborah Lupton (1999):

While we no longer view dead bodies lying about, while the plague has all but vanished as a cause of death, while infant mortality is extremely low and most of us expect to live well into old age, we fear being the victim of a crime, falling prey to cancer, being in a car accident, losing our jobs, having our marriage break down or our children failing at school (p. 10).

A recent study published in the Lancet (Li et al., February 2003, p. 363) and reported by BBC World News (2003) suggests that “women who lose a child are much more likely to commit suicide, die in an accident and even die from disease compared with other mothers. Fathers are also affected but to a lesser extent.” It’s no longer tragic enough to lose a child, but empirical evidence has told us the bereaved parent is more likely to die as well shortly after from “unnatural or unexpected causes.” Is the world made safer by this knowledge? The latest film from documentary film-maker, Michael Moore (2002), Bowling for Columbine, makes a compelling argument that the sensationalist American press, right wing political rhetoric, the gun lobby, and the military industrial complex are responsible for creating a culture of fear in the US which supports the ongoing ‘right to bear arms’ and the high incidence of homicide. The erosion of trust and the rise of fear, in his thesis, are responsible for what violent deaths and crimes do occur, so convinced are most people that conditions around them are deteriorating. Rather, in many parts of the world, living conditions are steadily improving. According to the Globe and Mail, many NGOs have stated that the figures for health, freedom, education and other measurements of global ‘wellness’ indicate that 2002 saw a general increase in the wellbeing of all of

the planet's inhabitants (Gee, 2003, p. A23).¹⁰ However, the columnist points out that most of his colleagues who reported this finding, referred in alarmist terms to what has not yet been accomplished, rather than to the slow but steady improvements.¹¹

1.2 The risk theory continuum

Theories regarding risk take a variety of forms, Deborah Lupton's (1994; 1995; 1999) work on risk describes a continuum within social science research on one end of which is the "realist" approach in which individuals are 'at risk' from objective hazards and lesser important risks are socially constructed. At the other end of the continuum is the "post-modern" approach, in which no real hazards exist, risks are created when value is assigned to our perception of them giving them the socially constructed label of 'hazard' (1999, p. 35). The "cultural/symbolic" perspective originally described by Mary Douglas (1982; 1985; 1992), whose work Lupton draws substantially from, recognizes objective hazards, but argues that our understanding of risk is determined by our cultural and institutional groupings and communities and what types of risk we choose to accept voluntarily and involuntarily.

This thesis takes a cultural/symbolic approach to risk theory, arguing that Canadian society perceives hazards, personal and collective, through a cultural lens, but this lens is also fractured into institutional perspectives; civilian risk perception being somewhat different from military risk perception. However, within larger Canadian

¹⁰ "According to the latest annual report from the New York-based Freedom House, which monitors the state of liberty around the world, 29 countries became more free this year, while 11 became less free—a net gain of 18.... According to a recent survey by the United Nations Children's Fund, fewer and fewer children are dying in their earliest, most vulnerable years. Since 1990, the under-5 mortality rate—a key measure of a society's state of health—fell from 93 per 1,000 live births to 82." (Gee, A23).

¹¹ "...when the Knight-Ridder news service wrote about the UNICEF report, its opening paragraph was: 'Millions of children worldwide are beaten by their parents, face starvation, suffer deadly illnesses and are forced to leave school to work, many of them as prostitutes, according to a study released Wednesday'" (Gee, A23).

society, from which the military is drawn, there is a growing suspicion of certain institutions and bodies of knowledge that is creating dissent at the borders of military risk acceptance. In Canadian society, as in most Western societies, there is a high level of reliance on science and technology, for example, medical technological advancements, as well as mistrust of new scientific methods, for example, genetically modified crops. Similarly, government institutions are, by necessity, relied upon, but very few institutions are completely above suspicion. Canadians, like the citizens of other developed nations, contribute to a culture of vastly increased personal autonomy while demanding greater government accountability and assurance of the protection of their health and wealth—a difficult balance to strike.

In Risk and Culture Mary Douglas and Aaron Wildavsky (1982) describe three different cultural approaches to risk, two existing at the centre, the hierarchical and the individualist, and the sectarian which inhabits the borders and challenges the centre. Those with a hierarchical perspective—a cultural description which best fits the military institution—rely upon tradition and conformity in their assessment of risk. Hierarchies do not seek radical solutions to threats, but seek solutions that are most like what they are already doing. Larger organizational decisions are anonymous and no one person or faction is allowed to dominate.

Individuals in such a society make it work by subscribing to common values. They first value the organization and its long term future. They value their traditions and rules. They believe that all humans are at least rational enough to follow rational instructions. In a sense the hierarchical way of life is a choice. At any moment, a hierarchy could be transformed into something else. If it endures recognizably and reappears irrepressibly at all times in history with the same strengths and weaknesses, this is because it is a feasible way for a large number of people to collaborate (p. 95).

The approach of the “individualist”, which describes the liberal-internationalist, and free-market economy approach to risk, is to value autonomy for himself and others; the individualist proclaims “the values of equality and individual self help” (p. 96). He does not trust tradition and relies on luck and sees uncertainties as opportunities. Current Western governments contain elements both of hierarchy and of individualism as government deliberately seeks to operate more along the lines of business requiring lower strata of government and individual citizens to accept greater responsibility for long term well being. Sectarian risk assessment mistrusts the received knowledge of science and experts and takes opposing positions to established norms. Sects, although supposedly suspicious of established norms, can take on the characteristics of institutions in ‘interest groups’ and ‘activist causes’ even developing hierarchical characteristics and demanding government response in the form of legislation for radical change to what are perceived as threats from technology and other institutions.

The sectarian approach as described by Douglas and Wildavsky in 1982 was at that time, in their thesis, a growing force in American society. Douglas’ observations regarding sectarian dissent predate Michel Foucault’s description of the “privatization of risk” occurring within states in which governments are moving away from “social insurance as a way of distributing risks, to a focus on individuals protecting themselves against risk” (Lupton, 1994, p. 5). Post-modern risk theorists—followers of Foucault’s governmentality perspective—are challenging “the dominant discourses and expert techniques and institutions that serve to render risk calculable and knowable” (p. 6). Douglas’ dissent from the borders and Foucault’s challenge of expert knowledge both

respond to a growing public and scholarly discourse regarding which risks are acceptable and who determines what is risky or threatening.

1.3 Risk and technology

Ulrich Beck's (1994) work on what he describes as 'risk society', also explores and challenges the connection between the historical and cultural construction of risk perception and the received expert knowledge of what constitutes 'risk'. Beck lodges the responsibility for heightened risk perception and competing labels on what is 'risky' with the wide-spread ideation that technology is the apparent solution to every problem. According to Beck, the increase in technology creates a concomitant increase in risk, the knowledge of which resides with experts who are contradicted by other experts: "risks only exist in (scientific or anti-scientific) knowledge about them. They can be changed, magnified, dramatized or minimized within knowledge..." (p. 8). Expert knowledge assures the end user that technology exists to mitigate risk, even when that technology has been developed in response to preceding technology that has itself created risk. Whether the latest technology eliminates, minimizes or magnifies risks to states, groups or individuals depends upon one's perception, as Beck points out, "some people are more affected by the distribution or growth of risks and there are winners and losers in risk definitions" (p. 8).

Gerald Wilder's (1999) theory of 'risk homeostasis', which describes individual risk assessment has derived from industrial risk analysis in which modelling of safety measures and how individuals respond to them indicates that technology which reduces risk does not change risk-taking behaviour. In addition to choosing whether or not to accept institutional or governmental assessments of risk, individuals have, in Wilder's

thesis, a 'thermostat' for risk acceptability. We engage in 'risky' behaviour at times out of choice, because a certain amount of risk in our lives is desirable to most people. If the amount of subjectively experienced risk is lower than what is considered acceptable, people will engage in actions that increase their exposure to risk, if the amount of subjectively experienced risk is higher than acceptable, people will adjust their behaviour to be more cautious, thus achieving homeostasis in their risk acceptability (p. 5). This would account for the rise in popularity of extreme sports in our objectively safe world. And more central to Wilder's thesis, it accounts for the fact that technologies or methodologies designed to reduce the rate of auto accidents or aid in the prevention of lifestyle-dependent diseases often fail, because most individuals resist the need to change their overall risk-taking behaviour, what changes is the set of risks they engage in.

Furthermore, individuals will only adjust their behaviour to accommodate risks which they *believe* they understand the nature of. If the knowledge they have is incomplete or erroneous in some fashion, or they believe that they are deliberately being supplied with incomplete information, their behaviour modification will be skewed in some fashion. If a technology or methodology claims to mitigate all of a particular kind of risk without requiring any behaviour modification, they will not change any of their associated behaviours, believing they are no longer at risk. If they believe that nothing can be done to mitigate certain risks, they will hyper-adjust their behaviour to respond to risks that they perceive as far greater than they have the skills or resources to combat. Douglas (1992) has also demonstrated this behaviour pattern with regard to risk familiarity: hazards which we are very familiar with, regardless of the high probability of negative outcomes associated with them, will not be avoided; whereas, hazards of which

knowledge is imperfect or suspect, but with a low probability of negative outcomes are avoided more assiduously (p. 56).

The thermostat for risk in Canadian society, as with other Western societies, has been lowered over the past ten years. We seek a compulsively safe environment and label more and more ordinary things as unsafe to the extent where a packet of peanuts will now display the label 'contains nuts'. The perception that our risks are no longer localized, but are being imported in a globalized world, has given rise to the desire to eliminate risky behaviour in other cultures as well. Seeing their behaviour as imposing involuntarily upon us by increasing our own risk for disease or war, we pursue global health and safety with missionary zeal, in what Marsh describes as a paternalistic mandate to ensure the 'wellbeing' of all of the worlds peoples. The World Health Organization has undertaken such misguided initiatives as "seat-belt wearing campaigns in Mozambique where the main form of transport is the water buffalo and cart" and diets to control the 'obesity' of Polynesian women who are "culturally valued" for their size and weight. Instead these women are "'encouraged' to become a more 'normal' size despite the fact that this will inevitably make [them] less culturally valued, and probably quite miserable" (Marsh, 2003).

If one accepts the 'underlying causes' thesis of terrorism, it is in part a backlash to this type of paternalistic exporting of values and norms. In our attempt to 'make the world safe for democracy and free market economies' we are encroaching on the cultural norms of other societies, in a way that is described by the centre in some cultures as "transporting evil into an essentially good world" (Douglas, 1982, p. 10). Cultures that apportion blame for 'natural' disasters and political or social upheaval, by attributing

them to sin or immoral behaviour on the part of individuals or certain sub-groups of a society, are likely to be unwilling to relinquish power over those groups, for example, women or ethnic minorities, by allowing a scientific or 'expert' explanation for circumstances or an influx of foreign knowledge or control. This does not apply strictly to non-Western societies, it can occur in all cultures if the risk is perceived as warranting such control. Societies attempting to resist "infiltration from the evil world" seek solutions by "refusing to compromise with evil and to root it out, accompanied by a tendency toward intolerance and drastic solutions" (Douglas, 1982, p. 11).¹²

1.4 Culture and risk in war

What the export of cultural norms is unable to accomplish, we have been at times willing to attempt with variations on force, from peacekeeping to peace-enforcement. Technology in warfare has mitigated some of the risks of engaging in armed conflict with or on behalf of other nations, but it cannot account for cultural perceptions of risk and the willingness to wage warfare with ferocity and intensity that indicates acceptance of higher levels of personal and institutional risk. Edward Luttwak (1995) describes this as a "new culture of war" (p. 110). Within this new culture, according to Luttwak, restraint exists almost entirely within the wealthy democracies and is almost completely absent in poor states. Wealthy states have returned to what is comparable, in his opinion, to pre-Napoleonic warfare, when casualties were minimized through protracted and carefully calculated siege campaigns. High tech weaponry is expensive, but not as expensive as human lives, or the political cost of casualties.

¹² One could as easily read the United States bent on 'rooting out' terrorism in those words, as the aims of their enemy cultures. This sentiment was attributed in the original text to non-Western cultures.

The experiences of soldiers in peace enforcement operations bear testimony to Luttwak's seemingly ethnocentric theory. While there are many highly trained, well-equipped non-Western militaries, there are belligerents and enemies that Western militaries have faced, whose individual fighters seem to have a much higher threshold for personal risk acceptability. The governments or 'regimes in power' behind these belligerents are much more willing to allow their citizens to accept inordinately high levels of risk. But Luttwak's assessment that new weapons technology eliminates risk applies in only limited circumstances. If one's enemies also have weaponry with a reasonable threshold of technological capability, the risk is very much increased. For example, it is no longer sufficient to have a high speed, highly manoeuvrable aircraft when enemy forces have anti-aircraft or air-to-air missiles because of their ability to lock-on to a target. As was seen in Somalia, even simple weapons can bring down sophisticated technology, e.g. black-hawk helicopters can be brought down by shoulder-launched, rocket-propelled grenades. And, as was demonstrated in the Gulf, naval warships are no longer safe in littoral waters where they can be the target of small crafts with the ability to inflict damage with high explosives.

The more intimate environment of peace operations on the ground creates proximity between belligerents, civilians, and military personnel, in which technology may alter the risk environment, without significantly reducing it. Fighters/ belligerents/ civilians engaging in theft, deception and warfare, both against professional military forces or against one another, in spite of the presence of professional soldiers, are problems against which technology has little impact. Technology cannot mitigate rage, desperation or hatred; it can perhaps compound it. Wilder argues that behaviour

associated with risk is only affected if the individual whose level of risk has been reduced has something to live for, then caution is induced. One can only speculate on the motivation of terrorists, but most appear to be motivated to willingly give their lives for their cause, even seeking cultural fame through martyrdom. The presence of professional soldiers reducing the climate of risk in the area may embolden belligerents to take other risks or their acquisition of high technology weaponry could increase their ability to take risks. Conversely, the benefit of reducing the climate of physical risk allows opposition groups to gain ground against oppressors.

Where technology has changed the norms of death in Western cultures allowing civilians and soldiers to live longer, it has not significantly altered the lifespan of either of these groups in many developing countries. Douglas argues that “new technology puts into question the old perceptions of the natural and normal...and provokes cultural reassessment” (1982, p. 35). In technologically advanced cultures, blame for death resides in the failure of technology and is assigned to whomever was behind the technological failure. Luttwack has argued that we should be able to trust technology to give us the siege advantage, and although this is not always the case, we have adopted this technological insulation as the new norm and have high expectations of its efficacy to protect military personnel. There is no longer a place for ill-fortune or fate. War has, therefore, lost some of its heroic mystique because technological advancements ought to insulate our people from anything ‘accidental’ or from the actions of those they’re sent to subdue. If the technology fails, it is assumed that someone or something is at fault. Civilians are now more likely to see soldiers as victims than as warriors, victims of political or technological mismanagement, and soldiers, sailors and aviators are

beginning to believe them. Governments have responded to this new cultural norm, undertaking a much higher level of political risk assessment involving a determination of which actions are more likely to reduce political risks and defer blame. They are responding to a population whose cultural assessment of normality is an ever safer, utopian existence.

1.5 Military culture and risk

Academics in various Western nations have written of the new risk aversion of their populations and its effect on their militaries. Paul Dixon's (2000) article on "Britain's Vietnam Syndrome" makes the case that Britons have become increasingly reluctant to allow their military to participate in high risk operations to the extent where, during the Falklands War:

...news of the conflict was managed by the government and military... There was concern that if relatives saw precisely what the military were engaged in they would express their concern in letters to relatives and this might undermine morale....in the television news, care was taken to present Task Force families as models of support for the war, possibly for fear of undermining the national will" (p. 107).

And Germany's population recently elected Gerhard Schroeder, in spite of being dogged by scandal and lacking economic policy, in large part, it is said, because he promised to keep his nation out of a war. Of course, the United States has been, until recently, more widely known than its allies for its aversion to risk, largely because it is to the US that the Western world frequently turns to set the parameters for military engagement. Through the 1980s and 1990s American military doctrine was recognized as emanating from the "Weinberger Doctrine" based on lessons learned from the Vietnam War (Campbell, 1998). It was a war that changed the level of risk the US is willing to accept in military operations. No longer would its politicians or senior officers—some of whom fought in

Vietnam—be willing to engage in a protracted fight without clear political justification. Drafted in 1984 and adopted by the Pentagon, the Weinberger Doctrine provided the criteria for the use of force requiring, principally: clear winnable objectives, adequate force size and the full support of the public and Congress. It was assumed that the ‘go big or go home’ approach would reduce military risk to a sufficiently invulnerable level. However, according to journalist Mark Bowden (2001), author of the book Black Hawk Down, which chronicles the American contribution to UN operations in Somalia, the firefight in Mogadishu that caused the death of 18 Americans

...ended a brief heady period of post-Cold War innocence, a time when America and its allies felt they could sweep venal dictators and vicious tribal violence from the planet as easily and relatively bloodlessly as Saddam Hussein had been swept from Kuwait. Mogadishu has had a profound cautionary influence on U.S. military policy ever since (p. 410).

In a frank admission regarding risk aversion, Gen. Wesley Clark, Supreme Allied Commander Europe (the top of NATO’s military chain of command) during the Kosovo campaign, described the cautious approach to post-Cold War campaigns and the modern military’s methods of responding to political risk assessments: “You go into it with your nose first, slowly. You get your grip. You get others to fight for you. And you use airpower as much as you can and stay as high as you can” (Stone, 2001). In the ‘war against terrorism’, the ‘fighters’ of the Northern Alliance as well as the nationals of other countries whom the US are training in counter-insurgency operations are the ‘others’ who you get to fight for you. Their casualties, while not acceptable to all, are much more acceptable to the general voting public of Western nations.

In addition to the Northern Alliance fighting close range combat with the Taliban there were other American, Canadian, Australian and British soldiers undertaking covert

operations, in small, discrete numbers. As militaries, particularly Canada's, are required to hide their war-fighting identities, they can do so in specialist units, which operate below the radar of the press and are, therefore, beyond public scrutiny. They pride themselves on being stronger, more lethal and more resilient. They are the Delta Force in the US, the Joint Task Force 2 (JTF2) in Canada, the Special Air Service in the UK and Australia, who had a significantly large role in Afghanistan and in Iraq. According to US Navy Commander Kerry Metz commenting on Afghanistan:

We were fortunate to have the finest special operators from a coalition of seven nations... We challenged our operators to conduct missions in some of the most hostile environments ever operated in. For example, we had special reconnaissance teams operating in the mountains of Afghanistan above 10,000 feet for extended periods without resupply (O'Malley, 2003).

These are conditions that Canadians would likely disapprove of if they knew regular force troops to be subjected to them: the logistics problems of the Department were publicized and problems regarding uniforms and rations received public outrage and derision in the press.

Having eliminated the Canadian Airborne Regiment, which embodied many of the same characteristics, JTF2 is one of the few elements of the defence force structure in Canada that has received increased funding after September 11, 2001.¹³ They are called upon to do the work of conflict and combat that is perceived by civilians to be more physically risk intensive and that they would prefer to keep the CF out of. Special units take responsibility for those things that governments don't want made public, perhaps that most civilians would prefer not to know. What they believe is that Canada is making a significant contribution to international peace and security primarily through

¹³ Budget allocations to DND, since 2001, have provided for increases to security and counter-terrorism measures, which have been distributed in part to "double the capacity of JTF2" (DND, March 2003).

‘peacekeeping’, which is perceived as a low-risk proposition in which Canada is always one of the ‘good guys’.

Most CF members in the lower ranks are not particularly concerned with the political background to the conflicts they are deployed into; they are more concerned with preparing to do the job and with proving their capability once there. Officers who must concern themselves with the political and strategic considerations of the operation may feel as much a humanitarian desire to create change as politicians or development officers. However, they are required by the fact of having the lives of others in their hands to be sure that the humanitarian aims are achievable through military means, that they have the knowledge, skills and equipment for the job and that the political resolve to finish the job is not going to disappear before an end-state is achieved.

They can be capable of both peacekeeping and war-fighting, but it is difficult to accomplish both in the same mission. It is politically and tactically difficult to engage in combat as a peacekeeper and it is challenging to morale to continue to plan and train for war-fighting when your public and political identity is ‘peacekeeper’.

1.6 What shall we become?

There is tension within DND and the CF regarding the proper role for the military in post-heroic, post-modern, post-Cold War conflict. Do they train for war or for peacekeeping and if the latter, how? Are they warriors or peacekeepers or both? How do they value their role as peacekeepers when they are sent public messages that those who fight wars are more highly valued than those who risk and lose their lives enforcing peace? They are in the process of transformation—a term used by today’s DND defence analysts to describe what the military is becoming—but the question which requires

further exploration is, transforming into what? They are engaged in what William Connolly (1999) describes as “the politics of becoming...by which new cultural identities are formed out of old energies, injuries and differences...the politics of becoming changes the shape and contour of established identities...” (p. 136). They are engaging in a radical shift of their cultural identity at the same time that they are charged with defending or subduing others who are also in the process of resisting a cultural norm, imposed by an internal other, or by external forces who have provided aid and want repayment in the right to impose cultural, political and economic standards.

They are engaged in this process without recognizing the constructed nature of their culture, rather it is assumed that the “end they pursue is already *implicit* in the culture” (p. 139). There are aspects of the culture that may be inescapable if the profession is to be maintained in its present form, but if they are recognized as constructed and their validity questioned, they may be strengthened in a different form that rejects debilitating norms of weakness and strength and reconstructs a “positive interpretation” (p. 131).

Can the fundamental character of the profession withstand the tension from the margins that challenges it to accept new norms of suffering, while remaining strong and capable of coming to the defence of others? They are caught in a grey-zone between an heroic past with a warrior image and an uncertain future as a ‘peacekeeping’ force that is occasionally called on to ‘ramp up’ for war. With the ambiguous and mixed messages they receive from a frightened and risk-averse populace is it any wonder that being a post-heroic member of Canada’s present-day Armed Forces is at times a confusing and depressing profession.

Chapter 2: Competing Perceptions of Operational Risk

2.1 Fighting fair

The changes to the CF over the decades, which have led to this identity crisis, are the result of: the relationship between the military and the political system within which it resides; its relationship with the general public from which it is drawn; and changes to the international system and the style of fighting the CF is called upon to do. This chapter will approach the problem from the macro, or organizational level, providing evidence regarding the differing natures of civilian, government and military risk aversion.

Each group's risk perception is irrevocably tied to the choices of the others'. These connections have become more constraining as the influence of media imagery has contributed to an atmosphere of intensified responsibility and blame. Those with the most personal stake in the risks of conflict are not necessarily the ones whose calculation of risk, and experience of the outcomes, is considered the most valid. As will be discussed in this chapter, the subsequent erosion of trust at various levels of decision making, has heightened fear and suspicion and reduced some of the organizational cohesion that once made the military a unique bastion of apparently homogeneous values. The shift in priorities that CF leaders have been forced to undergo, imposed by media and political awareness, has distanced them from the troops under them, at the same time that they are becoming more risk averse with the lives of those troops. The institution is perceived as responding to external pressures and neglecting deepening fissures between the upper and lower levels of the internal structure. How individuals understand the risks of being part of a large organization, over which their control is limited and on which they rely for their livelihood (and in this case their lives) is determined by the level of trust they place

in that organization and its willingness and ability to protect their interests. Mary Douglas' theoretical perspectives on institutional risk analysis are particularly relevant to a discussion of the perceptions of the individual within a hierarchical organisation. Douglas tells us, "It is often held that perception of risk is directed by issues of fairness. The more that institutions depend upon personal commitment rather than upon coercion, the more explicitly they are monitored for fairness" (1985, p. 5).

It could be said that 'fairness' is a quintessentially Canadian trait. From the federal policy on multiculturalism to the volunteer military, which one contributor to this study called "a most unmilitary military," (he was quoting others) Canada is a nation of fair-minded, internationalist, liberal democrats. The Defence Minister's Monitoring Committee on Change has suggesting adding the words "accountability, self-examination and self-improvement, *fairness* and openness" [emphasis added] to the core military values as described in the ethos statement of Canada's Army (1998).¹⁴ It is a reflection of elements of Canadian political and civil culture as individualist.

Critics in the opposing camp, who favour a more traditional assessment of risk, *do* openly call the CF thoroughly unmilitary and decry the 'social experimentation' and 'civilianization' of the organization.¹⁵ They argue that in moving farther away from coercion toward personal commitment, the striving for fairness and equity has created an ineffective force, one based far too much on personal autonomy and lacking discipline and the spirit of sacrifice. They believe that in its quest for fairness, and deficit reduction,

¹⁴ *Canada's Army: We Stand on Guard for Thee* is a statement of the Canadian Army's structure, purpose and ethos.

¹⁵ Sean Henry, "Recovery of the Canadian Armed Forces: Advice for the Minister of National Defence"; Douglas Bland, "Military Leadership and Change in the 1990s" and "The Government of Canada and the Armed Forces: A Troubled Relationship" (1996); John English, *Lament for an Army*; Peter Kasurak, "Civilianization and the Military Ethos: Civil-Military Relations in Canada" (1982).

the government of Canada is irresponsibly eroding the nation's ability to defend itself and to maintain its commitments to military allies, and that they are doing so in accordance with the general sentiments of what they believe is a largely misinformed public. Defence lobbyists frequently argue that, if only the Canadian public truly understood foreign affairs and security and defence issues, they would press the government for a stronger, more adequately funded military.

2.2 Public perception and Canadian values

According to Pierre Martin and Michel Fortmann (2001) many academics, politicians and media pundits presume that public opinion regarding foreign policy is volatile and based on information fed to them by "opinion leaders" (p. 30). Martin and Fortmann contend, however, that the general Canadian public is not only well informed in their opinions, but that their opinions are far less volatile and malleable than is largely presumed. They claim that, "the public tends to drape its internationalism in considerable nuance and caution" (p. 30). Their study of opinion polls from the 70s through the 90s regarding peacekeeping operations and war (the Kosovo Campaign specifically), show that support for peacekeeping remained relatively high throughout, in spite of occasional scandals. However, the nuanced and cautious approach of Canadians has fairly strict parameters regarding values. Public support has been specifically for 'peacekeeping' and its many incarnations, particularly missions that have a humanitarian ethos. Canadians maintain high regard for Canada's role as peacekeepers and their support for the Kosovo campaign was largely driven by the desire to 'do something' to alleviate the humanitarian disaster unfolding in the Balkans region. The statement Canadians most consistently associate with their military's role internationally is the assertion that they are 'proud of

Canada's role in UN peacekeeping operations' (p. 22). However, as risks increase, support for specific operations decreases:

In the case of peacekeeping in the 1990s...The public has strongly supported the principle of UN peacekeeping, but at the same time, it has had persistent doubts about intervention in the former Yugoslavia and about Canadian involvement in that dangerous context. In short although a large majority approves of UN peacekeeping operations, their support is sensitive to risk and cost... (p. 22).

It can be inferred that Canadians' support for UN operations is based more on their larger conception of the overall mission of the UN than on direct understanding of what 'peacekeeping' entails. While they may believe that they are making an informed choice regarding what risks they are willing to accept as a nation, they are in fact accepting a constructed view described by institutional norms of what peacekeeping is and media reports that describe the boundaries of peacekeeping and alert Canadians to when those boundaries have been crossed. Similarly, Canadians have prescribed ideas about Canada's other international obligations. They felt that "Canada should give the UN a higher degree of priority than NATO in its foreign policy" (p.22), perceiving NATO as a more dangerous institution, associated with large scale military engagements and the UN, conversely, with making the world 'safe'. The irony of this particular policy preference is that many Canadian Forces personnel who have served in both UN and NATO operations perceive lower risk associated with NATO operations, where mandates and political aims are clearer and they are more able to rely on the technology and skills of their allies than in UN missions (see #8 in Table 1 below).

2.3 Military skill sets and risk reduction

CF officers, as demonstrated by the Meeting the Challenges survey (2000/2001), have concerns that relate to many aspects of multinational missions from political to

tactical. Peace operations are complex political and military undertakings that frequently test the war-fighting skills of CF personnel and demand that, soldiers particularly, adopt additional diplomatic skills, to the extent where it is difficult to know which skill set is the more important. In describing the risk assessment of British soldiers in Northern Ireland, Paul Killworth (2000) argues that the lower intensity conflict of the cease fire (1995-96) actually heightened the feeling of personal risk for the soldiers.¹⁶ The Provisional Irish Republican Army (PIRA) had become so knowledgeable over time about the British Army's training practices and skill levels, that they were able to anticipate British actions and recognize lower skill levels and target their attacks accordingly: "...there was a strong sense that being attacked was in all likelihood a response to personal carelessness or poor tactics, normally by private soldiers, but occasionally due to the commander of a patrol" (p. 147). Low intensity conflict rarely starts out that way or stays that way, it can revert to higher intensity as the result of changes in the political climate or precipitous actions. Ensuring that it remains low intensity is the result of being constantly alert to changing threats. It is "only through acting as if there is a constant, severe risk of death or injury that the risk is in fact reduced to [lower] levels" (p. 143).

A peace operation can be a very fluid environment with multiple factions, political mandates and non-governmental agencies all operating within what the military considers its area of operations. As a highly skilled, highly technologized military, one particularly noted for its skills in peacekeeping, the CF has a responsibility to accept increased risks and adapt its training and skills to meet any and all threats. However, just

¹⁶ Not a peacekeeping operation *per se*, but a low-intensity operation monitoring a cease-fire, therefore, very similar.

as the PIRA developed knowledge of the British Army, belligerents in peace operations develop knowledge of the CF and its allies that can be used against them. UN soldiers have had their Rules of Engagement (ROE) 'tested' by belligerents who know that the soldiers are unable to react unless their lives are directly threatened.

On the way over [to Rwanda], we had read the Rules of Engagement. Basically, they were a collection of rules for different courses of action. They outlined when we could use force and how much, who we could protect and who we couldn't. At the end was a disclaimer that stated that everything in parenthesis was still under review. If you looked in the book, everything pertaining to the use of force was in parenthesis....

As an armed soldier, I could protect, by whatever means necessary, my own life and the lives of other Canadian soldiers. What was unclear were our rules governing civilians. For instance, if a patient was in the hospital's care and the [Rwandan People's Army] wanted to arrest the patient, could we intervene? If a civilian aid worker, say an American, asked us for protection from a local threat, could we do it?

In [Yugoslavia], I got tired of having to stand back and watch people being killed without our interfering because those were the rules (Davis, 1997, p. 219-220; 242).

They are required to have combat skills and, as one interview respondent put it, "don't-kill skills." This is particularly true for officers in command. Areas of skill and expertise, where leaders feel they are lacking, increase the danger to themselves and their troops and put the completion of the mission at risk. Not having the appropriate skills for the threat environment increases their sense of the risks to which they are subjecting their troops. Within the 54 questions posed by the Meeting the Challenges study, the respondents were asked their opinions on a variety of issues that pertain to the conflict environment in post-Cold War, multinational missions, the structure and readiness of the CF, the mandates and rules of engagement of the missions it undertakes and the competence of those involved in them. The purpose of the study was to determine:

...whether leadership challenges were posed in post-Cold War multi-dimensional peace operations that required significant modification of the way in which the CF educates, trains and prepares officers for such duty.

If a risk is acceptable it must be trained for and lived with, and if it is mandated and trained for it will gain acceptability within the organizational culture. The question being asked of the officers polled in this survey: "What skills or areas of expertise do you feel were lacking ...?" suggests that the institution has accepted that there are new standards of knowledge that respond to the new threat environment and that can and should be acquired by military officers. The political and diplomatic skills that officers in previous decades could cultivate at their discretion have become standard operating procedure in the new culture. They are being asked to become 'experts' in the political skills of conflict 'control' and 'resolution', areas of expertise for which the determined norms are still very much under construction and debate.

The questions were designed by DND researchers from the Directorate of Human Resources Research and Evaluation, and based on focus groups and the report from the Somalia Inquiry. They are indicative of the type of issues the Department perceives as important as well as those raised by the participants of the focus groups and the witnesses to the board of inquiry. For the table included below, the officers who responded to the Meeting the Challenges survey were asked to list in order of importance the skills or 'areas of expertise' they felt they were lacking in the operations they had commanded. Their responses were grouped under thematic areas and assigned an average numerical value. From the mix of skills and 'areas of expertise' it is apparent that CF officers perceive tangible and intangible threats to the success of operations both at home and abroad.

The skills they describe below are in many cases applied skills that relate to the larger responsibility of mediating between an armed force of highly trained, constantly alert and lethal troops, a culture whose risk perceptions regarding the outcomes of the conflict may be at considerable odds to the militaries sent to monitor it, and foreign political and civil society decision-makers trying to renegotiate the cultural and societal norms of the state or region. Skills that are particularly indicative of new norms have been highlighted and italicized.

Table 1 Skills and Areas of Expertise

Ranking of Skills / Areas of Expertise Respondents Felt Lacking by Operation					
#	Skills / Area of Expertise	Ranking UN Ch VI (peace- keeping)	Ranking UN Ch. VII (peace- making)	Ranking NATO / Coalition	Ranking Domestic
1	Operations experience: Standard Operating Procedures, logistics, urban combat, desert survival, self-defence, <i>crowd control, VIP protection</i> , tactical flying, battle procedure, technical knowledge of ballistics, training outside element/trade, night ops, more general experience	2	1	2	2
2	Cultural awareness / knowledge of theatre: <i>Briefing on history of conflict and area, culture of people, local politics, geographical knowledge</i>	1	4	4	4
3	Improve language skills: Local, NATO/UN allies, French, <i>general communication skills</i>	3	2	5	6
4	Better equipment / weapons training: Higher quality of equipment and weapons, better training with this equipment, better recognition of foreign weapons, improved operational/driving skills	5	7	1	5

Ranking of Skills / Areas of Expertise Respondents Felt Lacking by Operation					
#	Skills / Area of Expertise	Ranking UN Ch VI (peace- keeping)	Ranking UN Ch. VII (peace- making)	Ranking NATO / Coalition	Ranking Domestic
5	Negotiation / mediation / CIMIC skills: <i>Negotiation training, importance of diplomacy, mediation skills, civil-military cooperation, civil power skills</i>	7	3	3	7
6	Leadership / chain of command / unit organization: Lack of strong leadership and experience, lack of loyalty, discipline, ability to lead decisively, accountability, integrity, flexibility, too much micro-management, unclear chain of command, time in rank/position	7	6	6	1
7	Dealing with NDHQ / joint force ops: Inefficient reactions from NDHQ, inexperience with joint force ops, unclear doctrine/logistic support, inexperience running operational level HQ	4	7	7	3
8	Rules of Engagement / mission role / legalities: Unclear rules of engagement, unclear mission and role of contingent, how to react to threat, <i>knowledge of international law, legal responsibilities / parameters</i>	3	5	11	8
9	Proper briefings on operation from above / information gathering: Thorough briefing of operation plan, political and military developments, intelligence gathering and interpretation	7	8	10	5
10	Training sufficient / Miscellaneous: Training was not lacking, training was too much / inappropriate, various responses related to state of mind (patience, relaxation) or not directly related to mission.	9	9	8	6

Ranking of Skills / Areas of Expertise Respondents Felt Lacking by Operation					
#	Skills / Area of Expertise	Ranking UN Ch VI (peace- keeping)	Ranking UN Ch. VII (peace- making)	Ranking NATO / Coalition	Ranking Domestic
11	Working with other organizations / role of NGOs: <i>Working with NGOs and understanding their relationship with each other, working with other government departments / services, political savvy</i>	11	8	10	4
12	Media / public relations: <i>How to deal with media, public relations and the release of information</i>	6	9	12	5
13	Better understanding NATO/UN bureaucracy / procedures: Understanding decision making processes and procedures of NATO and UN bureaucracies	5	11	10	9
14	Dealing with personnel / instilling confidence / morale: Knowledge of staff capabilities, dealing with personnel's needs, human resource administration.	8	12	9	6
15	Working with foreign militaries: Dealing with NATO, non-NATO and local militaries and leadership, lack of knowledge of other national doctrines / abilities, working in a multi-national environment	10	10	13	10
16	Financial management / budgets: Experience with financial management in operational deployment, contracts, budgets.	9	12	14	9
17	Medical / first-aid: Emergency medical training, first aid, <i>paediatrics</i> .	8	11	15	0
18	Crisis management: Search and Rescue, natural disasters, <i>human salvaging, critical incident stress training</i> , emergency measures	12	13	16	8
19	Hazardous materials: <i>Dealing with nuclear, biological and chemical materials</i> , landmines etc.	10	0	17	0

2.4 War if necessary, but not necessarily war

Too much knowledge can be detrimental to one's level of risk perception, as in the case of the general population who believe—as a result of sensationalist news stories and an overflow of scientific and pseudo-scientific information—that they are at risk from a myriad of environmental and social hazards. And CF officers are presented with the problem of too little knowledge in the form of insufficient training and background information, thus generating increased risk. Knowledge is central to risk perception, because the ability to choose what risks are acceptable depends upon the individual's and the society's ability to rank risks according to what is most worth worrying about. We cannot know all of the risks that face us, therefore, we rely upon our social interactions and institutions to provide us with information regarding what risks are present in our environment, or what risks the future might hold. What follows, according to Douglas is a risk calculation involving “knowledge about the future and consent about the most desired prospects” (1982, p. 5). Government information brokers certainly know this and are careful in what information is imparted to Canadian voters in order that the voters are comfortable with the level of risk their Armed Forces are taking and that it matches the public perception of what is acceptable in a given ‘type’ of operation.

Canadian value statements in polling data and media articles stress peacekeeping, peacebuilding and humanitarian intervention—the language associated with the operation is extremely important—with the expectation of minimal casualties inflicted on either side.¹⁷ The Canadian government throughout the 1970s, 80s and 90s has been careful to

¹⁷ “In surveys taken from 1990 to 1992 peacekeeping was given a higher priority than any other role. (Longwoods Research Group, *Report to the Department of National Defence LC2136* (Nov.-Dec. 1990); Centre de recherche sur l'opinion publique (CROP), *The Canadian Armed Forces: Perceptions and Attitudes of Canadians*, (Report ~92411, November 1992). “In a May 1995 survey, a wide majority of 77%

perpetuate this image through the news media and Departmental promotional materials. The governing party in Canada, as with any political party, is concerned with staying in power and will therefore respond to its constituents' value statements and operate within them, to the extent possible, when considering foreign policy. During the UNPROFOR mission, when the intervention in the Balkan conflict was at its most volatile, the Canadian government downplayed the hazards of the mission because it was not indicative of what peacekeeping is supposed to be (Cohen and Moens, 1999). The risk to CF members lives in peacekeeping operations is supposed to come from land-mines, or from occasional rogue elements, not from well-armed, tactically efficient forces willing to engage them in combat. The firefight in the Medak Pocket in Croatia in 1993, "the largest Canadian military engagement since the Korean war," went virtually unnoticed in the press (p. 92). This was at a time when the Conservative government, under the leadership of Kim Campbell, was facing re-election and stories of Canadian casualties would not have been publicly popular.

Furthermore, Canadian soldiers don't 'win' or 'lose' in peace operations and reporting the outcome of skirmishes in this context is less interesting for most news services. Similarly, "the Battle of the Black Sea" (Mogadishu in Somalia), in which 18 American soldiers died, according to Mark Bowden, "...is one America has preferred to forget...there were no American reporters in Mogadishu on October 3-4, 1993," because in spite of it being a combat operation, the Clinton government maintained its

considered peacekeeping the most important international role of the CF," Insight Canada Research, *Canada and the World: Public Attitudes Regarding Foreign and Defence Policy* (Toronto, 1995). A poll conducted by Goldfarb in June 1999, during the Kosovo campaign, showed that 53% of Canadians chose "peacekeeping" as the Canadian "realization in the world" of which they felt the most proud. The Kosovo campaign was a war without casualties on the side of the NATO allies; it was also a 'humanitarian' intervention. The poll was reported in "Les Canadiens et la défense," Department of National Defence press release, July 1999 (Martin and Fortmann, p. 16; p. 17; p. 22).

peacekeeping veneer, putting the blame for the deaths of American soldiers on their being under 'UN command' (p. 410).

Conversely, in the most recent 'combat operation' in Afghanistan¹⁸, where the risks were communicated in a war context, the deaths of Canadian soldiers received substantial press coverage. It was not a 'peace' operation, an issue of some discomfort to Canadians, but it was much touted as the 'first combat mission for Canadians since the Korean war'. This was news to Canadian military personnel who had engaged in combat and lost friends in 'peace' missions in the intervening decades. Several members of the military with whom the author has spoken, including one prominent mental health practitioner found the media coverage of the friendly fire incident distasteful and were angered by it, principally because of how it downplayed the risks and diminished the importance of the losses of Canadian personnel in other operations. It was, to many, a distasteful display of temporary concern that cheapened the loss of so many others who had died unheralded. In Bosnia alone, between February 1992 and January 1995, 10 Canadian soldiers had been killed and more than 40 had been seriously injured (Cohen and Moens, p. 94). The motivation of the media to carry this story as far as they did defies explanation.

Although CF members were somewhat shocked and, of course, saddened by the deaths in Afghanistan, death as a result of friendly fire is among the accepted risks that are anticipated in war. Friendly fire incidents have claimed many lives in the 'war against

¹⁸ The CF's Operation Apollo in Afghanistan has been comprised of an Army component: 750 soldiers from 3 PPCLI Battle Group, which included a reconnaissance squadron from Lord Strathcona's Horse (Royal Canadians), and combat service support elements from 1 Service Battalion; it deployed February 1, 2002 and returned July 28-30, 2001; a Naval Task Group, which began deployments on October 8, 2001, and included six warships and about 1,500 Navy personnel; and Air Force components of the Army and Navy which included strategic air-lift, tactical air-lift, long range patrol aircraft, and Sea-king helicopters;

terrorism' and were responsible for "nearly half of the battlefield deaths of U.S. soldiers [in the first Gulf War]." ¹⁹ They were not widely reported at the time because, according to the CBC's Adrienne Arseneault (2003), the relationship between the press and the US military in the 1991 Gulf War as "distant and disastrous," allowing few opportunities for meaningful coverage. ²⁰ In many cases, the popular press cannot get close enough to 'the action' to report on it. Some do, and lose their lives trying to get the story.

In a Pentagon initiative designed not to repeat the press-related problems of the 1991 Gulf War, Arseneault and other international reporters underwent training with US soldiers to "embed" with infantry units to achieve prime reporting opportunities in "Gulf War II." However, the journalists in training to "embed" were also conscious that their independence was likely to be suspect if they were part of the combat unit they were reporting on. They were there to see casualties as they happened—and in some cases, with embedded and non-embedded media personnel, they became casualties of war—but one suspects that the feelings of the embedded reporters could not help but be skewed by the relationships they developed with the soldiers they were travelling with. ²¹ As Arseneault points out this was not done because "the Pentagon [had] been struck with First-Amendment fever. Rather, [it was] a savvy PR campaign to win the hearts and minds of the nation with the stories of fresh-faced troops in historic victories." The war

Air Force resources began deploying in October 2001. Currently still in theatre is a Naval Task Group comprised of the frigates HMCS *Montréal* and HMCS *Winnipeg* and ashore support personnel.

¹⁹ 148 Americans died in combat during the war or .03% of the Americans soldiers in the theatre. Non-combat casualties to troops were on the order of four times higher (Schmitt, 1991, A12).

²⁰ Adrienne Arseneault's piece on embedding was a three-part, on-line series, available on the CBC website: http://www.cbc.ca/features/iraq/correspondents/adrienne_arseneault.htm

²¹ It may also have partly been an exercise to dissuade journalists from getting too close to the action, as Arseneault discovered, it is difficult for someone not trained for combat to wear combat gear, carry safety gear and the tools of one's trade, attempt to get the story and keep from getting killed. Perhaps the training

had to be spun as a just and heroic cause in order to attach the appropriate level of public risk acceptability to the action. The political acceptability was a matter of strong debate.

2.5 Risk and the chain of command

The United Nations Assistance Mission in Rwanda (UNAMIR), in 1994, commanded by Major-General Romeo Dallaire, was an under-strength Chapter VI observer force that was unable to prevent the 1994 massacres, which world leaders, for reasons of political labelling and the responsibility entailed, refused to call 'genocide'. In The UN and the governments of the US and Canada were strongly criticised in international forums for not acting on behalf of the Rwandan people, when only 40 years earlier the world had promised never again to let such heinous acts take place. There was no particularly pressing political or economic reason for Western military powers to intervene in that country in what would likely be a very difficult, high risk, and protracted operation to cease hostilities. General Dallaire, being presumably more politically astute than most of the troops serving with him, understood the political calculations behind the decisions taken, but was no less troubled by the outcome. He attempted to use the press, who were ubiquitous, to shame the international community into taking action, but to no avail.

In a mission very similar to UNAMIR, the 'Congo Crisis' in 1963, Brig. Jacques Dextraze, in command of Canadian UN forces, also faced political ambiguity and unwillingness to mandate action to halt atrocities against Christian missionaries. In his recounting of Dextraze's command, Sean Maloney (2001) describes Dextraze as circumventing or defying UN mandates in order to save civilians from massacre, a risk he

experience alone changed their perception of the US Army and the risks they take and affected their interviewing and reporting style.

was able to take because of the greater communication distance between NDHQ and the Congo in the 1960s, and a risk that he and his troops not only found acceptable, but which gave them great personal satisfaction, and because of which they were able to maintain confidence in their military chain of command, beyond the theatre of operations, if not in their political leaders.

In both cases the leaders involved made moral and ethical decisions presumably based on what they felt they could reasonably ask of the troops they commanded and what they could plausibly expect to accomplish militarily. They did not, apparently, believe that the risks they were taking with the lives under their command were unacceptable to their troops. Their proximity—both figurative and literal—to the risk calculation gave them a far different perspective from that of civilian observers or political decision makers. As explained by Canadian BGen. Gagnon (2001), the present Canadian government's model of 'early in, early out' that usually applies to multinational operations, virtually guarantees that

...the desire to be part of the final political settlement or the desire to influence its outcome through military means is remote. That kind of political environment...may fall short of providing the commander with specific guidance. The sad part, from a military perspective, is the risk of becoming a fire-and-forget mission, since its insertion in theatre may be seen as an adequate reaction in a context where doing something is more important than the end result (p. 3).

The Meeting the Challenges study included a question regarding the priority ranking assigned to the outcome of the mission and the safety of one's troops and one's self. The question sought to determine "to what or to whom does a modern day leader, in the context of a peace operation, assign the most priority?" (p. 22) Its aim was to "investigate the possible dissonance CF officers might be experiencing between

traditionally accepted military (war) doctrine and the reality of peace operations” (p. 7).

The results from the sample of 537 officers revealed that a higher than expected number of Canadian Forces leaders value the lives of their troops above completion of their mission as shown in Table 3.

Table 2 Risk Priorities

Priority	The Mission		Troops		Oneself	
	Number	Percentage	Number	Percentage	Number	Percentage
1	353	65.7	171	31.8	8	1.5
2	142	26.4	352	65.5	37	6.9
3	37	6.9	3	.6	487	90.7
Missing	5	.9	11	2.0	5	.9
Totals	537	100.0	537	100.0	537	100.0

While the expected ranking still takes precedence, 31.8% or nearly one third of the 537 respondents stated that they would put the lives of their troops ahead of successful completion of the mission. The DND analysts who compiled the final report of the study were surprised by this outcome, but it's unclear whether this information reveals a new-found caution among military leaders, or the assumption that they would always put the mission first was based more on cultural norms than on past data.

Canadian officers are not known for being outspoken about their political views. As one retired general officer put it recently, “You express your concerns quietly, but in the end, if you're ordered to do something you don't agree with, you either say ‘yes’ or resign.”²²

In the context that the data was solicited, that of post-Cold War missions, it reflects the opinion of military leaders that civilian decision-makers may, in the process of making

²² Although he was not the source of that quotation, “Maj.-Gen. Cameron Ross, Director-General of International Security Policy at DND, decided to quit the military ‘for personal reasons’ after the announcement [to send Canadian troops to serve in ISAF] was made Wednesday, said Capt. Jason Steeves,

political determinations, undermine the safety of troops. If Canadian political outcomes are ill-defined, it would be difficult for that 33.1% of military officers to knowingly risk Canadian lives under their command.

Military officers and strategists calculate the objective risks associated with threats and potential operations to determine the likelihood of success and to reduce risks to troops involved.²³ It is an operational planning requirement, but it is also a question of leadership ethics. In the profession, the elements of training, discipline, culture and esprit de corps turn ordinary individuals into soldiers, sailors or aviators. And in an operational sense, planning, strategy, tactics, unit cohesion and morale combine to ensure that those same professionals are able to accomplish what they're ordered to do. These factors are the result of centuries of military knowledge borne out of experimentation, trial and error, victories and losses, good leadership and bad, to the extent where it is nearly impossible to define good leadership, but everyone 'knows it when they see it'. However, probably because of the traditional military preference for decisive, hard-hitting campaigns, military leaders have a reputation for 'war mongering', but recent polls have revealed that military 'elites' are less likely to accept casualties than are civilian 'elites' or the civilian

a spokesman in Ross's office. Sources told The Canadian Press that Ross quit over Ottawa's decision to send troops to a UN peacekeeping operation in Kabul, Afghanistan" (Thorne, 2003).

²³ An officer in command determines the specific number of troops required to complete a mission, a number which has decreased with time. However, the technological advancement that has allowed a smaller troop number per mission has a cost in terms of effectiveness in response to attrition; at the time of WWII a force that lost 80% of its troops would lose only 20% of its effectiveness. Today a force that loses 20% of its troops loses 80% of its effectiveness (Keegan, 1976, p. 245).

A reckless leader risks death at the hands of his own troops; stories of commanders being stabbed, shot, bayoneted, 'fragged' (army: using a fragmentation grenade), 'fodded' (airforce: using 'foreign object damage' in an aircraft) and a variety of other methods for getting rid of an incompetent or uncaring leader are common to all eras of warfare (Holmes, 1985, 329). "...coercion was indeed direct and personal on the gun-powder battlefield...the officer who flogged too hard risked a bullet should he turn his back..." (Keegan, 1976, 324). In 1993, Warrant Officer Matt Stopford, serving in Croatia, became ill and may have been poisoned by the men serving with him; the findings of the Military Police Commission were

general public. They are more likely to condone the use of overwhelming force, but because their sense of risk is mitigated by the ability to take appropriate action and knowledge of the threat environment, they assess threats carefully and judge the likelihood of casualties not in terms of whether it is politically acceptable for soldiers to die, but whether it is likely that they will as a result of the circumstances they will find themselves in.

Table 2 below arises from a study conducted at Duke University by Peter Feaver and Christopher Gelpi (1999) of the Triangle Institute for Security Studies in which they examined three possible intervention cases: stabilizing a government in the Congo, preventing Iraq from obtaining weapons of mass destruction, and defending Taiwan against invasion from China. The study's survey polled 4,900 Americans divided into three groups: senior military officers, the civilian elite and the general public with the question: *How many casualties are acceptable for each scenario?*

Table 3 Casualty Acceptance

Mission	Military	Civilian Elite	General Public
Congo	284	484	6,861
Iraq	6,016	19,045	29,853
Taiwan	17,425	17,554	20,172

Apparently, civilians are not particularly casualty averse when presented with an abstract scenario that addresses other more anxiety producing risks: i.e. safeguarding themselves from weapons of mass destruction and defending a democracy against communism. Interestingly, when Americans believed, hypothetically, that the cause in Iraq was just, they were willing to expend blood and treasure. They are less willing to

inconclusive. An early radio report quoted a member of his unit as saying that Stopford had been trying to "John Wayne," them into high risk missions (MPCC 2000-023, MPCC 2000-025).

sacrifice military lives when the goals of the operation are for stability in a nation with which they have no particular personal value affiliation, i.e. the Congo.

Civilian elites are similarly moved, in abstract terms when faced with scenarios that speak to political risk assessments. The study found that the threat of weapons of mass destruction in Iraq is a concern worthy of high losses, in the estimation of civilian elites; a fact that underwent thorough debate at that level prior to the war just 'ended' in Iraq. Likewise, and considered more threatening at the time of this study, the spread of communism was worthy of risk, but less so than WMD in Iraq, and civilian elites were not significantly more committed to loss in this context than military leaders.

What is meant to be surprising about this study is that military leaders are more casualty averse than civilian leaders or the general civilian population. However, it is not surprising that military leaders would be less willing to have those under their command killed. Their subordinates are people with whom they live and work and whose lives are entrusted to them. The numbers also illustrates that their risk and threat perception is different from the civilian calculation, particularly that of the civilian general public, because, knowing that they have more sophisticated military capability than Iraq and far more than the Congolese, they expect that their casualty numbers for the Congo and Iraq would be much lower. Moreover, this study illustrates a truism of leadership: that military leaders have always been casualty averse, it is what makes their job possible (and in some situations keeps them alive); no one will follow a leader into battle who they believe is determined to get them killed.²⁴

²⁴ An example of an obvious exception is when soldiers are more likely to get killed by their own forces for retreating, such as in the Battle of Stalingrad.

It has, since the advent of 'professional' leadership, been military doctrine and leadership training that officers must value the outcome of the mission ahead of the lives of their troops and far ahead of their own lives. It is understood, however, that a good leader will also put the lives of his/her troops ahead of the completion of a pointless or politically ill-advised mission. When in the late 1940s, British soldiers in the newly created state of Israel were being killed by Jewish terrorists while they tried to keep the peace between Israelis and Palestinians, Field Marshall Montgomery fought against Whitehall's "infirmity of purpose" and "lack of a clear political policy" to achieve results (Dixon, 2001). In Mark Bowden's account of "the Battle of the Black Sea" [Mogadishu], "in the weeks prior to [the] raid, [General] Garrison took more heat for being too careful about launching missions than about doing so recklessly" (p. 412).

The American soldiers in Somalia did not resent the losses they incurred during their mission to capture Aidid; they did, however, resent having the mission cancelled before they could finish the task they had been sent there to accomplish and thus justify the deaths of their comrades. The Canadian soldiers who participated in the coalition operation in Afghanistan were, according to an interview respondent, a really "switched on population; they were really enjoying it," in spite of the losses they incurred in theatre. They weren't on 'yet another' Bosnian rotation; they were undertaking a combat mission in new territory with a specific military purpose and a defined outcome that they were morally and professionally able to understand and support.

Soldiers are willing to incur great risk if they feel that what they are engaging in is a just, well-planned, and well supported endeavour. Douglas informs us that, in any organization, workers establish the "agreed norms for acceptable and unacceptable risk"

through monitoring (1985, p. 84). If workers feel that their rights and freedoms are being eroded to an unfair extent, they perceive that they are being subjected to increased risk. If their rights and freedoms are respected, they perceive no exploitation. This monitoring takes place by taking notice of mishaps and misfortune and giving those events greater importance than would normally be accorded them, which result in questions regarding responsibility.

2.6 Risk and choice

Autonomy in decision making and responsibility for outcomes are closely intertwined. According to social trends researchers Environics Research Group (2001), the norm in the 21st century is generally for greater personal autonomy, more choice, a more 'self'-centred individual. This movement toward personal autonomy erodes feelings of collective responsibility—a value that is as essential to government as it is to military hierarchy: "...a decline in the spirit of mutual aid has strengthened the notion of 'each man for himself' and contributed to the eroding social cohesion" (p. 15). In a military hierarchy, the willingness to accept responsibility and the ability to trust those above and below one's rank and position is both essential and constantly challenged. In the information age, high levels of oversight and force protection creates tension at all levels.

The relationship between CF members in the ranks and those in leadership positions, and also between those in the field and those at headquarters, is not always mutually respectful. The Meeting the Challenges survey found that

NDHQ Superiors [survey label] are not seen as supportive of the personnel on the ground, or as possessing key attributes which would encompass an overall perception of them as individuals of integrity. The effect this phenomenon may have on the overall morale and commitment of personnel should be a cause for concern....they see national headquarters as a monolithic and impersonal institution instead of a collection of

dedicated service people no different than themselves....it is also of concern that *Canadian Superiors in Theatre and Tactical Headquarters* [survey label] are seen as significantly lower on the attribute of **Loyalty to Subordinates** [emphasis in original] as they are a much closer, smaller and distinct group...

It may be fairly said that the above theme is not new, has been exhaustively studied, and repeatedly brought to the attention of the CF leadership. A 1995 Briefing Note to the CDS stated the following: '...there have been a number of independent and recurring indicators of a CF membership that has been alienated from its leadership. These have been expressed in, but are not limited to, the 1989 Officer Corps Study, the 1992 Forces Wide harassment survey, focus group research on leadership issues contributing to the development of 1993/94 Conditions of Service questionnaire, results of the 1993/94 Conditions of Service survey dealing with career and individual rights issues and a recent spate of 'brown envelope' incidents (p. 34/35).

A series of scandals in the 1980s and 90s, particularly the Somalia incident, in which some felt that the blame was unfairly apportioned toward non-commissioned members, has contributed to this lack of leadership credibility among the ranks for some aspects of the DND hierarchy. The "Executive Summary" of the Somalia Board of Inquiry notes in its chapter regarding the "Truncation of the Inquiry and the Unfinished Mandate" that:

The Government's decision effectively allowed many of those in senior leadership positions during the deployment to avoid entirely accountability for their conduct, decisions, and actions during and after the mission (p. 35).

When there are perceptions of misfortune and exploitation within the CF, those in the ranks are likely to believe that someone higher up the chain of command has sold them out, or the political system has betrayed them. The trust that previously existed—albeit sometimes thinly spread between NCMs and officers²⁵—is diminished to the extent that the essential esprit de corps that made one a member of an organization with pride, mutual responsibility and accountability becomes a system of ever shrinking circles of

²⁵ [An American sergeant in Bosnia] "I don't like officers, and never have. Most of them are full of shit" (Langewiesche, p. 58); [Canadian corporal in training] "leadership and loyalty for our NCOs and officers

trust, perhaps within a regiment or a trade or combat unit or perhaps even so far as an individual member feeling that he can only rely upon himself for his safety and wellbeing.

The message that the average member of the CF internalizes in times of scandal or turmoil is that their profession is not valued by their government, their chain of command has been infiltrated by careerists who are more concerned with their own advancement than with standing up for the Forces, and that those who are still concerned with military values may be overridden anyway by political concerns and powerless to protect them. In addition to this, they are receiving messages from the media that they are being put at grave risk of exposure to environmental hazards in conflict zones and that they are more likely to suffer from mental illness. Finally, as if the risks they encounter in their profession weren't enough, they have the same media-inspired fears and worries that other individuals in the Western world face compounded by their frequent absence from their families and their inability to protect them from such dangers.

2.7 Voluntary and involuntary risks

Risk acceptability hinges not only on cultural beliefs about the probability of hazards, but on whether risks are undertaken by choice or are imposed (Douglas, 1982, p. 16). In the military profession, the acceptance of unlimited liability, i.e. the willingness to risk death should the need arise or the order be given, implies a higher level of risk acceptance than is associated with everyday civilian life. This willingness is predicated on trust and respect for those making the choices regarding risk imposition. Leadership is getting others to do willingly what they would not normally do; as the military axiom

quickly became a matter of our respect for them and was no longer based solely on their rank" (Davis, 1997, p. 31).

goes: ‘a good leader is one who can order troops into hell, and they’ll look forward to the trip’. However, if the risks are hidden, or are perceived to be hidden because conflicting information is provided through channels that seem to subvert authority, previously voluntary risks can take on the appearance of being unreasonably involuntary. The voluntary/involuntary calculation is a moving target, and in this context would be judged against the likelihood of whether someone will profit from any damage caused to the innocent. Douglas warns that the backlash against technology or institutions that are imposing risks on individuals stems from the perception that risks are “involuntary (we would not willingly accept them), irreversible (there is no turning back), and hidden (we shall not know we are encountering them)” (1982, p. 16). Each individual’s or institution’s voluntary choices can lead to someone else’s involuntary danger. In the exercise of military force there is the assumption that information is distributed on a ‘need to know’ basis, but the climate of responsibility and trust required to invoke the willingness to accept unlimited liability requires that individuals believe that they have all of the information that they ‘need to know’.

As technology has increased and new weaponry has proliferated, the risk of involuntary exposure to hazards has increased and the suspicion that not all safety measures have been taken and that information regarding hazards is incomplete has also become more common. Douglas attributes this to “institutional mistrust,” a state of affairs which, in the case of health, has shifted the line for what is normal away from plausible medical explanations and toward ‘malpractice’ (1982, p. 34). Whether CF members suspect ‘malpractice’ or not, they sometimes suspect that they are not being given the whole story with regard to their health and the risks they’re expected to take. A prime

example of the hesitancy to accept medical information from military sources is the fear of environmental hazards, such as chemical and biological weapons and other toxins that may be present in the conflict environment, for example, depleted uranium. NATO's Committee of the Chiefs of Military Medical Services (COMEDS) established in 1994, specifically as a response to the "increased emphasis on joint military operations" was the credible body used by NATO to deliver the news to military personnel and concerned civilians that "a causal link cannot be identified between Depleted Uranium and the complaints or pathologies" experienced by members of alliance militaries who had served in the Balkans (NATO Press Briefing, January 16, 2001). This, however, was not necessarily credible enough for all sufferers or all interested parties, some of whom were and still are convinced that their proximity to depleted uranium munitions caused health complaints.²⁶ The question that arises is whether the physical illnesses experienced by NATO personnel are in fact the result of an environmental cause or are a somatic response to the real risks and perceived risks associated with functioning in a war zone.

According to mental health practitioners at DND, nearly every major military engagement is followed by a 'syndrome' of one form or another.²⁷ In the World Wars and the Korean War the distinction between psychological or physical illness was likely easier to make because the environmental toxins could be more easily isolated and the pathology of the disease determined. Warfare from Vietnam onward has involved a

²⁶ The question of the risk of depleted uranium weapons is again in the news as military personnel deploy to the Gulf. DND medical officers have been explaining to troops and to the press that there is no conclusive medical evidence to suggest health hazards (to Western allied troops) from depleted uranium weapons.

²⁷ Stephen E. Straus, "History of Chronic Fatigue Syndrom, (1991); Kenneth C. Hyams et al. "War Syndromes and Their Evaluation: From the US Civil War to the Persian Gulf," (1996); Edgar Jones et al. "Post-combat syndromes from the Boer War to the Gulf War: A cluster analysis of their nature and attribution," (2002).

variety of known and unknown chemical and biological agents that could be responsible either for genuine physical illness or for somatic illness due to the knowledge of them and fear of them if not actual exposure to them. One interview respondent characterized this as an “awareness bias—if you think something is ‘bad for you’ you’re more likely to experience health problems that you associate with it.” For example, an experiment of a mock chemical attack conducted in France in 1985 dropped red powder on French troops who were expecting water vapour. In the words of Richard Gabriel (1988) who writes about this incident in his book The Painful Field: “the whole battalion simply came apart. Scores of soldiers writhed on the ground manifesting all the symptoms of a genuine chemical attack; some almost died from their somatic symptoms” (p. 62-63).

And the environmental hazards encountered and feared need not all be military. In Kosovo soldiers experienced fear regarding coal fired plants, in Eritrea it was asbestos and in Croatia, contaminated soil. In many instances, medical and mental health practitioners have agreed that syndromes following military engagement are more likely due to psychological stressors than to environmental toxins. In attempting to determine the pathology of ‘Gulf War Syndrome’ Physicians David Anthony and Susan Ferry (1997) noted that:

Service men and women deployed in the Persian Gulf were exposed to several potentially serious physical and psychological stressors. These include immunisations, pyridostigmine prophylaxis, pollution from oil fires, and the liberal use of pesticides, a list that continues to grow. The campaign took place in inhospitable surroundings and was conducted under the threat of exposure to some of the most fearsome weapons yet invented (p. 239).

However, study after study has been unable to determine a clear causal relationship between Gulf War toxins and the physical symptoms manifest in the syndrome.²⁸

In an experiment ranking 25 known toxins and comparing lay-persons' beliefs to that of medical experts regarding the danger of exposure to them, the non-experts ranked the toxins in almost reverse order from that of the experts who knew their true lethality—what you think is 'bad for you' is likely to make you somatically sick. Troops who anticipated Gulf War duty as a high risk operation showed higher distress levels than those who approached duty in the Gulf as not posing any risks significantly higher than other operations (Solomon et al., 1991).

Since the Second World War, the incidence of idiopathic (of unknown cause) illness has increased as personnel return from theatres of operations with varied and chronic physical symptoms, certain that they have been exposed either to enemy munitions containing toxins or to toxins administered or weaponized by their own government. This timeline corresponds to Douglas' rise in institutional mistrust and the growing cultural belief that institutions are imposing a greater number of 'involuntary, irreversible and hidden' risks upon the general public. As Marsh pointed out, illness is no longer considered the result of misfortune, someone or something must be to blame. Add to this the military cultural belief, or cultural myopia, that psychological illness is far less probable and certainly less desirable as a diagnosis, and one encounters a high incidence

²⁸ Coker W., et al., "Clinical findings for the first 1000 Gulf war veterans in the Ministry of Defence's medical assessment programme," (1999); McCauley L., et al., "Strategies to assess validity of self-reported exposures during the Persian Gulf War, (1999); Suadcani P., et al. "Determinants of long-term neuropsychological symptoms: The Danish Gulf War Study," (1999); Fukuda K., et al., "Chronic multi-symptom illness affecting air force veterans of the Gulf War," (1998); Joseph S., "Comprehensive clinical evaluation of 20,000 Persian Gulf War veterans," (1997); Persian Gulf Veterans Coordinating Board, "Unexplained illnesses among Desert Storm Veterans," (1995).

of mental illness misperceived by society and sufferers as physical illness resulting from institutionally imposed, involuntary hazards.

In spite of hundreds of years of psychological research regarding mental disability as the result of combat and conflict, some CF members would still prefer to be diagnosed with a chronic physical illness as the result of poisoning by their own government than with mental illness. However, as will be discussed in Chapter three, the tide is slowly shifting away from a stigma of weakness associated with mental illness and toward an acceptance of its likelihood under certain circumstances—principally peacekeeping—but the need to place blame has remained.

Chapter 3: Military Psychology Then and Now – From ‘Nostalgia’ to ‘Social Phobia’

3.1 19th and 20th century syndromes

Along with changes to warfare have come changes to psychology and our means of dealing with psychological casualties. This chapter moves the discussion from the institution to the individual. It will discuss developments to the psychology of warfare along an historical timeline, demonstrating what has changed and what hasn't, as well as the means the CF uses to cope with mental illness in the military and how they compare with those of other militaries. The nature of mental health problems in the CF, as described by DND mental health practitioners, differs in many respects from the perception of civilian society and there are differing opinions within the organization as to how to approach mental illness. How to determine who is ‘at risk’ and their potential affect on the organization, is something that has been proactive at the level of the organization, and reactive at the level of the individual. Whether and how to retain persons perceived to be at risk for mental health problems and how to support them through difficult times are subjects of contention for DND mental health practitioners and for the leadership of the organization. The social supports that once existed to cope with mental illness—without naming it—have gradually disappeared with the introduction of specialized knowledge that singles out the individual for expert attention. As mental health practitioners have become more adept at treating mental illness, they have worked to remove the cultural barriers to mental health problems, but by making the problem more visible, by naming it—‘PTSD’—they have helped to solidify recruitment and retention barriers to the ‘at risk’.

Our first evidence of extreme stress leading to lasting physical and mental dysfunction, documented by physicians, comes from the American Civil War. It was the first war to combine the elements of total and industrial warfare in a prolonged conflict. The improved accuracy, range, reliability and durability of artillery and firearms of the industrial age, allowed armies to fire at each other across great distances with the kind of accuracy that made the pre-industrial strategy of standing in formation in the line of fire suicidal. However, when soldiers dug-in to create protection from enemies a distance away, who would be able to kill them with precision should they emerge over the top, they constructed a situation of interminable waiting which would create a psychological torment not experienced by pre-industrial combatants. Soldiers of the American Civil War experienced what those of the First World War would discover fifty years later; that the protection of a trench can also be a prison.

Union Army surgeon Dr. William Hammond noted the long term effects of battle trauma on soldiers in the form of limb paralysis and palsy, where no apparent injury existed (a 'Civil War Syndrome', if you will), and recurring nightmares which he termed "nostalgia" (Holden, 1998, p. 9). He treated hundreds of cases of epileptic type seizures, and paralyzed limbs, which he was sometimes able to restore to movement with massage. The most obvious cases of psychological distress were of soldiers who experienced "increased heartbeat and aroused feelings of alarm triggered by reminders of combat" (Holden, p. 9). He attributed these mysterious physical ailments and 'nostalgic' responses to the youth and immaturity of many of the recruits who were ill-suited to the "fatigues and deprivations of military life" (Holden, p. 9).

Just as some of their modern-day counterparts, American Civil War officers were reluctant to attribute mental 'weakness' to soldiers, and in the frantic search to find an explanation for the large number of such cases, the army proposed an external cause related to new technology. The 'railway spine' theory suggested that the new means of transporting soldiers was creating a percussive effect on the spinal chord that damaged the nervous system. It was given credence by the similarity of symptoms observed in victims of railway crashes. Whether the 'railway spine' theory survived beyond the duration of the war is unsure, but whatever Dr. Hammond may have deduced about 'nostalgia' doesn't seem to have been transmitted across the 50 years between the American Civil War and the Great War. A similar 'percussive impact' theory emerged to explain trauma cases in WWI trench warfare.

Dr. Charles Myers, who had been researching the psychology of primitive peoples at Cambridge University when the Great War broke out, was pressed into service along with all other available psychologists to deal with the enormous number of 'nerve cases' resulting as the war escalated. He observed that most of the soldiers he was seeing who were suffering from the symptoms of mental dysfunction had in common the experience of proximity to heavy shelling—hardly escapable during WWI. He hypothesized that the impact of the shells had a percussive effect on the nervous system, damaging the tissues of the brain and spinal column and creating neurological disorders such as blindness, loss of speech, deafness, palsy, paralysis, and a variety of other manifestations. As a result of this one commonality he coined the term "shell shock," a label which has stuck in common parlance, despite its being discredited as a medical theory, particularly by Dr. Meyers himself (Holden, p. 17). Both the American Civil War and the Great War were

perceived as heroic campaigns to which young men went willingly expecting a short and glorious war. Officers were larger than life, the stuff of legends, and troops were idealistic and driven by patriotic zeal. Attributing psychological vulnerability to these men would have been unthinkable in their time.

As WWI escalated thousands of cases of shell shock were admitted to hospitals in Britain, France and Germany, creating recruitment crises for the governments. The mentally unfit were depleting the ranks, which were being horribly reduced enough by the weaponry of the time. The budding psychiatric profession threw itself into finding a solution, and there was no shortage of patients about which to hypothesize. Symptoms remarkably similar to those noted by the Civil War physician Hammond were evident, “loss of memory, insomnia, terrifying dreams, pains, emotional instability...convulsive movements resembling epileptic fits, localized paralysis” (Holden, p. 12). Special wards, clinics and eventually large hospitals were set up to contain and treat the shell shocked cases. All manner of treatment was attempted from the moderate to the extreme, including hypnosis, psychotherapy, suggestion, judicious doses of rum, and electric shock. All methods seemed to provide varied results; spontaneous cures were just as likely as no cure at all. Dr. G. Eliot Smith (1917) recounts a spontaneous cure of ‘mutism’ by “the announcement at a ‘picture house’ of Rumania’s entry into the war, this cured two cases simultaneously” (p. 12).

3.2 In-theatre treatment

Wishing to standardize the treatment of shell shock patients, the British War Office arrived at a method of treatment, which comprised in sum: “isolation, rest, massage and a milk diet.” By the end of 1915, with the manpower shortage beginning to

become acute, medical stations were set up near the front lines where psychological casualties could be triaged and, whenever possible, receive immediate treatment and be sent back to the front. It had been discovered that those who were removed from the sounds and stress of battle and had time to reflect on their experiences often became worse. It was at this time that the distinction between the transitory nature of Combat Stress Reaction and more debilitating acute stress symptoms (decades later to become known as Post-Traumatic Stress Disorder) were first noted. As a result, fewer borderline cases were removed from duty and were instead treated close to the action and sent back as quickly as possible. This process of discovery would be repeated in WWII when a new brand of Freudian psychotherapists engaged in prolonged therapy of cases of 'war neuroses' and found that the symptoms increased with time and ultimately required lengthy treatment. American General Omar Bradley, in 1943, ordered that "soldiers showing psychopathological reactions be placed under observation for seven days and be classified as 'combat exhaustion'" and returned to active duty as quickly as possible (Holden, p. 29).

It is now generally accepted that psychiatric casualties during an operation, in cases where the individual is not a danger to him/herself or others, are best treated in theatre. The BICEPS model (or PIES to some): Brevity, Immediacy, Centrality, Expectancy, Proximity and Simplicity, describes the method of providing brief, local therapy to individuals experiencing psychological dysfunction, either prior to deployment as in the case of one young American NCO during the 1991 Gulf War (True and Benway, 1992), or during a deployment. Initially, showing signs of extreme anxiety, the young NCO was considered too "sick and fragile" by his commanding officer to lead his unit

into combat and it was recommended to the staff of Fleet Hospital Five that he be returned to the US as quickly as possible. Prior to his deployment to the Gulf, his record showed that he was “considered to be a fine leader who had led his unit well under difficult circumstances” (p. 380). However, during therapy in Saudi Arabia, it was determined that he suffered from a pre-existing personality disorder with episodes of anxiety and depression which the stress of the approaching action had exacerbated. He had no known psychiatric history, nor did he have a family history of psychiatric disorder, nor did he have a history of drug or alcohol abuse. However, knowing that he had emotional difficulties to overcome, he had joined the military as “a way of establishing independence from his family,” with whom his relationship was the source of his anxiety (p. 380). His mental health problems surfaced because he had been so accustomed throughout his life to his parents and his wife making difficult decisions for him that he feared taking decisions that might get him or those under his command killed.

Part of his in-theatre treatment included group therapy with others who “were also addressing their personal internal struggles with the same issues” (p. 381). He was returned to his unit, at his request, shortly after the in-theatre therapeutic intervention; “his commander personally picked him up from the hospital and welcomed him back” (p. 381). Had he been immediately offered medical evacuation to the US he would have accepted, but following therapy and return to duty he was glad that this had not occurred because, he stated, “I wouldn’t have been able to live with myself” (p. 381). His record in the Gulf War is unknown; however, his case provides a sharp contrast with that of Cpl. Christian McEachern (which will be discussed more fully in Chapter 4), in which McEachern was withdrawn from duty and isolated from his unit. During his stay in

hospital, the soldier in the above case study remained in uniform and in contact with his unit and other soldiers deployed to Saudi Arabia.

Had this one soldier been diagnosed unfit to serve, it's possible that given his diminishing self-esteem prior to treatment and the disappointment that he would have felt at being sent home, that his depression would have increased and the US military would have gained one more non-effective member who may have needed to be pensioned off for disability or who may have resigned. For this individual, joining the military was a way for him to deal with his personality problems, which became acute when triggered, but with the support of the therapists in theatre, he was able to overcome them and continue with the deployment.

3.3 Willingly accepting unlimited liability

There are those who might argue that he ought not to have been enlisted in the first place, or that his 'weakness' should have been detected earlier and he should have been directed into a safer trade than combat arms. There are screening mechanisms in most militaries, including the US Army, that attempt to accomplish this. In war-time, particularly in the situation of compulsory service, screening hopes to serve the purpose of enlisting only those individuals who will be able to withstand the extreme duress of military service, and who will not endanger the lives of those serving with them by not being there when needed. But in a peace-time, volunteer military, individuals who join make a 'personal commitment' to the risks associated with that profession. To exclude them on a presumptive basis using a tool with low predictive power (discussed in more detail below) may not only be *unnecessarily* prejudicial, but may also contravene their rights. They ask to be part of a culture and profession that they believe will contribute to

and enhance their worth and they believe that they, in turn, will add to the greater worth of the organization. Whether they live up to that commitment depends in part upon how that agreement is managed. How they perceive those risks will also be determined by whether they believe the organization is responsive to their needs and living up to its half of the commitment. The acceptability of risk as it relates to mental health is currently under negotiation in DND culture. At this stage, having mental health concerns is itself a career risk, as much as, if not more than the actual risk of feeling adversely affected mentally by deployment.

The socio-economic structure of the military is such that, in addition to being a profession of choice for some, it is a profession of last resort for others. It has always attracted talented, intelligent people drawn to a certain way of life, and it has also been society's repository for social misfits, those who are trying to escape something or trying to find something. Today's well-educated, professional force is a far cry from centuries past when military personnel were considered the 'dregs of society' and officers were drawn strictly from the aristocracy,²⁹ but there are still those who join because they have no where else to go, because they need the money or because it affords them the only possible avenue for a higher education. One young recruit interviewed by Andrienne Arseneault (2003) during her 'embedding' exercise joined the US Army because people told him "he wouldn't amount to much." He had been "trouble" with a bad attitude and a

²⁹ At the end of 1996, the majority of service members were in the 30 to 40 year old bracket and less than one-third were under the age of 30. Just ten years earlier nearly 60% were under the age of 30. The aging of the CF is particularly pronounced among officers. On average, officers were 34.7 years old and NCMs were 33.1 years old in 1996. Similarly, the bulk of the Canadian labour force is in the 25 to 54 age group. In 1996, 13.4% of service members possessed a university degree, and 10.7% had completed post-secondary education. This is up from 1987 when 10.5% of CF personnel had graduated from a university and 7.2% from a post-secondary institution. This trend holds for Officers and NCMs. As of January 1997, 60% of officers had university degrees (including 7% with post-graduate degrees) and 14.5% of NCMs had

bad relationship with drugs and food; he had lost weight, joined the Army and now considered himself “better in every way.”

Douglas, in her work on institutional risk acceptance notes that “the first choices before individuals lie between joining and not joining institutions of different kinds....The big choices reach them in the form of questions of whether to reinforce authority or to subvert it” (1992, p. 84). Following the September 11, 2001 attacks on the US and the resulting ‘war against terrorism’, recruitment has increased; a percentage of the Canadian population are experiencing a heightened feeling of patriotism, bolstered by an increase in popular media images of sacrifice and heroism.³⁰ Among the recruits that Arseneault interviewed there was talk of a “32-year-old in their ranks who left his New York job after September 11 to ‘do something important’.” And a young woman interviewed by a CBC reporter at a Calgary job fair said she was considering joining because she too ‘wanted to do something important’.³¹ They are choosing to join the institution, willing to incur the risks associated with unlimited liability—less likely drawn by the signing bonus than by the desire to be part of an important moment in history—and the institution would be well advised to ride that wave of nationalism while it lasts. Not all nationalism is dangerous, it is also the sentiment that draws some individuals into the civilian public service and into running for office; there is a place in society for those who wish to reinforce the authority and responsibility of the government and the nation, as much as there is for those who wish to subvert it.

completed post-secondary education or attended university (but not completed a degree). In 1987, only 9% of NCMs had attained the same education level (Truscott and Dupré, 1998).

³⁰ Following a period of heightened sensitivity immediately after September 11, 2001, the number of war movies released on the big screen and TV seems to have increased, e.g. “Black Hawk Down”; “We Were Soldiers”; “Hart’s War”; “Wind Talkers”; “Tears of the Sun”; “Gods and Generals”.

³¹ The National, Friday, March 7, 2003.

Neither the NCO with emotional angst nor the young infanteer overcoming a drugs and weight problem was detected through the normal processes of interviewing and screening that the US Army undertakes, which over the years have been more or less rigorous depending upon the prevalent opinion regarding screening and the size of the call-up required. It is not an entirely unreasonable proposition to screen out those with severe mental health issues. Medical Officers in the First World War found that they were charged with diagnosing soldiers who ought not to have been recruited in the first place: “the insane, imbecilic, epileptic and criminal” (Holden, p. 25). However, maybe if society provides young men and women who choose to volunteer their lives for military service, and who look to the military for something missing from their lives, the military has a responsibility *not* to try to screen them out, but to provide that support and that ‘character building’ experience, so long as it has the resources to do so. In past wars, attempts to avoid enlisting those predisposed to psychiatric disorders had failed, but that does not stop some from continuing to try and continuing to attempt to hone the instruments of screening.

3.4 Removing the ‘at risk’

Mindful of the lessons of WWI, the US Army attempted screening at the outset of WWII; however, the necessity of enlisting anyone available as the war dragged on, in time diminished the selectivity of the military. Post-WWII research conducted by the American National Research Council suggests that this practice was, in any event, largely redundant. Dr. Norman Q. Brill’s (1955) findings determined that the soldier most likely to resist breakdown was from a fairly select group: “young, single, well adjusted...with

moderate education attainment...and whose family history was negative for emotional illness, broken home, or parental conflict” (p. 18-20).

British psychiatrist Dr. Simon Wessely’s (2001) historical review of screening found that screening for predisposition to psychological disorders frequently creates ‘false positives’ and ‘false negatives’ (p. 3-4). A WWII study in which 2,054 men were initially rejected on psychiatric grounds, but were later inducted into the army anyway, ultimately discharged only 18% on the same grounds. Of the rest, nearly all gave “satisfactory duty”— 78% of the total sample (p. 11). In another study, which followed 138 soldiers who had shown “sufficient adjustment difficulty during training to necessitate psychiatric attention,” having fought the Battle of the Bulge, only one became a psychiatric casualty; the other 137 “remained on active duty and one received a medal of gallantry” (p. 12). Wessely’s review did find that where individuals showed signs of being predisposed to psychiatric breakdown, a marginally higher percentage of that group would succumb to breakdown than those who did not. However, most screening, whether conducted by questionnaire or by personal interview with a psychologist or psychiatrist was not sensitive enough to determine which of those individuals would breakdown and which would not. In fact, the predictions resulting from personal interviews were more frequently wrong than the questionnaires, and the variations across recruiting stations using identical criteria were startlingly high (p. 14).

Additionally, pre-deployment attempts to isolate personal characteristics as predictors of psychological breakdown are only part of the equation; the myriad differences in environmental factors encountered by individuals in theatre also reduce the predictability of screening. The implication of this research is that an instrument has yet

to be found that is specific and sensitive enough to predict with any accuracy which individuals will suffer from psychological disorder as a result of operational stress.

However, of those who might be 'flagged' for being predisposed to operational stress, in-theatre care may help keep them on active duty and thereby reduce the number of trained and capable personnel lost to the Forces.

3.5 Making involuntary risks voluntary

One of military psychology's findings throughout the period of the First and Second World Wars was that fear of the unknown, unfamiliar hazards and beliefs about them can be more debilitating than what is expected and can be detected and prepared for. This corresponds to Mary Douglas' research and previous discussions of perceptions regarding toxins and other environmental hazards: for most people, what is familiar, regardless of the objective hazard it poses, is less to be feared than unfamiliar, potentially low probability hazards, again, regardless of their objective dangers. Fear does not necessarily correspond to the probability of occurrence or the likelihood of negative outcome; rather, it corresponds more directly to information, and personal and cultural beliefs about the hazard. In order to prepare soldiers for what they might face and how they might react adversely to it, the US Army in WWII made efforts at stress training to attempt to reduce the incidence of breakdown from highly probable, but certainly unfamiliar events. According to Dr. Abram Kardiner (1947), Professor of Psychiatry at Columbia University,

...army personnel were psychiatrically oriented. The soldiers were indoctrinated in the manifestations of fear and anxiety. They knew the phenomenon and its significance, and there was more freedom in expressing it. Hence, there was less pressure to suppress the incipient manifestations of fear and therefore less need for explosive manifestations of accumulated tensions (p. 59).

Dr. Kardiner believed that these methods resulted in fewer severe epileptic cases during the Second World War. However, some of the methods employed in the early stages of pre-deployment psychological training would now be considered morally and scientifically questionable. The methodology of tests for stress-resistance was, at times, excessively and inhumanely stressful. Peter Watson's (1978) research into psychological warfare found that the secrecy surrounding 'psy-war' in the 1960s allowed studies to be carried out that

...did not always conform to the accepted scientific standards...In a series of experiments aimed at exploring whether troops could be battleproofed by making their training so stressful that they would enter battle injured to any further fears...men flew in an aircraft that 'developed' an 'engine fault'...[and] were 'accidentally' led into a 'shelling zone'. In the course of these experiments some men experienced real terror... (p. 168)

Extreme methods of hardening soldiers for the experiences of combat, known as 'battle inoculation', occasionally verged into the sadistic, in Watson's opinion. And the civilian population tended to agree with him: "...when news of the experiments broke, reaction was swift and they were condemned as inhumane" (p. 169). More recent methods attempt to simulate stressful events without emotionally harming personnel, by trying to prepare them for the new unexpected realities of operations other than war. Rather than simply throwing them into emergency situations, they incorporate stressful situations into training exercises, in which ethical decisions requiring quick thought and action are part of the process. The Americans have perhaps the most sophisticated and realistic training environments for their personnel. The "misplaced patch of Bosnia" that they construct on the base at Fort Stewart has

...a pre-existing urban-warfare site of cinder block structures ... a two-storey municipal building ... an Orthodox church with a little steeple, a

school serving as a weapons-storage site, a semi-functional café and a store where soldiers could buy soft-drinks and candy bars, a nice new graveyard, ... and a clinic labelled MÉDECINS SANS FRONTIÈRES, where an Army medic got to play the role of a hostile French doctor pretending not to speak English (Langewiesche, 2001, 67).

The realism of the training gets the better of some people as in the case of a National Guard lieutenant who “lost his temper and began to shoot civilians, and when his soldiers tried to stop him, he shot them too” (with a dummy weapon). It became known at Fort Stewart as the “Massacre on Lane Four” (p. 70). Although not specifically used as a predictor of behaviour under stress, this exercise provided an example of the value of realistic training exercises, in this case, demonstrating that this individual was perhaps not well suited to the stressors of a multinational peace support operation. The perpetrator of the ‘massacre’ apologized afterward, but as the author speculates “it’s hard to imagine that the lieutenant wasn’t quietly offered a desk job” (p. 70). Canadian soldiers preparing for deployments may not have the elaborate sets of their American counterparts, but they too train for and discuss hypothetical situations of extreme stress in which difficult choices quickly made are required.

In addition to realistic training scenarios, militaries employ a variety of individual and group psychological interventions such as pre- and post-deployment briefings and the distribution of information materials. The CF uses pre-deployment briefings to determine a member’s family situation, emotional state and ability/willingness to deploy. Group briefings are also given by social workers or mental health nurses describing some of the more common stressors likely to be encountered and how to cope with them. The British military employs an “Operational Stress Training Package”, which seems to be a series of

pre-deployment briefings.³² It is variously thought to be effective, or to have negligible effect, as is the case with most psychological testing (Deahl et al., 2000). In spite of the efforts of the British military to ‘inoculate’ against stress, British soldiers have recently sued “the UK Ministry of Defence for failing to prepare them for the horrors of war” (Furedi, 2002, p. 3).

Knowing how far to go in stress training, how much is too much or too little, is a classic scientific dilemma. According to Douglas, at any one time there is evidence that some course of action or widely held theory, previously considered benign, is being challenged by new evidence (1983, p. 27). Is it better to proceed with a particular course of action until it is determined that it is unsafe to do so, or to stop until it is proved safe? If the course of action is research that may benefit the subjects or may harm them, the researchers themselves encounter ethical choices, regardless of their subjects’ informed consent or freedom from coercion to participate. There are those for whom there is no such thing as too little research and those who believe that research should always be undertaken cautiously lest it prove more harmful than not doing anything at all. Their professional ethics and the best knowledge available provide guidance, as well as their desire to always do what’s best for the individuals and the organization they’re serving.

For many *military* mental health professionals, having had personal, in-theatre experience of the difficulties their research subjects and/or patients are facing provides an additional impetus to ensure that they are receiving the benefits of the best and most current knowledge available and are not subject to experimentation for its own sake. With military psychologists, as with military historians, credibility seems to be established by

³² I attempted to obtain further information regarding the training package by contacting the UK MOD and the UK High Commission in Ottawa, but was unable to.

going ‘into the field’ to work with the troops. One CF mental health professional in uniform stated that it’s a good idea to have psychiatrists/psychologists in uniform and in theatre “because they understand the environment and fit in with the troops,” although he didn’t identify specifically with the uniform he’d chosen to wear, the soldiers who saw him wearing it did.³³

Psychologists in uniform have been part of the war zone since WWII when they were drafted and attached as specialists to the army, navy and air force. Today’s militaries have a variety of mental health practitioners who provide care throughout the deployment cycle: social workers, chaplains, mental health nurses, medical assistants, psychologists and psychiatrists. The makeup of the team deployed depends upon the resources of the military, the size of the operation, the threat assessment of the environment and the resources available through multinational partners in theatre. According to one interview respondent, Canada considered sending a mental health component to its field hospital in Afghanistan, but determined that it was not needed because the American contingent, with whom the Canadians were deployed, had substantial mental health resources in theatre.³⁴

3.6 The erosion of risk-mitigating social supports

The training today’s military personnel undergo, whether in Canada or any other professional, volunteer force is expensive and, in the Canadian case, now includes provision of an ever wider array of social and familial supports (i.e. pre- and post-

³³ Medical officers undertake military training in one of the service elements, but their trade is medical, their uniform doesn’t necessarily connote any particular expertise in that area of military service, i.e. “I wear a green uniform.”

³⁴ The Americans have created “combat stress control units” within their medical battalions. There is currently a CSC unit deployed with the US Army medical group in Afghanistan, the primary aim of which

deployment supports). The CF is meant to care for personnel from induction to retirement. It still takes recruits as young as 17, with parental consent, and the educational requirement at induction is completion of Grade 10.³⁵ Therefore, it is potentially still acquiring a number of 'raw' recruits whose personalities and opinions are still forming and whose formal education is incomplete. It also has an aging core population with familial worries, career concerns and diminishing morale as they cope with increased PERSTEMPO, decreased and deteriorating resources and derision in the press.

Psychologists and psychiatrists suggest, however, that in addition to the increased work-load pressures and the changes to the job itself, the changes to the organizational culture of the military and the reduction in social supports that existed in decades past, may have a significant bearing on how personnel are coping with stressors. A few interview respondents pointed out that the social supports generally associated with the military have changed and the usual ways of interacting in peer groups have diminished, e.g. people don't use the mess as much or socialize as much. This concern was echoed by the retired officers interviewed for this study. They recounted stories of assisting men under their command with their personal, familial and financial problems. They were mentors and role models and had close personal interaction with the troops who served under them. Not all leaders, past or present, have been personally capable of or willing to fulfill such a role, but in the opinion of the respondents, in the CF prior to the 1970s/80s,

is to reduce the need for evacuations due to psychological injury. There are 15 such units in the American Army, across regular and reserve force bases (*US Army Reserve News*, February, 2003).

³⁵ At the age of 17, recruits are allowed to begin military education, i.e. as an RMC cadet or in trades training, but the CF is not allowed to put them through combat training or deploy them until they have reached the age of 18. This is in compliance with Canada's signing of the *Optional Protocol to the*

it was an expectation of the job. They believe that the introduction of ‘specialized knowledge’ with regard to social support and coping has eroded the important relationship that leaders had with their troops, to the extent that it has become distant, formal and strained. No longer are leaders expected to intervene in the personal problems of their troops, to provide advice and support. The days of junior and senior officers “chewing the fat” over a few beers in the mess seem to be gone and are replaced with surveys, questionnaires and mental health seminars.

It was also pointed out by medical practitioners that some of these changes have been beneficial, there’s less alcohol abuse and more time spent with families. However, the fact that the erosion of social supports has coincided with the reduction in personnel numbers and the resulting increase in PERSTEMPO is significant because it has contributed to problems of reduced unit cohesion (i.e. fewer people, going away more frequently as ad hoc units, but spending less social time together, results in strangers deploying together) which virtually all respondents cited as problematic for psychological supports.

The lack of social supports and isolation within the disconnected culture is a serious problem, but not one that mental health practitioners can solve simply by providing therapy to those who are experiencing loneliness as a result. As one interview respondent argued, as a means of responding to this gap, we need to create new supports commensurate with the other cultural changes we’re making in the military that are in turn responding to the new conflict conditions (this topic will be discussed further in Chapter 4). His analogy was that in past wars we dealt with gun shot wounds differently,

now we should deal with social and psychological issues differently as well. And another respondent added that “psychology isn’t magic; it’s education; it’s self-awareness,” therefore, we need to involve the individual and the community in their mental wellness. Mental health practitioners treat only those individuals they are able to diagnose and they’re only able to diagnose individuals who have been referred to them or who have determined on their own that they would benefit from a visit to the ‘care bears’.³⁶ Critics of this position argue that the mental health profession should not wait for members to come to them or be referred to them, but should be taking a proactive approach to treatment. They do not believe that more harm can be done by bringing a member in for assessment, rather than waiting for that member to seek help on his/her own. They base their argument on personal experience of individuals under their command who would have benefited from treatment, but who were reluctant to take that step.

3.7 Psychologists taking risks

There are a larger number of support personnel in theatre now to assist in detecting minor mental health problems before they become acute and certainly more advanced treatment methodology for all manner of mental health problems. As warfare has advanced, the treatment of mental illness has also advanced. CF psychiatrists are exploring ways to treat active-duty members experiencing minor pre-existing psychological problems with medication. Drugs are currently prescribed in theatre and in garrison, to treat anxiety, depression and insomnia (Thompson et al., in press). One DND Health Services professional is currently considering the possibility of deploying personnel who are taking psychotropic medications, suggesting they could serve just as

³⁶ ‘Care bears’ is a nick-name that some soldiers have applied to DND’s mental health practitioners.

effectively as any other member. Many of the diagnoses that he and colleagues are making are for minor psychological problems that are highly treatable and in his opinion there's no reason someone "on medication for a psychological disorder cannot still be a combat soldier."

Mental health problems such as depression, boredom, isolation, family problems, anxiety, alcoholism, social phobia (chronic shyness), dysthymia (chronic grumpiness), are all present in the CF population and are as much a cause for concern as trauma arising from combat or from particularly traumatic incidents, and the post-deployment effects of trauma.³⁷ Nearly every health and social science professional interviewed for this thesis reacted negatively to my suggestion that "combat stress reaction leading to PTSD" was the most significant mental health problem for the CF. Rather, they stated that it was one of several problems with which they are dealing, that symptoms continuing post-deployment appearing to be the result of a traumatic incident can often be the result of cumulative or pre-existing problems exacerbated by other prolonged or repeated stressors.

Table 4 Interview Responses – PTSD as the most important issue

Each year 20% of Canadians will suffer from some diagnosable mental illness and will get better on their own.
PTSD can be mistaken for other simple treatable disorders.
Cumulative strain is more damaging than critical incidents, it is the little things, like depression, anxiety, erosion of morale, etc. that add up over several deployments to form a cumulative strain that can cause a breakdown as a result of a single incident
The press and the Ombudsman's Report are too focused on PTSD, when the subject of "mental illness" would be more accurate.

³⁷ The Stats Can survey on mental health ought to provide some indication of the numbers associated with these disorders.

Suggestion might play a role in whether someone self-diagnoses, people have symptoms with no organic illness underlying it, so suggestion allows them to diagnose as PTSD.

There is a lot of pressure on members to have PTSD because it is an accepted medical diagnosis and there is monetary remuneration for it.

PTSD rates vary across [military] bases, whether its found in large numbers sometimes depends on how hard you're looking for it.

The label 'PTSD' which arose out of the Vietnam War was applied because of the manifestation of mental and social coping problems that persisted following the return of many American soldiers to the US. It became known as 'Post Traumatic' stress because of its likelihood of lingering long after the traumatic events of war had been left behind. Although cases of PTSD had occurred in large numbers in previous wars, the effects of psychological breakdown due to severe physical and emotional exhaustion in the World Wars had made psychological casualties appear to be more immediate and the lingering affects of war-time trauma experienced after returning home were brushed aside; the words, 'he was in the war', were explanation enough. It was not socially acceptable for anyone to voluntarily seek psychological help, let alone veterans, in the early to mid 20th century. Soldiers returning to the US from Vietnam, in the more liberal 1960s and 70s, were more likely than any from previous conflicts, to avail themselves of psychological support and it is widely speculated that their adjustment difficulties were more severe because of the social stigma already attached to that particular conflict. It was a war that did not enjoy public support at home and the soldiers who went to fight were not celebrated as heroes when they returned, a reality made worse by facing this public disengagement alone upon repatriation, rather than returning home with the unit they had fought with and having the social support of their comrades.

When the American government attempted to create programs to deal with the social adjustment problems being experienced by Vietnam vets they encountered protest amongst politicians and voters. According to Richard Fuller (1985) "Early proponents of post-traumatic stress disorder were characterized as 'crackpot, screwball, self-serving psychologists and psychiatrists who were...only looking for a way to get some money out of the Veterans Administration'" (p. 6). In spite of the advancements in stress biology and psychology and the move to behavioural treatments and evaluation of treatment in the decades following WWII and the Korean War, the psychological profession was still held in some suspicion by the hierarchical elements of government and military culture and general society. The American government was also on the defensive against public opinion regarding the risks American soldiers had been subject to in Vietnam and admitting to lasting psychological dysfunction and social adjustment problems as a result of this conflict would have required admitting to further culpability in a war that many felt they should never have fought.

Mental health workers still face an uphill battle in some cases getting approval of the treatment that they advocate or the programs that they wish to initiate. They must manage a difficult balancing act of doing what's best for the individual while also doing what's best for the organization. There is a tendency to assume that doctors and nurses, wishing only to diagnose and medicate, will overreact to the problems of the individual and their need for treatment to the detriment of the effectiveness of the organization. But, as was discovered in the post-Vietnam years and is rediscovered at intervals when problems surface, the social and political costs of not addressing mental health and social

adjustment problems among military personnel can be higher than the costs of implementing after-care treatment.

3.8 Military families at risk

The problem of adjustment faced by Vietnam veterans is still faced by soldiers of today's conflicts, and its manifestation as social problems in the home and the community make it one of the more visible problems for civilian society, for example, the murder of several military wives at Fort Bragg in the US following the return of American soldiers from Afghanistan.³⁸ The speed of return from Vietnam, as contrasted to the slower transitional return afforded by transportation by ship provided by the previous wars, and coincidentally the Falkland (Malvinas) Islands War, was cited as a contributing factor to adjustment problems. According to one respondent, DND psychologists have for years been advocating a 'cooling off period' between deployments and reintegrating with families and normal life, but when a chaplain and a commanding officer in Afghanistan took up the cause and recommended that it might assist CF members returning to Canada after that deployment, the idea was finally given credence.³⁹ Perhaps it was again the notion that it was 'war' and not a 'peace' mission that provided the justification for treating the mental health of the members involved more seriously.

As a result of the recommendation being accepted, the troops who had been involved in Operation Apollo in Afghanistan were taken to Guam for a respite from the

³⁸ Coincidentally, Fort Bragg is also the location of the 528th Combat Stress Control Unit. Carole and Melvin Ember have conducted extensive research on homicide rates as a consequence of war. They have found that "high rates of homicide/assault are inadvertent (unintended) consequences of the need to produce effective and unambivalent warriors" (Ember and Ember, 1994).

operation and a comprehensive debriefing exercise before returning to their home bases. The purpose of this exercise was to allow them time between being in a war zone with its accompanying threats, stressors and adrenalin high, in physically and mentally taxing conditions, to being at home again with friends and family and back in the less exciting, more routine aspects of their careers. One interview respondent made the point that CF members on military operations, particularly more intense operations have difficulty making that adjustment to routine work at home, and she has often heard officers complain: "I accomplish important things for the world [on international deployments] and then I come home and can't get a goddamn memo signed!" The cumulative effect of small stressors or the dramatic transition from war zone to home front are issues that I had not given sufficient importance in my hypothesis regarding problems of mental health in the CF. My assumptions regarding the stressors experienced by CF members are shared by many people inside and outside of DND. Because of the aforementioned trust issues, some members and/or their families assume that CF mental health practitioners are choosing not to diagnose members with PTSD because of pressure from the government to not diagnose them with an illness that earns a disability pension. There is a common misperception among CF members serving and retired that PTSD is the only pensionable mental health diagnosis. Provided that the psychiatric disability is service-related and severely affects the member's ability to continue to function in his/her employed capacity, a disability pension may be warranted.

Some of the interview respondents have expressed concerns that echo those of WWI physicians who felt moral pressure to diagnose soldiers with a particular illness. In

³⁹ The respondents who pointed this out did not seem embittered by the fact that it was not their recommendation that was accepted; they were more amused by the chain of events. They were glad that it

WWI, saying that a soldier was generally in reasonable mental health but was simply unable to stand anymore time in the trenches may have meant sentencing that soldier to death for malingering. Today, because of the stigma associated with mental illness, a member's career might be in jeopardy if he is not given a pensionable diagnosis, but he is also unable to work as a result of a psychological disability. If the individual is put on the Service Personnel Holding List for mental health reasons and withdrawn from duty with his unit, he might face social isolation within the organization that makes withdrawing from it completely the preferable option. But the doctor making the diagnosis must consider what is best for this individual's mental health in the long run and what is best for the effectiveness of the organization. Mental health practitioners argue that, if a soldier does not have a chronic, debilitating mental health problem as the result of an in-theatre trauma, diagnosing him with one would be detrimental both to him and to the organization.⁴⁰ One respondent pointed out that PTSD has received so much media attention that it has become the 'sensitive' soldier's illness and a badge of honour for some.

This is, in fact, the goal of some advocates of greater openness regarding PTSD. There are so called 'honourable' and 'dishonourable' wounds associated with military deployments. Being physically wounded is, generally speaking, an 'honourable' injury, whereas, being afflicted with a 'mind wound' is largely considered 'dishonourable'. Advocates for greater recognition of the prevalence of PTSD are arguing for recognition of the honourable nature of the illness. Although there is still a serious stigma attached to

had been done regardless of whose idea it was.

⁴⁰ The cause of the trauma must be diagnosed as having occurred 'in theatre' in order for someone to be diagnosed with PTSD. I was told that there have been incidents of soldiers attempting to claim compensation for mental illness that pre-dated the deployment cycle, but which had increased over time.

the notion of being weak and ‘getting’ PTSD, there are rumours of CF members who are not only willing to admit to feeling psychologically affected by deployments, but also a few are suggesting to colleagues that they should come forward and be eligible for their pensions, in spite of the fact that their colleagues may not feel particularly affected. There is a burgeoning sense that to be emotionally affected by deployment to the extent that one requires, at the very least, treatment, and at most, pension, is the new normality. If one is not ill one is not ‘normal’. Advocates for the greater recognition of PTSD believe it is worth a few unearned pensions to ensure that psychological issues are given greater acceptance within the military; they argue that the pendulum will swing back toward assured legitimacy once having a psychological disability is no longer stigmatized as cowardice or dishonour. This is not a path to acceptance the mental health service would like to take; they prefer not to ‘normalize’ PTSD.

Table 5 Interview Responses – Is it ‘normal’ to have PTSD?

We’re concerned that with doing too much to mitigate PTSD and creating an environment whereby personnel are worried if they <i>don’t</i> experience some form of severe operational stress; maybe they’re not “normal”.
One of my concerns is to de-stigmatize mental health issues without causing them to be more widespread by suggestion
Some members, rather than being adversely effected by trauma, are wondering why they’re <i>not</i> adversely affected and feeling ‘abnormal’ if they’re not
Perhaps we shouldn’t have PTSD as a ‘diagnosis’; it medicalizes what’s ‘normal’. Once you’ve labelled someone you cause them damage, there is no evidence that we should be screening for PTSD.
We’ve ‘medicalized’ the treatment of mental health issues in a harmful way – normal responses to abnormal situations are difficult to define.

The most difficult aspect of conducting psychological assessments, according to all of my interview respondents from the health services side of DND, is the impossibility of

interacting with subjects without affecting them: “Mental health can’t be observed without altering it.” One respondent said that he is very careful never to tell someone that he/she is ill “because it creates a perception of illness in the person that may be unwarranted.” The treatment of operational stress is inherently difficult to track and to empirically quantify because you “can’t measure stress, so you can’t say how much better you’ve made someone.”

Treatment of operational stress relies on the ‘best practice’ knowledge obtained from the results of research associated with the disorder, which is also very difficult to conduct. The Guam experiment was a particularly challenging data collection situation, in part because the process was decided too quickly to put in place a research methodology, but to a larger extent because there was not a control group to compare the results of the experiment with. Although awareness of the potential affects of research on participants may shape research, it does not prevent it. However, one DND respondent argued that had they created a control group by sending a number of troops from Afghanistan home without routing them through Guam, they might have been accused in the press of not caring about the welfare of that group of soldiers. Others had it suggested to them that they could compare the results of the Canadians’ post-deployment transition through Guam with soldiers from another country who did not have a debriefing en route, but the experiences of soldiers in theatre, depending upon their training, their support, their missions undertaken in theatre, are so subjectively different that it is nearly impossible to isolate all of the variables present in the groups compared. Some have also speculated that, like all psychological ‘experiments’, Guam may have detrimental consequences. One DND health professional noted that female CF members returning

from Afghanistan seemed to enjoy the stopover in Guam less because they “just wanted to get home.” In spite of the difficulties associated with getting good data from the experience, military mental health practitioners both in the US and Canada are eagerly awaiting whatever findings can be taken from the Guam experiment.

DND is conducting staged interviews with the CF personnel who participated in Afghanistan operations to determine how they were affected by their experiences there and how they are integrating back into their lives in garrison and with their families. It is information that they will be sharing with their American colleagues and with members of their profession in other allied countries as they participate in international forums. The health care specialists I spoke with claimed that Canada is actually on the leading edge of much of the research that is being done regarding operational stress injury and operational effectiveness. They cited international cooperation and collaboration on research, as well as being on top of developments in the field in other countries and other regions of the world. DND and the Australian Defence Force are currently sharing information on preventive measures in coping with operational stress injury.⁴¹ DND's Surgeon General (or representative) meets annually with his counterparts from other of NATO's COMEDS for the purposes of improving and expanding arrangements between member countries for coordination, standardisation and interoperability in the medical field; and improving the exchange of information relating to organisational, operational and procedural aspects of military medical services in NATO and Partner countries (NATO Handbook, 2002). Operational stress has been determined by all NATO members to be an important concern of operational effectiveness and what NATO is fond of

referring to as ‘capabilities’. A special working group appointed by COMEDS has been doing further research and information sharing to deal with the problem across the alliance. COMEDS has only been in existence since 1994, but according to Peter Walsh, NATO has been addressing “human factors in military affairs” since the early 1960s. Perhaps NATO has had to be more cognizant of human factors because its multinational forces were for 50 years engaged in psychological warfare with the nations of the Warsaw Pact. NATO’s large multinational force conducting training exercises and operating joint headquarters would have run into some of the problems that CF leaders identified in their responses to the Meeting the Challenges survey sooner than did the UN and at the pace of military change, would have responded to them 10-15 years on.

The efforts the DND and the CF can bring to bear on the human factors of their own personnel are limited by the time and resources available to conduct research and provide treatment. The challenges are cyclical and responsive to changes in the international system and social norms and can, therefore, require considerable time and effort in confronting the obstacles of media involvement, misinformation and cultural resistance. DND’s mental health professionals are armed with a wealth of information and professional knowledge, but are hampered by a resource base that has been severely depleted by cuts in recent decades. In spite of this, they are attempting to hone systems of treatment that respond to the needs of the organization and of the individual.

⁴¹ Members of the ADF health services met in Ottawa with representatives of CF health services in November 2002 to compare approaches to mental health strategies (*The Australian Defence Force Mental Health Strategy*, 2002).

Chapter 4: The Department of National Defence – Cultural Change

4.1 Assessing the need for change

Douglas (1982) has described hierarchies as requiring a longer view and a firm grasp on tradition in order to remain cohesive. A hierarchical society is unable to adapt to uncertainty without risking general collapse. The temporal nature of risk is such that if an individual makes a commitment to the long term acceptance of risk, he assumes that the social institution will endure to enable him to reap the rewards of his commitment: “if a whole society starts to adapt to general uncertainty, its future will be stripped of anticipated returns” (p. 86). A member of a hierarchical society “expects that the same stable social system that has protected his people so well in the past will be able to do so in the future.” Therefore, he is somewhat resistant to change, engaging in processes that are remedial and serial, “only a few ideas—those best known and closest to existing programs—are given attention” (p. 93). The sub-units of the hierarchy require interaction and compromise without the imposition of an overriding goal imposed over the entire structure. The sub-units of DND: Human Resources, Health Services, Quality of Life (the individual aims of which will be discussed below), have created a plethora of initiatives to address the problem of operational stress injury, but must operate within the larger cultural framework of the institution, which by its nature is very slow to change. Some of this attention is inspired by public and press scrutiny of the very public cases of LGen. (Ret.) Romeo Dallaire⁴² and Cpl. Christian McEachern⁴³. Increased public pressure for attention to the issue has allowed professionals in DND with the desire to create change in the human dimension an opening to exert greater influence over policy.

⁴² LGen. (Ret.) Romeo Dallaire, commander of UN forces in Rwanda in 1993/94, faced ethical and leadership considerations of an order of magnitude that would challenge the moral and emotional resources of any person of integrity. He witnessed horrific acts of brutality that he was powerless to prevent and was

Several interview respondents mentioned that Dallaire was a catalyst for change: “the media attention regarding General Dallaire created significant momentum; he was the first senior officer to break the culture barrier of admitting to mental illness.” In the years since Rwanda and his public admissions of emotional and psychological difficulty in dealing with the aftermath of the operation, the pace toward change in the CF has accelerated. He was also instrumental in the Department’s creating five Operational Trauma and Stress Support Centres across Canada, which provide anonymous counselling resources for CF members. However, in spite of his being respected by many for his efforts to assist other suffers of PTSD, Dallaire is not without critics. Newspaper op-eds from other retired officers have rejected the claims that peace operations can be psychologically debilitating, citing their subjective personal experience as evidence. Recently, civilian psychologist Tana Dineen, author of Manufacturing Victims: What the Psychology Industry is Doing to People strongly criticised the “psychiatrization” of the military in a newspaper op-ed describing the damage being done by turning “such problems [emotional response to combat] into illnesses and soldiers into patients” (Vancouver Sun, February 24, 2003) . Quoting Members of Parliament who claim to be “scared to death” of operational stress injury, or who believe that being a member of the CF is not “worth the risk,” Dineen takes issue with Ombudsman André Marin’s report

accused of not taking adequate action to prevent the deaths of a group of Belgian peacekeepers. His experiences in Rwanda led to a series of widely reported emotional breakdowns, subsequent interviews, newspaper articles and a public awareness campaign of his initiative to address the psychological consequences of operational stress and trauma.

⁴³ Cpl. Christian McEachern, who began his career as a reservist, augmenting a regular force unit in Croatia and later served in the regular force in Uganda, issued a complaint to the DND and CF Ombudsman of inadequate mental health treatment. His complaint was the catalyst for an extensive study by the Ombudsman’s office, and subsequent media coverage, of ‘the problems of post-traumatic stress disorder’—the diagnosis McEachern received from a military psychologist. Also under scrutiny were the process of treatment and its consequences on the emotional well being and the career aspirations of anyone suffering from PTSD as a result of military service.

and his media appearances with General Dallaire. It is an interesting challenge to internal military processes, from a civilian observer.

As an example of heightened media attention creating a response wave of fear, Dallaire's personal tragedy and his openness about it does challenge the institution in uncomfortable ways. As a typical hierarchical institution it persists in choosing, through processes not individuals, what to pay attention to and what to ignore. His public criticism of DND's approach to mental health has subverted its normal processes of problem solving, generating resistance from those who see his individualistic approach to change in the institution as threatening to its traditions and collective memory of war-fighting and resiliency. His argument and those of his critics are based on subjective valuations of the degree of operational stress encountered in peace operations, and his vision for the transformation of the CF differs greatly from that of some of his colleagues. As part of his vision for change, he has, together with subordinates who served with him in Rwanda provided the CF and its observers with a graphic film presentation of what life in Rwanda was like for Canadian troops.⁴⁴ However, he seems to some to have placed himself outside of the culture—perhaps beyond it—since retirement. He is a role model for some members and a threat to others who see him as spreading alarmist and negative imagery about Canadian operations and life in the Canadian military.

Dealing with the stigma of weakness is one of the most persistent demons that the CF is up against in coming to terms with mental illness. It is the legacy of past wars in which anyone who succumbed to emotional duress was derided for weakness and it is a

⁴⁴ As a result of the vulnerability and inability to act that they endured, many of the soldiers deployed to Rwanda have suffered lasting, debilitating trauma, and several have committed suicide. This information is not empirically verified, but was communicated to the author by a former CF member who served in UNAMIR and who knew personally several members who have committed suicide.

side-effect of a professional culture that requires courage and fortitude, qualities considered antithetic to psychological trauma or breakdown. Douglas' pollution theory argues that the 'pollution' of a culture is caused by the introduction of elements that subvert the natural order: "When the central establishment is strong, it holds the monopoly of explaining the natural order. Its explanations of misfortune make social outcasts carry the stigma of vice and disease" (1982, p. 47). The historical record of the military's approach to dealing with mental illness is one of courts martial and firing squads, attempting to weed out and dissuade any unsuitably weak members. In the American Civil War and at the outset of the First World War it was considered cowardice and malingering and was an offence punishable by death or imprisonment. It was not, nor is it now considered an adequate defence in a military court; Cpl. McEachern's defence on the grounds of PTSD arising from his employment in CF operations was refused by a court in Edmonton.⁴⁵

By WWII psychological duress was accepted by certain elements of the chain of command, but openly disdained by others—not substantially different from today's ratio. Military institutions attempted to create the new 'normal', by showing that there is normality in mental illness, so long as it is dealt with properly in the style and process to which the institution is accustomed. Training films were prepared showing allied officers discussing 'combat fatigue' and commenting that it is possible for anyone to succumb,

⁴⁵ Madam Justice D.A. Sulyma of the Court of Queen's Bench of Alberta, Judicial District of Edmonton, ruled on February 3, 2003, that the crown had proved beyond a reasonable doubt that McEachern had assaulted a peace officer and was driving without due care and attention, but she was not convinced that he was impaired. She also drew attention in her summary to the importance of "recognizing that this disorder can and does occur in many persons as a result of traumatic experiences, it is treatable and those who suffer from PTSD can and do function well with treatment, within the bounds of the law. Further, given that psychiatrists define PTSD as a mental disorder, there should be no stigma in the Court classifying certain automatic behaviour as resulting from a mental disorder" (R. v. McEachern, 2003 ABQB 87, p. 43).

and advising that symptoms must be dealt with properly (Holden, p. 99). This approach has persisted in a slightly different guise. The film Witness the Evil produced by Maj. Stephane Grenier, who served under Dallaire, interviews soldiers who served in Rwanda regarding their experiences there and shows footage of the conditions in theatre as well as some very graphic film of the carnage wrought by genocide. It was adopted by the CF as an educational training video with the addition of an announcement inserted in the middle of the film by then Chief of the Defence Staff General Maurice Baril. The added material shows Baril, posed at the war museum in front of a UN jeep, advising anyone watching the tape that:

Post-Traumatic Stress Disorder is nothing to be ashamed of. Like so many other medical conditions it can be treated. For more information on this disorder or to get professional help, contact your base medical unit, your unit doctor or your supporting social work officer.

In spite of the helpful tone, there is still a sense in the language chosen that the soldier has contracted a disease, i.e. it is a “medical condition” that “can be treated.” Other information provided earlier in the film describes PTSD as “an ailment...a physical condition in which the chemical signals of the brain change.” The film is specifically directed at “Canadian peacekeepers who have served in difficult environments such as Bosnia, Somalia and Rwanda.” We are therefore given to believe that it is a physical ‘disease’ that one is likely to catch from peacekeeping and in spite of decades of recorded history regarding psychological casualties in warfare, the film informs us that “much about the disorder is still unknown.” What apparently is known is that it “can affect a soldier’s behaviour in theatre and once they’re home.” Leaving the poor grammar aside, with the vague information about chemical changes to the brain and behavioural affects, is it any wonder that soldiers don’t have useful information regarding mental illness.

According to Cpl McEachern, in a training exercise in which soldiers were required to simulate injuries for medical care, the soldier who received the “PTSD card, who got hit, took off his shirt, started dancing, la-la-la-la-la, like playing the crazy clown sort of thing” (p. 16).

McEachern told the Ombudsman that, in spite of his having been on more than one overseas tour, he did not know anything about PTSD: “Cpl. McEachern indicated that he had never heard of PTSD before LCdr. Passey diagnosed him with the disorder in the fall of 1997” (Ombudsman’s Report, 15). He didn’t understand what was happening to him when he would occasionally break down in tears. He felt restrained by the cultural norms of the organization not to admit to his lack of emotional control. This may have been compounded by the fact that he was a reservist who was striving to be accepted in a regular force environment. McEachern described feelings of humiliation and shame associated with his downward spiral into depression and isolation from the other members of his unit: “it’s a humiliating experience having to admit that you’re having problems and they’re adding to it by ostracizing you immediately as a waste of rations” (p. 18).

According to my research interviews, social workers and others deliver pre-deployment briefings on stress management, but the information doesn’t seem to be breaking down barriers of misunderstanding, or creating real awareness. McEachern’s feelings of being ‘outcast’ from his unit compounded his symptoms. His need for assistance was beyond the present cultural framework of the institutional approach to mental health problems. And his case has increased the pressure on the leadership of DND to create change in the CF culture with regard to its perception of mental illness.

But according to Colonel Mike Capstick (2001), Project Director Land Personnel Strategy, cultural change is something that the CF has been pursuing for some time and the shape that change ought to take has proved difficult to determine: “although there is recognition that the Canadian military is in the midst of a period of ‘profound cultural change’ there is little consensus on the definition of the desired CF culture” (p. 2). Better understanding of mental health must be part of this cultural change. However, part of the problem with creating change is ensuring that it’s not being done for its own sake and if Douglas is correct, radical change is not only improbable for an institution that bases its long term survival on continuity, but may be harmful as well to its collective identity.

4.2 Institutional change without institutional collapse

The Assistant Deputy Minister Human Resources Military, LGen. Couture has created an ‘Operational Stress Injury Steering Committee’, as a means of dealing with the recommendations of the Ombudsman’s Report on the claim of Cpl. McEachern. It is a fairly consistent representation of the Department’s problem solving mechanism, to bring representatives of all services and ‘areas of expertise’ together, to properly distribute the responsibility and the decision making processes. The Steering Committee brings together members of Health Services (DHS) and the Directorate of Human Resources Research and Evaluation (DHRRE) as well as top brass from the three services and a variety of other parties important to the process of creating change with regard to mental health throughout the military. It has met twice to date and has divided up specific research and follow-up tasks and there is great hope that it will provide the basis for future collaboration that will permeate the overall culture of the institution. They are taking the opportunity of this collective body to take the temperature of the organization

with regard to mental health and have had presentations from commanding officers regarding their perceptions of operational stress. One interview participant was dismayed to note that a young commanding officer who appeared before them had a very negative attitude toward the incidence of operational stress among troops under his command, arguing that it was inadequate screening and training that resulted in anyone succumbing to mental illness.

There is a larger impression in the organization that this particular opinion is dropping away, as the collective identity shifts to allow the inclusion of other skills and other conceptions of risk and reward. However the culture of this particular society is very much informed by its purpose and there is as much confusion within the Department and the CF, as in the Canadian general public, about what the CF is for and what its role is and how that ought to inform cultural change. Quoting from two different documents that both describe the role of the CF, Col. Capstick poses the question—as do many others—whether the two roles can coexist in the same culture 1) “to defend the nation and, when called upon, to fight and win in war;” and 2) “to protect the fundamental human rights and values that Canadians and the international community espouse.”⁴⁶ As he points out, the two statements don’t necessarily express very different cultural ideals, one can fight and win wars in defence of human rights and values, and the two statements have in common the requirement that a civilian power must determine whether it wishes its armed forces to engage in a worthwhile military operation, i.e. “when called upon”

⁴⁶ The statements of ethos are drawn from two Government of Canada documents: *Canada’s Army: We Stand on Guard for Thee* (1998) and *Minister’s Monitoring Committee on Change in the Department of National Defence and the Canadian Forces, Final Report* (1999).

and “values that Canadians...espouse.”⁴⁷ The difference that is less apparent in the two statements is that the latter requires that Canadians and the international community *agree* upon what are their fundamental human rights and values are. The military cannot determine its collective approach to risk, what is acceptable or unacceptable, what skills are required to mitigate risk, unless it feels secure in what it will be called upon to do.

Leaders will make risk assessments at a tactical level, as was demonstrated by the data on ‘mission, troops, own self’ and will communicate their preferences regarding risk whenever possible at the strategic or political level, but as many a military commentator has pointed out “the soldier in battle is not forever whispering, ‘My cause, my cause.’ He is too busy for that. Ideology functions before battle to get the man in; and after battle by blocking thoughts of escape” (Manning, 1991, p. 460).⁴⁸ The risk assessment that takes place at a very personal and immediate level in the midst of a high intensity situation, whether a negotiation or a battle, is not imbued with ideology or larger national goals, it is a personal calculation of one’s own risks and those of one’s closest comrades and/or subordinates.

4.3 Risk and trust revisited

The collective risk assessment that begins with unlimited liability is fostered and protected through a relationship of mutual reliability and trust. The trust that exists between those with the decision-making responsibility and those for whom decisions are made is essential to the functioning of the institution of the military. It may seem naïve or

⁴⁷ They imply, however, very different theatres of operations. The first implies primarily fighting at home to defend Canada from outside attackers, and the second implies projecting Canadian and international values abroad.

⁴⁸ This was written by John Dollard (1944) “studying perhaps the most idealistic Western soldiers of the 20th century, the International Brigade of the Spanish Civil War.”

romantic to assert that individual morale, the cohesion of a combat unit, and the esprit de corps of a regiment, service element or of the Canadian Forces itself rests in part on how the Canadian public judges and supports its military, how the government expresses its respect or lack of it for the institution, and how its leaders display their integrity and accountability, but these are essential elements to the functioning of the profession. And this 'romantic notion' increases by degrees the further down the chain of command one interviews. At the upper levels, where political comprehension and participation are part of the job, there is less naïveté regarding political or public support, but respect or lack of it from civilian decision makers is still felt on a personal level and its impact is felt as it affects travel down the chain of command. Young NCOs I have spoken with at CFB Petawawa, some of whom have been on multiple tours of duty overseas, have told me that they "hope that average Canadians appreciate what they do."⁴⁹

The collective approach to the risk of unlimited liability is to ensure that the entire collective has the physical and mental strength and discipline to endure whatever hardships it encounters. This is accomplished in practical terms through education, training and drill, but in terms that ensure the survival of the institution it is accomplished through the psychological resources of morale, unit cohesion and esprit de corps. Frederick Manning's (1991) analysis of these psychological resources has divided the three areas into building blocks from the individual level to the level of the collective armed force. Morale is the individual's perception of his importance in the group: "the enthusiasm and persistence with which a member of a group engages in the prescribed activities of that group" (p. 455). Unit Cohesion is the importance of the relationships

⁴⁹ This conversation took place during a Civil-Military Relations class field-trip to CFB Petawawa in April 2001.

within a small group: “the bonding together of soldiers in such a way as to sustain their will and commitment to each other, the unit, and mission accomplishment, despite combat or missions stress” (p. 457). Esprit de corps exists at the macro level in which the justification for their job must come from the larger society from which they are drawn: “Soldiers...need to have some justification, however inchoate, to legitimate doing something which few would do willingly in other circumstances” (p. 457). Manning’s article on this subject, drawing on the WWII literature of psychiatrist E.A. Weinstein (1947), makes a direct link between the building blocks of enthusiasm, trust and job satisfaction and mental health:

The main characteristic of a soldier with a combat-induced neurosis is that he has become a frightened, lonely, helpless person whose interpersonal relationships have been disrupted...he had lost the feeling that he was part of a powerful group and had become instead a lonely and frightened person whose efforts to protect himself were doomed to failure (p. 456).

Studies of the German POWs by Morris Janowitz and F.A. Shils (1948) showed that far more than ideology, unit cohesion was responsible for the ability of the Wehrmacht to continue fighting a losing cause:

When the soldier’s immediate group, and its supporting formations, met his basic organic needs, offered him affection and esteem from both officers and comrades, supplied him with a sense of power and adequately regulated his relations with authority, the element of self-concern in battle, which would lead to disruption of the effective function of his primary group, was minimized (p. 456).

While this might seem a little extreme in a description of the CF today, cultural anthropologist Donna Winslow, in her work on the Somalia Inquiry, has described the culture in the CF in many of the same terms.

...an attacking enemy becomes so threatening that the soldier’s natural fear of loneliness and death, as well as his disinclination to take life, is less than his fear of losing those who provide him safety, security, a firm sense of

belonging, affection, status and prestige, order, system and structure (p. 356).

And it is an aspect of military culture and military mental health that Land Personnel Strategy, Health Services and Human Resources Research and Evaluation are all looking closely at—although they seem not quite sure yet what to do about it.

Many of the interview respondents characterized morale, unit cohesion and esprit de corps, or some combination of those variables as important or very important to good mental health in the CF.

Table 6 Interview Responses – How important are morale, unit cohesion and esprit de corps?

It is the little things, like depression, anxiety, erosion of morale, etc. that add up over several deployments to form a cumulative strain that can cause a breakdown as a result of a single incident
PTSD is a high profile issue, but there is no way to completely prevent it. Depression and family instability are greater problems than PTSD. Unit cohesion, clear direction, clear ROE, would be mitigating factors.
Social cohesion is a very strong moderator between stress and strain.
Unit cohesion is important, but how to create it – especially with low numbers and high operations tempo, if it is truly as low as it appears to be, it is shockingly low.
Why has support eroded? Aging population, drinking is not acceptable now so they don't have that bonding opportunity.
How do we create social support, or morale?
Recruitment still depends upon the attraction of a different way of life. ⁵⁰

The interview respondent who rhetorically asked “How do we create social support or morale?” is not alone in this quandary. Col Capstick’s preliminary paper on army culture recognizes the necessity of developing “unit level cohesion and esprit de corps within the context of an appropriate hierarchy of loyalties—Canada, the CF, the Army and the

Regiment,” with a significant proportion of the responsibility for this development going, in his opinion, to the Regiment.⁵¹ But how this is to be done is not described.

4.4 Risk in the social sciences

The Department has been accused in the press of insufficient action on behalf of those suffering from operational stress injury, and most people within the Department agree more could be done, but often cite the difficulty of creating change and cultural obstacles to change as impediments to accomplishing fully, and with maximum benefit for all involved, the work they are undertaking. Professional groups within the Department approach the problem differently depending upon their perception bias with regard to the dimensions of the problem and the appropriate scientific approach. The risks associated with operational stress injury have become a moral issue in Canadian society and, as such, have become a moral issue for the Department.

Other moral issues of well being that have preceded it, which had clearer cause and effect solutions, have been dealt with successfully, because the determination of whose responsibility it was proved far easier than determining how to tackle an issue that pervades the institutional culture. The Department’s Quality of Life Directorate (DQoL), was created to respond to problems of low pay, inadequate housing and other basic needs, which it has done quite successfully. Aside from occasional flare-ups regarding uniforms and rations, the basic needs of members of the CF are being adequately met. Therefore, DQoL is now carving out a niche for itself in Human Resources at the macro level

⁵⁰ Perhaps this isn’t immediately obvious as an addition to this table, but the idea that one is joining a ‘different way of life’ is central to esprit de corps. Many new recruits still cite ‘doing something important’ and ‘being part of something larger’ as primary reasons for joining the military.

⁵¹ A study of the regular force regimental system, recently begun, is being conducted by Cultural Anthropologist Dr. Donna Winslow for the Chief of the Land Staff and the under the direction of the Project Director Land Personnel Strategy. Its results are expected in 2004.

addressing other elements of the “human dimension” within the CF. According to those studying ‘quality of life’, NCMs and COs alike want more opportunity to provide feedback into the process and DQoL wants to give them as much as possible, wanting to do far more research into the human dimension than is currently undertaken.

In their desire to minimize the institution’s risk of losing personnel to poor mental health, DQoL is distributing an extremely large research instrument. The questionnaire they have designed has approximately 185, multi-part questions and is 45 pages in length, and according to its proponents is very well received and enjoys a high response rate because of the respondents’ desire to be more substantively involved in change—although some lower ranked members also indicated that they doubt that their contribution will have a noticeable effect. DQoL is deliberately supporting the border opinions within the collective that challenge the centre to recognize dissenting opinions and learn from them. However, as the survival of DQoL is dependent upon there always being an adverse quality of life within the Department, it will focus upon mitigating all negative experiences for the individuals it researches, perhaps to an unrealistic extent.

Others who are undertaking research into cultural issues that flow upward from the individual to the centre are Personnel Selection Officers (PSOs) whose chain of command also flows from DHRRE. Many PSOs are organizational psychologists very much concerned with the morale and unit cohesion in the CF. Their primary function is to ensure that personnel are assigned to positions and operations that fit their skills, abilities and career goals and that maintain the effectiveness of the force. According to one outside observer of their field, they were originally charged with ‘screening’ in WWII and have adapted their role to a ‘post-screening’ military. The PSOs have also developed

a research instrument, the “Unit Climate Profile” a fairly lengthy questionnaire (56 questions) that attempts to collect pre-deployment, in theatre and post-deployment data (5 sets per deployment) on everything from “standard of living conditions” to “training issues” to “skin rashes or itches”. They have collected an enormous amount of data, but are currently unable to use it for much more than providing direct feedback to COs in theatre because of the concern of those same COs that the opinions of subordinates not be used to evaluate their performance. Those who have collected the data would like to be able to use it to do comparison studies across units; and they would like to distribute it up the chain of command to illustrate their concerns regarding leadership and esprit de corps issues.

Their work seems to be more closely related to the larger cultural milieu of the CF than that of psychologists and psychiatrists. They deal with the macro relationships of troops amongst their peers, troops and COs, COs and HQ, and they are up against cultural challenges in getting commanders to cooperate with their desire to use this information to create change. They are taking a ‘risk as opportunity’ approach to operational stress, seeing the feedback of individual troops as an opportunity to remedy and strengthen the institution, but they are restricted by the individual risk perceptions of the commanding officers whose performance they are evaluating. They cite problems of “positive bias” among officers toward their own skills and abilities and the morale of their troops. Some officers are willing to accept criticism of their performance and to recognize when a change in their leadership style may be necessary to generate improved morale, but others deny that such problems exist and assume that the data is flawed.

Curiously, those in health services don't seem to have such problems regarding their work. They have stated that they have very little difficulty getting COs and NCMs to buy-in to their work and their programs. There is occasional resistance to pre- and post-deployment briefings, as one respondent stated: "some know it by heart and could deliver it themselves." But, for the most part, COs and troops do not resist 'the care bears'. Perhaps it is far easier to accept that there are individual problems that their help is required to address, than to accept that they could be the cause of problems, or that they could be a contributory factor in the macro problems of the organization; and certainly it is better to be seen to be caring so long as one's own career is not impacted.

The difficulty they do encounter is in bringing their expertise to bear upon the individual. The professional risks associated with determining whether one wishes to seek the assistance of DND's mental health professionals precludes many from doing so. And the risk of doing harm by taking their services to the user, and thereby creating an impression of illness in that user, precludes psychologists and psychiatrists from being more proactive in their endeavours. One also has to wonder whether members would feel that their rights had been violated, or their career needlessly jeopardized, if they were brought in for psychiatric evaluation against their will.

Certain collaborative instruments that have attempted to bridge this gap have recently been discredited in the health sciences because they have been tentatively proved to do the kind of harm that was feared by taking the cure to the victim, i.e. Critical Incidence Stress Debriefing (CISD), which has been put under scrutiny in recent years.⁵²

⁵² George S. Everly and Jeffrey T. Mitchell, "The Debriefing "Controversy" and Crisis Intervention: A review of lexical and substantive issues," (2001); Vanessa Pupavac, "Therapeutic Governance: Psycho-social Intervention and Trauma Risk Management," (2001); Maureen Carew and Jeff Whitehead, *Critical*

CISD is the intervention of trained practitioners (whether mental health professionals or others who have been certified) immediately following a traumatic incident, in which all who have witnessed the incident are required to recount their experiences and participate in a group catharsis regarding it. Assessments of its efficacy have determined that its beneficial effects are negligible and its detrimental effects could be far greater. CISD is not favoured by all organizational psychologists in DND, but it does have more credibility amongst their ranks than among clinical psychologists and psychiatrists. This particular method of treatment could be indicative of the professional bias that exists within DND's helping professions in their attempts to mitigate the risk of PTSD. The organizational psychologists and other practitioners of CISD wish to minimize the risks to the organization by doing everything possible to forestall the incidence of psychological trauma in the first place. They are not convinced of the clinical 'over'-caution of ensuring that harm is not caused by helping. Conversely, clinicians are more likely to want to avoid making a bad situation worse in the longer term by not risking treatment that not only is not proven effective, but is potentially harmful. This is a classical philosophical and scientific conundrum regarding risk, to do nothing while waiting for further research to ensure a safe approach, or to do something because it's better than nothing, whether to announce "every possible risk as soon as it arises, or [to wait] until there is more conclusive evidence or safer alternatives...is it better to hide the risks of action, or of inaction" (Douglas, 1982, p. 27). Thankfully, on this one area of treatment DND's sub-units have managed to achieve agreement. CISD will be done when requested, and with the voluntary participation of those who wish to be involved. It has

been retained largely because it has been determined that within the military population there are also those who want something to be done to mitigate the risk of PTSD and who enjoy the catharsis of group debriefing, regardless of whether it may or may not help. And there are also those for whom denial is a valid psychological tool for self-healing and who may seek help at a later stage.

This particular agreement was arrived at through 'negotiation', but based on external knowledge. There is less willingness within the Department to trust one another's expertise across disciplines. There are those in the medical sciences side of the Department who are appreciative of the work being done by social scientists, but they don't necessarily feel that it can benefit their work. There is an opinion that is spoken of, but to which no one ever claims personally to adhere, that organizational psychologists are not 'real' psychologists. There is an equally critical opinion, but again not one ever personally held by organizational psychologists, that clinicians just want to 'diagnose' and 'cure' to the detriment of the organization.

How much research is necessary seems to depend upon one's perception of risk to the individual and the institution from mental health problems. At present the DND professionals I interviewed exhibit varying degrees of concern regarding the mental wellness of the organization, although some were more worried than others, no one was willing to speculate on statistics. That the much anticipated Stats Can survey will help determine the mental health of the organization in comparison with larger Canadian society, was a common position taken. In the meantime, clinicians remain cautiously optimistic that they are not seeing anything particularly new, just a new societal response to mental health concerns that they hope will enable them to use existing mental health

guidelines to establish new norms within the organizational culture for detection and treatment. The organizational researchers wish to detect, through further research at all levels of the organization, the prevalence of mental health problems in order to minimize the risk to the organization. Questions regarding whether enough or too much research was being done in DND with regard to mental health elicited a broad spectrum of responses from “we’re a very screened and studied population” to “not nearly enough research is being done.”

In short, there are professional biases and rivalries, but there is also occasional collaboration and information sharing. The extent to which the sub-units of the professional cultures can adapt their knowledge to creating building blocks of internal change within the organizational culture will depend upon how much trust they are willing to put in each other’s expertise and how willing they are to allow one another to fulfil a particular role within the organization. The organizational psychologists and other social science professionals require the knowledge of the individual’s reactions to stressors and the variation of response and treatment that is present in clinical psychology to understand that not all risk of stress injury can be mitigated through screening, pre-deployment training or coping mechanisms. The clinical psychologists require the input of organizational psychologists in facilitating cultural change through the chain of command, putting in place mechanisms for feedback and information sharing from ‘laymen’ to ‘experts’ in order to create a dialogue that is inclusive and helps to restore community. The clinicians can only help those individuals who they see, and they will only get access to those individuals if the overriding cultural norms of the organization are amenable to their making use of these services.

Chapter 5: Health Promotion – Negotiating a New Cultural Norm for Mental Health

5.1 A hypothesis reassessed

The aim of this thesis was to test the hypothesis that a health promotion framework, as a contribution to overall operational effectiveness, would be the best course of action for approaching mental health problems associated with CF operations. My initial hypothesis was based upon previous research, of historical and contemporary documents, regarding the stressful nature of multinational operations and on recent reports in the press and public documents, regarding the prevalence of PTSD within the CF. As will be discussed in this chapter, health promotion, in its generally accepted framework, is insufficient to respond to the problems now diagnosed as PTSD. Before the organization can approach wellness, the true nature of the mental health problems presenting must be reasonably understood and accepted by all, and the place of the unique culture of the CF as contributory in addressing wellness, better articulated and incorporated into the process.

A health promotion framework would take the approach of normalizing the problem of mental illness by creating greater ‘community’ involvement in dealing with it, promoting knowledge and personal understanding of one’s mental health and personal coping mechanisms and preventive strategies for staying mentally healthy. The impetus for this hypothesis was an article in the journal Health Promotion International by Dr.’s Bensberg and Kennedy (2002) titled: “A framework for health promoting emergency departments.” The article provides guidance for emergency departments (EDs) of hospitals to engage in health promotion involving individuals and communities in their

own preventive wellness with an aim to preventing the critical and chronic health concerns that ultimately require treatment in EDs.

Central to the idea that the model devised by Bernsberg and Kennedy could provide a blueprint for prevention and intervention in operational stress was the understanding that military health services and emergency departments both exist to “provide treatment and care for acutely ill and injured people” (p. 180). As much as any segment of the health system, EDs have an interest in ensuring the health of individuals and communities; the better they are at health promotion, the more likely they are to reduce the number of acutely ill and injured people they must treat. Similarly, the military, particularly the CF, which is chronically short of personnel, is self-interested in maintaining the health and deployability of its forces. The CF relies on volunteers to enlist and remain in the Forces long enough to repay the investment in their training and education. It can’t afford to lose them because they feel mentally and emotionally unable to continue. Most of its allies are in the same position; the number of militaries in democracies that still require mandatory service is shrinking. The motivation to enlist and the will to remain will continue to be an important concern to these democratic militaries.

There is urgent research on recruitment and retention being done in the CF, but whether they are taking into account the ongoing ability of the culture to meet the strengthening and belonging needs of many new recruits, or whether that is taken for granted, is unknown.⁵³ As my research revealed, stress as a result of combat *per se* may not be the primary mental health concern of the CF, and using health promotion to exorcise the demon of mental illness in the CF would have to start with creating a dialogue about psychological response and mental illness in all its forms, a dialogue

which would have to be culture specific creating a sense of increased strength and capability within a healthier collective force, rather than removing weak individuals.

5.2 Individualism v collectivism in health promotion

The ‘theory’⁵⁴ of health promotion, with the individual taking responsibility for his/her own wellness by being more educated and aware of the risks to health, and being more personally involved in illness prevention in self and others, may be valid in the military context. It has been established that risk of exacerbated mental illness or adverse psychological reaction as a result of a military deployment, may be reduced by self-monitoring of stress levels and/or by diagnosis of pre-existing mental health problems. As mentioned above, one of my DND respondents pointed out “psychology isn’t magic; it’s education; it’s self awareness.” However, in the CF, as in any military, individualism and looking out for one’s self erodes the ability of the organization to function. The rise in individualism in society and the erosion of social supports and unit cohesion within the military is considered to be contributory to psychological problems in the CF or, at least, detrimental to recovery. Also, in consideration of the shame attached by many—in and out of the military—to having mental health problems, being singled out as unwell is further damaging; help within the community in a culturally relevant way may be of more benefit to the individual.

An integral part of the ethos of the military is for each member to be concerned with the physical wellbeing of the others with whom he/she works closely or is charged with protecting. If this is to be stretched to include mental wellbeing—beyond what has always been done traditionally and informally—the community aspect of health

⁵³ Perhaps some of the findings from the study of the Regimental System will speak to this.

promotion has to be the stronger level of approach. Where this becomes difficult is in determining what precisely is meant by community in the CF. In the military, community is a mobile entity; it exists in garrison and in the field. It is also fluid, with members leaving and arriving at intervals, and not always with prescribed or predicted regularity and it has levels imposed by rank, trade, linguistic background, amount of experience, etc., i.e. 'community' has many levels in the CF. Making the appropriate inroads to that community is a challenge.

5.3 Protecting the force

The Department has created a Health Promotion Cell (HPC), known as "Force Health Protection", within the Directorate of Health Services, which is focusing on the preventive approach in health care. Its purpose is to work with health professionals on CF bases, training them to collaborate with health services professionals at DND and to train members in coping skills.⁵⁵ The skills associated with alleviating stress include muscle relaxation techniques, meditation and rehearsal for stressful situations. They practice scenarios that reflect the 'soft skills' felt lacking by the officers who participated in the Meeting the Challenges survey, e.g. maintain neutrality, "self talk", "reframe", they drill "how *not* to kill." The HPC wishes to approach wellness as "professional development," giving soldiers, sailors and aviators the option of having as much input to the process as possible, rather than addressing it as "fixing a weakness." However, the atmosphere created by some of the accompanying health promotion language and some of the language used in the past to address PTSD clearly suggests fixing a weakness.

⁵⁴ As a multi-disciplinary field, health promotion has difficulty espousing a unified theory, although it has tried to do so as a means of increasing its credibility in the health sciences.

Force Health *Protection* suggests that soldiers need to be protected from something, rather than their being strengthened to deal with stress as part of their job. It connotes protecting the Force from the presence of the 'at risk'. It doesn't suggest approaching the problem from a position of collective strength. Like the operational term from which it is derived, "Force Protection", it connotes safety, but also suggests that soldiers can be insulated from the various physical and emotional dangers that might adversely affect their health. There have always been non-weapons threats to health in theatres of operations, from hypothermia to malaria, but, more recently, the addition of increasingly lethal chemical and biological threats and the fluidity of the conflict zone present CF members and commanders with the need to reassess risks at the personal and tactical level on a frequent basis. Perhaps the notion that they might receive greater protection from ill health is reassuring to the contemporary soldier who feels that he may be subjected to unreasonable involuntary risks or, conversely, awareness bias may create an atmosphere of increased risk and stress, induced by political and public perception, putting the Force on edge.

Lupton's (1995) discussion of public health describes the origins of health promotion in the 19th century desire to ensure a strong work force, it was based on "environmental factors and improved living standards" (p. 62). She implies that this was a subversive manipulation of the population to keep them strong and healthy for work, rather than being healthy for its own sake. Whether it's healthy for work or healthy for some other personal outcome, as Wilder's research suggests, it is necessary for most people to have a personal reason to pursue health. What better reason than the personal

⁵⁵ Perhaps, given the Department-wide concern over the erosion of social supports, and the diminishing personal connection between senior officers and lower ranks, the skills ought to be communicated through

effectiveness necessary to ensure that one's comrades are capable of protecting the lives in their unit?

James McCormick (1994) questioned the ethics of health promotion, doubting its efficacy and considering it potentially harmful because it requires the problems of the individual to be accentuated before offering solutions, much in the way that screening for mental health problems labels illness, potentially exacerbating it or creating it, without preventing the outcomes it is designed to eliminate. The psychological consequences of taking action are sometimes as important to consider as the consequences of not taking action. And perhaps there is something slightly disturbing and ironic about a health promotion campaign that has the underlying need of ensuring that its adherents are healthy enough to exert lethal force. But if one is to voluntarily join an institution that defends through the use of force, its population must be physically and mentally capable of force; and capable of individual restraint. The philosophical disconnect reflects the larger conundrum of how to function as peacekeepers with 'force health protection', 'don't kill skills' and 'meditation techniques' within a war-fighting institution.

5.4 Naming the problem

Arguably, the root of the problem lies in the difficulty of categorizing military operations in terms of 'peace' operations and 'war' fighting in order to create political and legal determinations of what constitutes ends and means (Capstick, 2002). When, in the 1990s politicians created categories of peace operations and determined that they were, at least politically, qualitatively different from war-fighting operations, society created a political, media and cultural language and mythology around them that has given rise to and supplemented the need for force protection measures that make the

the officer corps.

desired ends almost impossible to achieve. 'Peacekeeping' has become so dangerous, that Western nations are increasingly reluctant to send troops to UN operations and are, instead, leaving peace operations to the militaries of developing nations that need the money and have large (often conscript) armies (Lynch, 2000).⁵⁶ Perhaps their populations are more willing to have their militaries engage in high risk operations, sometimes ill-equipped, poorly-trained, and poorly-led. Or perhaps they simply don't know the level of risk their forces are undertaking, or their system of governance is such that their opposition would pose no threat to the regime. In any event, military personnel of developing nations are required to accept the involuntary risk of emotional trauma as a result of presence in 'peace' operations more frequently than those of developed countries. While Canadian soldiers are being less frequently deployed into high risk UN operations.

The language employed in the Report of the Ombudsman and the film Witness the Evil associates PTSD with peacekeeping and explains that it is highly involuntary to "develop" it. It also makes use of the vocabulary of illness and disease that DND's mental health professionals tell me they wish to avoid: "PTSD is an ailment that soldiers who have served in difficult environments such as Bosnia, Somalia and Rwanda may develop. The chemical signals of the brain change." By perpetuating the disease paradigm, soldiers are still left with the impression that PTSD is something that only the weak and the sensitive succumb to. Mental health concerns in their multiple forms are not given consideration, neither is the fact that soldiers in any type of operation, not specifically peacekeeping, can experience feelings of acute stress and physical ailments

⁵⁶ "Developing nations now contribute more than 75 percent of the nearly 30,000 UN troops taking part in 15 missions around the world. The five largest troop contributors—India, Nigeria, Jordan, Bangladesh and

resulting from in-theatre experiences. Admittedly, this level of acceptance and understanding would be difficult to achieve; getting soldiers to understand and accept PTSD may be challenge enough. Advocates of greater awareness specifically of PTSD would prefer to address it first and use it as a model for dealing with other mental health problems into the future when the 'honourable' nature of PTSD has been firmly established. However, many of the low-level cumulative stressors, such as boredom and separation from family can be associated with low-intensity peacekeeping operations (that's not to say that one can't be bored in a war zone) and pre-existing mental health problems can be exacerbated by situations that are not necessarily traumatic, but are no less serious or debilitating if left untreated.

The history associated with the issue is brushed aside by such statements as those in Witness the Evil: "much about the disorder is still unknown," perhaps perpetuating the idea that environmental factors such as toxins may be the cause. Perhaps it is felt that if mental illness as a result of military service were brought completely into the light, it would impact recruitment and retention, that it would be hard to perpetuate the "Be all that you can be," image if the incidence of psychological casualties were understood by all. The Croatia Board of Inquiry (2000) revealed the limits of understanding in the CF general population of what military psychologists know about idiopathic illness and the likelihood of a somatic syndrome developing following a particularly intense military operation. The Board of Inquiry was made up of civilian and military members who heard from "experts in the field of stress induced illnesses" who described

...combat stress reaction not as a new phenomenon, but as a very old one. Combat stress reaction has been documented among veterans of conflict in other military forces of other generations. For example, records show that

Ghana—supply about 13,700 soldiers, well over a third of all UN 'blue helmets'" (Lynch, 2000, p. A36).

for over 300 years soldiers returning from conflicts have reported a mysterious range of physical symptoms....the Board has been inexorably drawn to the conclusion that the health problems many have suffered relate to the horrific experiences and conditions experienced in theatre (p. 10).

Are military mental health professionals, in the interests of force protection, keeping the information too much to themselves because their expert knowledge would not be readily understood by all? They have earned the right to be experts, but much of their accumulated knowledge is based on the personal testimony of the experiences of lay-persons, in this case average soldiers, sailors and aviators. The body of knowledge they have accumulated is the collective experiences of the members of a unique community who rely on one another's strength for protection.

5.5 Personal normality

How to work within the community with the greatest benefit for all is challenging. Cpl. McEachern's experience suggests that greater understanding and support from his unit would have allowed him to better cope with memories of the incidents he witnessed overseas. Talking with others about how he was feeling might have allowed him to deal with those feelings, to find out how others are coping with similar memories, maybe even to understand something more about the incidents themselves. However, as was pointed out in the context of the efficacy of CISD, not everyone copes better with difficult emotions by discussing them. For some, denial or avoidance of memories of horrifying things is a valid psychological mechanism for not internalizing the horror. The strongest criticism regarding CISD is that reliving the event 'embeds' memories that otherwise might fade with time. But for others, the opportunity to discuss informally ought to be part of the process. The personal uniqueness of the experience, rather than the normalization of it may be required and only those closest to that individual are likely to

know when they're coping in a way that is 'normal' for them, and when they appear not to be coping. When soldiers, or reporters or development workers return from harrowing and/or stimulating experiences, they have difficulty recounting them to their friends and families. Only others who have experienced the same circumstances can truly understand the stories associated with them, or the lack of stories, the desire just to invoke a place or an incident with a few words and hear the response, "I know what you mean."

The results of this study support the recommendation that organizational norms in DND and the CF could in some ways be changed and in others regenerated to respond to mental health issues. Such measures would bolster the operational strength of the CF. The results also provide insight into the ways in which changes in Western culture and subsequent cultural approaches to risk are affecting the ability of the CF and other Western militaries to respond tactically in war zones. They are required to adjust their tactical responses to include greater political awareness, more precision, improved ability to track the movements and intentions of multiple factions in the conflict zone. The kind of decision making ability that previously might have been expected only at the officer level is being encouraged in all ranks. Furthermore, it is a requirement not only of the new risk environment, but also of the high technology work environment associated with new military equipment. And the expectation of a smarter force is the reality for a military that considers itself 'professional' and is drawn from a society that encourages higher education as a means of remaining competitive in the work force. But with the PERSTEMPO currently experienced by members of the CF and the reduction in resources throughout the Department in the past decade and a half, it is difficult to see how anyone can respond to these new educational demands.

The Force Health Protection cell wishes to address the issue of 'work/life balance' and the impossible demands placed upon the CF members by the currently unsustainably high level of PERSTEMPO and the changing demands of the profession. They wish to communicate to the senior leadership of the Department that 'unlimited liability' does not mean being worked to exhaustion in peace time. It is an aspect of health promotion education that is worth communicating.

There are aspects of the profession that have changed dramatically over the course of the post-Cold War period and there are aspects of the profession that are seemingly unchanged and unchangeable over time. It is within this nexus of past, present and future cultural forces that the DND health promotion cell must do its work. It must find the appropriate means of communicating mental health to a timeless culture facing modern challenges. Very likely it would be beneficial to soldiers to be more aware that the history of warfare contains the stories of courageous officers who also were unable to cope with the ongoing stresses of battle:

Lieutenant-General Sir Thomas Picton was reluctant to serve on the Waterloo campaign, and his letter to Wellington paints a sad picture of a man exhausted by the strain of command in an era when generals shared the risks of close-range battle with their troops. 'My Lord,' wrote Picton, 'I must give up. I am grown so nervous that when there is any service to be done it works upon my mind so that it is impossible for me to sleep at nights. I cannot possibly stand it, and I shall be forced to retire' (Holmes, p. 255).

And more recently:

I wasn't frightened either. I knew we would probably die if the shooting started, but I wasn't worried about it at the time. My mind was going a mile a minute, planning, assessing and observing. I didn't have time to worry.....As the excitement wound down later in the day, I went to sit on my bunk. The adrenaline high was wearing off and I began to have the shakes. I got really cold and curled up on my cot. Suddenly the fear hit me. I nearly felt like throwing up (Davis, 1997, p. 188).

Mental health professionals are justifiably concerned about the trend toward PTSD as a 'badge of honour', but perhaps, as advocates of this approach suggest, it provides an opening for addressing the issue in a culturally relevant way. Honour and glory are elements of the military identity that have been somewhat subsumed by neutrality and work/life balance. One interview respondent felt we should "honour our warriors more." Perhaps re-establishing some of the mentoring traditions between senior members who have helped to shape that heritage and junior members wishing to become part of it would strengthen the identity in ways that would allow other opportunities to demonstrate honour. Instead, military identity is being compartmentalized by operational descriptors such as 'war fighting' and 'operations other than war' and 'peacekeeping'. Another respondent speculated that we wouldn't see an outbreak of "Afghanistan Disease" among soldiers of JTF2, not because they are stronger or braver, but because of their much higher morale and unit cohesion, but this is rumoured not to be the case. The military identity is large enough to encompass sensitivity and bravery, neutrality and ferocity—if the rhetoric of the new soldier-statesman is to be believed. The 'vulnerability of warriors' may be the incongruous connection required.

Conclusions:

Today's Canadian Armed Forces recruits are entering an institution that is in a state of transformation, imposed by changes in the international system, resource constraints and a strained public and political relationship—but as a cultural and political institution, change is its natural state. That its ongoing transformation fills observers and participants with angst, regarding its identity and its ability to survive, is perhaps simply proof that it is a *Canadian* institution. The new recruits who join its ranks will blend their identity with that of the larger institutional culture; it becomes a reflection of their Canadian-ness, their regional identities, their gender, socioeconomic background, skills and ability to learn and innovate, as they in turn absorb its culture and ethos.

Canadians tend to identify themselves more by what they are not, than by what they are, and in the case of the Canadian military, more often than not, it is defined by what it is *not* capable of, rather than by its capabilities.⁵⁷ The impression recorded by former Airborne officer James Davis (1997) of his time in the CF was of an army that, because it was generally lacking in the latest technological advancements, had to innovate and was the more creative and skilled for it:

Typically, Canadians make up for their lack of sophisticated equipment with sheer aggression. Americans tend to prefer to hold back and let the technology do the work for them. When we combine this with encouraging initiative at the lowest levels, we have a formidable force. Also, we aren't slaves to tactics. All levels of commander are encouraged, within limits, to think and plan for themselves. A Russian general once wrote of Canadians

⁵⁷ The CF's 'capability gaps' and 'capability deficiencies' are frequently pointed out in the media by defence lobbyists and reporters; their identification is also part of the capability-based planning undertaken by DND to determine where to allocate limited resources.

in a Soviet military journal, “The Canadians are difficult opponents; they seem to have no desire to follow their own doctrine” (p. 60).

The CF is an institution that is more than the sum of its parts, and as it struggles through the process of becoming, in response to civilian value shifts, political pressures and internal structure and ethos transformations, it reassesses its collective approach to risk.

Embedded in the ethos of military risk-taking is the acceptance of ‘unlimited liability’: the willingness to risk death for the protection of the lives of others. However, as was discussed in Chapter 1 of this thesis, Canadian civilians, along with other Western populations, have so distanced themselves from acceptance of illness and death that they have subconsciously rejected the military’s unlimited liability clause in an expectation of casualty-free military operations. When Canadian values coincide with ‘peace operations’ the risks they are willing to have their military personnel accept are low and therefore the outcomes must be benign. Canadians’ desire to spread the fruits of Western culture around the globe has allowed the government to mandate CF members to extend their efforts at protecting the lives of others to include not just the Canadian other, or the European other, but the African, Asian and South American other as well. The civilian population is increasingly demanding that its military personnel respond to the suffering of people wherever it is occurring. LGen. (Ret.) Romeo Dallaire exhorts the Canadian people and the Canadian Forces to respond to “the suffering of all humanity,” in spite of the suffering that just such a response has caused him personally and those he has served with (Dallaire, 2002, p. A13). It is a call to arms that responds to the values of most Canadian civilians, but as General Dallaire knows, their desire to respond to the suffering of all people must be backed up with political commitment and clear, decisive objectives.

As discussed in Chapter 2, many CF leaders have determined that they are lacking in the political and intellectual skills that would enable them to function as negotiators and 'peace-builders' and that they will require additional training and resources if they are to accept the risks, to their troops and themselves, that come with these new missions. Political responses to the dangers of peace operations, of concealing the risk and demanding from commanders impossibly high levels of risk reduction have created gaps in trust and credibility within the CF command structure. Where there is unrealistic risk assessment, there is the desire to determine blame for the consequences of unplanned and seemingly involuntary consequences. The institution itself is put at risk in attempting to accomplish a mandate for which it is neither culturally prepared nor trained.

An individual in an organization that is structured on cohesiveness, trust and responsibility requires social and institutional supports to deal with the most personally challenging aspects of life within that institution, including psychological dysfunction. Chapter 3 of this thesis provided analysis of the relationship of the individual with the sustaining elements of the institution. It was explained that coping with debilitating risk and possible psychological consequences is a problem for the CF that is as old as the institution. Facing this problem requires the use of all available professional knowledge in the field of mental health practice as well as ongoing methodological change. However, in order for that methodology to be successful, the contract of mutual risk acceptance between the individual and the institution must be honoured by both parties. If the individual is willing to gamble his future on the continuity of the institution, the institution must be willing to accept and support him throughout his career. Some commanders have accepted the virtual inevitability of mental illness in the large and

diverse population of the CF and have factored psychological risks, to themselves and those under their command, into their revised risk assessment; while others are still unsure how to assimilate information regarding psychological risks. The organization itself must determine how far down the path of acceptance to travel before it endangers the institution by eroding its cultural foundations.

Chapter 4 discussed means of coping that are inherent to the profession and are being explored in various ways by mental health professionals in the Department. Limited resources and professional disjunction regarding the most efficacious approach have created barriers to change within the organization. Individuals who would create radical change are opposed by others who are fearful of and resistant to change. The nature of the organization itself makes it inherently risk averse to cultural upheaval. As a hierarchy, built upon conformity and collective identity, the CF relies on its collective memory and unified vision of the future to ensure its longevity. If it departs too far from those norms, it risks becoming unrecognizable to those who have joined with a desire to live and work within those collective values.

If strength and resiliency are central characteristics of the institution's professional identity, its members must reassess the meanings of 'strong' and 'resilient' and the values attached to those words if they are to accept psychological risks within the norms of their professional risk assessment. Chapter 5 discussed the ways in which a health promotion framework could assist in creating a dialogue that would bridge the gap between the vulnerabilities of the individual and the strength of the collective. Acceptance of the risks associated with new missions, requires the acceptance of the full spectrum of emotional and psychological response among the men and women who

comprise that collective identity. If the institution is a cross-section of society, it cannot expect that its members are capable of resisting the normal emotional and psychological response of that society. Therefore, it must make a new assessment of normality, but one which honours and upholds the traditional strengths of the organization. The needs of individuals must be openly supported within the culture of the institution, while recognizing the previously unsurpassed external influence on individuals of the tide of information regarding physical and mental risks emanating from the popular media.

Competing media and 'expert' opinions of the myriad hazards that face civilians and military members alike put excessive emphasis on blame, they disregard previous assessments of normal response in favour of identifying involuntary hazards that impinge on the otherwise truly safe, hazard-free environment that they believe technology ought to afford us. DND health services professionals put out fires from media information, which often employs vague pseudo-science with regard to military issues. Psychology is one of the professions most likely to suffer from the ministrations of zealous amateurs and well-meaning hobbyists, who seek out media attention. The media storm about PTSD may simply be another wave of temporary interest directed toward the CF prompted by attention paid to news-worthy cases, while the true problem must be addressed by the mental health and social science professionals within the institution, who are themselves under suspicion of not providing adequate care. Perhaps we are also defining the CF's mental health services by those they are unable to help, rather than those they succeed in helping.

There are policy implications for the Department of National Defence Health Services that are discussed in this thesis. It can be concluded from the material presented

here that the methodology of mental health practice in the Department of National Defence suffers from conflicting levels of analysis: the organization and the individual. Its practitioners have differing beliefs about the efficacy of various methods of prevention, intervention and treatment. Many of them generally agree that there is only so much that can be done to prevent psychological distress in military operations, but in the areas where there is agreement, the mechanisms for collaborative action are weak. Some of the specific observations of this thesis, regarding psychological methodology as pertains to operational stress injury, are that screening is of little use, treatment methods are imperfect and cures difficult or impossible to measure. Coping skills and awareness of self and others are important and potentially very useful—it's hard to be sure—but needlessly alarming members with tales of psychological breakdown is unlikely to be helpful. Openness regarding potential environmental hazards may reduce suspicion and fear regarding risks, or it may serve to heighten 'awareness biases'. In sum, very little is certain, but everything is certainly being tried. What is missing is intra-institutional trust and collaboration.

The larger International Affairs implications of the heightened risk perception of mental health problems in the Canadian Forces, as the focus of this thesis, speak to the cultural and political dilemma facing Canadians: what do they want their military to be and what do they expect it to do? Canadians demand impossibly high levels of risk reduction from their government and their military in their attempts to make the world safe for democracy and Western values. They are no longer willing to accept illness or death and consider that anyone who becomes ill or dies a victim of someone's negligence. Troops are put at physical and psychological risk by the fluid moral and

political environments they are operating within, but that is not to say that they don't wish to be there. Many of them have enlisted with the desire to be part of something important, to belong to an organization that represents their values and ideals, and the values of the population they have volunteered to defend. They have staked their future on the longevity of the institution and they are willing to accept its risks if the institution is willing to train them and support them in ways that enable them to operate in a high risk environment. They experience this risk as a requirement for new and different skills, that they are challenged by lack of time and resources to acquire. From the opinions of officers provided in the Meeting the Challenges survey, it appears that they are being expected to already have these skills. In addition to being invulnerable and able to win wars when required, they should also be capable of creating peace where political leaders have failed to do so.

There are leaders in the CF who are unwilling to accept this assumption. They are willing to enforce peace if given a strong mandate for force, but do not believe the CF exists to solve the world's intrastate conflicts. Their personal risk assessment is for a realist comprehension of the objective hazards of interstate warfare. For them, the potential for mental illness exists only in the weak and vulnerable; the use of the institution as a global police force to solve the world's problems has created mental health problems where they did not exist before. As obstacles to change, they would limit the ability of the institution to become collectively stronger because they would employ methods that have been proved ineffective to try to remove 'at risk' elements from the organization. They would use the traditions of the organization as a barrier to change, rather than employing them as a means of strengthening and sustaining the community.

Creating a healthy, resilient Force one member at a time is unrealistic and contrary to the basic cultural precepts of the military collective, but attempting to remove any 'at risk' elements so they do not weaken the collective is also untenable. Accepting that most every human being has his/her point beyond which optimal mental functioning is possible and using every method available to forestall arrival at that point (many of which have been discussed herein), is all that can be expected. If that point is reached, the cultural and knowledge resources of the institution must close-ranks around that member to assist him/her in regaining mental and physical wellness.

If CF members are to undertake the protection of the world's vulnerable as well as one another, they need the material, intellectual and emotional tools for that very complex job—for which the parameters have not yet been clearly defined. The circumstances of soldiering in the 21st century may involve fewer objective hazards, but subjective hazards abound. The risk to the mental health of CF members has perhaps increased in certain circumstances, but it is more dependent upon preparation for the task and clarity of objectives than political definitions of 'peace support' and 'war fighting'. The profession of arms has always been and will remain a high risk occupation with physical and mental hazards that are subjective and unpredictable. It is profession with the potential for great rewards and great sacrifices, within which one can hope only to remain as healthy as possible, under the circumstances.

Appendix 1: Interview Questions

1. How have you come to be working in this area and how does your work relate, directly or indirectly, to the study of operational stress in the CF?
2. What is your view of the severity of operational stress, specifically combat stress reaction (CSR) and post-traumatic stress disorder (PTSD), in the CF?
3. Could you describe any unique characteristics of CSR or PTSD that are associated with post-Cold War or UN peace operations?
4. What steps are the DND and the CF currently taking to address the issue of CSR/PTSD?
5. In what way does the work you do contribute to the DND's efforts to address CSR/PTSD?
6. What other work, by other agencies or departments, is being done in DND and the CF in this area?
7. How does your work contribute to or complement that being done by other departments or agencies in DND/the CF?
8. What has been your experience working with commanding officers to implement the research and/or programs you've initiated or the work you're directed to do?
9. If you work directly with non-commissioned members, what has your experience been in working with them to implement the research and/or programs you've initiated or the work you're directed to do?
10. The stigma of weakness associated with CSR is cited as a formidable obstacle in overcoming resistance to treatment in the CF. Have you seen evidence of this, if so, at what levels?
11. Studies in CSR and PTSD have described preventive methods. What is your view of the potential of preventive training or treatment?
12. Recent studies regarding CSR and PTSD caution against Critical Incident Stress Debriefing. How effective do you think CISD is in treating personnel who have experienced traumatic incidents in the course of an operation?
13. If you were to be given free rein to implement mental health programming for CF personnel, what approach would you consider?
14. What obstacles are there to realizing this program?
15. How closely does a health promotion framework (see attached information) approximate the vision that you might have for the provision of mental health services in the CF?

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