DND photo AR2006-P005-0011 by Sergeant Lou Penney

FROM COMBAT STRESS TO OPERATIONAL STRESS: THE CF's MENTAL HEALTH LESSONS FROM THE "DECADE OF DARKNESS"[1]

by Allan English

Introduction

Today, the care provided for members of the Canadian Forces (CF) and veterans who experience mental health problems as a result of military service is arguably as good as it has ever been in our history. This enviable situation came about because of many improvements to the ways the Department of National Defence (DND) and Veterans Affairs Canada (VAC) treat those with mental health problems, based upon lessons learned from the 'Decade of Darkness' – a time in the 1990s when the CF's reputation in this area was at a historic low.[2] The publication in 2000 of the findings of the Croatia Board of Inquiry (Croatia BOI) was the catalyst for many of these changes. It drew public attention to the shameful way Canada treated its wounded service personnel, suffering from both physical and mental wounds, in economically challenging times. Together, these changes resulted in a paradigm shift in how those suffering from mental health-related problems were dealt with by DND and VAC.[3] The adoption by the CF of the term "Operational Stress Injury" (OSI), to encompass a wide range of mental health issues, and to reduce the stigma associated with mental illness, was symbolic of this paradigm shift, and it represents the progress made in addressing these issues.[4]

However, the CF and veterans may be facing a new decade of darkness, as ominous economic circumstances and declining government support for the military have already reduced funding to all government programs, but especially defence - the government's largest discretionary expenditure.[5] This is to be expected, given the cyclical nature of public support for defence spending in Canada and that fact that, "Defence policy will receive, except in emergencies, what funds that are available and not funds white papers and rational strategies and commitments demand..."[6] These cuts have already affected both serving members' and veterans' health programs.[7] Furthermore, these cuts only address the current deficit in government spending, and it is widely recognized that, in the face of future efforts to reduce the national debt, current long-range defence spending plans are "unaffordable."[8]

Yet, while budgets decline, the incidence of OSIs among veterans receiving disability benefits from VAC has been increasing steadily since the late-1990s. A 2011 Parliamentary report noted that "… three quarters of the veterans taking part

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in VAC rehabilitation programs following their release for medical reasons are suffering from mental health problems," and over the next five years, it is expected that "… at least 6,500 (26%) of these new veterans will suffer from the consequences of an operational stress injury" and "… at least 2,750 (11%) will suffer from a severe form of PTSD."[9]

Therefore, to ensure proper long-term support for members of the CF and veterans, we must consider mental health issues in the wider context of having adequate resources to provide proper care in the future. This article will argue that considering these issues in an integrated and systemic fashion is critical to ensuring that the progress made in standards of care is maintained. It uses lessons from the past, especially those from the Decade of Darkness, to see how they might guide decision makers now and in the future in formulating policies related to military and veterans' mental health.

Perceptions of Mental Illness

The policy responses to the changing challenges of dealing with military stress casualties often appear in cycles with a number of phases. If we understand where we are in each cyclical process, we have a better chance of dealing with the different challenges that we find in each phase. Before describing these cycles, it is important to understand that the course of each cycle is affected by diverse perceptions of mental illness, which are influenced by factors such as: 1) explanations for causes of sufferers' symptoms; 2) national culture; and 3) the economic situation.

Explanations for the causes of illness have varied over time, and are, in part, cultural issues, since various societies at different times in their history have had many explanations for the causes of sickness, for example, organisms like bacteria, bad luck, divine retribution for misconduct, carelessness, and character flaws. Not surprisingly, whenever injury and illness among military personnel are perceived as being due to personal failings of any kind, support for military and veterans' health care decreases.[10] This is particularly true of psychological disorders like OSIs, which, even today, are often attributed to personal weakness or "lack of moral fibre."[11]

Under the heading of national culture, three factors can be highlighted: perceptions of the military in a society, perceptions of the conflict in which injuries occurred, and perceptions of how military personnel and veterans are being treated in relation to others in society. Extremes of perceptions of the military in a society can be illustrated by these contrasting views held by two prominent Canadian politicians, Sir John A. MacDonald (Canada's first prime minister) and W.F. Nickle (Kingston's Member of Parliament 1911-1919), respectively:

- …'regulars' are useful only for hunting, drinking and chasing women…they are soldiers because they are no good at anything else.[12]

- …this war has clearly demonstrated …that the hero is to be found under practically every jacket…[13]

It does not take a great amount of imagination to deduce how each man might differ in his views on the allocation of resources to military and veterans' health care.

Resource allocation is also related to society's perception of the conflict in which military injuries occurred. For example, Canadians today are much more sympathetic to compensating military personnel injured in operations in Afghanistan than they were to compensating those who were disabled as a result of service in Somalia or in the Former Yugoslavia in the 1990s.[14] However, perceptions of any given conflict can change over time as new interpretations of conflicts appear, or as the demographics of a society change.[15]

Lastly, perceptions of how military personnel and veterans are being treated in relation to others in society have also been an important factor in determining levels of public and government support for them. For example, between the First and Second World Wars, the annual cost of veterans' programs and pensions was the second-largest government expense, next to servicing the national debt. Furthermore, by 1939, in trying economic times, those outwardly uninjured veterans pensioned in Canada for "shellshock" represented 50 percent of the more than 70,000 veterans receiving pensions, causing many to think that veterans' pensions were too generous.[16]

In difficult economic times, comparisons will always be drawn between health care resources allocated to injured veterans and similar resources available to civilians, and the factors just discussed will influence how Canadians judge any discrepancies.

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Dealing with OSIs

I will now examine two models that can help to explain how Canadians perceive, and, therefore judge the funding of programs for those with OSIs. They are the *response cycle model* (awareness of and handling of stress casualties) and the *systems cycle model* (how stress casualties are handled from an organizational systems perspective). I characterize these models as cyclical because, over time, the phases of each cycle tend to repeat themselves, as we shall see.

Response Cycle Model. The first cycle is one way of describing how organizations respond to mental health problems in military personnel. This cycle has four phases: 1) "blissful ignorance," 2) awareness of the severity of the problem, 3) debate over how to handle the problem, and 4) implementing standardized procedures for dealing with the problem.

The first phase, which I call "blissful ignorance," is a period where there is no real awareness of the unique challenges of dealing with mental health problems in military personnel, and civilian models of diagnosis and treatment are the norm. Early during the First World War (1914-1915), those who could not cope with the mental strain of combat in the British and Canadian armies were often diagnosed as suffering from "hysteria," a disease believed to occur most often in young women, and thought to be caused by a lack of will-power, laziness, or moral depravity. Casualties were treated as they would have been in a civilian clinical setting. They were evacuated to Britain, where, given "rest and sympathy," and, while symptoms disappeared in some, most ended up institutionalized, and then became chronic cases.[17]

A similar situation occurred in the period 1990-1995 as most militaries, including the CF, believed that the only 'legitimate' stress casualties were those whose condition could be directly attributed to conventional combat. This was reflected in the terminology in use at the time to describe stress casualties, which was "combat stress reaction" (CSR).[18] In the 1990s, it was assumed that there was a clear distinction between *combat* and *non-combat* missions, and all CF operations at the time were considered to be non-combat, what the US military dismissively referred to as Military Operations Other Than War (MOOTW - pronounced "*moot*-wah"). When senior military leaders, like the Chairman of the US Joint Chiefs of Staff, declared, "Real men don't do moot-wah," the status of these operations was made clear to all.[19] Consequently, many believed that the nation had little or no responsibility for those injured on "non-combat" operations. This led to situations where even those who had suffered severe physical injuries received little official support. For example, Canadian Major Bruce Henwood, who lost both his legs below the knee as a result of his vehicle striking a mine in Croatia in 1995, was initially denied adequate compensation because his injuries were sustained on what was believed to be a benign peacekeeping mission.[20]

Another outcome of the assumption that the CF was not engaged in combat meant that there was little support for research on mental health issues related to CF operations. The resulting state of "blissful ignorance" was articulated by a Senate report on OSIs in the Decade of Darkness: "People conclude that since there is no data, it is questionable that PTSD exists."[21] Today, the CF acknowledges that OSIs can result from many types of military missions, from 'peacekeeping' and 'peacemaking' operations, such as those in the former Yugoslavia, Somalia, and Rwanda, to domestic operations, like Operation *Persistence* (Swissair 111body recovery).[22] Nevertheless, debate over the meaning of OSI appears to be ongoing as a clear definition, found on the Chief of Military Personnel website (and other CF websites) as late as September 2011, has now been removed. This leaves a number of different possible definitions available on the internet.[23]

The second phase of the cycle, awareness of the severity of the problem, normally occurs after some event draws public attention to the military stress casualties in a dramatic way. In the First World War, this phase began after the first Battle of the Somme in July 1916, when "several thousand soldiers" were withdrawn from battle due to "nervous" disorders, and most were permanently lost to the military because the civilian models of treatment that were used at the time proved largely ineffective in a military context.[24]

W.I. Castle/Canada. DND/Library and Archives Canada/PA-000912

Wounded Canadian soldiers en route to a dressing station via light railway, September 1916. The strain of combat is telling.

CFJIC PL-15626

Dinner being served to Canadian fighter pilots in the Middle East after a hard and trying day, 21 February 1943. Again, the fatigue is self-evident.

Real awareness of the severity of the problem in the Decade of Darkness era began in 2000 when the Croatia BOI reported that those who participated in the deployments under investigation suffered from certain stress-related illnesses at rates at least three times higher than those found in the Canadian population.[25] With public attention drawn to this issue, as well as the issue of the deplorable treatment of injured CF members, the stage was set for the next phase of the cycle.

A widespread debate over how to handle the problem often occurs once decision makers acknowledge that something must be done. In the First World War, debate in British Commonwealth forces over how to deal with stress casualties started in earnest in 1917, although concerns with respect to treatments used had been voiced early in the war, when "… the idea that the *British* soldier or 'hero' could not possibly show 'mental' symptoms" was raised [emphasis in original].[26] The medical community then engaged in a lively debate over the merits of various treatment regimes in competition for attention and resources. This situation was not resolved satisfactorily, and the lack of consensus among medical personnel and policy makers was reflected by official use of the term "Not Yet Diagnosed - Nervous" (NYDN) among Commonwealth forces from about 1917 until, at least, the middle of the Second World War.[27]

There is a similar, and ongoing, debate over the best ways to deal with OSIs. This debate reflects discussions in the civilian sphere about what should be included in the latest edition of the 'bible' of mental health (now in draft form – the Diagnostic and Statistical Manual of Mental Disorders (DSM) V), which spells out accepted definitions and treatments for mental illness.[28] While attentive to the debates in the civilian sphere, armed forces have sometimes eschewed civilian standards of treatment and created their own systems of dealing with those suffering from OSIs, based upon military needs and practices within the profession of arms, of which health care providers in uniform are members, according to Canadian doctrine.[29] If consensus about dealing with military stress casualties is reached, the final phase in the cycle may be achieved.

This fourth phase, implementing standardized procedures, is an ideal that is not always reached. It implies that within a military force there is an accepted process, both medical and administrative, for dealing with OSIs. For example, despite the inability of the medical community to reach consensus about diagnosis and treatment of stress injuries during the First World War, British and Canadian military medical authorities implemented a simple but effective forward treatment method for dealing with soldiers exhibiting signs of "shell shock." This system represented agreement on the immediate treatment of stress casualties, even if the nomenclature and causes of psychological disorders among military personnel were still a matter of debate.[30] Despite the existence of a relatively coherent and co-ordinated framework for dealing with stress casualties in the Canadian Expeditionary Force in 1918, by the time of the Decade of Darkness, much of this acquired knowledge had been forgotten.

CWM 19710261-2079 Beaverbrook Collection of War Art Canadian War Museum

Exhausted Canadian infantry near Nijmegen, Holland, late in the war, by Alex Colville.

It was only after a public outcry about the treatment of wounded soldiers and veterans, particularly those suffering from OSIs, during the Decade of Darkness that the CF began to rediscover many of the lessons of 1918, which led to the current CF system for dealing with OSIs.[31] While neither the 1918 system nor the current CF system could be characterized as perfect, they *were* and *are* a great improvement upon the chaos that had reigned in dealing with OSIs prior to their implementation. However, in order to devise effective responses to mental health problems in military personnel, policies must be based upon an integrated personnel sustainment system.

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Personnel Sustainment Systems Cycle Model

In 2002, it was estimated that the cost of recruiting, selecting, training, and preparing a single CF infantry soldier for operations was $315,000.[32] This gives an idea of the magnitude of the financial cost of preventable personnel losses, not to mention the future costs to society of caring for veterans and their families if they cannot lead fully productive lives following military service. The personnel sustainment cycle model (see Figure 1) is one way of seeing this issue from an organizational systems perspective, encompassing the creation (selection and training), employment, conservation, and recycling (re-employment) of military forces.

Figure 1 - Sustainment Cycle Model

In order to successfully optimize personnel sustainment, military organizations must address all parts of the sustainment cycle. Unfortunately, most militaries usually treat personnel issues as 'stovepipes,' and rarely use an integrated system to manage effectively all aspects of personnel sustainment, let alone OSIs.[33] And from a wider national perspective, if those released from the CF cannot lead productive lives in the civilian sector, they may require significant public financial support. Therefore, as a government department, it behooves DND to take a holistic approach to these issues to ensure that even if someone cannot remain in the CF, they will be able to contribute to society after leaving the military.

To illustrate the personnel sustainment cycle from an OSI perspective, examples primarily from the Royal Canadian Air Force's (RCAF) handling of "flying stress" casualties during the Second World War, and the CF's handling of OSIs in the past 20 years will be used. There are generally three approaches that we find to address OSIs from this perspective – disciplinary, medical, and systemic. The first two represent the 'stovepipe,' or uncoordinated approach.

Organizations typically see OSIs first as a disciplinary problem where certain individuals are singled out for punishment or released from the military, for example in the Second World War demoting or sending to punishment barracks Commonwealth NCO aircrew, and releasing officer aircrew deemed to have a "lack of moral fibre."[34] During the 1990s, those with stress-related illnesses were often released from the CF, based upon a belief that their behaviour was the result of a character defect. Others were punished, either formally or informally.[35] However, the disciplinary approach leads to avoidable losses in the personnel sustainment cycle, as conservation and re-employment of personnel is not a priority during this phase.

When the disciplinary approach fails to reduce the number of stress casualties, organizations often assume next that this is purely a medical issue to be dealt with principally by health care professionals. The medical approach normally has some positive effects upon individual health outcomes, but if medical treatment is not closely co-ordinated with all other phases of the personnel sustainment cycle, personnel losses often continue at unsustainable rates, with many being discharged who could be usefully employed in some capacity.[36]

The last approach (if it is reached, and often, it is *not*) has stress casualties dealt with as part of a holistic personnel sustainment system. For example, the creation in 1944 of the RCAF Reselection Centre, with a Special Cases Committee to examine the files of all aircrew removed from flying duties for what was often referred to as "flying stress," in combination with other administrative measures, led to a significant reduction in personnel losses due to mental health issues. Many of those previously discharged were gainfully employed, and this helped to mitigate a serious shortage of aircrew.[37]

The key to the effectiveness of the systemic approach is that senior decision makers must maintain oversight over all aspects of the personnel system to ensure that the various parts of the system are working in harmony and not at cross purposes.

DND photo IS2005-2024a by Sergeant Frank Hudec

main areas of inquiry – mental health issues among the troops.[40]

This experience shows that all those involved in military personnel policy making must stay abreast of the latest findings in defining and dealing with mental illness. In so doing, they can avoid both the "blissful ignorance" and the "awareness of the severity of the problem" phases of the response cycle, thereby enabling them to move expeditiously to the "debate over how to handle the problem" and the "implementing standardized procedures for dealing with the problem" phases. But even if awareness and standardization are attained relatively quickly, the effectiveness of dealing with OSIs will be limited if they are not managed systematically.

Lessons from the Decade of Darkness

I see four key OSI-related lessons that emerge from the Decade of Darkness. These lessons are actually *old* lessons, but they had been largely forgotten by the end of the 20th Century. They are presented here in the hopes that we will not have to learn them again as the CF and VAC face the mental health challenges of the post-Afghanistan era.

Lesson #1- Establish Consensus Quickly. One of the most difficult challenges for armed forces is to reach an internal consensus with respect to how to define and deal with OSIs. For over 300 years, similar symptoms have been observed in those military personnel with mental health problems, but they have been interpreted differently.[38] Studies in the field of cross cultural mental health have become increasingly influential in shaping our understanding of this phenomenon. Some pertinent findings are that: all mental illnesses are influenced by cultural beliefs and expectations; the expectations and beliefs of sufferers shape their symptoms; the expectations and beliefs of clinicians shape their diagnoses; and national and group cultures feature prominently in how a society defines 'abnormal' behaviour. These factors have a direct impact upon shaping responses to mental illnesses, which affects the outcomes for the sufferers.[39]

During the 1990s, we were in a "blissful ignorance" phase regarding OSIs. It was believed that behavioural disorders in military personnel had physical causes because, in the absence of traditional combat missions, the symptoms clearly could not be a "combat stress reaction." Therefore, when the Croatia BOI was convened, its explicit mandate was to discover the physical causes (expected to be environmental, like contaminated soil) that were presumed to be the source of the troops' illnesses. However, by the fall of 1999, scientists had told the Board that there were no discernible physical causes for the illness. The Chair of the Board then used an obscure paragraph in the BOI's terms of reference, which allowed it to examine essentially anything that it might consider relevant, to shift the attention of the Board to what then became one of its main areas of inquiry – mental health issues among the troops.[40]

Lesson #2 - OSIs are a Systems Issue. Ensuring that OSIs, as a force health protection issue, are addressed systematically remains a challenge for policy makers.[41] And dealing with OSIs dispassionately is perhaps an even greater challenge for them because of the cultural and social issues surrounding these injuries to the mind. Stigma remains a major barrier to dealing with OSIs *systemically* as a force sustainment issue. And yet, with the all progress made in treating diseases and injuries with physical causes, OSI casualties are potentially the greatest source of *loss*, and, therefore *savings,* in the personnel sustainment cycle.[42] However, even if OSIs are recognized as a systems issue, success in dealing with them will be limited if commanders at all levels do not take responsibility for dealing with them.

Lesson #3 – Commanders are responsible for the health of their troops. In both conceptualizing and dealing with force health protection issues, including OSIs, Western militaries frequently see them as a medical matter, and, therefore, the domain of health care professionals in the medical 'stovepipe.' This was true during both World Wars and during the Decade of Darkness. For example, the British 14th Army fighting in Burma in 1943 had high casualty rates because prescribed measures to prevent malaria were not being followed. The loss rates were only significantly reduced when its new commander, William Slim, held regimental officers directly responsible for ensuring that the prescribed prophylaxis routines were followed, and fired those in whose units malaria re-occurred, where it had previously been eradicated.[43] More recent examples of an absence of command responsibility resulting in outbreaks of diseases for which effective prophylaxis was available include Canadian soldiers in East Timor (2000) and Afghanistan (2003) and US Marines in Liberia (2003).[44] Related problems with leadership training shortcomings, command responsibility imbalance, and inadequate doctrine have also been identified as impediments to providing the CF with optimal health force protection.[45] Similarly, the issue of commanders' responsibility for the mental health of their subordinates is a longstanding issue that has been raised

during and since the Decade of Darkness.[46] A recurring criticism is that CF leaders have not done enough to effect the culture change required to reduce the stigma associated with OSIs, which would, in turn, reduce OSI casualties.[47] These issues remind us that the concept of leaders' responsibility for their subordinates' health, an old axiom, requires constant reinforcement. This leads to the final lesson – how to ensure that relevant knowledge is reliably transmitted to successive generations of military professionals.

***Lesson #4 – Lessons Must be Constantly Learned AND Taught*.** Perhaps the most important lesson to be learned from the Decade of Darkness is that unless we establish and maintain systems to distill and teach lessons from our past experience, the knowledge we have acquired so painfully in the past will be lost again - until necessity forces us to rediscover it, often at great cost to our troops.[48] The CF's current Surgeon-General put it this way: "…history teaches that we often do not learn from our past…Although low injury and disease rates are usually the fruit of persistent and prolonged health protection and promotion efforts, their achievement is often seen as justification to scale back such programs…as recent problems recede from memory, the cycle will predictably repeat itself."[49] And, transmitting "institutional memory" through effective CF-wide training and education programs to ensure that problems do not recede from our memory is the "… most effective way to reduce the stigma associated with operational stress injuries and tackle culture change."[50]

However, what is often referred to as "institutional memory" is only as good as the training and professional education that each generation receives, and only effective institutional *learning* creates "institutional memory." However, one of the biggest challenges the CF faces is in creating an enduring institutional memory is the establishment of a cohesive knowledge creation and education system that imparts the necessary information about OSIs to the right people at the right time, especially when these systems are often one of the first targets of budget cuts.[51]

CFJIC LG2005-0121d, by Corporal Bill Gomm

The official opening of the Occupational Stress Injury Clinic in Winnipeg, 11 April 2005.

Conclusions

The 1990s are not just our past - they may be our immediate future as well. A 2011 statement by the Chief of the Defence Staff (CDS) closely parallels statements by defence policy makers during the Decade of Darkness: "In the challenging financial conditions faced by our country, our ability to accomplish...priorities rests on our willingness to find better ways to deliver defence capability, while achieving savings and reductions mandated by the government."[52] With significant budget cuts either underway or forecast for all Western armed forces, the next ten years could easily be a new Decade of Darkness; therefore, the lessons from the 1990s have a particular relevance to us.[53] What follows are three steps, based upon past lessons, which might be used to deal with future challenges in dealing with OSIs.

The first step is to recognize the important effect of culture in its many forms (i.e., national, organizational, military, unit) on mental health issues. From an organizational response perspective, culture is assuming new prominence in discussions about mental health policy, and, while evidence-based studies are an important component in this process, knowing that culture affects what research is considered 'appropriate,' and how evidence is gathered and interpreted, gives us valuable insights into how culture shapes what society defines as and deals with 'abnormal' behaviour. From an organizational behaviour perspective, leaders at all levels play a part in shaping culture so that it supports organizational goals, because "…leaders are the ones who promote resiliency training, who create a supportive esprit within the unit, and who oversee the reintegration into the unit of those who have sought care."[54]

The second step is to treat OSIs as a *systems* issue. If we understand that OSIs are part of a larger personnel sustainment system, this often-overlooked approach allows us to see them as an important factor in reducing preventable personnel losses. The 1990s showed us that debates about OSIs have often revolved around value judgments about who was 'entitled' to have symptoms, frequently based upon the cause of the stress, i.e., combat vs non-combat. However, from a systems or organizational perspective, it is essential to reduce losses due to OSIs no matter how they are caused – this becomes a practical issue about reducing wastage. Implicit in this approach is that the CF consider moving beyond the label 'operational' in OSI, as it did with 'combat' in CSR, and deal with all CF stress injuries as part of a holistic system, no matter what their origin.

The third step is for DND to create and sustain a viable 'institutional memory.' A key problem during the Decade of Darkness was a failure on the part of DND to collect, analyze, and transmit data about many important personnel sustainment issues, including OSIs, an

area where relatively small investments can make a big difference. In fact, some of the first targets of cuts in that era were to what were seen to be non-essential capabilities related to research, education, and training. Today, we see calls to reduce or eliminate some of these functions once again as part of the CF's most recent Transformation and cost-cutting efforts – in the name of "operational effectiveness."[55] However, what is often forgotten amid these cries to keep 'sharp end' forces at the expense of other parts of the organization is that without proper knowledge of how to best use and conserve those forces, the sharp end can quickly lose its edge, due to unnecessary attrition. I am not arguing here that cuts are not necessary, only that cuts to the 'brain' of the organization (headquarters, staffs, and education and research capacity) need to be considered very carefully because strong limbs are not much use without intelligent direction.

These steps represent some new ways of doing things, without any need for additional financial resources. In fact, if implemented, they could not only improve the way we treat those members of the CF and veterans suffering from mental illness, but they could also help to realize the CDS's mandate to deliver better capability while reducing costs.

DND photo AR2011-0124-38 by Corporal Tina Gillies

Empathy

NOTES

1. This article is based upon a presentation given at the Annual Gregg Centre - Combat Training Centre Fall Conference – "The Mind at War: Understanding, Preparing, and Treating Combat Stress," 12-13 October 2011, University of New Brunswick, Fredericton, NB. My interest in this topic began when I wrote a study in December 1999 entitled, "Creating a System for Dealing with Operational Stress in the Canadian Forces," for the Croatia Board of Inquiry.
2. The 1990s has been referred to as DND's 'Decade of Darkness,' because cuts to the CF during the defence retrenchment at the end of the Cold War were exacerbated by public perceptions of wrong doing in the Somalia mission, and by widespread distrust in the senior leadership of the CF. Veterans Affairs Canada - Canadian Forces Advisory Council, "The Origins and Evolution of Veterans Benefits in Canada, 1914-2004," Reference Paper (March 2004), np, at http://www.vac-acc.gc.ca/clients/sub.cfm?source=forces/nvc/reference, accessed 18 December 2010; and G.E. Sharpe and Allan English, "The Decade of Darkness – The Experience of the Senior Leadership of the Canadian Forces in the 1990s," paper written for the CF Leadership Institute, dated 24 February 2004. The expression 'Decade of Darkness' was popularized by General Rick Hillier when he was CDS, but it was actually coined by Lieutenant-General (retired) Al DeQuetteville in an interview in 2003 with Joe Sharpe.
3. G.E. (Joe) Sharpe, *Croatia Board of Inquiry: Leadership (and Other) Lessons Learned* (Winnipeg, MB: CF Training and Material Publishing Centre, 2002), pp. vii-viii.
4. An OSI can be defined as "… any persistent psychological difficulty resulting from operational duties performed by a member of the Canadian Forces and includes a host of problems such as anxiety, major depression, alcohol abuse and post traumatic stress disorder (PTSD)." In September 2011, this definition was on the Chief of Military Personnel website under "Operational Stress Injury Social Support (OSISS) Program." It has since been removed. It can still be found, however, on the Air Force, Cold Lake, Deployment Support Centre website at http://www.airforce.forces.gc.ca/DSC/ColdLakeDSC/DIS/OSI_e.asp, accessed 28 May 2012.
5. David Pugliese, "Defence Department Bureaucrats Have Gone 'Rogue' Says Opposition, Auditor General Fights Back Against DND Claims," in the *Ottawa Citizen*, 16 May 2012, at http://blogs.ottawacitizen.com/2012/05/15/defence-department-bureaucracts-have-gone-rogue-says-opposition-auditor-general-fights-back-against-dnd-claims/, accessed 16 May 2012; and Murray Brewster, "DND cuts account for one-fifth of federal budget cuts over next three years," in the *Winnipeg Free Press,* 29 March 2012, at http://www.winnipegfreepress.com/canada/dnd-cuts-account-for-one-fifth-of-federal-budget-cuts-over-next-three-years-144956585.html, accessed 28 May 2012.
6. Allan English, "Not Written in Stone: Social Covenants and Resourcing Military and Veterans Health Care in Canada," in Alice B. Aiken and Stephanie A.H. Belanger, (eds)., *Shaping the Future: Military and Veteran Health Research* (Kingston, ON: Canadian Defence Academy Press, 2011), pp. 230-238; Douglas Bland, "What next for the military? A false dichotomy,"in the *Globe and Mail,* 27 October 2010, at http://www.theglobeandmail.com/news/opinions/opinion/what-next-for-the-military-a-false-dichotomy/article1773956/, accessed 28 May 2012.
7. Murray Brewster, "DND brass on defensive over cuts to mental-health research," in the *Globe and Mail*, 4 May 2012, at http://www.theglobeandmail.com/news/politics/dnd-brass-on-defensive-over-cuts-to-mental-health-research/article2423336/email/, accessed 6 May 2012.
8. Lee Berthiaume, "Government knew last year it couldn't afford billions in defence spending: documents," in *Postmedia News*, 4 June 2012, at http://www.canada.com/story_print.html?id=6728473&sponsor=, accessed 5 June 2012.
9. Jean-Rodrigue Paré, "Post-traumatic Stress Disorder and the Mental Health of Military Personnel and Veterans," Background Paper Publication No. 2011-97-E (Ottawa: Library of Parliament, 14 October 2011), pp. 7-9.
10. See Allan English, "Leadership and Operational Stress in the Canadian Forces," in the *Canadian Military Journal* Vol. 1, No. 3 (Autumn 2000), pp. 33-38 for a discussion of these issues.
11. Greg Jaffe, "New name for PTSD could mean less stigma," in the *Washington Post*, 5 May 2012, at http://www.washingtonpost.com/world/national-security/new-name-for-ptsd-could-mean-less-stigma/2012/05/05/gIQAlV8M4T_story.html, accessed 6 May 2012. The stigma associated with mental illness remains a significant problem in dealing with mental illness in civilian society as well: "Bell creates world's first chair in anti-stigma research at Queen's," in the *Queen's University News Centre,* 7 February 2012 at http://queensu.ca/news/articles/bell-creates-world-s-first-chair-anti-stigma-research-queen-s, accessed 31 May 2012.

12. Allan English, *Understanding Military Culture: A Canadian Perspective* (Montreal & Kingston: McGill-Queen's University Press, 2004), p. 87.
13. Cited in James Wood, *Militia Myths: Ideas of the Canadian Soldier, 1896-1921* (Vancouver: UBC Press, 2010), p. 259.
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15. English, *Understanding Military Culture*, pp. 111-114.
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