PTSD and Stigma in the Australian Army

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Executive Summary

While recovery from PTSD can be expected in the majority of cases, early identification, diagnosis, and timely treatment have been found to reduce the length of treatment and the disruption to the individual's social and occupational functioning. One significant determinant of whether people receive early diagnosis and treatment is fear of stigma and the negative judgements of those around them.

The Mental Health of the Australian Defence Force – 2010 ADF Mental Health Prevalence and Wellbeing Study Report found that stigma surrounding mental health issues is a considerable and consistent barrier to care in the ADF. It also highlighted that the Australian Army exhibits considerably higher levels of stigma and barriers to care compared to the other services.

De-stigmatising is not only important for the individual, but also critical for the Australian Army. This paper analyses Canadian, British and US initiatives and provides key recommendations to the Australian Army on how to combat stigma.
The Author

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Introduction

This paper seeks to identify the nature of the stigma attached to Post-traumatic Stress Disorder (PTSD) and other mental health conditions in the Australian Army, and the negative implications of such a stigma on the individual, the workplace and the Army as a whole. The paper will evaluate the Army’s current approach to removing such stigmas, discuss the approaches of international allies, and provide practical strategies and direction on how the Army can act further to remove the stigma attached to PTSD for the benefit of both wounded individuals and the Army as a whole.

Any discussion of PTSD should necessarily be prefaced by a definition of what constitutes this condition. It is useful at this point also to examine its prevalence in the Australian Army, other common conditions that are similar to PTSD and their consequences, and the importance of early intervention in minimising the impact on the individual, co-workers and the Army in general. This paper will then address the stigma attached to PTSD as a barrier to care, discussing its impact on vital early intervention and help-seeking behaviours. The presence and types of stigma in the Army will be analysed, as will the strategies currently employed to overcome them. The second half of the paper will present the results of an overseas study tour and discussions with international allies concerning their current methods for reducing such stigmatisation and will evaluate the success of these. Finally, practical strategies to assist the Army to overcome the stigmatisation of PTSD and the positive impact of this on the organisation will be presented.
Stigma and PTSD

81% of veterans tell us that they feel ashamed or embarrassed about their mental health problems.¹

PTSD is a normal reaction to extreme trauma.² The evidence-based treatments that exist for PTSD are highly effective in assisting afflicted individuals to make a partial or full recovery from the disorder and regain their sense of wellbeing. If left untreated however, PTSD can become a chronic and far more complex condition with negative consequences for the individual, family and community within which sufferers live and work. Thus it is vital to understand and remove any perceived barrier to the care and support available to individuals with PTSD. The stigma attached to the condition is one of these barriers and is consistently apparent within militaries, reducing combat effectiveness and leading to significant capability loss and social costs.

In order to explore how such a stigma can be removed, it is important to understand the dynamics of PTSD and some of the underlying reasons for the stigma that surrounds this psychological condition. This understanding is particularly vital as many within the military may have heard of PTSD but never studied it in depth.

What is PTSD?

PTSD is characterised by the development of a long-lasting anxiety response following a traumatic or catastrophic event. Typical examples of traumatic events include violent or sexual assaults, the experience of war and combat, incarceration as a prisoner of war and exposure to catastrophic natural disasters.³ For members of military forces who have deployed to war zones, the most commonly reported traumas are exposure to enemy fire, participation in armed combat, the sight of wounded comrades and civilians, witnessing the death of fellow soldiers and civilians, and indirect threats to one’s own physical security.⁴

While the majority of Australian Army personnel cope well with their deployment and service experiences, a significant minority will go on to develop PTSD. According to the World Health Organisation’s International Classification of Diseases, PTSD occurs when the individual:

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¹. [Source: veterans]
². [Source: evidence-based treatment effectiveness]
³. [Source: traumatic events]
⁴. [Source: military-related traumas]
• has experienced a traumatic event such as exposure to combat
• experiences repetitive and intrusive re-enactments of the trauma in memories, daytime imagery and dreams
• has developed actual or preferred avoidance of cues associated with the traumatic event
• does not have full memory recall of the traumatic event
• experiences increased psychological sensitivity and arousal indicated by at least two of the following: sleep disturbance; irritability or anger; difficulty concentrating; hypervigilance; or being easily startled.5

Children who are sexually abused and soldiers exposed to extended periods of threat often develop a complex form of PTSD which generally results in additional symptoms such as emotional regulation difficulties, dissociation, changes in relationships with others and changes in self-perception.6

Causes of PTSD

A brief look at the theoretical models of PTSD will explain why not all military personnel who are exposed to trauma will develop PTSD and why, with appropriate treatment, most PTSD sufferers can recover. In the immediate aftermath of trauma, most individuals experience at least some degree of intrusion, hyperarousal or avoidance symptoms. Two major theoretical orientations have emerged to explain why some individuals recover naturally while others develop PTSD. The first of these concerns information processing, emphasising the role of maladaptive memory structures in the development of PTSD. The second involves social cognitive theories which propose that the main determinant of natural recovery versus the development of PTSD is the ability of individuals to accommodate the traumatic event in their world view.7 The next section of this paper provides a comprehensive description of both information processing and social cognitive theories. Included in this description is an explanation of the scientific basis for PTSD which may assist in the process of de-mystifying the condition and thus reducing its stigmatisation.8

Information processing theories

Information processing theorists propose that PTSD occurs as the result of an inability to adequately process traumatic events.9 Initial research by Foa, Steketee and Rothbaum in 1989 hypothesised that PTSD develops due to the formation of a
fear network in the sufferer’s memory which is stable, broad and easily activated.\textsuperscript{10} When trauma reminders activate the fear network, the information in this network enters consciousness (intrusive symptoms) and subsequent attempts to avoid this activation result in avoidance symptoms, which serve to maintain PTSD. Ehlers and Clark expanded on this research in 2000 and proposed a cognitive model of PTSD focusing on threat and memory (Figure 1). They suggest that PTSD develops and becomes persistent when individuals process the trauma in a way that leads to a sense of serious and present threat. This sense of threat arises as a consequence of:

- excessively negative appraisals of the trauma and/or its consequences — the individual may make appraisals such as ‘I attract disaster’ or ‘I can’t cope with this’
- a disturbance of autobiographical memory which may cause the person’s trauma to be easily triggered and yet experience problems during intentional recall in therapeutic or workplace settings

In response to these negative appraisals and memory disturbances, individuals adopt various maladaptive coping strategies including rumination (excessive dwelling on the trauma), cognitive avoidance or substance use. These maladaptive strategies then perform the maintenance role in PTSD by increasing symptoms, preventing changes in negative appraisals and change in the trauma memory. This then produces the cycle illustrated in the model below.

![Figure 1: Ehler and Clark's Cognitive Model of PTSD.](image-url)
Social cognitive theories

Social cognitive theorists propose that those most at risk of PTSD are individuals for whom the details of the traumatic event/s conflict with the circumstances of their worlds to such an extent that they cannot assimilate the trauma into their existing world view. This means that their post-traumatic world subsequently becomes unsafe, uncontrollable, and unliveable. For example, individuals differ in their preconceived beliefs and attitudes to death. When a variety of individuals are exposed to a trauma that results in loss of life (e.g. a helicopter crash in Afghanistan), those individuals who have a pre-trauma belief that death is a part of life, or that people go to a better place after death may find it easier to assimilate the event than someone who holds rigid and negative views concerning death. This theory emphasises the implications of the event for the individual’s world view, both present and future.

Stigma attached to PTSD can also shape pre-trauma views. Individuals who believe that those with PTSD are ‘weak’ will have pre-trauma views that could adversely affect the way they cope with any past or future trauma. These individuals are also less likely to seek mental health support. Thus, de-stigmatising PTSD in the Australian Army is important for both those who have already been affected by trauma, and those who may be subjected to traumatic events on future operations.

Prevalence of PTSD in the Australian Army

The 2010 Mental Health Prevalence and Wellbeing Study, conducted as part of the Military Health Outcomes Program, found that 9.7% of Army personnel met the diagnostic criteria for PTSD, and an estimated 2462 individuals would have benefited from targeted PTSD treatment in the 12 months prior to the study. Furthermore, this study found that PTSD is the most prevalent anxiety disorder in the ADF, with the highest rates among males.

The study also identified that those who occupied a combat role or who operated outside a main support base had a higher PTSD score post-deployment than those working inside a main support base or outside Afghanistan. Longer deployments also correlated with heightened levels of PTSD. Deployments over six months, particularly those lasting between nine and 12 months, were more highly correlated with increased PTSD symptoms than those deployments lasting five months or less.
PTSD co-morbidity and consequences

PTSD also commonly occurs in combination with other mental disorders. In a community sample, the Australian National Mental Health Survey found that more than 80% of individuals diagnosed with PTSD also met the criteria for another mental disorder, particularly depression, anxiety or substance abuse disorder.\textsuperscript{16} This statistic, while not recorded in the Military Health Outcomes Program study, is possibly replicated in Defence samples, as the Australian National Mental Health Survey suggested that males in the ADF experience higher rates of depression than Australian community samples. Depression is believed to be the most commonly co-occurring condition, with approximately one third of people with PTSD also attracting a co-morbid diagnosis of a major depressive disorder.\textsuperscript{17} For most people with co-morbid PTSD and depression, the depression symptoms follow the PTSD symptoms, and the presence of co-morbid depression is often related to more chronic PTSD, including higher levels of distress and functional impairment.\textsuperscript{18}

The Military Health Outcomes Program study also examined PTSD and a range of co-morbid signs and concluded that a significant majority of participants with PTSD also experience general psychological distress and/or alcohol misuse as illustrated in Figure 2.\textsuperscript{19}
Although the Military Health Outcomes Program study found lower rates of substance abuse than were generally apparent in community samples, the majority of research indicates that ex-serving war veterans with PTSD have a higher risk of alcohol and drug abuse and dependence than other areas of the population.\textsuperscript{20} Alcohol abuse in particular is higher among males, and the Australian National Mental Health Survey found that over a third of all men with PTSD also had issues with alcohol abuse and dependence.\textsuperscript{21} This is particularly the case with military populations such as Australian Vietnam War veterans.\textsuperscript{22}

**Contextual problems**
In addition to distressing symptoms and high co-morbidity with other mental disorders, PTSD can also lead to disturbances in family and social relationships, functioning in the workplace, physical health and financial stability.\textsuperscript{23} The impact
of PTSD is widely recognised as extending beyond individuals to their immediate family and sometimes to the next generation. One study of Vietnam veterans revealed that individuals with PTSD displayed higher levels of violent behaviour and had increased problems with marital and family adjustment and parenting skills compared to individuals without PTSD.

The symptoms of PTSD place a significant level of stress on relationships. The avoidance and numbing symptoms in particular make intimacy and communication difficult and may lead to sexual dysfunction or lack of interest. When combined with high levels of irritability and anger outbursts, PTSD can make life difficult for partners who often find themselves isolated and full of self-doubt in the absence of positive emotional connections. Avoidance symptoms can also isolate families from the broader community. Stigma compounds this issue by creating a perceived barrier for family members, preventing them seeking psychological help both for themselves and the affected individual. Often PTSD can be a ‘family secret’ that is kept from friends and relatives so as to avoid shame or ridicule. Stigma of this kind can be driven by the internal perception that the family has failed to support the affected individual, and that if the family were stronger or more capable, the PTSD would be internally resolved.

The importance of early intervention
While recovery from PTSD can be expected in the majority of cases, early identification, diagnosis, and timely treatment have been found to reduce the length of treatment and the disruption to the individual’s social and occupational functioning. One significant factor which determines whether people receive early diagnosis and treatment is fear of stigma and the negative judgements of those around them. This was consistently apparent in both civilian and military samples.

De-stigmatising is thus not just important for the individual, but critical for the Australian Army. More effort must be devoted to de-stigmatising PTSD, including research into the predominance and forms of stigma within the Army. Stigma, put simply, erodes the ability of the Army to perform its core business effectively. It causes those who could recover and continue to soldier to instead reach the point at which they are no longer able to hide the condition, and are forced to seek more comprehensive treatment. This can lead to higher absenteeism and, in some cases, the inability to remain in their unit or even in the Army. Developing a comprehensive strategy to ensure that PTSD is treated in the very earliest stages is therefore vital not just to the individual but to the Army itself. The next section presents a detailed discussion of stigma as a barrier to care within the Army context.
Stigma as a barrier to care

Stigma is a unique barrier to psychological care. It is unique because other barriers such as a lack of trained health care staff or the provision of sick leave to attend sessions are physical impediments to recovery. The same cannot be said of stigma which, in the Army, represents an invisible barrier holding individuals back from good quality clinical support.

What is stigma?

Stigma is a term that can refer to various types of social, cultural and personal factors affecting access to mental health care. It is defined as a ‘negative and erroneous attitude about a person, a prejudice, or negative stereotype’. Stigma is one of the main reasons people do not seek mental health care. Social cognitive processes motivate people to avoid the label of mental illness that results when people are associated with mental health care.

Corrigan has identified two distinct types of stigma surrounding mental health injuries. The first is public stigma, which he defines as ‘what a naive public does to the stigmatised group when they endorse the prejudice about said group.’ The second is self-stigma which he refers to as ‘what members of a stigmatised group may do to themselves if they internalise the public stigma.’ The public stigma attached to having a mental illness and receiving a psychiatric diagnosis has been the subject of extensive study in both military and civilian contexts.

Public stigma

Those publically labelled as mentally ill are harmed in several ways. Stereotypes, prejudice and discrimination can prevent these people achieving important life goals. Evidence suggests that public identification of someone as ‘mentally ill’ can
cause significant harm. Research has shown that people with concealable stigmas (people who are gay, of minority faith-based communities, or with mental illness) decide to avoid this harm by hiding their condition. Alternatively, they may opt to avoid the stigma altogether by denying their group status and by not seeking assistance from those institutions that will signal their condition (e.g. mental health care). This kind of label avoidance is perhaps the most common way in which stigma impedes care-seeking and is the most relevant to institutional settings such as the Army.

Self-stigma

*I perceived myself, quite accurately unfortunately, as having a serious mental illness and therefore as having been relegated to what I called the “the social garbage heap”… I tortured myself with the persisted and repetitive thought that people I would encounter, even total strangers, did not like me and wished that mentally ill people like me did not exist.*

*Thus, I would do things such as standing away from others at bus stops and hiding and cringing in the far corners of subway cars. Thinking of myself as garbage, I would even leave the sidewalk in what I thought of as exhibiting the proper deference to those above me in social class. The latter group, of course, included all other human beings.*

Narratives such as this indicate that self-prejudice leads to negative emotional reactions; prominent among these is low self-esteem and low self-efficacy. Self-esteem is typically operationalised as diminished views of personal worth and is often experienced as shame. Families frequently report an intense sense of shame as a result of a member’s mental illness. It is for this reason that it is also vital to include families within the program of de-stigmatisation.

Fundamental suppositions of social psychological research on prejudice suggest why self-stigma would dissuade people from being labelled and seeking treatment. People are generally motivated to stigmatisate others because of ego or group enhancement.

**Stigma and PTSD in context**

When assessing stigma it is important to consider the context in which the psychological wounding has occurred. While almost every occupation has associated health risks, those linked to military service involve salient features not found in other professions. The act of training for and, in some instances, being involved in combat, either directly or through direct support, are features that remain unique to those who serve in the military.
Within society, PTSD is usually a reaction to an unexpected trauma that is either inflicted or witnessed. In the Army, soldiers spend their careers training and preparing for the trauma of combat. Soldiers are thus not passive ‘victims’ and instead take an active role preparing for and acting in combat.\textsuperscript{41} This context is important in understanding stigma and PTSD within the military and specifically the Army. Despite the unique nature of military service, the characteristics of stigma remain valid. Likewise the most effective support for PTSD remains the evidence-based treatments of Cognitive Behavioural Therapy and Prolonged Exposure. However the occupational context defines the best means of combating stigma. While the broad concepts of de-stigmatising PTSD remain valid, the specific programs must take into account the occupational requirements of the Army.

The study of stigma and de-stigmatisation initiatives within the Army context is also important as stigma can have a demoralising effect on the workplace as well as the individual. The earlier PTSD is identified and treated, the better the outcome for the Army. Stigma undermines the effectiveness of the unit and the team structures that are so vital.

**Stigma and allied nations**

-I think it is part of the Army culture. I do not blame anybody. I was the same when I was younger, when I first joined up, before I had an understanding. Maybe guys need to understand. … They do not know me specifically; they just see a broken corporal.\textsuperscript{42}

In order to develop and maintain the Army as an effective fighting force, the culture within the organisation must promote individual strength and devotion to the organisation and fellow soldiers. Yet such a culture can also prove detrimental to the mental and physical health needs of individual soldiers. Stigma within the military is mainly focused on negative attitudes and beliefs concerning mental health care, the notion that PTSD will affect unit cohesion and the performance of the unit.\textsuperscript{43} While research into such stigma within the Australian Army is limited, studies within coalition militaries have consistently highlighted these areas. Charles Hoge and his team investigated help-seeking and barriers to care among US soldiers and Marines following deployment to Iraq and Afghanistan. For those participants who scored above the cut-off on screening, only 38% to 45% indicated an interest in receiving help and only 23% to 40% had sought mental health care. The most common concerns were being ‘perceived as weak,’ ‘being treated differently by unit leadership’ and ‘members of my unit having less confidence in me’.\textsuperscript{44}
Within the Canadian Forces, one report found that ‘soldiers felt stigmatised and abandoned after seeking help and many had not sought help for fear of being ostracised.’ The report called for widespread systemic changes, education, and training at all levels to address negative attitudes surrounding PTSD.

Prevalence of stigma within the ADF and the Australian Army

*I asked for support several times which resulted in nil action and I began hiding my symptoms and lying about my recovery and ultimately attempted suicide which saw me admitted to hospital.*

The ADF Mental Health and Wellbeing Plan (2012–2015) identifies ‘addressing stigma and barriers to care’ as the number one priority action for Joint Health Command. The plan’s priority actions were determined by the findings of the 2011 Military Health Outcomes Program study and by the Dunt Review which ‘compared mental health care support in the ADF with world’s best practice and assessed the extent to which the mental health needs of serving and transitioning ADF members were being met.’

The Mental Health of the Australian Defence Force – 2010 ADF Mental Health Prevalence and Wellbeing Study Report provides the most current documentation on the existence of a stigma surrounding PTSD within the ADF. The report was extensive, with almost 49% of the ADF’s current serving members participating between April 2010 and January 2011. The report identified that 22% of the ADF — 11,016 members or one in five — had experienced a mental disorder during the previous 12 months.

Stigma and barriers to care were explored in this study through questions that asked the sample to rate on a five-point scale (strongly disagree, disagree, uncertain, agree, strongly agree) how much each of the concerns listed below might affect their decision to seek help. The response categories of ‘strongly agree’ and ‘agree’ were then combined to produce the prevalence rates for each of the six types of stigma and barriers to care.

Three types of stigma were covered in this study:

- it would harm my career or career prospects
- people would treat me differently
- I would be seen as weak.
Three types of barriers to care were covered in this study:

- I wouldn’t know where to get help
- I would have difficulty getting time off work
- It would stop me from being deployed.48

The highest rated perceived stigma was fear that seeking help would prompt people to treat sufferers differently. This was followed closely by concerns that seeking help would harm career or career prospects and fear that sufferers would be seen as weak.49 One Australian soldier commented:

_After my break down and subsequent hospitalisation words cannot express how lost I felt, the confusion and most of all the feeling of despair. My chain of command had no idea how to engage me and my unit turned its back on me. Life was hard enough, but it was made harder that I had served 18 years and I was not farewelled from my unit, mess, or Corps. It was not until then that I realised that the stigma surrounding mental health and especially PTSD within the Army was wide spread._50

Members of the Army were 14% more likely than Air Force members to perceive that people would treat them differently. Those in the Army were 30% more likely than those in the Air Force and 23% more likely than those in the Navy to perceive that they would be seen as weak.51

The greatest barrier to seeking help for a mental health reason in both the ADF and, specifically, within the Army, was the fear that the attached stigma would reduce the sufferers’ opportunity to deploy. A total of 36.9% of ADF personnel (36.0% of females and 37.0% of males) agreed that this was a concern.52

Another soldier commented on his experience of raising a mental health issue with members of his chain of command:

_When first asking for assistance for mental health support from within my immediate chain of command [sergeant and warrant officer class 2] I was met with an attitude that I was malingering and the immediate questioning of my integrity as a JNCO. I pursued the matter outside of my chain of command, although still within my unit, and a meeting with the unit RSM was arranged. I raised my concerns about my mental health and wellbeing and was told to ‘harden the f**k up’ and to get on with my job._53
Members of the Army were 40% more likely than those in the Air Force and 16% more likely than those in the Navy to perceive that seeking support would prevent them being deployed.⁵⁴

The findings of each of these three studies identify the stigma surrounding mental health issues as a considerable and consistent barrier to care in the ADF. The Army exhibits considerably higher levels of stigma and barriers to care compared to the other services. Research completed as part of the Dunt Review highlighted the fact that the ADF and particularly the Army has a significant issue with this stigma and that its nomination as the number one priority action for Joint Health Command is well founded.

**Stigma in coalition forces**

Gould et al. analysed whether stigma and other perceived barriers to mental health care differed among allied armed forces.⁵⁵ In an examination of the defence forces of five nations (US, UK, Australia, Canada and NZ) they found that, while practices and procedures differed considerably among the armed forces of the various nations, they were all similar in terms of the stigma and perceived barriers to psychological care. The study further identified that, although each nation differed in terms of organisational approach to the provision of mental health care, all needed to bridge the gap between the presence of mental health problems in service personnel and their reluctance to seek help.

In one of the earliest studies of soldiers and marines serving in Operation Iraqi Freedom and Operation Enduring Freedom, Hoge examined mental health service use, stigma and other barriers to care in four combat infantry units returning from active duty.⁵⁶ The results showed that approximately 20% of soldiers who screened positive for PTSD or depression reported discomfort in answering routine screening items honestly. Furthermore, those who screened positively for these conditions also had increased perceptions of stigma and barriers to care. The results of this study empirically demonstrate the potential effect of stigma on the reporting of mental health symptoms and care-seeking. More recent research on this topic by McGeary et al. in 2011 also found that persistent concerns of stigma and fear of potential long-term implications, including forced separation from the military, inhibited reporting.⁵⁷

*Invisible Wounds of War*, the seminal work on the effect on US forces of the wars in Iraq and Afghanistan, studied inadequacies in access to and the quality of mental health care for the current cohort of Iraq and Afghanistan veterans.⁵⁸ The study identified two categories of barriers: structural or financial barriers, including limited
availability of services and financial limitations; and personal or social barriers, including personal values and military culture (see Figure 3).59 The table illustrates the fact that, from both Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF), the perception of stigma as a barrier to care has diminished over a three-year period. However the table data still reflects an unacceptably high incidence of such stigma.

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<tr>
<td>It would be seen as weak.</td>
<td>65%</td>
<td>52.2%</td>
<td>56.7%</td>
<td>48.9%</td>
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<tr>
<td>My unit membership might treat me differently.</td>
<td>63%</td>
<td>53.7%</td>
<td>55.6%</td>
<td>46%</td>
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<tr>
<td>Members of my unit might have less confidence in me.</td>
<td>59%</td>
<td>44.9%</td>
<td>47.8%</td>
<td>41.8%</td>
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<td>My leaders would blame me for the problem.</td>
<td>51%</td>
<td>40.2%</td>
<td>43.9%</td>
<td>33.9%</td>
</tr>
<tr>
<td>It would harm my career.</td>
<td>50%</td>
<td>31.7%</td>
<td>31.2%</td>
<td>29.2%</td>
</tr>
<tr>
<td>It would be too embarrassing.</td>
<td>41%</td>
<td>32%</td>
<td>35.1%</td>
<td>28.6%</td>
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*Figure 3: Questions from OEF and OIF Mental Health Advisory Team on stigma as a barrier to care.*
In another major international study, the Joint Mental Health Advisory Team, a US body which assesses deployment-related psychological health concerns of service members and provides recommendations on their psychological care and support, commissioned further research in 2010 into factors that discourage members of the military from seeking psychological health services. The team described two main factors. The first involved privacy concerns such as losing respect, security clearance or job. A significant number of service members explained that they rarely considered seeking mental health care in the military system because of privacy concerns related to perceived stigma. Many respondents stated that if they needed care they would choose to use an off-base provider or seek counselling from a peer or a chaplain. The potential loss of security clearance, loss of professional opportunities and the adverse judgement of peers were among the fears most commonly identified.

The second primary factor was the desire to return to family. A significant barrier to the immediate reporting of mental health concerns following deployment was the desire to avoid any delay in reuniting with the individual’s family. In support of this finding, a focus group participant in the Burnam study of 2008 stated, ‘I lied on my post-deployment forms, whatever got me back to my family quicker.’ Both these factors are also key considerations in the presence of a mental health stigma within the Australian Army.

In addition to research into the general presence, perception and impact of stigma in allied forces, Green-Shortridge et al. analysed gender differences in relation to stigma, and disclosing and seeking help for mental health problems in the US military. The authors discovered a gender bias in help-seeking behaviour which suggested that men were more likely to perceive stigma and less likely to seek help. This posed a significant problem given the high percentages of men versus women in the US military and consequently implies that the number of reported psychological problems is likely to be considerably under-represented. It is also likely that a similar trend could be present within the Australian Army, as stigma surrounding males’ mental health and its perceived links to weakness are supported by broader community research.

The lack of research and detailed studies into stigma and perceived barriers to mental health care in the Australian Army necessitates the use of broad concepts and findings from coalition studies in this paper. Although the research in this section highlights similar concerns to those found anecdotally in the Australian Army, detailed research into stigma and its effects on mental health and help-seeking behaviours would allow the most effective methods for de-stigmatisation to be identified and tested, and is considered a key recommendation for further research.
De-stigmatisation

Research has shown that the prevalence and effect of PTSD is similar across ABCA nations; however, all other ABCA nations have devoted considerably more resources to stigma research and de-stigmatisation efforts than Australia. Thus, it is important to analyse the de-stigmatising initiatives of allied nations so that relevant lessons can be utilised for the Australian Army and recommendations developed for de-stigmatising PTSD in the Australian context.

De-stigmatising PTSD in the Canadian context

There are two main strategies used by the Canadian Forces to de-stigmatise PTSD. The first of these is the collaborative approach adopted by the Canadian Forces in linking with other major organisations to work towards their common goals. The second primary strategy is the use of the carefully selected term ‘operational stress injury’ (OSI) to describe psychological difficulties resulting from service.

Collaborative approach

The effect of a broad variety of organisations working toward supporting elements of the Canadian Forces could have been distracting and counter-productive; however, each of these organisations, the Canadian Forces and the Canadian Government has adopted a collaborative approach that has ensured the existence of a wide range of programs and services for those adversely affected by their service. This collaboration and the willingness of the Canadian Forces to embrace additional programs and services have helped reduce the barriers to care and stigma for those who have been affected by their operational service. This collaborative approach has also led to the Canadian Forces, government
and charitable organisations devising and agreeing on the use of the non-medical umbrella term OSI to include all mental wounds that can be attributed to operational service.

**Operational stress injury**

OSI is defined as any persistent psychological difficulty resulting from operational duties while serving in the Canadian Armed Forces or as a member of the Royal Canadian Mounted Police. It is used to describe a broad range of problems including diagnosed medical conditions such as anxiety disorders, depression and PTSD as well as other conditions that may be less severe but still interfere with daily functioning. The term OSI also encapsulates changes in mental functioning or behaviour due to the challenges of military operations other than combat, and allows those without diagnosed psychological conditions to be recognised for any negative effects or changes that may have stemmed from their service.

By moving away from diagnostic labels such as PTSD, depression and anxiety, the term OSI has a positive effect on the early identification and help-seeking behaviours of veterans with a wide range of symptoms and injuries. This early identification and treatment leads to better rates of recovery and less cost to individuals, their families, the Canadian Forces and the community as a whole.

Currently, within Australia, the main focus of mental health injuries associated with contemporary operational service is heavily concentrated on PTSD and the resulting effects on individuals and their families. While PTSD is considered the main mental health injury caused by operational service, there are a number of issues consequent on focusing so heavily on one condition within an organisational context. First, PTSD carries a significant stigma within the military. Despite attempts by senior military officers to reduce this stigma by dropping the ‘D’ (disorder) from PTSD, the Australian Psychological Society has identified that the stigma has little to do with the ‘D’, but rather the perception that individuals are no longer capable of performing their roles. A term such as OSI helps to move past this military vs. psychological debate by looking at a broader, overarching range of conditions associated with operational service under a single non-medical banner, and ensuring that no veterans experiencing psychological distress from their service feel overlooked or further marginalised as a result of this emphasis on PTSD.
US initiatives

In the US there are numerous de-stigmatisation initiatives pursued by the US military, each of the separate services and Veterans Affairs. Possibly the most comprehensive US program designed to reduce the stigma of PTSD is the ‘Real Warriors’ program. The Real Warriors campaign is a multimedia public awareness campaign designed to encourage help-seeking behaviour in service members, veterans and military families coping with invisible wounds. Launched by the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury in 2009, the campaign is an integral part of the Defense Department’s overall effort to encourage service personnel and their families to seek appropriate care and support for psychological health conditions.

Unlike recent Australian examples, the Real Warriors campaign is designed to reach the broadest possible audience by including a variety of strategies such as outreach and partnerships, print materials, media outreach, an interactive website, mobile website and social media. The Real Warriors website describes some of the most important features of the campaign:

*The campaign features stories of real service members who reached out for psychological support or care with successful outcomes, including learning coping skills, maintaining their security clearance and continuing to succeed in their military or civilian careers. These Real Warriors are proving through example that reaching out is a sign of strength that benefits the entire military community.*

Much of the basis for the Real Warriors campaign comes from recent studies of the US military. In the important study completed by Charles Hoge and his team, family and friends were identified as the most influential factors in overcoming barriers. The authors suggested that, while educational programs such as ‘Battlemind’ (a resilience program) were beneficial, more programs encouraging friends and family to identify and encourage members to seek treatment would reap significant rewards. Although Battlemind has now been replaced by Real Warriors, the point remains salient, that families often encourage affected individuals to receive treatment as a last resort. Better educated families will recognise the warning signs and ensure that treatment is sought earlier.

In 2007 Greene-Shortridge et al. reviewed stigma in relation to members of the US military disclosing and seeking help for mental health problems and suggested that broad community intervention could work. Their suggestions were based around four issues. First, education was key as it identified that PTSD cannot
be controlled. Second, the military should have greater exposure to those of its personnel who suffer mental illness. Having those who have been successfully treated discuss mental illness with others would significantly reduce the associated stigma. Third, the leadership of the US military should have more involvement with the identification of and support for PTSD sufferers. Like most institutional traits, the involvement of leaders has a ripple effect all the way through the ranks. Finally, the authors highlighted the fact that individuals should be able to retain their security clearances and that confidentiality should be assured. A recent review of these initiatives has indicated that they are beginning to achieve results in the battle to de-stigmatise PTSD within the US Army.

UK initiatives
The UK has launched two recent initiatives aimed at de-stigmatising PTSD, with the most successful program run by an independent charity ‘Combat Stress’, which is the UK’s leading charity specialising in the treatment and support of British veterans suffering mental health problems. Combat Stress currently supports over 5000 veterans and family members of various wars, and works with veterans aged from 20 to 101. The services they provide, such as a 24-hour help line, community outreach, six-week PTSD program and short-term stay program, are all free of charge and have been proven highly effective. In an effort to de-stigmatise PTSD and other mental health conditions, Combat Stress has launched ‘The Enemy Within’ appeal which is designed to raise awareness of the plight of veterans suffering from psychological injury, encourage veterans and their families to seek help sooner, and raise money to enhance the mental health services available to veterans.

The Enemy Within appeal identifies three key problem areas which are likely to be similar to those that appear in the Australian context:

- Significantly increased demand for services. The recent high-intensity operational climate has resulted in a 72% increase in demand for combat stress services since 2005.
- The 14-year ‘time lag’. On average, it takes 14 years from leaving the armed forces for veterans to approach Combat Stress, by which time their needs have become complex and more difficult to treat. Many do not seek help because of the stigma surrounding mental health. This time lag exacerbates the underlying condition and those suffering are more likely to develop serious physical illnesses in addition to psychological issues.
- Diverse needs of veterans. Older veterans have different needs to younger veterans, and the needs of the family are different again. It is important to have a variety of individual treatment programs so as to ensure the best outcome.
In addition to the Combat Stress initiative, the British Army has also launched a campaign designed to highlight the effect of PTSD on individuals and their units to encourage help-seeking behaviour. The ‘Don’t Bottle it up’ campaign aims to enhance efforts to break down the stigma associated with mental health issues and encourage service personnel to seek help earlier while also signposting the support and services available. The campaign is primarily designed around a one-minute video which advises that ‘keeping it on the inside’ is not the best option for long-term health. The British Army website links the video to the full suite of support services available to serving soldiers.

Evaluation of international initiatives

There is little doubt that Australia’s allies are far more advanced in their programs of de-stigmatising PTSD. The member countries of ABCA have a solid understanding of the level of stigma that exists within their militaries, established through army-endorsed research. These nations also have a range of programs that link the efforts of both their military and veterans affairs departments in a concerted campaign to de-stigmatise PTSD. Where the military has not fully embraced its own de-stigmatisation initiative, it has instead fully supported independent programs. The Australian Army has much to learn from its ABCA allies. However, as one US report concludes:

"Persuading the roughly 1.4 million active-duty military personnel that there’s nothing shameful about mental disorders is an enormous task, and one that will require years of continuous attack on several fronts, including service members’ attitudes and institutional barriers to seeking services."

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A brief evaluation of the US, UK and Canadian initiatives is presented in the next section, followed by recommendations for the Australian Army.

US initiatives

The Real Warrior program is a comprehensive campaign that aligns those services provided by the US military, Department of Veterans’ Affairs and supporting institutions, creating a multi-faceted platform which brings together otherwise disparate initiatives. Through this, the Real Warriors initiative has made a direct impact on stigma within the US military.79
One of the keys to the success of the Real Warriors campaign is its willingness to incorporate lessons learnt from several of the US military’s think tanks, and the advice of expert organisations such as the American Psychological Association (APA). The APA is considered the leading US psychology body and the US military has engaged it to provide practical guidance on how to de-stigmatise mental illness. The APA recommended two courses of action which were fundamental to the Real Warriors campaign:

*Increased confidentiality related to mental health treatment, whenever possible, and a public education campaign based on building resilience to help mitigate the effects of stigma. The latter recommendation derives from APA’s prior experience with public education campaigns where an approach based on building resilience was much better received by populations such as firefighters and police than the more traditional notion of treating mental health problems.*

While incorporating guidance from experts in the field, the Real Warriors program has ensured that it has adopted an evidence-based approach to the de-stigmatisation of PTSD and other psychological injuries, which appears to be proving successful.

**UK initiatives**

De-stigmatisation within the British Ministry of Defence and particularly within the British Army appears to have reached a similar standard to that of the Australian Army. However, the psychological care available to members of the British military is generally better than that provided to those serving in the ADF. The primary difference lies in the opportunities provided to the British Army through its Personnel Recovery Centres which are augmented by private funding through Help for Heroes, Combat Stress and other charities.

However, the British Army initiative lacks a single program to educate its soldiers on those services available to them. While the ‘Don’t bottle it up’ campaign sends an important and powerful message, it fails to adopt a comprehensive approach in educating its target population. To reach the modern veteran all forms of media must be utilised, particularly social media. A consistent and targeted campaign must be established that will ensure that the de-stigmatisation message is consistently in the mind of the soldier.
Although not solely focused on de-stigmatising PTSD, Combat Stress and The Enemy Within still indirectly assist with this objective. Combat Stress focuses on providing support to those who have been psychologically wounded on operations while recognising that the more acute cases comprise those who have not sought treatment soon after developing PTSD. The Enemy Within is a strong example of an education campaign that has the dual purpose of raising money to fund improved clinical care for those with PTSD.

Canadian initiatives
Like the UK, the Canadian military and its supporting organisations have no single program that compares with the Real Warriors campaign. However, the Canadian Forces’ use of the broader context of OSI in their work with military charities creates an environment that minimises the stigma surrounding PTSD and other psychological injuries. The concept of OSI allows those within the Canadian Forces and ex-service personnel to seek support for PTSD without being forced to reveal to anyone other than their treating clinician that they have been diagnosed with a mental health condition. This emphasis on confidentiality has been identified in much of the related research as one of the keys to reducing the stigma that surrounds PTSD and related conditions.

Current initiatives in the Australian Army
Despite the lack of quantitative research into this topic, the Australian Army has acknowledged that the stigma — or the perception of a stigma — associated with PTSD is an issue, and has consequently begun developing strategies to address this. This section identifies and evaluates some of these current initiatives.

The 30-minute Dents in the Soul documentary produced by the Australian Army in conjunction with Joint Health Command and Red Gum frontman John Schumann aims to address stigma, raise awareness of the issues surrounding PTSD, and to offer support for Army personnel and their families affected by this condition. The documentary features Army members who share their own experience of PTSD, which is also a common strategy for de-stigmatising mental illness in the wider community. Dents in the Soul was a successful program, but was not followed closely enough by other initiatives, and a single video or program is unlikely to remove deep cultural views or have a long-term impact on de-stigmatising PTSD.
The PTSD Coach Australia application is an education and awareness instrument which comprises tools for relaxation, positive self-talk, anger management and a scheduler to assist individuals to manage their self-care and various associated appointments. The Australian Army hopes this application will promote education, awareness and early identification of PTSD symptoms among its members while also demystifying PTSD with the aim of reducing stigma and barriers to mental health care. While the PTSD coach is based on proven US Veterans’ Affairs applications, this single application cannot be effective when used in isolation. Although the PTSD coach is part of the wider ‘At Ease’ program, de-stigmatising PTSD is not the primary aim of the application. Unlike the US PTSD Coach which is linked to the Real Warriors PTSD de-stigmatising program, the Australian version fails to draw the application user to a broad range of resources or links to successful case studies.

The ADF and the Army are also utilising their senior leadership to address the military and wider community on issues related to mental health in an effort to remove any stigma and encourage their members to seek help. In one such address during ADF Mental Health Week (7–13 October 2013), the Chief of Army, Lieutenant General David Morrison, launched a new YouTube video that encouraged members of the Army to seek help. Called ‘Not the Only One’, the video asks those affected with PTSD to seek support for mental health issues. In the video Morrison compares mental health care to physical care, telling viewers that ‘just like we’ve got doctors and physios to help with a physical alignment, we in the Army are supported by other agencies, we have a system that can provide help if you have issues around mental health.’ Morrison also admits that the focus of the Army on physical health often neglects a soldier’s mental health. He acknowledges that ‘there are concerns over asking for help’ and, during the video, states that there are ‘concerns that come into play, and a reticence on the part, of all of us to put our hand up and say, look listen I don’t think I am travelling all that well. But it’s inside me, it’s not visible for us all to look at, and I need help.’ This move by the senior leadership to recognise the importance of de-stigmatising PTSD is a vital first step.

While this YouTube video presents two convincing case studies that signal the need for people to address their PTSD, these are only two voices. To ensure that these education programs are fully utilised in the battle to de-stigmatisate PTSD they must become part of a wider de-stigmatising initiative. Rather than being limited to ADF Mental Health Week, videos of this kind must be continually produced featuring a variety of stories to assure those serving that the Army’s leaders believe that PTSD does not end a career and can be sympathetically treated by the system.
In another address designed to overcome stigma and barriers to help-seeking in the Australian Army and ADF, the Chief of Defence Force Mental Health Day message also highlighted psychological difficulties as a legitimate issue on a par with physical health problems. The specific message delivered by General David Hurley was that seeking support and admitting a mental health injury will not affect an individual’s career. However, suppressing the condition and not seeking treatment could potentially place the lives of individuals, their mates and their families at risk. This approach, designed to prompt people to seek help before reaching breaking point, is similar to the preventative stance adopted for both physical and mental health issues in the broader community. At present little research has been conducted to determine whether preventative messages in the military are effective in increasing help-seeking behaviour.

Recommendations for the Australian Army

The Australian Army does not have a cohesive and concerted approach to de-stigmatising PTSD. Instead the Department of Veterans’ Affairs and the ADF present a mixture of programs which provide a reasonable level of support to those with PTSD. However, the stigma associated with PTSD remains a significant barrier to individuals seeking this care. The ADF and particularly the Army have introduced a small number of programs that identify stigma as a considerable barrier to care, and both aim to reduce the incidence of this stigma. These programs, however, have generally failed to reach their intended audience, and their exposure to the highest risk groups has been limited. The recommendations discussed below have been drawn from research into the efforts of Australia’s allies and subject matter experts, and their implementation should be considered by the Australian Army as a practical and timely effort to de-stigmatise PTSD.

De-stigmatising terminology

The Australian Army has recently created a non-medical term to describe all mental health conditions that can be experienced in the course of military service — ‘mental health injury’. While a broader term that incorporates numerous types of mental health conditions such as depression and anxiety would reduce the marginalisation experienced by those members experiencing other mental health conditions, the term ‘mental health injury’ successfully avoids the connotations of the word ‘disorder’, although it still contains some stigmatising connotations. It is the recommendation of this paper that the Australian Army adopt the term ‘operational stress injury’ employed by the US military rather than ‘mental health injury’ for a number of salient reasons.
First, OSI has been specifically defined. There is no confusion over what the term covers or why. While any soldier is susceptible to mental illness given the often complex day-to-day life of modern society, the Australian Army should be focused on de-stigmatising mental health illnesses that are a direct result of the Army’s role. OSI is focused on ‘operations’ and the effects of operational stress on the individual, rather than on the individual’s mental health. This focus removes the individual’s responsibility for the condition and is the least stigmatising term of those currently identified by either the Australian Army or coalition forces.

Second, mental health is still a term that attracts a stigma within the Australian Army and the wider community. Just as the term ‘psycho’ is used to describe someone who acts irrationally, the term ‘mental’ still inspires similar connotations. To most people the term PTSD would be considered less pejorative than ‘mental health injury’.

Finally, the term OSI is supported by a body of knowledge in Canada, and its use by the Canadian Forces demonstrates that those suffering from psychological conditions in a military setting find this term more acceptable than other clinical terms. The term OSI also highlights the fact that this is an illness that originates in a non-typical job that places individuals in harm’s way, and requires them to perform tasks that are unusual. In effect, the term helps to de-stigmatise a normal reaction to a stressful occupational environment.

**Awareness campaign**

Currently there is no comprehensive awareness campaign within the Australian Army to help de-stigmatise PTSD. Although there is a range of quality psychological support services both within the Army and provided through organisations such as the Department of Veterans’ Affairs and the Vietnam Veterans’ Counselling Service, an education and awareness campaign must be developed to reduce the incidence of stigma as a barrier to care. It is recommended that:
1. The Australian Army develop a campaign that incorporates the successful aspects of the Canadian approach, Real Warriors and The Enemy Within. Utilising lessons learnt from these campaigns will assist Australia to design the best possible program.87

2. A multimedia campaign is implemented, augmented by research sheets, the use of social media and base visits. The focus of this multimedia campaign should be methods of resilience, stories of recovery and strong messaging that PTSD and OSI are natural reactions to an extraordinary job.

3. That the Australian Army consider a partnership with a non-government organisation that has successfully engaged contemporary veterans.

**Security clearances**

Security clearances are a vital part of each soldier’s life within the Australian Army, and the loss or removal of a security clearance can severely affect an individual’s ability to operate efficiently. The removal of a security clearance due to mental health concerns can also have a dramatic effect of the individual’s sense of worth and purpose. Although security clearances are not immediately removed on the disclosure of PTSD, in some cases they have been removed due to PTSD and a reading of the 2010 Australian Government Personnel Security Adjudicative Guidelines would raise concerns for anyone considering treatment:

Behaviour that casts doubt on a clearance subject’s judgement, reliability, or trustworthiness that is not covered under any other guideline, including but not limited to emotionally unstable, irresponsible, dysfunctional, violent, paranoid, or bizarre behaviour.88

Recently, the US Defense Department revised its security clearance questionnaire so that people who seek mental health care for combat-related reasons are not required to report this. A similar approach to security clearances within the ADF would be a positive step towards de-stigmatising PTSD and breaking down a recognised barrier to care.

**Family education**

The stigma of PTSD affects the family as well as the individual, and in many instances the family of PTSD sufferers will hide the condition and fail to seek support. In other situations it may be family members who, under extraordinary pressure, make the decision to seek care and support for the affected individual, sometimes without that person’s knowledge. In both scenarios a program aimed at educating and supporting the families of those with PTSD is a logical and simple
option to combat stigma. The Real Warriors campaign directly targets families and informs them of the care available, both for themselves and the individual suffering from PTSD. In Australia, FamilySMART offers support through regional face-to-face programs, although it still takes a considerable amount of searching to locate the available resources. In comparison, the Real Warriors program provides a ‘one stop site’ with links to all resources that may be required.

In the Australian context, the Army need only take responsibility for linking appropriate services and providing a means for families to access these. Currently, Australian military charities offer services to families to increase awareness and reduce the stigma associated with PTSD. These support mechanisms are single entities that work in isolation and, while it is not necessary for all these services to be provided by a single organisation, it is important that the information that links them to sufferers and their families be accessible at one source. This is the point at which the Australian Army could play a vital role in the education of families and individuals with PTSD.

**Job security**

Job security is vital to soldiers. Soldiering is key to the perceived self-worth of many who serve, and termination of employment by the Army is a dramatic and often confronting experience and one that soldiers will do almost anything to avoid. The fear of being discharged due to the disclosure of PTSD is currently a significant barrier to care, and a promise made by the senior leadership of the ADF and the Australian Army does little to reassure the lower ranks of the Army who are among those most affected by PTSD. The most effective way to allay fears over job security for those who seek treatment for PTSD is to highlight positive experiences from currently serving soldiers who have been rehabilitated and subsequently enjoyed successful careers. These soldiers’ stories, highlighting their successful return to an Army career, present a highly effective means of reassuring those with PTSD that they will only be medically discharged if they cannot be successfully rehabilitated. This message can also be useful in reinforcing the need for early intervention, signalling the fact that the sooner individual sufferers seek help, the greater the chance of their recovery, and the less likely they are to face discharge. This will ultimately reduce the burden of PTSD on the individual, the Australian Army and the wider community.
Conclusion

PTSD remains a significant problem within the Australian Army and the broader community, with a recent RAND study estimating that the two-year cost to society related to the treatment and lost productivity of returning service members with PTSD and depression is estimated to be around $6 billion. This cost is increased by the stigma associated with PTSD, which continues to afflict a high proportion of ADF members returning from deployment, particularly those in the Army. As this paper has argued, such a stigma represents a significant barrier to the early identification and treatment of PTSD, increasing the burden of illness for individuals, their families and the Army. This in turn results in a loss of effectiveness and productivity for units, and equates to a significant monetary and social cost, highlighting the vital importance of research into the presence of such a stigma and the employment of de-stigmatisation initiatives within the Army.

The ADF has announced that de-stigmatising mental illness is at the ‘top of the priority list’ in mental health for Joint Health Command. Despite this, there exists a considerable gap between the rhetoric and the information and programs that exist at unit level. Given the lack of research and dearth of initiatives in the Australian context, this paper has examined some of Australia’s closest allies to assess their programs and identify themes and initiatives that could prove pertinent to the Australian experience.

Analysis of Canadian, British and US initiatives has revealed that many of the key elements for a successful de-stigmatising campaign currently exist within the Australian Army, or in other organisations that support Defence such as the Defence Community Organisation, the Department of Veterans’ Affairs and the Vietnam Veterans Counselling Service. However, a lack of coordination to
effectively tie each of these programs together has prevented the cohesive approach typical of Australia’s allies. Other recommendations stemming from the study of the international experience include the implementation of a campaign based on minimising the three key fears of soldiers who are considering accessing treatment. These are job security, loss of security clearance, and letting down their unit. This paper also highlights the importance of adopting the de-stigmatising term ‘operational stress injury’, designing education campaigns targeted at families, and welcoming the contribution of military charities. Ultimately, the adoption of any of these recommendations by the Australian Army needs to be supported by comprehensive and informed research on this topic to increase understanding and awareness of the stigma associated with PTSD within the Army, and to ensure that all initiatives are evaluated for their effectiveness. Research and de-stigmatisation initiatives have the potential to benefit the Australian Army as a whole and the community that surrounds it, increasing productivity, retention and reducing the medical burden on both the ADF and the broader Australian community. This is imperative not just for those who have served, but for those who are serving now and those who will serve in the future.
Annex A

Canadian Study Tour Findings

One of the primary aims of the Canadian study tour was to gain some insight into and understanding of the strategies used by the Canadian Army, ex-service organisations and related not-for-profit organisations to reduce the stigma surrounding PTSD and the associated disability and loss of productivity. The Canadian Forces have commissioned extensive research into PTSD and its stigma while Australian Army research and initiatives remain in their infancy. The study tour thus presented an extremely valuable opportunity to learn from an allied force.

The Canadian Forces’ major military initiatives and the external organisations involved in the recovery, rehabilitation and transition of wounded members are described below, accompanied by additional explanation of the primary programs and aims of each organisation. These descriptions highlight the diverse range of organisations working alongside the Canadian Army to reduce the stigma associated with PTSD and enrich the lives of wounded members. This collaborative approach is one of the Canadian Forces’ key de-stigmatisation strategies.

Soldier On Canada
Soldier On is an integral component of the Department of National Defence and Canadian Armed Forces’ strategy for the recovery, rehabilitation and reintegration of serving and ex-serving members with visible or non-visible illness or injury. Soldier On Canada is also a registered charity that aims to provide ill or injured members opportunities to develop new skills, build hope and confidence in their abilities and move forward in life. Soldier On implements a range of programs based on physical activities, such as the adaptive sports week in Whistler, and provides both individual and activity grants aimed at supporting sick and wounded members to develop and maintain an active lifestyle.

Canada Company
Canada Company is an independent charitable organisation that seeks to build bridges between business and community leaders and the Canadian military. Its goal is to ensure that members of the Canadian Forces receive the best possible support, care, recognition and assistance in transitioning from the military. One of the most successful programs run by Canada Company is its Military Employment Transition Program. This is an initiative designed to assist members of the Canadian Forces to transition from the military and secure employment in the civilian workforce.
Wounded Warriors Canada
Wounded Warriors Canada is a non-profit organisation that helps Canadian Forces members, both full time and reservists, who have been wounded or injured during their service to Canada.92 Wounded Warriors Canada has a wide range of programs and services which help to fill any gaps in the Canadian Forces’ member support services. Currently, the organisation’s primary focus is on mental health and, in particular, the impact of PTSD under the wider umbrella of operational stress injury.

Veterans Transition Network
The Veterans Transition Network is a national non-profit initiative created to help re-integrate Canadian veterans into their families and communities.93 The Veterans Transition Network discovered that many servicemen and women have stories that they feel can never be told or that will never be understood by civilians. This emotional gulf between military and civilian life can take many painful years or decades to cross alone. The Veterans Transition Program provides a place where veterans can help one another to reduce the burden of their experiences and examine the impact of their military service. Refined through 15 years of research, the Veterans Transition Program has helped well over 200 veterans work through their traumas, find fulfilling careers and rebuild their relationships with spouses, partners, families and children.

Prince’s Operation Entrepreneur
Prince’s Operation Entrepreneur is a national program for assisting Canadian Forces members to realise their dreams of entrepreneurship.94 The program is run by the Prince’s Charities Canada, which is focused on the Prince of Wales’ core interests within the Commonwealth. This uniquely Canadian program offers servicemen and women the education, financing and mentoring required to start and sustain their own successful businesses.

True Patriot Love
True Patriot Love honours the sacrifice of past and present members of the Canadian Forces and their families. True Patriot Love supports programs that the Canadian Government is either unable to fund or has not provided sufficient funding to allow the program to meet its objective.95 The aim of True Patriot Love is to create a link between the Canadian public and the Canadian Forces, and to ensure that sufficient private funding is available to fill gaps in transition and support services. True Patriot Love also conducts a program that draws together like-minded charities and government organisations from allied countries to discuss various topics of mutual interest and benefit. For example, in 2014 a symposium was held in London to examine the best methods of employment and most effective transition strategies for those with both visible and invisible wounds once they leave the military.
Endnotes


6 Southwick and Charney, ‘A National Longitudinal Study’.


12 Resick et al., ‘Posttraumatic Stress Disorder’.


15 Ibid., p. xiii.


26 Resick et al., ‘Posttraumatic Stress Disorder’.


30 Ibid., p. 616.


Ibid., pp. 41–42.


44 Hoge et al., ‘Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care’; Dr Andrew Khoo, ‘Care of ADF Personnel Wounded and Injured on Operations’, TPH Group Therapy Day Programs, Committee Hansard, 25 March 2013, p. 12; Name withheld, Submission 6, p. 1.


46 Confidential interview with author, 28 July 2014.

47 Hon. Warren Snowdon, MP, then Minister for Defence Science and Personnel, launching Professor David Dunt’s Review of Mental Health Care in the ADF and Transition through Discharge (Commonwealth Government, Canberra, 2009).


49 Ibid.

50 Confidential interview with author, 28 July 2014.

51 Department of Defence, Mental Health of the Australian Defence Force – 2010 ADF Mental Health Prevalence and Wellbeing Study Report, Canberra, p. 16.

52 Ibid., p. 158.

53 Confidential interview with author, 28 July 2014.


56 Hoge et al., ‘Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care’.


60 See the team website, www.realwarriors.net


More information on the organisations that support de-stigmatisation in the Canadian context can be found in Annex A.

Such as those implemented by Canada Company, an independent charitable organisation that seeks to build bridges between business and community leaders and the Canadian military.

Veterans Affairs Canada at: http://www.veterans.gc.ca/eng/mental-health/osi

Veterans Affairs Canada, Evaluation of the Residential Treatment Clinic for Operational Stress Injuries (OSI) – Ste Anne’s Hospital, at: http://www.veterans.gc.ca/eng/department/reports/deptaudrep2011-oct-ste-Annes/1-0


Real Warriors website at: www.realwarriors.net

Hoge et al., ‘Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care’.

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See Combat Stress website at: http://www.combatstress.org.uk/

Ibid.


Dingfelder, ‘The military’s war on stigma’.


Dingfelder, ‘The military’s war on stigma’.


Lieutenant General David Morrison, ‘Not the Only One’, Australian Army Headquarters, YouTube Channel.

Ibid.

CDF’s Mental Health Day message at: http://video.defence.gov.au/?mediaId=ddd36e9f-6f07-442a-83a9-d93297fb1991

By 12 November 2013 the DVA video on PTSD had been viewed 1747 times in 11 months. See: http://www.youtube.com/watch?v=KvnJDnlk8o
87 J. Acosta et al., ‘Assessment of the Content, Design, and Dissemination of the Real Warriors Campaign’.


89 Tanielian, *Invisible wounds of war*. This is a US study and the figure cited relates to the US experience.


92 Wounded Warriors Canada, at: http://www.woundedwarriors.ca

93 Veterans Transition Network, at: http://vtncanada.org

94 Prince’s Operation Entrepreneur, at: http://www.princescharities.ca/initiatives/the-princes-operation-entrepreneur/

95 True Patriot Love, at: http://truepatriotlove.com