

crosscurrents

SUMMER 2012
VOL 15 NO 4

The Journal of Addiction and Mental Health

MILITARY LIFE



**THE POWER
OF PEER
SUPPORT**

**SUICIDE BEFORE
SERVICE?**

**PARENTIFICATION
OF TEENS DURING
DEPLOYMENT**

**BRINGING CHILD
SOLDIERS HOME**

PLUS

THE CANADIAN INSTITUTE FOR MILITARY AND VETERAN HEALTH RESEARCH;
NEUROETHICS AND THE SOLDIER OF TOMORROW; RETURNING VETS, PTSD,
ALCOHOL AND OTHER DRUGS; RESEARCH UPDATES; AN EXTENDED SUMMER
REVIEW SECTION

camh

Centre for Addiction and Mental Health
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Missing in Action (2009), Eileen Koyama, charcoal on newsprint, 11" x 12.5"

For Eileen Koyama, art is the conduit that brings her inner world into the outer world. Her artwork, in its simplest form, consists merely of emotions on canvas; in its most complex form, it is psychological constructs such as identity or exclusionism, plus every moment she has lived 'til now, given colour, light and form. Her work has appeared in galleries and cafés, on a magazine cover, in calendars, and on media boxes on TTC subway platforms. Eileen lives and works in Toronto.

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Welcome to my inaugural issue of *CrossCurrents*, a journal I've read for years and now have the opportunity to edit. When I came onboard, Hema Zbogor, editor extraordinaire for the past 10 years, said my first job was choose the theme of the next issue.

The pressure was on! I polled board members, researched hot button issues in psychiatry online, spoke to colleagues, hung out at Chapters scanning psychology magazines. At the time I was halfway through Roméo Dallaire's 2010 book *They Fight Like Soldiers, They Die Like Children: The Global Quest to Eradicate the Use of Child Soldiers*, and I had been following the *Ottawa Citizen's* stories on Cpl. Stuart Langridge, a 28-year-old soldier who died by his own hand March 15, 2008 at CFB Edmonton. Stuart had loved the army since he was 12, and went on to serve in Bosnia and Afghanistan. He came back with symptoms of PTSD, his relationship broke up, he self-medicated with alcohol and cocaine. He died by suicide after his sixth attempt. I felt for his parents, Sheila and Shaun Fynes. They knew he was sick, they did everything in their power to help him. What happened to Stuart's mental state before, during and after his military service? And on the nightly news: Why were more returning U.S. soldiers and veterans dying from suicide than from battle wounds? How do soldiers heal after a deployment? How do their families heal?

The theme of my first issue was clear. As for themes of future issues, I have an executive editor—Kwame McKenzie—and an incredible advisory board you can see on the opposite page. But I'd also love your input—in the immediate future and long term. You can e-mail me directly, or visit the website at www.camhcrosscurrents.net and mail me from there. Every reader has the opportunity to contribute to the journal's growth. I look forward to hearing from you!

a view from CAMH

History was made on May 8, 2012 when the Mental Health Commission unveiled Canada's first national mental health strategy. Five years in the making, with consultation and input from across the country, the strategy offers a six-part plan as a strategic blueprint for change.

The aims are to:

- foster recovery and well-being
- provide access to the right combination of services, treatment and supports
- reduce disparities in risk and access to services
- improve the health of Aboriginal peoples
- develop a strong infrastructure with the information and leadership needed to deliver change
- promote mental health across the lifespan in homes, schools and the workplace.

Though unemployment is a potent risk factor for mental illness, poor work environments can also impact mental health. But what if the nature of the work itself is hazardous and can cause mental health problems? What if you are in the military and your job exposes you to potentially traumatic situations? Though only a minority of soldiers develop diagnosable posttraumatic stress disorder, the

psychological scars may be much more common. Alcohol and substance use is endemic in the military and in veterans. What can the military do to decrease the impact of unavoidable hazards and what can they do to help support and treat people with psychological injuries due to the work they do for their country? These are some of the subjects of this issue of *CrossCurrents*.

But there is more. War is changing. Since the Second World War, psychologists, psychiatrists and now neurobiologists have become involved with the military. The original psych-ops warriors who helped the U.S. Army with propaganda and understanding the motivation of their enemies eventually led to the development of the CIA. Now a new paradigm is opening up in research with the rise of neuroethics to try to consider the ethical aspects of having mind specialists involved with the military.

If the nature of war is changing, so is the nature of being a soldier. The majority of the estimated 160 million people who died in "war" in the 20th century died in civil wars, uprisings or genocides. A tactic that has sadly become more common in these arenas has been the forced enlisting of children. Rehabilitating child soldiers is now a major

consideration in global mental health. A few years ago, a hostage situation in which former child soldiers had taken prisoners was resolved by offering them places in school.

It is, however, all too easy to focus on the military. We are all connected. The families of veterans are impacted by war. From the relatives who lose loved ones through to those who have to support and care for those with psychological issues, as in many mental health problems and illnesses, it is the relatives who offer support. Their needs are rarely considered or met.

There is one further issue I think is worth mentioning. There is surprisingly little prominence worldwide given to psychiatric research on the impacts of war on communities. In the 20th century, more civilians have died because of war than soldiers. This issue focuses on the military but, given the changing role of war and the increased deployment of peacekeepers, the military may be helped in the future by knowing what we need to do to heal the scars of war at a population level.

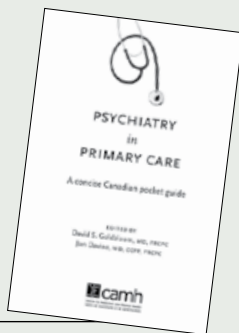
Kwame McKenzie, MD, MRCPSYCH (UK)
Executive editor, *CrossCurrents*; Medical Director CAMH; Professor of Psychiatry, University of Toronto

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National security, neuroscience and ethics

Barbara Russell

Is it possible to defend war on ethical grounds? Thirty-five years ago, American philosopher Michael Walzer wrote *Just and Unjust Wars*, in which he developed criteria applicable to civil uprisings, ethnic rebellions, and transnational defensive and offensive military actions. Since the 9/11 attacks in the U.S., ethical analyses have focused on permissible versus prohibited treatment of captured combatants, individual rights versus sovereign/state rights, and differences between what is permitted legally versus ethically in national security endeavours.

Recent advances in neuroscience—the study of the human nervous system and brain—have caught the attention of both the ethics and national security communities. The significance of recent advances' social, legal, policy and ethical implications has resulted in the newest branch of contemporary ethics: neuroethics. In 2006, a small group in the U.S. launched the Neuroethics Society. Its first conference in 2008 affirmed global interest and the name changed to the International Neuroethics Society. Several academic journals have published special neuroethics issues. *Neuroethics* and *AJOB Neuroscience* are new journals. This year, conferences have proliferated: NeuroPsycho-Economics in Rotterdam in June, Neurobioethics: The Human Person at the Center of Neuroscience, Ethics, Law and Society in Rome in July; Brain Matters 3 in Cleveland in October.

While neuroscience is central, psychology and psychiatry are involved too because the brain and the mind are connected in very complex—though sometimes disputed—ways. Causal connections between brain/mind and behaviour/performance are of interest to national security in three general ways: our abilities to accurately predict behaviour based on brain/mind processes and structure; our abilities to change these processes and structure to prevent or modify certain behaviours; and our abilities to change these processes and structure to enhance “normal” capacities and performance. Based on increased knowledge of and intervention in these connections, how can neuroscientific advances become effective means to safeguard or, if needed, restore national security?

In *Mind Wars: Brain Research and National Defense* (2006), American bioethicist Jonathan D. Moreno discusses a variety of “means.” They include creating new psychological and neurological weapons (e.g., humiliation, drugs, brain stimulation), developing “better” soldiers, “reading the brains/minds” of threatening individuals, and designing personal brain-to-computer devices. From an ethics perspective, two groups of people are particularly vulnerable to a nation's use of such measures: detainees and its own security forces.

Two examples help illustrate the kinds of ethical analyses and debate currently underway. The technology to scan and image the brain has burgeoned: fMRI (functional magnetic resonance imaging), SPECT (single photon emission computed tomography), MEG (magnetoencephalography), DTI (diffusion tensor imaging) and NIRS (near infrared spectroscopy). These are helping us better understand brain structures, activities and causal processes as well as their relationship to the mind (i.e., thoughts, beliefs, emotions, consciousness, etc.) and behaviours. In the context of national security, it is hoped that these technologies can help accurately identify individuals with threatening, violent, dishonest or deceptive thoughts and propensities that result in dangerous behaviours. However, there have been many ethics-related worries and challenges. They include imaging technologies' unproven scientific validity and reliability, reductionism (i.e., assumption that the brain fully defines and determines the person), immature and misleading hyperbole and labels, the public's faulty reasoning as well as continued stigma and discrimination.

Pharmacological measures that change or enhance the brain and nervous system are another example. In “Military medical research on cognitive performance: the warfighter's competitive edge” in *Aviation, Space and Environmental Medicine*, Eric Schoomaker, Commander of the North Atlantic Regional Medical Command and Walter Reed Medical Center, candidly states that a military objective is “providing our forces with the competitive edge required to win on the battlefield” (2007, B4). If national

security personnel are expected to perform consistently at high levels, should personnel be routinely offered pharmaceuticals to increase attentiveness or reduce fatigue due to sleep deprivation? Could individual choice be free of coercion? Perhaps consumption of such drugs should instead be required. Given the inescapable psychological trauma of combat, should those men and women likely to experience PTSD be given drugs to reduce memory consolidation and retention of gruesome events? Or would blunting these memories too much somehow blunt important basic human and humane responses? These kinds of questions ask us to openly discuss the limits of what a government and its citizens can either offer to or demand of those who voluntarily choose to risk their own well-being to protect them. Moreover, the pharmacological measures being debated have been studied and approved for specific health problems, not for national security situations or in healthy individuals.

National security issues challenge our views about freedom and privacy of thought, individual rights, collective rights, governmental duties toward its citizens and other nations, coercion, personal dignity, transparency and science's purposes. People deeply involved in neuroethics and national security consistently recommend a proactive partnership among the neuroscience, neuroethics and national security communities with appropriate oversight to protect universal human rights, individuals' moral conscience, and national welfare. As Choudhury, Gold and Kirmayer wisely conclude, “solutions [do not] lie within the skull, [but] rather in the social world” (2010, p. 19).

An online interview with Jonathan Moreno about the inescapable and important ethical complexities of national security and neuroscience is available at http://scienceblogs.com/developingintelligence/2009/06/mind_wars_jonathan_moreno_neur.php.

Barbara Russell, PhD, MBA, is a bioethicist at the Centre for Addiction and Mental Health in Toronto. She is connected with the University of Toronto's Joint Centre for Bioethics and is an assistant professor in the university's Institute for Health Policy, Management and Evaluation. She is also a contributing editor to the *Journal of Ethics in Mental Health*.

Mark de la Hey



Babies' responses to eye contact may provide early sign of autism

The way a baby responds to a person's gaze may provide an early indicator of their risk for developing autism, according to new research from the University of London in the United Kingdom. The study involved a total of 104 infants, 54 of whom had a familial risk for autism, and a control group of 50 who had no family history of autism. When the infants were between the ages of six and 10 months, researchers used electroencephalography (EEG) to measure electrical activity in their brains as they were shown pictures of people's faces on a computer screen: some were gazing toward the infant, while others were looking away. Seventeen of the infants in the at-risk group went on to develop autism by their third birthday. Those infants in the at-risk group who did not develop autism showed significant differences in their EEG responses to faces that were either looking toward them or away from them, and this was also true of infants in the control group. In contrast, the infants who later developed autism showed no difference in their responses to the two different types of faces. These findings indicate that, in the future, it may be possible to identify infants at highest risk of developing autism, allowing such infants to be targeted for early intervention.

Current Biology, February 21, 2012, v. 22: 338–342. Mayada Elsabbagh et al., Centre for Brain and Cognitive Development, University of London, London, United Kingdom.

Sleep disturbances among most distressing symptoms of cannabis withdrawal

Nightmares, angry outbursts and irritability are among the most intense symptoms experienced by individuals undergoing withdrawal from cannabis, according to research from the University of New South Wales in Sydney, Australia. Approximately 10 per cent of cannabis users develop a dependence, with the likelihood of dependence rising to about 50 per cent among daily users. The available treatments have low rates of success. The study looked at 49 cannabis users who were asked to abstain from using cannabis for two weeks. Ten participants relapsed during the abstinence phase of the study, while urinalysis indicated that another two participants who claimed to have maintained abstinence had actually relapsed. The most intense withdrawal symptoms experienced by participants were nightmares or strange dreams, angry outbursts, irritability and insomnia. Difficulty getting to sleep was the symptom that distressed participants the most, even though it was only the fifth most intense symptom. Highly dependent participants had more intense withdrawal symptoms and experienced more distress related to their symptoms than those who had lower levels of dependence. Overall, the researchers rated the intensity scores as mild to moderate, with highly dependent participants averaging only 28 per cent of the maximum possible score. The severity of cannabis withdrawal was predicted by the severity of dependence, but not by dependence diagnoses, the amount of cannabis consumed, age or gender.

Drug and Alcohol Dependence, December 2011, v. 119: 123–129. David J. Allsop et al., National Cannabis Prevention and Information Centre, University of New South Wales, Sydney, Australia.

Occasional use of hard drugs in middle age increases risk of death

People who continue to use hard drugs on an occasional basis in middle age have an increased risk of death, according to research from the Birmingham VA Medical Center in Birmingham, Alabama. Recent studies indicate that an increasing number of middle-aged adults use drugs occasionally, although their usage generally does not meet the criteria for diagnosis of a drug use disorder. Researchers looked at data on 4,301 adults in four American cities (Birmingham, Chicago, Minneapolis and Oakland) who were involved in a long-term cardiovascular disease study between the years 1987 and 2006. Based on self-report, 7.9 per cent of study participants occasionally used hard drugs (cocaine, amphetamines or opioids) when they were younger but discontinued in middle age (Early Occasional Users), 3.7 per cent reported occasional use that continued or increased in middle age (Persistent Occasional Users), and 2.6 per cent reported heavy use as young adults that continued on an occasional basis in middle age (Early Frequent/Later Occasional Users). The remainder were nonusers. Compared with nonusers, the three groups of users were less likely to have finished high school or college, less likely to be married, more likely to have experienced economic difficulty, and tended to have more adverse upbringings. They were also more likely to be smokers and to engage in risky drinking behaviours. By 2008, 4.6 per cent of participants had died. Early Frequent/Later Occasional Users were five times as likely as nonusers to have died. Persistent Occasional Users were more than three times as likely and Early Occasional Users a little over twice as likely to die, although these latter results were not considered statistically significant. These findings may help clinicians in advising middle-aged patients who continue to dabble in hard drugs.

Journal of General Internal Medicine, January 25, 2012 online, doi: 10.1007/s11606-011-1975-3. Stefan G. Kertesz et al., Center for Surgical Medical and Acute Care Research, Birmingham VA Medical Center, Birmingham, Alabama.





People with mental illness more likely to be victims of violence

Adults with mental illness have a significantly higher risk of being victims of violence than the general population, finds a study from Liverpool John Moores University in the United Kingdom. Researchers reviewed 26 scientific studies providing data on a total of 21,557 individuals with disabilities. Seventeen of these studies focused on people with mental illness, comprising a total of almost 5,000 participants. Overall, the studies showed that the prevalence of violence within the previous twelve months was a little over three per cent for people with disabilities in general, but that figure rose to more than 24 per cent for individuals with mental illness. Among people with mental illness, the rate of physical violence was 21.4 per cent, while the rate of sexual violence was 5.5 per cent. Three of the studies provided data indicating that rates of intimate partner violence among persons with mental illness are almost 38 per cent. People with mental illness were almost four times more likely than those without a disability to be the victims of violence, while disabled adults in general were 1.5 times more likely to be the victims of recent violence. The authors note that their data cover only recent violence, and that lifetime rates of exposure to violence are likely to be much higher. They also indicate that the studies they reviewed come from six high-income countries (Australia, Canada, New Zealand, Taiwan, the United Kingdom and the United States) and one middle-income country (South Africa), pointing to a need for comparable research on disability and violence in low- and middle-income countries.

The Lancet, February 28, 2012 online, doi: 10.1016/S0140-6736(11)61851-5. Karen Hughes et al., Centre for Public Health, Liverpool John Moores University, Liverpool, United Kingdom.

Sex-deprived fruit flies driven to drink

Researchers with the University of California, San Francisco, have found that when male fruit flies are deprived of sex, they show a markedly increased preference for alcohol. The researchers introduced one group of male fruit flies to females that had already mated and therefore spurned the advances of the males. A second group was paired with virgin females that were more receptive to their advances. The male fruit flies were then given the opportunity to consume either their usual food or food containing 15 per cent alcohol.

Rejected males consumed significantly more of the alcohol-laced food than their sexually satisfied counterparts. When rejected males were subsequently given the opportunity to mate, this reversed the effect of rejection, and they consumed less alcohol than rejected males who were not given such an opportunity. The researchers found that mating increased—while sexual deprivation decreased—levels of a neurotransmitter known as neuropeptide F (NPF) in the flies' brains. Researchers then demonstrated that when they artificially increased NPF levels in male fruit flies, this resulted in a decrease in alcohol consumption comparable to that seen among mated flies, while a reduction in NPF levels led to an increase in alcohol consumption. They therefore concluded that changes in NPF level were the causal link between sexual experience and alcohol consumption. A similar neurotransmitter, neuropeptide Y, is present in humans, raising the possibility that manipulation of neuropeptide Y in humans could one day offer an effective therapy for addictive behaviour.

Science, March 16, 2012, v. 335: 1351–1355. Galit Shohat-Ophir et al., Department of Anatomy, University of California, San Francisco, California.



Smoking to cope with chronic pain may be counterproductive

People who smoke cigarettes as a means of coping with chronic pain may find that their smoking actually exacerbates their pain and reduces their ability to cope with it, according to a new study from Portland VA Medical Center in Portland, Oregon. The study involved 151 chronic pain patients: 79 were smokers, while 72 were non-smokers. Thirty-nine of the smokers reported smoking to cope with their pain, while the other 40 denied doing so. Participants were asked to complete a number of questionnaires examining such things as mood, anxiety and pain-related functioning (the extent to which pain interfered with their life activities). Those who smoked cigarettes to cope with chronic pain reported more intense pain, poorer pain-related functioning, and more fear of pain. There was no difference between nonsmokers and smokers who did not use smoking to cope with their pain on any of these measures. Both groups of smokers had comparable levels of smoking frequency and nicotine dependence, so the differences between them were not likely due to the frequency of withdrawal symptoms. The authors note that it is possible that those smokers who reported using cigarettes to cope with pain may have been more preoccupied with pain, and this preoccupation may be the reason they reported poorer pain-related functioning. They recommend further research to clarify the causal relationships between smoking, coping strategies and pain-related functioning.

The Journal of Pain, March 2012, v. 13: 285–292. Alexander L. Patterson et al., Mental Health and Clinical Neurosciences Division, Portland VA Medical Center, Portland, Oregon.



The POWER of

Working out operational stress injuries—posttraumatic stress disorder in particular—finds success in a circle of soldiers

By Linda Hossie

Since warfare began, soldiers have come home from battle with psychological injuries. The first written record of a battle stress reaction was written by the Greek historian Herodotus in 490 B.C. He described the fate of an Athenian soldier who had not been physically injured but had been struck blind after seeing a fellow soldier die.

The historic evidence that these injuries exist and are real has not helped most of history's soldiers. The tell-tale symptoms of panic, confusion and flashbacks have long been a source of shame, things a "real" soldier wouldn't feel. Sufferers and their families have tried for the most part to hide the affliction.

The military was no better. Hundreds of soldiers were shot for cowardice and desertion in the First World War, many of them suffering from psychological injuries of war. The military's attitude was made notorious by Lt.-Gen. George S. Patton, commander of the Seventh U.S. Army, who on Aug. 3, 1943, slapped a soldier who was hospitalized for psychoneurosis, accusing him of cowardice. The incident almost ended Patton's career, but his gesture reflected generations of thinking about battle stress disorders.

Only in 1980 were these injuries—variously called shell shock, battle fatigue, soldier's heart—included in psychiatry's *Diagnostic and Statistical Manual of Mental Disorders* as posttraumatic stress disorder (PTSD).

Since then, slowly but surely, the medical and military communities and the world at large have started to take PTSD more seriously as a treatable medical condition. Using MRIs, doctors can now see that soldiers returning from war with PTSD have physical markers in their brains that explain the condition's behavioural symptoms.

PTSD is a serious chronic condition that can predispose

sufferers to violence, addiction and suicide. There are soldiers with PTSD who haven't left their basements in years, one who in desperation over his emotional state ploughed his SUV into a garrison building, another who woke up to find his hands around his wife's throat. Soldiers' families sometimes disintegrate under the pressure of trying to cope with the range of disabling symptoms.

In 2008, retired Lt.-Gen. Romeo Dallaire, who commanded the UN forces in Rwanda, described a 1997 flashback to a parliamentary committee in Ottawa.

"I was travelling with my family in Prince Edward Island," he said. "We were driving down a road where they had clear-cut the sides of the road where there had been principally spruce trees. The large branches had been piled along the roads with the ends facing the road and the leaves or the quills had all rusted and turned brown.

"As I drove down that road I immediately fell into a trance in which it seemed to me like I was right back in Rwanda and what was piled beside the roads were the bodies of dead and decaying Rwandans. It was so overwhelming that I in fact had to stop, and for a considerable amount of time took a lot of support from the family to be able to re-establish myself."

Dallaire has referred to PTSD as "by far the most prevalent injury of our timeframe," but statistics are difficult to come by. Some soldiers return with symptoms. In others, the signs show up months or even years later. Many never seek help and are neither diagnosed



Photo by Cpl. Tina Gillies, Task Force Kandahar, Afghanistan Image Tech, Roto 10



PEER SUPPORT

**“What do soldiers do?” he asked.
“They follow orders.” Calling their
stress injury a disorder “is like a slap
in the face with a two-by-four.”**

Cpl. Marc André Amyotte, a field medic from Canadian Forces Base Petawawa, hugs another fellow Canadian soldier while on foot patrol for Operation Mutay.

nor counted. Depending on how they are calculated, estimates of the prevalence of PTSD range from two to 30 per cent of the active military population.

Canadian Lt.-Col. Stéphane Grenier, who served in Rwanda with Dallaire, is one of the soldiers who returned with PTSD. After a period of depression and despair in which he narrowly avoided suicide, he was helped to come to terms with it by a sympathetic superior officer.

Grenier uses the term “cultural permission” to describe an acknowledgment within the military that PTSD is a real injury and that treatment is required. He received that permission from a former boss, Col. Chris Corrigan, who told him that he had been through a rough patch and needed to take some time to care for himself.

The empathy shown by Corrigan opened up a vision for Grenier of the benefit soldiers could receive from peer support, and he proposed a program within the military to provide it.

That program is the Occupational Stress Injury Social Support Program (OSISS), set up in 2001 and now available in every province. Until 2006, it was run by Grenier, who said in an interview that he had to “advocate, argue, confront, disagree and go against the grain to get this project up and running”

“The fact of the matter is that when a colonel comes out and admits they have PTSD and depression and that they are going to do

something to help soldiers and families who are falling through the cracks left, right and centre, you do not make friends.”

Political tensions with his political overseers eventually led to Grenier losing his job at OSISS in 2006. He was posted to Afghanistan and returned in 2007 to another mental-health assignment: setting up training for soldiers to help reduce the stigma for those with stress-related injuries. He has since left the military.

The training program he designed in his last military job was based on leadership principles and behaviours and included “granular, tangible” discussions, he said. Experienced veterans were recruited to provide the training and by the time they declared their own psychological struggles at the end of the day-and-a-half-long sessions, they had demonstrated their credibility as soldiers. Grenier calls it “leveraging people’s lived experience” to lessen stigma.

Grenier said the stigma is still there, but is significantly reduced from what it was 12 years ago, when he went public with his difficulties. Then, he said, it was a “minus 30 chill.” Now it’s like a “cold fall wind.”

Stigma still keeps some soldiers from seeking peer support. One such man is a retired major who agreed to tell *CrossCurrents* his story. He has been diagnosed with PTSD but he resists that diagnosis for himself. He will admit to depression and anxiety because depression and anxiety can occur regardless of military service.

Admitting to PTSD, he believes, would be admitting that he “can’t take” what military life demands. He would be one of the people his generation of soldiers was taught to look down on, excluded from a community that has been like a family to him for

most of his life. His father was also a soldier, a veteran of the Korean War, which makes the family connection even stronger.

Putting the emphasis on the word “injury” rather than “disorder” was Grenier’s innovation. He coined the term operational stress injury, and the logic for it comes from his knowledge of the military culture.

“What do soldiers do?” he said. “They follow orders.” Calling their stress injury a disorder “is like a slap in the face with a two-by-four.”

The OSISS program’s key rationale is that those who understand the chaos and disruption visited on soldiers with PTSD are best placed to help them come to terms with it. Its success has prompted international interest, and speakers from OSISS have made presentations in Europe, at NATO and in the United States. Dallaire was recently invited to the American Psychiatric Association’s annual conference to discuss changing its term—posttraumatic stress disorder—to posttraumatic stress injury.

“I never dreamed in 1,000 years that it would potentially become a clinical term,” Grenier said.

One group on the front lines with Canada’s soldiers is their wives. These women often recognize the importance of peer support because they see the way their husbands behave at home before and after deployments. One said that meeting other soldiers through therapy was “the most helpful thing” she and her husband had encountered.

“I mean, he is such good friends with these people now,” she said. “Phones them all the time, they talk and they all know what each other’s talking about. And that is huge—huge therapy for him. It may be better than having a counsellor who has no clue.”



Senator Roméo Dallaire (left), unwilling witness to the Rwandan genocide in 1994, and Stéphane Grenier (right), who served under Dallaire in Rwanda: both experienced PTSD firsthand, and led advances in PTSD recognition and treatment for Canadian soldiers.

The woman’s story, and that of five other military wives, was included in a PhD thesis in counselling psychology by Holly Beth McLean, submitted to UBC. The husbands of the women were all part of a non-military support group called the Transition Program for Canadian Soldiers.

To date, 6,300 soldiers have taken advantage of OSISS services. While the number seems small, Grenier pointed out that in its first year, the program had only four support workers and the numbers increased slowly in subsequent years.

“In the six years I managed the program, 70 per cent of our active cases were extremely unstable individuals [but] soldiers and families who availed themselves of the program have moved on and have embarked on the road to recovery.”

The program offers peer support for families—for anyone living with a soldier “who has an operational stress injury,” said Maj. Carl Walsh, OSISS national manager.

In actual meetings between peer support workers and a soldier with an operational stress injury, he said, one of the important jobs of the peer support staff is to “model” recovery for the soldier—“this is where you could be” once your symptoms are dealt with.

Peer support workers are hired, trained by “a PhD psychologist” and work under ongoing supervision, Maj. Walsh said.

The program also has staff people available on site. Soldiers who are returning from tours go through what is called “third location decompressions,” with staff advising them of the services available for a range of possible needs.

Grenier pointed out that whether a soldier needs OSISS help depends on the peer support available to him outside the program. Many commanding officers and units are very supportive of a soldier going through difficulties, he said. “What we inherit are the people who fall through the cracks.”

But he also pointed out that the current program has dropped its “seven or eight tier self-care protocol.” Because the peer support job is so demanding, under Grenier’s management, support workers were actively encouraged to follow detailed plans to look after their own mental health. Now a worker with difficulties is simply referred to the employee assistance plan, he said.

A point made by a number of soldiers is that the nature of modern peacekeeping is partly responsible for the disorder. Canadians have an honoured tradition as peacekeepers, but modern peacekeeping operations can involve situations of extreme violence and human rights abuse. After the civil war in the Balkans, in which more than 130,000 people were killed and war crimes committed on a massive scale, the 1999 Croatia Board of Inquiry

PTSD by the numbers

A 2011 Library of Parliament research paper made an effort to provide numbers, based on “the only major scientific study on PTSD in Canadian soldiers . . . based on a special sampling developed by Statistics Canada as part of the 2001 census,” which included 8,441 active service personnel.

- **When PTSD is narrowly defined to exclude other psychiatric conditions such as major depression, the report said, the incidence is about 2.3 per cent.**
- **When soldiers are included who have taken part in combat, the incidence of PTSD doubles; when soldiers who have witnessed atrocities are included, the rate jumps to almost 10 per cent.**
- **The report also notes that the lifetime risk of PTSD for those groups is two to four times higher, meaning many may go on to develop the disorder.**
- **A later and more specific Canadian Forces study, in 2011, Cumulative Incidence of Post-Traumatic Stress Disorder (PTSD) and Other Mental Disorders (<http://forces.gc.ca/health-sante/ps/mh-sm/osi-bso/default-eng.asp>) estimated that eight per cent of soldiers who had deployed to Afghanistan had been diagnosed with PTSD. The study involved medical record reviews of a sample of 2,045 personnel.**

concluded that stress was the likely cause of the high number of illnesses experienced by Canadian peacekeepers there.

Not only are soldiers in combat situations, but the combat is between civilian forces, and peacekeepers have stringent limits on their use of force. “The ethical and moral and legal dilemmas” in that situation, Dallaire has said, “have been added onto what the old combat stress used to be.”

Lt.-Col. Alexandra Heber, a psychiatrist with the Canadian Forces’ Operational Trauma and Stress Support Centre in Ottawa, doesn’t agree. Although record keeping was not good enough during the Second World War to allow comparisons with that period and

the PTSD rate of modern peacekeepers, she said two men can be standing right beside each other in a violent conflict and one will develop PTSD and the other will not.

For those who do, the peer support program can be a lifesaver. A peer support worker told journalist Randy Turner that in OSISS, “the important thing is that everybody has a common denominator. We all served in some sort of way. It doesn’t matter if you’re an officer or a junior rank. It doesn’t matter if you’re male or female. What matters is you went through a trauma, and we’re here to help bring you back.” ☞

PTSD: It’s a family affair

Last year, Kelly Thompson was eagerly awaiting the return of her soldier husband from a tour of duty in Afghanistan. In the first 40 nights he was home, however, the two of them slept in the same bed for only five.

“Mark’s body is so tense that once he falls asleep, his legs move non-stop,” she wrote in a blog for *Chatelaine* magazine in January, 2011.

“He kicks, flails and quite literally bruises my shins.... And when I gently wake him up, he mumbles something about fighting the Taliban or killing the monster from the Predator.”

The longer Mark was home, however, the more peacefully he slept. He and Kelly could look forward to resuming comfortable nights together.

Not all military families are so lucky. When a soldier returns home with full-blown posttraumatic stress disorder (PTSD) or develops it later, families are in the cross-hairs of a chronic and deeply debilitating condition. Not all of them survive.

The soldiers may have symptoms that range from mistrust, sleeplessness, anger and addictions, as well as loss of sensuality and sexual drive. Their spouses, trying to cope with the stranger who came home to them, also suffer anxiety, depression, social withdrawal and sleep problems. Those are only some of the symptoms.

“I... feel I am walking on eggshells, saying what he wants to hear,” said one woman. “There are some times now when I feel a little afraid. During those instances, I just leave the room and walk away.”

She was one of the subjects in a study of PTSD wives conducted by Holly Beth McLean for a PhD in counselling psychology at the University of British Columbia.

“Joe was taught as a soldier to show no signs of weakness and to react to things that are threatening with maximum violence, maximum aggression,” said another. “I wasn’t getting that full force, but it was there, just barely under the surface, and it really scared me.”

Not all PTSD wives feel that kind of fear. Jane, the wife of a major who did three peacekeeping tours in violent war zones, said that she and her husband have never suffered any alienation from each other as a result of his psychological symptoms. In an interview at their sunny, pleasant home, he called her “my best friend,” and said that without her, “I wouldn’t be here.”

That’s not to say they have it easy. A retired major, her husband has been diagnosed with PTSD, although he doesn’t accept the diagnosis. He does have many of the symptoms, though, including trouble sleeping. He’s jumpy, they both agree. He’s deeply depressed. He has sought

treatment for depression and anxiety, including electric shock therapy.

For a time he had such problems with his memory that he had to take a cellphone when he left the house—he got lost, even in the small central Ontario city where he lives. Jane goes with him to every medical appointment to fill in the holes in his memory.

“It’s been a long haul,” she said.

Children, too, suffer when a parent has PTSD. Attention has been focused on the symptoms children exhibit while a parent is away on duty. They have nightmares and anxiety about the parent’s safety.

But living with PTSD once the soldier is home presents its own challenges, as the Mood Disorders Society of Canada made clear in a report this year to the Government of Canada, quoting Deborah Harrison, a sociology professor at the University of New Brunswick.

“It changes their life and it completely changes the situation at home,” she said. “It’s a crisis like any other kind of major illness or violence in the home.”

One veteran with PTSD who took part in a study with the University of Western Ontario said he recognized the degree to which his condition affected his children.

“It really had a profound effect on my oldest son because... the relationship with him changed. He has a lot of anger and hurt. He was basically abandoned... unable to understand why I have these mood swings and anger.”

Even in families where violent behaviour or addictions are not an issue, a spouse may be left doing all of the family work, as well as working outside the home, in order to keep the family functioning.

“My job now is very well suited to my situation because I have alternate weeks working and being off and I can do my job and be at home more,” one woman told McLean. “I am home every day to get the kids ready in the morning for school. All Luke has to do is put them in the truck and take them to school. And I am home every day for lunch and I am home right after five. I am home to take care of everything at lunch, make sure everybody eats and everything is taken care of and go back to work and come back home... so I got very, very lucky to get this job.”

Even in these difficult stories there is a ray of light. All of the women in McLean’s study report strong memories of the life-loving, funny and healthy men they sent off to duty and all of them, in spite of the stresses they described, remained loyal to their husbands and stayed married. In the UWO study, only one of 10 Canadian peacekeepers who took part had experienced a separation and divorce.



SUICIDE BEFORE SERVICE?

Mental fitness concerns at Canada's Royal Military College

By Tracey Arial

When he saw two uniformed men waiting for him in his boss's office, Danny LeClair's worries were for his son Eric, a reservist at Gagetown. Instead, they told him his youngest son, Mathieu, a 20-year-old officer cadet at the Royal Military College (RMC), was missing.

"I wasn't even thinking of Mathieu until then," he said. "When they told me he never showed up for a class in the morning, I knew it was foul play or something happened. I knew right then. There's something really devastatingly wrong. Mathieu would never miss an appointment or anything."

Ontario Provincial Police divers pulled the body of Mathieu Robert LeClair out of Navy Bay later that same afternoon, Tuesday, February 28, 2012.

The image—an eerie replay of the discovery of officer cadet Joe Grozelle in the Cataract River on November 13, 2003—has reinvigorated concerns about how the Royal Military College handles the mental fitness of young people in its charge. While many eyes—teachers, leadership mentors, coaches, chaplains—fall on students during the day, the thousand or so officer cadets who live in the dormitories take care of themselves overnight.

Prior to their deaths, Mathieu and Joe combined the hectic life of any elite third-year university student with rigorous military training, and tests for bilingualism and fitness.

As one current officer cadet said: "You have to work hard all the time to get your degree. If you don't get your bilingual certificate, you don't get an RMC degree. We get the minimum military training, foot drill, drill with a rifle, drill with a sword, because the assumption

is that officers have to be able to fight too. We do fitness testing twice a year and ours is harsher than is required from other army personnel. We also have a student chain of command, so most students have responsibilities for others."

After three years, the cadet said, about 50 per cent of those who began in the college have been weeded out. "Some people to be non-commissioned left, some people failed and they can be given another trade. You can get away with failing a year and you can continue, but your pay can be withheld for the year."

A typical day at RMC is hectic with squadrons getting up at 5:50 a.m. and doing fitness together until 7:00 a.m.; they run in formation and then begin classes at 8:00 a.m. On Mondays, they have night classes. On Tuesdays and Thursdays, everyone has sports. Mathieu and Joe played on the basketball team. They had to work hard to succeed at everything while protecting their personal identities and maintaining privacy.

Mathieu disappeared sometime during the night on a Monday; Joe disappeared on a Wednesday. Mathieu was found the next day, but Joe was missing for 22 days. After they were found, military investigators focused on suicide as a likely explanation for their deaths.

"That's a mistake," said Joe's father, Ron Grozelle. Grozelle says the stigma of suicide around his son's death made people reluctant to talk and put too much blame for what happened on the victim. Investigators focused so closely on their presumption of suicide that they missed other clues. As a result, an autopsy, two coroner reports and an internal board of inquiry found no confirmation of how,

when or why Joe Grozelle died.

"I would have accepted suicide, if that's what happened to Joe," he said. "But they had to prove it to me. They couldn't do that."

He hopes the same thing doesn't happen to the LeClair family.

However they died, both Mathieu and Joe have now joined the ranks of high-profile controversial deaths of officer cadets at military academies around the world, including Stephen Hilder from the Defence Academy of the United Kingdom in Shrivenham, Wiltshire; Marc Henning from the Air Force Academy in Colorado Springs; and Gordon Fein and Alfred D. Fox from West Point, New York.

The three men in Colorado Springs and West Point killed themselves, something that's happening more often than it used to, according to a study published in the journal *Injury Prevention* last March. "Mental health risk factors for suicides in the U.S. Army, 2007–8" showed a higher suicide rate among U.S. Army personnel than the general population (20 instead of 12 per every 100,000 people). It also showed that almost a third of the U.S. soldiers who committed suicide in those years saw no combat. Half of those who killed themselves were between 18 and 24 years old.

The Canadian Forces produced a report about suicides in the Canadian military on April 27, 2012. According to the data, which was collected by the Directorate Force Health Protection, 12 male soldiers killed themselves in 2010, while in 2011, 19 male and one female soldiers killed themselves, a marked increase. In the 10 years from 2000 until 2009, 100 male and eight female soldiers killed themselves. The year Joe died, eight other male soldiers and two female soldiers killed themselves. No information about their ages or whether their deaths occurred prior to deployment was provided.

Boards of inquiry were held in all these cases, but the length of time for them to be completed led Canadian defence officials to create an additional review, led by teams of mental health professionals in April 2010. These professional suicide reviews are conducted as soon as possible following a suspected suicide.

Grozelle's last hope for answers in his son's case was an internal board of inquiry that began in 2008 and lasted until June 2010. He got the report four months later. He says the 800-page document contained no new answers. It did, however, contain five

recommendations designed to prevent officer cadet suicides: annual refresher courses highlighting suicidal behaviours; better awareness of student services such as the Peer Assistance Group (PAG) and chaplains; consideration of hiring a full-time on-site mental health counsellor; privacy reinforcement; and grief counselling.

One of those recommendations was being fulfilled while the board of inquiry met. General Walt Natynczyk, then Chief of Defence Staff, launched the "Be the Difference" campaign on June 25, 2009. "One in five Canadians will suffer from mental health injuries during their lifetimes," says the advertising. "I'm asking all Canadian Forces personnel, regardless of rank, to help combat mental health stigma and support colleagues in need."

As part of "Be the Difference," undergraduate officer cadets at the Royal Military College take an eight-hour suicide prevention class in their first year. After that, all military personnel regardless of rank take a two-hour annual refresher course to identify signs of mental health problems in their colleagues, such as sleep disruption, nightmares, and higher levels of frustration or tension than usual.

can be communicated.

Officer cadets who are reluctant to speak directly to medical practitioners can speak first to a volunteer member of the Peer Assistance Group (PAG). PAG members are officer cadets who volunteer to function as ad-hoc councillors and referral agents. They also organize morale-boosting activities throughout the year.

PAG was reinvigorated two years ago under the supervision of Major Bernadette Myslicki, a bilingual military psychology and leadership teacher who joined the Royal Military College of Canada in August 2008. When she began supervising PAG the following January, the program had only 30 volunteer cadet members. It now numbers 76 people and is still growing.

"A lot of people are talking about this," said Myslicki. "When you're helping your peers, you learn what's going on."

Their volunteer roles put PAG members on the front line both before and after Mathieu's death. During their planning session last May, for example, PAG volunteers asked for extra training in handling harassment. A civilian expert from Base Borden gave them an eight-hour intensive training course last August. "We talked

"Officer cadets who seek treatment for mental health injuries do so in complete privacy."

"A lot of our members didn't know what mental health issues were, or when they needed support," said Lieutenant Colonel Suzanne Bailey, a Canadian Forces social work officer and an Ottawa-based national practice leader for social work. "The aim has been to help people recognize where they are on the continuum of health."

"Officer cadets who seek treatment for mental health injuries do so in complete privacy," said Lieutenant Colonel Alexandra Heber, the Canadian Forces psychiatrist in the Operational Trauma and Stress Support Centre (OTSSC) in Ottawa, which supports the smaller centre on the Kingston base.

Those above them in the chain of command may be told about pertinent medical releases from service—this officer cadet can't drill daily or some other pertinent order—but no information about why

about perceptions and the definition of harassment," said Myslicki. "He outlined grounds of discrimination, case studies, what might you do, and self-help options."

Whether harassment played a role in Mathieu's death or not, Ron Grozelle hopes that PAG members will be among the witnesses whom investigators speak to during their investigation. "Here we have the death of another young man. If he did commit suicide, what were the factors that caused that to happen? Was there abuse, bullying or something else? The investigation needs to find that out." ☐

Tracey Arial is an independent writer who specializes in social justice. *I Volunteered: Canadian Vietnam Vets Remember* (Watson & Dwyer, 1996) is one of five books she has published; she also writes for newspapers, magazines, the web and corporate clients.

Parentification

Teens tell how they cope with parental military deployments

By Deborah Harrison and Patrizia Albanese

This abridged version of “The ‘Parentification’ Phenomenon as Applied to Adolescents Living Through Parental Military Deployments” is printed with permission. The full, original study appeared in the University of Alberta’s Canadian Journal of Family and Youth, 4 (1), 2012.

Many children and adolescents care for their family members in some form during their childhoods, but some take on adult roles and responsibilities beyond what is considered to be developmentally appropriate—a situation known in academic and clinical literature as *parentification*. Parentification is widely understood as an interactional pattern within families in which children or adolescents are assigned roles and responsibilities that are typically considered the responsibility of adults, but which parents have relinquished.

Parentified children are then expected to fulfil caretaking roles, which include the care of younger siblings, and providing comfort, advice, or protection to family members (Earley & Cushway, 2002). Hooper (2007) notes that some researchers have distinguished among different types of parentification. For example, some have used the term instrumental parentification to refer to children taking on an unreasonable number of instrumental tasks, such as household chores and food preparation. In contrast, emotional parentification involves catering to the emotional needs of parents or siblings, or acting as the peacemaker in the family.

Parentification and military deployments

Canada has experienced a recent sharp increase in the frequency and danger of military deployments. During the first 12 years of the post-Cold War period (1989–2001), Canadian Forces (CF) members were deployed on 65 missions worldwide, compared with a mere 25 peacekeeping missions during the preceding 40 years. The CF’s recent change in focus from peacetime to wartime deployments has

significantly altered the lives of affected CF members and their families.

In our study, we conducted two-hour semi-structured interviews with 61 adolescents from CF families, selected from the 1,066 (of the circa 1,200 enrolled) “Armyville” High School (AHS) students who, in 2008, had filled out a survey for our research team. Most of the survey had replicated parts of the National Longitudinal Survey of Children and Youth (NLSCY), and had compared CF and civilian youth on measures of psychological well being, family functioning, attitudes toward school and peer relationships. We recruited the 61 interview participants by inviting students who had participated in the survey to volunteer by filling out contact sheets attached to their surveys. From this pool we constructed a sample consisting of 15 “CF adolescents” from each grade, with gender divisions reflecting our volunteer pool demographics, and an attempt to include youth with parents representing all ranks, and both the regular and reserve forces. We interviewed 35 girls and 26 boys who, among them, had 69 parents who were current or recently retired CF members.

“Armyville” is a company town that has been dominated by the presence of a large army base for several decades, and whose residents are primarily white Anglo Saxons. The ratio of CF to civilian adolescents attending AHS was approximately 50:50 in 2008–09. The school district in which AHS is located prides itself on its proactive stance toward supporting the children of CF members deployed to Afghanistan since 2002, and it has supplied each of its schools with a large binder of information about how parental deployments affect children’s moods and progress in school.

Parentification and gender

Parentification was much more strongly at work in the experiences of the adolescent girls we interviewed about parental deployments than in the experiences of their male peers. It was evident that girls were significantly more active in domestic work of all kinds, especially emotional caretaking work.

Especially notable was Marlene, who looked after her entire household at the age of 12 when their mother was away on basic training:

I was the mother role now, 'cause my dad was working. So I got up early in the morning, ... got my sisters ready to catch the bus, ... made lunches and... got myself ready for school. And then, I would come home after school and... I had to make dinner and make sure the girls did their homework.... [When] my dad got home, I'd have dinner on the table.

And Heather, who reorganized her social life in order to prioritize her mother's social needs while her father was away on an unaccompanied posting:

I don't like going out with my friends, so I usually bring my friends over. 'Cause I don't like leaving my mom home.... She says it's fine when I go out, but I think she'd be bored.... She has friends, but she doesn't go out much.

Girls' emotional work additionally included self-censorship: that is, protecting both their deployed and undeployed parents from additional stress by refraining from sharing potentially upsetting personal problems with either of them. For example, Jasmine described how she, her mother, and siblings communicated with her father when he was in Afghanistan:

When my dad called, we talked to him and we'd tell him everything good that was going on. We'd never tell him anything bad, because that's the last thing you want them thinking about.... Like, he was just a couple hours away is the way that we made it sound when we were talking.

Chantal, a senior girl with a frequently deployed father and chronically ill mother, did not tell her parents for four years about the severe bullying she had been subjected to at elementary school:

Because I didn't want to make matters worse, I just kept it to myself.... I actually didn't tell them till about Grade 9... four years after I moved down here.

A few of the adolescent boys we interviewed were atypical in that they provided emotional support to their mothers when their fathers were deployed. For example, Mark, a senior boy, described suppressing his own needs during his father's deployments, to ease the burden for his mother, who is chronically depressed:

Having my dad go away constantly, Mom being depressed.... It's almost like you're living with yourself. Because you don't want to talk to your mom about it because she's depressed, and you don't want to make her more depressed, and you don't want to make her think about it. And then you're sitting there like, "What am I going to do?" and you have to come up with your own reasons, your own answers.

In general, however, the adolescent boys we interviewed appeared to provide significantly less instrumental and emotional support to their families when their parents were deployed.

Parentification and the adolescent's relationship with the undeployed parent

The essence of parentification is that the child or adolescent assumes adult roles in the household, to compensate for the fact that, for whatever reason, his or her parent(s) is "unavailable." The deployed parent is unavailable because he or she is deployed. The parent remaining at home is frequently also emotionally unavailable, owing to full-time work commitments, temporary new status as a solo parent, and/or an anxious state of mind brought on by the other parent's deployment.

Emotional unavailability of the undeployed parent was a frequent theme in our interviews. Justin, a junior boy, described the stress and anger continually expressed by his mother during his father's deployments:

She's very stressed out.... She just usually gets noticeably angrier.... Like if I had small problems, she'd flip. And every day after work, she's just so angry and stressed out that she won't talk.... I can't really find a word to describe [how horrible it is]. Just constantly tension everywhere.

Marlene (introduced earlier), whose mother spent almost a year on basic training, lived with a father who was unable to provide any nurturing to his children. She described her daily life as:

It was pretty much leave for work, come back for dinner, go to bed, leave for work, come back for dinner. That was it. We didn't really talk. It was just, "Here's your dinner. I'm going to go watch TV now"... That was it. I didn't talk to anybody.... I was really, really lonely.

THE QUESTIONS

How did your life change during the deployment?

How did the deployment affect your parent who went away? your other parent? your parents' relationship?

What was the hardest part of this deployment for you?

What was the best part of this deployment for you (if any)? (probing for reflections on resilience and self-esteem)

How (if at all) did AHS [the school] help you adjust to the deployment?

Generally, how good a job does AHS do supporting students whose parents are deployed?

After the interviews had been transcribed, we organized the responses to our open-ended questions thematically, via an inductive process of generating categories from data, which resembled (but was not synonymous with) grounded theory methodology.

After her mother's basic training, both of Marlene's CF parents were sent on long deployments back-to-back. She described how her self-censorship may have permanently eroded her ability to communicate with either of them.

We started getting really distant, and not telling him as much—and same with my mom. I didn't hide stuff from them. I just didn't tell them as much, so they could get back to being them again and not have to worry about me.... It's really hard, 'cause my mom and dad are gone so much. Like, my mom's gone on course. My dad's gone on course. My dad's gone to Afghanistan. My dad's gone to Country X.... It's never really stable.

Mark (introduced earlier), whose father was in Afghanistan and whose mother was chronically depressed, revealed his mother's permanent unavailability by expressing his extreme anxiety during the deployment at the prospect of the "only parent I could count on" not returning. He told us:

That was basically my only thought during the whole time. "I want him to come home, you better come home." Like, he's the only reason why our family stays together... [If he didn't come home] it would make things a lot more difficult.

In summary, parentification entailed intricate instrumental and emotional domestic work on the part of some of our research participants with deployed parents (especially the girls), in the context of both parents being unavailable to them as sources of support.

Our participants were proud of their domestic achievements during parental deployments. On the other hand, developing adolescents need to spend quality time with their peers, pursue extracurricular activities, establish romantic relationships, and be mentored through new challenges by their parents. For a significant

number of our participants, too few of these needs appeared to be being met during the parental deployments they discussed with us.

Parentification and perception of school support

In general, the participants who had experienced a recent parental deployment were more negative and more specific in their feedback about the quality of deployment support provided by teachers and guidance counsellors at the school than were their peers who had not experienced a recent parental deployment. For example, Jonathan referred to the school's "sugar coating" of the war in Afghanistan; Sarah criticized the guidance office's refusal to provide support without a prior appointment; Jasmine highlighted the deployment-related training that she believed school personnel had failed to receive; Joanne mentioned teachers' ignorance regarding which students' parents were deployed, and of how an adolescent's acting out during a deployment might reflect the stress his or her family was experiencing:

It's not their fault, but they don't know anything.... They [should] have at least a list... and bring it to the military, and say like, "Please tell me who are deployed right now." And get all those kids into a room. And I'll bet you they'll all be sobbing within 15 minutes of asking them questions, because they have it all bottled up inside of them.

She added that, partly because of this lack of information, teachers found it difficult to understand that a student who acted out during an Afghanistan deployment was doing so because they were missing and/or worried about a parent who was there.

If a kid is really obnoxious in class, or rude in class, there's obviously something behind it. There's some motive of why they may be acting out. Some teachers find it over and above their job to

PARENTIFICATION 101

The clinicians at The Phoenix Centre for Children & Families in Pembroke, Ontario, see many families from the Canadian Forces. *CrossCurrents* spoke to Greg Lubimiv, executive director of the centre, about parentification and its effects.

How do you tell if teens and children have been parentified?

What I look for is changes that have occurred from before the first deployment, since it's a process that often starts with the first time a parent is absent. This provides a baseline of behaviour that you are able to then compare to what the child is exhibiting at the present time. The child might not exhibit a lot of changes after the second or third deployment, because the changes happened earlier. I focus on losses related to four life areas:

Friendships: Children often lose friends because their new role as parent takes up their time, either instrumentally, because of chores,

or emotionally, because of the investment of time in the parent who is at home.

Interests: We ask children, "What were you interested in before your parent or parents were deployed the first time? Video games, baseball, swimming?" Then, we ask them what their interests are now, and receive such answers as, "Um, ah, I don't really know. I don't really know what I like to do" or "I used to like swimming a lot, but now I just go once in a while, or not at all."

Time for self: Teens (in fact all of us) need time for themselves to grow—to listen to music, watch TV or video, or just have "me" time. Here we look for a significant increase or decrease in that time. If a teen has no time for him- or herself, that's a definite problem; but if a teen has a lot of time, it could be because they feel distanced from their peers, or feel a need to remain in the home to be present for the parent there. The larger the net change of

time for self from the pre-deployment time, the more it needs to be explored further.

Grades/attendance: Again, we will typically see grades drop because the children do not have the time to spend or the capacity to pay attention in class or on homework. As well we may see attendance issues, or frequent lateness because the child is dealing with logistic issues at home.

Do parents see that they are parentifying their kids?

Much of the time, no. The parent or parents are in their own state of stress or need. The child or teen steps in, the parent's need is met, they are fulfilled, so no, they often don't see it.

What about parents who argue that extra chores for kids are actually a good thing?

There is the question of additional responsibility versus parentification. It's not necessarily wrong for kids to have added responsibilities

address it. Over and above like, “Oh, they’re just a troubled child.” Like, get them through this class with a 60, and then they’ll be off to the next teacher. I know a lot of them are just acting out to act out. But some of them are probably acting out because they have problems at home because one of their parents are being deployed, or one of their parents are going through things in the military.

Our data suggest that the real or perceived deficiencies in the school’s support system had been observed more intensively by CF students who had lived through recent overseas deployments than by their peers who had not. This would be a plausible interpretation, in view of the fact that students who had experienced difficult deployments, especially those who had been parentified, would have been those who had been most in need of support from the school, and consequently also most conscious of the kinds of school support that might have been missing.

Conclusion

The implications of our findings are two-fold. First, in keeping with traditional expectations about domestic labour and gender, deployments appear to demand more from the daughters of deployed members than they demand from sons. This statement should not be interpreted as an attempt to minimize the work and suffering that male adolescents put into their parents’ deployments. Indeed, a strong need exists for community organizations which provide support to children of deployed military members to develop effective strategies to assist adolescents of both genders. However, our findings suggest that girls could especially benefit from curriculum modules which focused on the costs to women of gender role socialization and the gender division of labour, and from support initiatives that were predicated on a realistic assessment of how gender socialization is likely to occur within communities located near army bases.

Second, between the lines of their comments, our interview participants appeared to express the need for more knowledgeable and proactive support to be provided by schools to adolescents who are affected by parental military deployments. Enhanced school support could potentially fill some of the vacuums created by the parental emotional unavailability that is the unavoidable by-product of the situation of adults who are responding as heroically as they can to the overwhelming stresses that deployments create. Enhanced school support could also ease some of the burdens that many undeployed parents now shoulder alone. Education is a provincial responsibility in Canada. However, since decisions to participate in overseas missions are made at the federal level, it would be appropriate for the federal government to assume responsibility for assisting provinces to enable schools located near military bases to increase their levels of support to students whose parents have been deployed. 

Earley, L. & Cushway, D. J. (2002). The parentified child. *Clinical Child Psychology & Psychiatry*, 7 (2), 163–178.

Hooper, L. (2007). Expanding the discussion regarding parentification and its varied outcomes: Implications for mental health research and practice. *Journal of Mental Health Counseling*, 29 (4), 322–337.

Deborah Harrison is professor (retired) and adjunct professor of Sociology at the University of New Brunswick, and professor (status only) of Sociology and Equity Studies in Education at OISEUT. Her books include *No Life Like It: Military Wives in Canada* (co-authored with Lucie Laliberté; Toronto: James Lorimer, 1994) and *The First Casualty: Violence Against Women in Canadian Military Communities* (with seven collaborators; Toronto: James Lorimer, 2002).

Patrizia Albanese is an associate professor and interim chair of the Department of Criminal Justice and Criminology at Ryerson University. Her most recent books include *Youth and Society: Exploring the Social Dynamics of Youth Experience* (Canadian adaptation of White and Wyn; Toronto: Oxford University Press, 2011); *Child Poverty in Canada* (Toronto: Oxford University Press, 2010); *Children in Canada Today* (Toronto: Oxford University Press, 2009).

when a parent is absent, say, taking over the care of the lawn. It’s when boundaries and roles get blurred, when the child starts acting as if he is the father, that trouble begins.

A teen cutting grass is one thing. A teen who is worried that the state of the yard will bring disgrace on him and his family, who watches for every weed, trims, fertilizes and ruminates over the lawn is in trouble. Parentification eliminates the time that kids get to spend in age-appropriate behaviours, and that is what creates the concern.

Is parentification the main way teens adapt to deployments?

Kids adapt to deployments in different ways: one family with two teens sought help for the younger teen, a boy, who seemed to the parents to be acting out. The older teen, a girl, had buckled down at high school and had gone from being a C student to an A student. What we saw as clinicians was different than

what the parents saw: we saw a son who was reacting to being a teen by testing boundaries and deemed this “normal” teen behaviour; we saw a daughter who was dealing with a lot of anxiety caused by the deployment by focusing exclusively on school as being in trouble.

What do you look for in a family with deployments?

We check the social support systems of the parents. In many career military families, there have been multiple moves for the family, to the point where the parents may have given up on a social support system—they’re not in any one place long enough to invest in making close friendships, and their familial support group is far away.

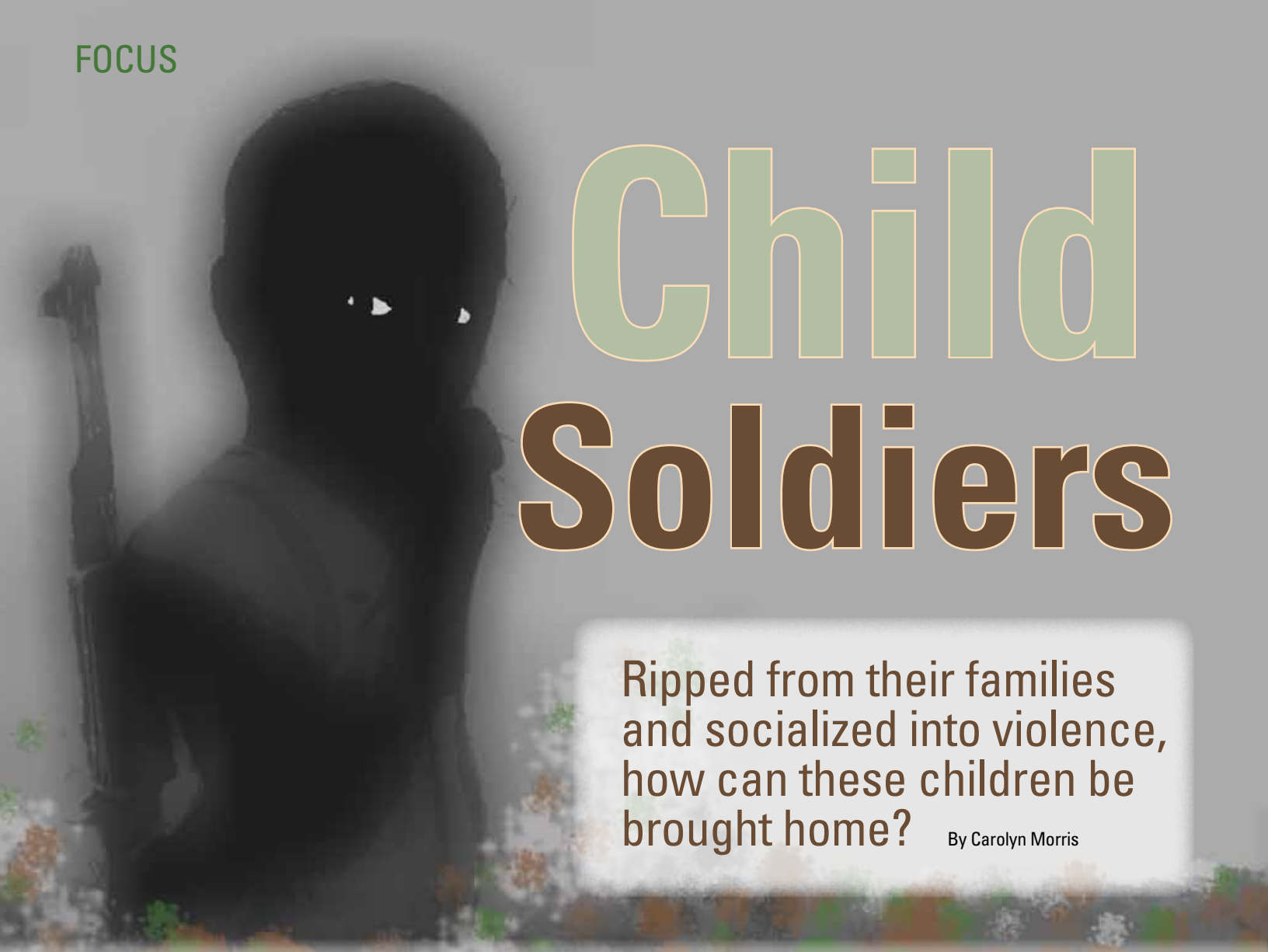
When the parent’s emotional needs are not being addressed during a deployment, the parent naturally turns to someone they are emotionally connected with. If there isn’t anyone in the adult world, the child, particularly

if the child is a teenager, may be the one who is engaged for emotional support. It’s when the parent begins to depend on the child that parentification takes place.

We also look at how the parents or family has developed rules and consequences for when both parents are at home, and then look at what changes when one or both parents are gone. When rules and consequences are followed only when both parents are at home, and are relaxed when a parent is deployed, the boundaries begin to blur and parentification can become nurtured.

Just as routines are important for toddlers and preschoolers, routine is vital for teens. The less change there is between at-home times and deployment times, the more anxiety is kept in check for both the remaining parent and the children. It also makes adjustment far easier for the returning deployed parent when rules and consequences are adhered to and kept routine.

—Jacquelyn Waller-Vintar



Child Soldiers

Ripped from their families and socialized into violence, how can these children be brought home?

By Carolyn Morris

Sahr^{*} was taken when he was seven. Captured by the Revolutionary United Front rebel group in the diamond-mining region of Sierra Leone, he was one of the many child soldiers recruited in the civil war that lasted from 1991 to 2002, leaving approximately 50,000 people dead, 20,000 mutilated, and around three quarters of the population displaced. Sahr started off doing chores for the rebels. But soon he was forced to injure and kill people, and witnessed massacres and amputations.

When the war ended after four years with the rebels, Sahr spent some time with a foster parent before being reunited with his mother, grandmother and uncle. While his mother and grandmother welcomed him back, his uncle, who was the head of the household, found him “troublesome,” and members of the community were not supportive.

“The townspeople would come and beat him,” said his mother. “There was a time when everybody gathered around him, wanting to beat him up. They said they wanted him to change, I don’t know which change they wanted.”

Sahr once pulled a knife in response to an attack. He started stealing, dropped out of school and then ran away.



Amina’s^{*} war story started much the same way as Sahr’s. Abducted by the rebels at 10 years old, she was first made to carry supplies and do chores, but soon she was given a gun and told to shoot. She might have wounded or killed two people, and although never sexually assaulted, she was badly beaten on several occasions and witnessed massacres, amputations and stabbings during her two and a half years with the rebels.

But after being reunited with her mother and grandmother, Amina’s life took a very different turn than Sahr’s. Although some other children in the community would taunt her and call her “rebel,” Amina’s mother explained the situation to her teachers and threatened to alert the town’s chief if anyone provoked her daughter.

Amina stayed in school. At 23 she was studying and taking care of her three-year-old daughter and seemed hopeful about the future.

^{*}Sahr and Amina’s stories are taken from Betancourt, T.S. (2011). The Social Ecology of Resilience in War-Affected Youth: A Longitudinal Study from Sierra Leone. In M. Ungar, M. (Ed.). *The Social Ecology of Resilience: Culture, Context, Resources, and Meaning*. New York: Springer.



Sahr and Amina are among the thousands of children who were abducted by the rebels during the civil war in Sierra Leone. The plight of child soldiers has most recently made headlines after a viral video produced by the American organization Invisible Children put a spotlight on Joseph Kony's rebel group, the Lord's Resistance Army, which has forced anywhere from 60,000 to 100,000 children into violence and is blamed for countless atrocities in Uganda, the Central African Republic, the Republic of Congo and South Sudan. According to UN estimates, there are still some 250,000 child soldiers worldwide—that is, children under 18 recruited and used by an armed group, whether it is as a porter or cook, a fighter or sexual slave, or in any number of other roles.

What happens to those children after they get out of captivity is what child health and human rights professor Theresa Betancourt set to find out when she launched a longitudinal study of psychosocial adjustment and social reintegration among child soldiers and war-affected youth in Sierra Leone. Director of the Research Program on Children and Global Adversity at Harvard's School of Public Health, Betancourt is especially concerned with the mental health of children affected by violence. For this study, she and fellow researchers interviewed hundreds of former child soldiers, including Sahr and Amina, who were being served by the International Rescue Committee's interim care centres. The interviews took place on three occasions: in 2002, 2004 and 2008.

Researchers found that, although the degree of violence that youth experience during the war was a major risk factor, strong community and family supports in the years following the conflict play a huge role in how well the youth are able to adjust. This is what could explain the different outcomes for Sahr and Amina.

"Kids who return home to supportive families, who are invested in them and help them get back in school, and advocate for them in the community when they see stigma—because they often do—those kids will benefit from those really powerful protective factors."

It's a hopeful finding—while no one can go back and change what happened during the war, a lot can be modified in its aftermath.

The power of these post-conflict protective factors is a central thread running through much of Betancourt's work. She takes a social ecological approach, looking at the context within which individuals try to re-establish their lives. Whereas toxic wartime experiences such as wounding or killing others or being a victim of rape make recuperation particularly challenging, protective factors such as strong community acceptance and access to school help mitigate the negative forces.

Betancourt is also involved with several other projects, including a family strengthening intervention in Rwanda, which aims to improve mental health services there, and an assessment of mental health service needs among the Somali Bantu refugee population in the greater Boston area. In each of these projects, she has seen much distress, but also tremendous resilience.

"I think a lot of people have very stigmatized views of former child soldiers," she said, "and jump to conclusions easily that they're sort of a throw-away generation, or in some way hopelessly damaged.

But that's not what I've seen."

Instead of "victims," she sees these war-affected youth as "survivors," a term that illustrates the strength it takes to keep on going after terrible suffering. In fact, her studies have shown that only about 10 per cent of war-affected youth show alarmingly high levels of impairment.

"That doesn't mean everybody else is symptom-free," she explained. Amina, for example, still suffered from anxiety-like symptoms and a sense of insecurity years after her return. "A lot of people are living with a great deal of stress, and still merit services. But in terms of those who are really in an extremely difficult situation," she said, "it's 10 per cent."



For children who spend their formative developmental years in a world of violence, the mental health consequences are complex. Further, mental health and psychosocial problems may manifest differently across diverse settings, explained Betancourt, and it is not sufficient to assume that war-affected youth from Sierra Leone will conform to Western definitions of, say, classic posttraumatic stress disorder.

For this reason, Betancourt and colleagues undertake extensive qualitative research prior to designing quantitative surveys. Using a "ground-up" approach, they start by asking local community members to list the problems of war-affected youth in general. Troubles that relate to thinking, feeling and relationships are then drawn out through more targeted interviews, and the team identifies clusters of symptoms that are united under specific cover terms. For example, the local term in Sierra Leone for depression-like problems is "poil hat." The literal translation into English would be "spoiled heart."

This process helps to build a mental health lexicon that is understandable and familiar to locals. "If you want to talk to people about what you're doing," explained Betancourt, "you can say, 'this is an intervention to help people who have problems like 'poil hat.' ' And it's very different from saying, 'We have this thing in the United States and Canada called "depression," do you have that too? And we have these symptoms, do you have those symptoms too?' It's a very different place to start, to go from the ground up and get at their terms."

Betancourt and her team take a similar ground-up approach to intervention development.

"If you ultimately want interventions to be acceptable and sustainable," said Betancourt, "they have to make sense locally, and they have to build on things that people do naturally to help each other." In designing interventions, she and her team carefully consider evidence-based frameworks and treatment components that have been successful in similar settings, and work to adapt these elements according to the needs of their particular study population.

For instance, Betancourt explained that in many collectivist societies such as Sierra Leone, there is enormous strength in the obligation and connection to those around you. The group therapy setting is one mechanism for improving war-affected youths' social skills and, eventually, helping them to leverage local sources of social support.



Theresa Betancourt, Director of the Research Program on Children and Global Adversity at Harvard's School of Public Health, holds two children in Sierre Leone where she launched a study of psychosocial adjustment and social reintegration among child soldiers and war-affected youth.

While many former child soldiers and other war-affected youth struggle to re-integrate with their communities, others are picking up the pieces far from home. Many survivors of war, both children and adults, end up in countries like Canada as refugees.

Betancourt believes that an approach that takes into account the protective and risk factors in a refugee's day-to-day life will be the most supportive.

She's on the steering committee of a new program at the Boston Children's Hospital Centre for Refugee Trauma and Resilience, where help dealing with these daily stressors is integrated into the therapy for the Somali Bantu population. One of the

central struggles, she explained, is that these people have been removed from a very collectivist society where they had extended networks of support. They are now trying to raise children in a very different context.

"In Somalia, especially for Somali Bantu," Betancourt offered an example, "when you go to the market, or you're farming, it's perfectly fine to leave your child out in front of your homestead, with other kids, playing. But when you do that in the housing project in a low-income neighbourhood in Boston, Child Protective Services is going to be called."

So, for refugees, just like other war-affected populations, Betancourt argued, it's important to think ecologically and contextually.

"If you just view that person out of context," she explains, "and you view them as a torture survivor and you don't ask about their family system, what other stressors are going on, and deal with their immediate needs related to housing or legal instability, or daily stressors in the family, then you're going to be very limited in your ability to address their larger symptoms of depression or PTSD."

Just as strong community and family support and staying in school are crucial factors for former child soldiers such as Sahr and Amina in Sierra Leone, refugees surely have their own sets of risk and protective factors. And while the past may often be a dismal place, at least the present is open to transformation. 

For more informaiton, check out http://childdsoldiersinitiative.org/pdfs/FACTSHEET-child_soldiers.pdf



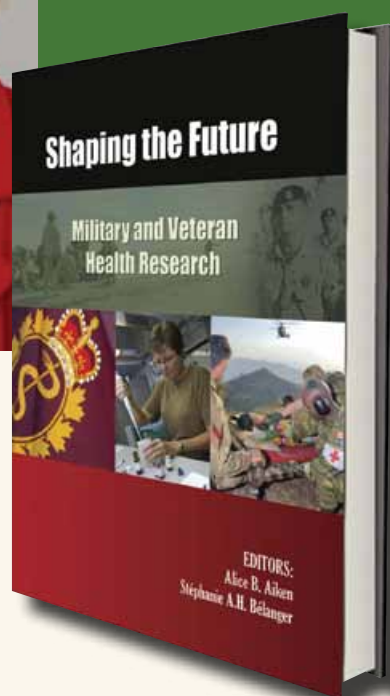
From left to right: Jim S. Kellie, Marian J. Gindeh, Miriam Fullah, Ishmael Alfred Charles, Elizabeth Newnham, Zainab G. Mansaray and Alimamy R. Kamara attend a training supporting the Youth Readiness Intervention for war-affected youth that is underway in Freetown.

Dr. Alice Aiken is the director of the Canadian Institute for Military and Veteran Health Research, an assistant professor in the Physical Therapy program at the School of Rehabilitation Therapy at Queen's University in Kingston, Ontario, and a co-editor of *Shaping the Future*, a compilation of research presented at the November 2010 Military and Veteran Health Research Forum.



Putting military and veteran health on the research agenda

By Avril Roberts



What prompted the creation of the Canadian Institute for Veteran and Military Health Research (CIMVHR) in 2010?

Several factors came together. The incoming Surgeon General of the Canadian Forces had an idea that the military needed to link more closely with the academic community. A retired general also approached me, expressing an interest in the research capabilities in Kingston, Ontario, which is home to both Queen's University and the Royal Military College (RMC), Canada's national military university. As a researcher, I immediately saw the possibilities.

We started connecting with government partners. The Department of National Defence has a large research capacity but it also needed arms-length organizations to do some of its research. Veterans Affairs Canada does remarkably well with a limited research budget, but it wanted to augment its research capacity and forge links with the research community. A co-ordinating body

would be able to facilitate links with the academic community and respond rapidly to research needs. In Canada, we were alone among our major military allies in not having an institute like this.

Public perception of the military had also changed. Canadians were gaining a better understanding of why we have a military and what the military does. The public perception is important, if you want to be able to get research funds and engage the research community. The research community has come to the table in droves. It has been a wonderful response.

How is CIMVHR structured?

CIMVHR is not a bricks-and-mortar institute. It is a network of 22 Canadian universities and growing. The hub is located at Queen's University and at RMC, which jointly run the institute and have a long tradition of working closely together. So it's a virtual institute, existing in the member universities where the researchers are located.

From a research standpoint, how does the institute make a difference?

We are a central co-ordinating body. If the government needs to communicate its research needs to the research community, it comes to us and we can disseminate that information. If people have novel research ideas that might benefit the government, we can help these researchers gain access to military and veteran populations. We have also built new research teams, bringing together people working in related areas. The institute is run by researchers who work in the area of military and veteran health, so we're building the capacity for military and veteran health research across Canada. The principal aim of CIMVHR is to engage the Canadian academic community in research related to the health needs of military personnel, veterans and their families.

What are current areas of research interest?

Mental health is a big issue for the military, so there's a lot of mental health research. Physical health and rehabilitation is a major topic. Transition to civilian life is another. When you leave the military, you leave the military health care system and enter a civilian health care system, so evaluation of existing health care policies and programs is a big element of what we do, as are occupational health and safety, the long-term impacts of exposure and operational patterns with mental and physical consequences, combat casualty care, recruitment health issues, health promotion, protection and disease prevention. Our starting point is the World Health Organization definition of health as a state of complete physical, mental and social well-being, so we also look at the social impacts of health on military personnel, veterans and their families, for example, children and spouses of people with posttraumatic stress disorder. All of this comes under our jurisdiction.

Is a specific ratio assigned to mental health research?

Not at the moment. There has been government-sponsored research relating to mental health, for example, looking at biomarkers of PTSD and effective treatment programs. Keep in mind that Veterans Affairs has a national network of operational stress injury clinics across the country and National Defence has operational trauma and stress support centres for people still serving in the military. They regularly evaluate these well-established programs and present the research.

Operational stress injury—is that the military's terminology for PTSD?

OSI refers to any operational stress injury, so all mental health injuries, not just PTSD. In fact, research has found that depression presents more often than PTSD. Addiction is another major issue.

Does the institute conduct top-secret or restricted access research?

Typically, no. The military usually contracts that type of research in-house because it is not the intellectual property of the researcher: it remains the intellectual property of the government. Many academic researchers are not interested in doing it because they need to publish.

What is the institute's relationship to National Defence and Veteran Affairs?

We work closely with National Defence and Veteran Affairs but we operate at arm's-length, which is critical for both sides. We cannot ask researchers to compromise what they want to do in research; also, if their results are not politically okay, the government needs to be in a position where it can say, "If that's what the research shows, so be it."

How does CIMVHR disseminate research findings?

The annual Military and Veteran Health Research Forum is our primary knowledge translation product and currently our main revenue source. As the premier event in Canada for military and veteran health research, it is attended by military personnel, veterans, the military medical community, research directors from Veteran Affairs and scientists from Defence Research and Development

Canada. The forum also attracts people from all over the world who want to present their research. It's a unique networking opportunity, bringing together the people who generate the knowledge, people who use the knowledge and potential funders. It has been sold out in the last two years and we anticipate the same for 2012.

The keynote speaker will be Dr. Jitender Sareen, a professor of psychiatry at the University of Manitoba, the director of Research and Anxiety Services in the Department of Psychiatry at the Health Sciences Centre in Winnipeg, and a consulting psychiatrist for the Veteran Affairs Canada Operational Stress Injury Clinic at Deer Lodge Hospital in Winnipeg. Dr. Sareen has authored more than 150 peer-reviewed articles in the areas of traumatic stress, anxiety disorders and military mental health.

How is the institute funded?

We are a network of researchers. We do not have sustainable funding. Queen's University supports my position and that of the administrative assistant; RMC funds Dr. Stéphanie Bélanger, the associate director. We administer the institute in our capacities as a professor at Queen's and a researcher at RMC, respectively. We have a small operating budget and we're looking to build sustainable funding, ideally through a public-private mix.

What changes do you envision for the near future?

The institute is fairly new so we're building our governance structure: we have an interim working board of directors and anticipate having a full board within a year; we have an advisory council that includes several government partners; a college of peer reviewers to review the abstracts for the MVHR Forum and all our publications; and we are creating committees. I anticipate that the research topics will change in response to government needs and to innovative ideas that bubble up from the researchers. We will continue to look for the best researchers and teams to respond promptly to the health research needs of the military and provide a basis for evidence-informed practices and programs.

On a personal note, you seem to bring a unique blend of military service, clinical experience and research expertise to your position as director of CIMVHR.

I was serving in the Canadian Navy as a ship's captain when I got my first degree, a BSc in Kinesiology. When I was accepted to study to become a physiotherapist, the military very kindly put me through school, so I was a physiotherapist in the military for several years. After I was released from the military, I pursued graduate studies, earning a doctorate in health services and health policy. I became a professor six years ago. Most of my research focuses on health systems change—particularly as it relates to special populations with unique health needs, including veterans—and knowledge translation. These two streams are not entirely unrelated because you have to be able to communicate best evidence in order to change a health system. ☐☐

For information on the 3rd Annual Military and Veteran Health Research Forum (MVHR2012), November 26 to 28 in Kingston, Ontario, e-mail chris.cornish@queensu.ca or call 613 533-6217. www.cimvhr.ca/forum

In celebration of summer days when you might, finally, get in some solid “me time,” *CrossCurrents* presents an extended review section—four books and one art exhibit—as well as a look at what some of your colleagues have on their summer reading lists....

This is your brain on drugs, er, Marc Lewis's brain

Memoirs of an Addicted Brain offers a unique blend of science and personal experience. A formerly drug-addicted neuroscientist tells his story and, along the way, discusses the neuroscience of it all. While one might expect this reviewer (also an addiction author—“PhD Crackhead”) to identify with Lewis, that wasn’t the case. Yes, Lewis’ book is a good read, but it is perhaps best-suited to the kind of reader who enjoys stories, be they fictional or true. The academic in me kept screaming, “I don’t care about your details! Get to the point!” But that’s me, and my own sensibilities are surely not universal. This is a fine book, and I recommend it to anyone wishing to learn about the neuroscience of addiction via personal anecdote. There is nothing like it out there.

Lewis offers a decent account of how an addiction can evolve, though he struck me as a little self-indulgent: “I could not invent a story as strange and frightening as the life I lived as an addict,” he writes. Come on, Marc, you’re a smart guy with a robust imagination, and your story isn’t all that special. I’m sure that you could. Still, as stories go, it’s as good as most other addiction tales, and the scientific tidbits along the way are perfect for any reader who lacks the inclination just to read the science. It really is a good book.

At times, specific highs are discussed in ways that got me reflecting: “Teenage thinking bears an uncanny resemblance to the delusional profundity of a marijuana high. Adolescents ... are completely spellbound by their own ideas.” While I will counter that the profundity induced by marijuana and other drugs is not universally delusional—many drugs are used in meaningful ways by shamans and others—Lewis still makes an interesting point.

Former addicts tend to demonize drugs, and Lewis does a bit of this. It might be worth noting that recovering alcoholics are more likely to give their single poison a fair shake, and it’s legal status undoubtedly makes that easier to do. While Lewis offers some good coverage of drug experiences, I think he rips them too hard. But that might be a question of taste (and ideology): as a staunch opponent of

drug prohibition, I have an agenda that not all readers will share.

The book is not a myopic account that attempts to reduce the issue of addiction to brain science. Psychological and social issues are addressed in conjunction with the bio. Lewis has studied philosophy, music and much more—he is a well-rounded thinker.

Yet at times, the blind spots are glaring: “I also know that drug addiction is enormously ugly, riding as it does on injury to others and deliberate self-injury, and on thrashing the virtues of honesty and self-control ...” (p. 304). Sorry, but not all addicts are liars, and some wouldn’t hurt a fly.

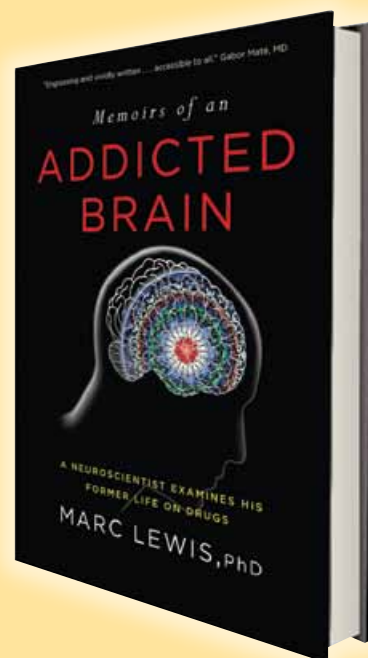
Addiction really is a mixed bag, yet Lewis engages in one stereotype after another: “As is well known in the addiction lore, there is no final cure, just recovery, abstinence, and self-awareness” (p. 301). Lewis is right to insist that much of what we do to our brains is irreversible, and hence he is right to discuss addiction in terms of the brain, but the generalization about abstinence is questionable. Few addicts remain abstinent for anything like 10 years, let alone a lifetime. Typically, recovery in the real world involves stops and starts, reduced consumption of one’s drug of choice, substitute drugs and many other options.

I would throw out a question, not so much to the author as to his potential readers. This book does a fine job of showing how all drug highs play upon natural sensations associated with functions such as eating, sex and companionship. If one has been addicted to these sensations, is it wise to single out drug use as the target for recovery? Like so many other neuroscientific accounts, this one draws tight links between the drug experience and every other experience. Maybe the real lesson is that we should stop singling out drugs for special attention. ☐☐

www.memoirsofanaddictedbrain.com

***Memoirs of an Addicted Brain: A Neuroscientist Examines His Former Life on Drugs.* Marc Lewis. Doubleday Canada, Toronto, 2011, 320 pp., \$32.95 paper.**

Peter Ferentzy, author of Dealing with Addiction: Why the 20th Century Was Wrong, is an addiction expert and a self-proclaimed crackhead out to take on the system.



DR. IVAN SILVER

What's on his summer reading list?

***Thinking, Fast and Slow*, Daniel Kahneman. Farrar, Straus and Giroux, 2011.**

Why I am reading: It's about how we make choices when faced with uncertainty...

***Quiet: The Power of Introverts in a World That Can't Stop Talking*, by Susan Cain. Crown, 2012**

Why I am reading: Because I identify with the title.

***Calico Joe*, John Grisham. Doubleday, 2012.**

Why I am reading: It's for reading on the plane...

Ivan is the vice president of Education at the Centre for Addiction and Mental Health, and recent recipient of the prestigious President's Teaching Award from the University of Toronto. www.camh.ca/en/education



A new view of William Kurelek

An important retrospective of one of Canada's most beloved painters, William Kurelek, makes it clear that a crucial stage in the life and artistic development of the man occurred in the early 1950s at Maudsley and Netherne hospitals in England where he sought psychiatric treatment. While in care, Kurelek came in contact with clinicians, including pioneering art therapist Edward Adamson, who used painting as a fundamental part of treatment. Unsurprisingly for such a period of intense self-reflection, Kurelek painted a series of startling self-portraits and other works, with titles such as *Where Am I?* *Who Am I?* *Why Am I?* and *I Spit on Life* that attempted to represent his memories, thoughts and feelings.

These paintings arguably culminated in *The Maze* (1953), a depiction of the artist's bisected head represented as a maze. In this maze, made up of a series of compartments, are painted a series of harrowing vignettes.

At the top of the painting is a boy crouched, alone and vulnerable in the middle of a large field. To the right is a boy being beaten by a bigger boy while other children look passively on. In another is a surreal depiction of self-mutilation, while in the middle of the painting, there is a rat, walled in and dying. Each of the many haunting scenes is unresolved, leading the artist to transcend any simple naming of his condition, or diagnosis, and instead create a space for its dynamic expression.

A newer version of *The Maze*—*The Maas Maze*—painted in 1971, along with many other career-spanning works have been brought together under the title *The Messenger* in a major exhibition organized by the Winnipeg Art Gallery, the Art Gallery of Hamilton and the Art Gallery of Greater Victoria. *The Messenger*, in Victoria, B.C., from May 25 to September 3, 2012, features many privately held paintings that have rarely if ever been publicly exhibited, along with paintings held in smaller collections throughout North America. Above all, *The Messenger* makes it clear that Kurelek was much more than a painter of sentimental Canadiana. Known to many for *A Prairie Boy's Winter* (1973) and other series that were published as



The Maas Maze

1971

mixed media on panel

90.8 x 121.3

Gift of James B. Maas; Herbert F. Johnson Museum of Art, Cornell University

Photography Herbert F. Johnson Museum of Art, Cornell University

popular books, Kurelek made a decision at the outset of his career to make work that had ready popular appeal and make more serious work that conveyed a message, usually founded in his Roman Catholicism, a religion he converted to in 1957.

While there may be a temptation to draw a line between the tortured paintings Kurelek made through the early- and mid-1950s and his later popular and message works, to do so is a mistake. The reason is that Kurelek never stopped mining his memories, thoughts and feelings in his work. No longer troubled and ill, the mature Kurelek nevertheless externalized his inner states, concerns and anxieties (especially about nuclear apocalypse) in sometimes subtle and sometimes shockingly vivid ways. In one, *Dairy Farming in Manitoba* (1963), we see the kind of farm scene we have come to expect from Kurelek. In the foreground is a farmer examining his wheat. Behind him is a prosperous-looking farm complete with cattle and outbuildings. Upon close inspection, though, is a tiny figure kneeling in prayer tucked into a patch of brush. To see it, the painting demands the viewer's full and close attention. And when seen, the kneeling figure demands contemplation. Why is the person there?



Where Am I? Who Am I? Why Am I?
c. 1953–1954
watercolour on paper
73.6 x 58.5
American Visionary Art Museum,
Baltimore; Gift of Edward Adamson
Collection, London, UK7

Why kneel in prayer when there is so much farming to do? As usual it seems that Kurelek was saying, even amongst abundance one must attend the importance of God.

A similar strategy is played out in *Light Trading Day, Toronto Stock Exchange* (1971), a masterful realist rendering of the exchange when the traders actually plied their trade in a real space. Look closer though and amongst all the activity and gesturing figures and discarded paper is a tiny crown of thorns, referring to the Christian belief in the sacrifice of Jesus for all the sins of humanity. The theme comes up again: focus all you may on material things, what truly matters is the spiritual.

The question of how an artist's mental health struggles relate to their creative life is not only a perennial question, but one that seems unanswerable in any meaningful way, even if that rarely stops us from asking. What we know of Kurelek, and what the current exhibition makes clear, is that his struggle with his psychiatric problems, in part, made him a great artist. What he also possessed was a talent, a drive to become an artist and a legendary work ethic that allowed him to create an astonishing number of works (more than 2,000) in the relatively brief period between the early 1960s and his death in 1977. [CC](#)

Andrew Johnson is a writer and editor. His writing on visual art has appeared in *Canadian Art* and *Border Crossings*. Andrew is also a product developer at the Centre for Addiction and Mental Health.

I Spit on Life
c. 1953–1954
watercolour on board
63.5 x 94.0

Adamson Collection, London, UK
Photography Adamson Collection



All photographs are © the Estate of William Kurelek, courtesy of the Wynick/Tuck Gallery, Toronto

William Kurelek | The Messenger

is at the Art Gallery of Greater Victoria May 25 to September 3, 2012.

The website for the exhibit—kurelek.ca—offers an extraordinarily detailed look at this show.

The cutting edge of self-injury research: 40,000 chat room posts later

The Tender Cut: Inside the Hidden World of Self-Injury presents the sociological research of Patricia and Peter Adler on the practice of self-injury since the early 1990s. From 2001 to 2010, the authors conducted in-depth interviews by phone or in person with more than 135 people who self-injure. They also studied thousands of Internet postings on websites dedicated to self-injury. The book traces the evolution of self-injury from its origins as an apparently uncommon, privately practiced behaviour to a more widely acknowledged and widespread phenomenon, and describes how the Internet contributed to this transition.

The book is clearly written and is well-organized. Vivid quotes from interviews and Internet posts illustrate the different ways people begin to self-harm, details of the experience itself, relation-

ships between self-injurers in the real world and the cyber world, and the different ways people may cease to engage in the behaviour.

The authors review the rise of self-injury in disaffected youth from punks to Goths to emos, and note that in the 1990s it spread to a broader swath of the population. They posit that 1996 was the year that self-harm emerged into public awareness, such that most self-injurers who began the behaviour prior to 1996 did so by “self-invention,” while many of those who started after 1996 had heard of it from others or from the media. The Internet became a resource for self-injurers in the early 2000s and allowed them to build a sense of identity and community. Unfortunately since the research methodology is not included in this volume, it is not possible to comment on the reliability of the authors’ conclusions.

The detailed vignettes in this book provide a useful resource for mental health professionals who are not familiar with self-harm and need a primer on the range of behaviours, attitudes and beliefs common to this population. At the same time, the descriptions of self-injury are so graphic that they could intensify self-harm urges in readers who engage in the behaviour. Family members of people who self-injure should also approach the book with caution. Although it may be highly informative, some readers may find the graphic content overwhelmingly disturbing.

A broader concern involves the perspective of the authors, who make a laudable and overt effort to be accepting and non-judgmental of self-injury and self-injurers, but at times risk moving into the territory of promoting the behaviour. An example is the cover of the book, which shows a scarred forearm with the book’s title cut into it in red letters. This rather sensational illustration could contribute to the very social contagion the book discusses. The authors also minimize the risks of serious damage and suicide as possible consequences of self-harm. Furthermore, they suggest that if it were not for the medical establishment pathologizing the behaviour, self-harm could become a coping strategy that is accepted in mainstream society.

In what may be an effort to validate self-injurers’ frequently unhelpful or stigmatizing experiences in medical settings, the authors repeatedly position both the sociological perspective and self-injurers’ perspectives in polar opposition to the perspective of the “psychomedical community.” In so doing, they actually portray the psychomedical perspective inaccurately; for example, stating that “Axis II disorders are environmentally rather than organically caused,” and inconsistently, at times viewing self-injury as a symptom of mental illness, and at other times as “caused” by early trauma. In fact, the prevailing understanding of self-harm is that it stems from a deficit in emotion regulation. Emotion dysregulation does not have a single cause; rather, like all psychological patterns including psychiatric illnesses, it results from a complex interplay of specific temperamental (biological) and environmental (social) factors. The book’s emphasis on the clash of perspectives has the potential to discourage self-injurers and their families from turning to medical or mental health professionals for much-needed assistance with a serious and distressing problem. 

***The Tender Cut: Inside the Hidden World of Self-Injury.* Patricia and Peter Adler. New York University Press, New York, U.S.A., 2011, 264 pp., \$22 paper.**

Dr. Carmen Wiebe is a psychiatrist in the Borderline Personality Disorder Clinic at the Centre for Addiction and Mental Health in Toronto.

What’s on her summer reading list?

When Quietness Came: A Neuroscientist’s Personal Journey With Schizophrenia, Erin L. Hawkes. Bridgeross Communications, 2012.

Why I am reading: I met this Vancouver author and read the preview of her book. I liked the style of prose and am intrigued to learn more about her experiences.

Nail Your Novel: Why Writers Abandon Books and How You Can Draft, Fix and Finish With Confidence, Roz Morris. Charleston, 2009.

Why I am reading: As a writer, I’m always interested in books on writing.

Gordon Smith: The Act of Painting, Ian M. Thom and Andrew Hunter. Vancouver Art Gallery.

Why I am reading: Gordon Smith is one of my favourite Canadian artists. In his current work, he creates images of the British Columbia landscape using abstract elements.

Sandra is an artist and writer in Vancouver, B.C. She wrote *My Schizophrenic Life: The Road to Recovery from Mental Illness and Hell’s Fire* and received the 2012 *Courage to Come Back Award* in the mental health category. Her website is full of interviews, reviews and links to her art: <http://symackay.blogspot.com>

Why not? Fifteen reflections on reasons to live

As novelist Ray Robertson writes in *Why Not? Fifteen Reasons to Live*, everyone lives “in his or her own particular darkness.” For Robertson, obsessive-compulsive disorder (OCD) and depression turn out to be his brand of darkness, which he experienced particularly intensely in the summer of 2008, after finishing the first draft of his novel *David*.

Robertson describes how, during that summer, the obsessions and compulsions that he had struggled with intermittently for years came out of abeyance—this time in full force. While Robertson writes that he was no stranger to feelings of “meaning withdrawal” when completing a novel, he was surprised at the intensity of the OCD: powerful feelings of abandonment and postpartum inertia, and the sense that “something or someone other than me controlled my mind and body” led to a suicidal depression.

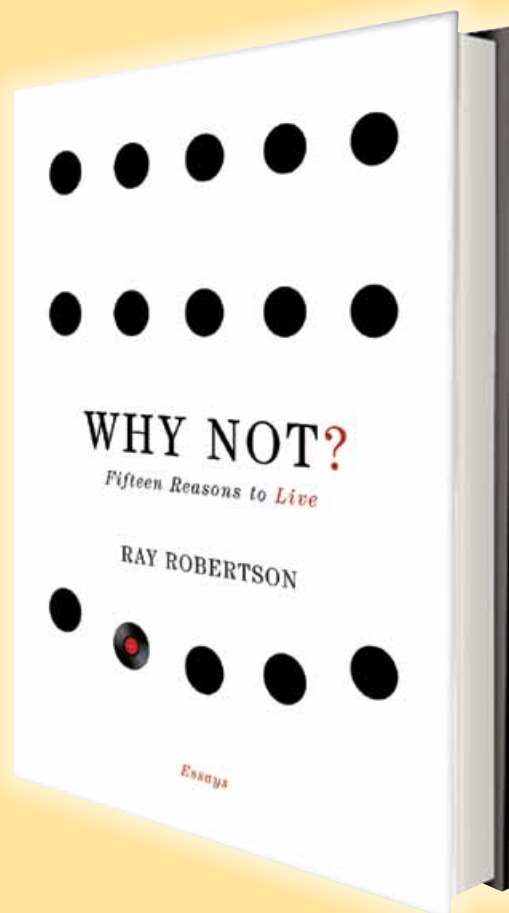
“People don’t become depressed from merely having OCD—or, for that matter, from anything else external—but from the psychologically and physically punishing effects of OCD,” writes Robertson in the introduction to this collection of essays describing 15 reasons why life is worth living.

Ah, finally, an intelligent, non-sensationalizing, non-indulgent commentary on OCD from someone who has experienced it. Only about two per cent of the population, know first-hand how incapacitating the full-blown symptoms of OCD can be. Fortunately, Robertson is willing to open up to readers, challenging the stigma around this condition, and showing that you can live with and live well in spite of OCD. Judging from the response to this book, his message clearly resonates for readers—many of them strangers to the author, but not to the disorder.

Interestingly, Robertson doesn’t choose to write a standard memoir about life with a psychiatric disorder. Instead of describing how life isn’t worth living, he chooses to describe the reasons why it is. He writes, “I knew I’d been provided with an uncommon opportunity. *Not* to write a memoir of my illness and recovery—this has been done, and done, and done, and usually from a retrospectively falsely sagacious point of view—but instead to write a book that explores two of life’s most central and enduring questions... What makes human beings happy? What makes life worth living?”

The discussion of his illness is exclusively contained in the introduction. The rest of the book is divided into 15 chapters, each entitled by and describing a separate reason to live. Many reasons we might assume: work, love, friendship, intoxication (what Robertson refers to as “episodic escapism”—or, as he quotes Byron, a “mere pause from thinking”), solitude (though it can be toxic when you’re depressed) and humour. Others are less predictable, such as the critical mind, praise, duty and death.

Each chapter presents a clever reflection on the topic, punctuated with quotes from the many philosophers, intellectuals and authors who have inspired him—from Nietzsche to Emerson to Sartre, Tolstoy, Kerouac, Sartre and Burroughs. My only disappointment is that, after the introduction, we lose Robertson’s personal reflections on his emotional world—and move into a more cognitive or intellectual realm of life’s merits, without a link to how depression or OCD has influenced his reasoning.



For instance, in the last chapter—Death—he writes, “Unfortunately, the nearest most of us come to truly recognizing and relishing our lives is when they’re directly threatened—by a life-threatening disease, for example, or a near fatal accident.” But what about being threatened by a mental health problem: presumably losing the capacity to enjoy life has made it all that more relishable for Robertson, once the darkness dissipated, and the tedium of angst and repetitious thoughts and actions subsided.

If anything, I came to the end of *Why Not?* wanting to hear more of Robertson, not less. *Why Not?* is a fine read with a brave beginning and a thoughtful end from an intelligent thinker. No doubt, it has and will continue to resonate with people with OCD, and others who simply enjoy Robertson’s irreverent sense of humour and twist on topics that might otherwise seem almost banal if the writing was not so clever. CC

***Why Not? Fifteen Reasons to Live.* Ray Robertson. Biblioasis, Emeryville, ON, Canada, 2011, 175 pp., \$19.99 paper.**

Diana Ballon is an editor at CAMH and a freelance writer specializing in mental health issues. She also has a history of OCD.

The Sounds of Silence

“It never really occurred to me I was experiencing the world any differently from them; I thought it was just that I was terrible at coping.”

Erin Hawkes’s memoir, *When Quietness Came: A Neuroscientist’s Personal Journey with Schizophrenia*, documents the half-dozen years after a failed suicide attempt and her first hospitalization in 2001. She describes in raw detail the doctors, diagnoses and treatments that follow as she struggles to hold on to some semblance of a “normal” life. Through linear and straightforward prose, the author provides insight into an internal landscape that offers few such structured comforts.

“But hitting bottom, I have come to realize, does not mean that you will bounce magically away from that low place, never to return.” Schizophrenia occurs in cycles of remission and relapse. Hawkes, a neuroscientist, guides her reader on two levels: anecdotal and academic. Along with her personal story, she is careful to define the medical language of her disease, explaining terms like “ideas of reference” and “anhedonia.” She also details the varied diagnoses offered by countless doctors who, it seems, cannot agree.

Early on, a harried doctor decides the author is dysthymic; she is deemed “a little depressed, most of the time.” But as symptoms persist (and opinions pile up), Hawkes is also told she has Asperger’s, reactive attachment disorder (RAD), and borderline personality disorder. While a schizophrenia diagnosis appears early and often, the lack of consensus is, perhaps, a testament to the complexity of mental illness.

But, as Dr. Richard O’Reilly writes in his introduction, it is this complexity that demands more patience from those who would practice in its shadow: “A dose of humility is needed... we are only scratching the surface of understanding the brain.”

“It was my initiation into the mental health system, where notes and reports and discussion are shared between professionals and hidden from the patient.” Although generally presented without editorial comment, it is heartbreaking how often Hawkes’s decisions are made for and without her. It leads her to question after the fact. “If he did not think I had schizophrenia, why did he put me on clozapine?” she asks, or wonders why electroconvulsive therapy sessions are cancelled with “no reason charted” and a doctor changes her prescription “with no explanation.”

One might excuse physicians who, rightly or wrongly, believe patients unable to comprehend clinical reasoning, but there seems no logical explanation why the same enigmatic approach would be taken to talk therapy: “I was supposed to be working on my issues... but I needed help identifying them. This was not being provided.”

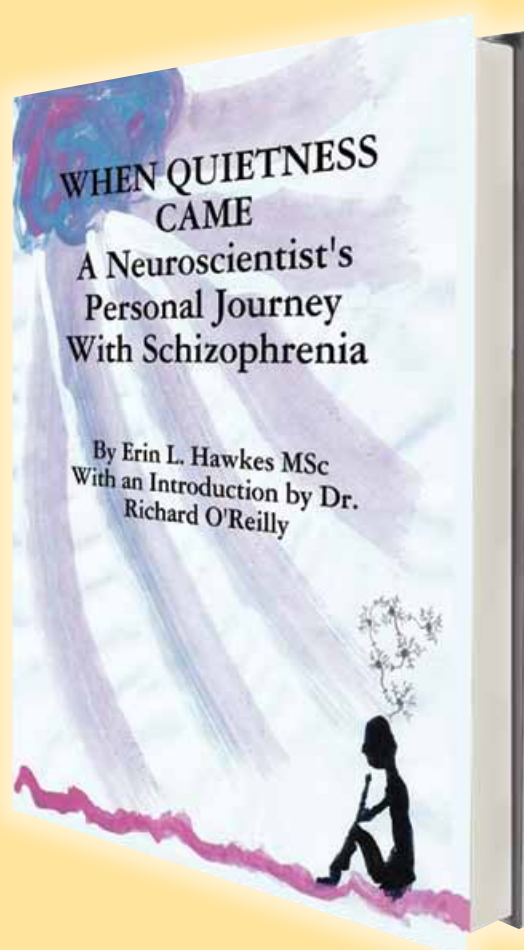
Hawkes presents systemic concerns as well. In her epilogue, she questions the use of restraints even when self-soothing behaviours (pacing, sitting under a particular air vent) were

harmless. Though essential when they might prevent harm, they are also violently pre-emptive if agitation never manifests.

“I looked to others intently in an attempt to know myself through their reactions.” So many illuminating aspects of this story are presented indirectly—as it is often indirectly Hawkes finds comfort and support. Whatever the machinations of her mind, the author is no different than anyone in her desire to be validated and understood.

Hawkes talks about her long-held belief that “everyone had their own voices and suicidality.” Who doesn’t, at some point, believe a personal experience is universal? She describes attempts to deny her illness through good hygiene and diligent study; an outward “appearance of normality” might negate an unwanted diagnosis. And she finds comfort in a medical chart noting her psychosis as “genuine”; as her symptoms wane between schizophrenic episodes, she wonders if she imagined them.

As humans, we all search for our reflection in others. Hawkes’s inclusion of these simple details infuses her singular experiences with the familiar insecurities and desires all people share. She knows schizophrenia is only one part of who she is, and her emotions resonate, inviting the reader to connect.





The author, Erin Lynne Hawkes, was in her last year of undergrad studies in neuroscience when she had her first psychotic break. She graduated the next year with Honours, won an NSERC scholarship, and went on to earn an MSc in Neuroscience at UBC.

“I don’t know what schizophrenia will take from me. But I do know I will not give it things it does not take.” In many ways, this memoir documents a desire for control. In a world where meaning is gleaned, deciphered, and often self-determined, Hawkes resists the internal and external forces exerting themselves on her existence.

From the Voices and neuron-eating rats (Hawkes’s self-described hallucinations) and her concurrent struggle with bulimia, to (and through) the mysterious mental health system, the author never stops fighting to live the life she wants. And despite 13 hospitalizations (voluntary and otherwise) and the constant cerebral undertow of anti-psychotic medications, she invests in romantic relationships and successfully pursues an ambitious academic career.

Although she often describes herself as “meek” and “obedient,” these are only outward traits. Hawkes’s will in the face of overwhelming odds makes this story an optimistic and inspiring one. *Quietness* promises insight not only to those navigating the same territory, but to their families, laypeople and clinicians as well. **CC**

When Quietness Came: A Neuroscientist’s Personal Journey with Schizophrenia Erin L. Hawkes, MSc., Bridgeross Communications, Toronto, 2012, 248 pp., \$19.95 CDN.

G. Stegelmann is a department secretary in the Knowledge and Information Support Unit at the Centre for Addiction and Mental Health in Toronto. She is also managing editor of WORN Fashion Journal.



NICHOLAS WATTERS

What’s on his summer reading list?

Dissemination and Implementation Research in Health: Translating Science to Practice. Ross C. Brownson, Graham A Colditz, and Enola K. Proctor, eds. Oxford University Press, 2012.

Why I am reading: It is truly an encyclopedia for dissemination and implementation research written by the leading minds in the field.

Evaluating Health Promotion Programs, Dr. Tomas Valente. Oxford University Press, 2002.

Why I am reading: It is one of the only pieces of work by Dr. Tomas Valente that I haven’t read. If you are interested in networks, and network analysis, I highly recommend reading his 1995 book *Network models of the diffusion of innovations*.

The Hunger Games, Suzanne Collins. Scholastic Inc., 2008.

Why I am reading: I think I may be one of only a handful of people who have not read the book, or watched the movie, and I don’t want to be the last!

Nicholas is a capacity building specialist, Knowledge Exchange Centre at the Mental Health Commission of Canada www.mentalhealthcommission.ca



JOANNE JONES

What’s on her summer reading list?

Changing Directions, Changing Lives: The Mental Health Strategy for Canada, Mental Health Commission of Canada. May 2012.

Why I am reading: This strategy is about improving the well-being of those with mental health challenges and will shape the future of the system that will meet the needs of those living with mental illness and their families.

Wild: From Lost to Found on the Pacific Crest Trail, Cheryl Strayed, 2012

Why I am reading: This book was highlighted in Oprah’s book club and is a powerful memoir of a solo journey for the author through a challenging terrain of discovery and recovery.

Joanne is the client services manager, Mental Health and Addictions, Central East CCAC, is on the Ontario Board of Directors for the Canadian Federation of Mental Health Nurses, and has recently been awarded the prestigious Leadership Award in Nursing Education (Staff Development) by the Registered Nurses’ Association of Ontario (RNAO).



Substance use in the service: How many drops in the bucket do we need?

By Alex Roslin

Nearly 40,000 Canadians served as soldiers in the Afghanistan mission. These men and women have huge mental health and substance use needs that appear to be going unmet. Many soldiers are reportedly turning to alcohol and other drugs as a form of self-medication because of poor treatment options for posttraumatic stress. When the double whammy of substance use and PTSD strikes, it's a dangerous mix.

Unfortunately, the Canadian military doesn't seem inclined to acknowledge the extent of the problem and has been painfully slow to help veterans and their families.

Stuart Langridge's story is an extreme example of what can happen. He had been a poster boy for the Canadian military—a triathlete and mountain man competitor who won two commander's coins for his service in Afghanistan. Langridge was rated as a "superb" soldier in performance reviews and fast-tracked for promotion, and for doing well on tests for advancement to master corporal, according to his father, Shaun Fynes.

But after returning to Canada, Langridge fell into a spiral of posttraumatic stress, heavy drinking and cocaine use. He hung himself at Canadian Forces Base Edmonton in 2008.

Despite five previous suicide attempts, the military didn't offer Langridge adequate treatment. Medical records show he was afraid to talk about his trauma because he feared career ramifications. When he checked himself into a rehab clinic for his substance abuse, the military ordered him to leave before the treatment was finished, according to a Military Police Complaints Commission hearing into the case heard in April. Ten days later, he was dead.

"They just pushed him right over the edge. After

Stuart died, everyone ran for cover," Fynes told me last summer for a story I wrote in *The Montreal Gazette*.

"They are callous and don't care about the young men and women once they are through with them," Langridge's mother, Sheila Fynes, told me. "We gave them a whole person, and they gave us back a dead son."

You'd think Canada's military would have seen this coming. Previous wars have led to similar problems. Back during the Vietnam War, studies found one in five U.S. soldiers became addicted to heroin. Suicide reportedly claimed two times more Vietnam vets than combat. But despite precedents like this and stories like Langridge's, the Canadian military has underestimated the extent of the problems for returning Afghan vets, according to critics, and it has been reluctant to offer adequate treatment for traumatized soldiers with substance use issues.

Just one in three soldiers who had major substance misuse symptoms after serving in the Afghan mission was getting treatment, according to a 2010 Canadian Forces (CF) survey. Another CF survey in 2009 found that one in six soldiers admitted to using drugs in the previous 12 months. One in four soldiers said they had worked with troops known to be taking illegal drugs in the past year. Of soldiers age 18 to 29, one in three said the same thing.

Heavy drinking was an especially big issue. One in two male CF members and 30 per cent of women reported drinking more than the recommended maximum of two drinks a day, the survey found. (That's higher than the rates in the Canadian population—20 per cent for men and eight per cent for women.)

Few programs exist for Canadian veterans that treat both PTSD and substance abuse. In Stuart Langridge's case, the military sent him to a treatment centre for substance use, but he turned out to be the only soldier at the centre. Most of the other clients were well-to-do youngsters who couldn't relate to his combat trauma. "I'm not going to talk about my stuff from Afghanistan with those kids," he told his parents.

Tim Laidler, who served in Afghanistan in 2008, also struggled with PTSD on his return and started drinking heavily. He eventually attended a session of the Veterans Transition Program, a UBC-based program that offers group therapy to soldiers coping with trauma. The program was created with funds from the Royal Canadian Legion. It helped him turn his life around. He is now the program's operations director and is working on expanding it to other provinces.

About one in three of the program's clients has full-blown addiction issues—mostly related to alcohol, but also cocaine and marijuana. "The overwhelming majority [of the program's clients] have said they used alcohol to self-medicate," Laidler told me. The program is one of the few in Canada to offer group therapy to soldiers with trauma and also to address substance abuse issues. Some other programs turn soldiers away if they have problems with substance use.

But amazingly, Laidler's program gets no funding from the Defence Department or Veterans Affairs. And even if the expansion proceeds as planned, the program will only be able to accommodate about 100 soldiers per year.

That's clearly a drop in the bucket compared to the need.

You'd think the military would have funded programs like Laidler's in every city across Canada long ago given the demand that was obviously coming.

Shaun Fynes believes his son would be alive if the military had given him better care. "He was self-medicating because he wasn't getting proper treatment. We lost our son, and they were totally negligent. The soldiers are just not getting the help they deserve. The resources in place have been overwhelmed."

His wife Sheila agrees. "There are so many families with problems similar to ours. The problems they will see have hardly even begun."

If we want to prevent similar tragedies in other families, we must do better.

Alex Roslin is an award-winning journalist in Lac Brome, Quebec, and president of the board of the Canadian Centre for Investigative Reporting.

Stuart Langridge



CANADA

Advance Studies Institute Conference

Global Mental Health: Bridging the Perspectives of Cultural Psychiatry and Public Health
July 5–7
Montréal, Québec
tel 514 398-7302
e-mail tcpych@mcgill.ca
www.mcgill.ca/tcpych/training/advanced/2012

International Conference on Special Needs Offenders

August 26–29, 2012
The Westin Ottawa, Ottawa, Ontario
Contact: Erica Townson
tel: 416-694-9713
e-mail etownson@specialneedsoffenders.org
www.specialneedsoffenders.org

Canadian Society of Addiction Medicine Annual Meeting & Scientific Conference (CSAM2012)

September 20–22
Fairmont Royal York Hotel, Toronto, Ontario
www.csam.org

Canadian Psychiatric Association 62nd Annual Conference

September 27–29
Montreal, Quebec
tel 613 234-2815
e-mail conference@cpa-apc.org
www.cpa-apc.org

The Many Faces of Addiction, 4th Annual Addiction Symposium

October 16–17
Ontario Science Centre 770 Don Mills Road, Toronto, Ontario
contact: Marie Cooper
tel 416 495-0926, ext. 301
e-mail mcooper@bellwood.ca
www.bellwood.ca

Canadian Mental Health Alliance National Conference

All Aboard! Our Collective Journey to a Stronger CMHA
October 18–19
Regina, Saskatchewan
contact: Phyllis O'Connor
tel 1 800 461-5483

Aging in a Changing World

41st Annual Scientific and Educational Meeting (CAG2012)
October 18–20
Vancouver, British Columbia
organizer: Canadian Association on Gerontology
toll free 1 855 224-2240
www.cagacg.ca

3rd International Conference on Violence in the Health Sector

October 24–26
Vancouver, British Columbia
e-mail conference.management@freeler.nl
www.oudconsultancy.nl

Health Care

October 30–31 Toronto, Ontario
organizer: The Conference Board of Canada
contact: Rhonda Bradbury
tel 416 481-1904
e-mail bradbury@conferenceboard.ca
www.conferenceboard.ca/conf/12-0146/default.asp

American Academy of Psychiatry and the Law 43rd Annual Meeting

October 25–28
Montreal, Quebec
tel 860 242-5450
e-mail office@AAPL.org
www.aapl.org/meetings.htm

The Summit on Sustainable Health and The 54th International Conference on Alcohol and Addictions

November 12–16
Palais des Congrès, Montreal, Quebec
e-mail ICAA2012@jpd.com
www.icaa-cipat.org/

3rd Annual Military & Veteran Health Research Forum (MVHR2012)

November 26–28
The Ambassador Conference Resort
Kingston, Ontario
e-mail chris.cornish@queensu.ca
613 533-6217
www.cimvhr.ca/forum

3rd Annual Healing and Treating Trauma, Addictions and Related Disorders Conference

November 28–30
Coast Edmonton Plaza Hotel, Edmonton, Alberta
toll free 1 800 456-5424
e-mail registration@jackhirose.com
conference2012.jackhirose.com

UNITED STATES

International Association for Relationship Research Conference

July 12–16
Chicago, Illinois
e-mail iarr2012conference@gmail.com
www.iarr.org/Conferences

International Narcotics Research Conference

July 14–20
Kansas City, Missouri
e-mail cw.stevens@okstate.edu
www.inrcworld.org/2012/2012mtg.htm

5th National Conference on Behavioural Health for Women and Girls

Health, Empowerment, Resilience, and Recovery (HERR CONFERENCE)
July 17–19
San Diego, California
organizer: Substance Abuse and Mental Health Services Administration (SAMHSA)
e-mail SAMHSAWomensConference@ahpnet.com
samhsawomensconference.org/

American Mental Health Counselors Association Annual Conference

July 19–21
Orlando, Florida
tel 703-548-6002, ext. 106
e-mail mhobson@amhca.org
www.amhca.org

American Psychological Association 120th Annual Convention

August 2–5
Chicago, Illinois
tel 202 336-6020
e-mail convention@apa.org
www.apa.org/convention/index.aspx

National Conference on Addiction Disorders (NCAD)

September 28–October 2
Gaylord Palms Resort, Orlando, Florida
Contact: NCAD Desk, 702 944-8753
www.NCAD12.com

American Psychiatric Association 64th Institute on Psychiatric Services

October 4–7
New York, New York
tel 1 703 907-7300
toll-free 1 888-357-7924
e-mail apa@psych.org
www.psych.org/ips

Society for Neuroscience 42nd Annual Meeting

October 13–17
New Orleans, Louisiana
tel 202 962-4000
e-mail info@sfn.org
www.sfn.org

American Academy of Child & Adolescent Psychiatry 59th Annual Meeting

October 23–28
San Francisco, California
www.aacap.org/cs/cme_and_meetings

American Public Health Association Annual Meeting

October 27–31
San Francisco, California
tel 202-777-2742
e-mail natalie.sorkin@apha.org
www.apha.org/meetings/pastfuture

2012 Summit on the Science of Eliminating Health Disparities

Building a Healthier Society Integrating Science, Policy and Practice
October 31–November 3
National Harbor, Maryland
e-mail 2012Summit@mail.nih.gov
www.nimhd.nih.gov/summit_site/index.html

American Psychiatric Nurses Association 26th Annual Conference

November 7–10
Pittsburgh, Pennsylvania
www.apna.org

Association for Behavioral and Cognitive Therapies 46th Annual Convention

November 15–18
National Harbor, Maryland
tel 212 647-1890 ext. 210
e-mail mebrown@abct.org
www.abct.org

42nd National Council Mental Health and Addictions Conference

April 8–10, 2013
Las Vegas, Nevada
www.thenationalcouncil.org/cs/conference

American Psychiatric Association 166th Annual Meeting

May 18–22, 2013
San Francisco, California
www.psychiatry.org/learn/annual-meeting

ABROAD

International Association for Child and Adolescent Psychiatry and Allied Professions 20th World Congress

July 21–25
Ile-de-France, France
e-mail iacapap2012@clq-group.com
<http://iacapap.org/world-congresses>

Breaking the Mould: Humanitarian Aid and Empowering Local Communities Conference

August 1–3
Durham University, Durham, United Kingdom
www.dur.ac.uk/conference.booking/

Measuring Behavior Conference

August 28–31
Utrecht, the Netherlands
e-mail info@measuringbehavior.org
www.measuringbehavior.org

International Society of Addiction Medicine Annual Meeting

October 15–18
Geneva, Switzerland
e-mail office@samweb.com
www.isamweb.org

World Psychiatric Association International Conference

October 17–21
Prague, Czech Republic
e-mail wpaic2012@guarant.cz
www.wpaic2012.org

The 17th World Congress of the International Union of Anthropological and Ethnological Sciences

August 5–10, 2013
University of Manchester, United Kingdom
e-mail John.Gledhill@uiaes.org
www.uiaes2013.org/



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