

Looking After the Clinical and Social Support Needs of Military Families Impacted by Operational Stress Injuries

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ABSTRACT

Over the last two decades, Canadian military members have experienced a significant increase in their participation in military operations, both abroad and at home, escalating the number of soldiers¹ dealing with psychological injuries. Those returning home from deployment with symptoms of psychological distress and reduced functioning have a profound impact on their family system. Families, specifically spouses, are often the sole source of support for the injured persons. Their long-term efforts to empathize for their partners and cope with the effects of caring for them, directly impacts their health and social functioning. Thus, assisting the supporting spouses to repair any damage done to the system itself is crucial to prevent burn out, but also to ensure the successful treatment of these military members. To do so the Canadian Forces has established two programs dedicated to assisting military members and their families dealing with psychological injuries resulting from military operations. These programs work in collaboration to offer different services that compliment each other and provide a holistic approach to prevention, education and treatment. The first program provides clinical expertise in treating these families; while the second, offers a new approach to providing social support services, through the utilization of a network of peers, who have also experienced the stress of caring for psychologically injured members. Even with this cohesive service system, there are still barriers and challenges to providing care to this population, and future enhancements to this system are required in order to fully meet their needs.

¹ The term soldier will be used throughout the document and is intended to refer to military members from all elements, including Navy, Air force and Army.

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1.0 INTRODUCTION

Since the first Gulf War in the early 1990's members of the Canadian military have been more actively involved in difficult operations with involvement in peacekeeping missions such as Rwanda, Somalia, Yugoslavia, and more recently, the war on terrorism in Afghanistan. Canadian Forces personnel from all elements have played an important role in most United Nations and NATO peace missions since the inception of the Lester B. Pearson peacekeeping model. Unfortunately, many military members are paying a high psychological cost for their participation in these missions.

To describe any persistent psychological difficulty resulting from operational duties, the term operational stress injury (OSI) has been coined by the Canadian Forces. OSIs include diagnosed medical conditions such as anxiety, depression and posttraumatic stress disorders (PTSD), as well as a range of less severe conditions [1]. Many military members experience symptoms for years after their initial injury, prior to seeking help. Unfortunately, a lack of understanding of the symptoms of their injuries and the fear associated with stigmatization often delay seeking treatment. As well, the possible negative implications for their military career may also force them to suffer in silence. Thus, over time the condition becomes chronic, symptoms worsen and functioning deteriorates. However, the military member is not the only victim, for beside every member suffering in silence, there is a family suffering along with him or her.

When considering deployment interventions for family members, one must reflect on the needs of those families who are also paying a high psychological cost for their loved ones' participation in various military missions. OSIs such as PTSD and depression are not individual problems; rather they are problems that impact the entire family system. Furthermore, for many Canadian Forces members and Veterans, immediate family is their sole source of support. Thus, treating and assisting these families is not only crucial to help repair any damage done to the system itself, but also to ensure the successful treatment of the individuals diagnosed with the OSIs.

The Departments of National Defence and Veterans Affairs Canada began, in the late 1990's, to address the clinical and social support needs of military members and their families suffering from operational stress. In an attempt to offer the support and treatment they required, two programs dedicated solely to assisting those who suffer from these injuries were established. The first program offers clinical services through five Canadian Forces Operational Trauma and Stress Support Centres (OTSSC), scattered across the country. These Centres follow national policies and best practices guidelines in providing assessment, intervention and outreach services to military members and their families, but each of them is an independent clinic. As well, recently the Department of Veterans Affairs Canada has also opened similar clinics to provide treatment to OSI Veterans and their families, these services mirror that which will be described throughout this paper in the OTSSC. The second program, the Operational Stress Injury Social Support program (OSISS), created in 2001, offers social support services through an organized and formalized national peer support network. The program mandate is not only to provide peer support across the country, but also to look at shifting the attitudes towards OSIs in the Canadian Forces by raising awareness and understanding and creating acceptance toward psychological injuries. Providing social support through a formal government driven peer support program is a fairly new concept. It was designed to include peers, who have themselves suffered from an OSI or supported a loved one with an OSI, to be part of the frontline care team and compliment the existing clinical services. In April 2005 the national family peer support component was launched and will be described throughout this paper.

Prior to describing the familial services provided by these two Canadian Forces programs, this paper will present a literature review, highlighting some of the key findings with regards to the impact OSIs, such as

PTSD and depression, have on family functioning. It will also review the findings of a Canadian Forces Military Family Needs Analysis [2], conducted in 2004, investigating the bio-psychosocial impact of OSIs on spouses and their resulting support needs. The paper will then detail the clinical interventions provided by the OTSSC Ottawa, as well as the family peer support intervention model developed by the OSISS program. Finally, the current challenges in providing care for these families will be examined along with recommendations for future program planning.

2.0 LITERATURE REVIEW

In 2000, Veterans Affairs Canada conducted a survey [3] of its clients; including currently serving members and retired veterans. More than 70% of the client base responded. The questionnaire was extensive and designed to reveal the incidence of PTSD. The survey concluded that 15% of respondents presented symptoms consistent with a PTSD diagnosis and an additional 10% presented symptoms that fall just short of the diagnosis. Similarly, major depression was also evaluated in 28% of the respondents during the same survey.

In 2002, the Canadian Forces asked Statistics Canada to undertake an Epidemiological Survey, designed to determine the frequency of certain mental illnesses experienced by Canadian Forces members. The results of this survey were published in the Canadian Forces Supplement to the Canadian Community Health Survey (CCHS) [4]. This survey found that the most common mental health issue experienced by Canadian military members is depression, at a prevalence rate of 7.6 % and a lifetime prevalence of 16.2%. The next most common problem is alcohol dependency. According to the Statistics Canada survey the one year and lifetime prevalence of alcoholism is 4.2 % and 8.5 % for members of the regular forces. Finally, following these two illnesses were Social Phobia, at 3.6 % (one year) and 8.7 % (lifetime), and PTSD, at 2.8 % (one year) and 7.2% (lifetime).

In light of these results, this literature review will focus on the impact of both anxiety disorders, such as PTSD, and depressive disorders on military families.

2.1 Post Traumatic Stress Disorder

Research examining the impact of PTSD on family members is sparse compared to the amount of research focusing on the individual components of this illness. Familial research has focused on either the difficulties in interpersonal functioning associated with this illness or the impact of this illness on the psychological health of spouses² and, to a lesser extent, children. There is also research in the area of family functioning.

Studies have demonstrated that Vietnam Veterans with PTSD have more social and interpersonal problems, greater marital and family dysfunction, increased displays of hostility and aggression, increased problems with emotional and sexual intimacy, and difficulty with communication and affective expression [5, 6, 7, 8, 9, 10, 11].

Jordan and colleagues (1992) studied a nationally representative sample of 1200 American Vietnam Veterans and 376 partners of these veterans [6]. Results indicated that veterans with PTSD had high levels of marital and relationship problems, higher levels of parenting problems, higher rates of family violence, and poorer family functioning in both areas of adaptability and cohesion. Spouses reported lower levels of marital

² The terms partner and spouse will be used to denote individuals in relationships with affected service members whether married or living in common law.

satisfaction and happiness, higher demoralization scores, and greater mental health issues. Jordan et al. also found that children living with PTSD veterans had significantly more behavioural problems.

Calhoun et al. in a 2002 study examined 71 partners of Vietnam Veterans with PTSD and compared this group with help-seeking Vietnam Veterans without PTSD [12]. They found that those partners living with PTSD veterans had poorer psychological adjustment, greater levels of familial conflict and interpersonal violence, and increased caregiver burden. These partners also had increased incidence of depression, anxiety, hostility, somatization and obsessive-compulsive behaviours. Other studies with this population yielded similar results [13, 14].

Research examining a different population of veterans, namely 382 Israeli soldiers suffering from Combat Stress Reaction, found that higher rates of PTSD were associated with greater familial conflict, lower expressiveness, lower cohesiveness and greater rigidity [15, 16]. In a very recent study Dekel and colleagues (2005) interviewed nine wives of Israeli veterans with PTSD to examine these spouses' experiences [17]. Their findings support Figley's concept of secondary traumatization, also referred to as compassion fatigue [18]. This concept describes the phenomenon of wives demonstrating symptoms similar to that of their PTSD partners over time. Compassion fatigue can be considered the "cost of caring too much", as it results from the spouses' efforts to empathize with their injured partners and cope with the long-term effects of OSIs [19]. It supports the view that spouses married to people with PTSD are greatly impacted by this illness, experiencing high levels of care giving burden, deep loneliness and ambiguous loss. "This loss is experienced when a person is physically present but psychologically absent. When a veteran has PTSD he is physically part of the family but no longer functions in the same roles or is as involved with the family as he used to be [15]." This loss contributes to ambiguity and feelings of depression and anxiety in spouses of PTSD partners.

Evans et al. (2003) studied the impact of each of the clusters of PTSD symptoms (arousal, intrusion and avoidance) as well as symptoms of depression, alcohol and anger on family functioning [20]. They found that, for veterans, all clusters of symptoms were associated with self-reported difficulties in family functioning. However, for partners, symptoms of avoidance and arousal, as well as depression and alcohol, were identified as causing familial problems.

Finally, Galovski and Lyons (2004) recently conducted an extensive review of the literature in regards to the impact of PTSD on family functioning, spouses and children [21]. These authors concluded "the literature clearly demonstrates that when the violence of combat leads to PTSD in the veteran, it can dramatically impact the veterans loved ones in a broad range of ways." According to Galovski and Lyons symptoms of emotional numbing, withdrawal, and anger have the greatest negative impact on familial relationships.

The evidence unmistakably indicates that PTSD negatively impacts both family functioning as well as the psychological health of partners and children. Therefore, when considering treatment for soldiers suffering from this anxiety disorder, the needs of these families must be addressed not only to assist the member's recovery, but also to prevent spousal compassion fatigue.

2.2 Depression and Anxiety

As with PTSD, there is a dearth of studies examining the impact on partners and children living with depressed patients. Much of the research in regards to depression has focused on the individual psychological and biological components of this illness as well as treatment. However, recently, researchers have begun to explore the ways in which caregivers are impacted by depression. Some of the key findings are listed below.

Van Wijngaarden et al. (2004) conducted a large-scale study of the consequences in 260 care giving spouses of people suffering from depression [22]. They found that more than 80% of spouses reported high levels of distress. The partners described themselves as suffering from irritability, anxiety, tension, fatigue, sleeplessness, and interpersonal stress. These spouses indicated that the depression of their loved ones impacts daily routines and familial roles. Furthermore, children were found to be significantly impacted by long-term exposure to a depressed parent. Chronic consequences included behaviour problems, loss of appetite, sleeplessness, playing less with friends, and being less attentive at school.

Benazon and Coyne (2000) studied 49 wife-depressed couples and 30 husband-depressed couples and found that spouses of depressed patients have higher levels of depressed mood compared to population norms [23]. They also found that partners of depressed patients tend to have high levels of subjective burden, which can be defined as attributions of negative feelings to the patient's behaviour and to their role as a caregiver.

Coyne et al. (1987) studied 42 adults who were living with a depressed individual [24]. Their findings indicate that people living with a depressed person were more distressed than those living with a patient not in a depressive episode. These respondents were also found to be suffering from significant burden related to the patient's depressive symptoms including lack of interest in social life, fatigue, hopelessness, and worrying.

Jeglic's et al. (2005) research supports other studies in this area regarding the contagion model of depression, in that higher levels of depressive symptoms in patients results in higher levels of depression in spouses [25]. These authors found that greater amounts of subjective care giving stress and burden, as well as negative patient behaviour, resulted in increased incidence of depression in the patients' spouse.

It appears that even less research has been conducted on the impact of anxiety symptoms on family members. A review of the literature in this area produced only one study conducted by Hickey and colleagues (2005) examining family and marital profiles of couples in which one partner had depression or anxiety [26]. In this study 29 depressed couples were compared with 21 couples in which one partner had an anxiety disorder (panic disorder, social phobia, agoraphobia, simple phobia or generalized anxiety disorder), and 26 couples with no apparent mental health illness. They compared these couples on measures of quality of life, stress and support, family functioning, marital satisfaction and relationship attributions. Hickey et al. found that the depressed group had significant difficulties in all areas, and although the anxiety disorders group fared better than their depressed counterparts, they also reported more problems in these areas as compared to the non-distressed couples.

Other than the research described earlier examining the impact of PTSD on the family, no studies could be found which specifically explore the impact of anxiety and mood disorders on families or spouses of veterans and military members. However, the symptoms found in civilians suffering from these illnesses are comparable to those experienced by soldiers, thus similarities can be inferred. Research clearly demonstrates the negative impacts that living with and caring for a depressed loved one can have on family members.

2.3 Canadian Forces Military Family Needs Analysis

In 2003, the OSISS program conducted a Family Needs Analysis to identify the current problems that family members of Canadian soldiers who have been psychologically injured as the result of their participation in military operations encounter in their daily lives [2]. The Needs Analysis was designed to gather information and measure the bio-psychosocial impact of these problems on the spouses, as well as their social support needs. The results led to the development of a model of intervention offering a range of social support services that are presented herein.

Both qualitative and quantitative information were collected in the Needs Analysis. First, nine focus groups held throughout Canada gathered 56 voluntary spouses providing daily support to their loved one affected by an OSI for at least six months. Areas covered during the interview included (a) challenges they face as the spouses of an OSI sufferer (b) changes in their life, and (c) needs for support. Second, semi-structured interviews were conducted with 33 professionals, including psychologists, nurses and social workers supporting OSI military members and their families at various locations across the country. The interview grid contained essentially the same themes as the ones used during the focus groups to counter-check the accounts of the participants and access the professionals' experiences in providing services to this population. Finally, the Health and Daily Living Form (HDLF) [27], which assesses the social resources used to prevent and cope with life's stressful events and functioning was administered.

2.3.1 Results

The Needs Analysis provided a number of significant findings with respect to the population studied. First, drawn out of the qualitative results, the challenges faced by spouses of OSI military members and the impact these injuries have on their health and social functioning are presented, with supporting excerpts. These are followed by the quantitative results of the health and family indices measured by the HDLF. Finally, the family assistance and support needs are identified.

2.3.1.1 Qualitative Results

In the qualitative analysis the five major challenges described by these women included: (1) a lack of understanding of the illness which contributes to self-doubt; (2) feeling over burdened with extra roles and responsibilities; (3) social isolation; (4) a lack of intimacy in their relationship; and (5) neglecting their own needs, which results in psychological and physical symptoms. Each of these will be discussed in detail.

As mentioned in the introduction section, many factors including negative attitudes with respect to psychological injuries may cause military members to struggle with their symptoms on their own and postpone seeking help when the initial symptoms manifest themselves. As a result of such delays, healthy spouses may be exposed for periods of varying durations to disturbing behaviour and personality changes before being informed that such behaviours are in fact symptoms of a psychological injury. The spouses who were interviewed expressed their distress and their incomprehension in the face of their partners' changes in behaviour and personality. One spouse describes her experience as:

I didn't know what it was. Of course, you think you're going insane in your own mind because you can't understand many things.

Unfortunately, this missing information caused many women to question their own behaviour, to doubt themselves, and to draw inaccurate conclusions. In the end they attempt to problem solve a situation for which they are not responsible.

The participants also mentioned that they have to take on more responsibilities than before because their injured partner has withdrawn from day to day life activities. Often they describe having to become caretakers for both the injured spouse as well as their children. Here one participant describes the exhaustion that results in these over extended roles and responsibilities:

So much of my physical and mental energy is taken up making sure that he's where he's supposed, he's you know, and then you have kids, I mean, mother's do that, that's second nature, but then to have to do that for a thirty-six year old man, you know, I don't have the mental capacity.

The spouses also indicated that they often operate as mediators between the soldier and the outside world in order to avoid confrontations and anger outbursts. This situation results in a climate of constant instability wherein conflict is always a possibility, and the healthy spouse is forced to take steps to try and improve the situation or at least maintain stability. One participant describes her efforts to protect her daughter from her husband's anger:

He doesn't have a lot of patience for like a two year old. He'll lose his temper and that stresses me out a lot. I over-compensate because I don't want her to feel his stress or to feel like if he's angry.

Another challenge for these women was the social isolation they experienced. They indicated that the number of activities that the couple and the family undertake together had diminished. The participants also related that they themselves participated in less social activities than before because of being too tired, too worried about leaving the injured spouse alone, or feeling as though they have been cut off from contact with their friends. The following excerpt illustrates this phenomenon:

I was trying to maintain my friends, you know, my social life without my partner. Well, I couldn't do it. So I have isolated myself and that was like part of the care-giving role I mean. I felt guilty if I went out anywhere, even, you know, just to have lunch with a friend.

For many spouses their current marital relationship lacks intimacy and as a result they experience a range of sentiments including guilt, anger, shame, rejection, confusion, and isolation. One participant expressed her loneliness as:

We used to cuddle when we were going to bed. Now, if he can give me a hug, it's like a blue moon.

During the interviews the spouses indicated that they felt responsible for the care of the injured partner and for other members of their family, and admitted neglecting their own health issues and other needs. This excerpt from a social worker summarizes the impact of OSIs on the health and functioning of spouses:

In our clinical experience, we observe that many spouses reach a burn out point before the members become healthier. They're so overwhelmed a lot of the time and also end up getting ill in the long run and getting sick themselves, physically and psychologically sick.

Many of these spouses suffer from anxiety, memory loss, and mood swings. They describe having difficulty concentrating and sleeping. A number of spouses interviewed mentioned having to take sick leave from work, having to change their employment to a job that was less demanding, or even quitting their employment as a result of being constantly exhausted. Despite these changes and the impact on their health and social functioning, they continue to put the needs of the injured person ahead of their own.

2.3.1.2 Quantitative Information

In order to support the qualitative data an objective measure was used to corroborate the information gathered. The HDLF had the advantage of both measuring the social resources used to cope with life's stressful events and functioning, as well as to offer control group normative data, drawn from an American community in the 1980s [28]. While ideally the control group would have been from the same time frame and socio-demographic characteristics, in order to overcome obstacles such as confidentiality and the significant cost and time needed to compose such a control group, this appeared to be a viable alternative. In comparison to the control group, the average age was the same (39 years), as was the educational level (13 years vs 14 years).

Table 1 presents the health and family functioning indices measured. As expected, spouses reported substantially greater health symptomatology (all *t* tests with a *p* < 0.05) over the controls on all depressive features (37.20 vs 19.21 - possible score of 72), and physical symptoms (6.39 vs 2.25 of 12 possible symptoms) confirming statements to that effect made during the data collection. However, contrary to what was reported about low self-esteem by the participants and the professionals interviewed, spouses test results did not show significantly lower self-confidence than the control group (13.39 vs 14.63 – possible score of 24). As for the family functioning indices, they reflect the situations described by the respondents. Concerning the rate of conflicts for the families in this study it is twice that of the control group (5.75 vs 2.48 – possible score of 14), and the level of family activities is substantially lower than for our families than controls (3.51 vs 4.82 – possible score of 12). Thus, supporting the concept of social isolation and high levels of conflict and tension reported by the participants.

Table 1: Mean (M) and standard deviation (SD) of health and family functioning indices (HDLF)

Indices	Spouses (n = 49)		Control group (n = 424)	
	M	SD	M	SD
Health Indices				
Physical symptoms (scale 0 - 12)	6.39	3.28	2.25	2.54
Depressive symptoms (scale 0 - 72)	37.20	13.12	19.21	11.79
Family Functioning				
Number of family activities (scale 0 - 12)	3.51	2.46	4.82	2.84
Number of family conflicts (scale 0 - 14)	5.75	3.36	2.58	2.59

All differences between means (spouses vs. control group) are significant, based on a *t* test with a P-value of < 0.05.

2.3.1.3 Assistance and support needs

The needs for support identified during the Family Needs Analysis are presented in Table 2. The resulting clinical and social support interventions provided to Canadian Forces families addressing these needs will be discussed at length later in the paper.

Table 2: Synthesis of the assistance and support needs of spouses

Assistance and support needs (presented in chronological order)
To be made aware about the existence of OSIs prior to deployments.
To be educated about the symptoms and behaviours associated with OSIs and helping resources.
To be informed of the treatment protocol of the OSI military members and in the intervention strategies.
To be sensitized to the importance of early intervention (seeking help).
To be listened to and receive emotional support.
To reduce the feeling of isolation.
To legitimize the emotions, experiences and suffering.
To learn concrete crisis management techniques.
To develop and enhance self-care and relationship skills (e.g.: healthy coping strategies, communication, anger management, coping with life transitions, meeting one's needs).
To recognize the signs of stress and depression in caregivers (oneself).
To have access to specialized psychological services for the treatment of OSIs and compassion fatigue.

2.4 Clinical Intervention

“Wives of veterans must also be included in intervention strategies not only because they can be crucial elements in the successful adjustment of their husbands but also because they, too, are victims of (operational stress injuries) [29].” Several articles discuss the treatment of families suffering the effects of PTSD and depression [15, 23, 27, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40]. Effective interventions include: education about the illness and its impact on the family; self-care strategies that assist the partner to deal effectively with stress and replace unhealthy coping strategies; improving social support networks; and family/marital therapy.

In a recent review of the literature, Riggs (2000) concluded that marital and family therapy was an effective adjunct treatment for PTSD [41]. He found two different approaches to family/marital therapy in the literature: systemic and supportive. Systemic interventions take a more traditional systems approach to marital therapy and focus on the responses of the family to the traumatic event and the related distress. Supportive interventions tend to focus more on reducing the symptoms of the individual who was exposed to the traumatic event by educating and supporting family members of trauma survivors to help them provide more useful support to the victim. Unfortunately, Riggs concluded that few empirical examinations of the efficacy of marital/family interventions exist, thus much of the evidence supporting the use of these interventions tends to be based on clinical and theoretical writings. One intervention that has been studied more extensively is behavioural marital and family therapy, which has been found to be an effective treatment approach for both PTSD and depression [36, 37, 42].

3.0 CANADIAN FORCES PROGRAMS

In order to effectively meet the needs of military families suffering from the effects of operational stress and to provide a holistic approach to care, the Canadian Forces has established two distinct yet complimentary programs, the OTSSC and OSISS. While these programs offer services to both the military members as well as their family, this paper shall focus solely on the familial components.

3.1 Operational Trauma and Stress Support Centre (OTSSC)

In an attempt to ensure that military members suffering from an OSI, get the assessment and treatment they require, Operational Trauma and Stress Support Centres (OTSSC) were opened in 1999 in various locations across Canada. Initially these Centres were designed to provide specialized services to Canadian Forces members suffering from psychological injuries due to operational duties. Since then services have been extended to include families.

The approach adopted by the OTSSC recognizes stress-related disorders as a disruption in adjustment due to significant life events that result in sustained activation of normal coping processes, both biological and psychological. The approach also recognizes that the more severe stress disorders are long-term disorders, which affect the individual, family and the community. As with physical rehabilitation, treatment is aimed at helping the person achieve his or her highest level of functioning.

While all five OTSSCs function under centrally developed policies and standards, each of them has some latitude in the application of these policies and standards so as to meet local concerns. Recognizing this, the description of services, which follows, is particular to the Ottawa OTSSC.

3.1.1 Ottawa OTSSC

The Ottawa OTSSC is comprised of a team of interdisciplinary professionals working together to provide evidence-based care for military members and their families. The team includes representatives from psychiatry, psychology, social work, nursing, and chaplaincy.

Clinical intervention at the Ottawa OTSSC has been based on the existing evidence regarding best clinical practice with families suffering from operational stress. Currently, combinations of both supportive and systemic interventions are used to address the needs of partners. This includes psychoeducational groups, marital therapy and concurrent individual therapy for both military members and their partners. At this time, the services provided to the military members' children are limited to psychoeducational sessions and, on occasion, brief behavioural family therapy. However, it is clear that the needs of these children far outweigh what is currently being provided and further program planning will be discussed later in this paper.

The mandate of the Ottawa OTSSC is to provide assessment, intervention and outreach services to military members and their families who are suffering from an OSI. Prior to reviewing each of these interventions in detail, it is important to discuss the role of familial assessments at our Centres.

3.1.2 Familial Assessments

When a military member has been identified as potentially suffering from an OSI, s/he is referred to the OTSSC for a comprehensive assessment to establish an accurate diagnosis. The person is interviewed by psychiatry and psychology and given a number of objective measures. At the Ottawa OTSSC it is not uncommon for partners to be interviewed for collateral information to confirm the military member's current symptoms and level of functioning. During this initial phase of assessment the focus is almost exclusively on the individual victim. However, once the diagnostic assessment has been completed and the existence of an OSI confirmed, the focus then shifts to the couple and family. The purpose of conducting a comprehensive familial assessment is two-fold. First, to assess the impact of the OSI on marital and family functioning and second, to assess the individual needs of each of the family members.

The primary means of assessing family functioning is through a clinical interview often with only the couple; however, clinicians may choose to include the entire family in the initial interview. This interview can be augmented by the use of objective measures that measure family functioning. Research has repeatedly demonstrated that the areas most impacted by PTSD and depression includes: communication, anger management and aggression, problem solving, intimacy and affective expression, sexual functioning, and withdrawal and detachment. Therefore, couples are asked to reply to open ended questions describing their current functioning in each of these areas. The couple is also asked to provide a detailed description of their relationship history, in order to assess pre-trauma functioning.

In addition to the initial couple interview, each partner is then interviewed separately. For the victim of the OSI the focus of this interview is to confirm the information gathered during the diagnostic assessment in relation to family history and current symptomatology. The military member is also asked to describe his/her view of the presenting familial problems and his/her treatment expectations. The spousal interview is more extensive as this is often their first opportunity to discuss their own feelings and concerns [29]. Areas focused on during this interview include: level of caregiver burden, symptoms of depression and anxiety or any other mental health issues (both as a result of the OSI and any pre-existing illness), the availability of social supports, and his/her view of the current familial problems and treatment expectations. Information is gathered again through open-ended questions and a psychosocial history is obtained. If the clinician has decided to conduct a complete family interview, separate interviews with each of the children should also be

conducted. This provides the children an opportunity to discuss their feelings and concerns separate from that of their parents.

Finally, the couple/family is seen together for assessment feedback and recommendations. The clinician provides participants an opportunity to discuss their reactions to the clinical impressions and provide input into the development of a comprehensive treatment plan. This treatment plan contains suggestions for both the family/couple as a whole, as well as recommendations for each individual family member.

3.1.3 Psychoeducational Groups

The Ottawa OTSSC currently offers a psychoeducational group for partners and extended family members. The group is two and a half consecutive days, as opposed to once per week over a number of weeks, in order to accommodate family members from across an extensive geographical area. It is designed to provide education and skills training. The goals of the program are: to increase the family members understanding of the OSI and treatment process, to increase their knowledge of how these illnesses can impact family functioning, to normalize current emotions and reactions, to improve relationship skills as well as the skills necessary to care for themselves, to decrease feelings of isolation and to instil hope. The goals of this program reflect the needs identified by the Family Needs Analysis. According to the classification described earlier by Riggs this would be considered a supportive intervention [39].

The program begins with a focus on education as this has been demonstrated to reduce feelings of self-blame, rejection, anger and confusion. It assists family members to reframe the illness as a family problem, and helps them to understand the ways in which the illness has impacted not only their spouses, but also their family and individual functioning. In a 2001 study of spouses of PTSD veterans, Lyons and Root discovered that spouses require therapies to reduce their own stress level in addition to education [43]. Therefore, family members are taught relaxation skills including diaphragmatic breathing and progressive muscle relaxation, anger management techniques to manage both their partner's anger outbursts as well as their own feelings of anger and irritability, assertive communication skills, and healthy lifestyle and coping strategies. Lyons and Roots also found that these spouses were interested in social activities to offset the isolation that they feel. Therefore, the psychoeducational group is designed to introduce spouses to others experiencing similar issues, as well as to ensure they are aware of the OSISS program services.

3.1.4 Behavioural Marital Therapy

As mentioned earlier, one of the more promising marital interventions for addressing the impact of operational stress on relationships is Behavioural Marital Therapy. Galovski and Lyons have referred to this approach as a supportive intervention; however, Riggs' description of this intervention as a systemic treatment approach appears to be more accurate [19, 39]. Behavioural Marital Therapy has evolved out of traditional systems theory of family/marital intervention whose primary goal is to improve the functioning of the couple rather than target only the individual's operational stress symptoms.

Currently this is the primary approach to marital therapy at the Ottawa OTSSC. Elements of this therapy include: education regarding the illness and marital distress; increasing exchanges of positive behaviour; improving essential relationship skills such as communication and problem solving, as well as anger management; increasing acceptance of each partner's differences and reducing blaming behaviours; reducing negative thinking about the self, partner, world and the future; and planning for setbacks in the future [34, 36].

There are a few situations when marital therapy may be contraindicated, such as when ongoing domestic violence is occurring, when one partner is participating in an ongoing marital affair, and/or when the military

member's operational stress symptoms are so severe as to prevent him/her from being able to participate in the therapy. In these cases concurrent individual therapy would be a more appropriate treatment option, until such time as these conditions are no longer a factor.

3.1.5 Concurrent Individual Therapy

In light of the high levels of depression and anxiety symptoms found in partners of military members' suffering from operational stress, it is important to address their individual needs. In such cases where the spouse is unable to attend the psychoeducational group described earlier in the paper, and where marital therapy is contraindicated, the spouse may be provided treatment on an individual basis. Individual therapy in these cases would comprise many of the same interventions listed in the group and marital sessions, as well as address any individual psychological difficulties (such as depression or anxiety symptoms) the spouse may be experiencing. Unfortunately, due to the Canadian Forces limited mandate in providing individual care for partners, long-term treatment is not an option. Spouses requiring ongoing treatment are referred to civilian resources in the community; however, this is not without its problems and will be discussed at greater length later when challenges to care are addressed.

3.1.6 Outreach

The final mandate of the Ottawa OTSSC is to provide information, education, and training to Canadian Forces medical care providers; personnel, veterans and their families; civilians and community care providers; peer support efforts; and the Canadian Forces leadership. The goals of these outreach activities are to accelerate identification, treatment and recovery for operationally related trauma and conditions. This last community intervention is a very important component of the program and focuses on many of the same problems the OSISS program was designed to address; in fact, often the two programs will collaborate in order to facilitate outreach activities that deliver both the family peer support component and the medical treatment perspective.

3.2 Operational Stress Injury Social Support Program (OSISS)

The OSISS program was conceived, and is currently managed, by a military member suffering from an OSI. It began as recognition that those suffering from OSIs were isolated and abandoned by their peers at a time when they most required their support. It is a partnership between the Departments of National Defence and Veterans Affairs Canada. The management team is made up of a number of experts, advisors and mental health specialists including a psychiatrist, nurses, social workers and former service members.

The OSISS program consists of two networks of government employees who provide social support to military members, Veterans and their families suffering from OSIs. The first network is composed of Veterans who have suffered an OSI. This network consists of 23 Peer Support Coordinators that have been carefully screened, and have been found to be at a level of recovery in their own treatment process, as to be able to provide peer support to others. This is designed to lower the risk of relapse and further traumatization, which can be possible when performing this function. The second network is formed of family members who have suffered the effects of an OSI. Launched less than a year ago, this network is composed of six Family Peer Support Coordinators. The main role of the employees is to provide social support, and to develop a network of volunteers who, in turn, assist others. The volunteer network is a very important pillar of OSISS as it enables the program to reach a greater number of people.

The OSISS program is built on the concept of social support. This concept has been well researched and although there are a variety of different definitions, Kaniasty's (2005) definition is most closely aligned with the OSISS philosophy. Kaniasty states that social support is referred to as social interactions that provide

individuals with actual assistance and embed them into a web of social relationships, which are caring and available when needed [44]. The literature has demonstrated that social support not only mitigates the impact of trauma and assists in recovery, but also is beneficial to psychological well being and physical health [45, 46, 47].

As mentioned earlier, providing social support through a formal government driven peer support program is a fairly new concept. When people undergo stressful life events, it is not uncommon for them to seek out others who have been through the same situation in order to receive empathy and support, as well as to integrate this new condition into their lives [48, 49]. Rosenroll (1994) defines peer support as:

an umbrella term used to describe a sanctioned program where individuals receive appropriate training and supervision so that, formally and informally, they can directly and indirectly offer assistance in a variety of ways to individuals who, based on their situational defined similarities, would refer to themselves as peers [50].

This definition clearly describes the OSISS program whereby it is a sanctioned program where individuals receive appropriate training so that they can offer support and assistance to their peers.

All employees are required to attend a two-week training designed for the OSISS Program, which is delivered by mental health staff. The course material includes training in the skills necessary to provide effective peer support (i.e. conflict resolution, empathetic listening, understanding and respecting boundaries and problem solving), as well as general information regarding available resources within the government and local communities, which will assist them in helping their peers. Another key component of this training deals with on respecting program boundaries and practicing self-care. The program also provides on-going professional development and support through quarterly workshops. Similar to this training, all selected and screened volunteers within the OSISS program are also provided a three-day training course dedicated to skills development. The goal is to empower the recruited volunteers to help them support others in a safe way [51].

3.2.1 Family Peer Support Intervention Model

The mandate of the Family Peer Support Coordinators is to *reach out, inform* and *communicate*. They strive to educate and support family members and thus complement the clinical approach undertaken by the OTSSC.

The Family Peer Support Coordinators must first *reach out* to family members, as well as people from the community within their assigned region to increase awareness about OSIs. The Family Needs Analysis indicated that most spouses seeking assistance have reached the point of emotional exhaustion and are experiencing serious difficulties in one or more aspects of their social functioning. One of the goals of the OSISS family initiative is to find methods to reach out to these partners pro-actively so as to intervene early with support and skills to prevent burnout and, thus, ameliorate their health and social functioning, as well as that of their family.

One way Family Peer Support Coordinators achieve this goal of early intervention is to join with the Canadian Forces and Veterans Affairs Canada in improving pre and post deployment information sessions. This assists spouses' ability to deal with the challenges and stress associated with the different stages of deployments and may prevent the development of problems. During these information sessions OSISS also provides information about OSIs in order to increase awareness about the symptoms, decrease negative attitudes about psychological injuries, identify available resources of support, and advocate for earlier intervention. This may prevent exposure to symptomatic behaviours for long periods of time prior to seeking help, thus mitigate the extent of the impact on their health and social functioning. For example, it may increase a partner's ability to place the military member's unusual behaviours into an understandable context and avoid self-doubt.

Once OSISS has reached out and engaged spouses increasing their awareness about OSIs, the second role of the Family Peer Support Coordinator begins; specifically to *inform* families about available and relevant resources to assist them. In order to complete this task the Family Peer Coordinators must *communicate*. This is the third pillar of the Family OSISS program. The term communicate was chosen because it highlights the need to relate to others and provide information. OSISS philosophy promotes empowerment. In this way, Family Peer Support Coordinators provide alternatives rather than direction or solutions, letting individuals be responsible for their own decision making process. Therefore, communication is integral within the outreach and the information pillars of the model.

Education is the key to *informing* spouses and thus completes the final pillar of this model. In order to reach a wide audience education is provided through a number of different mediums, including an OSISS brochure and website, general information sessions, handouts and educational articles which are distributed through various newspapers and VAC publications, as well as a video production and peer support groups. These last two mediums are described below in more detail.

In March 2006, OSISS completed an educational video entitled “A Stranger in the House”. This video is targeted specifically at family members living with and supporting a military member with an OSI. In the video, family members talk about their experiences including the difficulties they encountered and the importance of seeking appropriate help. Clinicians who work with this population in the OTSSC reflect on family members experiences. The presentation of this video is facilitated by the Family Peer Support Coordinators. It encourages group discussion and is accompanied by an information brochure, which includes a brief list of available resources.

Family Peer Support Coordinators also facilitate family peer support groups. This is a forum for education, personal growth, and fosters mutual support and resocialization both within the group meetings and beyond. The group allows participants to acquire tools and skills to help them accept, deal with and adapt to their common situation. More specifically, emphasis is put on fostering self-esteem, learning to strike a balance between the needs and demands of the victim and the needs of the helping spouse without feeling guilty, and understanding that they cannot change the symptomatic behaviours of the injured person. Participants are active in selecting the education focus of the meetings, as well as sharing the group’s operational tasks. Whenever possible, the group is co-facilitated between the Family Peer Support Coordinator and a trained volunteer participant. Together they encourage the development of both individual and collective knowledge to help the participants empower themselves. Guest speakers are invited to deliver specific educational topics as determined by the participants’ needs. Participation in the family peer support group can help address many of the spouses’ identified needs, however, for some, it is only the beginning and needs to be complimented by the intervention provided through other resources of support, like the OTSSC.

4.0 CHALLENGES TO CARE AND FUTURE DIRECTIONS

4.1 Barriers to seeking help

Even though continuous education within the Canadian Forces community is creating a greater understanding and acceptance of OSIs among military members and their families, the stigma associated with mental illness remains an important barrier to seeking help. This, combined with the natural tendency to attempt to overcome difficulties on one’s own, prevents not only soldiers from coming forward early in their illness, but also their family members. In addition, spouses often view OSIs as individual problems rather than familial issues; this belief prevents them from seeking help for their own needs, and that of their family. Furthermore,

even if they do understand the familial nature of these issues, if the injured member is not yet ready to seek assistance, many services remain unavailable to them.

Since the available treatment services within the Canadian Forces are structured around the care of the military member, many spouses cannot access these resources. Either they are not aware of the options for care, or they are forced to rely on the injured member to convey the information. This barrier is a challenge in itself for the family members and it can be compounded by the confidential nature of the client / professional relationship, which prevents mental health professionals from contacting the partners of OSI victims directly. Unfortunately, as pointed in the Lyons article, and as reported by some clinicians and coordinators working with Canadian military members, the soldiers often express reservation about discussing any part of their situation with their spouse. The fear of having to discuss the traumatic experience or of being perceived as weak may help to explain these phenomena [47]. Furthermore, in light of their symptomatology, the injured persons may simply forget to tell their partners.

Other more practical barriers to care include the large geographical area covered by the OTSSC and the OSISS Family Peer Support Coordinators, thus, creating problems with transportation and travel. They also report problems accessing childcare, time away from their place of employment, and simply finding the time in their busy schedules because of overextended roles and responsibilities. These findings have also been supported in the literature [2, 47].

Unfortunately, as mentioned earlier, the OTSSC's current mandate for family members is limited to providing service to the family where it is deemed to be in the best interest of the military member. For this reason family members may not be able to meet their most pressing identified need, which is for individual therapy within the Canadian Forces services. Accessing therapy offered by the provincial health care system often involves being part of a long waiting list, high costs, and seeing a therapist who may have very limited knowledge of the military culture and OSIs.

4.2 Future directions of services to family members

As pointed out earlier, a lack of understanding and knowledge about OSIs are major barriers to supporting family members and preventing compassion fatigue. Consequently, finding creative and positive ways to deliver continuous education remains a priority for both programs.

It is believed that one way to increase awareness and to educate family members, and the broader community, is to establish a family-oriented speaker's bureau. Such a group will be composed of family members who have achieved an optimal level of healing and mental health professionals who will deliver medically relevant information. The trained family speakers will provide reliable information on OSIs and discuss their personal experiences. Research on attitude changes has demonstrated that vivid anecdotal experiences have an ability to generate an emotional response that can have a powerful impact on attitudinal change [52]. This initiative is clearly one that OSISS can undertake in collaboration with the OTSSC, and could possibly be integrated within the existing pre and post deployment sessions.

The OTSSC may be able to provide greater flexibility in the delivery of the services to family members through the anticipated staff increases already mandated by the Canadian Forces. This would help in overcoming some of the barriers related to scheduling conflicts and the distances separating users from services. Looking at the possibility of scheduling therapists to work evening and weekend hours would partly alleviate conflicts related to family obligations and employment. In addition, offering services via the telephone and videoconferencing to family members living at some distance from the OTSSCs and other CF

mental health providers could help solve this problem. In fact, the OSISS Family component is presently developing the tools and the protocol to offer psychoeducational telephone support groups for family members living in remote areas. This service would complement the OTSSCs efforts to provide clinical services for those in remote areas as mentioned above.

Within the current OTSSC mandate it is not possible to offer direct therapy to family members and it can be difficult to provide them with greater access to specialized psychological services. Ideally, the mandate would be expanded to include all therapeutic services to family members even when the military member is not able/willing to seek treatment him/herself.

To this point in time those two Canadian Forces programs have not been able to devote particular attention to the needs of children and teenagers living with an OSI parent. In part, this has been because of the priority need of reaching out to the sufferers themselves and the partners. It is, however, critical that children and youth not be forgotten in our attempts to meet the needs of OSI families. Several methods are available to reach out to children and youth of all ages. Illustrated age appropriate booklets and other written materials have been used successfully in parallel contexts. In a similar fashion, videos could also be developed to be used in small group workshops or classroom settings. The OTSSC Ottawa is currently looking to develop psychoeducational groups for children and youth, similar to that provided to the partners described earlier in the paper. Finally, the OSISS Website can be extended to provide parents with useful information and education through which they can discuss the potential impacts of OSIs on the entire family.

5.0 CONCLUSION

This paper has outlined the two Canadian Forces programs established to meet the needs of families who share their lives with military members suffering from OSIs; the Operational Trauma and Stress Support Centre (Ottawa) and the Operational Stress Injury Social Support program. These two programs work together to provide a holistic approach to prevention, education, and treatment.

Research clearly demonstrates the damaging affects OSIs, such as PTSD and depression, have on partners and children. The symptoms of these psychological injuries contribute to disruption in family functioning, as well as create problems in both the spouse's and children's own psychological well-being. Along with the other literature reviewed in this article, the Canadian Forces Military Family Needs Analysis undoubtedly highlighted this impact, as well as the need to address these issues. The partner's of OSI soldiers report feelings of depression, anger, isolation, confusion and exhaustion. They find themselves carrying the burden of familial responsibilities, while trying to care for their injured spouse. Many of these spouses neglect their own needs and health issues. Over time, this situation contributes to compassion fatigue syndrome, the stress of caring too much.

The OSISS program was designed to address the needs of families through the establishment of a national family peer social support network. This program provides individual peer and group support, education, and assists spouses to connect with the available resources. Furthermore, in an effort to be proactive and prevent the damaging impact of OSIs on families, OSISS is involved in pre and post deployment information briefings to reach out to military families and increase their awareness of OSIs. These services are provided through government employees who themselves have experienced the stress of caring for an injured partner, as well as trained volunteers who are at a level of recovery in their own treatment process as to be able to help others.

The OTSSC Centres have a clinical mandate to assess, treat and educate OSI family members. Interdisciplinary professionals work together to ensure that the clinical needs of military members and their

families are addressed. At the Ottawa OTSSC, each family is provided a comprehensive assessment to ensure that their specific needs are attended to. Then the partners have access to a number of different treatment interventions that are based on best clinical practice, marital/family therapy, psychoeducational groups, and individual counselling.

As discussed in the final section of this paper, these services are not without their challenges. Barriers to care including limited access to services, scheduling difficulties and significant distances between the service care provider and the users, as well as many others. These can prevent families from utilizing the programs available to them. Therefore, the OTSSC and OSISS need to continue to modify and enhance the services they provide in an effort to overcome these challenges. Future directions include developing more services for children, utilizing technology to access families in remote areas, increasing staff, and finding other creative solutions.

The theme of this HFM-134 symposium is to examine the human dimensions in military operations and strategize on how best to address issues of stress and psychological support. Many other militaries are afflicted with the impact of difficult operations on their troops and thus have soldiers experiencing the devastating effect of this operational stress. However, when considering treatment for these victims, one must not forget the families who are also deeply distressed. Throughout this paper the services of the OTSSC Ottawa and OSISS were reviewed in great detail in order to afford the reader an opportunity to replicate these types of interventions in other locations. Familial treatment cannot only improve family functioning and the health of the spouses and children, but also assist the military member in their recovery process and expedite his/her return to full operational duties.

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