



Mood Disorders Society of Canada
La Société Pour **Les Troubles de L'Humeur** du Canada

Operational Stress Injuries and Other Traumatic Stress: Therapies and Treatment for Veterans





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INTRODUCTION



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Mood Disorders Society of Canada (MDSC) is pleased to present this educational resource as part of our popular public mental health awareness series; *Operational Stress Injuries and Other Traumatic Stress: Therapies and Treatments for Veterans*.

This important resource could not have been developed without the dedication of Dr. Barbara Everett, PhD in assisting in the researching and writing of this handbook and the members of our advisory panel, along with all those who have contributed their time and effort to this project.

Mental illness affects all Canadians. The overarching message that MDSC wishes to convey in all its work is that recovery from mental illness is possible. This resource book is meant to be a general guide and is not intended to be the “final word” in every area. In delivering this resource to Canadians, our goal is to offer an easy to read resource that provides knowledge and links to assist Veterans and their families.

Mood Disorders Society of Canada wishes to express our sincere gratitude to The Centre of Excellence on Post-Traumatic Stress Disorder (PTSD) and Related Mental Health Conditions who provided funding and support to produce this publication. We greatly value their contribution to this project.

Operational Stress Injuries (OSIs) are “any persistent psychological difficulty resulting from operational duties performed while serving in the Canadian Armed Forces or as a member of the Royal Canadian Mounted Police. It is used to describe a broad range of problems which include diagnosed psychiatric conditions such as anxiety disorders, depression, and post-traumatic stress disorder (PTSD) as well as other conditions that may be less severe, but still interfere with daily functioning.”¹ The term OSI is not a medical or diagnostic term itself, and there is great variability in how people use it.

This educational resource describes how OSIs are comprised of PTSD, depression, anxiety, and substance use disorders. It also briefly describes other potential sources of OSIs such as military sexual trauma, discrimination and other forms of oppression and moral injury.

1 Veterans Affairs Canada (May 12, 2021). Understanding mental health. Available at: veterans.gc.ca/eng/health-support/mental-health-and-wellness/understanding-mental-health

The mental illnesses associated with OSIs are discussed in detail along with helpful therapies. Treatment for substance use disorders is acknowledged as an important aspect of recovery.

Families members and Veterans have their own struggles. If you are a family member or caregiver, turn to Chapter 5 where the uniqueness of your situations and some sources for help are discussed.

This is a hopeful publication. It ends with a section on relapse prevention strategies and ways to provide yourself with ongoing support.

Recovery is possible.

Appendix 1

Medications for PTSD, depression and anxiety – a reference for you and your medical team.

Appendix 2

Summarizes resources mentioned in this booklet that are available to you for assistance.

CHAPTER 1 *Operational Stress Injury*



Military personnel returning from combat, deployment or other stressful duties, can find themselves changed and not always in a good way. They can feel distant from their surroundings and may have trouble relating to friends, family and even fellow military members. They often feel alienated from society – no longer able to fit in. But they push on, sure that things will eventually return to the way they were before deployment – except this doesn't always happen.

Some can't put their finger on what's wrong. Others have the deep worry that they might have emotional problems but, being strong people, they are committed to powering through. To ease their pain, they might turn to alcohol and drugs for temporary relief. While these tactics may numb their fears for a while, they could have worrisome consequences like damaging the relationships they once valued or getting in trouble at work or with the law. Some might feel they are becoming people they don't recognize: angry, combative, anti-social, and – sad and alone. Above all for many, is the numbness – they just can't seem to feel anymore.

OSIs don't just result from combat-related service. They may also result from difficulties that may occur during peacekeeping missions, after serving in a war zone, or following other traumatic events not related to combat.² It is estimated that 30% of people who serve in combat zones will develop Operational Stress injuries (OSIs).³ There are a range of OSI symptoms including overall numbness, hyper-vigilance, overwhelming anger, explosive temper, nightmares, inability to sleep, interrupted relationships, and suicidal thoughts which may result in suicide attempts.

2 The Royal. Operational Stress Injury Clinic. Available at: theroyal.ca/patient-care-information/clinics-services-programs/operational-stress-injury-clinic

3 Tararouk, T. (2012). Treatment of co-occurring operational stress injury and substance abuse. Available at: drugabuse.gov/international/abstracts/treatment-co-occurring-operational-stress-injury-substance-abuse

The risk of developing post-traumatic stress disorder (PTSD), one of the most common OSIs, is about three times higher in the military and law enforcement than the general population, although this could be low because of under-reporting.⁴

Common OSIs include the following psychiatric diagnoses:

- PTSD,
- depression,
- anxiety, and
- substance use disorders.

Operational Stress Injuries need to be taken very seriously. It is never too late to seek treatment. Evidence suggests that recovery is possible even for those with chronic symptoms.⁵

Brief history of OSIs

The term Operational Stress Injury was first coined by a Canadian Lieutenant Colonel in 2001.⁶ It was designed to describe – not medicalize - service members' and Veterans' experiences. Another motivation was to give the same legitimacy to their injuries as is given to physical injuries.

For a fuller overview on Operational Stress Injuries (combat-related stress) go to: cafconnection.ca/getmedia/4aee355d-6b62-4bc8-a9ef-e099cd-c743b9/Guide-BSO-EN

veterans.gc.ca/eng/health-support/mental-health-and-wellness/understanding-mental-health/ptsd-warstress

4 Rynor, B. (2010). Veterans stepping forward for treatment of operational stress injury. Canadian Medical Association Journal, Available at: cmaj.ca/content/182/7/e281

5 The Royal. Operational Stress Injury Clinic. Available at: theroyal.ca/patient-care-information/clinics-services-programs/operational-stress-injury-clinic

6 Canadian Institute for Public Safety Research and Treatment. (2020). Operational stress injury (OSI). Available at: cipsrt-icrtsp.ca/en/glossary/operational-stress-injury-osi

Resources

Operational Stress Injury Clinics are what are called a ‘tertiary’ service, meaning that they provide highly focused and specialized care to people with Operational Stress Injuries. You must have a referral from Veteran Affairs Canada to access these clinics. Serving Canadian Armed Forces (CAF) members can also be referred under certain circumstances, through CAF Health Services. There are 10 outpatient clinics (some with additional satellites) around the country: Vancouver, BC; Calgary, AB; Edmonton, AB; Winnipeg, MB; Ottawa, ON; London, ON; Montreal, QC; Quebec City, QC (French only); Fredericton, NB; and Dartmouth, NS. As well as one inpatient clinic at St Anne de Bellevue, QC. See: veterans.gc.ca/eng/health-support/mental-health-and-wellness/assessment-treatment/osi-clinics

Operational Stress Injury Social Support (OSISS) is a national peer support network for CAF members, Veterans, and their families experiencing an Operational Stress Injury. cafconnection.ca/National/Programs-Services/Mental-Health/Operational-Stress-Injury-Social-Support

Veteran Affairs Canada also has a 24/7 health counselling and psychological support line available at: 1 800 268 7708 or TDD/TTY 1 800 567 5803. This help line is available whenever needed.

Other sources of OSIs



In recent years, the Canadian Armed Forces has recognized other experiences that can result in an OSI.

1. Military sexual trauma

Military sexual trauma⁷, includes sexual harassment; sexual assault; and/or discrimination on the grounds of sex, gender, gender identity, or sexual orientation during the course of military service.⁸ Sixteen to 27% of female-identifying CAF members have experienced sexual assault or harassment while 1 to 4% of men have had these experiences.⁹

7 Cotter, A. (2019). Sexual misconduct in the Canadian Armed Forces Regular Force, 2018. Available at: www150.statcan.gc.ca/n1/pub/85-603-x/85-603-x2019002-eng

8 The Royal. Operational Stress Injury Clinic. Available at: theroyal.ca/patient-care-information/clinics-services-programs/operational-stress-injury-clinic

9 Hillnotes (2019). Women veterans experience a different reality than their brothers in arms. Available at: hillnotes.ca/2019/04/02/women-veterans-experience-a-different-reality-than-their-brothers-in-arms

Military sexual trauma does not always result in an Operational Stress Injury but it can and it does. It can also exacerbate an already existing OSI.

With the best of intentions, the sexual misconduct policies within the Canadian Armed Forces included a mandatory reporting requirement, meaning that any member of the Forces who receives a complaint must report it to the hierarchy. An unintended consequence has been that some survivors are now afraid to report.

Those who report sexual assaults are guaranteed anonymity but it is important to note, that even with these assurances, some survivors simply do not trust that their information will not, somehow, get out, placing themselves and their careers at risk. As a self-help alternative, some establish private Facebook pages for communication and support.

Resources

Sexual Misconduct Response Centre is an entity that operates outside of the Canadian Armed Forces chain of command. It provides 24/7 counselling and/or support. It also helps survivors navigate their workplace or make a complaint. See: [cafconnection.ca/National/Programs-Services/For-Military-Personnel/Sexual-Misconduct-Response-Centre-\(SMRC\)](http://cafconnection.ca/National/Programs-Services/For-Military-Personnel/Sexual-Misconduct-Response-Centre-(SMRC))

Information on sexual trauma during service:
veterans.gc.ca/eng/health-support/mental-health-and-wellness/understanding-mental-health/sexual-trauma-during-service



2. Discrimination and oppression

The Canadian Armed Forces is a voluntary force with diverse people within its membership. However, discrimination, including systemic racism, continues to exist and is considered to be under-reported.¹⁰ The military is working on new policies to address systemic racism and discrimination, particularly hateful conduct. This is important work because racism, discrimination, bullying and microaggressions in any form are harmful.¹¹

Experiencing various forms of oppression, such as sexism, racism, homophobia, and transphobia, among others, can have negative consequences for mental health. In fact, research suggests that oppression is a form of trauma.¹² People who are part of multiple equity-seeking groups may experience the cumulative stress of intersectional discrimination which may increase the risk of developing PTSD and other mental and physical health problems.

Help is available. Whether you choose to seek professional treatment or not, there are also self-help strategies to protect your mental health. Chapter 7 offers some suggestions, as a start.

Resources

Information about research and other initiatives related to diverse Veteran communities. Veterans Affairs Canada, Building Communities: veterans.gc.ca/eng/about-vac/what-we-do/women-LGBTQ2/building-communities

10 Gibbson, V. (June 10, 2020). Feds still working on settlement with ex-military members alleging systemic racism, harassment. Available at: canada.ca/en/department-national-defence/maple-leaf/defence/2020/07/caf-releases-policy-defines-addresses-hateful-conduct

11 Government of Canada (July 13, 2020). Canadian Armed Forces releases policy that defines and addresses hateful conduct. Available at: canada.ca/en/department-national-defence/maple-leaf/defence/2020/07/caf-releases-policy-defines-addresses-hateful-conduct

12 Holmes, S., Facemire, V., & DaFonseca, A. (2016). Expanding criterion for posttraumatic stress disorder: Considering the deleterious impact of oppression. Available at: apa.org/pubs/journals/features/trm-trm0000104.pdf

3. Moral injury



Veterans can have both physical and Operational Stress Injuries and into that mix may come what is called a moral injury. A moral injury refers to “the psychological, social, and spiritual impact of events involving betrayal or transgressions of one’s own deeply held

beliefs and values occurring in high stakes situations.”¹³

There are two general types of moral transgression events: moral transgressions that involve people doing or failing to do things themselves (deliberately or unwittingly); and being exposed directly or indirectly to transgressions on the part of someone else (betrayal, bearing witness to grave inhumanity). These events are called *potentially morally injurious events*. Recognizing that not everyone will respond in the same way to these types of events, just like in the trauma field, where it is understood that individual responses to potentially traumatic events that involve a threat to one’s life or person will differ according to the individual.¹⁴

When a moral injury does occur, the outcomes are wide-ranging and can include:

- feelings of guilt, shame, anger, sadness, anxiety and disgust;
- intrapersonal outcomes including decreased self-esteem, high self-criticism, beliefs about being bad, damaged, unworthy or weak, and self-impeding behaviours;
- interpersonal outcomes including loss of faith in others, avoidance of intimacy and lack of trust in authority figures; and
- existential and spiritual outcomes including loss of faith in previous religious beliefs, and no longer believing in a just world.

People who struggle with a moral injury can say that the things they have seen and done will haunt them for the rest of their lives. While moral injury, like OSI, is not an official diagnosis, it can interfere with people fully embracing health and recovery because of the belief that they don’t deserve a better life.

Operational stress and moral injuries need to be taken very seriously.

13 Phoenix Australia Recovery Online Toolkit (2021, p6). Available at: phoenixaustralia.org/recovery/recovery-online/

14 Centre for Excellence - PTSD. (2020). Moral stress amongst healthcare workers during COVID-19: A guide to moral injury. Available at: moralinjuryguide.ca/wp-content/uploads/2020/07/Moral-Injury-Guide.pdf



Who do you turn to and where do you go?

When you decide the time has come to ask for help, you're going to have to find the energy to do it. Getting help also requires knowledge of who to ask and where to go. Veteran Affairs Canada and the Canadian Armed Forces have a dedicated mental health system with a banquet of services but, paradoxically, this can actually be a barrier. There are so many choices. Where do you start? What do you ask for?

Path 1: Applying for and being granted disability status with Veterans Affairs Canada

1. Get a diagnosis

The very first task is getting a medical diagnosis. Although people know they are suffering, they may believe it will pass with time. In order to proceed with the next steps, you must feel confident that you can adequately demonstrate that your distress and thus your diagnosis, is related to your military service.

Some people fear the undeniable reality of a diagnosis. Others are only too glad to finally have the formal medical system acknowledge what they knew all along – not only is something wrong, something is seriously wrong and at long last, something is going to be done about it.

Preparing for your appointment

There is a lot your doctor is going to want to know in order to arrive at an accurate diagnosis. You may need to describe your good vs bad days. How you feel then. How you function then. How you manage your household then. It will be helpful if you write down in advance a brief description of:

- the symptoms you are experiencing,
- whether or not you have other illnesses,
- a past or a present substance use disorder, and
- what medications you are on, including over-the-counter supplements.

Symptoms

The following are the areas of your life and current experience that are relevant:

- mood
- thinking
- behaviour
- relationships
- day-to day functioning and stresses
- sleeping and eating patterns
- energy levels

It may help to write down in advance what you would like to discuss in your appointment so that you can be prepared and remember key details. If you can, take someone with you to your first appointment. When you are struggling with the symptoms of mental illness, along with the anxiety of this important first step, it is invaluable to have a second set of eyes and ears with you – to listen, to ask questions, and to take notes. They will remember the details that you missed. With your permission, they may also provide observations because, in all likelihood, they have noticed things about your symptoms and behaviours that you may not have noticed yourself.

As a courtesy and in the interest of clear communication, it is important to ask your doctor if you can bring your support person into the interview with you. Some doctors may prefer to see you, for at least part of the visit, on your own.

Right now, you can see that this is likely to be a lengthy discussion and your doctor won't have the time to go through everything in one appointment. It is perfectly reasonable to ask for another appointment (as soon as possible) to finish this discussion. The goal is for your doctor to understand thoroughly what's been going on.

Here are some questions for you to consider asking. Choose two or three of the most pertinent questions at a time. Your support person can take notes so you can study the answers after you have left the office.

- What do you think this is?
- What are your treatment recommendations?
- Do people get better? How long does it take?
- What medication(s) do you recommend? What are the possible side effects? How long do they take to work? What do we do if they aren't working? Is this the best medication for my needs?
- What will I notice if the medication is working for me? How long should I wait before I conclude that this medication is not working and we need to try something else? (Note: two to four weeks is reasonable.)
- How long will I need to take this medication?
- My family is concerned about me; how can I reassure them?
- What about my job? Will the medication affect my ability to work? Should I take time off?
- Should you refer me to a psychiatrist?
- Where can I go for more information?
- What can I do to help myself?
- When should I come back for my next appointment? (Note: it is optimal for your doctor to see you every two to four weeks until you are feeling better.)

2. Download an application form.

Forms are available online from the Veterans Affairs Canada website or you can visit your local VAC Regional office. Alternatively, you can call 1 866 522 2122 and an application will be mailed to you.

Veteran Affairs offices not only provide you with the application but will offer advice on completing it and collecting documentation needed to go with it.

Your application with its supporting documentation is reviewed by a judge who is looking for answers to the following questions:

1. Is there evidence of a disability?
2. Is the disability related to - or partially related to - your service?
3. What is the extent of your disability?

Benefits, once awarded, are tax-free.

While you are waiting for approval, you can:

- Obtain mental health and addiction services (if you haven't already) through the various mental health clinics, some of which have specialized Operational Trauma and Stress Support Centres.
- Veteran Affairs Canada also has a 24/7 health counselling and psychological support line available at [1 800 268 7708](tel:18002687708) or TDD/TTY [1 800 567 5803](tel:18005675803). This help line is available whenever needed but might be especially helpful during the disability application process.
- Investigate Operational Support Clinics. There are 10 outpatient clinics (some with additional satellites) around the country: Vancouver, BC; Calgary, AB; Edmonton, AB; Winnipeg, MB; Ottawa, ON; London, ON; Montreal, QC; Quebec City, QC (French only); Fredericton, NB; and Dartmouth, NS. As well as one inpatient clinic at St Anne de Bellevue, QC. Many have additional satellites. After approval, you may qualify for a referral.
- If you are in the process of transitioning to civilian life, a Canadian Forces Transition Centre may help smooth your move to civilian life.

Path 2: Applying for and being granted rehabilitation services with Veterans Affairs Canada

If the disability route is not for you but you are having trouble adjusting to life outside the active duty forces such that your working life is compromised, you may be encouraged to apply for rehabilitation services. They are available to people who have a barrier to adjustment which is a health issue (temporary or permanent) at work, at home, or in the community.

Applications can be submitted online or in person at your regional VAC office. As with the disability process, help is available at 1 888 522 2122.

Eligibility for rehabilitation services can be determined within a few weeks. If approved, you are assigned a case manager who will work with you to create your individual rehabilitation plan. The plan will include your personal goals including what services and benefits you will need to reach your goals.

In addition to VAC services, you may be referred to local community services (which are covered by VAC). You can also ask your case manager about whether you are eligible for certain home care services, through the Veterans Independence Program.

Your plan will also include a timeframe.

You may be eligible for additional disability-related benefits available through other government departments, such as Canada Pension Plan Disability Benefits and tax credits for people with disabilities.

For more information: canada.ca/en/employment-social-development/services/benefits/disability/living

Resources

VAC regional offices. See: veterans.gc.ca/eng/contact to find an office near you

Veterans Affairs Canada website's disability application page. See: veterans.gc.ca/eng/health-support/physical-health-and-wellness/compensation-illness-injury/disability-benefits#03

OSI Clinic Location Finder. See: veterans.gc.ca/eng/health-support/mental-health-and-wellness/assessment-treatment/osi-clinics

VAC Transition Centers. See: veterans.gc.ca/eng/resources/transition-centre

Canadian Armed Forces Transition Centres (for families too). See: canada.ca/en/department-national-defence/services/benefits-military/transition/understanding-transition/transition-centres

Bureau of Pension Advocates. See: veterans.gc.ca/eng/veterans-rights/how-to-appeal/bureau-pensions-advocates

Veterans Independence Program. See: veterans.gc.ca/eng/housing-and-home-life/help-at-home/veterans-independence-program

VAC 24/7 counselling line: When you call, you are talking to a mental health professional. Your information is completely confidential. 1 800 268 7708, TDD-TTY 1 800 567 5803.

CHAPTER 3 *Mental Health Diagnoses and Therapies Associated with an Operational Stress Injury*

This chapter reviews in detail these diagnoses including a full description, associated symptoms, and relevant therapies.

Appendix 1 lists all relevant medication.

Post-traumatic stress disorder (PTSD)



Many people experience or witness extremely distressing events during their lifetime, but few go on to develop PTSD.¹⁵ Studies show that approximately 50% of the general population will experience at least one traumatic event during their lifetime. Of these, 7 to 8% will develop PTSD.^{16 17}

PTSD is talked about in the media most often in relation to military service and it is one of the most common OSIs.

However, there are many other areas of human experience that can put people at risk of developing PTSD. Childhood physical or sexual abuse can lead to PTSD in adulthood. Public safety personnel such as police, firefighters, emergency measures services (EMS), and rescue workers are also at risk. Other experiences such as domestic or physical assault, rape, accidents, robberies, and natural disasters can also be risk factors.

It does not matter if these experiences actually result in physical injury (although many do). It is the belief that injury or death is coming that is one of the criteria for PTSD. People who witness frightening and traumatic events are also at risk.¹⁸

15 *ibid.*

16 National Institute of Mental Health. (2019). Post-Traumatic Stress Disorder. Available at: [nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd/#part_145373](https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd/#part_145373)
(Note this is a US figure. The PTSD Association for Canada uses this figure.)

17 *ibid.*

18 Viewing these events online or on television is not a risk factor for PTSD.

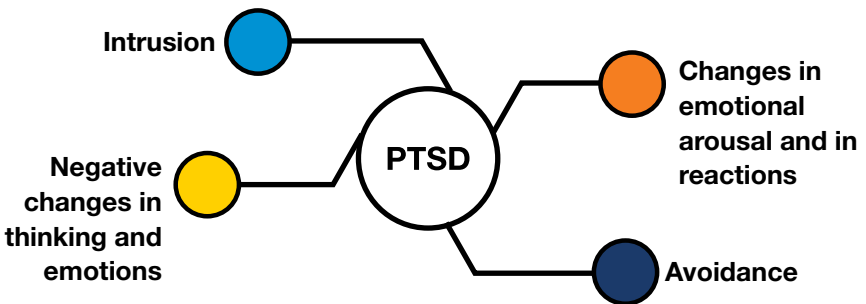
There are commonalities among people who develop PTSD; the severity of the traumatic event, having poor or no social support before or after the trauma, a history of childhood abuse, mental illness or a family history of mental illness, living or having lived in poverty, and ongoing life stresses. Being female also heightens one's chances of developing PTSD.¹⁹

Additionally, many people are at increased risk for PTSD as a result of experiences outside of a work-related setting such as survivors of sexual or interpersonal violence, refugees, LGBTQ2S+ populations, Indigenous Peoples, people experiencing homelessness, as well as survivors of major accidents or disasters. Each of these groups face a distinct set of circumstances, complexities, and challenges that impact the diagnosis, treatment, and management of PTSD.²⁰

Factors that protect against developing PTSD are having a secure personal support system, having access to an understanding forum to talk about what has happened, and learning, or already knowing about, ways of coping with adverse life events.

Symptoms

There are four areas of symptoms that make up a diagnosis of PTSD.^{21 22}



- 1. Intrusion:** Examples are: Unwanted and unbidden memories of the traumatic event, nightmares, and flashbacks. Flashbacks are a sudden state of altered consciousness where people re-experience aspects of the traumatic event, as if it were happening in the present. Flashbacks can involve one or more senses, such as seeing visions of the traumatic event, hearing the related sounds or smells.

19 Brewin, C., Andrews, B., & Valentine, J. (2000). Meta-analysis of risk factors for post-traumatic stress disorder in trauma-exposed adults. Abstract available at: content.apa.org/record/2000-02835-001

20 Public Health Agency of Canada. (2019). Federal Framework on Posttraumatic Stress Disorder: Recognition, collaboration and support. Available at: canada.ca/en/public-health/services/publications/healthy-living/federal-framework-post-traumatic-stress-disorder

21 *ibid.*

22 Note: PTSD is currently listed in The DSM-5 under trauma and stress-related disorders.

- 2. Avoidance:** Certain places, sounds, smells, sights, or even words summon feelings of the fear that people felt during the trauma so, understandably, they avoid these “triggers” as much as possible. But this strategy often results in limiting more and more aspects of everyday life, to the point of isolation - not seeing friends, and even avoiding leaving the house. In addition, adding to the burden, it is possible that the number of triggers to be avoided can actually increase. These avoidance symptoms are very difficult to overcome.
- 3. Negative changes in thoughts and emotions:** People may fixate on the trauma. Memory may be affected to the point people can't recall important features of the event. They now know the world can be dangerous and they worry that more traumatic events are around every corner. People feel that no one understands what they've been through. They may feel extremely angry that nobody warned them and now, it appears, no one will help them (even if people are trying). Self-blame is a common symptom. They may feel guilty for surviving when others didn't or they feel ashamed because, if they'd just reacted differently, said something, fought back, they could have saved themselves or others. At the same time, people can feel emotionally numb, lose interest in their usual activities and lack a sense of future or purpose.
- 4. Changes in emotional arousal and in reactions:** Irritability and sudden angry outbursts are common symptoms of PTSD. People may lose their temper with little provocation. They startle easily. They are wary and tend to look over their shoulder a lot of the time, which is called hypervigilance. With their brain occupied in this way, they have difficulty thinking, remembering, and concentrating.

Current research is examining the structural and chemical changes in the brains of people with PTSD.²³ One finding is that there is too much activation of the fear circuitry, as well as changes in neurotransmitter and hormone regulation.

It is estimated that 50% of people with PTSD also experience major depressive disorder.²⁴

Medications for PTSD

After diagnosis, a major aspect of your treatment may include medication.

Medications all have a brand name and a chemical name (both are often listed on your prescription bottle). They can be used interchangeably, confusing patients.

23 Public Health Agency of Canada. (2019). Federal Framework on Posttraumatic Stress Disorder: Recognition, collaboration and support. Available at: canada.ca/en/public-health/services/publications/healthy-living/federal-framework-post-traumatic-stress-disorder

24 *ibid.*



In addition, medications used for one disorder can be helpful for other disorders and vice versa. Therefore, there can be considerable overlap in discussing medication whether you have been diagnosed with depression, anxiety, or post-traumatic stress disorder.

You and your doctor will be making the final decision on which medication (or combination of medications) is best for you.

Please see [Appendix 1](#) for a full listing of medications.

Alternative treatment

Cannabis

Although medical marijuana has been legal in Canada for years (and recreational cannabis for some time now), physicians remain skeptical about prescribing it (although VAC funds eligible cases). There is a reason for this. Care of all their patients must be informed by evidence-based medicine. Because it has been illegal, academic research has tended to look at the harms of cannabis use – not its benefits. Physicians do not have access, yet, to enough research to guide their decision-making when asked to prescribe medical marijuana.

There are warnings, however. While cannabis use can help PTSD, it may also lead to overuse and possible addiction.²⁵

Visit the Mood Disorders Society of Canada website for a comprehensive publication called Cannabis and You: mdsc.ca/cannabis-and-you.

25 Yarnell, S. (2015). The use of marijuana for post-traumatic stress disorder: A review of the current literature. *Primary Care Companion for CNS Disorders*. Vol 17(3). Available at: ncbi.nlm.nih.gov/pmc/articles/PMC4578915/

Psychotherapies, particularly for PTSD

As with depression and anxiety, the best results occur when medication is paired with therapy. The following are therapies especially for PTSD.

The three-phase model

The three-phase model of PTSD treatment informs the therapies described below. Each therapy has its own approach to treatment but all will address, in some way, the following:

Phase 1 Safety and stabilization: This involves developing skills to self-soothe and to pay close attention to self-care. The skills provide a platform of emotional and physical safety from which to move through other aspects of the chosen therapy.

Phase 2 Trauma memory processing: People will begin to talk through their experiences of trauma in a safe and secure way, pacing themselves as slowly as they wish. As much as possible, people begin to make sense of the traumatic events that have shaped their lives. This is typically not a linear process. People can go back and forward in time as it suits them.

Phase 3 Recognition: People's experiences of trauma become part of their lives but no longer define them or drive their thinking and actions. They can go on to grow and develop and they are in charge of their own life decisions.

Prolonged exposure therapy

While it has a different name, this form of therapy is desensitization therapy for phobias. Its goal is to help people control their fears by re-experiencing their trauma (in small steps) and while using relaxation techniques and coping strategies. It begins with the absolutely least threatening version of the traumatic event – identified and agreed to by the person experiencing PTSD. Over time, there is a very gradual increase in the details along with a precise description of emotions and bodily sensations. This cannot be rushed. It goes exactly at the pace the person with PTSD can tolerate.²⁶

Cognitive restructuring

This form of therapy helps people “restructure” their thoughts and memories in a realistic way. Examples can be: It was not my fault, there is no need to feel shame or guilt. There was nothing I could have done.

26 PTSD: National Center for PTSD. (March 19, 2021). Clinician's Guide To Medications for PTSD. Available at: [ptsd.va.gov/professional/treat/txessentials/clinician_guide_meds](https://www.ptsd.va.gov/professional/treat/txessentials/clinician_guide_meds)

The overall goal of both these therapies is to allow people to integrate their traumatic memories into their life story. Doing so takes away the power of their memories to run their lives in distressing and negative ways. In short, to make the memories part of who they are.

Cognitive processing therapy²⁷

Cognitive processing therapy has four stages:

Stage 1: Education on the kinds of thoughts and emotions that accompany PTSD: Some you will be aware of while others are unconscious. These thoughts may be worsening your PTSD.

Stage 2: Writing an account of your trauma: When completed, your therapist will ask you to read it aloud in your sessions. Once out in the open, you can identify which thoughts and feelings are contributing to the prolonging of your PTSD.

Stage 3: Once identified, you can develop skills and strategies to address these negative thoughts and feelings in a more healthful way.

Stage 4: You and your therapist develop positive ways to manage these thoughts and feelings outside of therapy.

Anger management

Many people without a diagnosis of PTSD can have difficulty managing their anger and PTSD places people at a much higher risk of outbursts and assaults. Anger management is a process of learning to monitor the early signs of your anger and then, learning skills to deal with it effectively. This form of skill development does not ask you to avoid being angry (it's a natural human emotion) or to hold it in. Instead, you learn how to express anger effectively – before you reach the blow-up stage.²⁸

Eye movement desensitization and reprocessing therapy (EMDR)

In this therapy people follow a stimulus back and forth with their eyes (a light or the therapist's finger) while they are processing their traumatic memories. The theory is that the rhythmic eye movements help them to integrate their memories into a more whole sense of self, while at the same time, diminishing the intrusive power of the trauma.²⁹

27 American Psychological Association. (2017). Clinical Practice Guideline for the Treatment of PTSD. Available at: [apa.org/ptsd-guideline/ptsd.pdf](https://www.apa.org/ptsd-guideline/ptsd.pdf)

28 MayoClinic. (June 10, 2017). Anger management. Available at: [mayoclinic.org/tests-procedures/anger-management/about/pac-20385186](https://www.mayoclinic.org/tests-procedures/anger-management/about/pac-20385186)

29 US Department of Veterans Affairs (2017). VA/DOD Clinical Practice Guideline for the Management of Posttraumatic Stress Disorder and Acute Stress Disorder. Available at: [healthquality.va.gov/guidelines/mh/ptsd/](https://www.healthquality.va.gov/guidelines/mh/ptsd/)

Peer support for PTSD



It is hopeful and uplifting to be with people who have gone before you, who have survived and even thrived.

Peer support groups are run by and for people who have had similar experiences to yours. There are no professionals involved.

Peer support may also involve one-on-one relationships where you informally go out for coffee, for example. This also allows you an opportunity to give back by volunteering to

provide support – if you want to.

Peer support is especially useful for those who are members of particular professional cultures; military, police, EMS, firefighters, or rescue workers. In fact, they may be comfortable only when they are among members of their own profession who “get it.”

Resources

Operational Stress Injury Social Support (OSISS). A national peer support network for serving members, Veterans and their families. They are in multiple locations across the county. See: canada.ca/en/department-national-defence/services/guide/dcsm/osiss

Depression

Major depressive disorder

People with major depression are not merely feeling down or blue. Sadness and hopelessness have overwhelmed almost all aspects of their lives. They have difficulty sleeping and trouble getting up in the morning. They can't concentrate at work or at home. Their thinking has become slow and confused. Decisions are difficult. They pull away from relationships. They have no energy.³⁰

Your doctor will ask how long you've been feeling this way. Formally, the diagnostic criterion is “more than two weeks” but practically, many people struggle much longer before they ask for help.

30 Mood Disorders Society of Canada (2012). What better feels like. Available at: mdsc.ca/what-better-feels-like/

Some specific symptoms of depression include:³¹

- persistent deep sadness
- feelings of worthlessness or guilt
- irritability
- muddy and slowed thinking, difficulty concentrating, remembering and making decisions
- loss of interest in work, relationships and leisure activities
- slowed movement and talking
- low energy
- troubling alterations in sleep patterns; difficulty getting to sleep, staying asleep, waking up too early or sleeping too much
- noticeable weight gain or weight loss
- thoughts of suicide or, most frightening, suicide attempts

**Canada Suicide Prevention Service, Crisis services
for all Canadians**

CALL 1-833-456-4566 (available 24/7)

**TEXT 45645 (available 4pm to Midnight Eastern
Time Zone)**

Local Resources and Supports (by region)
crisisservicescanada.ca/en/

Sometimes, people experience physical pain in various places in their body and this discomfort is what brings them to their physician. Over time, however, despite real suffering, there seems to be no identifiable cause for the pain. This is a signal to you and your doctor that what you may really be dealing with is depression.³²

31 Habert, J. et al (2016). Functional recovery in major depressive disorder: Focus on early optimized treatment. Primary Care Companion, CNS Disorders, Vol 18(5). Available at: psychiatrist.com/pcc/depression/early-optimized-treatment-in-mdd/

32 Mood Disorders Society of Canada (2019). What is depression. Available at: mdsc.ca/edu/what-is-depression

Other types of depression:³³

Persistent depressive disorder or dysthymia:

This is a less debilitating form of depression where people continue to function but life is sad and grey. This can last for years with people thinking that this is just the way life is.

Post-partum depression:

Post-partum depression is much more serious than just the baby blues – feelings of being overwhelmed, anxious and sad that a mother may experience for a few days to a couple of weeks. People with post-partum depression experience ongoing deep sadness, guilt, poor sleep (even when they have quiet time to themselves), irritability, excessive worry about the baby's health, and a lack of joy – just when the world expects them to be celebrating. Adding to the confusion can be the naturally-present stressors of having a newborn.

In its most severe and rare form, post-partum depression can evolve into post-partum psychosis where both mother and child are at severe risk. Post-partum psychosis means that the mother's thinking has lost touch with reality. She may be hearing voices, or she may believe her baby is going to die. She may even think that she and her baby would be better off dead. It cannot be stressed strongly enough that a mother with post-partum psychosis must get to the Emergency Department and see a doctor immediately.

Psychotic depression:

Here, a person's depression occurs with false beliefs (delusions) and sometimes hallucinations (e.g. hearing voices). Neither are based in reality nor are they believable to others. Anyone who develops psychotic symptoms along with their depression should see a doctor immediately.

Seasonal affective disorder (SAD):

This is an intermittent form of depression thought to be triggered by the lack of sunlight, most often felt in the winter but can emerge at other times. Sometimes SAD is mild and requires no treatment, while others experience it in more severe forms. Many of the symptoms are listed under the topic of major depressive disorder. Treatment (medication and specialized light boxes that simulate sunshine) will help.

33 *ibid.*

Depression with anxiety³⁴

About 50% of people diagnosed with depression are also diagnosed with anxiety. The reverse is also true; 50% of those diagnosed with anxiety are also likely to experience a depression.

People with both anxiety and depression may have poorer responses to anti-depressant medication. They also report more severe symptoms and their lives may be affected more deeply.³⁵ That said, if you have these combined disorders, do not give up hope!

Psychotherapies for depression and anxiety

Research has shown that medication combined with therapy gives the best results for people with depression and also for people with anxiety and post-traumatic stress disorder (PTSD).

All therapies described below are time-limited and goal-focused. You work with your therapist to identify the problems that are concerning you and together, you develop solutions. In other words, reflection and exploration are combined with skill development and action.

Cognitive Behavioural Therapy (CBT)

CBT therapists teach you how your emotions can affect your thinking and your behaviours. They also show you how it is a two-way street. Behaviours can also affect thinking and emotions. By bringing these connections to your awareness and learning coping strategies, you become much more in control of these factors and you can interrupt or even prevent entirely a downward spiral.

Mindfulness-based cognitive behavioural therapy

CBT is used with mindfulness meditation which helps you identify thoughts and feelings – and observe them objectively rather than reacting to them automatically. It creates an additional level of awareness of how unrecognized thoughts and feelings are impeding your recovery.

34 Anxiety and Depression Association of America (2021). Facts & Statistics. Available at: adaa.org/about-adaa/press-room/facts-statistics

35 National Institute of Mental Health (February 25, 2008). Archive - Co-occurring Anxiety Complicates Treatment Response for Those with Major Depression. Available at: [nimh.nih.gov/archive/news/2008/co-occurring-anxiety-complicates-treatment-response-for-those-with-major-depression](https://www.nimh.nih.gov/archive/news/2008/co-occurring-anxiety-complicates-treatment-response-for-those-with-major-depression)



Interpersonal therapy

This form of therapy focuses on you and how you are dealing with the relationships and stressors in your life. The things life throws at you do not cause mental illness but, if unresolved, they can certainly interfere with your recovery.

Marital or family therapy

Your partner (or family members) attend sessions with you and together, you work on identifying problems and try out solutions. These are important relationships and if they are not in good working order, they can drag you down and worsen of your mental illness.

Group therapy

People come together based on a shared experience, in this case a particular diagnosis of mental illness. The therapist acts as a resource and a facilitator as group members share experiences, their first-hand knowledge and coping tips. Group therapy is a unique form of comfort because you may have felt alone in your struggle. It is empowering to know there are others just like you. There may also be specialty mental illness groups for women only, men only, seniors, teenagers, or the LGBTQ2S+ community – as examples.

Psycho Education

As the name implies, this is a time-limited group for educating you about your illness – like this publication. The underlying theory is that the more you know, the better equipped you are going to be to partner with your medical advisors, manage your medications, and monitor the symptoms of your illness.

Treatment resistant depression³⁶

If you and your doctor, and then your psychiatrist, have tried a number of medications and you are not getting better – or you get better for a while but your depression returns, you are experiencing treatment resistant depression.³⁷ No one is giving up on you. There is much more that can be done.

When your psychiatrist reviews your situation, they may choose to try more medication combinations but they may also suggest neurostimulation such as electroconvulsive therapy (ECT) or repetitive transcranial stimulation (rTMS). Both have been studied and found as effective.³⁸

Neurostimulation interventions

ECT

With ECT, patients receive a light sedative prior to treatment, so that they are asleep when the treatment occurs and they have no memory of it afterwards (much like during minor surgery or certain medical tests). ECT involves using a controlled electric current to induce a mild seizure in one area of the brain. ECT has been used for many years, and has improved over time. It is usually used for people with severe depression who do not respond to other treatments. It is one of the most effective treatments for major depressive disorder and treatment resistant depression.

rTMS

rTMS requires a magnetic generator (coil) to be placed near your head. It emits a small electric current called electromagnetic induction.

Special note: Some patients may be anxious about neurostimulation treatments. Don't hesitate to discuss your options with your psychiatrist so you feel that your decision is fully informed.

36 Treatment resistant depression or TRD is not a formal diagnosis. Instead it is a clinical description of your situation.

37 Fava, M. (2003). Diagnosis and definition of treatment resistant depression. *Biological Psychiatry*, Vol 53(8), pg. 649 – 59. Abstract available at: pubmed.ncbi.nlm.nih.gov/12706951

38 Kennedy, S. et al (2009). Canadian Network for Mood and Anxiety Treatments (CANMAT). Clinical guidelines for the management of major depressive disorders in adults. IV. Neurostimulation therapies. *Journal of Affective Disorders*. Full journal available at: canmat.org/2019/03/17/2016-depression-guidelines

Anxiety disorders

Anxiety disorders are the most common mental illnesses. Approximately 12% of Canadians are affected in any given year.³⁹ The good news is that anxiety is highly treatable.

An anxiety disorder is characterized by ongoing and excessive worry with generalized fear and overwhelming stress. It can also have physical symptoms such as irregular heart beats, shortness of breath, and sweating.⁴⁰

Anxiety can occur with depression or can occur on its own.

Types of anxiety

Generalized anxiety disorder:

People are anxious and worried most of the time and about many different things – things that others would not see as bothersome. They expect the worst even though they have no evidence that disaster is about to strike. They may have narrowed their lives and limited their activities, feeling that this will keep them safe from catastrophe. These feelings can last for years without treatment but, for a formal diagnosis, the specified period is 6 months.

Panic disorder:

Terror can suddenly strike in response to a specific experience or it can occur completely out of the blue. Accompanying physical symptoms are overwhelming; sweating, chest pains and a feeling of choking. People can feel that they are dying. If the panic attack is tied to a place or event, people start to avoid these at all costs. However, if the attacks occur with no identifiable trigger, people begin to isolate as they never know where or when their panic attack may occur.

Social anxiety disorder:

People are extremely self-conscious, fear that they will be judged negatively by others, or that they might say or do something that will make others dislike them. They are also afraid of embarrassing themselves in some unspecified way. They stay away from social situations and become isolated and alone.

39 Anxiety Disorders Association of Canada. Available at: anxietycanada.ca

40 Mayo Clinic (May 4, 2018). Panic attacks and panic disorder. Available at: mayoclinic.org/diseases-conditions/panic-attacks/symptoms-causes/syc-20376021

Specific phobias:

People develop an unreasoned fear of objects or situations out of proportion to the danger they pose. Common examples would be snakes, spiders or a fear of flying, but exactly what people are afraid of can be as unique as they are. Agoraphobia (agora is the Greek word for a public gathering place) is the fear of going out of one's homes. Some people with phobias can work but they typically follow exactly the same route to and from daily. They tolerate their workplace and their home but very little else.

Special note: While medications may be prescribed for phobias in the short term, the main treatment is desensitization therapy which includes three phases:^{41 42}

1. Learning relaxation techniques and coping strategies.
2. Identifying a fear hierarchy starting with the least threatening version of the frightening stimulus.
3. Working through the hierarchy of fear by exposing yourself (with the therapist's support) to the stimulus at each level of fear while practicing relaxation and coping strategies. The idea is that, overtime, the fear response is unlearned and the object of the phobia becomes linked to coping or maybe even relaxation.

Obsessive compulsive disorder (OCD):

People with OCD have repeated and obsessions that cause them overpowering worry. Examples are: they've left the stove on, they didn't lock their front door, their hands are covered in germs, and other thoughts specific to who they are as individuals. In response, they have developed rituals that must be performed, called compulsions. If repeated often enough, these behaviours can temporarily calm their fears. Untreated, OCD is debilitating and interferes with most aspects of life.⁴³

41 Simply Psychology (2021). Systematic Desensitization as a Counterconditioning Process. Available at: simplypsychology.org/Systematic-Desensitisation

42 Anxiety Disorders Association of Canada anxietycanada.ca

43 Anxiety and Depression Association of America (2021). Facts & Statistics. Available at: adaa.org/about-adaa/press-room/facts-statistics

CHAPTER 4 *Substance use disorder*



Operational Stress Injuries have been found to have a reasonably high chance of occurring with a substance use disorder.

Some people say that they began to use drugs or alcohol as a form of self-medication – hoping to relieve themselves of the troubling symptoms of their OSI.

What the medical community agrees on is that OSIs and substance use problems should be treated together – and by multi-disciplinary teams.⁴⁴

Usually, people with both an OSI and a substance use problem are treated in groups that do not include people with an addiction only as their needs are different.

Harm reduction

Most people are familiar with Alcoholics Anonymous (AA),⁴⁵ a many decades old all-volunteer model of alcohol addiction recovery. AA demands complete abstinence.

The harm reduction model is not an all or nothing approach like AA. It is designed to be paced and supports gradual change. You and your therapist will develop strategies to cut down on your alcohol and/or drug use. Some people will quit alcohol or drugs altogether. Others will cut down until they feel they are back in control. An overall feature of the harm reduction approach is to prevent the negative consequences of substance use and improve health.

44 Tararouk, T. (2012). Treatment of co-occurring operational stress injury and substance abuse. Available at: drugabuse.gov/international/abstracts/treatment-co-occurring-operational-stress-injury-substance-abuse

45 There are also programs for family members – Al Anon and Alateen. Whether their family member is in AA or a harm reduction model of treatment, families find these programs helpful.

CHAPTER 5 *Families and caregivers*



The military acknowledges that families of serving members also, themselves, serve.

When a serving family member shows the signs of an Operational Stress Injury, the whole family may be upended. A person with an Operational Stress Injury may not be easy to live with and even though families may know that what they are experiencing are the results of the injury, it's hard not to take the symptoms and behaviors personally. They may feel they are now living with a distant stranger – one who has disturbing and in some cases, frightening behaviors and angry outbursts. They also can and sometimes do, self-medicate with drugs or alcohol – or both.

Children may not know that the upsetting changes they are seeing in their parent are due to an OSI. They just feel sad and neglected. There is a name for what they (and their other family members) are feeling. It is called ambiguous grief: their parent (loved one) is there but is emotionally unavailable.

Persons with OSIs tend to isolate so they can handle, as best they can, their symptoms: hypervigilance, angry outbursts, and triggers, but this too can be hard on families. The help and support families and caregivers try to offer can be fiercely rejected.

Then, there are the children to care for. They have their own growth milestones to meet and lives to live, but they are deeply affected by living with an unpredictable and volatile visitor whose needs are now greater than their own, exactly the opposite of what a parent/child relationship should be.

Intellectually, family members know their injured loved one is not to blame, but their hearts are sore, nonetheless. Some live in fear or “walk on eggshells” because of excessive angry outbursts and even violence.

Transition to civilian life is as hard on families as it is on the serving member. Families have integrated into the military culture which is an exclusive club. There have been so many moves over the course of the serving member's tenure that families haven't had time to get to know a new community before

they were on the move again. The kids may have attended many schools.

In these days of Facebook and other social media, there are many ways to stay in touch with their support systems once CAF members have transitioned out, but their new reality is not the same as the supports they have left behind. It can be hard not to feel lonely.

There are many resources for support (as you will see below). A commonality among the many words of advice are, “take care of yourself” which appears to be the most ignored. Families are used to managing on their own and taking care of business (including everyone else’s well-being) by themselves.

But the advice stands: Take care of yourself so you don’t break down too. If you need support, reach out. If your mental health is suffering, seek treatment. You don’t have to do it alone.

Informal supports

There is particular comfort in talking with other family members who are going through what you are. To a large degree, people trust advice and support from peers who are struggling too.

Reading and studying on your own can also be helpful.

The following books are there for you when you can find the time:

1. The post-traumatic stress disorder relationship by Dianne England
2. Love our vets: Restoring hope for families of Veterans by Welby O’Brien
3. PTSD: A spouse’s perspective by Erica David
4. Loving someone with PTSD: A practical guide to understanding and connecting with your partner after trauma by Aphrodite Matsakis
5. When someone you love suffers from post-traumatic stress disorder: What to expect and what you can do by Claudia Zafert and Jason C. DeViva
6. Shock waves: A practical guide to living with a loved one with PTSD by Cynthia Orange
7. Healing together: A couple’s guide to coping with trauma and post-traumatic stress disorder by Suzanne B. Phillips (author) and Dianne Kane (contributor)
8. Wounded warrior, wounded home: Hope and healing for families living with PTSD and TBI by Masshele Carter Waddel and Kelly K. Orr
9. The war at home: One family’s fight against PTSD by Shawn Gorely.⁴⁶

⁴⁶ Nothing but room to grow (book recommendation blog). Available at: nothingbutroomblog.com/

Resources

Military Family Resource Centres are the heart of military communities providing multiple programs and services. 1 866 522 2122. See: [cafconnection.ca/National/Programs-Services/Deployment-Support/Deployment-Support-for-Families/Military-Family-Resource-Centres-\(MFRC\)](https://cafconnection.ca/National/Programs-Services/Deployment-Support/Deployment-Support-for-Families/Military-Family-Resource-Centres-(MFRC))

Helping a Family Member Who Has an OSI.

See: osiconnect.theroyal.ca/families

OSISS Family Peer Support Coordinator to help connect family members to community resources and information. See: cafconnection.ca/National/Programs-Services/Mental-Health/Operational-Stress-Injury-Social-Support/Family-Member-and-Friends

The Veteran Family Program is for Veterans and their families who are medically releasing from the military. You don't need an appointment, you can just walk in. See: cafconnection.ca/National/Programs-Services/For-Transitioning-Veterans-and-their-Families

Veteran Family Journal helps service members and their families transition from military to civilian life. See: cafconnection.ca/National/Programs-Services/For-Transitioning-Veterans-and-their-Families/Veteran-Family-Journal

VAC will provide therapy for families if the Veteran's treatment calls for it as integral to their recovery.

CHAPTER 6 *Relapse prevention*



You've worked so hard to deal effectively with your Operational Stress Injury – and you have achieved wellness that once upon a time, you felt was impossible. You can relax now.

That's not exactly the case. Although it doesn't seem fair, you have to actively maintain your wellness or it is in danger of slipping away. In other words, you need to guard against a relapse. Relapse cannot always be prevented but you are in a much stronger position to avert it if you know that it is possible and if you have strategies to prevent it (or make it as short as possible), as much as you can. It means keeping a close eye on things.⁴⁷

- Know the language of response and remission and how these terms relate to your situation.
 - Response: You may respond to your medications, meaning things are much better, but you're still not back to normal. There is more that can be done and you need to work with your doctor or therapist to find options. Don't wait.
 - Remission: You feel back to normal. Remission implies that there could be a relapse.
- Just knowing that relapse can occur puts you ahead of the game. If it does happen, it can be disheartening but you will be well again. No, it's not easy to hang onto hope but you've gotten better before and you will again.
- Identify the early warning signs of not doing well. Don't wait. Take action. Hope is generally a good thing but when you use hope as a form of denial - to delay facing facts, it stops being helpful and starts being dangerous.

⁴⁷ *ibid.*

- Enlist trusted friends and family in your relapse prevention plan – you may not be your own best observer but family and friends have seen you when you are well, when you start to slide, and at your worst. They know what to look for and will tell you - because you have informed them that your wellness journey is now at the point where you will listen to their feedback and act on it.
- Keep working on your support strategies. After all, they are just plain good for you. Who wants to argue with maintaining mental and physical health?
- Maintain contact with your physician and psychiatrist, for regular wellness checks.
- If you have included peer support in your personal wellness strategy, stay engaged with your group or other peers.
- Do not discontinue your medication unless on medical advice. One of the pitfalls of the joy of achieving wellness is feeling like you don't need medication anymore. You begin to feel that it's over and done with – when it may not be at all. Never discontinue medication suddenly, even when you get the go-ahead from your medical supports. Your body has become used to it and will react in what is called a rebound effect. Taper off slowly as rebound is serious and can tip you right back into having symptoms.

CHAPTER 7 *Ongoing support strategies and recovery*



py improves your chances of recovery, there are lots of things you can do to support your own wellness.

Developing an array of “do-it-yourself” strategies is empowering. Illness of all kinds, but particularly mental illness and/or OSIs, leave you feeling a loss of control over your life. While your physician or psychiatrist, and your other medical supports offer important help, they are only a small part of your day-to-day reality. There are many things you can do for yourself.⁴⁸

The following are some examples, but support strategies are as individual as people are. This is just a place to start.

Some places to start

Let friends, family, co-workers and others help:

You cannot do this alone. It may seem that there is no one who cares, but they are there; family, friends, co-workers or fellow military colleagues, and others, along with people who have experienced what you are experiencing. These people can be there for you. You also know that some will ignore you or turn their backs. The stigma of mental illness is lessening but it still exists. Even just a few close supports can make all the difference in your recovery. However, it is wise to choose carefully. People who drag you down only add to your burden. Perhaps now is the time to take a stock of your relationships and distance yourself from people who diminish, rather than enhance, your health.

48 Mood Disorders Society of Canada (2012). What better feels like: Wellness guide. Available at: mdsc.ca/what-better-feels-like/

Peer support:

Veterans with OSIs have a military community and another community in peers who are also dealing with an OSI.

There is no substitute for being among people who've "been there." This may involve a formal peer support group like Operational Stress Injury Social Support (OSISS) or connecting with individuals who will meet you for coffee. You will learn from these people and they will learn from you. What peers offer is the knowledge of their experience - practical, every day and common sense. Online peer-to-peer support can also be valuable.

Peer support can also help your family or friends who are going through their own struggles. Coping with an Operational Stress Injury has likely been all-consuming for you but it is also no walk in the park for your support system. They can use a place of their own to turn to so they know that they, too, are not alone.

Strategies for handling stigma:

It's there and it can hurt. Know that you don't have to tell anyone that you have a mental illness or an Operational Stress Injury unless you want to - and you believe they will help, not hinder, your recovery. Develop ways to assess places and people for whether or not they are safe.

Taking care of your physical health:

As you strive for a healthy mind, it is important to remember that your head should be attached to a healthy body. Yes, we all know we should exercise, eat right, get a good night's sleep, stop smoking and go easy on the alcohol. But knowing and doing are two different things. Now is the time to get serious about your whole body health - if you haven't before. Commit to yourself. After all, you deserve it.

Inform yourself:

Research on the Internet, ask questions, track down information, learn about and bookmark trusted sources. A knowledgeable patient is a medical professional's best friend. Your questions for them will be more targeted and you will provide them with information that will help them better manage your care.

Alternative and traditional therapies:⁴⁹

Usually, the medical profession takes the view that, if alternative therapies work for you and create no harm, then go ahead. Some people stand by meditation and it has shown itself to enhance calmness, reduce stress and sharpen concentration. It is a central feature of mindfulness-based cogni-

49 Kennedy, S. et al (2016). Canadian Network for Mood and Anxiety Treatments (CANMAT). Clinical guidelines for the management of major depressive disorders in adults. Section 3 Pharmacological treatments. Canadian Journal of Psychiatry, Vol 61 (9). Full chapter available here: ncbi.nlm.nih.gov/pmc/articles/PMC4994790

tive therapy and can, on its own, become part of your individual support strategy. Taking dietary supplements is also a choice even though scientific research on their effectiveness is not strong. However, there is no question that people value them since they are a billion-dollar industry. The exception to these results is St. John's Wort which has shown itself to be effective for mild depression. Exercise, especially aerobic exercise like jogging, helps lift mild depression too, sometimes just as well as anti-depressants. Of course, it's also good for your general physical health. Light therapy for seasonal affective disorder is endorsed by the medical community and widely used. Yoga has shown itself to be helpful for people with mild symptoms, although positive evaluative research results are not strong. Indigenous healing practices, traditional Chinese medicine or Ayurvedic medicine have much longer histories than Western practices. They focus on a balance between the mind, body, and spirit. They also have the advantage of connecting people to their culture.

Having fun:

An OSI steals the enjoyment out of life. Having fun may seem only a memory and it just doesn't seem right that you have to work at something that used to be so simple and so spontaneous. Knowing that fun is not a luxury but an essential part of your health may help you get out and get going. If you've been isolating for a long time and if you don't yet feel particularly well, this is going to be tough. Maybe all you can manage is to put it on the to-do list. But that's a start.

Giving back:

As you progress in your wellness, you may benefit from helping others, noting that you must have a firm grip on your own health before offering support.

Recovery

Recovery is a term to describe living well despite having a mental illness or a substance use disorder. Recovery focuses on strengths and talents. It preserves your hope and optimism. It is a concept that urges you to live a full life every day.

Referring to yourself as in recovery signals that you have integrated the experience of your Operational Stress Injury into your sense of self and into your life. You are not your illness. It is only one aspect of your identity.⁵⁰

50 Mood Disorders Society of Canada (2012). What better feels like: Wellness Guide. Available at: mdsc.ca/what-better-feels-like/

Resource

Operational Stress Injury Social Support (OSISS). A national peer support network for serving members, Veterans and their families. They are in multiple location across the county. See: www.canada.ca/en/department-national-defence/services/guide/dcsm/osiss

APPENDIX 1 Medications for PTSD, Depression and Anxiety



This Appendix is for your reference. You may wish to consult it as you and your physician discuss which medication is best for you.

Medication is an important ingredient in your overall treatment plan. Your job and your doctor's job is to find the right one or the right combination for your needs.

Anti-depressants

Anti-depressants have been available for a number of decades and has evolved and improved over that time. The Canadian Network for Mood and Anxiety Treatments (CANMAT), a partnership among researchers, psychiatrists and other clinicians, has published detailed depression treatment guidelines for clinicians. The guidelines provide an extensive review of available research on depression and present recommendations for anti-depressants.⁵¹ The guidelines categorize them as first, second, and third line, according to the strength of the research showing effectiveness.

The following anti-depressants are from CANMAT's first and second line listings.

There are more anti-depressants on the market than these and your physician may recommend something else for you. That's OK – as long as it works for you.

51 Kennedy, S. et al (2016). Canadian Network for Mood and Anxiety Treatments (CANMAT). Clinical guidelines for the management of major depressive disorders in adults. Section 3 Pharmacological treatments. Canadian Journal of Psychiatry, Vol 61 (9). Full chapter is available here: ncbi.nlm.nih.gov/pmc/articles/PMC4994790

First line (strongest evaluation research results)

Brand name	Chemical name
Wellbutrin	bupropion
Celexa	citalopram
Pristiq	desvenlafaxine
Cymbalta	duloxetine
Cipralex	escitalopram
Prozac	fluoxetine
Luvox	fluvoxamine
Remeron	mirtazapine
Paxil	paroxetine
Zoloft	sertraline
Effexor	venlafaxine
Trintellix	vortioxetine

Second line (strong evaluation research results)

Brand name	Chemical name
Fetzima ⁵²	levomilnacipran
Manerix	moclobemide
Seroquel	quetapine
Emsam	selegiline
Desyrel	trazodone
Viibryd	vilazodone

Important to know: Anti-depressants can take a while to work. But you don't have to wait forever before returning to your doctor and asking for a medication evaluation. Experts recommend giving a medication two to four weeks to show benefits.

52 This is a CANMAT list of second line recommendations but included on advice of a member of MDSC's Expert Panel.

Anti-convulsants⁵³

In the case of depression, anxiety disorder, or post-traumatic stress disorder, anti-convulsants can be given, not for their anti-convulsant properties, but as mood stabilizers.

Brand name	Chemical name
Lyrica	pregabalin
Neurontin	gabapentin

Research has shown that anti-convulsants used for people with PTSD show very few positive results, with one exception; Topamax. However, evaluative research is in early stages and no strong clinical recommendation has emerged.^{54 55}

An anti-convulsant especially recommended for PTSD is:

Brand name	Chemical name
Topamax	topiramate

Other useful medications

The treatment of depression, anxiety, and post-traumatic stress disorder can involve medications other than (or as well as) anti-depressants. They are as follows:

Atypical anti-psychotics

Atypical anti-psychotics are called second generation anti-psychotics. They have shown themselves to have fewer side effects - but some do remain so it is wise to talk with your psychiatrist before choosing this course of action. In the case of mental illness, they are most often used in combination with an anti-depressant to boost its effect.

53 Kennedy, S. et al (2016). Canadian Network for Mood and Anxiety Treatments (CANMAT). Clinical guidelines for the management of major depressive disorders in adults. Section 3 Pharmacological treatments. Canadian Journal of Psychiatry, Vol 61 (9). Full chapter is available here: ncbi.nlm.nih.gov/pmc/articles/PMC4994790

54 PTSD: National Center for PTSD. (March 19, 2021). Clinician's Guide To Medications for PTSD. Available at: ptsd.va.gov/professional/treat/txessentials/clinician_guide_meds

55 Berlant, J. (2006). Topiramate as a therapy for chronic post-traumatic stress disorder. Psychiatry, Vol 3 (3). Available at: ncbi.nlm.nih.gov/pmc/articles/PMC2990556/

Examples of atypical anti-psychotics are:⁵⁶

Brand name	Chemical name
Abilify	aripiprazole
Seroquel	quetiapine
Risperdal	risperidone
Latuda	lurasidone
Zyprexa	olanzapine

Medications for anxiety

Note that people often experience depression and anxiety together so it is common for anti-depressant and anti-anxiety medications to be taken together.

Benzodiazepines (tranquilizers)

This category of drugs is prescribed with caution. People who are taking them find that they do, indeed, provide calm and peaceful feelings. However, the danger is that our bodies can adjust to the initial dosage level to the point where it starts to be ineffective, meaning higher doses are needed to get the same effect. This is known as habituation. The very serious downside of habituation is addiction. Your physician or psychiatrist will monitor your usage closely.⁵⁷

Brand name	Chemical name
Valium	diazepam
Ativan	lorazepam
Xanax	alprazolam

56 Kennedy, S. et al (2016). Canadian Network for Mood and Anxiety Treatments (CANMAT). Clinical guidelines for the management of major depressive disorders in adults. Section 3 Pharmacological treatments. Canadian Journal of Psychiatry, Vol 61 (9). Full chapter is available here: ncbi.nlm.nih.gov/pmc/articles/PMC4994790

57 ibid.

Medication for substance use disorders

Brand name

Chemical name

Camprel

acamprosate

This drug eases alcohol withdrawal symptoms.

Revia

naltrexone

Revia prevents opioid effects and decreases the desire to drink as well.

Sublocade

buprenorphine

This drug is administered sublingually or by injection and used to treat opioid addiction.⁵⁸

More to know about medication

Additional factors in making a prescribing decision

Whenever your physician or psychiatrist is prescribing medication for you, they will take the following into account (as well as your diagnosis):

- age
- weight
- whether you are pregnant or nursing
- if you have other illnesses
- other drugs you are taking

The role of your pharmacist

When you leave the office with your prescription, know that valuable information can also be obtained from your pharmacist. Pharmacies often have private rooms for confidential discussions and you can make an appointment. Sometimes you can just walk in and if the pharmacy is not busy, you can be seen. The pharmacist usually has information sheets (in plain language) or can recommend Internet sites for you to visit. They may also be able to take more time with you than your physician.

If this is your regular pharmacist, they will have all your medications on record. They can advise you about possible interactions which you can then discuss with your physician.

⁵⁸ Dolophine (Methadon) is a controlled substance (a synthetic opioid) often used as a less harmful substitute for heroin or other opioids. Narcan (naloxone) is administered through nasal spray or by injection. Narcan kits are carried by first responders, users and their families. It interrupts the effects of an overdose and has saved thousands of lives.

Other things to know

Some terms related to medications you should know about – for your own research - your family doctor or psychiatrist can explain them further to you.

Contra-indications: Given your health, other illnesses, allergies, or other medications you take, you should not be prescribed this specific drug.

Interactions: Happen when certain drugs, taken together, affect you in negative ways.

Side effects: Most medications have side effects – they may be common, experienced only by some people, or experienced rarely. Your physician will educate you about them. This information is also readily available online. Side effects are an important factor in your decision-making process. If you experience side effects, document them and report them to your doctor or psychiatrist. You may want to choose another medication.

Special note: Common side effects for anti-depressants are nausea and headaches, and a lowered sex drive. Some also lead to weight gain - all of which can be managed but they are nonetheless troubling for people. The newer versions of anti-depressants have substantially reduced side effects.

Adverse reactions: An adverse reaction is a rare health event or even a life-threatening result for some people, discovered after a medication has come to market. Pharmaceutical companies are required by regulation to report adverse reactions to Health Canada and your doctor and psychiatrist should do the same. If you believe you are having an adverse reaction, contact your doctor immediately or go to the Emergency Department of your local hospital.

Some general pharmaceutical terms

Generics: When patent protection for a brand named drug expires, generic versions become available. Government and most employee drug benefits programs insist that pharmacists substitute available generic versions for their brand named counterparts when filling your prescription. Generics are less expensive than brand name medications. If you feel only the brand name drug is effective for you, your doctor or psychiatrist can direct the pharmacist not to substitute it for a generic. On the other hand, if you don't mind a generic substitution (or even request a generic instead of a brand name because you are

paying out-of-pocket and want to limit your expenses), your physician should make it clear to your pharmacist that they must fill your prescription with the same generic each and every time.

Formularies: Each province and territory in Canada has a formulary which lists approved medications for people entitled to government paid drug benefits (for example, seniors or people on social assistance). Each province or territory can have a somewhat different formulary, making coverage uneven across the country. New drugs and rare drugs usually can't be found on formularies, meaning people have to pay out-of-pocket. The federal government has its own formulary.

APPENDIX 2 *Summary of resources that you can go to for assistance*

Operational Stress Injury

Operational Trauma and Stress Support Centres (OTSSC) are available as a specialized service of the overall Mental Health Program on all Canadian Forces bases with OTSSC programs housed only on larger bases: Halifax, Gagetown, Valcartier, Ottawa, Petawawa, Edmonton and Esquimalt.

See: forces.gc.ca/en/caf-community-health-services-mental

Operational Stress Clinics are what are called ‘tertiary’ service, meaning that they provide highly focused and specialized care to people with Operational Stress Injuries. You must have a referral from Veteran Affairs Canada. The clinics provide assessment, treatment, prevention, support, and substance use disorder treatment. There are 10 clinics (some with additional satellites) around the country: Calgary, Dartmouth, Edmonton, Fredericton, London, Montreal, Ottawa, Quebec City (French only), Winnipeg and Vancouver.

See: veterans.gc.ca/eng/health-support/mental-health-and-wellness/assessment-treatment/osi-clinics

Veteran Affairs Canada also has a 24/7 health counselling and psychological support line available at 1 800 268 7708 or TDD/TTY 1 800 567 5803. This help line is available whenever needed.

Military sexual misconduct

Sexual Misconduct Response Centre is a civilian entity that operates outside of the Canadian Forces chain of command. It provides 24/7 counselling and/or support. It also helps survivors navigate their workplace or make a complaint.

See: [cafconnection.ca/national/programs-services/for-military-personnel/Sexual-Misconduct-Response-Centre-\(SMRC\).aspx](https://cafconnection.ca/national/programs-services/for-military-personnel/Sexual-Misconduct-Response-Centre-(SMRC).aspx)

veterans.gc.ca/eng/health-support/mental-health-and-wellness/understanding-mental-health/sexual-trauma-during-service

Paths to treatment for OSIs

VAC regional offices.

See: veterans.gc.ca/eng/contact to find an office near you.

VAC Transition Centers.

See: veterans.gc.ca/eng/resources/transition-centre

Canadian Armed Forces Transition Centres (for families too). They are operated in partnership with Veteran Affairs Canada. They offer workshops and resources for people transitioning to civilian life. Multiple locations.

See: canada.ca/en/department-national-defence/services/benefits-military/transition/understanding-transition/transition-centres

Bureau of Pension Advocates who specialize in reviews and appeals related to claims for disability benefits.

See: veterans.gc.ca/eng/veterans-rights/how-to-appeal/bureau-pensions-advocates

VAC 24/7 counselling line: When you call, you are talking to a mental health professional. Your information is completely confidential.

Call: 1 800 268 7708, TDD-TTY 1 800 567 5803.

Peer Support

Operational Stress Injury Social Support (OSISS). A national peer support network for serving members, Veterans and their families. They are in multiple location across the country.

See: canada.ca/en/department-national-defence/services/guide/dcsm/osiss

BSO Legion OSI

See: portal.legion.ca/member-programs/bsc-legion-osi

Veteran's Transition Network

See: vtncanada.org

MDSC Peer and Trauma Support Systems

See: mdsc.ca/new-peer-and-trauma-support-systems

VETS Canada

See: vetscanada.org/english/get-help

Families and caregivers

Military Family Resource Centres are the heart of military communities providing multiple programs and services. Call 1 866 522 2122.

See: [cafconnection.ca/National/Programs-Services/Deployment-Support/Deployment-Support-for-Families/Military-Family-Resource-Centres-\(M-FRC\)](https://cafconnection.ca/National/Programs-Services/Deployment-Support/Deployment-Support-for-Families/Military-Family-Resource-Centres-(M-FRC))

The Veteran Family Program is for medically releasing CAF members and their families. It provides information on mental health first aid, transitioning topics and financial planning. See: cafconnection.ca/National/Programs-Services/For-Transitioning-Veterans-and-their-Families

Veteran Family Journal helps service members and their families transition from military to civilian life.

See: cafconnection.ca/National/Programs-Services/For-Transitioning-Veterans-and-their-Families/Veteran-Family-Journal

OSISS Family Peer Support Coordinators help connect family members to community resources and information.

See: cfmws.com/en/AboutUs/DCSM/OSISS/Pages/Families

Defence Fitness is for families and Veterans. It offers exercise videos, personalized meal plans, and customized training programs.

See: dfit.ca

VAC will provide therapy for families if the Veteran's treatment calls for it as an integral to their recovery.

Other resources

VAC policy: The Veteran Affairs Canada Well-being Act. It is accompanied by a conceptual framework, policies, regulations and research.

See: veterans.gc.ca/eng/about-vac/research/research-directorate/info-briefs/veteran-well-being



Mood Disorders Society of Canada
La Société Pour **Les Troubles de L'Humeur** du Canada

MDSC.CA



Centre of Excellence – PTSD
Centre d'excellence – TSPT

VETERANSMENTALHEALTH.CA