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A LEADERSHIP APPROACH TO THE MANAGEMENT OF OPERATIONAL STRESS IN THE CANADIAN FORCES

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ABSTRACT

It has long been recognized that combat can have a psychological effect on those who participate. Through the experiences in wars throughout the 20th century, much has been learned about the causes, mitigating factors and appropriate treatment of combat operational stress reactions (COSRs) and operational stress injuries (OSIs).

The *Croatia Board of Inquiry Report* of 2000 and the 2002 Ombudsman Report *Systemic treatment of CF members with PTSD* brought to the forefront the issue of OSIs suffered by Canadian Forces (CF) members as a result of participation in deployed operations. In the intervening years, a number of initiatives have been implemented by the CF to address the concerns raised by both reports, resulting in increased awareness of the issue and better treatment, care, and support for members of the CF affected by OSIs.

A more effective approach, based on leadership, is now required to further advance the yardsticks. Senior CF leadership must establish the conditions for success by providing direction, ensuring the alignment of programs and policies, and taking action to influence cultural awareness and foster an environment of openness and acceptance. Leaders at all levels must be given the tools they need to increase their own resilience, positively influence the resilience of their subordinates, recognize symptoms of COSRs and take appropriate action to promote effective management and treatment of COSRs and OSIs. The use of stress management principles should be incorporated into all types of training to ensure that effective stress responses become inculcated through practice and repetition. Implementation of a leadership approach to COSR prevention and OSI management will enable the CF to build and sustain a resilient force capable of effectively conducting military operations.

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INTRODUCTION

The Croatia Board of Inquiry Report of 2000[1] and the 2002 Ombudsman Report *Systemic Treatment of CF members with PTSD*[2] brought to the forefront the issue of operational stress injuries (OSIs) suffered by Canadian Forces (CF) members as a result of participation in deployed operations. In the intervening years, a number of initiatives have been implemented by the CF to address the concerns raised by both reports. The approach taken has been largely from the medical perspective – creating awareness of the issue and providing treatment, care, and support for members of the CF affected by OSIs as well as support to their families.

Many have argued that operational stress management is primarily a leadership rather than a medical issue, but what does this mean? Research has shown that effective leaders can positively influence the responses to stressful circumstances of their

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[1] Board of Inquiry Croatia, *Final Report: Board of Inquiry Croatia* (Ottawa: Department of National Defence, 2000); available from http://www.dnd.ca/boi/engraph/about_boi_e.asp; Internet; accessed 17 September 2007. The Croatia Board of Inquiry was called in August 1999 to "investigate whether Canadian Forces members serving in the Canadian Contingent United Nations Protection Force (CC UNPROFOR) and assigned to the area of operations, commonly referred to as 'Sector South' during the period 1993 to 1995, were exposed to environmental contaminants in quantities sufficient enough to pose a health hazard during the course of their duties". Although the Board was unable rule out environmental contaminants as a possible cause of at least some of the symptoms reported by Canadians serving in Sector South, they concluded that stress experienced during the operation was a major cause of illnesses, including Post Traumatic Stress Disorder and other stress-related ailments reported by these soldiers.

[2] André Marin, *Special Report: Systemic Treatment of CF Members with PTSD* (Ottawa: Ombudsman National Defence and Canadian Forces, 2002); available from http://www.ombudsman.forces.gc.ca/rep-rap/sr-rs/pts-ssp/doc/pts-ssp-eng.pdf; Internet; accessed 14 September 2007. In 2001, the Ombudsman conducted an investigation into a complaint by Cpl Christian McEachern that the Canadian Forces (CF) treats members who have been diagnosed with post traumatic stress disorder (PTSD) unfairly. The Ombudman's Report provided a number of recommendations wrt management of PTSD in the CF.

subordinates. As well, leaders set the tone for how OSIs are viewed within their units. In order for any approach to operational stress management to be effective, these factors must be considered and incorporated.

This paper will argue that a leadership approach is required in the CF to effectively manage the effects of operational stress and to build a resilient force capable of conducting sustained military operations. It will outline the various aspects of a leadership approach, including the requirement for an overarching plan and policy, the responsibilities of senior leadership in establishing the conditions for success and effecting cultural change, and the education and training of leaders at all levels in the prevention and management of combat operational stress reactions (COSRs). Finally, it will present a plan for embedding a leadership approach to operational stress management in the CF.

SCOPE

Stress is a vast and complex issue. This paper will focus only on operational stress, as defined below (i.e., it will not address workplace stress, family stress, etc.). Further, the discussion will be limited to the effect of operational stress on military personnel, as opposed to public servants, personnel from non-governmental organizations, or other civilians who may also participate in or be affected by operations. Although some of the references cited pertain primarily to army personnel, this paper is not intended to be land-centric; discussion points and recommendations are applicable to navy, army, and air force personnel.

DEFINITIONS

This paper will make use of a few key terms pertaining to stress resulting from participation in combat or other operations, as follows:

Operational Stress: Stress experienced by service members during or as a resultof participation in combat or military operations other than war.[3]

Combat and operational stress reaction (COSR): "The expected, predictable, emotional, intellectual, physical and/or behavioural reactions of Service members who have been exposed to stressful events in combat or military operations other than war".[4]

Operational Stress Injury (OSI): An OSI is "any persistent psychological difficulty resulting from operational duties performed by a Canadian Forces member. The term OSI is used to describe a broad range of problems which usually result in impairment in functioning. OSIs include diagnosed medical conditions such as anxiety, depression and post traumatic stress disorder (PTSD) as well as a range of less severe conditions, but the term OSI is not intended to be used in a medical or legal context."[5]

Post traumatic stress disorder (PTSD): PTSD is "a condition which can develop following exposure to an extremely stressful situation or series of events outside the usual range of human experience, which may manifest itself in recurrent nightmares or intrusive vivid memories and flashbacks of the traumatic event, and in withdrawal, sleep disturbance, and other symptoms associated with prolonged stress or anxiety."[6]

Psychological Resilience: The ability to bounce back to a normal state of psychological functioning after exposure to a traumatic or potentially traumatic event.[7]

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[3] Definition developed by the author of this paper for the purposes of this paper.

[4] Department of the Army, *Combat and Operational Stress Control: FM 4-02.51* (Washington, DC: Headquarters, Department of the Army, 2006), Glossary-5.

[5] Department of National Defence, "Operational Stress Injury Social Support," http://www.osiss.ca/engraph/def_e.asp?sidecat=1; Internet; accessed 25 September 2007.

[6] Oxford English Dictionary.

[7] Definition provided by Dr. McCreary, Chair Defence Research and Development Canada/CF Psychological Resilience Research WG.

HISTORICAL PERSPECTIVE

Over the years, a number of terms have been used to describe the psychological effects of combat on those who participate. During the American Civil War, some soldiers exhibiting signs of stress were thought to be suffering from nostalgia and homesickness. In the intervening years, the terms used to describe combat stress include shell shock, effort syndrome, war neurosis, gas hysteria, Da Costa's syndrome, irritable heart syndrome, not-yet-diagnosed nervous, psychoneurosis, combat exhaustion, battle fatigue, operational fatigue, combat stress, posttraumatic stress syndrome, and posttraumatic stress disorder.[8] The most common terms currently in use to describe the emotional, intellectual, physical and/or behavioural reactions of service members who have been exposed to stressful events in operations include combat stress reaction, operational stress reaction, combat operational stress, and combat operational stress reaction.

Today, it is widely recognized that some personnel exposed to stressful events in combat or operations other than war will experience COSRs, some of which will develop into OSIs. Statistics on the incidence of COSR and OSI vary rather widely. For example, of US veterans assessed 15 to 20 years after service in Vietnam, the prevalence rates for current PTSD were 15 percent for males and 9 percent for females; an additional

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[8] Rick L. Campise, Schuyler K. Geller and Mary E. Campise, "Combat Stress," in *Military Psychology: Clinical and Operational Applications,* eds. Carrie H. Kennedy and Eric A. Zillmer, 215-240 (New York, NY: Guilford Press, 2006), 215; William A. Mosier *et al*, "Combat Stress: Posttraumatic Stress Disorder in the Military - Identification, Diagnosis, and Intervention," *Joint Center for Operational Analysis (JCAO) Journal:* 28; Steve J. Lewis, "Combat Stress Control: Putting Principle into Practice" in *Military Life: The Psychology of Serving in Peace and Combat (Vol. 2): Operational Stress*, eds. Amy B. Adler, Carl Andrew Castro and Thomas W. Britt, 121-140 (Westport, CT: Praeger Security International, 2006), 122, 123.

11 percent of males and 8 percent females had current partial PTSD.[9] Three percent of US Army personnel who participated in the Gulf War met the criteria for PTSD upon return to the United States; the rate increased to 8 percent about two years after returning.[10] During Operation Iraqi Freedom, there were 3.5 psychiatric evacuations per 1,000 US service members.[11] Among male veterans who served in the Canadian Forces from 1990 to 1999, rates of probable PTSD were 10.92% for veterans deployed once and 14.84% for those deployed more than once; the rates of probable clinical depression were 30.35% for veterans deployed once and 32.62% for those deployed more than once.[12] Findings from a compulsory screening interview programme for CF members who served in Afghanistan/SW Asia from September 2001 through October 2002 indicated that 20% of all members had symptoms suggestive of at least one mood, anxiety, or alcohol use disorder.[13] Reported rates are dependant on many factors such as

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[9] Shira Maguen, Michael Suvak and Brett T. Litz, "Predictors and Prevalence of Posttraumatic Stress Disorder among Military Veterans" in *Military Life: The Psychology of Serving in Peace and Combat (Vol. 2): Operational Stress*, eds. Amy B. Adler, Carl Andrew Castro and Thomas W. Britt, 141-169 (Westport, CT: Praeger Security International, 2006), 144, 145.

[10] J. Wolfe *et al*, "Course and predictors of posttraumatic stress disorder among Gulf War veterans: A prospective analysis," *Journal of Consulting and Clinical Psychology (*Boston, Massachusetts, 1999): 67, 520-58, quoted in Maguen, Suvak and Litz, "Predictors and Prevalence of Posttraumatic Stress Disorder"…, 147.

[11] Army Office of the Surgeon General, *Operation Iraqi Freedon mental health advisory team report* (Washington, DC: U.S. Army Office of the Surgeon General, 2003), quoted in Lewis, "Combat Stress Control"…, 123.

[12] Don Richardson, James A. Naifeh and Jon D. Elhai, "Posttraumatic Stress Disorder and Associated Risk Factors in Canadian Peacekeeping Veterans with Health-Related Disabilities," *Canadian Journal of Psychiatry* 52, no. 8 (August 2007): 510.

[13] Canadian Forces Health Services, Deployment Health Section, "PHYSICAL AND MENTAL HEALTH STATUS OF CANADIAN TROOPS 4 TO 6 MONTHS AFTER RETURN FROM SERVICE IN AFGHANISTAN: FINDINGS OF A COMPULSORY SCREENING INTERVIEW PROGRAMME,"

type and intensity of the operation, what is being measured (report of symptoms vs confirmed diagnosis, stress reactions vs stress injuries vs PTSD), length of time after participation in operations (rates tend to be higher as more time passes), methods and criteria used for assessment, etc. Suffice it to say that in most if not all operations, there will be a certain proportion of personnel, generally in the 10 to 15 percent range, which will experience psychological effects as a result of the participation of those personnel in that operation.

COSR MITIGATION

Influences

COSRs occur as a result of exposure to stressful events such as witnessing death or suffering, injury, direct life threat, maltreatment or traumatic loss, and/or other stressors such as mission ambiguity, role conflict, powerlessness, betrayal by the organization, or harsh living conditions.[14] Although COSRs are a natural reaction to stress, not all personnel who are exposed to stressors will develop COSRs. Research has shown that there are many factors that can prevent or reduce the development of COSRs. Adequate rest, sleep, and nutrition are essential to the prevention of COSRs. Pre-deployment briefings and training on stress management can provide members with the tools to build personal resilience.[15] For example, a study on British Peacekeepers deployed to Bosnia contended that comprehensive pre-deployment training on

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http://www.forces.gc.ca/health/information/engraph/Depl_Health_research_e.asp; Internet; accessed 13 October 2007.

[14] Lewis, "Combat Stress Control"…, 125, 126; Maguen, Suvak and Litz, "Predictors and Prevalence of Posttraumatic Stress Disorder"…, 142.

[15] Lewis, "Combat Stress Control"…, 128, 129.

operational stress may have contributed to the low rates of PTSD observed in their sample group.[16] Unit cohesion, good leadership and high morale are the most important factors in preventing COSRs. Members must also have confidence in their abilities and equipment. Conducting realistic and demanding training promotes individual and collective effectiveness and members' beliefs in their own ability and the ability of their team to successfully perform operations.[17] Training with live ammunition and actual danger is believed to provide psychological "antibodies" that help to protect individuals from COSR in their initial exposures to actual combat.[18]

Symptoms

While COSRs can be mitigated, they cannot be prevented entirely. All personnel need to be aware of the symptoms so that members affected can receive the care they need in a timely manner. Physical symptoms of operational stress reaction include: respiratory problems (e.g., dizziness, shortness of breath); cardiovascular complaints (e.g., pounding heart, rising blood pressure); digestive issues (e.g., nausea, vomiting, constipation, diarrhea); headaches; exhaustion; impaired speech; impaired vision, touch or hearing; and weakness or paralysis. Behavioural symptoms include: inattention or carelessness; impulsivity; sleep disturbance; social isolation; impaired duty performance; erratic behaviour or outbursts; recklessness; going absent without leave; combat refusal; criminal behaviour; torture; alcohol or drug abuse; panic; deterioration in personal care; and negligent injury or self-inflicted wounds. Cognitive symptoms include:

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[16] Martin Deahl et al, "Preventing Psychological Trauma in Soldiers: The Role of Operational Stress Training and Psychological Debriefing," *British Journal of Medical Psychology* 73, no. 1 (March 2000): 73, 77-85, quoted in Lewis, "Combat Stress Control"..., 129.

[17] Lewis, "Combat Stress Control"..., 128, 129.

hyperalertedness, concentration problems; loss of confidence; loss of hope and faith; memory impairment; suicidal ideation; homicidal ideation; apathy; and delusions or hallucinations. Emotional symptoms include: fear or anxiety; anger or rage; grief; guilt; self-doubt; terror; and depression.[19]

Treatment

It is crucial that members experiencing COSRs be identified and "treated" promptly in accordance with established principles, as embodied in such concepts as PIES (proximity, immediacy, expectancy, simplicity)[20] or BICEPS (brevity, immediacy, contact, expectancy, proximity, simplicity).[21] Table 1 below refers. These principles were learned by the Allies in World War I, relearned in World War II, and reconfirmed by the Israelis through their experiences in the 1973 Yom Kippur War and the 1982 War in Lebanon.[22] COSRs are normal responses to abnormal events and recovery should occur within hours or days with the appropriate intervention. This is the key message that should be conveyed in dealing with personnel experiencing COSRs. Members suffering from COSRs should not be "medicalized" or viewed as mental health patients.

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[18] Franklin D. Jones and Gregory L. Belenky, "Summation," in *War Psychiatry*, ed. Franklin D. Jones (Falls Church, VA: Office of the Surgeon General, United States Army, 1995), 476.

[19] Lewis, "Combat Stress Control"…, 124; Campise, Geller and Campise, "Combat Stress"…, 218, 219.

[20] According to Dr. Boddon, the National Practice Leader for Psychiatry and Mental Health in the CF, PIES is the combat stress control approach endorsed by the CF, although not specifically incorporated into CF medical doctrine.

[21] BICEPS is the combat stress approach used by the US Army and USMC. The USMC defines the "C" in BICEPS as *centrality*.

[22] Allan English, "Leadership and Operational Stress in the Canadian Forces," *Canadian Military Journal* (Autumn 2000): 35; available from http://www.journal.dnd.ca/engraph/Vol1/no3/pdf/33-38_e.pdf; Internet; accessed 29 September 2007; Department of National Defence, "Stress Injury and Operational Deployments," *Dispatches - Lessons Learned for Soldier* 10, no. 1 (February 2004): 28.

They should continue to wear their combats, not hospital gowns. Members should be provided with sanctuary and rest in a location as near to their unit as possible, housed separately from hospital patients, enforcing the expectancy that they will soon return to their unit. The majority of personnel who present with symptoms of COSR can be returned to duty in a short period of time following the above-mentioned approach.[23] If not handled properly, however, COSRs can develop into OSIs, including PTSD.

Table 1 – BICEPS Principles

Principle	Description
Brevity	Initial treatment services may last only a few hours, but should last no more than a few days.
Immediacy	Treatment is to be initiated as soon as possible after the member begins to exhibit COSRs.
Contact	The chain of command must be directly involved in the soldier's recovery and return to duty. Members of the unit should visit or send messages to the extent possible, confirming that the member is wanted and needed back at the unit.
Expectancy	It must be made clear to the member that he or she is experiencing normal reactions to conditions of extreme stress, that these reactions are temporary, and that he or she is expected to recover and return to the unit shortly.
Proximity	Treatment services should be provided as close to the member's unit as possible.
Simplicity	Treatment focuses on reassurance of normality, rest, replenishment (water, food, hygiene, and sleep), restoration of confidence, and return to duty.

Source: United States. Department of the Army, *Combat and Operational Stress Control: FM 4-02.51* (Washington, DC: Headquarters, Department of the Army, 2006), 1-7, 1-8.

Critical Incident Stress Debriefing

In the past, it was believed that intervention, in the form of Critical Incident

[23] Campise, Geller and Campise, "Combat Stress"…, 223, 224; Mosier *et al*, *Combat Stress: Posttraumatic Stress Disorder in the Military…*, 33 – 35.

Stress Debriefing (CISD), as defined below, was required for all personnel involved in a critical incident (CI):

> A structured intervention to assist those who have experienced a CI, to reduce the intensity and duration of associated physical and emotional reactions to the stress experienced and allow personnel to return to their duties and to a normal family/social life in the fastest possible time. It consists of an organized group meeting held ideally 24 to 72 hours after a CI to allow those involved to openly discuss their thoughts, feelings and reactions related to the CI. The CISD may be held in subgroups if there are natural divisions such as survivors, rescuers and relatives of casualties. The CISD must be led by a trained and mandated member of the helping professions.[24]

Over the past few years, however, research has suggested that in many cases CISD is not useful and in some cases can be harmful.[25] In the Netherlands, the National Institute of Mental Health developed consensus statements with respect to CISD, noting that single intervention sessions do not consistently reduce risks of developing PTSD or related difficulties, early interventions should be tailored based on the circumstances, participation in early intervention sessions should be voluntary, and follow-up sessions should be offered to high-risk individuals. According to Dr. Zamorski, head of Deployment Health in Director General Health Services (DGHS), current thinking in the CF is along the same lines, i.e., interventions should be tailored to meet the requirements of the circumstances and individuals involved based on an assessment by a mental health care provider, and participation should be on a voluntary basis only. Unfortunately, that thinking has not yet been incorporated into CF policy. Canadian Forces Administrative

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[24] Department of National Defence, Canadian Forces Administrative Order 34-55 *Management of Critical Incident Stress in the Canadian Forces* (Ottawa: DND Canada, 1995); available from http://www.admfincs.forces.gc.ca/admfincs/subjects/cfao/034-55_e.asp; Internet; accessed 17 September 2007.

[25] Paul T. Bartone, "Resilience Under Military Operational Stress: Can Leaders Influence Hardiness?" *Military Psychology,* 18(Suppl.) (2006): S132; Lewis, "Combat Stress Control"…, 134.

Order (CFAO) 34-55 - *Management of Critical Incident Stress in the Canadian Forces* still indicates that "CISDs should be provided to all affected parties, including CF members, immediate family members and DND civilians, following an occupationally related CI", which is no doubt confusing for leaders in the field.

Redeployment Programs

Redeployment programs can prepare members for the often difficult transition and reintegration into their families, home units, and communities by providing information on the likely reactions of all involved, strategies to deal with conflict and problems, and where to get support when required. Such programs can be provided in-theatre or at a third location.

Third Location Decompression

In years gone by, service members were normally redeployed by ship, which afforded them a period of rest, reflection and social interaction with their colleagues before arriving home. These days, with air travel being the norm, a member can be in theatre in the morning and arrive home the same day, leaving little time to decompress. A number of countries, including Canada, the Netherlands, and Australia, have addressed the problem through the use of third location decompression (TLD).[26] TLD provides members who have been involved in combat or otherwise stressful operations with a period of rest, relaxation, and education at a location away from the dangers and stresses of theatre before they return home, and prepares them for reintegration with their families

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[26] André Marin, *From Tents to Sheets: An Analysis of the CF Experience with Third Location Decompression AfterDeployment* (Ottawa: Ombudsman National Defence and Canadian Forces, 2004), 13-21; available from http://www.ombudsman.forces.gc.ca/rep-rap/sr-rs/tld-dtl/doc/tld-dtl-eng.pdf; Internet; accessed 14 September 2007.

and communities.[27] In a recent study on the perspectives of Canadian military personnel who participated in the TLD in Cyprus after OP ATHENA Roto 1 in July 2006, the vast majority of participants indicated that they considered TLD to be a worthwhile and positive experience.[28] In particular, members appreciated the opportunity to talk with their peers about their experiences in theatre; they noted that without TLD, these discussions would normally take place at home and generate friction with the family.[29] Although there is no evidence that TLD mitigates the risk or severity of OSIs, it stands to reason that reinforcing the fact that COSRs are normal and expected but can be treated, and providing information on where to get help, will serve to reduce the stigma of OSIs and encourage members to seek treatment. The Canadian study appears to support this theory as the majority of participants indicated that as a result of the educational phase of the TLD, they knew where and how to get help for themselves, their peers, and their subordinates in dealing with OSIs, and that they would have no reluctance to seek help, if required.[30] There has been some controversy about the use of TLD in that there has been a tendency for participants to overindulge in alcohol at the TLD location. The counterargument is that many members who have been in a dry theatre for some time will drink, and often to excess, at the first opportunity. It is arguably better that they do so in a controlled environment, especially one in which no driving of any kind is allowed, than in the presence of families or friends where things may get out of hand.

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[27] *Ibid*., 7.

[28] G. E. Sharpe *et al*, "Perceptions on the Effectiveness of Third Location Decompression on Reducing Post-Deployment Reintegration Stress and Increasing Psychological Resliency" (Draft report submitted to Dr. Don McCreary, Defence Research and Development Canada - Toronto, April 2007), 1.

[29] *Ibid*., 6.

[30] *Ibid*., 7

Post-deployment

In many cases, COSRs or OSIs will not arise until the member returns home from deployment or some time thereafter. Positive homecoming experiences and perceived social support can reduce incidence of OSIs.[31] In the CF, commanders are required to provide guidance regarding recognition activities in their reintegration plans such that all deployed personnel are properly recognized for their contributions to the operation.[32] Military Family Resource Centres (MFRCs), located at most CF bases/wings, offer a wide range of courses and activities to assist members and their families in the pre-deployment, deployment, and post-deployment phases of CF operations. Operational Trauma and Stress Support Centres (OTSSCs) in Halifax, Valcartier, Ottawa, Edmonton, and Esquimalt provide support to CF members and their families affected by military operations, and complement the existing network of CF health care services. Also, under the Operational Stress Injury Social Support (OSISS) project, trained peer-support co-ordinators located across the country, who themselves have been injured by operational stress, provide CF members suffering from OSIs with emotional support and guidance on resources available in the Department of National Defence, Veterans Affairs Canada, and their own community.[33]

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[31] Maguen, Suvak and Litz, "Predictors and Prevalence of Posttraumatic Stress Disorder"…, 160.

[32] Department of National Defence, *Deputy Chief of Defence Staff Direction for International Operations (DDIO)* (Ottawa: Deputy Chief of Defence Staff, 2001), 12-16/19, 12-17/19.

[33] Department of National Defence, BG-02.034 *Backgrounder - Operational Stress Injury Social Support (OSISS) Project* (Ottawa: DND, October 29, 2002); available from http://www.forces.gc.ca/site/newsroom/view_news_e.asp?id=427; Internet; accessed 17 September 2007.

THE CF APPROACH TO OPERATIONAL STRESS

Measures to date

There is a vast amount of information now available on the subject of operational stress, some of which is summarized above. The problem is how to make the best use of this information to the benefit of the CF as an organization, CF units, CF members, and their families. Following the Croatia Board of Inquiry and the Ombudsman's Report on PTSD, a number of initiatives were put in place to address the issue of OSIs in the CF. Mandatory pre-deployment psychological screening, pre-deployment briefing on stress management, and post-deployment psychiatric assessment were incorporated into the *Deputy Chief of Defence Staff Direction for International Operations* (*DDIO*).[34] TLD was left to the discretion of the Task Force Commander (TFC), but has been widely used since 2006. The OSISS project, created in May 2001, established an OSI peer-support program, which supplemented the support provided to members and their families through OTSSCs and MFRCs. A section on building resilience was included in the leadership manual titled *Leadership in the Canadian Forces: Conceptual Foundations* that was published in 2005[35], and information about OSIs has been published on various CF websites and in the *Personnel Newsletter.*[36] Clearly, the CF has come a long way in

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[34] DND, *DDIO*…, Chap. 4 Annex A, 12-14/19, Chap. 9 Annex K.

[35] The OSISS program, "The reality of operational stress injuries," *Canadian Forces Personnel Newsletter,* Issue 10/05 (19 October 2005); available from http://www.dnd.ca/hr/cfpn/engraph/10_05/10_05_e.asp; Internet; accessed 17 September 2007.

[36] Department of National Defence, *Leadership in the Canadian Forces - Conceptual Foundations* (Ottawa: Canadian Defence Academy - Canadian Forces Leadership Institute, 2005), Chap. 6; available from http://www.cda-acd.forces.gc.ca/CFLI/engraph/leadership/documents/DND_Conceptual_e.pdf; Internet; accessed 13 October 2007.

terms of education of the CF community and providing treatment, care, and support for members of the CF affected by OSIs. That said, there are a number of problems with the current approach.

Coordination of Action

One problem with the current approach to dealing with OSIs in the CF is that there does not seem to be an overarching plan. Although an OSI Working Group (WG), chaired by Assistant Deputy Minister (Human Resources – Military) (ADM(HR-Mil)) with the National Defence Headquarters (NDHQ) Level Ones[37] or their representatives as members, was established after release of the Ombudsman Report, the WG only met a few times and has not met over the past couple of years. Without appropriate direction/guidance, CF initiatives and actions related to OSIs have been disjointed and uncoordinated. For example, there are a number of organizations involved in operational stress training - Canadian Defence Academy (CDA), Director Casualty Support and Administration (DCSA), DGHS, and the Peace Support Training Centre (PSTC) - but no one organization has the lead. CDA is responsible for common professional development training, but the OSISS project, under DCSA, was mandated to "validate the development of educational packages and pre-deployment training modules in partnership with CF and civilian health-care professionals."[38] Chapter 4 of the *DDIO* indicates that the PSTC, under Land Force Doctrine and Training System (LFDTS), is

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[37] Environmental Chiefs of Staff and ADMs.

[38] DND, BG-02.034 *Backgrounder - Operational Stress Injury Social Support*….

responsible for the Training Standards for Peace Support Operations (PSO), including a segment on Stress Management, which is a pre-deployment training requirement for personnel deploying on international operations.[39] According to Capt Elms of the PSTC, the current PSO briefing package on OSIs was developed by PSTC staff in coordination with their local Health Services Support personnel. It was not based on CF standards because at the moment there are none. According to Dr. Zamorski, as a result of a Best Practices Exchange in 2003, ADM(HR-Mil) tasked DGHS to develop standardized operational stress briefing packages for pre- and post-deployment, but this has not happened yet due to competing DGHS priorities as well as lack of agreement and among the stakeholders (including the Chief Psychiatrist, operators, Personnel Selection Officers, OSISS coordinators, padres, etc). Dr. Zamorski is hopeful that the OSI WG will be re-activated and provide direction for coordination of activities related to operational stress.

Policy

A further problem in the CF is that there is very little in the way of policy related to operational stress. Defence Administrative Order and Directive (DAOD) 5017-0 - *Mental Health* is a short (two page), concise document outlining responsibilities with respect to mental health, with no specific mention of OSIs. CFAO 34-55 is an outdated

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[39] DND, *DDIO*…, 4-2/6-4-4/6, Chap. 4 Annex A. In accordance with *DDIO*, PSO training is required prior to deployment on any international deployed operation. PSO training may be attained at the PSTC or through the Force Generator (FG). Generally, members of formed or composite units receive PSO training as part of the collective pre-deployment training provided by the FG, and individual augmentees receive PSO training at the PSTC. Although PSO training is to be conducted in accordance with the PSO Training Standards established by the PTSC, at the moment there appears to be little consistency among the FGs in terms of the amount and content of pre-deployment OSI training provided to personnel deploying on international operations.

document that directs CISD for all CF personnel involved in critical incidents. *Chief of the Defence Staff (CDS) Guidance to Commanding Officers*, Chapter 14 – "Stress Management", provides very basic information about stress, the results of stress, and CO responsibilities for dealing with stress-related problems in a timely manner, and does not provide any references or resource links. The *DDIO* mandates pre-deployment screening and stress management training, post-deployment recognition for service and individual follow-up with a social worker, and consideration of TLD by the TFC. It is noted that although the Quality of Life Directorate was tasked in 2003 to work on establishing guidelines for deciding when third location decompression periods should be used as part of the redeployment process, such guidelines have yet to be published.[40] *DDIO* is still the main policy document for international deployments of CF personnel despite the fact that the DCDS organization was dissolved in February 2006 with the formation of the four new operational commands. Canadian Expeditionary Force Command (CEFCOM) staffs are in the process of preparing *CEFCOM Standing Orders*, which will replace the sadly outdated *DDIO*. CANFORGEN 082/07 - *PERSTEMPO POLICY FOR CF INTERNATIONAL OPERATIONS* provides guidance on normal lengths and frequencies of tours, and outlines the current policy with respect to exemption and respite periods following deployment and waivers thereof. To summarize, there are very few policy documents pertaining to operational stress, and most of those documents are overly succinct or outdated. There is a requirement for comprehensive policies outlining the CF approach to operational stress education and training, leadership responsibilities with respect to COSR mitigation, and managing CF personnel who suffer from OSIs.

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[40] Sharpe *et al*, *Perceptions on the Effectiveness of Third Location Decompression…,* 5.

A LEADERSHIP APPROACH

Rationale for a Leadership Approach

The main problem with the current approach to dealing with operational stress is that it comes from a medical rather than leadership perspective. Certainly it is important to increase awareness of OSIs and provide treatment and care to CF members suffering from OSIs. However, leadership is a key factor in reducing COSRs and changing cultural attitudes towards OSIs the military. Leaders, by virtue of their position and authority, can exert control and influence over their subordinates. Leaders set the tone for how OSIs will be viewed and managed within their commands, units, and sections. Through their directions, policies, actions, advice, and attitudes, they can alter the ways in which their subordinates think about OSIs and translate their own experiences.[41] Leaders have not only the ability to influence the resilience and attitudes of their subordinates; they have a responsibility to do so. As outlined in Chapter 6 of *Leadership in the Canadian Forces: Conceptual Foundations*, leaders must strive to positively influence mission performance and effectiveness by: "building individual and collective resilience (stress prevention measures, situational awareness, improvisational skills) to allow people to withstand the stresses of operations and recover from misfortune or adversity" and "instilling the military ethos (socialization practices, establishment and reinforcement of appropriate group or unit norms) to ensure high standards of professionalism and self-discipline."[42]

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[41] Bartone, Resilience Under Military Operational Stress..., S138, S139.

[42] DND, *Leadership in the Canadian Forces - Conceptual Foundations…, 95*

Senior Leadership Responsibility

Senior CF leaders, as "leaders of the institution", are responsible for establishing the conditions for successful management of OSIs, by ensuring the development and alignment of policy and programs and influencing cultural awareness and change. The key to implementing change in the military is the active engagement of senior leadership. As explained in a Rand report on implementing policy change in large organizations:

> Military leaders can and must become a major driving force for change. They take on this role when they are perceived to be supportive of the change and to be concerned that it be successfully implemented.[43]

In order to effect a cultural change regarding operational stress in the CF, it is imperative that the senior CF leaders (i.e., the Chief of Defence Staff, Environmental Chiefs of Staff and other L1s, and Operational Commanders) visibly endorse an environment that fosters acceptance and open discussion. They must articulate to subordinate leaders their responsibilities to increase their own resilience, positively impact the resilience of their subordinates, create unit cohesion, know their subordinates, watch for symptoms of COSR, and work with medical experts to ensure that subordinates affected by operational stress get the help and support they need to recover. An excellent example of this was (then) Lieutenant-General Hillier's foreword, as Chief of the Land Staff, to a *Dispatches* article on Stress Injury and Operational Deployments, wherein he emphasized the role of leaders in creating a supportive and open environment to enable prevention, identification, and treatment of OSIs.[44] Over and above articulating expectations to their

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[43] The National Defense Research Institute, "Implementing Policy Change in Large Organizations," in *Sexual Orientation and U.S. Military Personnel Policy* (Santa Monica, CA: Rand, 1993), 368-394; available from http://www.rand.org/pubs/monograph_reports/MR323/mr323.ch12.pdf; Internet; accessed 2 October 2007.

[44] DND, "Stress Injury and Operational Deployments"…, 1.

subordinates, senior leaders must demonstrate commitment to their stated principles through their own actions. In addition, senior leaders who have suffered from OSIs and recovered need to come forward and tell their stories. This will help to remove the stigma associated with OSIs and provide hope to CF members suffering from OSIs.

Operational Commanders

Operational commanders, in particular, must be aware of their role in preventing COSRs. Mission ambiguity, role conflict, and poor leadership affect the psychological well-being of the troops, thereby contributing to the development of COSRs. For example, on Operation Harmony in the former Yugoslavia, members expecting to make a humanitarian difference became angry and disillusioned when restrictive rules of engagement (ROEs) prevented intervention in violent acts occurring around them.[45] On Operation Restore Hope in Somalia, soldiers often felt conflicted between their warrior and humanitarian roles.[46] In order to prevent mission ambiguity and role conflict, operational commanders must convey the intent and importance of the mission, ensure that forces in theatre are trained and ready to adapt to multiple and changing roles, and make certain that ROEs are appropriate to the mission.

Formal Training Requirement

Leaders at all levels must be provided with the tools they need to implement their commanders' expectations and intents concerning operational stress management. Although the required knowledge can be gained through research or self-study learning packages, the truth of the matter is that most personnel are too busy with their day-to-day

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[45] *Ibid.*, 15, 16.

[46] Lewis, "Combat Stress Control"…, 126.

responsibilities to pursue this type of option. Training on operational stress is best delivered through formal training opportunities, where personnel can devote their full attention to the lessons at hand.

Training Junior and Intermediate Leaders

In the CF, stress management training is currently provided to personnel selected for deployment and new recruits. Additionally, a Lecture Discussion on OSIs has been added to the Joint Command and Staff Programme.[47] At this time, operational stress training is not provided to the vast majority of CF members, including that segment of the CF population that could benefit the most from this type of training: junior and intermediate level leaders. Non-commissioned members at the rank of Master-Corporal and above and junior officers, as section and platoon commanders, have the greatest numbers of direct subordinates and are therefore best positioned to impact unit cohesion and resilience through the application of COSR mitigation principals. It is essential that operational stress training be developed and implemented for junior and intermediate leaders in the CF as soon as possible. OSISS is in the process of developing an operational stress briefing package for the Primary Leadership Qualification course and intends to create another briefing package for the Intermediate Leadership Qualification course. This is a good start, but does not go far enough. Operational stress training should also be included on the Senior Leadership Qualification course, Chief Petty/Warrant Officer training, the Officer Professional Military Education (OPME) programme, and post-occupation training for junior officers (e.g., the Army Operations

[47] A Lecture Discussion consists of a presentation of curriculum material, followed by a syndicate discussion of the presented material and related pre-readings, followed by a plenary question-and-answer session.

Course, the Air Force Operations Basic and Advanced Courses).

Leader-focussed Training

At present, operational stress training packages in the CF provide general information about operational stress and methods of building personal resilience. As training is extended to various levels of leaders in the CF, the scope needs to be expanded to include the role of leaders in mitigating COSRs. The U.S. Army has clearly recognized the requirement for different foci in operational stress training, depending on the audience and the phase of deployment. The Walter Reed Army Institute of Research (WRAIR), which is part of the U.S. Army Medical Research and Materiel Command, has developed a program called "Battlemind Training" aimed at building psychological resilience and reducing COSRs. The program provides pre-deployment training modules focused on four distinct groups: Soldiers, Leaders, Spouses, and National Guards/Reservists. The Leader training module focuses on ten tough facts about combat and the actions that leaders can take to address these facts, thereby mitigating risk and building resilience.[48] A similar approach, targeting specific audiences and leaders in particular, should be considered in the CF.

Leader Actions to Mitigate COSRs

Operational stress training for CF leaders must provide the information leaders need to positively influence the responses to stressful circumstances of their subordinates, recognize symptoms of COSRs and take appropriate action to facilitate the best possible

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[48] C. A. Castro, C. W. Hoge and A. L. Cox, "Battlemind Training: Building Soldier Resiliency," in *Human Dimensions in Military Operations - Military Leaders' Strategies for Addressing Stress and Psychological Support* (Neuilly-sur-Seine, France: RTO, 2006), 42-2; Battlemind, "Leader Battlemind," http://www.battlemind.org/leader_battlemind.html; Internet; accessed 2 October 2007.

outcomes for subordinates with COSRs and OSIs. Many of the actions that contribute to collective resilience are simply basic leadership principles such as: team-build, encourage involvement, protect subordinates, be fair and just, admit mistakes, communicate, instill discipline, and use punishment judiciously.[49] Operational stress training for leaders should provide instruction on how to apply and supplement basic leadership principles to mitigate or prevent COSRs in subordinates. Table 2 below is a compilation of practices that have proven to be effective:

Table 2 – Leader Actions to Mitigate COSRs

Principle	Leader Actions
Promote unit cohesion and esprit de corps[50]	• Ensure that team members have the opportunity to "train, work, live, and experience stress together" to foster group cohesion.[51] • Foster social cohesion, encouraging team members to spend spare time together and form emotion bonds, as this has been shown to be more critical than task cohesion in terms of reducing the impact of stressors.[52] • Implement a buddy system to discourage individual isolation and encourage mutual monitoring for COSRs.[53] • Appoint a sponsor to new arrivals to help them integrate into the unit quickly.[54] • Welcome recovered stress casualties back and give them meaningful tasks.[55]

[49] C. A. Castro *et al*, "Leader Actions to Enhance Soldier Resiliency in Combat," in *Human Dimensions in Military Operations - Military Leaders' Strategies for Addressing Stress and Psychological Support* (Neuilly-sur-Seine, France: RTO, 2006), 3-5 - 3-9.

[50] Lewis, "Combat Stress Control"…, 128.

[51] Jones and Belenky, "Summation"..., 484.

[52] DND, "Stress Injury and Operational Deployments"…, 12, 13.

[53] *Ibid*., 13; John Pearn, "Traumatic Stress Disorders: A Classification with Implications for Prevention and Management," *Military Medicine* 165, no. 6 (June 2000): 435.

[54] DND, "Stress Injury and Operational Deployments"…, 14; Department of the Army, *Leader's Manual for Combat Stress Control: FM 22-51* (Washington, DC: Headquarters, Department of the Army, 1994), 1-11.

[55] Ibid., 1-11.

Principle	Leader Actions
Know your subordinates [56]	• Watch for changes in their demeanour, attitude, or behaviour, which could be indicative of problems related to stress.[57]
Conduct realistic and demanding training[58]	• Give troops an understanding of the threat(s) and environment they are likely to face.[59] • Permit training scenarios to play out in the event of significant or stressful events, thus allowing leaders to practice stress management and disciplinary control measures, as required.[60]
Practice stress control/ management	• Teach and practice stress coping skills and measures.[61] • Keep troops busy, minimizing boredom and time spent worrying about stressors.[62] • Prepare unit members for battle losses.[63] • Be prepared to deal with adrenaline rush (a response to life-threatening situations in which the adrenal glands pump adrenaline into one's system, increasing blood pressure, muscle tension, and blood sugar levels). Be aware that there may be a requirement to control or divert excessive energy to prevent unnecessary violence.[64] • In the event of a critical incident, seek the advice of a mental health service provider to assess the requirement for CISD.[65] • Understand the PIES principals for treatment of COSRs and work with medical staff to ensure proper application.[66]

Principle	Leader Actions
Counter mission ambiguity	• Use a directive and supportive leadership style. Demonstrate competence, commitment, courage, candour, and caring.[67] • Communicate mission goals, ensuring that they are ethical, justifiable and lawful.[68]
Keep information flowing[69]	• Keep subordinates informed about upcoming missions and changes.[70] • Prior to combat, provide a realistic but positive briefing on the mission, expectations, and likely outcomes. After combat, conduct a debriefing, allowing each combatant the opportunity to describe his or her perspective. This will better align individual interpretations with reality, recognize the performance and contributions of team members, and permit sharing of lessons learned.[71] • Monitor the flow of information within the unit and quickly dispel inaccurate rumours before they can cause harm.[72] • Ensure that your policies and views on all matters are clearly expressed and understood.[73] • Keep unit members informed on the status of injured evacuees.[74]

Training Delivery

The way in which information is delivered is also an important consideration. Thompson and McCreary have suggested that while stress management briefings provide

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[67] Lewis, "Combat Stress Control"…, 129; DND, "Stress Injury and Operational Deployments"…, 15; Dept of the Army, *Leader's Manual for Combat Stress Control*..., 1-10, 1-11; Campise, Geller and Campise, "Combat Stress"…, 231.

[68] DND, "Stress Injury and Operational Deployments"…, 16.

[69] Lewis, "Combat Stress Control"…, 128.

[70] DND, "Stress Injury and Operational Deployments"…, 15.

[71] Jones and Belenky, "Summation"…, 477.

[72] Dept of the Army, *Leader's Manual for Combat Stress Control*..., 1-10, 1-11.

[73] Battlemind, "Leader Battlemind"….

[74] *Ibid*.

the required information, the effects may be limited due to pre-conceived notions linking psychological problems to weakness, resistance to the message when delivered by mental health professionals rather than operators, and failure of the lecture format to engage students.[75] They contend that stress management needs to be promoted in ways more meaningful and pertinent to military personnel. Their recommended approach is to incorporate the practice of stress management principles into regular training situations to provide relevant context, reinforce the use of these principles, underscore the prevention of combat stress casualties as a command responsibility, and reduce the stigma associated with OSIs.[76] Campise, Geller and Campise state that stress management training should be incorporated into all types of training, including annual readiness training, professional military training, and base exercises to ensure that effective stress responses become inculcated through practice and repetition.[77]

FORCE SUSTAINMENT

A leadership approach to the issue of operational stress should help to mitigate the development of COSRs, influence cultural attitudes, and encourage early OSI intervention and treatment. This type of approach will better enable the CF to take care of its members, but beyond the moral aspects, a leadership approach is essential if the CF is to sustain the forces needed to conduct military operations.

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[75] Megan M. Thompson and Donald R. McCreary, "Enhancing Mental Readiness in Military Personnel", in *Human Dimensions in Military Operations - Military Leaders' Strategies for Addressing Stress and Psychological Support* (Neuilly-sur-Seine, France: RTO, 2006), 4-3.

[76] *Ibid*., 4-6, 4-7.

[77] Campise, Geller and Campise, "Combat Stress"…, 233.

The operational tempo of the CF has been extremely demanding over the last decade and is expected to remain so. Canada's Defence Policy Statement describes the anticipated future demands on the CF as follows:

> The role of the Canadian Forces in protecting Canadians and their interests and values will remain essential in the future. The heavy demands on our military, both domestically and internationally, will not diminish-they may well increase. Canada must possess a military that is well adapted to the evolving security environment and ready to respond to the country's future needs.[78]

CF members can expect to deploy on several operations over the course of their military careers. CF soldiers, sailors, airmen and airwomen members will require personal resilience to perform effectively in operations and to manage the effects of operational stress again and again. The CF must do all it can to build and retain a resilient force capable of conducting sustained military operations.

The CF is facing a demographic challenge as the pool of potential recruits is shrinking and will continue to decrease for the next several decades. The young people now entering the workforce are more urban, better educated, less fit, and looking for challenging, though not necessarily long-term, careers. The CF will be required to compete with other employers in a highly competitive market and will find it difficult to meet recruiting targets.[79] The problem is exacerbated by the current years of service distribution in the CF. As a result of the Force Reduction Plan (FRP) in the 1990's, there is a large group of service members approaching 20 years of service, at which point they will become eligible for unreduced pensions and severance packages. Even a normal

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[78] Department of Foreign Affairs and International Trade, *Canada's International Policy Statement - A Role of Pride and Influence in the World: Defence (*Ottawa, DFAIT, 2005), 1; available from http://www.forces.gc.ca/site/reports/dps/main/toc_e.asp; Intenet, accessed 20 October 2007.

[79] Department of National Defence, *Canadian Forces Recruiting - Strategic Level Guidance on Winning the War for Talent* (Ottawa: DND, 2---), 2, 3.

rate of attrition for members of this group will result in significantly elevated numbers of releases for several years in a row.[80] The CF will look to the recruiting system to replace those who leave, which will add further strain to an already difficult situation.

If the CF is to sustain the numbers needed to defend Canadians and protect Canadian interests abroad, there will have to be considerable focus on retaining skilled and experienced serving members. It is interesting to note that over the past two decades, releases for medical reasons have increased from 309, or 5.14 percent of total releases, in fiscal year 1985/1986 to 1104, which is 20.43 percent of total releases, in 2006/2007.[81] A breakdown of the medical release numbers is not available as releases are only tracked by release item; however, the numbers cited include releases for mental health reasons. A leadership approach to operational stress would lead to a reduction in the number of CF members who experience COSRs, and facilitate early identification and treatment of OSIs. This would result in fewer personnel being forced to take their release due to unmanageable mental health issues, which would translate into increased retention.

Another factor in retention is confidence in senior leadership. According to Ankerson and Techong, "subordinates… want to be led by people of vision and integrity" and "if leadership is poor, people leave the organization."[82] Results of a CF Retention Survey conducted in 2003 and 2004 indicated a lack of confidence in senior CF

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[80] Karol Wenek, "Retention: If we build it, you will stay," *Canadian Forces Personnel Newsletter*, Issue 3/06 (22 March 2006); available from http://www.forces.gc.ca/hr/cfpn/engraph/3_06/3_06_dmep_retention_e.asp; Internet; accessed 17 September 2007.

[81] Release statistics provided by Paul Bender, Personnel Operational Research Team, DSMPRA 4 - Workforce Modelling and Analysis on 1 October 2007.

[82] Christopher Ankerson and Losel Techong, "Retain Or Perish: Why Recruiting Won't Save the CF," *Strategic Datalink,* no. 95 (March 2001): 3, 4.

leadership, with many personnel reporting "a lack of confidence in how senior leadership overcomes organizational problems and challenges" and "a perception that the organization is not supportive (i.e., in areas of work-family balance)."[83] A leadership approach to operational stress would help to reinstate confidence in the senior CF leadership, as leaders demonstrate their commitment to addressing organizational issues effectively and looking out for the welfare of CF members. This would in turn strengthen member allegiance to the organization, encourage retention, and improve the CF's sustainment capability.

CONCLUSION

Over the past decade, the CF has made progress in the management of operational stress through an approach concentrating on education and treatment. A more effective approach, based on leadership, is required to further advance the yardsticks. Senior CF leadership must establish the conditions for success. The OSI WG must be reconvened to develop an overarching plan of attack and oversee its execution. The WG must establish priorities, responsibilities and timelines for the development and implementation of OSI policies and programs, and direct and coordinate the efforts of various organizations across the CF. Comprehensive policies are required to outline the CF approach to operational stress education and training, leadership responsibilities, and managing CF personnel who suffer from OSIs. Leaders at all levels must be given the tools they need to increase their own resilience, positively influence the resilience of their subordinates,

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[83] The National Retention Team. "Building and sustaining a retention culture in the CF," *Canadian Forces Personnel Newsletter,* Issue 11/04 (15 December 2004); available from http://www.dnd.ca/hr/cfpn/engraph/11_04/11_04_nrt_e.asp; Internet; accessed 20 October 2007.

recognize symptoms of COSRs and take appropriate action to promote effective management and treatment of COSRs and OSIs. The use of stress management principles should be incorporated into all types of training to ensure that effective stress responses become inculcated through practice and repetition.

Implementation of a leadership approach to COSR prevention and OSI management will contribute to the development of individual and collective resilience, thereby enhancing the ability of CF members and units to perform effectively on operations. Promotion of cultural awareness and acceptance, and provision of OSI education and training, will encourage CF members affected by operational stress to get the treatment they need in a timely manner to best improve their chances of recovery, thereby reducing attrition due to mental health issues. Active leadership engagement will promote confidence in the senior CF leadership, thus encouraging member allegiance and retention. In summary, a leadership approach to the management of operational stress in the CF is required to build and sustain a resilient force capable of effectively conducting military operations.

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