CANADIAN FORCES COLLEGE / COLLÈGE DES FORCES CANADIENNES

JCSP 35 / PCEMI 35

EXERCISE/EXERCICE NEW HORIZONS

Operational Stress and the Canadian Forces: Reduction, Re-Integration and Remember.

A Return to First Principles

By/par Maj M.J. (Mason) Stalker

ABSTRACT

Since Canada's commitment in Afghanistan was announced in 2001, the pace of deployment for Canadian Forces (CF) personnel has been unprecedented. Not only has there been a higher proportion of personnel being deployed, but operations have been longer while breaks between missions have been increasingly shorter. Despite lower physical casualty rates and findings that the majority of CF personnel returning from operations successfully readjust back to Canadian society, casualties of a different kind – invisible wounds – have affected thousands of CF personnel. While the CF has instituted many positive initiatives to address operational stress injuries (OSIs), this paper will illustrate that a significant deficiency in a comprehensive and integrated approach remains. To bridge this gap, the paper will demonstrate that the CF must change the way it approaches OSIs. In order to address the need for a systematic and cohesive approach, it will propose a holistic solution based on a military operational design that will suggest that key to addressing OSIs rests with leadership, vice the clinician. In doing so the paper will offer that, based on the Pigeau-McCann model for command capability, current leaders do not possess the requisite command envelope to effect address operational stress effectively. Given this deficiency, the paper will conclude by proposing a return to first principles and re-alignment of the command envelope in order to empower commanders.

INTRODUCTION

> The operational capability of the Canadian Forces is ultimately derived from its people. These young men and women of whom we ask so much, rely on their leaders to look after their well-being and interests.[1]

Since Canada's commitment in Afghanistan was announced in 2001, the pace of deployment for Canadian Forces (CF) personnel has been unprecedented. Not only has there been a higher proportion of personnel being deployed, but operations have been longer while breaks between missions have been increasingly shorter. The nature of deployments has also evolved. Unlike the Cold War experience, the operational tempo in Afghanistan is unparalleled and CF personnel are engaging in direct combat with an asymmetric enemy. Intense combat notwithstanding, advances in both medical technology and equipment such as body armour have caused casualty rates of killed and wounded to be lower than historical campaigns such as Korea and Vietnam.[2] Despite lower physical casualty rates and findings that the majority of CF personnel returning from operations successfully readjust back to Canadian society, casualties of a different kind – invisible wounds – have affected thousands of CF personnel.[3] These wounds, characterized as operational stress injuries (OSIs), not only severely reduce unit combat effectiveness, but can have hazardous impacts on a CF member's health and interpersonal relationships. Reports by the Surgeon General of the CF indicate that as many as 27% of CF personnel redeploying from operations are suffering from an OSI and that as of January 31st,

---

[1]Department of National Defence, *Military HR Strategy 2020. Facing the People Challenges of the Future* (Ottawa: Canada Communication Group, 2002), i.

[2]Deborah Warden, "Military TBI During the Iraq and Afghanistan Wars," *Journal of Head Trauma Rehabilitation* 21, no. 5 (Summer 2006): 399.

[3]Andre Marin, *Special Report: Systematic Treatment of CF Members with PTSD* (Ottawa: Canada Communication Group, 2002), vi.

2008 there were 4,917 active mental health cases within the CF.[4] While the CF has instituted many positive initiatives to address OSIs, this paper will illustrate that a significant deficiency in a comprehensive and integrated approach remains. To bridge this gap, the paper will demonstrate that the CF must change the way it approaches OSIs. In order to address the need for a systematic and cohesive approach, it will propose a holistic solution based on a military operational design that will suggest that key to addressing OSIs rests with leadership, vice the clinician. In doing so the paper will offer that, based on the Pigeau-McCann model for command capability, current leaders do not possess the requisite command envelope to effect address operational stress effectively. Given this deficiency, the paper will conclude by proposing a return to first principles and re-alignment of the command envelope in order to empower commanders.

DEFINITIONS

Before examining what needs to be done by the CF to address OSIs, it is necessary first to define the term OSI. For the purposes of this paper, "an OSI is any persistent psychological difficulty resulting from operational duties performed in the course of military service."[5] The term OSI is more comprehensive than post-traumatic stress disorder (PTSD) and is often thought of as an umbrella term for PTSD, other anxiety disorders and depression. Most importantly, the term OSI re-characterizes these conditions as an injury. With this in mind, and because

---

[4]House of Commons, "Military Health Care - National Defence," *Report by the Standing Committee on Public Accounts*. (Ottawa: Communication Canada, April 2008) 11-12.

[5]Department of National Defence, *Operational Stress Backgrounder – February 2009*, http://www.forces.gc.ca/site/news-nouvelles/view-news-afficher-nouvelles-eng.asp?id=2871; Internet; accessed 13 March 2009.

operational stress affects its sufferers in a non-discriminatory fashion, this paper will treat both combat-induced stress and other forms of operational stress as a single entity.[6]

OSIs can often lead to other psychological conditions. As noted by the Surgeon General for the CF, the most common conditions are PTSD and depression.[7] PTSD is defined as an anxiety disorder – an emotional illness that can develop as a result of a frightening, life-threatening, or otherwise unsafe experience. PTSD is not exclusively a military phenomenon and can be experienced by any person regardless of workplace. Given the nature of military operations, it is of no surprise that military rates of PTSD are much higher than the one in ten reported national average.[8] For the purposes of this paper, the term OSI is meant to include all types of stress-induced disorders.

HISTORICAL CONTEXT

> As long as there have been wars, individuals have suffered from the after-effects of traumatic experiences. Stories of nightmares, involuntary trembling, and dramatic reactions to sudden noises are part of the lore of every combat veteran's family. Folk memory and literature, if not formal history, are full of examples of the returned soldier who became a burnt-out case, the promising young man who was never the same again, the chronic alcoholic who couldn't get over the war. The universal character of this phenomenon is easy enough to establish. What requires investigation are the intellectual and ultimately social constructs developed to explain the persistence of pain and the reality of chronic neurosis.[9]

---

[6]Tomi S. MacDonough, "Noncombat Stress in Soldiers," in *Handbook of MilitaryPsychology*, eds Reuven Gal and A. David Mangelsdorff, (Chichester: John Wiley, 1991), 548-549.

[7]House of Commons, "Military Health Care - National Defence," 11.

[8]Department of National Defence, *Operational Stress Backgrounder*, 1.

[9]Peter Neary and J.L. Granatstein, *The Veterans Charter and Post-World War II Canada* (Montreal*:* McGill-Queen's University Press, 1998) 149.

OSIs are not a new phenomenon. At the onset of World War One, the CF approach to OSIs was primitive and lacked a coherent system to address operational stress issues. Mis-diagnosed soldiers were categorized as suffering from hysteria and evacuated to Britain for treatment, which most commonly comprised 'rest & sympathy'.[10] By 1916, 'shell-shock' losses were so great that during the Battle of the Somme, several thousand soldiers had to be evacuated due to nervous disorders.[11] In an attempt to mitigate these losses, a "new treatment regime was instituted that, by 1918, had evolved to the point where it was very similar to the present day treatment for operational stress near the front line,"[12] emphasizing three principles: (1) proximity—treatment is administered close to the front line; (2) immediacy—treatment is administered close in time to the symptoms' onset; and, (3) expectancy—the expectation is that the soldier will recover rapidly and resume functioning.[13]

At the end of the war, many Canadian veterans sought medical assistance for various symptoms resulting from the trauma of war. At the time, the psychiatric community labelled these as "neuroses," "neurasthenia" or "neuropsychiatric problems" and treatments varied from electric shock to psychotherapy.[14] When World War Two broke out in 1939, instead of implementing the system that evolved by the end of World War One which emphasized

---

[10]Dr Allan English, "Leadership and Operational Stress in the Canadian Forces," *Canadian Military Journal*. Autumn (2000): 34.

[11]Ibid., 35.

[12]Ibid., 35.

[13]Zahava Solomon, Rami Shklar, and Mario Mikulincer, "Frontline Treatment of Combat Stress Reaction: A 20-Year Longitudinal Evaluation Study," *American Journal of Psychiatry* 162, no. 12, (December 2005), 2309.

[14]Andre Marin, *Special Report: Systematic Treatment of CF Members with PTSD*, 32.

immediacy, proximity and expectancy; the methods used to treat operational stress had regressed back those used at the commencement of World War One.[15] For example, during a visit to a field hospital in August 1943, then Lieutenant-General George Patton publically berated a psychiatric casualty. Although the event caused a public uproar and Patton later apologized, his actions inadvertently brought the issue of combat stress to the forefront and demonstrated the key role that leaders' play.[16] Despite the issue of combat stress being elevated, the return to proven principles was not quickly re-implemented. It was not until the manpower crisis of the 1944-45 North-West Europe campaign caused the allies to re-examine their methods used to treat operational stress and finally return to World War One's proven methods.[17]

The goal of the forward psychiatry principles adopted during World War One and Two was to mitigate OSI and "return soldiers to their fighting units and limit the tide of psychologically precipitated evacuations."[18] Frontline treatment was guided by the notion that

> . . . the soldier's response is not evidence of an underlying disorder but a natural, appropriate response to the extreme stress of war. This psychiatric first aid is time-limited, lasting between 48 and 72 hours. The aim is to meet the casualty's physiological needs & provide temporary relief from harsh battle stressors. In frontline treatment, human contact is used to reassure the soldier and humanize and legitimize fears. Frontline treatment allows expression of grief, guilt, and shame but challenges self-depreciation. It conveys to the distressed soldier the expectation of recovery and resumption of functioning.[19]

---

[15]Todd C. Helmus and Russell W. Glen, *Stealing the Mind: Combat Stress Reactions and Their Implications for Urban Warfare*. (Santa Monica: RAND, 2004) xiv.

[16]Todd C. Helmus and Russell W. Glen, *Stealing the Mind: Combat Stress Reactions and Their Implications for Urban Warfare*, 15.

[17]Dr Allan English, "Leadership and Operational Stress in the Canadian Forces," 35.

[18]Todd C. Helmus and Russell W. Glen, *Stealing the Mind: Combat Stress Reactions and Their Implications for Urban Warfare*, 87.

[19]Zahava Solomon, Rami Shklar, and Mario Mikulincer, "Frontline Treatment of Combat Stress Reaction: A 20-Year Longitudinal Evaluation Study," 2309.

When applied, these principles appeared to have minimized psychiatric battle casualties during Korean, Vietnam and Yom Kippur Wars.[20] For example, the Israeli experience during the Yom Kippur War demonstrated that once the Israeli military implemented these treatment methods, their return rates drastically improved, with over 70 percent of soldiers returning to combat.[21] Recent examination of these principles suggests while they remain valid, applying these principles alone will not necessarily constitute an OSI reduction.[22] To suggest that OSI reduction is that black and white is simplistic and contradicts the inherent complexity of an individual's reaction to a traumatic event.

CURRENT SITUATION

> …the mission in Afghanistan may potentially have a significant long-term mental health impact, but the Canadian Forces strives to improve, and has improved, a robust program to deploy forces that are mentally ready, to support them well in-theatre, with mental health resources, and to maximize the early identification and treatment of conditions that manifest after deployment.[23]

The disregard of the lessons learned during World War One, and later during World War Two, has reoccurred recently, most notably in the Balkans. It was not, however, until a Board of Inquiry (BOI) was called in 1999 to investigate the health and welfare of Canadian soldiers that a

---

[20]Ibid., 2309.

[21]Dr Allan English, "Leadership and Operational Stress in the Canadian Forces," 35.

[22]Todd C. Helmus and Russell W. Glen, *Stealing the Mind: Combat Stress Reactions and Their Implications for Urban Warfare*. (Santa Monica: RAND, 2004) 91-92.

[23]Lieutenant-General Michel Gauthier, Minutes of the Standing Committee on National Defence, 3 April 2008; http://www2.parl.gc.ca/HousePublications/Publication.aspx?DocId=3387918&Language=E&Mode=1&Parl=39&Ses=2; Internet; accessed 13 March 2009.

confounding picture emerged about the mental health of CF personnel. As a result of the Croatia BOI, the increasing incidence of stress-related injuries became widely known to Canadians. The Croatia BOI concluded that the system in place to provide care for OSI patients was insufficient in the past and had remained insufficient in 2000.[24] Recognizing that Canada had regressed to a state without an organizational system dedicated to operational stress, the Ombudsman for the Department of National Defence (DND) and the CF launched an investigation into the way the CF was addressing OSIs, specifically PTSD.

On February 5, 2002, the Ombudsman for the DND and the CF published his findings related to PTSD in Canada's military. In his special report, entitled *Systemic Treatment of CF Members with PTSD*, he found that the military's approach to mental health injuries was inadequate and that the organization was not treating individual members who suffered from it appropriately.[25] When the Ombudsman released his report, he provided 31 recommendations to the DND and the CF which aimed at helping them to identify and treat post-traumatic stress disorder in the military. The CF took action and immediately began to implement many of the recommendations, many within the first ten months of the report. In December 2002, the Ombudsman released a follow-up report, which illustrated that a number of new programs had been put in place to deal with post-traumatic stress disorder and other operational stress injuries. While the report highlighted a considerable increase in the level of awareness of OSIs, the Ombudsman also found that little progress had been made in the areas of training and in

---

[24]Department of National Defence, Croatia Board of Inquiry Final Report, (Ottawa: January 2000) 53.

[25]Andre Marin, *Special Report: Systematic Treatment of CF Members with PTSD*, 227-230.

particular the overall level and effectiveness of leadership and coordination at the strategic level.[26]

In December of 2008, a second report by the DND and CF Ombudsman titled *Along Road to Recovery: Battling Operational Stress Injuries* was released on DND and CF action in addressing OSIs. Although the report highlighted that the DND and CF have made progress between 2002 and 2008 in addressing many of the issues and challenges related to OSIs, the report noted that 18 out of 31 original recommendations had either not been implemented at all, or not to the satisfaction of the Ombudsman investigators. The bulk of the non-implemented recommendations dealt with broader issues of leadership, governance, data collection and monitoring.[27] The report concluded indicating that because the current mission in Afghanistan was characterized by intense combat operations, a robust, holistic and integrated institutional approach to address OSIs was urgently required.[28]

It is not the intent of this paper to suggest that current military commanders do not realize the importance of leadership when addressing OSIs nor downplay the key steps taken to combat OSIs. The DND and the CF have taken important steps in addressing OSIs. For example, Operational Trauma and Stress Support Centres (OTSSCs) are located across Canada and closely partnered with Veterans Affairs Canada (VAC) Operational Stress Injury Clinics. The OTSSCs employ a mixed military and civilian staff of psychiatrists, psychologists, social workers, mental

---

[26]Mary McFadyen, *A Long Road to Recovery: Battling Operational Stress Injuries: Second Review of the Department of National Defence & Canadian Forces Action on Operational Stress Injuries* (Ottawa: Queens Printer, 2008) 2.

[27]Mary McFadyen, *A Long Road to Recovery,* 3.

[28]*Department of National Defence & Canadian Forces Action on Operational Stress Injuries* (Ottawa: Queens Printer, 2008) 3-4.

health nurses and chaplains and use a multidisciplinary treatment model to provide assessment, educational outreach, treatment and research on OSIs. [29] In addition to OTSSCs, the federal government committed $98 million in 2004 to the CF Mental Health Initiative**,** to permit the hiring of 218 additional mental health practitioners, for a total of 447, by 2010.[30] Furthermore, in spring 2008, the former Chief of Defence Staff, Gen Hillier announced the re-establishment of the OSI Steering Committee where senior CF leaders will discuss innovative concepts to deal with OSIs. Funding was also increased for the Operational Stress Injury Social Support program (OSISS), which provides confidential peer support to CF personnel, veterans and families affected by OSI. To coordinate the approach, General Hillier appointed a Special Advisor to the Chief of Military Personnel (CMP) to oversee the management of nonclinical matters related to OSI.[31]

Given the many initiatives the CF has championed over the past 10 years, one must ask why a gap still exists in addressing OSIs? While there are likely a myriad of reasons for a gap in he CF approach, the most compelling is the lack of an integrated systematic strategy to combat OSIs at the national level. Current initiatives, while by themselves positive, lack coordination and are seldom linked.[32] Although there are many commendable initiatives being pursued at the tactical level to address OSIs, no amount of tactical brilliance can compensate for strategic

---

[29]Canadian Forces Health Services, Operational Stress Support Trauma Centre Web-site; http://www.forces.gc.ca/health-sante/ps/mh-sm/otssc-cstso/default-eng.asp; Internet; accessed 28 March 2009.

[30]Anca Gurzu, "The Battle at Home," *Capital News Online*, 6 March 2009, available from http://www.carleton.ca/Capital_News/06032009/n1.shtml; Internet; accessed 28 March 2009.

[31]Dave Noppe, "New Initiatives for OSI Sufferers" *Maple Leaf* 11, no. 20. (28 May 2008) 14; available from http://www.forces.gc.ca/site/commun/ml-fe/vol_11/vol11_20/1120_full.pdf; Internet; accessed 28 March 2009.

[32]Mary McFadyen, *A Long Road to Recovery*, 10.

miscalculation. Moreover, current practice leaves much of the responsibility for development and implementation of policy with regards to OSIs to the medical profession, yet holds leaders accountable for the welfare of their personnel. This miscalculation of the main and supporting efforts to address OSIs is directly related to the lack of a holistic and comprehensive institutional approach. To bridge the OSI gap, leaders must be designated the main effort and clinicians supporting.

A RETURN TO FIRST PRINCIPLES – THE NEW OLD ROAD

Unlike the title of the last report from the DND and CF ombudsman, this paper does not necessarily suggest the road to recovery is long. While clearly it will differ from individual to individual, what is important is that a different way to think about and address OSIs is established. This fresh approach must address the current gaps identified, leadership and vision, through a comprehensive integrated approach. Borrowing from operational art, one method to illustrate a holistic approach to addressing OSIs is an operational design. Operational art is the application of creative imagination in order to design strategies, campaigns, and major operations whereas operational design is the conception and construction of the framework that underpins a campaign and its subsequent execution. A systems perspective of the operational environment is fundamental to operational design:

> . . . it considers more than just an adversary's military capabilities; it also strives to provide a perspective of the interrelated systems that comprise the operational environment . . . It identifies nodes in each system and the links between the nodes. . . [Militaries] use a number of operational design elements

> (e.g., termination, end state and objectives, effects, COG, decisive points, lines of operations, arranging operations) to help them visualize the arrangement of actions in time, space, and purpose to accomplish their mission. [33]

The result of an operational design should be a framework that forms the basis for a campaign plan and the conceptual linkage of ends, ways, and means.

Titled the *CF OSI Reduction Operational Design*, Figure 1-1 is one example of an integrated holistic operational design created by the author to address OSIs in the CF. Although the *CF OSI Reduction Operational Design*, appears linear on paper, the reality is a system that consists of a large number of interactive parts and relationships. That said, in its simplest form, there are five main parts to the *CF OSI Reduction Operational Design*: phases, decisive points, end-state, lines of operation (effort), and centre of gravity. Regrettably, due to the scope of this particular paper, a brief overview of phases, decisive points, end-state and lines of operation will be presented. Conversely, as the key to the operational design and the nexus for bridging the CF OSI gap, a more detailed analysis of the centre of gravity, leadership, will be offered.

The *CF OSI Reduction Operational Design* designates three phases: (1) shape; (2) dominate; and, (3) sustain. Notwithstanding the initiatives taken to date, the CF remains in the shape phase. Upon implementation of a coordinated systematic plan to address OSIs like the *CF OSI Reduction Operational Design*, it is likely that the CF will quickly progress to the dominate phase. In order to transition to phase two, the *CF OSI Reduction Operational Design* identifies seven decisive points that must be completed. A decisive point is "a geographic place, specific key event, critical factor, or function that, when acted upon, allows a commander to gain a

---

[33]Ibid., xix.

marked advantage over an adversary or contributes materially to achieving success."[34] It is important to note that the seven decisive points in the shape phase are institutional issues that must be addressed at the strategic level.

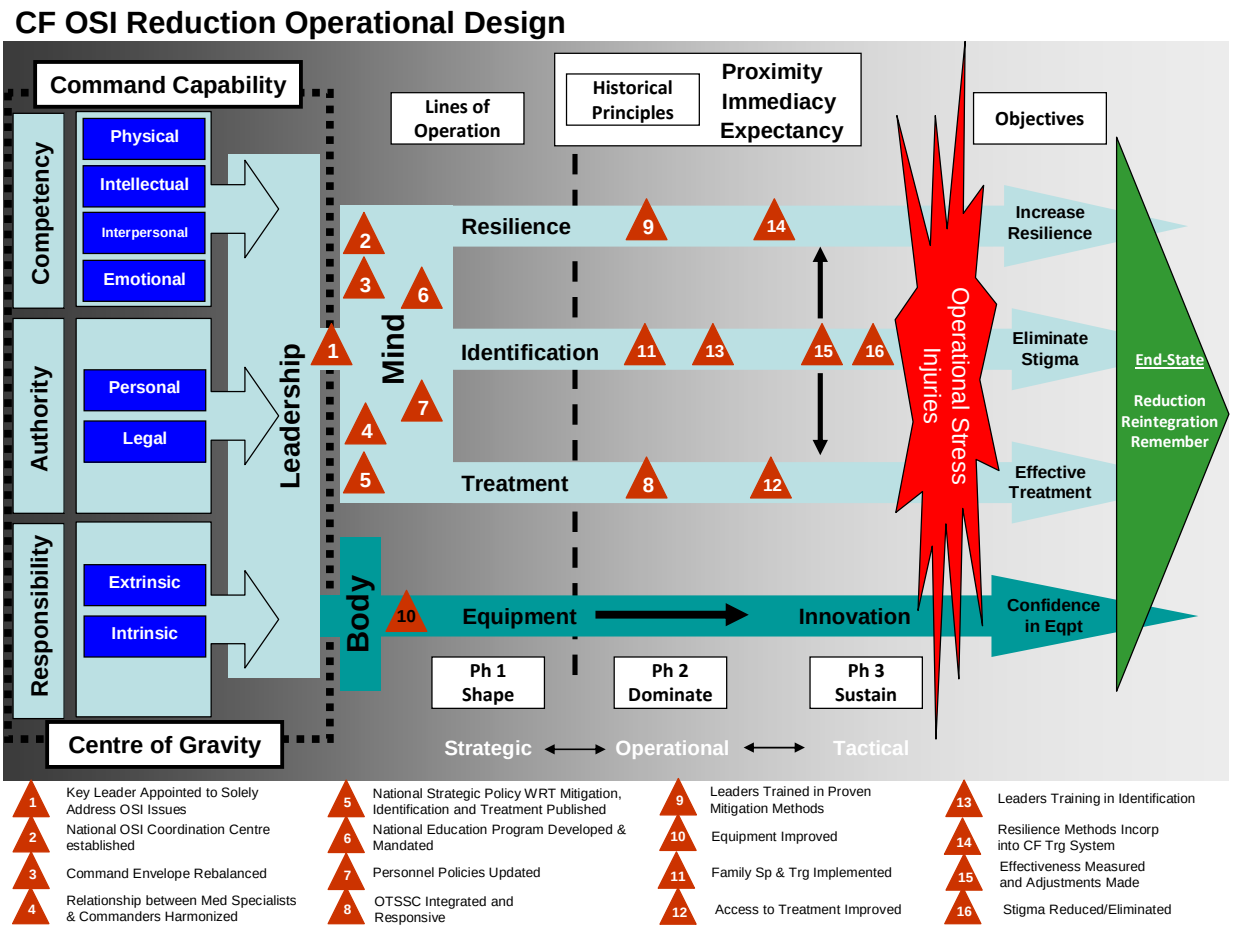

Figure 1-1 – CF OSI Reduction Operational Design

In designing a holistic and integrated campaign design to combat OSIs, one must return to first principles. We have seen from historical analysis that the principles of proximity, immediacy and expectancy have proven to be effective. Based on these principles, current and

[34]Ibid., IV-12.

historical analysis, four equally significant lines of operation become paramount: resilience,[35] identification, treatment, and equipment. These lines of operation, or lines of effort, are meant to be a framework that groups together the multiple objectives required to address OSIs in a logical fashion. In short, resilience, identification, treatment, and equipment, enable the integration of all of the means available to achieve the ends. These ends (or end-state) of the *CF OSI Reduction Operational Design* are characterized by three key principles: reduction, reintegration and remember (3Rs). The 3Rs, a reduction in OSIs in CF personnel, effective treatment and reintegration of those CF personnel diagnosed with an OSI, and remembering those with OSIs (and other injuries for that matter) through constant contact by the CF, represent a return to fundamental 'first' principles that constitute clear conditions that define achievement of the *CF OSI Reduction Operational Design*.

In order to illustrate the importance of body and mind as a soldier system, the equipment line of operation is intended to provide amour for the body. Improved soldier systems that enhance soldier survivability, ultimately give the soldier increased confidence and can reduce a soldier's fear of injury.[36] The CF has drastically improved its equipment over the last ten years and although arguably unrelated to any integrated campaign plan to combat OSIs, this line of operation is progressing well and will not be further addressed in this paper. Focusing on providing armour for the mind, the lines of operation of resilience, identification and treatment

---

[35]The term resilience is used deliberately. Many scholars often use the word prevention, however, given the definition of OSIs, the author believes that the term prevention is misleading and can create false expectations that you can prevent all cases of OSIs.

[36]Marine Corps Combat Operational Stress Control Program, available from http://www.marines.mil/news/messages/Pages/2007/MARINE%20CORPS%20COMBAT%20OPERATIONAL%20STRESS%20%20CONTROL%20(COSC)%20PROGRAM.aspx; Internet; accessed 4 April 2009.

are intended to group the multiple, and often disparate, actions arranged in a framework unified by the first principles of proximity, immediacy and expectancy respectively. The resilience line of operation has the objective of increasing resilience to OSIs by CF personnel. This line of operation sees two key decisive points particular to education and training. Of importance on this line, is that the approach to resilience education and training be institutional and from established methods. Current practice sees a disparate execution of low-level education and training programs with no unified or integrated structure. While these tactical level initiatives are admirable, most have been originated due to an institutional deficiency. Not only is this inefficient, if resilience training is not trained properly and based on proven methods, it can be potentially deteriorate the member's condition vice addressing the OSI.

Three key decisive points focusing on identification training, family integration and support as well as stigma reduction form the identification line of operation. This line of operation has the ultimate objective of properly identifying members with an OSI and eliminating the associated OSI stigmas. Particular to this line is the requirement for properly resourced research and development, as well as a performance measurement function. The performance management function will be of particular value as it will act as an azimuth check for the design, adjusting to meet changes in the situation as required. Equally important, this line requires the leadership to effect a culture change in the CF in order to ensure OSI stigmas are eliminated and those suffering are not afraid to approach their chain of command to receive the care they need. Alternately, the treatment line of operation is designated the objective of providing CF personnel modern, accessible and effective treatment. With two key decisive points focusing on improving treatment access and methods, this line of operation will be a joint function between the chain of command and specialists.

THE CENTRE OF GRAVITY

Balancing design and planning while remaining open to learning and adapting to change, the *CF OSI Reduction Operational Design* draws its strength from leadership. Leadership as the focal point to addressing OSIs is not new. As with operational art, military commanders must bear ultimate responsibility for the campaign plan and it is no different when addressing OSIs. In short, commanders are the plan's centre of gravity: the force where the many parts of the design will draw their strength from. Studies completed over the last century continue to make a definite association between OSIs and confidence in leadership.[37] American trauma experts such as Dr Shabtai Noy concluded after extensive research of literature and historical analyses that leadership is the main factor that have had a consistent impact on reducing operational stress casualties throughout history.[38] Canadian experts agree. For example, Dr Allan English from the Royal Military College of Canada concluded that the most effective model to address OSIs is through focus on stress prevention by improving leadership practices and strengthening unit cohesion.[39]

It is not only academic and medical scholars who have recognized the importance of leadership in addressing OSIs. Recent military commanders to the Canadian mission in Afghanistan have also recognized the critical role it plays. Colonel Ian Hope, Commander of Task Force ORION in 2006 concluded in his recent chapter on resilience and fear that "the

---

[37]Dr Allan English, "Leadership and Operational Stress in the Canadian Forces," 36.

[38]Shabtai Noy, "Combat Stress Reactions" *Handbook of Military Psychology* (New York: Springer Netherlands, 1994) 517-520.

[39]Dr Allan English, "Leadership and Operational Stress in the Canadian Forces," 36.

management of fear and resilience was an imperative of combat leadership, and that my own personal efforts to contain emotions and to practice good command – with an appearance of being unaffected by the violence – involved a constant exercise of self-control."[40] Colonel Hope's Deputy Commanding Officer, Lieutenant-Colonel Tod Strickland, based on his operational experience and his combat experience in Kandahar Afghanistan also saw firsthand the centrality of leadership when dealing with operational stress:

> . . . it is all about leadership. This is not to imply that operational stress will only occur when poor leadership practices exist; that is to over-simplify a complex mechanism of injury. What I do know is that units and sub-units with strong leaders seem to be better able to handle the incredible stresses of combat and I suspect demonstrate a lower likelihood of injury. Leaders who demonstrate compassion for their soldiers, and resolve to complete their missions seem to trigger something in the Canadian solder which helps fight off the ravages of operational stress. A commander who makes esprit de corps more than slogans and badges, and grows a spirit of family in his sub-unit will likely see fewer physical or psychological injuries - we know that and have seen it before. Combat is a difficult environment, but how we lead our soldiers directly impacts their ability to withstand its rigours.[41]

Lieutenant-Colonel John Conrad, based on his experience as Commanding Officer during Operation ARCHER Rotation 1 in Kandahar Afghanistan from January 2006 to August 2006, identified the central role leadership played in addressing OSIs in his unit:

> the best thing to heal wounds on the moral plane is to remain engaged with your soldiers. Nothing that happened is out of bounds for discussion. OSI is swaddled with memories, sensations and alien feelings of inadequacy, guilt and a sense you have "let down the side." Continued engagement is vital to combat these aspects. That is not to say that the chain of command can cure OSI in all cases—far from

---

[40]Colonel Ian Hope, Commanding Officer Task Force ORION, Kandahar Afghanistan January-August 2006, "Fear and Resilience" (Essay wrote for US Army War College: 2008) 1.

[41]Lieutenant-Colonel Tod Strickland, Deputy Commanding Officer Task Force ORION, Kandahar Afghanistan January-August 2006, Interview, 25 February, 2009.

> it. We do need specialist help in some cases at the appropriate juncture. My point is that chain of command involvement is <u>always</u> required as a way station on the road to recovery from OSI.[42]

Other agencies and nations also see the importance of leadership in addressing OSIs. Although outside the scope of this particular paper to discuss police, fire-fighter, ambulance and other nation's militaries approaches to OSIs, it is relevant to note that the United States has identified leadership as the foundation to their strategy to combat operational stress. Not only has the United States identified leadership as its core tenant, it has published an institutional policy with regards to its approach to operational stress and instituted a national *Wounded Warrior Program*.[43] Led by military commanders and assisted by clinicians, the *Wounded Warrior Program* "is an outreach-driven program that provides severely wounded or injured Soldiers and their Families with a system of advocacy and personal support."[44]

Returning to our *CF OSI Reduction Operational Design* at Figure 1-1, if we accept that leadership forms the centre of gravity and leaders are effectively executing the operational design, why does a gap still exist? Using the Pigeau-McCann competency-authority-responsibility model[45] as a basis to analyze where additional focus must be applied at the

---

[42]Lieutenant-Colonel John Conrad, Commanding Officer National Support Element, Kandahar Afghanistan January-August 2006, Interview, 11 March 2009.

[43]United States Army Wounded Warrior Program; available from http://www.armywell-being.org/skins/awb/display.aspx?moduleid=8cde2e88-3052-448c-893d-d0b4b14b31c4&action=display_user_object&mode=user&objectid=39fb37b4-b3a5-4cf6-883c-30c0e4371614&AllowSSL=true; Internet; accessed 22 April 2009.

[44]2008 US Army Posture Statement, *Information Paper – US Army Wounded Warrior Program*; available from http://www.army.mil/aps/08/information_papers/sustain/US_Wounded_Warrior_Program.html; Internet; accessed 22 April 2009.

institutional level, it becomes immediately apparent that the current CF organizational arrangement has created an unbalanced command envelope. More specifically, before effective leadership alone can address operational stress and its associated resilience, identification, treatment and equipment issues, it is imperative that the institution ensure leaders at all levels have the competency, authority and responsibility to effect these changes.[46] By addressing the command capabilities of competency, authority and responsibility of leaders with respect to OSIs, a balanced command envelope is created, providing an effective centre of gravity to combat OSIs.

The first dimension of command capability is responsibility. Responsibility is defined as "the degree to which an individual accepts the legal and moral liability commensurate with command."[47] According to the Pigeau-McCann model, there are two aspects to responsibility: intrinsic and extrinsic. Few argue that most, if not all, leaders in the CF have the intrinsic responsibility, or the resolve and motivation necessary to address operational stress in their units. Extrinsic responsibility, however, involves the obligation for public accountability and is not as concise. While there is no question that CF leaders have been given the legal responsibility for the welfare of their personnel, the conflict arises because responsibility has been externally imposed without the other aspects of command capability: competency and authority.

Leadership lacking competency is ineffective. Competency, the second dimension to command capability in the proposed *CF OSI Reduction Operational Design*, is defined as "the

---

[45]Pigeau, Ross, and Carol McCann. "Re-conceptualizing Command and Control." *Canadian Military Journal* 3, no. 1 (Spring 2002): 53-63.

[46]Ibid., 57-58.

[47]Ibid., 59.

necessary skills and abilities for accomplishing missions successfully."[48] The Pigeau-McCann model identifies four elements to competency: physical, emotional, intellectual and interpersonal. While all four components are important, the key component missing with regards to OSIs is intellectual competency. Intellectual competency must be addressed through designing a comprehensive education campaign on operational stress.[49] Resources must be expended on training and speciality courses to empowered leaders with the requisite knowledge to coordinate the ways and means to achieve the *CF OSI Reduction Operational Design* end-state. Although it will not be discussed in this paper, it is important to note that key decisive points dealing with education are also found throughout all lines of operation in the proposed *CF OSI Reduction Operational Design*.

Pigeau-McCann's final dimension to command capability is authority. In terms of the proposed *CF OSI Reduction Operational Design*, the authority dimension requires the most re-balancing. In Pigeau-McCann's model, authority refers to command's domain of influence. It is the "degree to which a commander is empowered to act, the scope of this power and the resources available for enacting his or her own will." [50] Pigeau-McCann distinguish between authority earned by personal credibility, or personal authority, and that assigned from the institution, or legal authority. Specifically legal authority is expressed in institutional regulations and policies and formally assigns resources and personnel to accomplish a mission. Based on the proposed *CF OSI Reduction Operational Design*, in order to effectively address operational

---

[48]Ibid., 58.

[49]Dr Allan English, "Leadership and Operational Stress in the Canadian Forces," 38.

[50]Dr Ross Pigeau and Carol McCann, "Re-Conceptualizing Command and Control," 61.

stress, leaders at all levels must be given the authority commensurate to their responsibility. When this balance does not occur, the result is a commander who is responsible to complete a task, but does not have the necessary resources or personnel to do so.

Current CF commanders do not have the necessary legal authority to address operational stress. In an attempt to address OSIs, the CF as an institution has gradually reduced the authority of the chain of command in favour for specialists. Conversely, the responsibility for the welfare of their subordinates, both physical and mental well-being, has not eroded. In many cases, issues of privacy, authority for leave, etc have caused a rift between the chain of command and health care professionals, both who believe they should have the authority and have the responsibility for dealing with operational stress. While it is admirable that both professions understand the importance of addressing operational stress, ultimately, the chain of command is responsible for the care of their soldiers. Not only have we seen that when this authority is delegated to others unnecessary operational stress casualties occur,[51] in the end the chain of command is accountable for the outcomes of any campaign plan against OSIs and therefore will ultimately be held responsible. Based on these realities, the chain of command must take the lead and be intimately involved in all lines of operation of the proposed *CF OSI Reduction Operational Design*. Any process which sees clinicians leading the approach not only ignores medical research, but the very foundation of the nature of military command. According to Lieutenant-Colonel John Conrad, Commanding Officer of the TF 1-06 National Support Element:

> . . . to put the soldiers immediately in the hands of the mental health care professionals is to miss a significant step in the normalization of what has occurred. Furthermore, there is a moral contract that the chain of command must

[51]Dr Allan English, "Leadership and Operational Stress in the Canadian Forces," 36.

> honour with the affected soldier. A duty to recover a body no matter how badly mutilated the duty to talk it through no matter how awkward or clumsy. All of this equates to psychological first aid that is essential in the soldier's mental recovery. Cutting out the chain of command (which happened a number of times early on during Task Force 1-06 deployment and perhaps throughout the tour—not sure)is analogous to sending a physical casualty back to the casualty collection point or Kandahar Airfield Role 3 Medical Unit without applying a shell dressing or a tourniquet.[52]

In order to re-balance the command envelope and empower the proposed operational design, additional authority must be given to the chain of command. This will mean a fundamentally different approach to addressing OSIs. Clearly this approach will require the expertise of both the profession of arms and the medical profession. The fundamental difference, however, is the balance of authority must shift from clinician to commander. We must return to first principles and re-emphasize what *Duty with Honour: The Profession of Arms in Canada* highlights as a key organizational framework to the Canadian Forces: military health-care providers are first part of the profession of arms and second the medical profession.[53] This paper is not suggesting the view that authority must be shifted in such a way that violates key aspects of either the medical profession or the profession of arms. Clinicians play a vital role to addressing OSIs and it is not the intent of this paper to downplay their role in treating this injury. Treatment, however, is only one aspect in addressing OSIs and in order to bridge the gap, the problem must be looked at from a wide-angle lens to ensure tunnel vision is avoided. Based on his experience in Afghanistan, Lieutenant-Colonel John Conrad, Commanding Officer of the National Support Element during Task Force 1-06 commented on the relationship between the chain of command and the clinician:

---

[52]Lieutenant-Colonel John Conrad, Interview, 11 March 2009.

[53]The Chief of Defence Staff, *Duty with Honour: The Profession of Arms in Canada.* (Ottawa: Canadian Defence Academy, 2003): 49.

> Do we need the surgeon to put on a shell dressing or a tourniquet? Medical involvement is necessary but at the right juncture for the right cases. The medical corps knows the mind but they can never have the context where the injury/explosion occurred. Only the soldier's chain of command will have context. Context and medical savoir faire are both required ingredients in the healing process. In my opinion, recovering from an OSI demands the normalization of the abnormal - putting an emotional reference or framework around things that occur on the battlefield. Treating OSI requires therefore the correct blend of leader/chain of command and medical involvement.[54]

Rebalancing the command envelope is not a new concept. Canadian Forces members are subject to unique conditions which set them apart from the remainder of Canadian society and an institutional shift of authority to empower the chain of command with the necessary resources to affect the welfare of their subordinates is a principle that is central to being a member of the CF.[55] While changing the Canadian Forces organizational culture will not occur overnight and will likely be measured in years, it is the author's belief that before in order for the current gap in addressing OSIs can be addressed, empowering the centre of gravity by re-aligning the command envelope is necessary. With specialists in support, leaders must have the right balance of competency, authority and responsibility if they can be expected to effectively deliver the effects of the proposed *CF OSI Reduction Operational Design*.

CONCLUSION

The greatest casualty with regards to an OSI is being forgotten. Clearly this cannot occur and the CF is committed to ensuring that it never again regresses into a stage where no system to address operational stress exists. As described, this will require a significant shift in how the CF currently addresses OSIs. First and foremost, leadership must be identified as the centre of

---

[54]Lieutenant-Colonel John Conrad, Interview, 11 March 2009.

[55]The Chief of Defence Staff, *Duty with Honour*, 49.

gravity to address OSIs. This change in culture must begin with a specific appointment of an officer by the Chief of Defence Staff to champion the CF approach to OSIs. This officer must be an operator who has given the necessary resources, command authority and responsibility to bridge the gap that has been created by a misunderstanding of the centre of gravity and a reluctance to return to first principles. Leadership, empowered by a balanced command envelope, must then develop an all-inclusive operational design and campaign plan to combat operational stress at the institutional level. This focus on leadership and implementation of a comprehensive and harmonized operational design is not only required to effectively address OSIs today, but also to set the necessary conditions to prevent regression of proven OSI methods in the future. The end-state, the care of our soldiers, a chain of command responsibility, is not a new road for the CF. In order to effectively address OSIs, it's a road we must return to; a road where leaders lead and specialists support. It's a return to first principles. Reduction, reintegration and remembering depend on it.

BIBLIOGRAPHY

Blanchfield, Mike. “Forces Failing its ‘Stressed’ Members.” *National Post*. 18 December 2008.

Canada, Canadian Forces Health Services, Operational Stress Support Trauma Centre Web-site; available from http://www.forces.gc.ca/health-sante/ps/mh-sm/otssc-cstso/default-eng.asp; Internet; accessed 28 March 2009.

Canada. Canadian Forces Joint Publication 1.0. *Military Personnel Management Doctrine*. Ottawa: Director General Military Personnel, June 2008.

Canada. Department of National Defence. *Croatia Board of Inquiry Final Report*. Ottawa: Canada Communications Group, January 2000.

Canada. Department of National Defence. *Department of National Defence & Canadian Forces Action on Operational Stress Injuries*. Ottawa: Queens Printer, 2008.

Canada. Department of National Defence. *Operational Stress Backgrounder – February 2009*; available from http://www.forces.gc.ca/site/news-nouvelles/view-news-afficher-nouvelles-eng.asp?id=2871; Internet; accessed 13 March 2009.

Canada. Department of National Defence. *Military HR Strategy 2020. Facing the People Challenges of the Future*. Ottawa: HR-Mil, 2002.

Canada. House of Commons. “Military Health Care - National Defence.” *Report by the Standing Committee on Public Accounts*. Ottawa: Communication Canada, April 2008.

Canada. The Chief of Defence Staff. *Duty with Honour: The Profession of Arms in Canada*. Ottawa: Canadian Defence Academy, 2003.

Conrad, Lieutenant-Colonel John. Commanding Officer National Support Element, Kandahar Afghanistan January-August 2006. Interview, 11 March 2009.

English, Dr Allan. “Leadership and Operational Stress in the Canadian Forces,” *Canadian Military Journal*. Autumn 2000.

English, Allan. Command and Control of Canadian Aerospace Forces: Conceptual Foundations. Ottawa, Minister of National Defence, 2008.

Gauthier, Lieutenant-General Michel. Minutes of the Standing Committee on National Defence, 3 April 2008; available from http://www2.parl.gc.ca/HousePublications/Publication.aspx?DocId=3387918&Language=E&Mode=1&Parl=39&Ses=2; Internet; accessed 13 March 2009.

Gurzu, Anca. “The Battle at Home.” *Capital News Online*. 6 March 2009; available from http://www.carleton.ca/Capital_News/06032009/n1.shtml; Internet; accessed 28 March 2009.

Helmus, Todd C. and Russell W. Glen. *Stealing the Mind: Combat Stress Reactions and Their Implications for Urban Warfare*. Santa Monica: RAND, 2004.

Hope, Colonel Ian. Commanding Officer Task Force ORION, Kandahar Afghanistan January-August 2006. “Fear and Resilience” United States War College: 2008.

Marin, Andre. *Special Report: Systematic Treatment of CF Members with PTSD.* Ottawa: 2002.

MacDonough, Tomi S. “Noncombat Stress in Soldiers.” in *Handbook of Military Psychology*. Editors Reuven Gal and A. David Mangelsdorff. Chichester: John Wiley, 1991.

McFadyen, Mary. *A Long Road to Recovery: Battling Operational Stress Injuries: Second Review of the Department of National Defence & Canadian Forces Action on Operational Stress Injuries*. Ottawa: Queens Printer, 2008.

Neary, Peter and J.L. Granatstein. *The Veterans Charter and Post-World War II Canada.* Montreal: McGill-Queen’s University Press, 1998.

Noppe, Dave. “New Initiatives for OSI Sufferers.” *Maple Leaf* 11, no. 20. (28 May 2008); available from http://www.forces.gc.ca/site/commun/ml-fe/vol_11/vol11_20/1120_full.pdf; Internet; accessed 28 March 2009.

Noy, Shabtai. “Combat Stress Reactions.” *Handbook of Military Psychology.* New York: Springer Netherlands, 1994.

Pigeau, Ross, and Carol McCann. "Re-conceptualizing Command and Control." *Canadian Military Journal* 3, no. 1. Spring 2002.

Sharpe, Joe, Don Richardson, Kathy Darte, Stephane Grenier and Allan English. “Operational Stress Injury Social Support: A Canadian Innovation in Professional Peer Support.” *Canadian Military Journal* 9, no. 1.

Sharpley, John G. “Pre-Operational Stress Briefing: Does it have any Effect? (1 April 2006); Available from http://stinet.dtic.mil/cgi-bin/GetTRDoc?AD=A472786&Location=U2&doc=GetTRDoc.pdf; Internet; accessed 4 April 2009.

Smith, Joanna. “Soldiers’ Stress Takes Long-Term Toll.” *HealthZone*; available from http://www.healthzone.ca/health/articlePrint/555678; Internet; accessed 12 January 2009.

Solomon, Zahava, Rami Shklar, and Mario Mikulincer. “Frontline Treatment of Combat Stress Reaction: A 20-Year Longitudinal Evaluation Study.” *American Journal of Psychiatry* 162, no. 12, (December 2005).

Strickland, Lieutenant-Colonel Tod. Deputy Commanding Officer Task Force ORION, Kandahar Afghanistan January-August 2006. Interview, 25 February, 2009.

Tanielian, Terri and Lisa H. Jaycox. *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences and Services to Assist Recovery*. Santa Monica: RAND, 2008.

United States Army Wounded Warrior Program; available from http://www.armywell-being.org/skins/awb/display.aspx?moduleid=8cde2e88-3052-448c-893d-d0b4b14b31c4&action=display_user_object&mode=user&objectid=39fb37b4-b3a5-4cf6-883c-30c0e4371614&AllowSSL=true; Internet; accessed 22 April 2009.

United States Army Posture Statement. *Information Paper – US Army Wounded Warrior P*rogram; available from http://www.army.mil/aps/08/information_papers/sustain/US_Wounded_Warrior_Program.html; Internet; accessed 22 April 2009.

United States of America, Marine Corps Combat Operational Stress Control Program; available from http://www.marines.mil/news/messages/Pages/2007/MARINE%20CORPS%20COMBAT%20OPERATIONAL%20STRESS%20%20CONTROL%20(COSC)%20PROGRAM.aspx ; Internet; accessed 4 April 2009.

United States of America, Chairman of the Joint Chiefs of Staff. *Joint Publication 3-0: Joint Operations – Change 1*. (Washington: February 2008).

Warden, Deborah. “Military TBI During the Iraq and Afghanistan Wars.” *Journal of Head Trauma Rehabilitation* 21, no. 5. Summer 2006.

Wessely, Simon and Edgar Jones. “Forward Psychiatry in the Military: Its Origins and Effectiveness.” *Journal of Traumatic Stress* 16, no. 4. August 2003.