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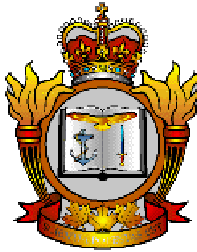

MENTAL INJURIES SUSTAINED BY VETERANS OF THE AFGHANISTAN CAMPAIGN: A COMPREHENSIVE ISSUE

Major Christian Lillington

JCSP 38

Master of Defence Studies

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Master of Defence Studies

MENTAL INJURIES SUSTAINED BY VETERANS OF THE AFGHANISTAN CAMPAIGN: A COMPREHENSIVE ISSUE

By Major Christian Lillington, CD, BA

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CONTENTS

Table of Contents	i
List of Figures	ii
List of Abbreviations	iii-iv
Acknowledgements	v
Abstract	vi
Opening Reflection	vii
Chapter	
1. Introduction	1
2. Chapter 1	6
3. Chapter 2	31
4. Chapter 3	55
5. Conclusion	91
Bibliography	95

LIST OF FIGURES

Figure 1.1: Causes of OSIs 10

Figure 1.2: "Leaky Bucket" metaphor for stress 11

Figure 2.1: Caring for Our Own Manual 39

Figure 2.2: Phases of Caring for Our Own 40

Figure 2.3: Annex A from Caring for Our Own 41

Figure 2.4: Road to Mental Readiness Aide Mémoire 46

Figure 2.5: Road to Mental Readiness Continuum of Training 47

Figure 2.6: Mental Health Continuum Model 51

Figure 2.7: Sliding scale of responsibility 52

Figure 3.1: Flow Chart for Resiliency Training 60-61

Figure 3.2: Institutionalization of Resilience Training 62

Figure 3.3: Warrior Ethos Model 64

Figure 3.4: Leadership Guides 67

Figure 3.5: Junior Leadership Guides 70

Figure 3.6: United States Army Comprehensive Soldier Fitness Program 72-73

Figure 3.7: Australian Defence Force Psychology Resilience Continuum 76

LIST OF ABBREVIATIONS

ADF	Australian Defence Force
AO	Assisting Officer
CA	Canadian Army
CSF	Comprehensive Soldier Fitness (US program for mental health)
CDS	Chief of the Defence Staff
CF	Canadian Forces
CMP	Chief of Military Personnel
CO	Commanding Officer
CT	Collective Training
DCSM	Directorate of Casualty Support Management
DND	Department of National Defence
DMH	Directorate of Mental Health
DP	Developmental Period
DRDC	Defence Research and Development Canada, also Defence R&D Canada
GoC	Government of Canada
HDO	Human Dimensions of Operations
IPSC	Integrated Personnel Support Centre
ISAF	International Security Assistance Force
IT	Individual Training
JPSU	Joint Personnel Support Unit
JSB	Joint Speakers Bureau
LFDTS	Land Force Doctrine and Training System

MHCM	Mental Health Continuum Model
mTBI	Mild Traumatic Blast Injury
NATO	North Atlantic Treaty Organization
OSI	Operational Stress Injury
OSISS	Operational Stress Injury Social Support
OTSSC	Operational Trauma Stress Support Clinics
PD	Professional Development
PRes	Primary Reserve
PTSD	Post-traumatic Stress Disorder
R2MR	Road to Mental Readiness
RegF	Regular Force
RSM	Regimental Sergeant-Major (CWO)
STF	Strengthening the Forces
TLD	Third Location Decompression
U of S	Universality of Service
US	United States
VCDS	Vice Chief of the Defence Staff

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This paper represents a multifaceted learning experience that was both professionally enlightening and emotionally demanding for me as an officer and a commander. I have realized the perceptions and magnitude of mental health care in the Canadian Forces (CF) are frequently skewed by a lack of education and knowledge by many inside and outside the service. Health care professionals within the CF have made great strides in the care of our wounded soldiers but the issue remains a leadership function which must never be abdicated. On that same note, the duty for the ultimate care and stewardship of mentally injured soldiers resides with everyone who is in contact with the victim, namely their leadership, the medical system, family and peers. No matter how strong or prepared a soldier is for battle, even warriors can break. The question is not why they broke but what is required to remedy the issue and mitigate the risk of it happening again without assigning them a label or ignoring their needs.

I would like to thank the fraternity of spirited and passionate leaders who have provided me with the information and understanding required to bring this broad topic under one cover. It is evident that the future of the Canadian Army (CA) resides in its fighting spirit, which is fostered through training and a warrior culture that embraces mental health as a foundation pillar. I can only hope that the barriers begin to crumble and the stigma surrounding mental injuries dissolve as we learn from the past and embrace the future by caring for Canada's most valuable resource; the Canadian soldier.

Finally, I would remiss if I did not thank Dr Okros, Teresa, Wayne, Murray and most importantly, Marie-Chantal for their encouragement and honesty.

ABSTRACT

The CF has fought hard in Afghanistan for nearly a decade. Though the members of the CF have grown in their capability and experience through their involvement fighting counter-insurgency, the war has taken a significant toll on the soldiers involved. Having suffered precious loss of life and countless injuries, one specific ordeal which continues to challenge the CF is Operational Stress Injuries (OSIs).

OSIs have existed under different names and labels since warfare has been practiced, be it Soldier's Heart, Shell Shock, War Neurosis, Combat Fatigue, Combat Stress, Battle Fatigue or Post-Traumatic Stress Disorder (PTSD). Despite the different forms and designations, the reality is that mental health injuries continue to plague many soldiers and must be carefully managed as many cases will not surface until years after re-deployment.

As the tempo of operations in Afghanistan decrease and the mission draws down, many of the victims of these injuries will require assistance from the multifaceted system of care which has been established and improved under the umbrella of many new initiatives in the CF. In order to encourage soldiers to seek help for their trauma, all parties involved in the process must understand the injury, the assets available and the expectations of the organization and the individual.

This paper aims to provide a broad appreciation of the mental health injuries and the related issues, the programs and structure which exists in the CF to aid in this sometimes daunting challenge, in addition to key steps required to prepare the CF and specifically the CA for the future.

OPENING REFLECTION

Mental Cases

Who are these? Why sit they here in twilight?
Wherefore rock they, purgatorial shadows,
Drooping tongues from jaws that slob their relish,
Baring teeth that leer like skulls' tongues wicked?
Stroke on stroke of pain, --but what slow panic,
Gouged these chasms round their fretted sockets?
Ever from their hair and through their hand palms
Misery swelters. Surely we have perished
Sleeping, and walk hell, but who these hellish?

-- These are men whose minds the Dead have ravished.
Memory fingers in their hair of murders,
Multitudinous murders they once witnessed.
Wading sloughs of flesh these helpless wander,
Treading blood from lungs that had loved laughter.
Always they must see these things and hear them,
Batter of guns and shatter of flying muscles,
Carnage incomparable and human squander
Rucked too thick for these men's extrication.

Therefore still their eyeballs shrink tormented
Back into their brains, because on their sense
Sunlight seems a bloodsmear; night comes blood-black;
Dawn breaks open like a wound that bleeds afresh
-- Thus their heads wear this hilarious, hideous,
Awful falseness of set-smiling corpses.
-- Thus their hands are plucking at each other;
Picking at the rope-knouts of their scourging;
Snatching after us who smote them, brother,
Pawing us who dealt them war and madness.[1]

---

[1] The Wilfred Owen Association, "Mental Cases."
http://www.wilfredowen.org.uk/poetry/mental-cases; Internet; accessed 16 April 2012.
Note: As noted by one critique of the poet by Wilfred Owen, "the poem focuses on the effects (physical and mental) on returning soldiers from WWI. Owen develops animalistic characteristics and imagery of these men suffering shell-shock, or as we know it, post-traumatic stress. He describes how the men are continuously haunted by their horrific experiences, and by the memories of their friends and fellow soldiers who were not as fortunate to survive; which is ironic, as the men are seemingly or (wished they were) already dead." This poem has been included as an opening reflection on the stress and turmoil that soldiers can experience in operations and war. It is not argued within this paper that veteran soldiers of Afghanistan lived through the same type of warfare as those soldiers in WWI. The practices and operational stress experienced in a counter-insurgency environment have brought on a different form of 'shell-shock' which will be explored within this paper.

INTRODUCTION

AN OVERVIEW OF THE CURRENT SITUATION

Once divided…nothing left to subtract…
Some words when spoken…can't be taken back…
Walks on his own…with thoughts he can't help thinking…
Future's above…but in the past he's slow and sinking…
Caught a bolt 'a lightnin'…cursed the day he let it go…
Nothingman…

- Eddie Vedder, Pearl Jam[2]

Since 2002, Canada has been engaged in security operations in Afghanistan that have demanded combat skills specific to a counter-insurgency operation unlike anything we have experienced since the Boer War. The decision to move the weight of the Canadian contingent and its fighting force from, at the time relatively quiet capital of Kabul, to the southern and more volatile province of Kandahar in 2006 brought with it secondary and tertiary order of effects that were predominantly unfathomable at the time.[3] The soldiers of the CA adapted with a surprisingly, yet historically characteristic, indomitable warrior spirit to the ruthless and unpredictable tactics of the insurgency. However, there was a quantifiable costly toll as veterans returned home to Canada with injuries that impacted the health and wellness of the force in both the short and long-term. There is no doubt in the minds of many serving soldiers and retired veterans of

[2] Eddie Vedder, *Nothingman*, Vitalogy, Brendan O'Brien, (Epic Records, 1994), track 5.

[3] Note: A key Surgeon General report date November 2011 titled "Cumulative Incidence of PTSD and Other Mental Disorders in Canadian Forces Personnel Deployed in Support of the Mission in Afghanistan, 2001 – 2008" indicates very clearly that, "the Canadian Forces (CF) have deployed over 40,000 individuals in support of the mission in Afghanistan since its inception in 2001; more than 150 have lost their lives, and many more have been seriously injured. For this reason, interest in long-term psychological effects of CF deployments has never been greater." An exceptional but absolutely required emphasis is being placed on mental health and it is important to make this statement at the beginning of this paper.

the CF that our role in the long, bloody fight of Southern Afghanistan was extremely worthwhile for many reasons if not for anything else, the professional credibility that we reaffirmed as a modern combat-capable force that went toe-to-toe in partnership with like-minded countries against an enemy that had terrorized the world.

Though highly adaptable, agile and resilient in battle, in Afghanistan the Canadian soldier was confronted by a seemingly uncontrollable environment characterized by the use of the non-discriminant improvised explosive device and unconventional ambush tactics. Despite the very recent preceding years of organizational operational experience gained in the Balkans and other missions, the ruthlessness and resolve of the Taliban foe consistently tested the will and ability of the CA to fight and win. In this regard, soldiers of all ranks and trades lived through many dark days of strain and sadness, which for some, created injuries that would not easily be diagnosed or identifiable to the leader's eye or in many cases, by the soldiers themselves. Known as OSIs and PTSD, these silent and often invisible injuries have imposed a considerable tax on the wellness and operational effectiveness of a small, yet very capable Army. Certainly not a new phenomenon, it is somewhat reassuring that OSIs and the symptoms associated with PTSD appear to more commonly recognized by an institution that has been taking enhanced professional measures to facilitate the healing of soldiers who require assistance on their own personal road to recovery from these sometimes fatal wounds.

So what is the CF and more specifically, the CA, doing to address the impact of these injuries on the soldiers, their units and their families today? Before attempting to explore the issues related to mental health injuries, it is first prudent to understand some of the key aspects of these injuries as defined by experts around the world who are embroiled with battling these serious wounds and developing an inherent professional understanding to assist the individuals and organizations to cope with the after effects.

Stress as a condition of human reaction to extraordinary situations is certainly not a new phenomenon. The ability of individuals to manage stress is exactly that, an individual's ability to react and manage. Veterans Affairs Canada (VAC) defines an OSI as:

> "any persistent psychological difficulty resulting from operational duties performed while serving with the Canadian Forces. These psychological difficulties can include post-traumatic stress disorder (PTSD), depression, anxiety, and addictions. An OSI can occur as a result of a variety of stresses including exposure to a traumatic incident, cumulative exposure to human atrocities, or simply the sustained exposure to intense military operation."[4]

Therefore, by its definition, OSIs includes PTSD. "The term operational stress injury is unique to the Canadian Forces. It defines any persistent psychological difficulty resulting from operational duties performed by a Canadian Forces member."[5] Having said this, for clarity and the benefit of the discussion in this

---

[4] Veterans Affairs Canada, "Evaluation of the Operational Stress Injury (OSI) Clinic Network." http://www.veterans.gc.ca/eng/department/reports/deptaudrep/osi_eval_oct08#ftn2; Internet; accessed 27 February 2012.

[5] Lieutenant-Colonel Philip F.C.Garbutt, "The Paradox of Fight or Flight: A Leadership Guide to Understanding and Mitigating Operational Stress Injuries." *In Human Dimensions in Military Operations – Military Leaders' Strategies for Addressing Stress and Psychological Support* (2006): 15-1.

paper, it is prudent to provide a very concise definition of PTSD as it is recognized by the military community. VAC further defines PTSD in simple terms as:

> "a psychological response to the experience of intense traumatic events, particularly those that threaten life. For military personnel the trauma may relate to direct combat duties, being in a dangerous war zone, or taking part in peacekeeping missions under very difficult and stressful conditions. PTSD can affect people of any age, rank, culture or gender."[6]

Commonly, there are two distinct categories of PTSD that are known as 'acute' and 'chronic'. In simple terms, acute is a condition that is temporary and chronic is more enduring in nature and can last a lifetime.

This paper will explore the effectiveness of the various tenets of the education system and support services for mental health injuries provided by the CF and more specifically, within the CA. Though it would be expected that a conclusive and pointed stance is required in a paper of this stature, it seems more practical and realistic to adopt a 'devil's advocate' approach to the subject in order to draw out both the positive and not-so-positive aspects of the care being rendered. This approach will also help to identify the gaps that need to be resolved in this extremely important subject so that 'total care' is achieved through the various stages of deployment for both the Regular Force (Reg F) and Primary Reserve (PRes) soldiers of all ranks that suffer from these invisible injuries. Equally, issues of this magnitude must be considered insofar as how they are managed institutionally notwithstanding many excellent initiatives have

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[6] Veterans Affairs Canada, "Post-Traumatic Stress Disorder (PTSD) and the Family." http://www.veterans.gc.ca/eng/mental-health/health-promotion/ptsd_families#a01-2; Internet; accessed 27 February 2012.

been made to prepare soldiers at all levels through resiliency and hardiness training.

The scope of this paper will be broken down into three chapters, each exploring different aspects of mental care. The first chapter will explore the issue at hand in order to define the many related problems that stem from mental health injuries, namely some of the root causes, the stigma associated with mental injuries, family and peer support, negative coping and suicide. The overall impact of this unique stress trauma on soldiers is well documented by the CF and its Allies. The second chapter will examine the programs that are present pan-forces to cope with the mental health conditions that have been identified by medical health professionals. These programs span strategic policy to tactical effect, having been developed in response to the growing need of the CF to acknowledge, recognize and manage the lasting effects on our soldiers while serving and on retirement. The final chapter will discuss the 'next bound' in this evolving fight, focusing on the tools available to leaders at the "coal face" who must become and remain attuned to the needs of their soldiers throughout every phase of deployment. It will study the specific CA initiatives in the professional development (PD) realms in order to institutionalize the comprehensive understanding of the effects of mental health as indicative across the phases of war and across the full spectrum of conflict. This chapter will also draw out some of the principles and linkages posited by examining findings and examples from the PRes and our like-minded Western Allies.

CHAPTER 1

EXPLORING THE SCOPE OF THE ISSUE

For many families, the memories of the departure, and all the plans and hopes for tomorrow, are shattered when the loved one returns. He comes home, but he's different. He returns from that faraway place, but yet a part of him seems to be there still, thousands of miles away.[7]

-Colleen McCarty-Gould

INTRODUCTION

As an institution that has a very unique mandate from the government and the Canadian people, it should come as no surprise that the life of a soldier and their inherent health are vital to the overall effectiveness of the organization. Though it is beyond the scope of this paper to explore the detailed medical science behind stress injuries, it is important to understand the breadth of mental injuries and some of the related challenges that exist for soldiers while exposed to combat operations and when they reintegrate back into their home units and families. As the Army Dispatches journal noted,

> "Soldier's Heart. Shell Shock. Combat Fatigue. Combat Stress. Battle Fatigue. Post-Traumatic Stress Disorder. Stress injury is not a new phenomenon. The terms above demonstrate the sad reality that stress injury has been around for a considerable period of time but has never quite been understood properly. Whatever terms are used to describe stress injury—rightly or wrongly, as the terms above are not all related to the same disorder—they all describe soldiers who for any number of reasons are unable to cope with the demands of battle at a certain point in time. Dealing with stress reaction involves the ability to control stress not avoid it."[8]

[7] Colleen McCarty-Gould, *Crisis and Chaos: Life with the Combat Veteran*. (New York: Kroshka Books, 1998), xiii.

[8] Department of National Defence, Dispatches Volume 10, no. 1. *Stress Injury and Operational Deployments*. (Ottawa: DND Canada, 2004), 2.

Therefore, the aim of this chapter is to outline the various types of operational stress injuries as they are recognized today, their major causes, and the effect that they have on the soldier, their families, and the institution as a whole.

In order to best understand the trials and tribulations of someone suffering from mental injury, it is important to highlight the stigma that can frequently inhibit the immediate care for some soldiers who may avoid seeking help due a perceived negative impact on their careers, as well as a tarnished image in the eyes of their peers, families and chain of command. This perception management concern has been a priority for the institutional leadership within the CF for many years, but it can only truly change with a shift in the culture that is inclusive of all CF members, from the trained recruit to the very top echelons of command. In that respect, it is undeniably an organizational cultural issue that must be transformed over time. Additionally, throughout this examination, the intent is to also outline some of the major secondary and tertiary effects of soldiers who are faced with injuries that they may or may not recognize they possess due to the obscure symptoms that can sometimes surface many months and years after re-deployment.

TYPES AND CAUSES OF OPERATIONAL STRESS INJURIES

OSIs and PTSD were defined in the introduction but like most medical terminology and labels, the average soldier has a tendency to refer to any stress injury as PTSD even though there are various types and degrees of injury that exist. This perception and common mislabeling is partially due to the media over

generalization associated with PTSD (in an American context), whereas within the CF, it is the term OSI that covers a broad range of injuries. In an article of a recent CF medical book focused on deployed mental health care resources for CF members while in Afghanistan, the authors delineated clearly these different conditions and expanded on some of the common misbeliefs as follows,

> "Contrary to popular thought only about half of all cases presenting to mental health are related to psychological trauma. The remaining cases represent other illnesses and likely reflect the base rate of these illnesses in the population. Most cases fit into four categories: pre-existing conditions, new onset of illness; trauma related disorders and psychosocial issues."[9]

Therefore, not all stress injuries fit neatly into a category of new OSIs incurred during a combat tour. Additionally, though this definition was written to reflect care while in theatre, it speaks to the range of issues that must be managed by the mental health professionals and unit chains of command whether they are deployed or at home.

Coupled with the above delineation of categories of mental health injuries are those which result from other incidents like blast injuries. The re-immergence of the condition known as mild traumatic blast injury (mTBI) has also created widespread research and attention within the CF and other troop-contributing nations to Afghanistan. According to some US press articles "[mTBI] has sometimes been referred to as the signature injury of the Iraq and Afghanistan

[9] Colonel Rakesh Jetly and Major Alexandra Heber, "Mental Health Care for Canadian Forces Members in Afghanistan." in *Shaping the Future: Military and Veteran Health Research* (Kingston: Canadian Defence Academy Press, 2011), 154.

wars."[10] As one article on blast induced mTBI suggests, there is frequently overlap between those soldiers who experience mTBI and PTSD. It further explains that,

> "One of the striking features of the mild TBI cases being seen in the current OIF/OEF [US named operations in Iraq and Afghanistan] veterans is the high prevalence of PTSD. PTSD or depression is present in more than one-third of OIF/OEF veterans with suspected postconcussion syndromes secondary to mild TBI. This coincidence could reflect dual exposure to blast as well as stressors that can independently cause PTSD. However, the clinical distinction between a postconcussion syndrome and PTSD is often difficult, with the 2 disorders having many overlapping symptoms. In both disorders, complaints of fatigue, irritability, and poor sleep are frequent."[11]

This paper will not expand on mTBI experienced amongst Canadian Afghan veterans as it would require significant explanation. Having said this, it is important to note that beyond the scope of well-known stress injuries, there are other conditions that may exist within those soldiers that experienced blast injuries in the course of their duties. These injuries present an additional serious challenge prevalent in the CF, which requires the close attention of both the medical community and unit leadership.

The types and array of mental health injuries are important to appreciate because they speak to the complexity of the issue for the CF insofar as providing treatment to the soldiers. Within the OSI spectrum of injuries, the causes can be viewed by a simple depiction as illustrated in figure 1.1 below.

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[10] Gregory A. Elder, Effie M. Mitsis, Stephen T. Ahlers and Adrian Cristian, "Blast-induced Mild Traumatic Brain Injury." Psychiatric Clinics of North America Vol. 33, Issue 4, (2010): 757.

[11] *Ibid*., 769.

Figure 1.1: Causes of OSIs extracted from Legion Magazine article titled "Minds At War: Operational Stress Injuries" which the author adapted from the National Defence Joint Speakers Bureau[12]

Many sensationalized media stories may lead the public to believe that all soldiers suffer from OSIs due to close encounters with the enemy or bloody battles. Despite these claims, which may be applicable for some soldiers, there are many root causes for such injuries and trauma, fatigue, grief and moral injury as depicted above encapsulate the actual sources of wounds. Also, contrary to what may be expected of soldiers in extremely stressful situations, not every soldier exposed to the same situation will react the same, which infers that some could develop an OSI while others will not. There are several reasons for the different individual reactions to stressful situations. Frankly, no reaction is more justified than the other, they are simply different and they must be understood by both leaders and soldiers. The effect of stress on the soldier is explained in an

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[12] Sharon Adams, "Minds at War: Operational Stress Injuries." http://www.legionmagazine.com/en/index.php/2009/12/minds-at-war-operational-stress-injuries/ ; Internet; accessed 10 March 2012.

analogy of a paper describing the US Marine Corps model as seen in figure 1.2 below.

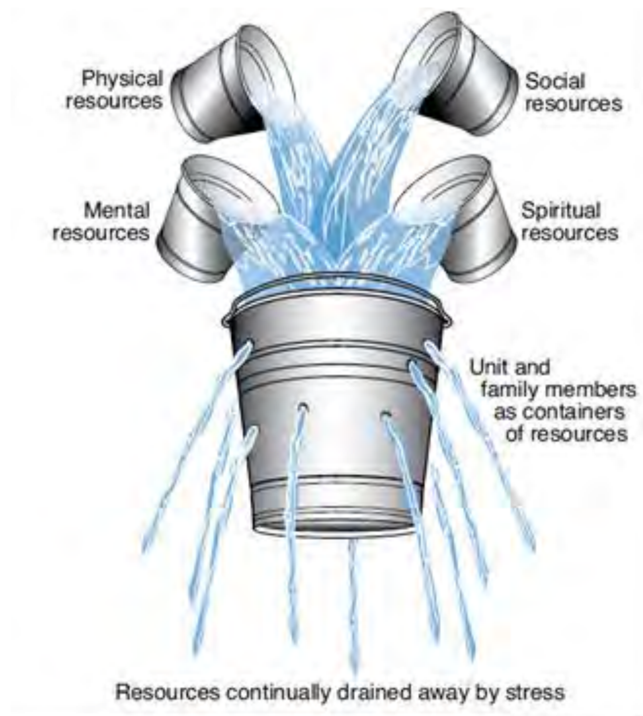

Figure 1.2: "Leaky bucket metaphor for stress" extracted from "US Marine Corps and Navy combat and operational stress continuum model: A tool for leaders."[13]

Figure 1.2 depicts the influence of stress on the soldier with the objective of presenting a model to assist in mitigating these stressors. As noted by William Nash, "because no service member, however strong and well prepared, is immune to stress, the prevention of stress injuries and illnesses requires continuous

[13] William Nash, "US Marine Corps and Navy combat and operational stress continuum model: A tool for leaders." *Combat and Operational Behavioral Health*. Journal on-line: available from http://www.bordeninstitute.army.mil/published_volumes/combat_operational/CBM-ch7-final.pdf; Internet; accessed 15 March 2012.

mitigation of stressors to which the unit and individuals are exposed."[14] This careful balance is undoubtedly a daunting challenge for today's leaders in unpredictable operating environments like those experienced in counter-insurgencies in Afghanistan. The Marine Corps model serves as an example of the acute awareness and action required of the individual soldier and their leaders to ensure the bucket does not dry out as it must, "be constantly refilled through sleep, rest and other forms of replenishment."[15] The six phases of the Road to Mental Readiness (R2MR) which will be described in chapter 3, aid in addressing this constant replenishment. Throughout all stages of the deployment, soldiers are encouraged to leverage the education, activities and facilities which will enable this revitalization. In summary, this leaky bucket analogy truly speaks to the requirement for a soldier to enhance their overall resilience through sustained structured replenishment.

FIGHT OR FLIGHT- WHAT IS IT?

It has behooved many military experts to study the theory of "fight and flight" as it has pertained to soldiers in combat for many generations though sometimes coined or referenced differently. As summarized in a 2004 CA Army Dispatches journal, it is summarized as follows:

> "Life-threatening situations will cause your adrenal glands to begin pumping either adrenaline or noradrenaline into your system. In the case of adrenaline, your body is placed in a state of hyper alertness: your heart rate, blood pressure, muscle tension and blood

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[14] *Ibid*., 113.

[15] *Ibid*

> sugar level all increase. The adrenaline surge allows your body to become more capable of either fighting back against, or running away as powerfully as possible from, the threat. This is often referred to as the fight-or-flight response. Essentially, your body has been given a super boost of energy. The boost in energy also manifests itself in heightened sensory data. Sounds, smells and other sensory data become more acute and tend to be impressed upon our memory more fully than normal. This explains in part why trauma is sometimes played back over and over when triggered by certain stimuli."[16]

Therefore, another aspect to OSIs can be explained through this well-known reaction which has been studied and briefed very recently by such prominent figures as Dr David Grossman, Daryl Paulson and Stanley Krippner[17]. Paulson and Krippner explain this condition as it relates to PTSD as:

> ". . . the physiological pattern of PTSD involves the endorphins that are released into a person's bloodstream during the 'fight or flight" emergencies. This is an adaptive response; endorphins have a tranquilizing effect as they release one from the feelings of anxiety, depression, and inadequacy that accompany trauma and subsequent PTSD."[18]

Without delving too elaborately into the actual physiology of the brain and the chemicals released, it is suffice to say that these dissimilar responses within soldiers can result in mental health injuries.

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[16] Department of National Defence, Dispatches Volume 10, no. 1. *Stress Injury and Operational Deployments*. (Ottawa: DND Canada, 2004), 2.

[17] Capt J.N. Rickard, "The Canadian Army and Fighting Power." The Army Doctrine and Training Bulletin, Vol. 6, No. 3 (Fall/Winter 2003): 37.
Note: Dr Grossman has written extensively on the 'fight and flight' concept and has championed many speaking engagements with militaries and paramilitaries around the world in particularly the US and Canada. His two major books titled *On Killing: The Psychological Cost of Learning to Kill in War and Society* and *On Combat: The Psychology and Physiology of Deadly Conflict in War and in Peace* have been part of professional development for leaders preparing their soldiers for combat in Afghanistan.

[18] Daryl S. Paulson and Stanley Krippner, *Haunted by Combat- Understanding PTSD in War Veterans*. (Lanham: Rowman & Littlefield Publishers, Inc., 2010), 5.

MENTAL HEALTH STIGMA AND PERCEPTION MANAGEMENT

There should be little doubt that the personal journeys of General (retired) Roméo Dallaire or Lieutenant-Colonel Stéphane Grenier after their deployments in Rwanda have assisted tremendously in the exposure of the effects of mental health disorders on soldiers who operate in extraordinary conditions in service to their country. Unfortunately, the struggles of these veterans alone are not sufficient to eliminate the stigma that accompanies mental injuries within the CF and Canadian population writ large.[19] The attitude that is commonly fostered in the military is such that it creates barriers for those who require help. Not being perceived as a warrior or worse, being seen as a weak individual, is unfortunately a major dilemma that can prevent a soldier from seeking the assistance required to heal their suffering. One US guide noted, "the reality is that injuries, including psychological injuries, affect the strong and the brave just like everyone else."[20] In a House of Commons committee report on support for veterans with PTSD and OSI, it provides insight into this stigma as follows:

> "While this is mostly a military issue, it is important to recognize that the attitudes of others are still a major influence on what injured individuals, whether they are in the military or have become veterans, think about their situation. If there is still a stigma attached to people who seek treatment for an operational stress injury, it is almost certain that many injured individuals will

[19] A recent CA Senior Leader's Guide to Mental Health published in September 2011 defines stigma as, "a mark or token of infamy, disgrace, or reproach. Stigma includes the use of negative labels to identify a person living with mental illness. It is about disrespect and keeps mental illness in the closet. Stigma is a barrier and discourages individuals and their families from getting the help they need. It closes minds and fuels discrimination. Many say that living with the stigma is worse than living with the illness itself."

[20] Cheryl Lawthorne and Don Philpott, *Combat-Related Traumatic Brain Injury and PTSD- A Resource and Recovery Guide*. (Lanham: The Rowman & Littlefield Publishing Group, Inc., 2010), 113.

> remain reticent to seek treatment or to even admit that they should consult a psychologist. The fact that, for example, the stairs leading up to offices dealing with operational stress injury at CFB Valcartier, are called by some the 'stairs of shame' indicates that there is still work to be done to educate persons within and outside the military and to change attitudes."[21]

Two general characteristics shared by most soldiers are esprit de corps and a guarded sense of warrior spirit. Ingrained in the mindset of soldiers from the day they join and undergo their basic training, these cherished qualities signify their ability to perform in battle alongside their comrades and any threat to the perception that they are capable of continued performance in adverse conditions would be a slight to their individual strength and may injure their pride. As Keron Fletcher stated about the US experience in Iraq, "terms such as 'lack of moral fibre', 'malingerer' or 'neurotic' carried the implication that some form of shameful weakness, moral fault or cowardice played an important part in the development of psychological and behavioural problems."[22] Later in this paper, the resilience required for soldiers to continually perform in high stress environments will be discussed. Having said this, it is clear that continued stigma is a factor that deters from adequate care for some individuals within the military system. As Paulson and Krippner indicate, "instead of feeling stigmatized by asking for psychological help, veterans should realize that it takes strength and courage to request assistance."[23] Additionally, they add that, "[seeking

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[21] *Report of the Standing Committee on Veterans Affairs*, The Honourable Rob Anders (Ottawa: Communication Canada, 2009), 9.

[22] Keron Fletcher, "Combat Stress (The Ex-Services Mental Welfare Society), Veterans and Pyschological Trauma." Chap. 5 in *War and Health- Lessons from the Gulf War*. (Chichester: John Willey & Sons Ltd., 2007), 101.

[23] Paulson and Krippner, *Haunted by Combat*…, 54.

assistance] is not shameful nor an act of weakness; it is a manifestation of self-love and self-respect that enables one to love others as well."[24] All of these comments within the US context indicate that stigma and perception is not only a problem within CA soldiers but also one that persists in other Armies around the world.

In an article titled, "The Operational Stress Injury Social Program: A Peer Support Program in Collaboration between the Canadian Forces and Veterans Affairs Canada," the authors explore the creation of the Operational Stress Injury Social Support program (OSSIS) and articulates the obstacles in the CF as follows:

> "Common barriers to seeking treatment include fear of loss of military career, the stigma attached to having psychological problems, feelings of shame, fears of being considered weak or a burden by the chain of command, and fears of being considered a faker or freeloader by the institution or by one's friends."[25]

It is not suggested that the CF take the issue of stigmatization lightly as a significant amount of progress has been made within the CF to combat the stigma, attitude and prejudice related to mental health injuries, such as the creation of the Mental Health and OSI Joint Speakers Bureau.[26]

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[24] *Ibid*

[25] Stephane Grenier, Kathy Darte, Alexandra Heber and Don Richardson, "The Operational Stress Injury Social Program: A Peer Support Program in Collaboration between the Canadian Forces and Veterans Affairs Canada." Chap. 13 in *Combat Stress Injury- Theory, Research, and Management* (New York: Routledge Taylor & Francis Group, 2007), 286.

[26] *Report of the Standing Committee on National Defence*, The Honourable Maxime Bernier (Ottawa: Communication Canada, 2009), 45.

Based on the abundance of research in Canada and like-minded nations, it stands to reason that one of the systemic issues that continue to preclude soldiers from seeking care is the attitude within society and the military cultural perceptions pertaining to mental health.[27] Compounding the individual challenges of those who have injuries and avoid care are the other behavioural problems that fester as a result of untreated trauma. A soldier's actions and behaviours while dealing with the darkness of stress injuries at home with their families and within society can lead to additional crippling stress. It is therefore worthwhile to explore the impact on military families and the negative coping that stem from personal struggles.

MILITARY FAMILIES AND PEER SUPPORT

It is the author's opinion that the life balance of most soldiers stems from their professional fulfillment (realized or expected) for their chosen profession, the respect of their fellow soldiers (buddies) and most importantly, the love of their families. It is recognized within the CF that military families are exposed to extraordinary stressors uncommon of other Canadian families due to the lifestyles created by having a service member within their household.[28] Frequently posted between bases within Canada and abroad, adapting to new environments and social structures, the CF family is also forced to manage and cope with the soldier

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[27] Stephane Grenier, Kathy Darte, Alexandra Heber and Don Richardson, "The Operational Stress Injury Social Program…, 281.

[28] *Report of the Standing Committee on National Defence*, The Honourable Maxime Bernier, 1.

who leaves and returns with an increased frequency and duration. Deployment on operations to places like Afghanistan have created new stressors on the modern day military family that tend to manifest more on reintegration than on departure or during absence. As the Chief of Defence Staff (CDS), General Natynczyk wrote in a 2010 editorial for Frontline Defence, “we put on this uniform because we want to go somewhere and make a difference for Canada. Yet the pressure, the pressure is always on our families.”[29] These challenges are not simple nor are they the same for every family.

So what happens to a military family when a mentally injured soldier comes home? A multitude of different scenarios can be expected when an injured soldier returns home from deployment and commences the reintegration phase, with the outcome often dependent on the individual’s willingness to seek help or even acknowledgement that a problem exists.[30] There is extensive research and documentation that explore the different feelings and attitudes of both the members and their families during this awkward but crucially important phase of deployment. As noted by Lawthorne and Philpott, “stress reactions in a returning war veteran may interfere with the ability to trust and be emotionally close to others.”[31] A common theme that is broadly understood is the requirement for soldiers to re-adjust back into their home lives after having lived in a high stress

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[29] General Walt Natynczyk, “Projecting Power.” FrontLine Defence, Issue 3 (May/June 2010), 18.

[30] R. Blaine Everson Charles R. Figley, “Seeing Systems: An Introduction to Systematic Approaches with Military Families.” Chap. 1 in *Families Under Fire*. (New York: Routledge, 2011), 17.

[31] Lawthorne and Philpott, *Combat-Related Traumatic Brain Injury*…, 148.

environment unlike their normal routines. In the book *Courage After Fire*, which explores coping strategies it notes that, "after someone experiences war, connecting with others becomes much more difficult. Because war was often involves loss or threat of loss, you might worry that others won't be there when you need them, even now that you're home."[32] Based on these comments and numerous other sources, it is unquestionable that family members play a key role in providing support and restoring the relationships particularly for injured soldiers, but equally families too experience stress which must be carefully managed. This observation has been noted by the Ombudsman and has been considered by the CF, for example, among the numerous initiatives that exist, OSISS also targets complete assistance to families.[33]

Though not all military families have negative experiences when their loved ones return from Afghanistan, the complexity of re-uniting with a deployed member is inevitably challenging. As noted in a Government of Canada (GoC) report, "many witnesses and published studies have noted the importance of the family which can provide assistance and support to an individual with an

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[32] Keith Armstrong, Suzanne Best and Paula Domenici, *Courage After Fire*. (Berkeley: Ulysses Press, 2006), 172.

[33] Veterans Affairs Canada Responses to the Office of the Veterans Ombudsman (OVO) Observation Papers. *National Defence and Canadian Forces Ombudsman December 2008 report entitled: A Long Road to Recovery: Battling Operational Stress Injuries (Second Review of the Department of National Defence and Canadian Forces' Action on Operational Stress Injuries).* http://www.veterans.gc.ca/eng/department/reports/ovo-response/ovo-report; Internet; accessed 10 March 2012.
Note: The OSISS program is well aware and understands the impacts operational stress injuries can have on the family unit which can sometimes lead to family breakdown. The OSISS program is there to support all families whether together as a unit or separated. The OSISS program definition of family is very broad and support can mean support for spouses, children, parents, siblings and significant others.

operational stress injury."[34] In addition to the injuries to the soldiers that create stress for their families, there are the individual challenges for spouses and children who also endure a unique situation throughout the various stages of deployment. Having exposure to combat, a soldier's "habits, roles, and viewpoints have usually altered in some way."[35] Despite the best efforts of the programs within the CF, the re-integration of soldiers in their respective families is equally an individual effort. Having said this, education and robustness awareness programs will help to educate both the soldier and their families on the signs and symptoms of mental health injuries from post-tour re-integration struggles to chronic PTSD. Through the consistently improving efforts of the CF, a soldier's family is becoming well-positioned to navigate the issues which come home with the soldier so they encourage professional care. The improved structure and emphasis placed on the staffing and professionalization of Military Family Resource Centres (MFRCs) has allowed for consistent resources to be available:

> "MFRCs provide information on subjects of interest to military families, including mental health. They can also provide psychological support through counseling and referral services to complementary programs in the larger, local community."[36]

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[34] *Report of the Standing Committee on National Defence*, The Honourable Maxime Bernier, 1.

[35] Judith A. Lyons and Natasha Elkovitch, "Post Deployment: Practical Guidelines for Warriors' Loved Ones." Chap. 13 in *Families Under Fire*. (New York: Routledge, 2011), 259.

[36] Department of National Defence, The Maple Leaf. *Checking up on Mental Health*. Volume 14, Number 29, (Ottawa: DND Canada, 2011), 11.
Note: Another informative link is www.familyforce.ca.

The careful balance of soldier care in the CF was recognized during the Afghan conflict as it had been in previous CF operations. With many of the Army bases being located in smaller communities within rural Canada, the MFRC provides a strong baseline of support while soldiers are deployed and when they return. In this regard, the care available for spouses and military children is exceptional and continues to evolve as the CF adapts to the challenges of key issues such as mental health.

Coupled with peer assistance, the support of the military family can never be underestimated as it can be, more often than not, the driving mechanism and deciding factor behind those soldiers who self-identify and those who continue to fight their injuries on their own.[37] As the Vice CDS, Vice-Admiral Donaldson noted in a 2011 Speech to the Ottawa Conference on Defence and Security, "…we'll keep working to improve our support to personnel suffering from PTSD and other mental health issues…but we're not perfect. We need to learn and improve how we support our veterans."[38]

As mentioned, peer support of injured soldiers is also a very effective method which has been leveraged in many programs with the CF. A prime example of this type of care is the OSISS program launched within DND in 2001 which grew from the concepts of peer-support using the principles of four models, "mutual support groups; consumer or peer-run services; peers as part of the

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[37] *Report of the Standing Committee on National Defence*, The Honourable Maxime Bernier, 63.

[38] Vice-Admiral Bruce Donaldson, "Speaker Notes from themed conference- The Canadian Forces Post-Combat Mission in Afghanistan." Speech, 2011 Ottawa Conference on Defence & Security, Ottawa, ON, February 25, 2011.

Mental Health Team and workplace embedded peers."[39] The 'invisible injuries' of soldiers can often be observed best by those who they trust and who know them at a very personal level in addition to those who have experienced a similar traumatic event. The encouragement of peers, like those of families, is sometimes the key deciding factor when a member seeks help or not.

MENTAL HEALTH INJURIES AND NEGATIVE COPING

One of the more compelling and damaging sides of mental health injuries grows from the negative coping that many veterans with mental health injuries develop. In a clinician's guide to PTSD it states:

> "There is overwhelming evidence that PTSD, and trauma exposure, are associated with substance abuse disorders. The most common model of posttraumatic substance use disorders is that people self-medicate to minimize the distress associated with posttraumatic responses." [40]

Soldiers suffering from OSIs can sometimes try and cope with their issues through a broad number of destructive mechanisms such as alcoholism, drug abuse, anger, over-working and negative thinking to name a few. By example: "Other potentially long-term problems that may linger after a deployment are feelings of helplessness and powerlessness, somatic complaints, antisocial behaviour, hostility, alcohol and drug dependence, risky behaviours, suicides, and

[39] Grenier, Darte, Heber and Richardson, "The Operational Stress Injury Social Program…, 270-271.

[40] Richard A.Bryant, "Treating the Full Range of Posttraumatic Reactions." Chap. 9 in *Clinician's Guide to Posttraumatic Stress Disorder*. (Hoboken: John Wiley & Sons, Inc., 2010), 217.

accidents."[41] In the course of solving the substantial issue of care for soldiers with OSIs, there is a requirement for the CF to also deal with the other aspects of health that may adversely affect soldiers who try and cope with their injuries by other harmful methods. Each of the negative coping practices bring with them a separate problem, one which further clouds and complicates a soldier's situation on both the personal and professional instances. It is therefore useful to briefly survey these negative coping mechanisms as the impact that they can have is obviously an additional challenge in trying to mend the wounds of a soldier.

Alcohol and tobacco are common vices for soldiers because they are legal and accessible. Alcoholism is a social problem that has deep historical roots within militaries.[42] In McCarty-Gould's book on *Crisis and Chaos: Life with the Combat Veteran*, she indicates that, "alcohol, tobacco and drug use are typical addictions of vets with PTSD."[43] So what is the root of the issue with addictions and the injured soldier? McCarty-Gould further explains that, "the real problem with addictions, the experts claim, is that they confuse the picture of what's

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[41] Deniz Fikretoglu and Donald R. McCreary, "Development of Norms for the Post−deployment Reintegration Scale." Technical Report Prepared for the Defence R&D Canada. (Toronto: Defence R&D Canada, 2010), 366.

[42] Michael Hobson, "After-Care in the Canadian Forces: A New Approach to Traditional Concepts." Speech, Canadian Centre on Substance Abuse National Conference 2007, Edmonton, AB, November 25-28, 2007.
Note: Based on a 2007 report examining the recent history of alcoholism in the CF which was presented to the Canadian Centre on Substance Abuse National Conference, it is stated "as early as 1955 the Canadian Forces recognized a need to assist Canadian Forces members who were experiencing difficulties with alcohol…Around 1974, the Canadian Forces established the first administrative orders, governing alcohol abuse and its treatment across the Canadian Forces as a whole. And the first treatment programs were established, treating some 900 personnel between 1974-1980 for alcohol misuse." It goes on to explain that, "by 1990, the Canadian Forces Medical Services assumed the responsibility for the treatment and care of members experiencing alcoholism. With that standardization of training for aftercare people was seen as a priority." Therefore, the use of alcohol within the CF is not a new issue.

[43] Colleen McCarty-Gould, *Crisis and Chaos…*, 96.

actually going on. Drinking and drug use commonly mask the underlying problem of PTSD."[44] Soldiers who seek venues to relieve their suffering may lean on substances which help them relax or as indicated, mask their injuries.[45]

It is not meant to be implied that all soldiers suffering from OSIs have an addiction but it is well documented in a broad array of current research that soldiers will pursue self-treatment because they are adverse to professional assistance or deny their condition exists.[46] As one CF soldier who was struggling with post-traumatic stress noted in a recent news article, "it [alcohol] numbs the pain. We call it self-medication."[47] Testimonies like this coupled with the professional knowledge of the CF medical system highlight the sometimes surreal situations that can develop in soldiers. Drug use as an avoidance mechanism is not the only form of coping resident within soldiers; anger and negative thinking can also lead to vicious outcomes and aggravate a soldier's OSI.

Within the context of negative coping mechanisms, anger is an ugly and disagreeable emotion which is experienced by many OSI victims. As noted in many recent US publications on anger and PTSD, the regularity and degree of anger expressed as a method of coping with mental injuries is something that is

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[44] *Ibid*

[45] John W.Klocek, "The Physical and Pyschological Impact of Your Injury and Disability." Chap. 4 in *Returning Wars' Wounded, Injured, and Ill: A Reference Handbook*. (Westport: Greenwood Publishing Group, 2008), 36.

[46] Armstrong, Best and Domenici, *Courage After Fire*…, 26.

[47] Alex Roslin, "Alcohol, drug abuse the dirty secret of returning Afghan veterans." Postmedia News, February 27, 2012, accessed March 10, 2012 http://www.canada.com/news/Alcohol%2Bdrug%2Babuse%2Bdirty%2Bsecret%2Breturning%2BAfghan%2Bveterans/6213223/story.html

difficult to hide due to its explosive nature and potential effect on recipients or witnesses.[48] As noted in a US resource and recovery guide, "anger is a frequent problem for trauma survivors, and outbursts of anger are a symptom of PTSD."[49] Irritability is also a characteristic of soldiers suffering from OSIs and these feelings are clearly not healthy and may lead to further alienation and impact relationships.[50] Anger can also lead to violence and within the CF, close attention is focused on domestic abuse and other acts of violence like fighting. Therefore, without delving too deeply into the topic of the secondary effects of mismanaged feelings like anger, it is undeniable that anger as a coping strategy will degrade a soldier's condition in addition to creating other problems which will inevitably be costly such as a broken and alienated family or disciplinary sanctions in the workplace.[51] Anger management courses are prevalent within the CF and are also a part of other OSI specific programs like those found in OSISS.[52]

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[48] Stewart Bedford, *War and PTSD*. (Baltimore: America House Book Publishers, 2002), 55.

[49] Lawthorne and Philpott, *Combat-Related Traumatic Brain Injury*…, 67.

[50] *Report of the Standing Committee on National Defence*, The Honourable Maxime Bernier, 60.

[51] Note: Not all negative coping is experienced outside of the observation of a soldier's leadership. In addition to the health effects of negative coping, soldiers who experience these problems may equally encounter additional stress in their workplace. Abuse of alcohol, fighting and related behavioural issues can lead to disciplinary and administrative actions against a soldier. There is little doubt that this increased exposure in a negative context with a soldier's chain of command can lead to further aggravation and negative feelings for the soldier coping with his injuries.

[52] Department of National Defence, *Operational Stress Injury Social Support (OSISS) Program Policy Statements*. (Ottawa: DND Canada, 2006), 8.
Note: The OSISS Program is a joint Department of National Defence (DND) and VAC Program designed to address some of the many dimensions of OSIs. The OSISS Program is Co-Managed by VAC at the national level.

Another quantifiable characteristic that can be observed within those soldiers suffering from an OSI is negative thinking, self-esteem problems and self-directed blame: "as if the trauma were not enough, the harsh personal judgment and self-rebuke of the sufferer exacerbates the condition. Dysfunctional moods lead to negative self-talk, which increase symptoms, which initiate the cycle anew."[53] Defensive in nature, obviously all forms of negativity cannot be regarded as healthy emotions or productive techniques for a soldier to manage their thoughts and feelings about trauma and experiences they endured. "War often pollutes beliefs about human worth and value . . . you may feel ashamed for having been so scared. These feelings go against your military training and society's expectations that military personnel should be strong and fearless."[54] Linked directly to self-esteem, depression and other darker feelings of despair, negative self-talk could be a downward spiraling behaviour which can reduce a victim to feelings of hopelessness and force them to alienate themselves and their injuries from others. Connected to these heavy emotions are guilt, grief and fear. As a US reference book noted, "someone with PTSD or depression-or anyone who starts to feel down- can start thinking in problematic and non-productive ways that will increase the feelings of helplessness and can make the problems even worse, creating a 'doom loop' style of thinking."[55] There are no leaders,

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[53] Paulson and Krippner, *Haunted by Combat…*, 3.

[54] Armstrong, Best and Domenici, *Courage After Fire…*, 133.

[55] Nathan D Ainspan and Walter E. Penk. *Returning Wars' Wounded, Injured, and Ill: A Reference Handbook*. (Westport: Greenwood Publishing Group, 2008), 43.

families or soldiers who want to fall into this 'loop' but unfortunately, some soldiers do not recover from this potentially crippling or fatal vortex.

MENTAL HEALTH INJURIES AND SUICIDE

The last section of this chapter is one that brings sadness to everyone who encounters a mentally injured soldier and must understand their suffering only after they have taken their lives. Suicide is a real problem and despite the fact that some CF experts would argue that the statistics in the CF are comparable to Canadian society. It can be argued that notwithstanding the comparative analysis of CF members to Canadian population, it is a real problem in the CF and particularly in soldiers suffering from OSIs.[56] From an institutional point of view, the CF and the CA take suicide very seriously and this has been messaged publically by many of the top commanders including the CDS on numerous occasions. As the Chief of Military Personnel (CMP) noted before the Standing Committee on National Defence, "every time there's a death in the Canadian Forces… the announcement of that comes across my desk and I always pause particularly when a suicide comes across. They tend to hit me harder than others."[57] The public battle and tragic stories of soldiers like Corporal Stuart

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[56] Mark Zamorski, *Report of the Canadian Forces Expert Panel on Suicide Prevention*. Report Prepared for the Canadian Forces Health Services Group. (Ottawa: Canadian Forces Health Services Group, 2010), 2.
Note: Suicide is an important public health problem in industrialized nations. It is the second leading cause of death in the demographic group that makes up the bulk of military organizations, namely young and middle-aged men. Hence, it is an important contributor to premature mortality in the armed forces.

[57] House of Commons, Standing Committee on National Defence. *Minutes of Witnesses on the Care of Ill and Injured Canadian Forces Members*. Tuesday, October 25, 2011, 1:41.

Langridge invoke concern from the public, politicians and families of soldiers.[58] As difficult as suicides can be on all concerned, a recent suicide panel noted that, "nearly all suicidal individuals have mental health problems, but more than half are not in care at the time they commit suicide."[59] Therefore, as mentioned earlier, stigma and other barriers continue to be sometimes insurmountable obstacles for some soldiers who do not seek care regardless of the widespread suicide prevention programs and awareness within the CF and Canada.

Coping using anger, substance abuse and negative self-talk can all be managed and many quality outlets and resources exist for dealing with these matters but the suffering which twists a soldier into levels of despair to the point of taking their own life is a very frightening and real problem in militaries today.[60] These outlets and resources within the CF are explored in the next chapter. A plethora of literature in both the CF and US militaries exist insofar as suicide prevention and related topics but the bottom line is detection of high risk soldiers and suicide prevention are not perfect vehicles because this problem continues to affect many units still today.

The complexity of suicide and other negative coping mechanisms is clearly another profound aspect of mental health injuries. These sometimes

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[58] Jordan Press, "Dead soldier's family should have legal funding: military commission." Postmedia News, October 27, 2011, accessed April 21, 2012 http://news.nationalpost.com/2011/10/27/dead-soldiers-family-should-have-legal-funding-military-commission/
Note: Cpl Stuart Langridge was noted as a strong soldier but suffered mental injuries after a combat tour in Afghanistan which led to PTSD, heavy drinking and cocaine use. He committed suicide at CFB Edmonton in 2008 and his parents have been publically displeased with the handling of his situation and critical of the military's actions during and after the tragedy.

[59] Zamorski, *Report of the Canadian Forces Expert Panel on Suicide Prevention*, 6.

[60] Erica Goode, "After Combat, Victims of an Inner War." New York Times, August 1, 2009, accessed April 27, 2012 http://www.nytimes.com/2009/08/02/us/02suicide.html?_r=1&ref=posttraumaticstressdisorder.

awkward and difficult matters must be taken into serious consideration by the members of the CF and specifically, the leaders who are entrusted the care and well-being of their troops through all phases of deployment. Suffice to say that voluntary programs and education may not be the most viable or organizationally sound approach to adopt as a deliberate strategy. Lessons are only ever learned if they are institutionalized simply because institutional amnesia can overwhelm a high-tempo military which, is unfortunately forced to learn hard lessons repeatedly; sometimes at the cost of life.

SUMMARY

The scope of the issues related to mental wellness is broad in many regards but each aspect of these injuries must be understood by the leadership at all levels and the institution as a whole. Though it is beyond the scope of this paper to explore the exact science and medical analysis of OSIs and related illnesses, the focus remains the culture and attitude towards mental injuries that must be successfully applied within the CF and CA to face the challenges of today's operating environment and whatever lies in the future. Undoubtedly, the effectiveness and readiness of the trained Army is inextricably linked to the strength of the individual members within the units designated for operations. Though some may argue that health is an individual responsibility, within the CF overall wellness must be shepherded by leaders. If not, there is a chance that poor health will lead to systemic weaknesses within the deploying forces. Having said this, the next step in this paper will be the examination of the very elaborate programs that exist in the CF to support their members and their families in response to the growing needs of mental health.

CHAPTER 2

KEY PROGRAMS THAT EXIST PAN-FORCES

It has been said that the manner in which a society or institution treat their most vulnerable members is a hallmark of their quality. In the military, none are more vulnerable than those who are injured or become ill. For them, the duty and responsibility to care for our own resides especially with the leadership of the CF, DND, and VAC. I assume my share of that duty and responsibility willingly and completely.

- General W.J. Natynczyk, CDS[61]

INTRODUCTION

As a means of review and comparison, it is critical to examine the broad range of CF programs that exist to assist soldiers and their families. Through the examination of these programs and those of some our closest allies, it will become apparent that a significant amount of time, care and thought is invested into the care of soldiers. Universally, it is recognized that the type of warfare being fought by soldiers today is not only complex but the tempo and duration of operations, tour-length, and repeated tours have a compounding effect on injury susceptibility. Within the CF there are distinct (and sometimes subtle) differences between the care soldiers receive while active members of the Army and those services that fall within the scope of responsibilities of VAC once they are released or retire. The governance models for each organization undoubtedly have some overlap but the end state that is envisioned is one which should, in theory, ensure thorough care for soldiers whether they are fit and return to full duties or released for medical reasons and transition to civilian life.

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[61] Department of National Defence, *Caring for Our Own*. (Ottawa: DND Canada, 2011), 1.

This chapter will focus solely on the programs that exist within the CF for the care of subordinates. These programs range from garrison programs to a very elaborate R2MR and also include task-tailored programs for families. A very important aspect of mental health for soldiers is resilience or hardiness training but this will be covered in chapter 3 as it reflects the future of mental health with the institutional realm of the CA at the professional development levels of the development periods (DP) of training. Within the CF, the emphasis on mental health has been established very clearly from the CDS and it resonates throughout the various levels of command through a multitude of platforms to the soldier. The stewardship and overall ownership of many of these programs and initiatives resides with Chief of Military Personnel (CMP) and more specifically the medical services branch but the execution remains a responsibility of all members and leaders.

This chapter will be broken down by program beginning with the high level messaging to the baseline processes. The intent is to expose the reader to the various dedicated options which are interwoven and complementary in nature but aims to improve the system of care and management so that the all soldiers are afforded top notch attention. References have already been made to the messages of the top generals of the military who recognize that the CF is improving but that it is not perfect. In the void of a perfect all-encompassing solution, leaders must all be charged with the responsibility to harness the good work of the medical professionals and dedicated program staffs in order to aggressively move the yardsticks forward and to close the gap on individuals who

may inadvertently get lost in the system. At the end of the day, the mix of 'canned' programs coupled with personal compassion and discovery will provide the chemistry required to manage the injured and their families so that the forces remain a healthy, highly trained and deployable entity.

STRENGTHENING THE FORCES- OVERALL WELLNESS

One of the primary overarching programs which were initiated by the CF early in the 1990s and recently re-invigorated in 2002 is "Strengthening the Forces (STF)".[62] It is aimed at Regular Force (Reg F), Reservists, DND civilians and their families. Though focused more broadly on the overall health of the Forces vice a particular focus on mentally injured soldiers, the aim of the program is highlighted on the website as follows:

> "Strengthening the Forces is a health promotion program designed to assist Canadian Forces (CF) members, Regular and Primary Reserve, to take control of their health and well-being. Maintaining a high level of health improves one's ability to perform effectively and safely on CF operations, and to enjoy a high quality of life. Some programs are also available to families and other members."[63]

Health issues in the CF, just as they are across society today, are broad in scope and ever-changing. By ensuring the overall wellness of its members across the span of health concerns, STF aims to assist the CF in, "[assisting] its defence mandate [through] the health and physical fitness of its personnel, which is

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[62] Department of National Defence, "Strengthening the Forces FAQ." http://www.cg.cfpsa.ca/cg-pc/Toronto/SiteCollectionDocuments/Strengthening%20the%20Forces%20%20FAQ.pdf; Internet; accessed 16 March 2012

[63] Department of National Defence, "What is Strengthening the Forces?" http://www.forces.gc.ca/health-sante/ps/hpp-pps/wstf-qelf-eng.asp; Internet; accessed 16 March 2012.

fundamental to effective employment and deployment."[64] It will achieve this goal through a strong plan rooted in health-based elements: "a robust and responsive preventive health component is needed to ensure mission capability, sustainability, and success."[65]

In response to some of the negative coping mentioned in the previous chapter, the STF has been designed to attempt to tackle some of the dark mechanisms leveraged by soldiers such as those who are battling mental trauma:

> "The CF also offers evidence-based primary risk factor reduction through its "Strengthening the Forces" health promotion program. These programs target risk factors such as alcohol use disorders, relationship conflict, psychological stress, and anger. The programs may plausibly attenuate suicide risk through risk factor modification.[66]

This evidence draws out a crucial point which is the "risk factor". STF and similar programs provide positive redundancy through overlapping themes on issues which can harm a soldier's health and wellness. They help to reduce risk to soldiers knowing very well that the complete elimination of risk is likely not possible.

Similar to many of our closest North Atlantic Treaty Organization (NATO) partners, the STF program has been designed as one of the fundamental platforms for overall well-being in light of the many problems which can deter from soldier and unit effectiveness. As quoted in the 2010 Surgeon General's report, "STF is designed to enhance wellness, foster healthy lifestyle behaviours,

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[64] Department of National Defence, "Strengthening the Force." http://www.forces.gc.ca/health-sante/pub/sgr-rmc-2010/page-23-eng.asp; Internet; accessed 16 March 2012

[65] *Ibid*

[66] Zamorski, *Report of the Canadian Forces Expert Panel on Suicide Prevention*, 5.

and support leadership in strengthening the culture of health in the CF."[67] This model is complementary to the programs which will follow which focus specifically on mental health. Additionally, any program which aims to improve organizational culture will also help break down barriers like those mentioned previously.

BE THE DIFFERENCE CAMPAIGN- STRATEGIC OVERSIGHT

Without the collective buy-in and confidence of leadership at the very highest echelons, programs can get lost within the system to the many competing demands of a very busy CF in operations abroad and in garrison. As noted earlier in this paper, a major obstacle for soldiers suffering from OSIs is the condemning stigma associated with mental injuries. In response to the growing challenges of soldiers coming home with mental injuries who were sensitive to these labels and inadvertent shame, the CF under the leadership of General Walt Natynczyk and the Minister of National Defence, Honourable Peter McKay, launched the "Be the Difference" campaign in June of 2009. At its release, the campaign was explained as follows:

> "It is essential that all military personnel and former personnel recognize mental health issues when they occur, and that they do not avoid or delay accessing treatment and support services as a result of perceived stigma. With this in mind, the CF are launching a Forces-wide awareness campaign with the theme of "Be the Difference. All personnel, from Sergeants to Admirals, can make a difference in helping their colleagues meet and overcome any mental health challenges that they may encounter – in the course of their military career, and after. This long-term campaign will be sustained by two non-clinical mental health initiatives, the Joint Speakers Bureau and the Operational Stress Injury Social Support

[67] Department of National Defence, "Strengthening the Force."

> (OSISS) network, which were established in 2007 and 2001 respectively to enhance the CF suite of mental health programs and services."[68]

Having been applauded by both the US and the Canadian Mental Health Association, this campaign is the vital message required and has set the example to all leaders with the CF who must now educate themselves and their troops. As noted by the CDS when speaking about the necessity at the unveiling, "you're strong, you're well-trained, but guess what? We don't show weakness particularly well and therein lies the problem."[69]

As seen in media coverage and the film industry, the culture of military organizations has always been symbolized by a style of machismo and stoic resolve in its soldiers. Soldiers are tough warriors with physical prowess and dogged determination. While attempting to inculcate a sense of confidence, motivation and durability in soldiers, they must recognize that they can be injured. Though these statements may hold some truth, it has equally been recognized that there are different stressors which can wound a soldier and they do not all result in an injury which is visible or easily diagnosed. The two non-medical elements and enduring aspects of this campaign are the Joint Speakers Bureau (JSB) and the Operational Stress Injury Social Support (OSISS) network which have been noted already in this paper. In that regard, it is worthwhile to explore a little further OSISS as it relates to mental health injuries.

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[68] Department of National Defence, "Be the Difference: The Canadian Forces Mental Health Awareness Campaign." http://www.forces.gc.ca/site/mobil/news-nouvelles-eng.asp?id=3015; Internet; accessed 16 March 2012.

[69] Cynthia Munster, "MPs push government to take action on PTSD in Canadian Forces." The Hill Times, July 20, 2009, accessed March 10, 2012 http://www.hilltimes.com/news/2009/07/20/%3Cb%3E-mps-push-government-to-take-action-on-ptsd-in-canadian-forces-%3C/b%3E/22147?page_requested=2.

OSISS- PEER SUPPORT BEYOND THE NORM

Though it was explained in the introduction of this chapter that the focus on programs would not include those offered by VAC, a noteworthy exception that is in fact an overlap of DND and VAC is the OSISS program.[70] With that, and in studying OSIs and the institutional structure created to aid in their management, it is fundamental to describe the background and *modus operandi* of a key entity like OSISS. To begin, the mission of the OSISS program is, "to establish, develop and improve social support programs for CF members, Veterans and their families affected by operational stress; and provide education and training in the CF community to create an understanding and acceptance of operational stress injuries."[71] Based on this mission, it can be deduced that OSISS also serves as an educational arm for the CF in addition to its vision which is to "accept, help, and support CF members and veterans injured by operational stress, as well as their families."[72] This noble two-fold effort is over a decade old and it continues to provide extremely worthy services to all soldiers and their families due to its complete coverage and extensive network. Operating under a strong hierarchy and using a strict code of ethics, this program is an essential aspect of soldier care and as mentioned in chapter 1, it models itself off of the use

[70] Note: As noted on the OSISS website (www.osiss.ca), "In 2001, a small group of veterans set up a peer support network composed of staff and volunteers. The network grew and now includes a separate network supporting the families of serving CF members and Veterans suffering from OSIs. These individuals have experienced firsthand what it is like to live with an OSI, or live with someone with an OSI. They have managed to regain their health and are now on a position to help [the soldier with OSI]."

[71] Department of National Defence, *Operational Stress Injury Social Support*…, 3.

[72] *Ibid*

of peer support which is a known successful technique for aiding injured veterans and their families.

JOINT SPEAKERS BUREAU- OUTREACH WHERE IT IS NEEDED MOST

Also covered in the CDS' 'Be the Difference' campaign is the JSB which ultimately aims to actively reduce the perception and alter the negative mindsets towards mental health injuries: "The Mental Health and Operational Stress Injury Joint Speakers Bureau (JSB) was created to build awareness of mental illness and operational stress injuries (OSIs) and to increase understanding and acceptance of these conditions."[73] Awareness and education are well-known successful strategies when it comes to effectively changing attitudes and as mentioned, the scope of OSIs is no exception to this circumstance. Building mindfulness in others through various venues in the CF, the JSB aims at early awareness and can be utilized as a tool by respective units and chains of command in order to promote a healthy outlook on mental health which will inevitably aid those who suffer today and those who may incur injuries in the future.

[73] Department of National Defence, "Mental Health and Operational Stress Injury Joint Speakers Bureau (JSB)." http://www.cmp-cpm.forces.gc.ca/cen/ps/mhosijsb-bccsmbso-eng.asp; Internet; accessed 13 March 2012.
Note: As indicated in the CF Mental Health Awareness Campaign 25 June 2009, "the [JSB] is a partnership of the CF and VAC. Speakers are trained and accredited CF personnel and former personnel, family members and civilian mental health professionals. They spread awareness through formal mental health and OSI training sessions delivered at CF educational facilities, through professional-development briefings delivered at the unit level, and through seminars tailored to the needs of families. Additionally, they deliver the CF's vital pre- and post-deployment training sessions. To date, the CF have identified several ways to reduce the risk of personnel experiencing service-related mental injuries. As part of this reduction of risk, personnel deploying on stressful overseas missions are educated on stress-coping skills, unit cohesion and social support, and awareness of the potential effects of stress. The Joint Speakers Bureau ensures that this training is realistic and that it bolsters confidence in both individual and team capabilities."

CARING FOR OUR OWN- THE OPERATIONAL CAMPAIGN PLAN

Having explained the overarching strategic intent insofar as wellness and awareness, it is now appropriate to turn focus on the baseline program developed with the CF for the care of soldiers through all phase of deployment and upon resulting OSIs. The *Caring for Our Own* program is a comprehensive framework "which organizes the programs and services offered by the government into an integrated system of care for both ill and injured military personnel. Under this system, ill and injured CF personnel can receive the care and support they require."[74] In this regard, it is clear that this package was not solely developed to treat soldiers with mental health injuries but these soldiers are definitely encompassed in the vision and spirit of the founding tenets. Because this model of care is so intricate and has been newly released within the CF, it is important to comprehend its operating basis and its application to the injured soldier.

Figure 2.1: Caring for Our Own Manual published 2011.

[74] Department of National Defence, The Maple Leaf. *Care of our own*. Volume 14, Number 29, (Ottawa: DND Canada, 2011), 10.

Caring for Our Own spans the entire breadth of a soldier's injuries through the recovery, rehabilitation and reintegration phases. As seen below, the common underpinning theme and end state for care remains the soldier's ability to meet the universality of service (U of S) requirements to function as a fit member.[75] Failing to meet the U of S, the CF has developed other initiatives which can see to continued employment in an alternate military occupation or transition to civilian life. Though some critics may see the latter as an unfair consequence of a soldier's service to their country, the CF remains extremely diligent in their approach to soldier care but there must be an element of wellness and a standard by which the military operates based on its demanding national mandate. The phases as explained above are not distinct or separate, as explained in the guideline, but rather they overlap based on the individual soldier's condition.

Figure 2.2: Phases of Caring for Our Own

[75] Department of National Defence, *Caring for Our Own*, 4.
Note: The CF are committed to upholding the U of S principle according to which all CF personnel are liable to perform general military duties and common defence and security duties, and not only those of their military occupation or occupational specialty. The minimum operational standards associated with this principle are the following: a CF member must be physically fit, employable without significant limitations, and deployable for operational duties. U of S is a necessary and equitable approach to reserving the CF's trained effective strength and operational capacity.

The conundrum of U of S and meeting the obligation to wounded soldiers is extremely sensitive and equally difficult to articulate. The important aspect of this dilemma is that a soldier should never be abandoned or ostracized. Between the CF and VAC, they must be provided the care required to assist them in whatever eventuality.

Innovative and inclusive, *Caring for Our Own* is designed to evolve as the science, needs and knowledge of its broad team of CF medical professionals and leaders develops. As stated in the policy, “continuous quality improvement is a fundamental aspect of an effective health care culture; practitioners continually acquire new knowledge and develop new skills to update practice, improve health care outcomes and adapt to changing circumstances.”[76]

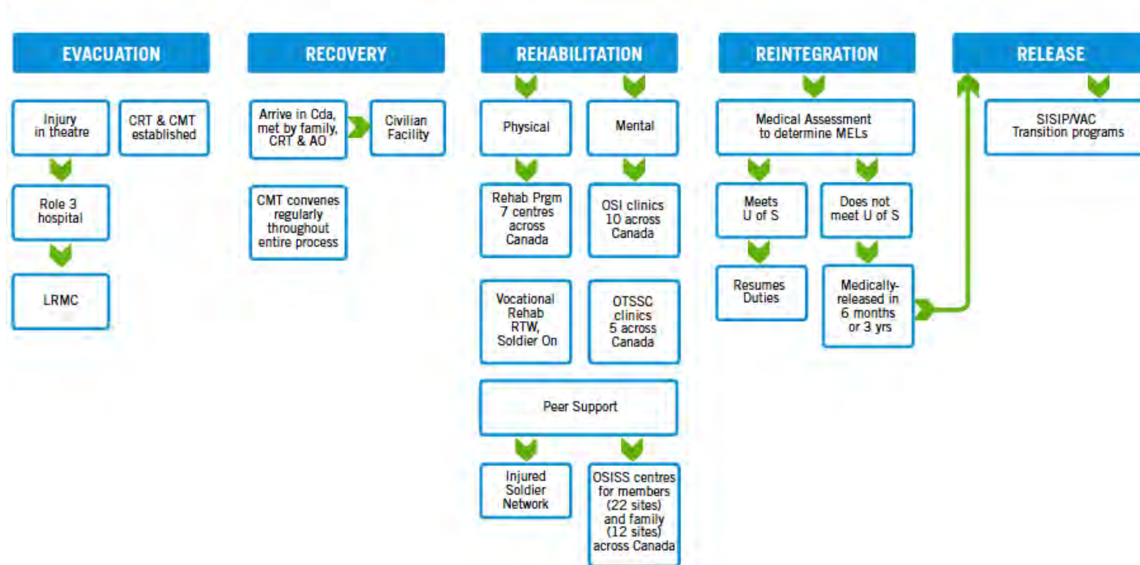

Figure 2.3: Annex A from Caring for Our Own Manual
explains the flow of care from evacuation to reintegration or release.

[76] *Ibid*., 11.

This plan can be viewed as operational in the sense that it appears to be designed using many of the same elements used in operational art; lines of operation, decisive points, centres of gravity, objectives and endstates, language which is readily understood and interpreted by military members.[77]

MENTAL HEALTH FACILITIES- SERVICE SUPPORT

Caring for Our Own makes specific mention to mental health injuries under rehabilitation and states:

> "The psychological fitness of military personnel is an essential component of operational effectiveness, and the provision of mental health care is a key part of the fundamental obligation of the CF to promote the well-being of their personnel. This challenge has become all the more pressing in recent years given the increased reporting rates of mental health disorders among CF military personnel and the heightened risk of operational stress injuries among members returning from deployed operations."[78]

Therefore, mental injuries and specifically OSIs, are nested within this framework and remains a focus area for the CF leadership and medical professionals. A noteworthy initiative as it pertains to this paper is the creation of Operational Trauma and Stress Support Centres (OTSSC) throughout the CF "in response to the increasing prevalence of PTSD and other OSIs."[79] On a large scale, these new

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[77] Note: The author makes this reference because among the many quality programs that exist in the CF, there appears to be a positive structure of plans at each level, strategic, operational and tactical. *Caring for Our Own* is an overall framework for injured soldiers similar to a campaign plan and from it stems the tactical enablers and professional tools required to nurture a soldier using all the powers within the military system.

[78] *Ibid*., 21.

[79] *Ibid*., 23.

programs with its enabling facilities such as the OTSSC are indicative of the exceptional system it provides to the soldiers.

Another recent creation within the CF and nested within the *Caring for Our Own* structure are the Joint Personnel Support Units (JPSUs) and Integrated Personnel Support Centres (IPSCs) which were created and announced in early Spring of 2009 as a means of harmonizing and coordinating services for ill and injured soldiers. As much a resource for soldiers as units managing injured soldiers, their aim is noted as:

> ". . . an integrated and individual-centric service delivery model, to ensure the coordination and facilitation of standardized, high quality, consistent personal and administrative support during all phases of recovery, rehabilitation, and reintegration on return to service or transition following release, for all injured and ill Canadian Forces personnel and former personnel, their families and the families of the deceased."[80]

Though heavily criticized by some political realms for the poor treatment of ill and injured soldiers, the CF generated the JPSU/ IPSC as part of the greater support services required for soldiers. As noted, these centres are equally designed for soldiers who hope to return 'fit full duties'[81] as they are for those who must transition to civilian lives. In any event, the intent behind the initiative is to attempt to standardize services and capture soldiers who would otherwise "fall through the cracks" of the system. The problem of inaccessible support services is something that plagues the PRes Force and it will be further elaborated

[80] Department of National Defence, "Director Casualty Support Management." http://www.cmp-cpm.forces.gc.ca/cen/index-eng.asp; Internet; accessed 14 March 2012.

[81] Note: the term 'fit full duties' is commonly used within the rank and file of the CF to refer to a soldier who meets their medical category for their respective trade. It assumes that the soldier is not on a temporary or permanent medical category and that they are capable of deploying without major restrictions.

in the next chapter. Like OSISS and the JSB mentioned above, the JPSU construct is managed nationally by Directorate of Casualty Support Management (DCSM) within CMP which provides oversight and coordination.[82] Not all of the general services and peer-based services managed by the DCSM have been explained herein but all programs aim to offer options and solutions for the injured soldier and their families.

The last primary and heavily used resource for serving injured soldiers is the accessible and top-rate medical health services within the CF through the 26 Mental Health Clinics across Canada (with the largest mental health clinics being the regional clinics in Halifax, Valcartier, Ottawa, Edmonton and Esquimalt).[83] The Directorate of Mental Health which was officially established in 2009 provides the management and oversight for these facilities. These clinics leverage the expertise and care of numerous professional experts namely, "psychiatrists, psychologists, social workers, mental health nurses, addictions counselors, and chaplains with advanced training in pastoral counseling."[84] The only disadvantage to most mental health services outside of formal screening before and after tours is the voluntary nature by which a soldier accesses these experts. Notwithstanding the stigma discussed throughout this paper, soldiers must generally bring themselves to access services and 'self-identify' for help by going directly to a clinic similar to how they would attend a CF medical clinic for a

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[82] Department of National Defence, "Mental Health." http://www.forces.gc.ca/health-sante/pub/sgr-rmc-2010/page-5-eng.asp; Internet; accessed 16 March 2012.

[83] *Ibid*

[84] *Ibid*

sprained ankle or the common cold. At this juncture, there is no mandatory mechanism which forces soldiers to see mental health professionals outside of the deployment system and this reality will unfortunately lead some soldiers to opt out of care for a number of personal reasons. It is therefore extremely important that the culture of mental wellness change so that more soldiers feel welcome to seek treatment on a regular basis.

Having outlined the strong support services prevalent within the greater CF community, leaders should be empowered by knowing that the CF has "the highest ratio of mental healthcare workers per military personnel of any [NATO] country."[85] The OTSSCs, which were explained earlier, fall within the scope of this new directorate and have major centres in Halifax, Gagetown, Valcartier, Petawawa, Ottawa, Edmonton and Esquimalt.

Based on the programs and services highlighted thus far in this chapter, it could be argued that the CF has established many positive steps insofar as its infrastructure and the quality of its care created within the last two years. Though many of these initiatives are not yet mature, their inception is largely successful and with momentum and continued investment based on experience, they should make rapid progress. Based on the scope of mental health injuries and the size of the active force within the CF and specifically, the CA, it is vital that leaders know how to access these services, be trained to recognize warning signs and counsel their soldiers in order to maximize the impressive support services available so that no soldier goes without the essential care they require. The next

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[85] *Ibid*

program will illustrate a baseline user program (can be viewed as the tactical level) utilized by the CF through all phases of deployment.

ROAD TO MENTAL READINESS- TACTICAL BASELINE

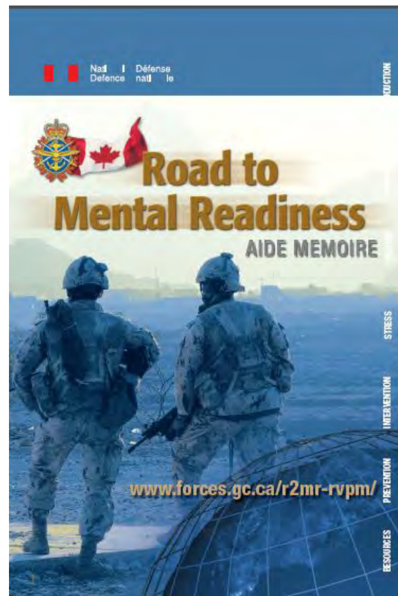

Figure 2.4: Road to Mental Health Readiness Aide Memoire published 2011.

Training has always been a pillar of successful militaries and will continue to be the backbone of how we prepare for battle. The predominant culture within the CA today would determine key training for deployment to be weapons training, driver training, low-level tactics, or communication procedures among many other tactical enabling skills. Despite this mindset, leaders must appreciate in greater depth the other critical aspects of battle preparation as it will inevitably harden their warrior spirits.[86] The R2MR has a strong theme of soldier and family

[86] Department of National Defence, DGM-10-07-00285. *Road to Mental Readiness- Aide Memoire*. (Ottawa: DND Canada, 2011), 1.

preparedness through a series of educational objectives. Some of the key topics covered within the Aide Memoire are the effects of stress on the soldier, strategies to mitigate stress such as the 'Big Four'[87], roles during intervention and suicide prevention. Mental readiness training or as it is known, the R2MR continuum of training as seen in the figure below is a six phase model employed in the CF today.[88]

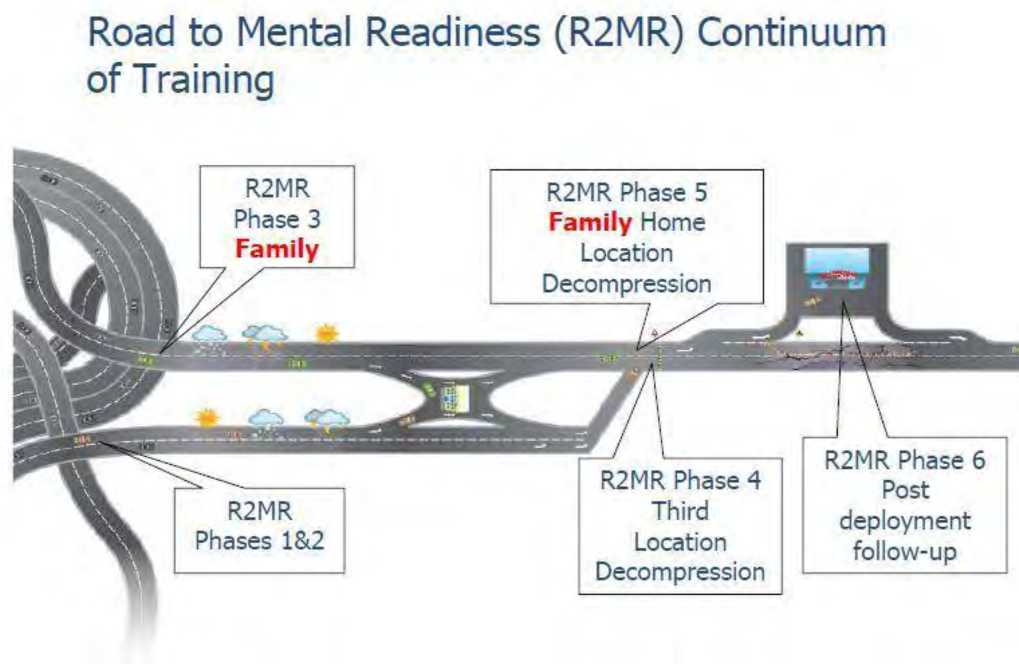

Figure 2.5: Road to Mental Readiness Continuum of Training analogy

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Note: As quoted in the R2MR Aide Memoire, "Leaders should remember that the more troops know about normal reactions to stress, the more resilient they will be at dealing with the stress of military operations." Later in chapter 3, the initiatives of the Army Tactics School will explain the warrior ethos and the role of mental health/ resiliency as a pillar.

[87] Note: As described in the R2MR Aide Memoire, the Big Four is described as "goal setting, mental rehearsal/ visualization, self-talk and arousal reduction: tactical breathing. These countermeasures are also described in the CA's *Senior Leaders' Guide to Mental Health* which was developed in 2011.

[88] Department of National Defence, "Road to Mental Readiness." http://www.forces.gc.ca/health-sante/ps/mh-sm/r2mr-rvpm/default-eng.asp; Internet; accessed 14 March 2012.

The R2MR within the CF is described as:

> "…a Canadian Forces mental health education training package that includes a series of briefings/modules addressing each stage of the deployment cycle for military personnel and their families. While not referred to explicitly as 'resilience training', the curriculum does intend to increase both short term performance effectiveness as well as long term mental health outcomes for soldiers and their families. It aims to prepare CF personnel, leaders and their families to identify and meet the challenges related to deployed operations and geographical family separation."[89]

Working in close conjunction with their Allies, the CF have made significant progress in developing packages like the R2MR and there is little doubt that the nature of the conflict in Afghanistan and the injuries being incurred by our soldiers is a major driving factor in the evolution of these programs. Portrayed as a proverbial road, the time-based phases of this program are aimed at providing a total package for the soldier and their families through a standardized system of training and events. The resilience aspects of this program will be discussed in greater detail in the next chapter as it pertains to the future or the next bound within the CF and specifically, the CA.

It is generally understood that this series of training has become fundamental in the operational effectiveness and overall mission success of deploying soldiers. One report on the findings of the enhanced post-deployment screening of those returning from OP ARCHER (Task Force Afghanistan/OP ATHENA) as of 11 February 2011 states that the existent programs appear to

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[89] *Ibid*

address the personnel requirement and conclude that, "the CF's policies and programs appear to be working increasingly well to keep the psychological impact of the mission to operationally acceptable levels."[90] It is not suggested that training alone will prevent injuries or prevent the stress that lead to OSIs but it certainly aims to equip the soldier with tools required to recognize the mental health challenges of deployment. This curriculum draws on experience of CF members vice pure theoretical training.[91]

It is important to understand the impact of each phase on the soldier. Arguably, in the initial phases of deployment, most soldiers remain focused primarily on their impending tasks in combat and rarely give heed to the confluence of the many constant stressors. Having said this, the last three phases of the R2MR namely, third-location decompression (TLD), family home location decompression and post-deployment inevitably challenges veterans because they are forced between two realities; their tour life and their home life. A couple of recent CF technical reports highlight these differences. In denoting the importance of the post-deployment reintegration period, a DRDC report states,

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[90] Mark, Zamorski, *Report on the Findings of the Enhanced Post-Deployment Screening of those returning from OP Archer/Task Force Afghanistan/OP Athena (as of February 2011)*. Report Prepared for the Canadian Forces Health Services Group. (Ottawa: Canadian Forces Health Services Group, 2011), 1.

[91] Suzanne Bailey, "Overview of Leadership Mental Health Curriculum." (PowerPoint, Canadian Forces Department of Mental Health, Ottawa, ON, February 20, 2012), with permission. Note: The speaker notes of this presentation go on to describe the instructional approach for this training as "[redesigned] packages to ensure that the content is based on the latest scientific evidence, and is relevant. But more importantly than the 'what', 'how' it is delivered has changed." The curriculum aims to create partnerships between clinicians and peers to meet the following principles "Credibility and authenticity, experience with OSI/mental health illness, anchors theory in real life, emotional resonance with audience, cultural understanding and language – connection with audience and de-medicalized language." There is also a "strong focus on interactive methods of teaching with some didactic teaching (doing as close as possible – teaching skills)."

"the time period that immediately follows return from military is an extremely important window of opportunity for readjusting to in-garrison work roles, for re-connecting with family, and for putting the events of the tour in perspective."[92] The last section of this chapter will focus on the mental health continuum model as it will aid in the understanding of OSIs.

MENTAL HEALTH CONTINUUM MODEL

Cooperation within like-minded nations and their militaries has led to many shared experiences and programs which enable more effective tools to be available faster for leaders and medical professionals within the CF. The immense force contribution and recent war experiences of the US in Iraq and Afghanistan cannot be underestimated in this regard and a great deal of their dedicated research and lessons learned have made their way into the CF and other NATO countries. For example, a model which is now utilized by the CF as part of the R2MR is the Mental Health Continuum Model (MHCM). The model is designed for both mental and physical injuries and is explained using four blocks as follows:

> "The model goes from health, adaptive coping (green), through mild and reversible distress or functional impairment (yellow), to more severe, persistent injury or impairment (orange), to clinical illnesses and disorders requiring more concentrated medical care (red)."[93]

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[92] Deniz Fikretoglu and Donald R. McCreary. "Development of Norms for the Post−deployment Reintegration Scale." Technical Report Prepared for the Defence R&D Canada. (Toronto: Defence R&D Canada, 2010), 1.

[93] Department of National Defence, "CF Personnel - Mental Health Continuum Model (Military)." http://www.forces.gc.ca/health-sante/ps/mh-sm/r2mr-rvpm/cfp-pfc/mhcm-mcsm-eng.asp; Internet; accessed 14 March 2012.

Illustrated in the figure below in a tabular scale, the model outlines reactions which can be expected within injured soldiers.

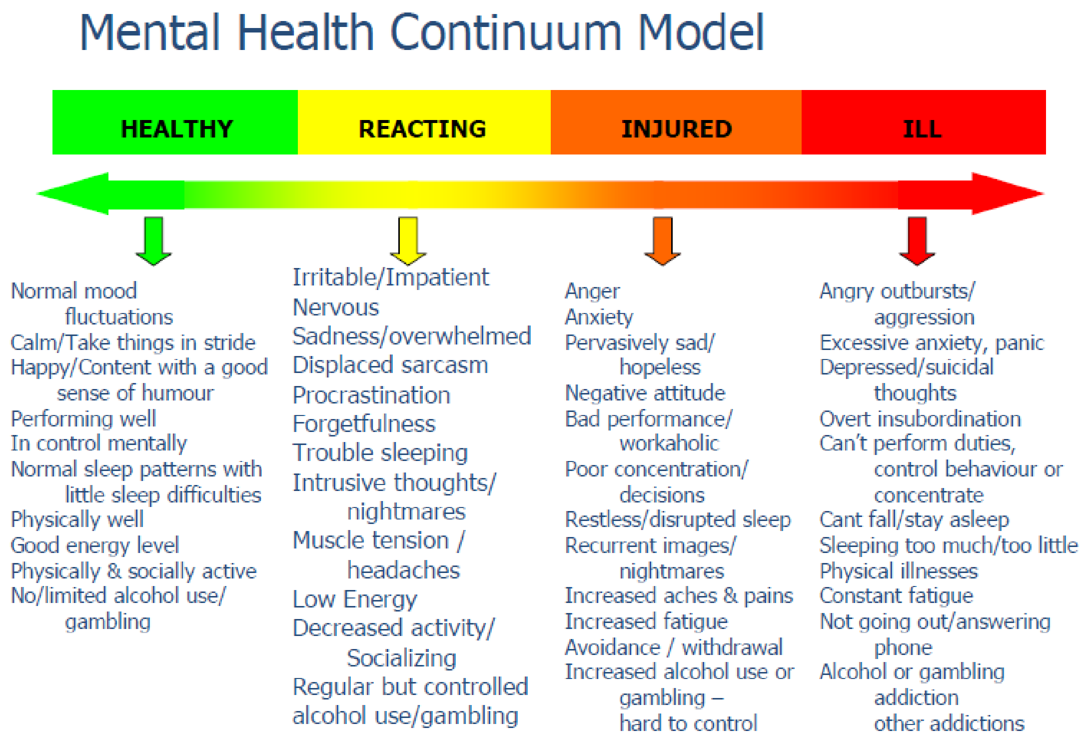

Figure 2.4: Mental Health Continuum Model extracted from a presentation given by CMP at a conference titled Caring for Our Own

This continuum is not aimed at labeling soldiers or fixing them into a given colour and box but rather, it explains the possible movement along the axis and expected behaviours. Movement across the spectrum indicates "that there is always the possibility for a return to full health and functioning."[94] With that in mind, the model also delineates the influence and roles of unit chains of command and health services using a sliding scale as seen in figure 2.7 below. This model is significant because it re-emphasizes the importance of the soldier, health services

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[94] *Ibid*

and the chain of command throughout a shifting balance of responsibility. No party involved is ever absolved of their role and care for the soldier is maintained. This sharing and collaborative approach may appear simplistic but it is vital.

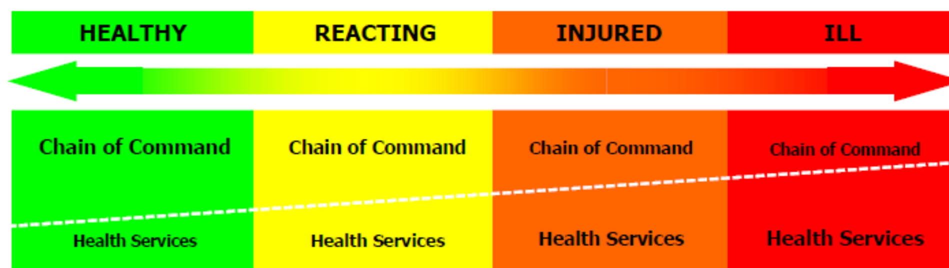

Figure 2.7: Sliding scale of responsibility for the MHCM between a soldier's Chain of Command and Health Services

Most prominent literature on mental health injuries, prevention and treatment elaborate in detail on the critical importance of morale, cohesion and leader responsibilities. The MHCM makes no exceptions and the CF aide memoire notes, "leaders are responsible for their personnel and have a vital role to play in preventing and managing distress . . . the Chain of Command never abdicates responsibility of the member."[95] The growing and valuable system of facilities and programs are not a substitution for genuine leadership which must continue to be omnipresent in a soldier's life. Though this education and training is essential, it is important to appreciate that with increased tempo in both the RegF and PRes Units, additional training like mentioned above will be rationalized with the other competing demands. Therefore, priorities must be clearly established so mental health is not sidelined.

[95] Ibid

SUMMARY

In summary, the CF has made many advances in the recent decade and specifically since 2009, to develop the resources and programs required to address the issue of OSIs within the rank and file. This chapter highlighted some of the major programs and outlets that exist for the soldier through all phases of deployment but it is by no means an exhaustive review of the complete spectrum of initiatives. The important message which must be gleamed from this overview is that the CF and its leadership have taken very positive measures towards health and specifically, mental health and it is by no means a low priority. The span of strategic to tactical assets indicates that OSIs are recognized as a potential injury particular to deployed soldiers which must be mitigated where possible and treated if necessary due to the impact on both the soldier's and institutional effectiveness.

As alluded to in the introduction, a partnership has been created between the DND and VAC which has improved in light of the growing demands and complexities of injuries incurred in operations. Though this chapter set out to focus specifically on the CF system, it is imperative to appreciate the other organizations, both voluntary and governmental which have bolstered the services and options available to those who suffer from mental health injuries.

Both chapter 1 and chapter 2 have made reference to the barriers and stigmas related to mental health injuries and the effect that these may have on the soldier who is suffering but may intentionally avoid assistance because of how they will be perceived. The intent of this chapter was to demonstrate that positive

momentum is being gained to close this gap so that no soldier goes without the attention they require to either return to full duties or manage their illness and transition to civilian life.

Now that the OSIs have been explored in addition to an explanation of the CF's present strategy to cope with the needs of their soldiers, it is worthwhile to take a look at the future of mental health within the CF.

CHAPTER 3

THE NEXT BOUND IN THE EVOLVING BATTLE

Just as physical fitness is an integral part of our lives, so should mental fitness be just as important.

—LGen Peter Devlin, Canadian Army Commander[96]

INTRODUCTION

So what does the future of mental health wellness in the CA look like? What continued measures or new initiatives regarding mental health should the CF as an institution aspire to implement now that combat operations in Afghanistan are allegedly complete which will complement those programs highlighted in the previous chapter? Despite the sometimes critical assessment by the media and the general public about the state of mental health in the CF as was witnessed with the unfortunate tragedies of Corporal Stuart Langridge, Corporal Shaun Arntsen and Corporal Jamie McMullin, there have been many exceptional enhancements made in the past couple of years as noted in the previous chapter.[97][98][99] In studying the comprehensive issue of mental health in the CA, it is worthwhile to reflect on the next leg in this journey because the subsequent conflict may be similar and worse than operations in Afghanistan insofar as time

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[96] Department of National Defence, The Maple Leaf. *Maintain Your Mental Fitness*. Volume 14, Number 30, (Ottawa: DND Canada, 2011), 11.

[97] Jordan Press, "Dead soldier's family should have legal funding: military commission." Postmedia News, October 27, 2011, accessed April 21, 2012 http://news.nationalpost.com/2011/10/27/dead-soldiers-family-should-have-legal-funding-military-commission/.

[98] John Ivison, "Haunted by the ghosts of war." National Post, July 9th, 2011, accessed March 10, 2012 http://afghanistan.nationalpost.com/haunted-by-the-ghosts-of-war/.

[99] Joe O'Connor, "A different person came back." National Post, July 9th, 2011, accessed April 21, 2012 http://afghanistan.nationalpost.com/%e2%80%98a-different-person-came-back%e2%80%99/.

is concerned, and could commence at any moment. Therefore, this chapter will examine several of these noteworthy developments and equally, one of the perceived gaps in the mental wellness institutional strategy.

This chapter will be broken down into four subsections: key baseline individual training (IT) and PD initiatives in the CF; comparisons to the US and Australian approaches to similar programs; spirituality as it relates to OSIs within the CF; and the treatment of OSIs within the CA PRes Force.

Though mental resiliency training is nested within the R2MR which was previously studied, the appetite of some key personnel within the CF Mental Health Branch and the CA individual training system to further develop this aspect of mental health is a clear indication of the weight which is placed on enhancing and protecting the mental health of our soldiers. The specific focus throughout this chapter will be the range of complementary tools available to today's leaders. Notwithstanding the great efforts regarding resiliency which will be explained in this chapter, it is important to study the initiatives of our close allies like Australia and the US as the CF moves forward. There is definitely a relationship between these two Allies and Canada and the commonality of programs is no coincidence.

In a lot of the US military literature on mental health injuries, religion, spirituality and pastoral care are discussed as a means by which some soldiers cope with their trauma and critical incidents.[100] The link between trauma and

[100] Alan N. Baroody, "Spirituality and Trauma during a Time of War: A Systematic Approach to Pastoral Care and Counseling." Chap. 9 in *Families Under Fire*. (New York: Routledge, 2011), 179.

spirituality can also be seen in many key aspects of the CF's system of soldier care and during operational deployments. The chaplaincy of the CF plays many fundamental roles in the lives of soldiers at home and abroad as can be seen by their involvement as members of care teams in the new OTSSC construct.[101] The aim of reviewing the relationship of spirituality and OSIs is not to infer the requirement for a more robust religious paradigm in the CF but rather to provide an insight into the bond that frequently exists between chaplains and soldiers during stressful events. These relationships continue to be important and will remain part of the mental health equation for the CF's future endeavours. Equally, while exploring the topic of spirituality, it is worthwhile to examine the concept of the soldier's "soul" and the inherent wounds that prevail when a soldier experiences an OSI.[102]

Lastly, in discussing the future or 'next bound', it is essential to examine PRes care and to better understand the challenges of reservist veterans with OSIs. For example, what are the gaps in the consistency by which OSIs are being treated in the PRes as compared to the Reg F? The question of reservist care has generated some consternation within many circles as was highlighted by the 2009 Report of the Standing Committee on National Defence titled, "Doing Well And Doing Better: Health Services Provided to Canadian Forces personnel with an

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[101] Anne Frances Cation, "Onward Christian Soldiers? Religion in the Canadian Forces." On Track, Volume 14 No. 1 (Spring 2008): 43.

[102] Capt G.E. Bailey, "On Spiritual Shrapnel." Speech, Journey through Military Trauma Conference, Owen Sound, ON, November 16, 2011.

emphasis on Posttraumatic Stress Disorder"[103] and the 2008 DND/CF Ombudsman report titled, "Reserved Care- An Investigation into the Treatment of Injured Reservists."[104] To look at the future through a honest and clear lens means asking the question of whether the tools available to all soldiers are being applied to a standard that ensures fairness and reciprocity.[105] This care of reservists suffering from OSIs is a difficult issue to solve but based on the decade-long conflict in Afghanistan, it behooves the leadership at every level to understand the unique challenges to reservists so that all programs and training can be applied diligently.

MENTAL HEALTH TRAINING CURRICULUM- TACTICAL ENABLING

In the previous chapters, the strategic oversight and to a large extent, the operational guidance in the mental health realm was studied. In many regards, the objective of a thorough system of care appears to be achievable due to the positive steps that have been taken by the CF and to a large extent, the CA in caring for its subordinates in the growing spectrum of mental health injuries. The level which all leaders are generally more comfortable is the tactical dimension and essentially, the 'interface' where soldiers are commanded, cared for and managed.

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[103] *Report of the Standing Committee on National Defence*. The Honourable Maxime Bernier.

[104] National Defence and Canadian Forces Ombudsman, "Special Report- Reserved Care: An Investigation into the Treatment of Injured Reservists." http://www.ombudsman.forces.gc.ca/rep-rap/sr-rs/rc-str/rep-rap-02-eng.asp; Internet; accessed 16 April 2012

[105] Note: As stated in the CF publication, Duty with Honour, reciprocity, "speaks to the need to ensure an appropriate, principle-based balance of the expectations and obligations both between the profession and Canadian society, and between the profession as a whole and its members."

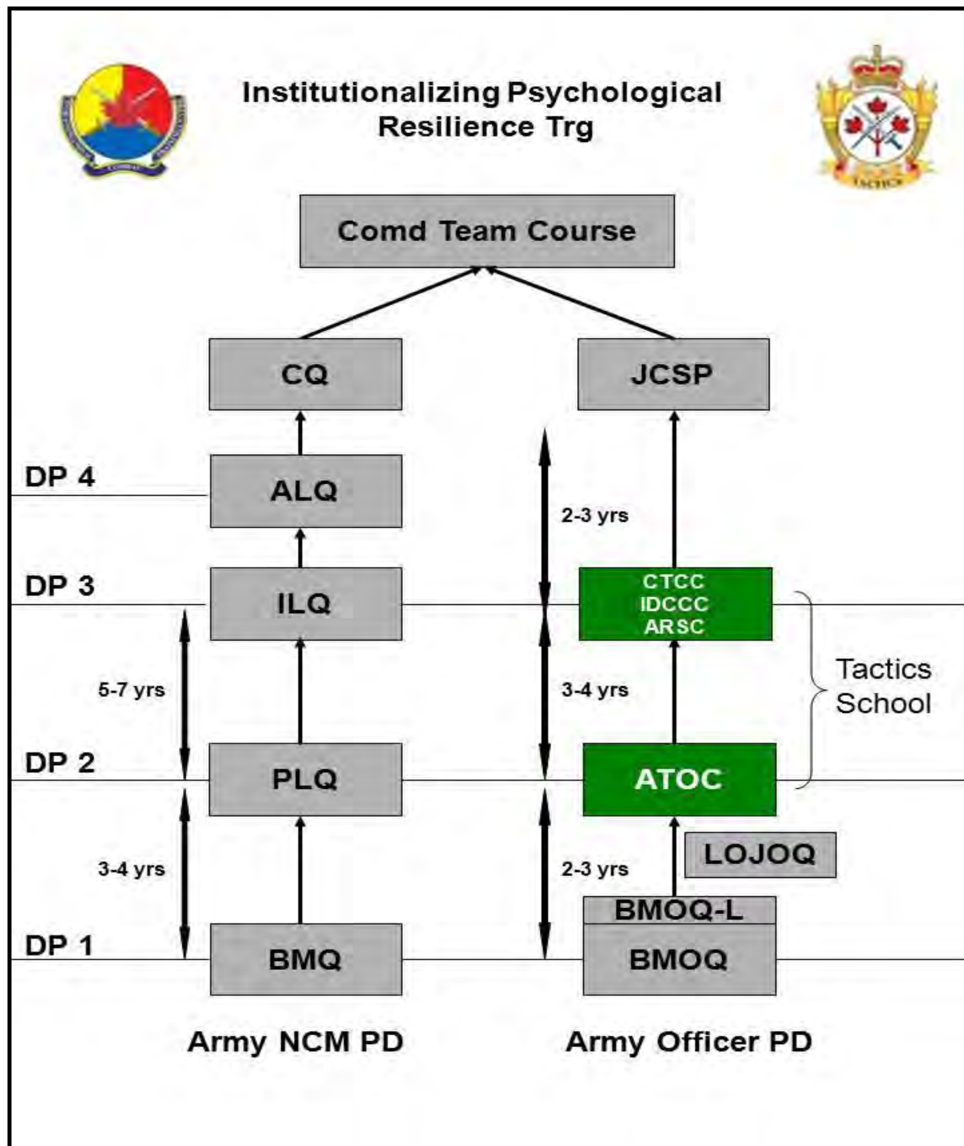
The following section will scope out the newly developed training regime which is being put in motion by the CA Tactics School and Land Force Doctrine and Training System (LFDTS) with the guiding hand of the CF Directorate of Mental Health. The goal of this overview is to understand the culture that is shifting towards a more comprehensive hardiness of subordinates in all phases of conflict from initial training to post-deployment using resiliency training (or as it is known in the CF, mental health training).

MENTAL HEALTH TRAINING IN THE INDIVIDUAL TRAINING SYSTEM

Over the recent decade, experts within CMP have been working with like-minded nations within NATO to develop tangible and practical methods to train and equip young leaders to deal with the resilience and psychological support of their soldiers. From these working groups, there have been a couple of cornerstone tools that have come to fruition such as the "Leader's Guide".[106] Before delving into the key components of this manual, it is prudent to examine the present state of mental health training in the CA at the various steps. Due to its intimate involvement in Afghanistan, the CA has been very aggressive in the implementation of resiliency training within the IT and PD system. The figures below indicate where mental health training has been emplaced in courses along the career streams of both Officers and Non-commissioned Officers in the Developmental Periods (DP) from basic training up to and including the Army

[106] NATO Research and Technology Organisation (RTO-HFM-081), *Leader's Guide to Psychological Support across the Deployment Cycle*. (Brussels: NATO, 2008).

Command Team course which is offered to designate Commanding Officers (COs) and their respective Regimental Sergeants-Major (RSMs).



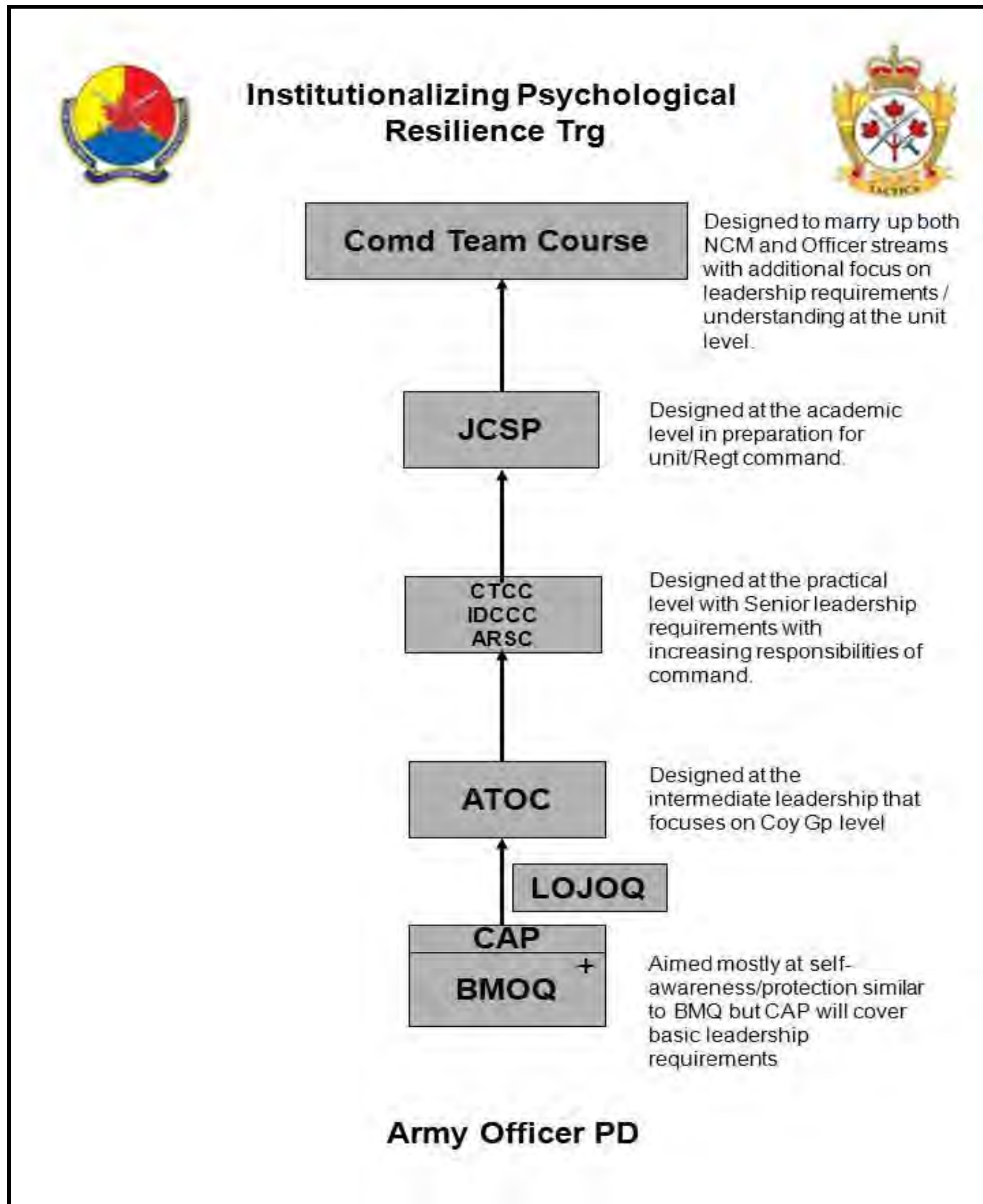


Figure 3.1: Flow chart of how resiliency training is emplaced in the Army PD and IT cycle which was extracted from a PowerPoint presentation from the CA Tactics School explaining the Mental Health Curriculum

Figure 3.2: Institutionalization of Resilience slide extracted from PPT presentation on R2MR which further explains the time commitment along both the Officer and NCM training spectrums

Undoubtedly, one of the key aspects to shifting a mindset and culture in deeply-rooted profession like the military is consistent education throughout the different generations of leaders and their subordinates. Training and education can ultimately shift the approach that is assumed by leaders in their interactions with soldiers and in the care that stems from the assessments that they develop. This cultural shift is not something that can be applied automatically or instantaneously due to the human dimensions of the profession. Change over time through an enhanced understanding of the complexities of mental health wellness is fundamental. Having endured a significantly shifting operational threat since the end of the Cold War, training at all levels has been thrust into a state of perpetual evolution in order to remain relevant to the missions being assigned to the CF and

CA. This evolution and rationalization with both the IT and PD dimensions to construct programs that are streamlined generally aims to reduce redundancy at the cost of efficiency. For mental health training as viewed above, it is important to adopt a graduated approach so that the in-depth understanding is acquired as soldiers mature in rank.

Afghanistan is a unique example of an environment which forced the CA to rapidly respond to an agile adversary in order to increase the likelihood of success in operations in addition to the care of its subordinates. Hardiness and resiliency training have existed in different forms for decades but due to the dynamic threat environment, these fundamental aspects of training have been pushed into the training establishments in order to encapsulate the growing need to prepare soldiers for arduous and unpredictable operating settings. The figures below have been extracted from a presentation from the CO of the Tactics School and outline how the CA has embraced resiliency through a layered approach. It also indicates where resiliency fits into the overall preparedness of a soldier. The foundation of a "warrior ethos" needs to become a frame of mind.[107]

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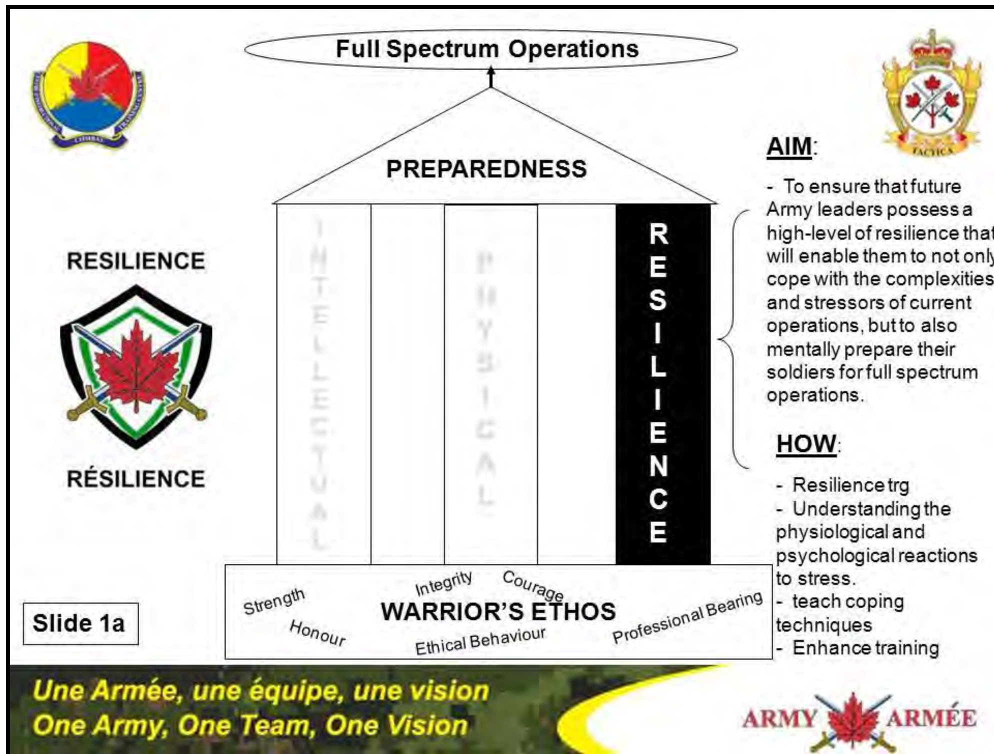
[107] LCol Martin Lipscey (CO Tactics School), personal correspondence with author, 26 March 2012.
Note: LCol Lipscey elaborates that, "this culture and the adoption of the Warrior's Ethos is not a couple of articles people read or lessons they receive and they become Warriors. Mental resiliency alone must become a frame of mind, a way of life that is used towards being a better soldier and leader."



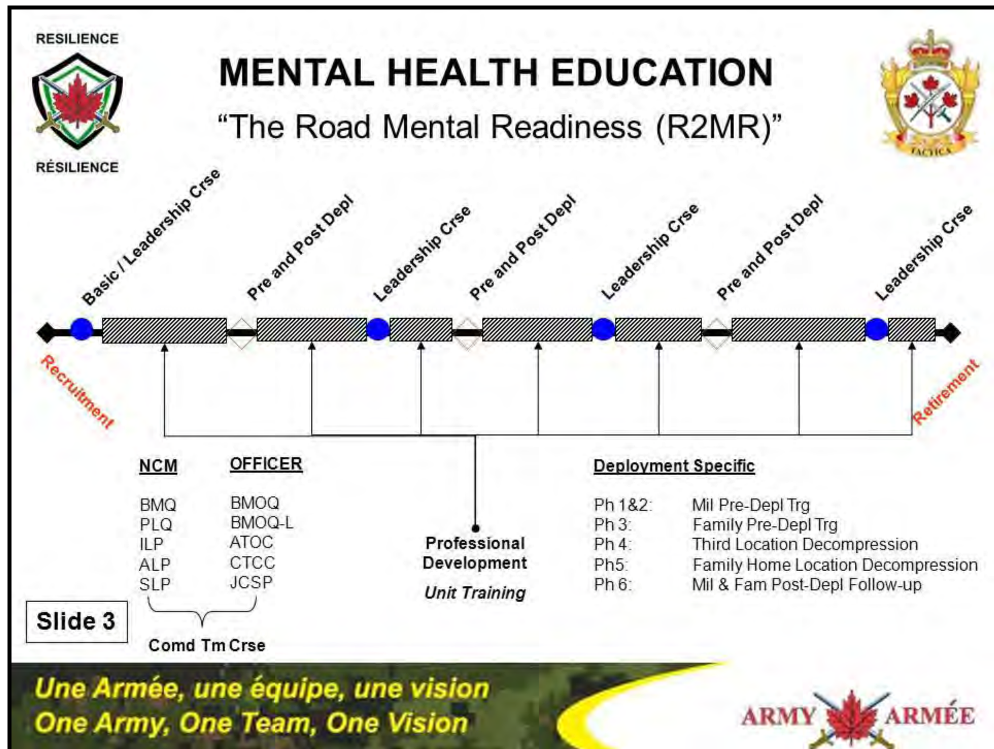


Figure 3.3: Warrior Ethos Model slides extracted from PPT presentation on R2MR from the CA Tactics School which illustrates the resilience within the Warrior Ethos and also the combination of this training in the IT and deployment phases.

As indicated in the notes of the below slides:

> "The CF leadership takes the health of their personnel and their families very seriously; as such mental health education and resilience [training] is embedded into both the career and deployment cycles. The goal of this [training] is to increase both short-term performance/effectiveness as well as long term mental health outcomes for CF personnel and their families. Career cycle [training] starts in basic training and layered in at each leadership level to ensure that leaders at all levels of the CF know what to do to protect and support their subordinate's mental health. During the deployment cycle [training] the focus is on giving the personnel the MH info they will need at various points during the deployment and this includes family briefings. Recently, in light of how difficult it can be to reach family members who may require this information, all [training] has been put online so families anywhere in the world can access it."[108]

It is therefore very important to note that these concrete steps are both part of the baseline training system as well as part of the deployment phases. All components are clearly positive improvements to the overall approach of the CA and the future. In this regard, mental wellness continues to be at the forefront of education and the professionalization of the CF. Having seen the training regime in place, it is equally important to look at the complementary tools that have been developed to assist leaders in their duties to manage the mental health of their subordinates.

EXISTING DOCTRINE AND GUIDEBOOKS

There is a growing arsenal of guidebooks that continue to be developed in order to equip the leaders within today's Army to recognize and deal with mental health injuries. In changing a culture, it can be argued that it takes a generation to

[108] LCol Martin Lipscey (CO Tactics School), personal correspondence with author, 26 March 2012

move initiatives forward because of the required shifts in mindsets and the problems that stem from "functional fixedness"[109] amongst those who believe that nothing is broken or needs to change. Many admirable advances have been made in the CA within the past ten years due to the requirement to adapt to the conflict in Afghanistan. For example, the collective training (CT) system was forcibly changed in order to integrate lessons being captured overseas to such aspects of critical training like evolving IEDs. Though just one example of how the CT system shifted quickly in order to meet the changing needs of deploying soldiers, other notable changes which pertain to this paper are those developments in the mental health system and soldier care domain.

COs clearly have the greatest responsibility and authority in the CF and CA insofar as ensuring the complete care for their subordinates. Having acquired years of experience, training and education, the selective process by which they are chosen for their roles as commanders is indicative of the trust invested in their judgment. COs leveraging their unit leadership essentially become the torch-bearers of care. Being delegated a large scope of duties by their higher command, COs are invested and charged with the welfare of the soldier at the tactical level. Though their subordinate sub-component commanders and staff are capable of managing the daily rigour within units, unit commanders must adhere to the consistent application of policy throughout their tenure. The "Commanding

[109] Psych Central. "Functional Fixedness." http://psychcentral.com/encyclopedia/2009/functional-fixedness/; Internet; accessed 17 April 2012.
Note: "Functional Fixedness" is the term that is used to describe the sometimes stagnant culture that persists within the CF and stems from leaders who are narrow, limited and fixed on the way they always do things. By definition, it is a form of cognitive bias in which a person is unable to think of other, more creative uses for an object aside from its traditional use. (http://psychcentral.com/encyclopedia/2009/functional-fixedness/)

Officer Guide to Casualty Support and Administration" provides this consistency as a baseline within the CF. Knowing how to task their leaders and chain of command with the duties that stem from casualties is crucial to the overall care that needs to be applied across the CF. Examples of such duties are those that are inherent to the Assisting Officer (AO) who is assigned to the subordinate and their family in the event that an injury is occurred.

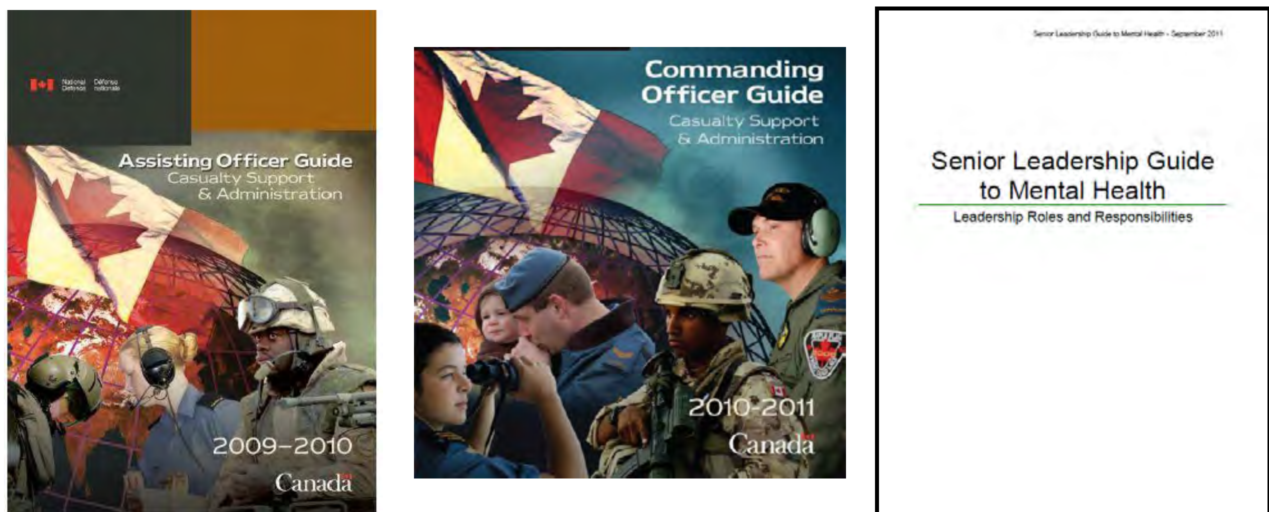


Figure 3.4: Three prominent guides: Assisting Officer Guide published in 2009, the Commanding Officer Guide published in 2010, and the Army-generated Senior Leadership Guide to Mental Health published in 2011.

The care and consideration that are given to the selection of AOs is something that is left to the discretion of COs. Though it is not implied that the selection of young leaders is rendered without due consideration, it is vital that those individuals selected are extremely cognizant of the primary importance of these duties as ambassadors of their respective chain of command and the CA as a whole. That is why the training that is provided for AOs is crucial to building the foundation for reliable care. Having said this, the relationships that are built by these young leaders with soldiers and their families is generally reliant on the

character, personality and motivation of those receiving the task. In this vein, it is particularly important that COs ensure that their intent is clear when the task is assigned so that the priorities are distinctly understood. As stated in the COs guide, "AO duties must take priority over normal tasks"[110]. In the fast-paced environment of multi-tasking, young leaders can potentially lose focus on the importance of their competing priorities when they are not provided with clear intent.

The "Leader's Guide to Psychological Support across the Deployment Cycle" is a thorough guide for leaders at all stages of deployment and is a practical manual for use in the CA. Developed in concert with many health and military specialists within a NATO working group, it has been harnessed by the training system and implemented in a number of IT courses as mentioned earlier. As highlighted in the preface of the manual:

> "Military leaders at all levels have a key role in sustaining the mental readiness of service members under their command. They also play an important part in maintaining morale on the home front for military families. The aim of this guide is to provide military leaders with information and practical strategies for dealing with stress and the provision of psychological support. The goal is to enhance unit effectiveness in modern military operations."[111]

The usefulness of manuals such as the *Leader's Guide* can only be measured by the consistent application that it is given by the leaders at all rank levels across the tactical spectrum. It is therefore critical that its existence is well-communicated to the leaders within the CA during both the IT and CT training venues. For the

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[110] Department of National Defence, A-PS-007-000/AF-009. *Commanding Officer Guide: Casualty Support and Administration*. (Ottawa: DND Canada, 2010), 18.

[111] NATO RTO, *Leader's Guide to Psychological Support…*, preface.

Officer Corps within the CA, the guide must be introduced and studied during the development periods prior to assuming command within the line units. It should be revisited frequently after this point when Officers are loaded on the Army Tactical Operations Course and the Army Operations Course. Without a solid communication plan through the CA's "school houses" and an institutionalized approach, this guide will become another tool that is misunderstood or forgotten when troops conduct their training for missions like Afghanistan.

A key aspect of the *Leader's Guide* is the comprehensive layout of the full range of psychological readiness that must be fostered. From initial psychological readiness to action drills on what to do when things do go wrong, this manual provides an excellent guide for leader's to aid in their primary leadership and command duties through the various phases of deployment. Arguably, some of the duties which are the hardest for leaders to master are those which take them out of the comfort zone of tactical maneouvres and trade-specific skills and into the realm of dealing with tough personal issues like mental health injuries. Another recent publication which compliments the *Leader's Guide* is "The Military Leadership Handbook" which was published in 2008. Together, these two guides offer solid information on how to approach leadership and how to provide support to soldiers in garrison and during deployment.

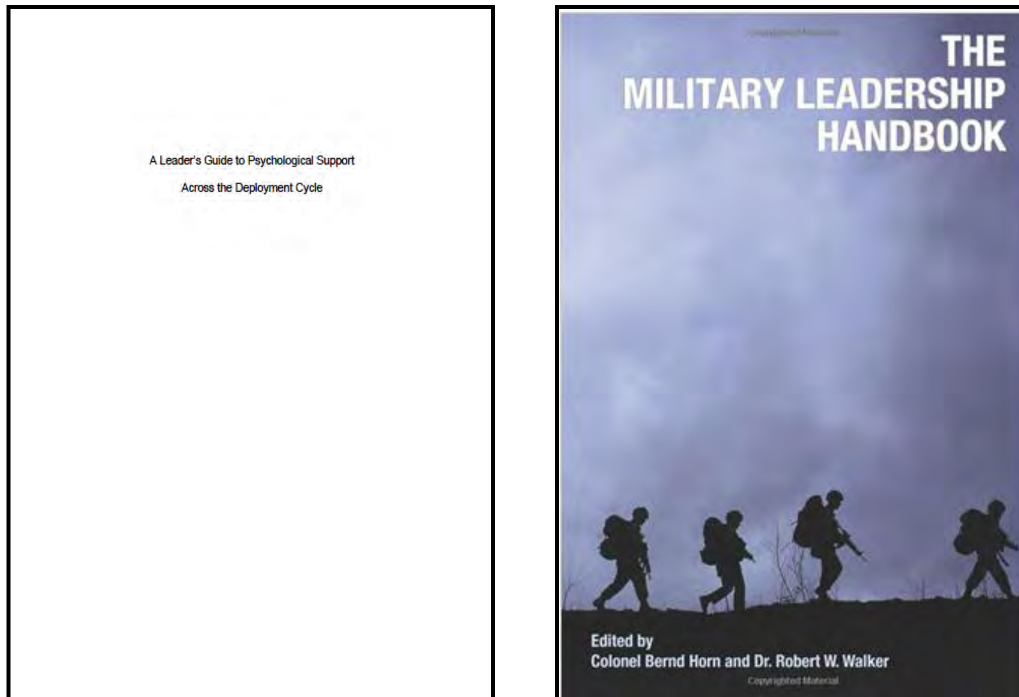

Figure 3.5: Two junior leadership guides: Leader's Guide to Psychological Support Across the Deployment Cycle and The Military Leadership Handbook published in 2008.

Leading is sometimes referred to as an 'art' because it is nearly impossible to teach true leadership and generally speaking, it is only through hard work and experience that genuine leaders develop. As stated in "Leadership in the Canadian Forces: Leading People":

> "Effective leaders understand their responsibilities, have and convey a sense of duty, and understand and work well with people. However, good leaders know that they must first start with themselves. They must master the skills, techniques, attitudes and knowledge relevant to their position. This is a lifelong process that does not end with the completion of a course or leadership position or the achievement of a career goal. It is an ongoing process in two senses. First, for as long as they occupy a given leadership position, leaders must continually develop their expertise. Second, as they are posted or appointed to different positions, with or without promotion, leaders must acquire different skills and knowledge. Leaders do not, and in fact cannot, know everything their followers know. They must, however, be familiar with their

> skill sets and understand how they fit into the organization and how these skill sets are best utilized to achieve mission success."[112]

In this regard, effective leadership is fostered over time and through deliberate and diligent individual effort. An aspect of growing expertise in an important field is the knowledge that must develop within the leader's understanding of psychological wellness for their soldiers. Very few young leaders are equipped with this knowledge when they join the CF but the educational structure and tools are available for their betterment.

UNITED STATES SHIFT FROM 'BATTLEMIND'

Most leaders in the CA today may have some knowledge of US programs for mental health training and when asked, they would probably make reference to the US 'Battlemind' program. The US has evolved from 'Battlemind' into a program similar to R2MR and it is called the "Comprehensive Soldier Fitness (CSF) program".[113] Established in 2009, CSF aims to "enhance the resilience, readiness and potential of Soldiers, Army Civilians and Family members."[114] Furthermore, the CSF overarching strategy is to assist in preventing "potential problems due to stress by shifting the focus from intervention to prevention, from

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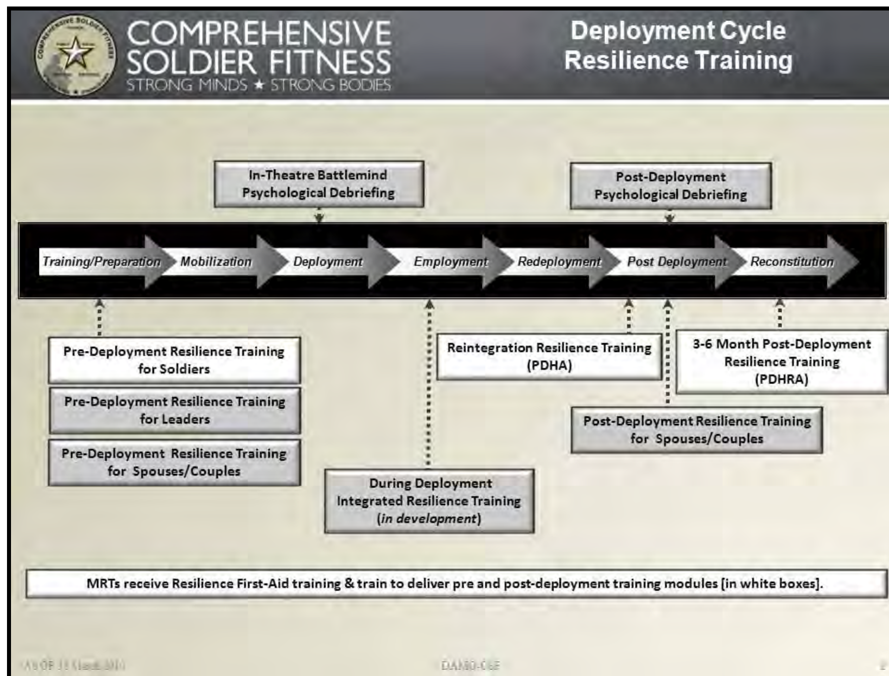
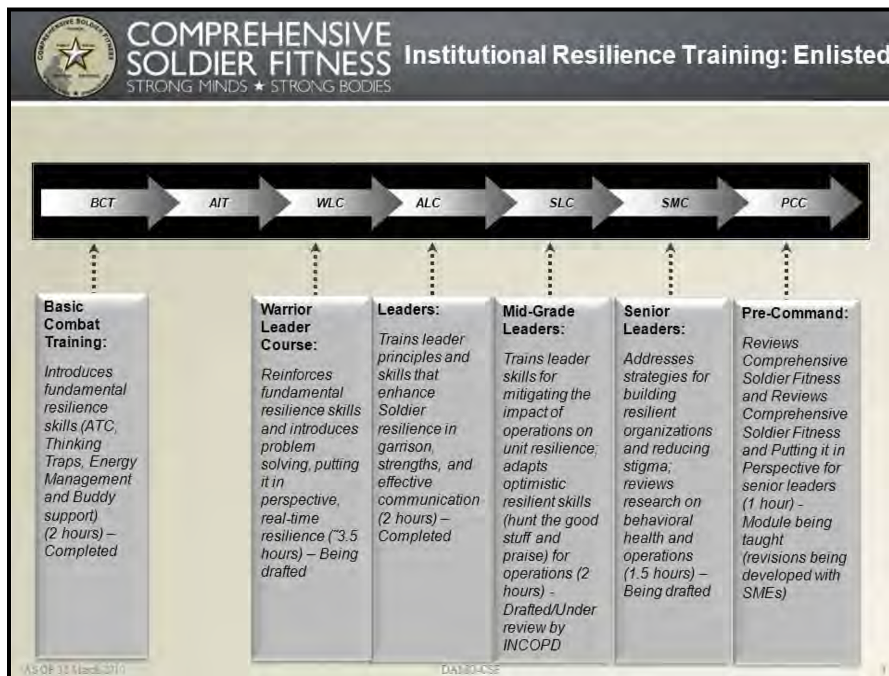
[112] Department of National Defence, A-PA-005-000-AP-005. *Leadership in the Canadian Forces: Leading People*. (Ottawa: DND Canada, 2007), 40.

[113] United States Army Medical Department, "Comprehensive Soldier Fitness." (series of training presentations). https://www.resilience.army.mil/; Internet; accessed 21 February, 2012.

[114] *Ibid*

illness to wellness."[115] The below figures depict the layout of their program across the deployment cycle and within their institutional context.





[115] Ibid

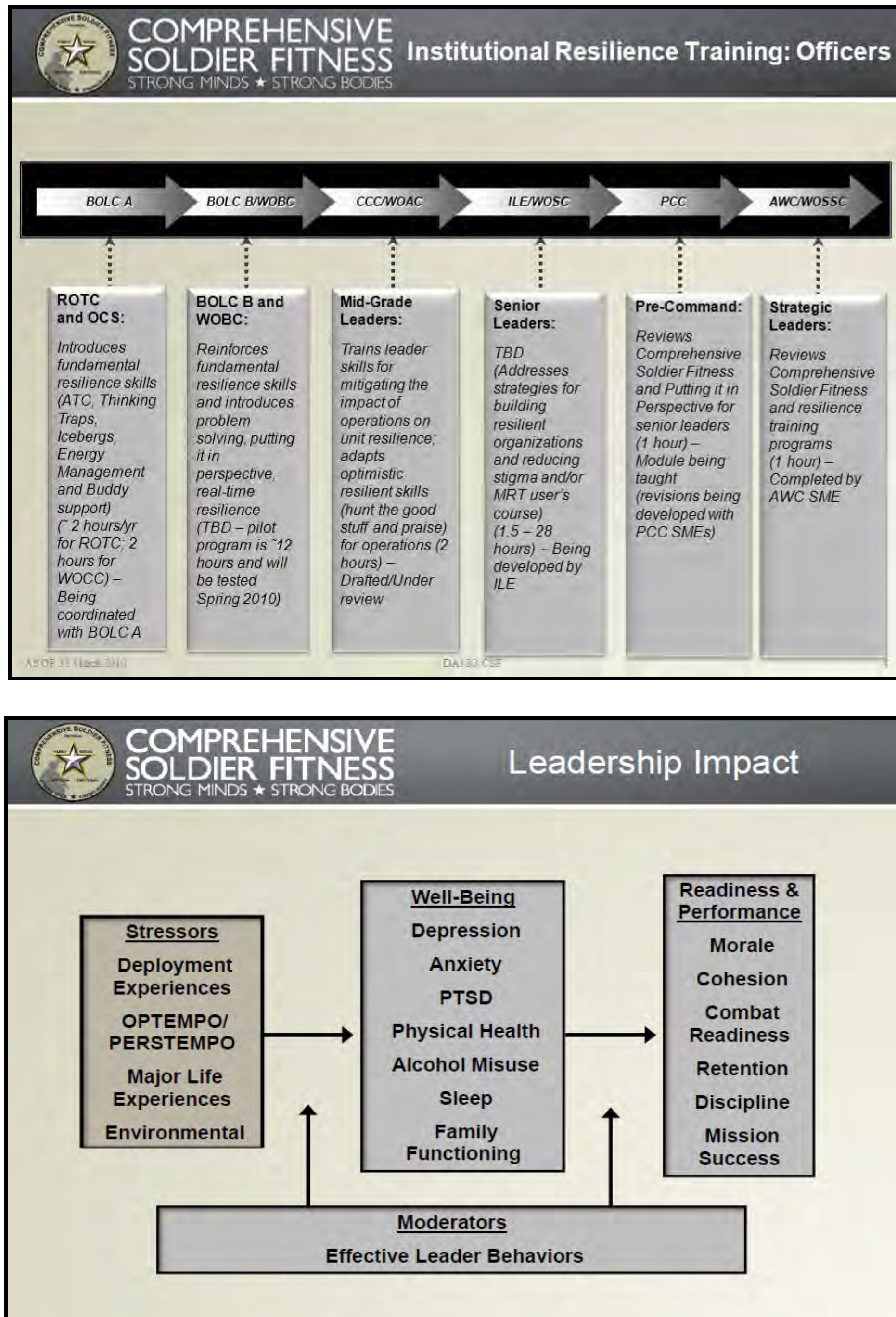


Figure 3.6: Slides extracted from PowerPoint presentations published 31 March 2010 on the US Comprehensive Soldier Fitness which is focused on resiliency.

Backing their program with years of scientific research and a large number of hard lessons from injured soldiers, the US continue to use training and education

as the tool to improve their soldiers preparation for battle. Somewhat dissimilar from the CA which does not provide formal 'trainer' courses for its leadership cadre, the CSF uses a Master Resilience Trainer (MRT) to deliver the material. The MRT must embark on a formal 10-day course in order to provide instruction. Though only developed in 2009, the US Army recently evaluated the overall program and published a report December 2011 which assessed the program as a success, "[the] evaluation provides solid evidence showing that the MRT skills are having a positive effect on Soldier-reported resilience and psychological health."[116]

It is apparent that the US CSF program has striking similarities to the CF mental health training program. These commonalities can be largely attributed to the collaboration of our two countries through venues like the NATO working groups. Though the baseline and fundamental tenets of the two systems appear to be similar, clearly the scale of training is quite different. The pure largeness of the US Army necessitates a more structured, formalized and even robotic approach. It can be argued that the relative small size of CA in comparison enables a more intimate and reactionary approach to training. In other words, the US Army is such a huge 'machine' that despite their best efforts, their system must be rigid. The CA can adapt its approach faster as the subject and material evolves. This advantages and disadvantages can be judged either way but having a more personal methodology like that found in the CF model enables leaders to

[116] United States, Department of the Army, "The Comprehensive Soldier Fitness Program Evaluation Report #3: Longitudinal Analysis of the Impact of Master Resilience Training on Self-Reported Resilience and Psychological Health Data." http://dma.wi.gov/dma/news/2012news/csf-tech-report.pdf; Internet; accessed 21 April 2012.

play the primary role vice that of a MRT. This active role will also build credibility for the CF leader with their soldiers and develop their knowledge of each and every soldier under their command.

AUSTRALIAN PSYCHOLOGICAL RESILIENCE CONTINUUM

As mentioned earlier, the work of the US Army and the Australian Defence Force (ADF) is interchangeable and certainly comparable in many ways with the CF. As a matter of interest, the ADF has modeled a number of their present programs off of CF initiatives.[117] This sharing of information does not mean that the ADF follow the exact format that the CF or the US Army do because each country's needs are very different and they must be task-tailored to suit their dynamic requirements and the resources available. The ADF has too experienced a number of mental health casualties from their operational commitments in Iraq and Afghanistan. A recent article titled "Traumatised diggers fighting new war at home" released 11 April 2012 indicated that, "the number of cases of post-traumatic stress disorder has skyrocketed since the start of the century, the result of brutal campaigns in Iraq and Afghanistan."[118] It is clear that the important issue of mental health injuries is shared similarly with some of our closest Allies. Having noted the similar challenges faced both our

[117] Australia, Department of Defence, "Mental Toughness for Operations: a multi-level program to build resilience in the Australian Defence Force." http://www.internationalmta.org /Documents/2008/2008066T.pdf; Internet; accessed 9 March, 2012.

[118] Hayden Cooper, "Traumatised diggers fighting new war at home." ABC News, April 12, 2012, accessed April 11, 2012 http://www.abc.net.au/news/2012-04-11/aussie-soldiers-struggling-with-combat-stress/3944270.

countries, the ADF has adopted a slightly different approach to resilience as illustrated below.

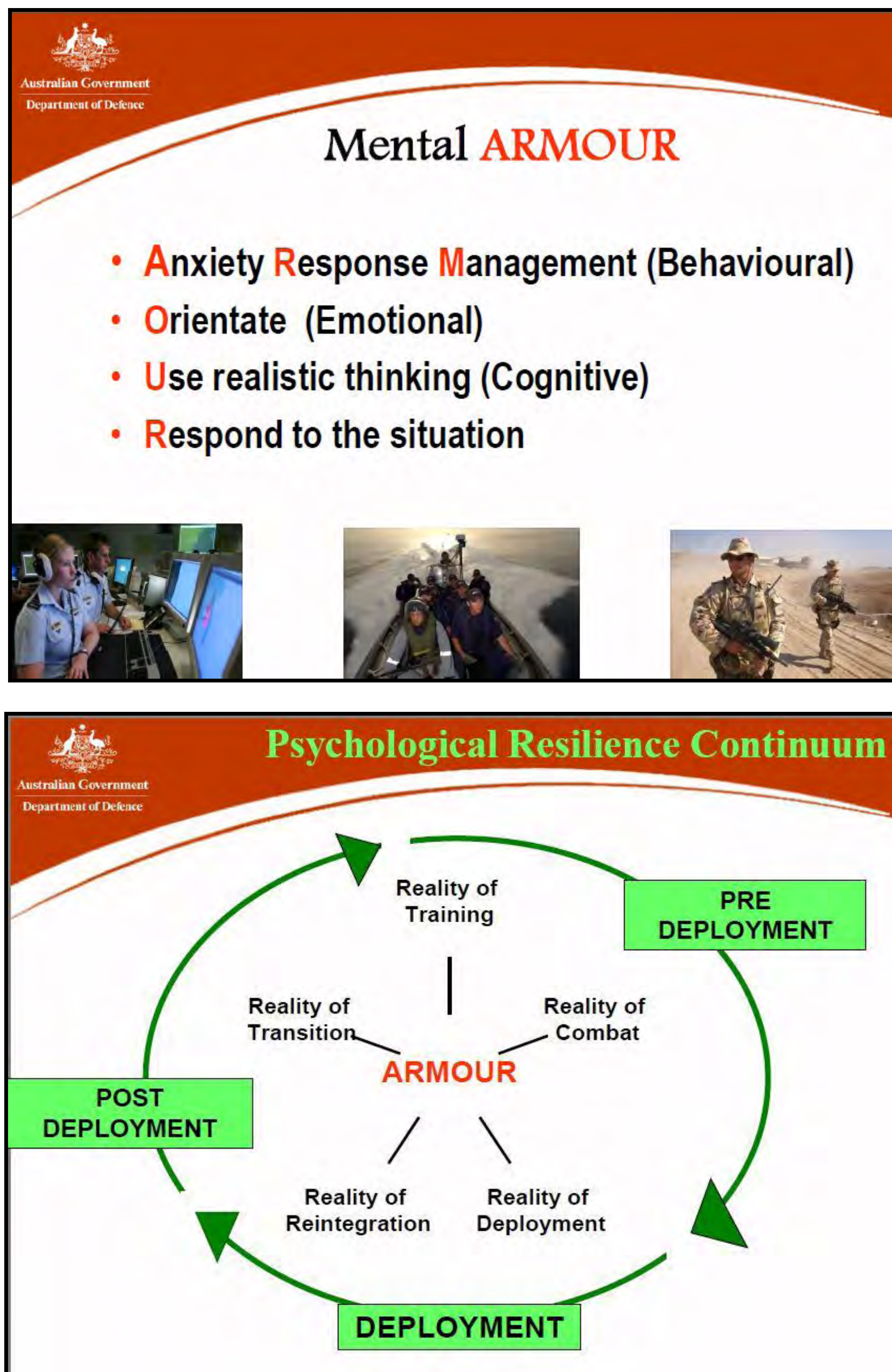


Figure 3.7: Psychological Resilience Continuum extracted from ADF PowerPoint presentation on Mental Toughness for Operations: a multi-level program to build resilience in the Australian Defence Force September 2008

The above figure illustrates the ADF psychological resilience continuum. Similar to the US Army and the CF, the ADF does focus on all phases of deployment insofar as resilience training is concerned. As indicated above, the acronym "ARMOUR" stands for "Anxiety Response Management (Behavioural), Orientate (Emotional), Use realistic thinking (Cognitive) and Respond to the situation." [119]

As part of the mandate to the ADF Directorate of Mental Health, it is recognized that for their soldiers, psychological resilience is vital to success:

> ". . .[the] requirement to be able to respond effectively to adverse, potentially dangerous and high risk situations, whether personnel are in a war zone or disaster relief situation. In response to such requirements, a significant amount of research and development is occurring in the field of psychological resilience."[120]

The emphasis on this type of training within the ADF is less than a decade old and in that sense, the CF are not necessarily lagging behind their Allies in the development and implementation of this type of training. In an effort to institutionalize these initiatives, the ADF created a program called "BattleSMART" which is explained as follows:

> "The resilience training program, dubbed BattleSMART (Self-Management and Resilience Training), is a cognitive-behavioural based program that aims to develop both arousal reduction techniques (i.e., the Self-Management component) and adaptive cognitive coping strategies. ADF personnel are taught to identify adaptive from maladaptive responses to stressful situations and adjust their responses as necessary."[121]

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[119] Australia, Department of Defence, "Mental Toughness for Operations."

[120] Andrew Cohn and Ken Pakenham, "A Cognitive-Behavioural Intervention for Enhancing Psychological Resilience in Military Recruits." http://www.internationalmta.org/Documents/2006/2006023P.pdf ; Internet; accessed 10 March 2012.

[121] *Ibid*

Therefore, as a means of comparison, it is evident that the correlation between the CF and the ADF is concrete and the continued working relationships of the respective mental health experts are such that experiences will be shared and improved as science evolves and lessons are learned. Comparatively, the ADF focuses heavily on the recruit vice the CF model of layered training through the DP cycle and it does not appear to be as elaborate or extensive as the CF model. Additionally, the ADF resiliency model is based off of a lecture format, whereas the US and CF models appear to be much more interactive. Though there is evidently merit in each of the national military programs, they vary only slightly. Similar to the CF, the ADF has a much smaller force composition and the primary training audience in comparison to the US Army. As such, they will likely have more success adjusting their program as analysis dictates. Lastly, all three programs indicate a comprehensive understanding of the importance of mental health and readiness in today's current operating environment.

OVERVIEW OF SPIRITUALITY AND MENTAL HEALTH

As mentioned in the introduction, it is worthwhile to briefly study spirituality and the role it plays in dealing with OSIs now and into the future. Significant literature has been published about leveraging spirituality in order to assist OSI casualties. As one source notes,

> "Religious beliefs and practices (spirituality) aid many people in developing personal values and beliefs about the meaning and purpose in life. They can provide an avenue for coping with difficult life events including trauma. Mental health professionals increasingly recognize spirituality as a primary human dimension, and potentially robust area of research. The military has a long

> tradition of providing for the spiritual needs of its troops through chaplains representing many faith traditions. However, the direct spiritual consequence of participation in war has only recently begun to be studied, as has the potential role spirituality may play as a healing resource for those recovering from war-zone trauma."[122]

This passage notes the importance of spirituality as a concept and specifically as a healing resource. Most of the reading available on spirituality and mental trauma are not specifically focused on religious practices and respective soldier faith but the structure and outlet that it offers soldiers when dealing with OSIs. The chaplaincy within the CF, or "Padres" as they are more commonly referred to, continues to be omnipresent on bases and during deployed operations. Often the first interfaces with soldiers who experience trauma, chaplains provide a critical service as active, unbiased listeners. As Baroody notes,

> "The theological and psychological training received differs from chaplain to chaplain, yet by virtue of the mission, they are first responders to the wounded, the emotionally traumatized, the grief stricken, and the heart broken. They are expected to listen to horrific accounts of combat and respond appropriately."[123]

The chaplain network within the CF goes well beyond their parishes as they have been fully integrated as part of the mental health care teams in key organizations like the IPSCs and OTSSCs. They continue to provide stellar care and a sometimes immeasurable service to veterans and their families.

Soldiers dealing with OSIs, bereavement or full blown chronic PTSD inevitably have injuries to a very personal aspect of their being, that is, their soul.

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[122] Kent D Drescher, Mark W. Smith and David W. Foy, "Spirituality and Readjustment Following War-Zone Experiences." Chap. 14 in *Combat Stress Injury- Theory, Research, and Management*. (New York: Routledge Taylor & Francis Group, 2007), 295.

[123] Baroody, "Spirituality and Trauma during a Time of War…" 178.

Capt Bailey, a CF Chaplain presented a paper for a Military Trauma Conference in November 2011 where he stated that,

> "Spiritual shrapnel is the effect on the soul, of a traumatic event of such magnitude that recovery can only happen by exposing the effect of the event to the light of day, by talking about it, and by intentionally using tools of recovery to help the victim deal with the issue. They are spiritual ailments because they tear the soul and blur meaning."[124]

Capt Bailey's experience on operations and domestically with injured soldiers is elaborated in his speech and the importance of a soldier's soul. As Edward Tick describes in his book on *War and the Soul*, "The soul is at the centre of human consciousness and experience. Yet we cannot see or measure soul directly."[125] From Bailey's insights on the human soul as quoted by his reference to Tick's book, it becomes clear that this piece of a soldier's mindset is important to understand. Not all leaders will be equipped with the knowledge or skillsets required to counsel soldiers with injuries of the soul, therefore, chaplains will continue to provide this expertise.

In Joanne Rennick's book, *Religion in the Ranks- Belief and Religious Experience in the Canadian Forces*, she quotes a fellow chaplain who was working as a clinical counselor and she further explains the relationship between the chaplaincy and soldiers with OSIs, "chaplains give people opportunities to include spiritual and religious experience [in their treatment] to help them get

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[124] Bailey, "On Spiritual Shrapnel", 5.

[125] Note: Quote extracted from Capt Bailey's paper as quoted by Dr Edward Tick (Tick, Edward. *War and Soul*. Wheaton, Illinois, USA. Quest Books, 2005.).

over their PTSD."[126] It can be concluded that when examining the next bound, military history has shown us that the role of chaplains remains vital. Chaplains remain integral members of the CF mental health program and continue to provide a service well outside their religious affiliations. Though spirituality and religion are sometimes confused as being the same thing, it is reasonable to believe that though they can sometimes be related, they are equally different ideas.[127] Not all soldiers suffering from an OSI will necessarily leverage these assets and services but for those that may, it provides them an option in their journey to wellness.

EXAMINING THE APPROACH TO *TOTAL FORCE* CARE

Based on the prominent role PRes soldiers have played in operations like Afghanistan over the past decade, this paper would not achieve its aim if some focus was not given to the care provided to these soldiers now and in the immediate future. As was seen with the 2008 McFayden special report "Reserved Care- an Investigation into the Treatment of Injured Reservists" and the 2009 Standing Committee on National Defence report, "Doing Well and Doing Better: Health Services provided to Canadian Forces personnel with an emphasis on posttraumatic stress disorder", there continues to be some active public debate in regards to the support being provided to PRes soldiers. As stated by Senator

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[126] Joanne Benham Rennick, *Religion in the Ranks – Belief and Religious Experience in the Canadian Forces*. (Toronto: University of Toronto Press Inc., 2011), 64.

[127] *Ibid*., 13.

Roméo Dallaire, Deputy Chair of the Standing Senate Committee on National Security and Defence in December of 2011,

> "Reservists have been deployed in every mission since the Gulf War of 1991. They have fought and bled, and some have died. They have proven themselves to be worthy, courageous, and equal to the task. They remain essential to the Canadian Forces and deserve exactly the same care."[128]

For these reasons and also for the need to remedy the gap in coverage, commanders within the CF are presently seized with addressing these apparent shortcomings.

What is the scope of the issues for Reservists? Some of the main issues that have been elaborated in recent media and governmental reports of PRes care include: access for PRes soldiers to major bases and facilities; the understanding of their chains of command upon return from deployment especially as it pertains to tracking and mandatory screening; post deployment contractual issues as PRes soldiers move from Class C to Class B or Class A contracts[129]; the availability of

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[128] House of Commons, The Standing Senate Committee on National Security and Defence. *News Release- Senate Committee Urges Protections for the Primary Reserve*. Thursday, December 15, 2011.
Note: Senator Romeo Dallaire continues to be a major advocate for soldier care as it relates to OSIs and has also been extremely active in outlining the vital importance of equitable care to PRes soldiers since they have been extremely active in expeditionary operations and suffer from the same illnesses but with less access to the support services that exist for RegF members.

[129] Note: For clarification, the classes of service can be explained as follows: Class A: This class involves short periods of reserve service with a maximum continuous duration of 12 consecutive calendar days including weekends and holidays. Duty normally takes place at the reservist's home unit. The member is paid a per diem rate from the reserve budget. Class B: This requires service of 13 consecutive days or longer, normally performed away from the reservist's unit, in support of Regular and Reserve Force activities. A longer-term Class B enables reservists to serve for periods in excess of six months to a year or longer alongside their Regular Force counterparts. The reservist on Class B is paid at the same rate as that which applies to Class A service, and from the same budget. Class C: This class entails full-time reserve service in a Regular Force position, normally for a period in excess of one year, with entitlement to all Regular Force benefits. Members on Class C service are not restricted in the length of time they may serve, so long as the position is vacant, funding is available, and filling the position can be justified. The governing

unit positions (Class A) for these soldiers within their parent units after a prolonged absence; the understanding of their civilian employers of their mental health injuries and the extensive care requirements to treat their OSIs; and a general understanding of the scope of the problem that a soldier experiences having fought in a war and re-integrating into civilian society vice into a robust structured cadre of support like their RegF brethren. Therefore, the challenges for a PRes soldier suffering with an OSI are exceptionally lengthy and unquestionably unique.

Not only are PRes soldiers absent for the duration of their tour (which can be as long as twelve months) but frequently, they participate in training well in advance of their deployment for both individual courses and CT regimes. Coupled with these extended absences from their home units is their affiliation with their RegF units where they are 'augmentees' into positions.[130] Therefore, they do not deploy with their own chain of command or leadership and upon re-deployment, their re-integration will take place with an organization that is not intimately knowledgeable of their experiences or their mental health issues. These are important points to note because the majority of CF Health care

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factor for Class C is the non-availability of a Regular Force member to fill the position. Class C reservists are paid at the regular rate of pay from the Regular Force budget.

[130] Note: The term 'augmentee' is frequently used within the Army and CF to indicate personnel who augment deploying forces in unique roles. The percentages of PRes soldiers who deploy on mission varies from mission to mission and generally increases as a mission matures (e.g. more PRes positions generally become available as time moves on and the RegF cadre is extended in its commitments). Augmentees are cared for in the same manner as soldiers who belong to the deploying force but the main difference for these soldiers is that upon return, they move back to a parent organization for care and continued primary employment.

facilities as indicated in chapter 2 are located on major CF bases.[131] Reserve units within Canada are spread throughout the provinces and can sometimes be well outside of reasonable commuting distance for daily care and follow up procedures:

> "My concern is that unlike the Regular Force, many Reserve members have no real support mechanism following their return from theatre and their units also may not be able to recognize their symptoms. A further point is that Reserve units are frequently a fair distance from the nearest support base (example: CFB Gagetown is the support base for the PEI Regiment in Charlottetown). In addition, some Reservists have had difficulty in accessing military healthcare when they revert to Class A (part-time) status."[132]

Though the precise issue of civilian employment and contractual related issues that stem from a PRes soldiers' deployment in operations like Afghanistan are beyond the scope of this paper, it is important to note that there are mechanisms in place to assist PRes soldiers with these problems. The *Canadian Forces Liaison Council*[133] and private endeavours like members of *Canada Company*[134] aim to

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[131] Locations of Army Reserve units can be seen at the site- http://www.army.forces.gc.ca/land-terre/maps-cartes/reserves-eng.asp

[132] Captain RCN Craig Walkington, personal communication with long-term Reservist, 17 January 2012.

[133] Department of National Defence, "Canadian Forces Liaison Council." http://www.cflc-clfc.forces.gc.ca/acf-apc/index-eng.asp; Internet; accessed 19 April 2012. Note: As noted on their website, the Canadian Forces Liaison Council is a group of more than two hundred Canada-wide senior business executives and educational leaders, a full-time Secretariat and a national network of Reserve officers. The civilians volunteer their time and efforts to promote the primary Reserve Force by highlighting the benefits of Reserve Force training and experience to the civilian workplace. They also support individual Reservists as well as Reserve units in matters related to employer support. The Council's mandate is "to enhance the availability of Reservists for their military duties by obtaining the support and co-operation of organization leaders in Canada."

[134] David Pratt, "Paying attention to Canada's reservists." The National Post, April 12, 2012, accessed April 17, 2012 http://fullcomment.nationalpost.com/2012/04/12/david-pratt-paying-attention-to-canadas-veterans/.

provide guidance and assistance for PRes soldiers. Though respective reserve chains of command must always being engaged on matters of soldier care, these organizations provide a healthy and established conduit and must continue to be leveraged and supported as their services are vital to the soldier care in the future.

In studying the programs within the CF as outlined in chapter 2 and the many aspects of the R2MR as reviewed throughout this paper, does the ResF soldier fit into the system for their overall welfare? It can be argued that all of the programs in the CF as explained in chapter 2 apply equally to the PRes as they do to the RegF. The important linkages come from the knowledge of these aforementioned packages to the PRes soldier who has returned to their unit. Therefore, in this respect, the reserve chain of command must embrace these concepts and educate them so they provide the mentorship required to access resources for their soldiers. An aggressive and more concerted effort to track soldier's post-deployment screening will be required in order to ensure that the identification of injuries is achieved wherever possible. As recommended in the 2009 report,

> "Reserve unit chains of command must be intimately and proactively involved in ensuring their returning personnel complete the post deployment process on time, including all necessary administration, interviews and medical appointments. Where individual Reservists are undergoing continuing care and treatment after full-time service, Reserve unit chains of command must remain in regular contact with CFHS case managers and take an active interest in the soldier's treatment programme."[135]

Note: This April 2012 article by David Pratt in the National Post highlights the assistance being provided by members of Canada Company and notes the importance being placed by many prominent Canadians on the sacrifices PRes soldiers endure in service to their country.

[135] *Report of the Standing Committee on National Defence*, The Honourable Maxime Bernier, 53.

In attempting to resolve some of the difficulties described above as documented in numerous recent reports, it is equally important to apply a solution that addresses these concerns across all reserve units for PRes soldiers of all ranks.

There are many positive aspects to PRes treatment which aid in the recovery from OSIs like peer support and the resiliency program on the R2MR. Peer support continues to resonate as a crucial enabler in dealing with OSIs and there have been some ingenious initiatives to explore further this aspect of healing by organizations like "Wounded Warriors".[136] Additionally, as outlined at the beginning of the chapter, resiliency plays a major role in the future of mental health and it remains vital to ensure that PRes soldiers receive this training in the IT, CT and PD realms in step with their RegF counterparts. There is no doubt that due to the uniqueness of reserve training, the delivery of resiliency and other related programs will be different. The most important point is that the training includes PRes needs.

In concluding this section on PRes soldiers and OSIs, it is essential to note that the challenges which exist for the PRes dimension of OSIs and the future have been acknowledged. This point does not mean that all of the viable solutions and answers have been established or institutionalized with the CA or

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[136] Wounded Warriors Foundation, "How We Help." http://woundedwarriors.ca/what-we-do/; Internet; accessed 25 March 2012.
Note: Wounded Warriors is an example of an organization that aims to improve the lives of Canadian soldiers and has been created out of the passion and good will of its members who saw a need to provide support. Complementary to the many CF and Veteran's Affairs programs, Wounded Warriors place a specific focus on "Operational Stress Injury Awareness". It has taken steps to provide this awareness and support to soldiers suffering from OSIs with a recent focus on PRes soldiers in their inaugural Big Battlefield Bike Ride 2012. As noted on their website, "17 Canadian Forces Members who have been affected by Mental Health Issues as a result of their service and screened by CF Health Services to participate in Big Battlefield Bike Ride 2012."

CF. As the system moves forward and makes improvements like those that resulted in the R2MR model, these policies must pertain and take account of the PRes contribution and employment dynamic. PRes soldiers need access to mental health care and vital support services like JPSUs.[137] Additionally, the reserve force as an entity, namely its leadership, must be disciplined and move forward using the same tenets of care, training and professionalization that apply to the RegF. Without closing existing gaps in soldier care and moving forward together as a total force, PRes soldiers with mental health injuries will continue to experience a more difficult road to recovery and complete re-integration.

[137] *Report of the Standing Committee on National Defence*, The Honourable Maxime Bernier, 88.

SUMMARY

The future appears to be very positive as the CA within the greater CF leans forward in a number of domains to better prepare the soldier for mental challenges. The CA has always practiced preparing soldiers for success on the battlefield through strong leadership, cohesiveness, a broadly shared military ethos, realistic training and a discipline within the rank and file. Having said this, the ruthless but fair attitude which has characterized the CA does not preclude self-assessment or constant improvement because a failure to meet the challenges of today will result in a failure tomorrow.

This chapter intended to provide an overview of the CA's next bound insofar as mental health injuries with specific institutional focus on resiliency and leadership training. In reviewing the work of the US Army and ADF, it becomes readily apparent that the CF is not trailing in our efforts to learn from some of the very hard lessons of the war in Afghanistan in addition to our other operational commitments. Certainly, the close cooperation which stems from various NATO working groups and the technical networking which always prevails within militaries has led to a number of true success stories as illustrated in the *Leader's Guide*. Though other countries may have managed their soldiers differently, the underlying tenets of care and complete fitness of a fighting force are common goals which are judged as a shared priority.

Additional tools which were explained in this chapter were the series of well-written leadership guides and the options which are available for soldiers insofar as leveraging spirituality as a means of dealing with OSIs. The dedication

of many leaders continues to be invested in making sure the correct tools are available so soldiers are cared for. In the same regard, the CF Chaplaincy remains an active branch of soldier care and have adapted to the changing operational environment to bring the soldier the services they require.

The challenge that has developed with PRes soldiers in the CF and mainly within the Army Reserve is something that clearly needs to continue to be heavily massaged and mitigated because the gap with the Reg F is apparent. Similar to the augmentees that work within formed units while deployed, inconsistency of care in all phases of deployment will inevitably result in fractured care and a wounded soldier can easily go without access to the same services offered to the Reg F member.

Albeit awareness and education are essential tools in this battle against OSIs and related challenges, the understanding of leadership must deepen from a simple baseline comprehension to a more elaborate appreciation of the condition as key personnel progress in rank and authority. In this regard, leaders must seek and accept responsibility for all soldiers despite their injuries and this ownership and compassion will improve the outcome. The tools presented earlier are just some of the many exceptional resources which exist with the CF and the CA. They must be used and actively communicated to really maximize their usefulness. Additionally, they must be improved and adjusted as experience, science and demands indicate. Lastly, an unfortunate characteristic of all the tools and programs presented herein which should be noted is the fact that despite their significance, very few of the resources explained in this paper can be accessed

through one portal. Young soldiers and leaders in need and who may not want to engage the chain of command for sometimes purely informational purposes may not know where to find this information because a “one-stop shopping” site does not exist. This technical shortcoming cannot be understated because more and more soldiers leverage the Internet for research.

CONCLUSION

CONTINUING THE COLLABORATIVE EFFORT WITH POSITIVE MOMENTUM

I firmly believe that within the next 20 years, the advancements in our mental abilities and their direct application to leadership and warfare will contribute to a Revolution in Military Affairs. Less technology little has changed in warfare for the past couple of centuries. A left flanking is still a left flanking. However, tapping into the power of our mental abilities and maximizing its potential is what will really change how we perceive warfare in the future.

- LCol Marty Lipscey, CO Tactics School[138]

Though presented in a very broad scope of related themes, the mental health of the CF and specifically, the CA is a topic of utmost importance for the overall effectiveness of the institution and the care of its members. The mental health injuries incurred by veterans of the Afghanistan theatre are unique due to the combat conditions where they developed. Many positive steps have been taken at the various levels of command to address the growing need for a stigma-free culture of wellness in the CF and this has been initiated and continually reinforced by the CDS himself in his philosophy and approach. However, it is evident even today that barriers still exist and therefore, the culture must still evolve and improve.

This paper highlights some of the programs that the CF has recently developed in a proactive approach towards addressing the psychological welfare of its members at the strategic, operational and tactical levels. These initiatives will only continue to grow and improve under the auspice of a positive working environment fostered by all active participants whether they are immediately

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[138] LCol Martin Lipscey (CO Tactics School), personal correspondence with author, 26 March 2012.

affected or not. Beyond the glossy covers and flow diagrams, there has to be the will and education of CF personnel down to the lowest leadership cadre. It is the leadership of the forces which must nurture its members and only time and genuine effort will enable this attitude change.

Though all individuals must grasp the importance of mental fitness, it remains the unit command teams, namely the COs and RSMs who are invested with the authority and key roles to ensure that mental injuries are understood and managed successfully. With succession plans that essentially have COs move in and out of command every two years, consistency of these efforts is essential for soldiers. Therefore, though the system provides solid policy and guidelines on how to deal with mental injuries, it is the emphasis placed by leadership through the "changing of the guard" which will support or adversely affect the care in situations that outlast the command of a single CO.

Despite many local efforts to close the gap on PRes soldier care, it is quite apparent that more focus is required in order to provide them with equitable support services before and after deployment. Disparate efforts are not the long-term solution and numerous examples can be drawn from the Afghanistan conflict which suggests that the system attempts to be inclusive but falls short in this category of soldier care. Though there are no perfect solutions in this regard, all leaders from the medical field to the PRes Unit leadership must better comprehend the distinct challenges that result from injuries and specifically OSIs so that the same degree of care can be applied in all phases of the R2MR.

Notwithstanding some of the points noted above, the resources available to the leaders of the CA and to the individual soldier have improved drastically in the past five years. Studying, understanding and leveraging these tools and the exceptional medical professional assets within the CF now become the work of every member of the greater DND team. Communicating aggressively through the chain of command in addition to the IT and CT venues will become the next challenge. An example of useful guides for young leaders was illustrated through the description of the *Leader's Guide*. Like many of the other tools designed to assist today's leader, these documents remain guides only and without consistent application and improvements, they become irrelevant. It is no longer acceptable to rely solely on the individual interest of leaders to attend workshops on stress and suicide or the short decompression cycle of the TLD in theatre to identify problems that sometimes only surface months and years after trauma has occurred. Equally, the impact of negative coping can further complicate the desired care. These issues must be understood and approached with diligence as they too can harm the cohesiveness of a unit and deter from the intended care of those who require help.

As military members, it is common to focus on physical fitness as a pillar for performance as it has become a very fundamental aspect and inculcated lifestyle within all ranks from the very first day military training commences. The only troublesome aspect of focusing on fitness in just this regard is that it does not proportionally reflect mental fitness. Overall wellness is undeniably essential to the effectiveness of a unit and in order to ensure this level of proficiency, fitness

as an accepted norm within the CF must include those mental and spiritual facets which are frequently forgotten. In other words, the culture must permanently shift to reflect the obvious need for complete wellness within the soldiers of the CA.

This paper also explored the effectiveness of the various tenets of the education system and support services for mental health injuries provided by the CF and the CA. Similar to many other aspects of leadership in a professional Army, the training and education system within the CF and CA must continue to address the evolving span of issues that relate to mental health and warrior ethos of the force. The rapid changes to the DP levels serve as an example of how key this education is to our leaders despite the limitations that can sometimes rationalize and stream-line the course content and spirit of various courses within a resource-constrained era. As long as the policies and senior leadership continue to demonstrate their support for mental wellness, the 'needs' of the mentally injured should be cared for in a manner which will enhance the long-term health of the organization.

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