



Battle stress: Canadian troops in a front-line trench, France 1915.

NAC PA 1326

LEADERSHIP AND OPERATIONAL STRESS IN THE CANADIAN FORCES¹

The Final Report of the Board of Inquiry-Croatia concluded that illnesses reported by veterans of Operation “Harmony” “go far beyond what can be expected to result from environmental contamination... It is highly probable that at least some of these symptoms result from the very high level of chronic stress experienced during the operation.” Among other things, the Board found that “CF [Canadian Forces] members are poorly informed about mental health issues and the link between physical and mental health.” It therefore recommended that attitudes and procedures concerning mental and physical health issues be changed in the CF.² In a recent letter outlining an “Action Plan” to respond to the Board’s recommendations, the Chief of the Defence Staff (CDS) indicated that he was “totally committed to doing what needs to be done to see that CF members are provided with the right guidance to conduct operations and a standard of care that is comparable to that available to the majority of Canadians.”³ On the face of it, the issues relating to stress on operations have been identified and are in the process of being addressed.

However, there are some problems with the present approach to addressing the issues raised by the Board that should be considered before the CF can claim to have resolved the issues identified by the Board. This paper discusses some of the problems with the present approach based on testimony given before the Board and past experience in dealing with operational stress. It concludes by making recommendations for designing a comprehensive and integrated system to reduce the effects of the stress of operations on military personnel.

In this discussion, no distinction is made between combat-induced stress and other forms of operational stress, based on the evidence that stress has an impact on humans whether caused by exposure to combat or any other type of stressful operational incident.⁴ Therefore, the term “operational stress” is used in this paper to include all types of stress encountered by CF

Dr. Allan D. English teaches in the War Studies programme at Royal Military College. He was an advisor to the Board of Inquiry-Croatia on issues related to combat stress reaction.

personnel while deployed on operations. The focus here is on stressors encountered as a result of the operation, but it is recognized that other stressors, such as financial or family problems, will also contribute to the overall stress experienced by the service person.

THE CURRENT SITUATION

Canadian veterans of the deployments under investigation by the Board of Inquiry-Croatia suffer from certain stress-related illnesses at rates at least three times higher than those found in the Canadian population.⁵ The types of stress-related illness found among veterans of Operation “Harmony” are comparable to the same types of illness found in veterans of other overseas deploy-

had regressed to essentially a pre-1918 model of dealing with operational stress.¹² Some limited progress in dealing with these issues has been made since the time under investigation by the Board, but the current system is still based on a model of stress as a disease, and it emphasizes treatment over proven methods of prevention.¹³ Current practice has been to leave much of the responsibility for the development and implementation of policy related to operational stress with the medical profession. While it has a vital role to play, the main focus of the medical profession is on treating illness and disease in individual patients. This focus may have actually led to an increase in the number of people who are labelled with stress-related diagnoses, because we know that relatively healthy people categorized as ‘sick’ may exhibit symptoms of the diagnosis whether or not they are ill.¹⁴

Another problem with the current system is that health care practitioners have been unable to gain the trust of the veterans who report symptoms of stress-related illness. One significant concern in this regard is that many of the health care professionals employed by the CF have not worked closely with those who have been deployed overseas. Evidence has shown that unless health care practitioners involved in treating veterans have credibility based on operational experience, usually in-theatre, veterans are reluctant to see them.¹⁵

HISTORICAL CONTEXT

Starting with the First World War, the treatment of operational stress in the Canadian military has gone

through three stages in repetitive cycles. The first stage has been characterized by a lack of any organized system to deal with operational stress. This led to large numbers of stress-related casualties, variously labelled as hysteria, shell shock, neurosis or lack of moral fibre. The second stage comprised a variety of unco-ordinated efforts by various groups, e.g., medical officers, psychologists, psychiatrists and military officers in the chain of command, to deal with the problem, but preventable stress casualties were still numerous. The third stage, when it was achieved, was distinguished by an integrated and comprehensive system for dealing with operational stress and a significant reduction in the number of preventable operational stress casualties. In the third stage, the development and implementation of policies was under the direct supervision of military commanders who received advice from various experts,



The stress of modern peacekeeping: Canadians injured by a mortar round are prepared for evacuation, Bosnia 1994.

ments, including the Gulf War, Somalia, Bosnia and Rwanda.⁶ Research has shown that the wide ranging and varied symptoms, sometimes categorized as Medically Unexplained Physical Symptoms (MUPS),⁷ reported by CF veterans of “Harmony” are consistent with those exhibited by those exposed to operational stress since at least the First World War.⁸ In addition, there were reports of “a lot of mental illness” during Operation “Harmony”⁹, and some cases of mental breakdown in-theatre similar to that observed in previous wars or operations.¹⁰ Finally, veterans of other operations are now reporting delayed MUPS (i.e., reporting MUPS up to five years or more after their deployments), comparable to past conflicts.¹¹

Part of the reason for this high incidence of stress-related illness is that, during the period of time under investigation by the Board of Inquiry (1993-95), the CF

including operations researchers, behavioural scientists and various members of the health care community, including the medical profession.¹⁶ Stage three was achieved at the end of the First and Second World Wars, but after each war the Canadian military regressed to stage one.

The earliest antecedent to operational stress in the medical literature can be found in an article by Johannes Hofer published in 1678. He described a disease that afflicted Swiss mercenaries serving in France who exhibited various symptoms described as: dejection, continuing melancholy, incessant thinking of home, disturbed sleep or insomnia, weakness, loss of appetite, anxiety, cardiac palpitation, stupor and fever. Unless the soldiers could be returned home they sometimes died or went mad. Hofer's clear description of these cases led to the acceptance of 'nostalgia' by the medical profession, based on the most conspicuous symptom, as a recognizable disease of soldiers serving far from their homes. By the 19th century many physicians, believing that symptoms of nostalgia were caused by pathological changes in patients' internal organs, noted alterations in the brain and other structures after death when none actually existed because, for the most part, they were grappling with problems beyond their capacity to solve.¹⁷ Nevertheless, the diagnosis of 'nostalgia' was widely accepted until the First World War, when dramatic changes took place in the diagnosis and treatment of non-physical battle casualties.

At the beginning of that war, those who could not cope with the mental strain of combat in the British and Canadian armies were categorized as suffering from hysteria, a disease believed to be caused by a lack of will power, laziness or moral depravity.¹⁸ Casualties were treated as they would have been in a civilian clinical setting. They were evacuated to Britain where, given 'rest and sympathy', some had their symptoms disappear, but most ended up institutionalized and became chronic cases.¹⁹ These losses took their toll on both armies but became critical when, after the first battle of the Somme in July 1916, several thousand soldiers had to be withdrawn from battle due to nervous disorders: many of these were permanently lost to the military. A new treatment regime was quickly instituted that, by 1918, had evolved to the point where it was very similar to the present-day treatment for operational stress near the front line, emphasizing the principles of immediacy, proximity and expectancy.²⁰

The neglect of many of the lessons of the First World War after 1918 led to a regression to the first and most ineffective stage of treating operational stress at the beginning of the Second World War. For example, in the US Army's initial campaigns in North Africa and Sicily, 35 percent of all nonfatal casualties were diagnosed as



Engineers clear a minefield, Croatia 1993.

CF Photo Unit ISC 93-5104-21

'psychiatric'; however, because most of them were evacuated 90 miles or more from the front lines for treatment, no more than three percent were ever returned to combat.²¹ Despite the preference of many psychiatrists for their usual hospital-based treatment methods, the manpower crisis of the North-West Europe campaign (1944-45), with combat units suffering an average ratio of 25 percent of casualties classified 'neuropsychiatric', finally forced the Allied armies to return to the proven forward treatment methods of the First World War.²²

The modern Israeli experience mirrors the experience of the Allies in the Second World War. During the catastrophic early days of the Yom Kippur War in October 1973, the Israeli Defence Forces reported that operational stress (the Israeli's referred to this as Combat Stress Reaction (CSR)) casualties comprised 60 percent of total casualties, and treatments involving evacuation of these casualties to civilian hospitals in the rear meant that only 16 percent were returned to combat duty. Once the Israelis implemented the proven First World War methods of treating casualties, return rates improved dramatically with 70 percent of soldiers who received forward treatment returning to combat.²³

The current missions of the CF, variously termed operations other than war, such as peacekeeping or peacemaking, may actually be more stressful than combat in war. A study by the Walter Reed Army Institute of Research of a US battalion deployed in the Sinai in 1982 with the Multinational Force and Observers (MFO), noted that the lack of action and the defensive posture

of the peacekeeping mission was potentially more stressful than active operations for elite troops. The study concluded that the health of the battalion was worse in theatre than it had been in the US, and that a number of physical illnesses were probably a result of

effects of the inevitable stress of operations on military personnel. The central principle for success in designing and running this type of system has always been that military commanders must bear the ultimate responsibility for the system. When they have delegated this responsibility to others, such as those in the health care professions, the results have inevitably been unnecessary operational stress casualties.²⁷



Strathcona Cougar returns to camp after a foray along the line of confrontation between Muslims and Serbs, Bosnia 1994.

psycho-social stress.²⁴ The experience of Canadian peacekeepers has been consistent with those of the US MFO battalion. A recent study concluded that those going on peacekeeping missions needed to be carefully screened to avoid taking those who could not cope with the stress of the mission; that maintenance of cohesion and morale in theatre requires more attention; and that while improvements have been made to the personnel support system there is still dissatisfaction among those surveyed with the support they have received.²⁵

The current method of dealing with operational stress in the CF appears to be in the second stage as some steps have been taken to address operational stress issues, but they lack co-ordination and do not appear to be capable of dealing with some of the fundamental causes of operational stress casualties.²⁶ The next section outlines some steps that could be taken to move to the third stage of dealing with operational stress in the CF.

A NEW SYSTEM

In both World Wars and in subsequent conflicts, it has been found that the most effective way to decrease preventable stress-related casualties was through a comprehensive and integrated system designed to reduce the

effects of operational stress. There has been very little empirical research done in this area in the CF³⁰; however, the small number of studies that have been published indicate that there is a “definite association” between certain stress-related illnesses on deployments and the confidence that personnel had in unit leaders.³¹ These results are consistent with the findings of other studies done on the effects of leadership in reducing preventable operational stress casualties.³²

LEADERSHIP

Leadership at all levels is the key to reducing the effects of operational stress. There has been very little empirical research done in this area in the CF³⁰; however, the small number of studies that have been published indicate that there is a “definite association” between certain stress-related illnesses on deployments and the confidence that personnel had in unit leaders.³¹ These results are consistent with the findings of other studies done on the effects of leadership in reducing preventable operational stress casualties.³²

One of the few empirical studies on the subject of leadership and operational stress in the CF, in this case on Operation “Harmony”, revealed that as many as 41 percent of unit personnel expressed “low confidence” in the leadership of junior officers and that up to 33.8 percent of unit personnel expressed “low confidence” in the leadership of senior officers.³³ This indicates that there are potentially serious shortcomings in leadership in the

CF. However, until much more research is done to put these figures in context, e.g., are these numbers comparable to or better than other military forces or civilian organizations, they can only serve to alert us to a situation that requires attention. A recent statement by the CDS that calls into question “the quality of the leadership” during part of Operation “Harmony” adds extra urgency to this issue.³⁴

A NAME FOR THE PROBLEM

It is clear that the name given to the problem of operationally-induced stress will have a significant effect on the outcomes of any DND program to reduce the effects of stress on deployments. The Israeli CSR model is based on the assumption that many mental breakdowns are short-term responses to transient operational conditions rather than the result of some weakness or defect on the part of the soldier. Terms such as ‘battle exhaustion,’ ‘combat fatigue,’ and ‘combat reaction’ have been used since the Second World War to avoid the stigma attached to such terms as ‘war neurosis,’ ‘psychoneurotic,’ etc.³⁵ The current widespread use of the Post-Traumatic Stress Disorder (PTSD) label to include many of those who have experienced operational stress is a regression to inadequate pre-1944 methods, which contributed to high rates of operational stress casualties, and of inappropriately labelling stress casualties with terms usually reserved for mental illnesses with clearly defined symptoms, .

It is important that any name chosen for this problem in the CF avoid labels like PTSD associated with illness and disease, and instead use terms like ‘operational stress’ that reflect non-judgmental ways of describing the problem.

CREATING A NEW SYSTEM

It is encouraging to see that the CF has published an “Action Plan” to deal with recommendations from the Board of Inquiry–Croatia; however, in its initial stages the plan still reflects a piecemeal approach to these issues. At this point, quality of life issues are foremost and health care professions appear to have a prominent role in initiatives to address the Board’s recommendations.³⁶ While there is no doubt medical and quality of life issues are an important part of preventing operational stress casualties, they are only parts of what should be an integrated system that is focused on leadership.

The task of designing a new system to deal with operational stress in the CF requires the expertise of different professions. The lead profession, because it bears the final responsibility for the system, should be the

profession of arms, i.e., officers in the operational chain of command. Historical research is required to put the lessons of the past in a context that can be useful to those confronting today’s challenges, and to analyze the strengths and weaknesses of past systems so that we can build on their strengths and avoid their mistakes. Behavioural science insights into individual and group performance, including leadership and cohesion, have vital contributions to make. Operations researchers are required to quantify certain aspects of the problem. Health care professionals bring to the team practical insights and expertise in the treatment of those who become ill from stress-related causes. The team should also have a number of officers with operational experience and formal education in some of the disciplines mentioned above to provide opinions based on field experience blended with academic rigour. Most impor-



Exhausted Royal 22e Régiment soldier, Bosnia 1992.

tantly, the team leader should represent the operational chain of command, which is in the end accountable for the outcomes of the system.

Of course once the system is in place, the key step in implementing it will be making operational stress issues an integral part of professional military education

in the CF. To accomplish this task a comprehensive leadership education program will need to be designed based on research relevant to the Canadian situation.³⁷ However, until problems of operational stress are seen as leadership issues, that must be addressed by military professionals in a systematic and integrated way, the

historical record suggests that no real progress will be made in dealing with them.



NOTES

1. This paper is based in part on an unpublished paper titled "Creating a System for Dealing with Operational Stress in the Canadian Forces" prepared for the Board of Inquiry-Croatia in December 1999. The author would like to thank LCol Brian Sutherland, a former member of the Board of Inquiry-Croatia and currently a staff officer in NDHQ assigned to coordinate, track, and regularly report on the progress of implementing recommendations of both the Thomas Review and the Board of Inquiry-Croatia, for commenting on this paper.

2. Operation "Harmony" was the name given to the Canadian portion of the United Nations peacekeeping mission in Croatia, *Final Report - Board of Inquiry-Croatia*, pp. 1, 2, 27.

3. General Maurice Baril, "Final Report of the Croatia Board of Inquiry and the Thomas Report," letter dated March 2000. website http://www.dnd.ca/boi/enrgraph/CDSletter_e.asp.

4. Tomi S. MacDonough, "Noncombat Stress in Soldiers," in *Handbook of Military Psychology*, Reuven Gal and A. David Mangelsdorff, eds. (Chichester: John Wiley, 1991), pp. 548-549; and Franklin C. Pinch, "Lessons from Canadian Peacekeeping Experience," unpublished report prepared for the Department of National Defence (DND), (November 1994), pp. viii-xiv.

5. LCol Donald Gregory Passey, testimony before the Board of Inquiry-Croatia (BOI), 12 Oct 1999, pp. 12-13; and Greg Passey and David Crockett, "Psychological Consequences of Canadian UN Peacekeeping," unpublished paper, Department of Psychiatry, University of British Columbia, (revised 18 Aug 1997), Exhibit No. 51 BOI, p. 8.

6. Maj Timothy Cook, testimony before the BOI, 19 Nov 1999, pp. 7, 14, 17, 21, 27; Goss Gilroy Inc., "Health Study of Canadian Personnel Involved in the 1991 Conflict in the Persian Gulf," (20 April 1998), http://www.dnd.ca/menu/press/Reports/Health/health_study_e, pp.5, 7, 8-9; "Canadian Gulf War vets report similar symptoms as same frequency says study," (22 Nov 1999), GulfLINK, Office of the Special Assistant for Gulf War Illnesses [USA], website http://www.gulfink.osd.mil/news/na_canadian_study.html, and Passey and Crockett, Exhibit No. 51, p. 10.

7. LTC Charles Engel, [a US Army psychiatrist], testimony before the BOI, 23 Nov 1999, pp. 7-8, 13, 16.

8. Dr Kelly Ray Brett, testimony before the BOI, 22 Sep 1999, pp. 36-38; Cook testimony, pp. 21, 35; Zahava Solomon, *Combat Stress Reaction: The Enduring Toll of War* (New York and London: Plenum Press, 1993), pp. 31-38; Dr Wolter de Loos, Central Militair Hospitaal, Netherlands, cited in Engel testimony, pp. 9-10;

and Allan English, "Historical and Contemporary Interpretations of Combat Stress Reaction," prepared for the Board of Inquiry-Croatia and presented at the 1999 Conference on Defence Ethics, Ottawa, 2 November 1999, published on the Board of Inquiry-Croatia website http://www.dnd.ca/boi/enrgraph/study_e.asp, pp.1-4, 7-14.

9. Brett testimony, pp. 4, 6, 32.

10. For example see Dr Theodore J. Bachynski, testimony before the BOI, 23 Sep 1999, 16; and Brett testimony, p. 23.

11. Cook testimony, pp. 7, 8-10, 12, 15-18, 27.

12. Brett testimony, pp. 6, 8-9, 29; Greg Passey and David Crockett, "Stress Disorders in UN Peacekeepers," unpublished paper, Department of Psychiatry, University of British Columbia, [nd], Exhibit No. 52 BOI, pp. 16, 25-6, 37; and Dr Mark J. Tysiaczny, testimony before the BOI, 9 Nov 1999, pp. 6-8, 11-12. For the historical comparison see English, "Historical and Contemporary Interpretations..."

13. Pinch, p. 128.

14. Cook testimony, pp. 10-11, 23; Engel testimony, pp. 17-19.

15. Brett testimony, pp. 29-30, 36; Pinch, p. 129; Passey testimony, pp. 19, 22-4; and Tysiaczny testimony, p. 18.

16. See English, "Historical and Contemporary Interpretations..." for a more complete overview of the history of the treatment of operational stress.

17. George Rosen, "Nostalgia: a 'Forgotten' Psychological Disorder," *Psychological Medicine* 5 (1975), pp. 340-54.

18. Michael J. Clark, "The Rejection of Psychological Approaches to Mental Disorder in Late Nineteenth-Century British Psychiatry," in *Madhouses, Mad-Doctors, and Madmen*, Andrew Scull, ed. (London: Athlone, 1981), pp. 293-7.

19. Sidney I. Schwab, "The War Neuroses as Physiologic Conversions," *Archives of Neurology and Psychiatry* 1 (1919), p. 593; and Arthur F. Hurst, "Hysteria in Light of the War Experience," *Archives of Neurology and Psychiatry* 2 (1919), p. 565.

20. Colin K. Russel, "War Neurosis," *Archives of Neurology and Psychiatry* 1 (1919), pp. 34-35. A current Canadian approach to dealing with operational stress is outlined in "Stress Management in Operations," Army Lessons Learned Centre Dispatches - Training for Operations, <http://www.army.dnd.ca/allc/website/english/products/dispatch/3-2/dis323c.htm>.

21. Richard Gabriel, *No More Heroes: Madness and Psychiatry in War* (New York: Hill and Wang, 1987), pp. 117-118.

22. Terry Copp and Bill McAndrew, *Battle Exhaustion: Soldiers and Psychiatrists in the*

Canadian Army, 1939-1945 (Montreal and Kingston: McGill-Queen's Univ. Press, 1990), pp. 58, 81, 114, 135, 149-50; and Gabriel, p. 46.

23. Stasiu Labuc, "Cultural and Societal Factors in Military Organizations," in *Handbook of Military Psychology*, Reuven Gal and A. David Mangelsdorff, eds. (Chichester: John Wiley, 1991), pp. 484-5; and Shabtai Noy, "Combat Stress Reactions," in *Handbook of Military Psychology*, p. 520.

24. Joseph M. Rothberg, et al., "Illness and Health of the US Battalion in the Sinai MFO Deployment," *Armed Forces and Society* 11, No. 3 (Spring 1985), pp. 413-4, 421-2.

25. Pinch, pp. viii-xiii.

26. Cook testimony, pp. 24-5, 31-2.

27. See for example Copp and McAndrew pp.149-161; and Allan D. English, *The Cream of the Crop: Canadian Aircrew 1939-1945* (Montreal and Kingston: McGill-Queen's University Press, 1996), pp. 145-154.

28. Noy, "Combat Stress Reactions," pp. 517, 519, 520. Noy's conclusions are based on an extensive review of the literature on the subject that have been supported by historical analyses of the subject in a Canadian context (see note 27).

29. Stasiu Labuc, "Cultural and Societal Factors in Military Organizations," in *Handbook of Military Psychology*, Reuven Gal and A. David Mangelsdorff, eds. (Chichester: John Wiley, 1991), pp. 484-5; and Noy, pp. 510, 522.

30. Pinch, p. xi.

31. Passey and Crockett, Exhibit No.51, p. 9; and Pinch, pp. 133-35, 139-43. Quote from Passey and Crockett, Exhibit No. 51.

32. See for example Noy, pp. 517, 519, 520; and English, *The Cream of the Crop*, pp. 79, 92-97.

33. Passey and Crockett, Exhibit No. 52, pp. 13-17. For a specific example of low confidence in senior officer leadership see Brett testimony, pp. 23, 24-5.

34. General Maurice Baril cited in Jeff Sallot, "Officer Poisoned by Own Platoon," *The Globe and Mail* (31 May 2000),

35. Solomon, pp. 29-30.

36. "Croatia BOI Action Plan,"

37. Despite some limited efforts to deal with these issues locally, a recent report of Minister's Monitoring Committee on Change in the Department of National Defence indicated that, while certain educational initiatives are proceeding in the CF, "a central plan was absent." "Second Interim Report of the Minister's Monitoring Committee on Change in the Department of National Defence and the Canadian Forces," nd [July 1999], http://www.dnd.ca/menu/press/Reports/monitor_com/eng/leader_e.htm, chapter 5, "observations," np.