Program Research Project

MITIGATING PTSD: EMOTIONALLY INTELLIGENT LEADERS

BY

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MITIGATING PTSD: EMOTIONALLY INTELLIGENT LEADERS

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ABSTRACT

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The War on Terror is characterized by a tenacious enemy, longevity, repeated deployments, unpredictable risk of injury and death, and an expectation of higher order of performance. It has extracted a tremendous toll on Soldiers exposed to combat related stress. Post Traumatic Stress Disorder (PTSD) is a signature injury of this war with far reaching implications that include reduced unit operational effectiveness, damaged lives, and enormous resource expense. In addition to identification, evaluation and treatment of PTSD, effective leadership may be a means to reduce the impact of PTSD. Research indicates that some combat units are more resilient than others and that this is directly attributable to leadership. PTSD is an emotional response to situational or environmental stressors that requires leaders who understand the influence of emotions on human response and can use emotional competence to create environments that enhance resilience. Current military doctrine does not adequately emphasize integration of emotional intelligence in leadership development. The incidence of PTSD is anticipated to continue in OEF. Every avenue for reducing the impact of it should be leveraged.

MITIGATING PTSD: EMOTIONALLY INTELLIGENT LEADERS

Since 2001 approximately 1.6 million military service members have served one or more times in Iraq and Afghanistan. Many of them have deployed multiple times and have been involved in combat operations. The operational environments of OEF and OIF are characterized by a cunning, ruthless enemy that employs guerilla warfare, a vastly different culture, and a political arena that demands a higher level of individual and collective military performance. The unpredictability of injury or death from IED explosion that requires constant vigilance and the absence of safe zones compromise the psychological resilience of even the most conditioned, experienced Soldiers.[1] While better armor and training have reduced the number of physical injuries and fatalities, psychological injuries have extracted a toll with far reaching implications and are signature injuries of this war.

Psychiatric casualties are not peculiar to OIF/OEF. Known by names such as "A Soldier's Heart", "Shell Shock", "Combat Fatigue" and now called Post Traumatic Stress Disorder (PTSD), psychological damage resulting from exposure to combat has always existed. Current interest in the identification and treatment of post-combat psychiatric problems of Soldiers is in part a result of the negative impact that PTSD has had on veterans of the Vietnam War.

PTSD is an anxiety disorder resulting from exposure to a terrifying event or ordeal that involves actual or threatened death or serious injury to one's self or others. It is a complex psychobiological condition that can emerge in the aftermath of life-threatening events when normal psychological and somatic stress responses to the event are not resolved. The response involves intense fear, helplessness, or horror.[2]

The precipitating traumatic event is persistently re-experienced through recurrent, intrusive recollections of the event. These include distressing realistic dreams, acting or feeling as if the event is recurring, intense psychological distress to internal or external cues that resembles the event, and persistent avoidance of stimuli associated with the event.[3] PTSD disrupts the ability to meet daily needs and perform basic tasks. Victims are fearful not only of the trauma but their reactions to it. Their ability to orient to safety is reduced and ordinary events are perceived as dangerous. Interest and participation in significant activities are diminished. Victims feel disconnected, display flat affect, and are less hopeful about their longevity.[4] Prospective studies have shown that the majority of trauma victims display a wide range of reactions in the weeks following the event and most overcome them within three months. Those who do not adapt are at risk for chronic PTSD. One-third of them fail to recover even after many years of mental health treatment.[5]

The most common precipitating factor of PTSD for Soldiers is combat duty. The correlation between exposure to combat operations and psychological injury has been well documented.[6] Multiple deployments increase the risk for PTSD. OEF and OIF are characterized by multiple deployments of Soldiers that has been unprecedented in the history of the all volunteer military forces. The OEF Mental Health Advisory Team (MHAT) VI 2009 survey found that Service Members on their third/fourth deployments reported more acute stress, psychological problems and higher use of medications for psychological or combat stress problems than those on their first deployment.[7] The 2009 OIF MHAT VI survey had similar findings, although the number of reported mental health problems was less than any year since 2004, reflecting the decrease in combat

operations in OIF.[8] There has also been a positive correlation between higher rates of PTSD among units deployed for 12 months or more.[9] There was lower prevalence rates for PTSD in Soldiers deployed to Afghanistan than Iraq, reflecting the lower level of combat intensity occurring in Afghanistan at that time. Although combat exposure is a common precursor of PTSD, other characteristics have been implicated. A study of UK Soldiers in OIF reported higher incidence of PTSD in lower ranking, less educated members, those who had experienced childhood adversity, and who were single, separated or divorced.[10]

The number of Soldiers affected by PTSD is difficult to determine accurately due to the wide array of entities reporting these statistics and variation in data collection and interpretation. Incidence and prevalence rates of PTSD vary extensively and are disputed. A common statistic cited for U.S. Troops with serious mental health problems is 30%.[11] In a study to determine the relationship between combat deployment and mental health care use during the first year following deployment, 19%, 11.3% and 8.5% of Soldiers returning from Iraq, Afghanistan and other areas, respectively, reported mental health problems. Thirty-five percent of those returning from Iraq accessed mental health care services during the first year of redeployment.[12] Between 2004 and 2007, 103,788 OIF/OEF veterans received health care at VA health care facilities. Thirty-one percent of them received mental health diagnosis and 56% of those had two or more distinct mental health diagnoses.[13] This number represents only those Service Members who had been discharged from active duty after serving in OIF/OEF. Since it does not include Service Members still on active duty who receive care in military treatment facilities, the actual number of Service Members with mental

health problems is conceivably far greater. Based on a survey conducted independently from DoD and the VA a representative sample of the 1.64 million Service Members deployed for OEF/OIF, researchers estimated that 18.5% or approximately 300,000 veterans met criteria for PTSD. The impact of PTSD goes beyond the direct effects of the trauma to Soldiers.[14] While most of the information on long term effects of PTSD on Soldiers is based on studies done on Vietnam era veterans, similar findings exist for OIF/OER veterans. The incidences of marital problems, interpersonal violence, parenting problems, substance abuse, and engagement in risk taking behaviors is increased for Soldiers with PTSD.[15] PTSD can also be detrimental to the mental health and wellbeing of the Soldier's partner and family as a result of coping with the Soldier's PTSD symptoms.[16]

The financial cost of treating Service Members with PTSD is significant. The Military Health System recorded 39,365 diagnoses of PTSD and spent an estimated $76.9 million for mental health care and prescriptions for these patients between 2003 and 2007.[17] A Rand study that considered costs for PTSD and depression in terms of treatment modalities, patterns of co-morbidity and lost productivity for a two year post redeployment period estimated that costs could range from $4.6 to $6.2 billion based on 1.64 million deployed Service Members. While the cost of treatment for mental health problems is significant, it is small compared to the long-term individual and societal costs resulting from lost productivity, reduced quality of life, domestic violence, strain on Families, and suicide.[18]

Psychological injury negatively impacts Soldier and unit readiness. Successful combat operations are predicated on optimal individual and unit performance.

Casualties are a consequence of war, but most are not battle injuries. In 2005 psychiatric problems in OEF/OIF were the first and fourth leading causes of evacuation out of theatre and accounted for six to nine percent of all evacuations. Of those who returned to CONUS only 3.6 percent eventually returned to theatre. Reasons for the low rate of return are multifaceted and complex and include illness acuity that was not amenable to treatment in theatre, seriousness of illness such as attempted suicide, the need for prolonged treatment, and command decisions not to redeploy these Soldiers to theatre. As of September 2009, 5,480 Soldiers were evacuated for mental health disorders, accounting for 10% and the fourth leading cause of all evacuations.[19] Because psychological problems have been recognized as having a significantly detrimental impact on combat readiness, enormous investments have been made to address them, particularly with regard to PTSD. The mitigation strategy appears to be multi-focal and includes resiliency training, assessment, treatment, and leader education.

Numerous resources exist for Service Members and leaders to use in addressing psychological stress. Each service has leader's guides for managing Troops in distress or controlling combat stress. Military OneSource provides free counseling services accessible by Soldiers without the knowledge of their chains of command. Websites and blogs including DoD, each military service, and the VA provide information and opportunities for sharing of experiences.

Since WWII Division Mental Health (DMH) assets have been available in garrison and combat deployments. In 2003 the transformation to Brigade Combat Teams (BCT) realigned these assets. At the division level DMH resources include a psychiatrist,

senior NCO, psychologist and social worker. Enlisted mental health technicians are assigned to each BCT. The DMH team provides multiple education briefings for senior and company level leaders on the effects of stress on combat readiness. The team also provides preventive, treatment and restorative services during deployment that include critical incident debriefs, command consultation, unit morale surveys and pharmacologic treatment and monitoring. DMH teams also track combat and operational stress reactions and psychiatric disorders.[20]

Mandatory pre and post deployment screening assessments for all Soldiers, including officers, are accomplished through the use of a standardized process. The post deployment health assessment survey includes four questions specifically related to PTSD to determine presence of symptoms. After completion of the survey Soldiers and officers undergo a face-to-face interview with a medical provider. Dependent upon the results of this evaluation Soldiers are referred for behavioral health consultation and treatment.[21]

Treatment of PTSD generally includes counseling, medication, or both. Critical event debriefing after combat related trauma, long used in an effort to prevent or minimize psychological reactions in theatre, has been found ineffective and is no longer recommended by VA/DoD clinical practice guidelines.[22] Cognitive Behavior Therapy (CBT) has been shown to be one of the most effective in preventing development of chronic psychopathology following trauma. CBT involves helping Soldiers understand and change how their thoughts and beliefs about the trauma cause stress and sustain symptoms. The various types of CBT have individual and overlapping components designed to help Soldiers recognize and adjust trauma-related thoughts and beliefs,

reduce anxiety and avoidance behaviors, and modify beliefs about safety, trust, power/control, esteem and intimacy.[23] Other counseling modalities include group and Family and couples therapy.

Pharmacologic agents such as antidepressants and sedatives have also been helpful in relieving PTSD symptoms and insomnia.[24] Complementary and alternative approaches such as herbal and dietary supplements, acupuncture, and yoga are also being used with varying degrees of success.[25] New technologies such as virtual reality therapy that use computer generated simulation, use of the internet for therapy, and video teleconferencing are also being used but clinical trials have not yet established their efficacy. These modalities do have utility for increasing accessibility and are reportedly more comfortable for those fearing stigma about receiving treatment.[26]

The increased availability resources and mandated assessments have made it easier for Soldiers to get treatment for behavioral health problems but barriers and stigma prevent many from getting the help they need. Less than half of redeployed Soldiers from OIF in 2004 diagnosed with a mental health problem were interested in receiving help, and only 23 to 40% reported actually receiving help. Soldiers with positive PDHA assessments for mental health problems were twice as likely as others to report fear of stigmatization.[27] This has not appreciably changed over the last six years. The OIF MHAT VI report revealed that barriers related to seeking behavioral health care were comparable to previous years, with more barriers and greater perception of stigma for maneuver than support and sustainment units.[28] The OEF MHAT VI report revealed higher barriers to care than in 2005, particularly for maneuver units. This is likely a reflection of higher troop dispersion and changes in the survey

instrument. Stigma rates for both types of units remained the same for 2005 to 2009.[29] Soldiers cite fear of negative consequence on their military careers if they seek mental health care. Many are more concerned about their peers knowing they have problems than their chains of command. There is a pervasive sense of distrust in mental health counselors in the DoD or VA, primarily related to confidentiality concerns.[30] Behavioral healthcare providers are required to notify commanders in the event that a Soldier is a danger to him/herself or others, and if child abuse is involved. This may be perceived by Soldiers as a betrayal of confidence when action is taken by the command. Actions have been taken to mitigate the stigma associated with receiving treatment for psychological problems. An example of this on a broad scale is the change in DoD policy that Service Members do not have to report receiving mental health care for combat-related reasons in security clearance investigations.

Admission of a mental health problem can have negative societal consequences. People tend to distance themselves from persons with psychological health problems. This may be in part because the public sees these persons as more responsible for their problems than those suffering with physical ailments.[31] Researchers have used the Attribution Theory components of causality and controllability to explain societal stigmatization of individuals with mental health problems. Psychological disorders may be viewed by the general population as being somewhat controllable and subsequently elicit more negative responses from others.[32]

Soldiers with PTSD may encounter social distancing from members of their units who are uncomfortable around them and may even blame them for their problems. Soldiers who experience PTSD are aware of the potential negative impact of admitting

they have a problem to peers or their chain of command. There may also be a component of self imposed stigma when Soldiers view themselves as responsible for their psychological problems and feel they should have control over them.[33] The military culture heavily encourages mutual support and reliance upon one another within military units. This close sense of community may hinder Soldiers from seeking care if they think they have disappointed fellow members by taking their problems outside the unit.

Previous attempts to mitigate the impact of PTSD have largely been unsuccessful. Historical approaches have focused on identification of Soldiers with PTSD symptoms and encouraging them to seek care. Most previous efforts have not changed the culture that promotes reticence about seeking treatment and have not focused on methods to help Soldiers achieve the resiliency important for preventing and mitigating effects of PTSD.[34] A widely recognized effort to focus on this area was the development and dissemination of Battlemind Training. It was designed to help Soldiers understand their experiences and responses to combat as normal for those conditions and to help them make successful transitions from theatre to home.[35] Battlemind Training was the precursor to the current Army Comprehensive Soldier Fitness Program. This program represents the transition to a preventive model designed to build resiliency and better prepare Soldiers for combat duty through five domains of health (physical, emotional, Family, social and spiritual). Army leadership has endorsed this program with intended establishment through the military career cycle and believes it can reduce PTSD, the incidence of destruction behaviors and lead to a greater likelihood of post-adveristy growth and success.[36]

The role of leaders at every echelon is pivotal in mitigating the impact of PTSD. Leaders with responsibility for the day to day environment of Soldiers have a fundamental impact on their Soldiers' health and welfare. Senior leaders set policy and direction to subordinate leaders on a broader scale that filters down to leaders at the battalion and company levels and influences subordinate leadership. The OIF MHAT VI survey identified resilient maneuver platoons that had relatively low reports of behavioral health problems. Perception of officer and NCO leadership was the most important factor associated with unit resiliency.[37] Stigma, not being able to get time away from work for treatment or transportation to appointments, and the lack of emphasis placed on assessment and treatment are barriers to care that directly reflect on leadership. Leaders set the environmental climate in their units. This greatly influences the monitoring of Soldier wellness, acceptance of psychological stress as an expected consequence of combat, encouragement to seek early treatment, and the expectation that all levels of leadership will support these elements. Combat leaders have become increasingly aware of the impact of PTSD on their Soldiers and unit readiness and are taking measures to mitigate the impact. Training of subordinate leaders to address combat stress with their Soldiers and deal with their own stress rather than adhere to a "suck it up" mentality have been recommended by battalion and company level leaders to prevent poor leader decisions that decrement Soldier performance, reduce escalation of force incidents and diminish stigma associated with seeking treatment.[38]

The symptoms displayed by Soldiers with PTSD are emotional in nature and pose specific challenges for leaders who are responsible for Soldier wellbeing and

maintaining positive unit organizational climate and mission accomplishment. Creating the kind of environment conducive to mitigation of the effects and impact of PTSD requires leaders with an enhanced set of skills and attributes that include self-awareness, empathy, self control, and interpersonal relations ability. In short, they must be emotionally intelligent.

Emotional Intelligence and Leaders

Emotion represents a universal and intrinsic aspect of human consciousness which functions as an evaluative representation of the environment and moderates cognitive, behavioral and physiological phenomenon. Emotions are internal representations of the affective evaluations one attaches to events in the external environment. They play a central role in shaping how people perceive the world, bias their beliefs, make decisions and adapt their behavior to the physical and social environment.[39] This is the basis from which emotional intelligence (EI) has evolved. EI refers to the ability to perceive, control and evaluate emotions. Researchers Salovey and Mayer define it as the subset of social intelligence that involves the ability to monitor one's own and others' feelings and emotions, to discriminate among them, and to use this information to guide one's thinking and actions.[40] The theory of EI encompasses intrapersonal and interpersonal intelligence. Intrapersonal intelligence refers to an individual's ability to fully understand his own emotions and thoughts. Interpersonal intelligence refers to the ability to notice and interpret the moods, temperaments, motivations, responses and intentions of others.[41]

The importance of emotion in understanding social behaviors such as leadership, persuasion, self-regulation, social intelligence, productivity and organizational effectiveness has been fairly well established. Goleman's research involving over 200

major corporations found that the most effective leaders were distinguished by high degrees of self-awareness, self-regulation, motivation, empathy, and social skill – the essence of EI. Additionally he found that emotional intelligence was twice as important as technical skills and IQ for job performance at all levels and describes EI as the sine quo non of leadership. "Without EI a leader can have the best training in the world, an incisive, analytical mind, and an endless supply of smart ideas, but he still won't make a great leader."[42] Leaders who understand emotions are more successful in motivating subordinates through inspirational vision and sense of mission that raises levels of optimism and enthusiasm.[43] These elements are strongly associated with high morale and unit cohesiveness which subsequently enhances hardiness and resiliency. In the military arena such team cohesion exerts a powerful influence on unit resiliency in times of stress.

Goleman identifies four dimensions of EI: self awareness, self-regulation, motivation and empathy. Self awareness involves a deep understanding of one's feelings, strengths, weakness, needs and drives. It enables leaders to recognize how their feelings affect them and those of other people. Self-awareness is a precursor to the ability to control, or self-regulate, their feelings and impulses. Self-regulation permits leaders to seek feedback and use it to tailor actions that are perceived as positive. Motivation refers to an intrinsic desire to achieve beyond expectations. Leaders with high motivation remain optimistic even against adversity which enhances the ability to overcome frustration and set that tone for subordinates. Empathy refers to the ability to consider the individual needs of others.[44] It allows leaders to perceive and understand

emotional cues, helps them to sense moods of individuals and groups and communicate information in a way that promotes understanding and acceptance.[45]

The attributes of EI are most clearly exhibited in effective interpersonal skills that enhance the ability to work with and through other people. Unfortunately, for many leaders there is far less emphasis on development of interpersonal skills than technical and operational competencies whether by design or ignorance. In a study by Eichinger and Lombardo of executives, the most prevalent reason for failure was poor interpersonal skills that included over managing, insensitivity, defensiveness, arrogance, failure to build teams and lack of self composure.[46] Similar results regarding ineffective leader traits exist in military leadership.

The Army has long recognized that its success depends upon its people and emphasizes effective leader-subordinate relationships, teamwork, *esprit de corps* and organizational climate. Much emphasis has been placed on leadership development (LD) but there is a belief that the Army continues to practice and teach leadership as it has for decades and fails to grasp the nuance of what leadership is and what developing leaders means.[47] In a LD summit conducted in November 2008 discussion involved interpretation of the meaning of LD, utility of the current model and redundancy of LD roles and functions internal and external to TRADOC. The general consensus of participants was that current LD is too institution focused when 80% of LD occurs in units through experience or osmosis rather than by design and ignores operational and self development.[48] A Rand study that surveyed junior and senior officers reported that there is no standard set of activities that comprise unit level LD programs.[49] Given that institutional curricula fails to adequately address LD and that there is no standard LD

program for units, LD requirements may not be met for the traditional leadership elements or the facets of EI.

Army doctrine has recognized a more holistic view of increased emphasis on what are considered to be emotional factors of leadership. FM 6-22, Army Leadership, addresses Soldier and leader self awareness and control, empathy, stability, balance and interpersonal tact which are all elements of EI.[50] FM 6-22 articulates these elements as attributes and competencies, and they closely resemble the EI dimensions described by Goleman. However, the doctrine falls short in not discussing the importance of understanding and applying the emotional aspects of leadership. It does not discuss how to develop the skills that enable application of emotions effectively.[51]

In studies of command climate and leadership evaluating leader attributes most valued by officers, interpersonal skills rank among the top. Many who have experienced "toxic" leaders understand the importance of self awareness, empathy, and desire to develop the unit environments that produce team cohesion and resilience. The most highly respected senior officers were consistently those who were perceived to have strong interpersonal skills.[52]

The same characteristics of EI that officers value in such surveys are the same characteristics that have the potential to produce leaders, environments and a culture to reduce the impact of PTSD individually and collectively. The development of leaders with EI attributes requires integration of the concepts in leadership development curriculum beginning with the Warrior Leader and Officer Leader Basic Courses and continues throughout the career cycle. The utilization of standard models through LD curricula would be an effective method for developing a common language and

understanding of the concepts of EI among all strata of leaders. EI means that understanding one's own emotions, strengths and weakness is a prerequisite to developing the self-awareness pivotal to emotionally intelligent leadership. Introduction to the concepts of EI in the classroom setting should include utilization of an evidence-based self assessment tool. The self assessment should be completed prior to attendance at Leadership courses so that follow-up with interpretation, explanation and discussion of the implications of the results on leadership led by knowledgeable facilitators can be done during the courses. Self assessment conducted early in career leadership courses can enhance the ability of officers to understand their behavioral responses and develop self-awarness. At the intermediate and senior levels when NCOs and officers have had more leadership experiences, a 360 degree assessment should be included in LD courses using the same methodology for interpretation, explanation and discussion of results. A possible model for these assessments is the Leadership Practices Inventory development tool created by Kouzes and Posner, which includes self assessment and observer assessments. The assessment tools are part of a leadership challenge program based on five practices of exemplary leadership: model the way, inspire a shared vision, challenge the process, enable other to act, and encourage the heart.[53] The practices of leadership articulated in the Leadership Challenge program integrate the elements of emotional intelligence. This program is being used in some senior leader and pre-command courses with positive feedback, but is not routinely used either in LD curricula or unit level LD. It is reasonable to suggest that if these assessments were implemented earlier in LD courses the impact on leader effectiveness through enhanced self-awareness and development of interpersonal skill

competency would occur earlier in the career cycle. It is also reasonable to suggest that as these leaders are promoted into senior level positions with greater organizational influence, a cultural change that operationalizes the value of EI could result. Leaders at the battalion and lower levels generally have closer relationships with subordinates, are more likely to recognize Soldiers with PTSD, and set a climate for effectively addressing their psychological stress.

Adult learning theory asserts that adults learn best by application of education through relevant experiences. Military leaders highly value their operational experiences and feel that they learn the most from them. Implementation of experiential learning during LD courses could be an effective method for leaders to learn and apply the concepts of EI in a low-risk environment that permits feedback and encourages discussion from instructors/facilitators and fellow students. Facilitators with successful leadership background using situational scenarios could provide opportunities for leaders to analyze their behavioral responses to situations and receive feedback that reflects their interpersonal skills. In his paper on leadership self awareness and interpersonal relations, Montgomery suggests implementation of an interpersonal integrative experience at the beginning of all LD courses that explores interpersonal dynamics of inclusion, control and openness. The concept of inclusion involves determining how one initially fits into an organization. Control involves testing one's ability to exert influence and determining and the degree of freedom that exists within the group. The concept of openness promotes examination of interpersonal dynamics and determining how much trust one wants to foster within the group. This learning experience about relationships in group development provides an opportunity for

interpersonal issues and behaviors to be acted out. He asserts that leaders who understand these dynamics will have a better comprehension of subordinates and be better able to foster trust and group cohesiveness.[54]

Self and feedback assessments have already been selectively used in the Army. Special Forces require Soldiers who are adept at developing teams and working effectively with a wide variety of people and recognize that self-awareness and interpersonal skills are critical to mission success. Cadre use self and 360 degree assessments to help candidates reconcile their self concepts with those of others. Candidates who are unable to accept feedback and grow from it are generally not accepted. This helps to ensure that those selected have high levels of self-awareness, which is one of the characteristics of emotional intelligence.[55] The standard use of such assessment tools at even the lowest leader levels may have the potential to generate serious acceptance of EI attributes, particularly if they are used for position and promotion selection.

At least one Army Division has used feedback assessments to improve leadership development of senior leaders and create a system of performance benchmarks. The leadership core competencies assessed included self-management, organizational capabilities, team building, problem-solving and sustaining the vision. Within these competencies the assessment tool imbedded leadership characteristics that reflect emotional intelligence: self-awareness, self control, resilience, interpersonal skills and working with and through others. Officers were given feedback about their potential in the five core performance competencies which allowed them to identify areas for improvement. The feedback reports also allowed individual officers to

benchmark their competencies against those of others in the division. The interest level of the officers being assessed and division leadership was very high. The aggregated feedback data permitted a comprehensive view of the entire senior leadership landscape and enabled command visibility into areas that required further development on a large scale.[56]

The development of emotionally intelligent military leaders is a beginning point. Unless the skills learned are incorporated consistently into a style of leadership they are virtually useless. Herein is the challenge. The Army culture is one that values toughness and bravado because the mission it is responsible for is difficult and requires those attributes to achieve success. While the concepts of self-awareness, empathy and effective interpersonal skills may on face seem at odds with this, the culture also embraces “taking care of Soldiers” who are human beings with emotions that must always be considered, whether in developing cohesive teams, preparing them mentally for combat operations or helping them overcome psychological stress or damage. Leaders who can reconcile these seemingly contradictory requirements are those who inspire trust and build the self-confidence in subordinates ultimately resulting in resilience that protects and sustains them in the difficult situations they will encounter. This is particularly salient with regard to Soldiers experiencing PTSD.

Great emphasis has been placed on creation of environments that produce hardy, resilient Soldiers through cohesive team building. Experienced commanders recommend candid group discussion about the potential for psychological problems prior to deployment. They also cite the importance of knowing their Soldiers so that changes in performance, attitude or affect can be recognized early and setting

the expectations that they will be quickly and appropriately addressed.[57] Combat leaders are not experts in psychology but they have access to resources that are. They should not wait until problems surface but actively incorporate behavioral health providers as a matter of course, routinely, so that they become a fixture Soldiers become accustomed to and are readily available so that they more easily approach them to discuss small issues. This has the potential to prevent larger issues that compound psychological problems resulting from combat exposure. It also sets the tone that psychological issues are an anticipated and acceptable part of combat experience that need to be addressed in much the same way that physical injuries are. This kind of environment could conceivably build Soldier trust in leaders, reduce the perception of stigma and encourage Soldiers to seek help. While doctrine has placed emphasis on mandatory behavioral assessments, leaders are the real enforcers. The adherence to policy and the quality of the assessments are direct reflections of unit leader emphasis. Behavioral health providers are experts in gauging unit climate and can provide candid and useful feedback to leaders if they are consulted, and their advice is trusted and taken seriously as opportunity to improve Soldier and unit combat readiness.

When Soldiers do demonstrate psychological problems they need to be handled in a way that preserves their dignity and respect. Leaders have many competing demands. Determining how best to respond takes careful consideration and is time consuming. It is often difficult for leaders to be empathetic because the symptoms of PTSD may be demonstrated in ways that appear to reflect dereliction of duty, hostility, slovenliness, and drug or alcohol use which are unacceptable behaviors in the military

culture. Conversely, the symptoms of PTSD can be mimicked by Soldiers who do not have PTSD. Even behavioral experts sometimes have difficulty diagnosing PTSD. This is when leaders need to know their Soldiers, understand their own emotional responses, and use all of their emotional intelligence to select the response that will benefit rather than punish the Soldier who needs help. Emotionally intelligent leaders are far more likely to be able to do all of these things because they understand the criticality of human emotions.

Merely having knowledge of the concepts of EI will not ensure that leaders incorporate them into their leadership style. "The costs of selecting and promoting leaders with poor emotional intelligence are lost unit effectiveness and junior leadership disenchantment,"[58] NCO and officer evaluations should include emphasis on interpersonal skills effectiveness. Currently NCOERs and OERs list characteristics intended to reflect valued leader attributes, but unless the evaluated leader is profoundly deficient there is little emphasis placed on them in the evaluation. Doctrinal implementation of a mandatory 360 degree assessment could provide a window through which not only unit command climate might be viewed but also provide a mechanism for holding leaders accountable. Results of the assessment should be made a required element addressed in the rater's evaluation and should be used to evaluate NCOs and officers for subsequent leadership positions. Command Climate Surveys have long been used in the Army as a way for commanders to obtain anonymous feedback from subordinates in a variety of areas that include confidence and trust in leaders and indicate areas for improvement. Positive command climate reflects unit

cohesiveness and resiliency. This, in turn, enhances the creation of unit environments that can mitigate the effects of psychological stress on Soldiers with PTSD.

PTSD as a consequence of war has enjoyed a long history leaving in its wake psychological pain and destruction of lives. The impact of it to society in terms of lost productivity, reduced military performance and treasure is in the billions of dollars. The detrimental impact of the damage to Soldiers and Families over the next generations is inestimable. Soldiers have borne the brunt of this war and many may have lifelong problems because of it. The sacrifices they make in fighting America's wars should not include long lasting psychological damage. While the substantial investment and emphasis placed on preventive measures, assessment and treatment regimens have made substantial inroads, more emphasis needs to be placed on the development of emotionally intelligent leaders who possess and demonstrate effective interpersonal skills. The development of emotionally intelligent leaders should begin early in the military careers of enlisted Soldiers and officers, and continue throughout the career lifespan. Elements of EI should be incorporated into leadership curricula. Use of self and 360 degree assessments and rater evaluations should be implemented and incorporated into consideration for promotion and leadership positions. While these initiatives will not prevent or cure all PTSD, they have the potential to build resiliency and promote a culture change that reduces the stigma that prevents Soldiers who need care from seeking it and encourages the unit support necessary to mitigate the detrimental effects of PTSD.

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