Staff Sgt. Jean M. Whaley, the suicide prevention program manager for the Mississippi Army National Guard, fistbumps a soldier after a conversation 6 June 2016 at Fort Hood, Texas, during a multiechelon integrated brigade training exercise (MiBT). Whaley is a member of a behavioral health team composed of a nurse practitioner, a behavioral health specialist, a medic, and a chaplain from the Mississippi National Guard, whose mission is to take care of the soldiers during the 155th Armored Brigade Combat Team's MiBT. The stigma associated with mental health counseling in the military has decreased greatly, but leader involvment can also be an effective way to help poorly adjusting soldiers. (Photo by Sgt. Connie Jones, 102nd Public Affairs Detachment)

Rediscovering Leadership as an Antidote to Adjustment Problems in the Army

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Leaders must reclaim their role as mentors who teach soldiers how to adapt to the Army. Seamless access to behavioral health resources may inadvertently reduce leader involvement with poorly adjusting soldiers. Diversion of these soldiers to behavioral health deprives leaders of the opportunity for deeper involvement with them and ultimately from creating a cohesive unit culture. Displaced leader presence may perpetuate soldier adjustment problems and ingrain a leader practice ill-disposed to the future battlefield. The anticipated rigors of large-scale war will stifle routine access to behavioral health, suggesting the need for leader-driven methods of maintaining mental readiness and unit integrity without strict reliance on behavioral health.

Army leadership doctrine explicitly states that leaders work to integrate new members rapidly and effectively into the unit and use unit activities to build esprit de corps.[1] Army leaders are coaches and mentors who develop cohesive teams and who lead by example. According to doctrine, Army leadership is an engaged and dynamic social adhesive constantly at work with subordinates; in practice, however, Army leadership is a corporate process focused on deliverables and outputs to higher levels of the rank structure.[2] The effects of the corporate process are clearly seen at the company level where leadership is overworked often due to excessive tasking from higher echelons.[3] The focus on providing support for installation functions, noncombat-related training, and any number of details and working parties keeps units fragmented and preoccupies company-level leaders with ensuring that deliverables are met. There is little time for the vast array of individual and team-building practices prescribed by doctrine.

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Insufficiently cohesive and overly stressed units become social groups that suffer anomie. Anomie occurs when the norms of a group are unclear.[4] People feel less tied to their group during anomie and individual goals become confused. Anomie contributes to a feeling of meaninglessness, and in the extreme, it is a driver of suicide.[5] Units that are bogged down with tasks unrelated to their functional mission will not be able to create the organic solidarity needed for cohesion. Soldiers tasked to beautify the installation, check identification cards, and complete online trainings, in addition to their other duties, may question their purpose. With their soldiers completing stove-piped tasks, often in disparate locations, leaders will not have the opportunity to instill the institutional, or moral, regulation needed for cohesion. Leadership becomes an impersonal series of task directives, and soldiers are soldiers insofar as they complete their tasks. Anomie may occur in such a situation and contribute to a source of distress that propels soldiers to behavioral health.

Perception of behavioral health utilization is greatly improved from the recent past. The decrease in stigma across the military can be seen in the long wait getting an appointment with a behavioral health provider.[6] So many service members are using behavioral health that the system is backlogged. One estimate of Army behavioral health utilization found that 21 percent of soldiers used mental health services in a twelve-month period.[7] Soldiers seek behavioral health treatment for several reasons. Some soldiers may have had an undiagnosed mental disorder upon entry to the Army, and the distress related to that disorder only became apparent during their time in service. Soldiers may have also had a predisposition to a mental disorder that manifested in conjunction with the stress of the Army. Furthermore, soldiers may have acquired a condition, such as posttraumatic stress disorder or adjustment disorder, during their time in the Army. Yet, soldiers commonly seek behavioral health services for reasons less emergent. High-functioning soldiers may believe they have attention-deficit/hyperactivity disorder and seek pharmacologic treatment for their disorder when they perceive they are not performing to their standard. Soldiers in training status may have difficulty with the military lifestyle and seek behavioral health

Adjustment disorder accounts for over one quarter of the soldiers receiving behavior health treatment. (Photo taken 8 September 2016 by Erin Bolling, USAMMDA PAO)

counseling for the malaise brought on by the novelty of the military. Leaders may also send their soldiers to behavioral health when they see a range of problems, including soldiers having difficulty with others, soldiers not performing well at work, or soldiers exhibiting disciplinary problems.

Army behavioral health often serves as a venue for working with soldiers who have difficulty adjusting to the psychosocial circumstances of the military. Some of the psychosocial circumstances soldiers struggle with include dealing with a boss, interacting with peers, missing life back home, facing the reality of adulthood, or just wanting to be away from the workplace. Soldiers with these complaints, and their attendant anxiety and depression, may be diagnosed with adjustment disorder if their distress is great or if their symptoms impair their ability to function. If so, they are provided psychological and pharmacologic therapies with the expectation that they will adjust to their perceived stress and return to full functionality. Many of the psychosocial problems that grow into an adjustment disorder are preventable, suggesting the need for more emphasis placed on prevention.

The Leader's Role in Preventing Adjustment Disorder

Adjustment disorder is a condition commonly treated by Army behavioral health. An adjustment disorder is the development of distressing and impairing symptoms that occur in response to a stressor.[8] Across the military, adjustment disorder accounts for 25 to 38 percent of service members receiving behavioral health treatment.[9] In a sample of Army aviation personnel who received a behavioral health diagnosis, 38 percent had an adjustment disorder.[10] Military suicides occur more frequently with adjustment disorder than many other psychiatric conditions.[11] The military environment may foster adjustment disorder through the nature of the military: strict discipline, loss of control, increased feelings of stress, and reliance upon others. Young people are also removed from their social support and stress-buffering systems when they join the Army, which may result in the magnification of feelings of stress if they do not acquire new methods of coping. It is important to recognize that an adjustment disorder is a psychiatric

disorder that requires professional attention. Army leaders must leave treatment to the behavioral health professional. Leaders, however, play an integral role in preventing adjustment disorder.

Anomic situations at the unit level may be a driving force of individual soldier maladaptation. Units may lack solidarity because of a focus on tasks and deliverables that are disconnected from the unit's military mission. Esprit de corps is not established when the unit is engaged in relatively uncooperative, seemingly irrelevant tasks. Soldiers may become understimulated, resentful of work or of others, and nihilistic in their outlook. In these situations, leaders do not guide their soldiers and foster a culture of solidarity beyond ensuring that tasks are complete. Soldiers become familiar to leaders when they exhibit behavior problems, such as avoiding work or not getting along with peers. These soldiers may eventually go to behavioral health because of feelings of anger, depression, or anxiety, or their leaders may recommend they go to behavioral health out of a good-faith concern about the soldier's well-being. Once at behavioral health, the soldier is assessed as appropriate, and if symptomatic, becomes a psychiatric patient.

The association between poor unit cohesion, leadership, and behavioral health disorder was noted in the Military Health Advisory Team 9 study.[12] Ratings of perceived unit cohesion and unit readiness were lower in Military Health Advisory Team 9 than previous studies. The study found a significant correlation between a poor perception of leaders and high behavioral health risk, while effective leadership was associated with improved behavioral health and organizational effectiveness. The study found that soldiers consistently complained about disengaged leadership, of "people sitting in the TOC [tactical operations center]" not having awareness of what was happening on the ground. The themes of "teamwork" and "common objectives" were rated highly by study participants. Participants cited "sharing hardships," "sharing burdens," and "mutual respect" as important to morale and cohesion.[13]

The author of this article served as an organic behavioral health officer in an infantry brigade combat team for fifty-five consecutive months, during deployment and in garrison, and observed how leadership has a direct impact on mitigating or instigating adjustment problems. One brigade commander had the effect of lowering suicidal behavior within the brigade by keeping the brigade focused on combat-related training. Although various battalions had different tasks—some overseas, some training other units in the continental United States, and others in the field—they all were focusing on missions that reinforced their military identity. The brigade commander attributed the decrease in behavioral health emergencies to an "idle hands" theory, but he tapped into something much deeper. By giving his unit a military mission and zealously executing that mission, his soldiers had shared meaning and purpose—the opposite of anomie.

> "Soldiers from 'that unit' do not have unusual cases of mental illness; rather, they are exhausted, distrustful of leadership, dejected, and confused. They feel like they have no purpose."

The author's experience in Army clinics, Army community hospitals, and Army medical centers provided opportunity to notice a trend across installations pertaining to "that unit." "That unit" is familiar to any behavioral health provider who works for the Army. "That unit" denotes an organization with high behavioral health utilization due to organizational problems. The high utilization is more specifically related to the unit's leadership as evidenced by soldiers complaining about the unit, by specific names of leaders becoming familiar to behavioral health providers because so many of their soldiers complain about them in therapy, and by soldiers heavily relying on the emergency walk-in service. Soldiers from "that unit" do not have unusual cases of mental illness; rather, they are exhausted, distrustful of leadership, dejected, and confused. They feel

like they have no purpose. The unit cohesion is evidently poor, and at least from the perspectives of the unit's soldiers, it is due to leadership. Anomie is apparent in those units and contributes to adjustment problems. "That unit" could come from infantry, cavalry, aviation, transportation, medical, Advanced Individual Training, or any other units.

A unit's anomie and associated adjustment problems may become particularly manifest during red cycle taskings. Red cycle is the part of the Army's green-amber-red time management system where a unit executes higher-headquarters-directed taskings.[14] During red cycle, soldiers may be sent to disparate locations on post or elsewhere to accomplish tasks that oftentimes do not have a military character. Soldiers complain about understimulation and disconnectedness when on red cycle tasks. They may also experience feelings of meaninglessness and rage as they contemplate the futility of their work or the leave they feel was unjustly denied. They are away from their parent unit and social support during red cycle, so their stress management resources are often compromised. Red cycle taskings provide a clear example of how lack of meaning and purpose can lead to the feelings of stress that manifests as an adjustment disorder.

Army leaders should consider how their unit cohesion contributes to stress that eventually manifests as a behavioral health condition. It is necessary to recognize that many leaders, especially those at lower levels, are constrained by higher echelons on what they can do. Subordinate leaders must communicate to higher echelons the impact expected deliverables have on the health of their unit, while meeting the prescribed tasks. Despite their constraints, company-level leaders can work to provide a greater sense of belonging, fairness, and shared identity that may buffer the stress inherent to Army life and work against anomie. On an individual level, for example, leaders can proactively help soldiers who display problems integrating into the unit or help settle disputes between soldiers. This requires leader presence to identify potential problems before they become problems and willingness to become involved in soldier matters.

When they are more involved with their units, leaders reclaim an important leadership role that has been unintentionally usurped by behavioral health—mentoring. Leaders should be the ones teaching their soldiers about the realities of the military, about maintaining perspective, and about how to get along with their battle buddies. Yet, it is often a psychotherapist who helps the soldier problem solve out of their difficulties, or who helps them better understand their leaders and peers. These human problems are not psychiatric disorders in and of themselves; however, they are seeds of something more serious the longer they are misperceived. A leader who genuinely helps a new soldier understand the realities of the military may prevent a range of misinterpretations by the soldier if left to the soldier's own perception of the matter. For example, leaders can help soldiers understand that everyone gets chewed out in the Army, while at the same time helping soldiers see they are still part of the team afterward.

Leaders may potentially decrease some of the behavioral health conditions that interfere with future readiness by mentoring and fostering a cohesive unit culture. Leaders can help soldiers understand the meaning of their work, find enjoyment when living in the barracks, and solve any number of difficulties related to young adulthood and Army service. These military-specific, relatively common experiences can become the source of a soldier's private despondency, ill-advised decisions, and ultimately behavioral health condition, if soldiers are incapable of figuring them out on their own.

The solution to the adjustment problem in the military is more complicated than a simple "follow the doctrine" or "do what you are supposed to be doing" response. The current generation of soldiers may have a greater propensity to behavioral health dysfunction than previous generations. Soldiers who comprise "Generation Z" or the Network Generation ("NetGens") have higher levels of mental health complaints than other generations.[15] This might suggest that more soldiers entering the Army have mental health problems, or they may have a lower threshold for the stress that precipitates a mental health problem. Current leaders have also led in an era of pervasive behavioral health access and may have become accustomed to outsourcing soldier matters to behavioral health. Units often have uniformed behavioral health officers and may even have a whole team of embedded behavioral health providers serving the specific unit. Other behavioral health assets are found at the installation clinic, hospital, or medical center. These behavioral health providers become familiar to leaders who communicate with them on matters pertaining to fitness and rehabilitation. Behavioral health

Soldiers of the 1st Theater Sustainment Command (TSC) participate in a 1st TSC unit run at Fort Knox, Kentucky, 6 August 2021. The 1st TSC held the run to build esprit de corps and maximize the unit's physical readiness. Leaders can help minimize adjustment disorder by encouraging events that foster a sense of inclusion. (Photo by Sgt. Owen Thez, U.S. Army)

providers may even attend unit-led high-risk meetings and serve as an ongoing source of consultation for leaders. Overtasked leaders may see a ready-made solution to their soldier challenges in the form of behavioral health.

Leader-Driven Solutions

Current leaders might consult past Army leaders to see how they led before the era of behavioral health. This might offer insight into how unit cohesion and readiness was maintained without seamless recourse to a behavioral health provider. The military-related stress that propels soldiers to behavioral health today was undoubtedly present in the past. But, since behavioral health was much less prevalent, how did leaders keep soldiers in the fight? Consider the Army suicide rates from calendar year 2008 (20.2 per 100,000) and calendar year 2019 (29.8 per 100,000).[16] Army suicides were substantially lower in 2008 despite fewer behavioral health resources and greater stigma against behavioral health. One possible reason for the lower rate is the clear mission focus in 2008 on the wars in Iraq and Afghanistan, which offered an undeniable sense of purpose and cohesion. Leaders, nevertheless, had to orchestrate this sense of shared purpose through things such as counseling, consoling, advising, and training.

A challenge for leaders is to be both an authority figure, who maintains the standard and delivers punishment if needed, and a trusted figure, who can be approached as appropriate and offer a good faith response to a soldier's issue. It may be difficult for leaders to reconcile these roles. Yet, it need not be one or the other; leaders can discipline when appropriate but also be a source of safety for soldiers. This situation challenges implicit understandings of relationships for both the soldier and leader. Soldiers may receive punishment from an authority figure and misinterpret, overinterpret, and magnify certain aspects of the situation that may be salient to their personal history. This could mean a rather benign correction, or a

correction that applies to several soldiers, is interpreted as something extremely personal to the soldier. The soldier may be prepared to see the leader a certain way, and the soldier's interpretation can significantly deviate from the facts at hand. In addition to soldiers, the leader's history also affects how he or she interacts with soldiers. Leaders may find it easy to be one or the other—authority or mentor. The Army might invest in an executive coaching paradigm for leaders at all levels to develop leaders capable of understanding their strengths and weaknesses in the interpersonal domain and bolstering their skills in developing others.

All levels of Army leadership can contribute to the reduction of stress in the ranks. Although the emphasis of this article is on first-line, company-level leaders, leaders at higher echelons also have a role in reducing adjustment disorder. Budgeting priorities, for example, should consider securing funds for contractors to perform basic installation functions that company-level soldiers have been the bill-payer for. Higher echelons might also consider how their taskings interfere with activities that cultivate the type of unit environment prescribed in doctrine. The can-do attitude of lower-level leaders may obfuscate the impact taskings have on unit cohesion, necessitating higher-level leaders to see how their subordinate commanders are actually faring with tasks.[17]

The institution and leaders have accepted behavioral health as the answer for soldiers experiencing difficulties. This is good, and unfettered access to behavioral health should be normative in Army culture. The presence of behavioral health, however, should not displace the leader's role in concern for their soldiers and support of their well-being. Encouraging soldiers to visit behavioral health when they are experiencing stress may be seen by leaders as an act of caring for the soldier. It is, but more can be done from a leader's perspective to understand the soldier's stress, particularly if the source of stress is the leader's unit. A behavioral health referral should not be a "fire and forget" experience for leaders. If a modicum of trust exists, the soldier may disclose how work or family life impacts the soldier's well-being. Leaders may be in a unique position to effect positive change for the soldier and alleviate a source of distress. Leaders may also proactively offer insight and ongoing support for dealing with stress commonly experienced by soldiers, and in this way, develop a mentoring relationship.

> "Unfettered access to behavioral health should be normative in Army culture. The presence of behavioral health, however, should not displace the leader's role in concern for their soldiers and support of their well-being."

Large-Scale War and Behavioral Health Access

Access to medical resources, including behavioral health resources, will be significantly curtailed during large-scale combat operations (LSCO) when compared with Operations Iraqi Freedom and Enduring Freedom. The curtailed access may be attributed to emphasis on mobile, dynamic forces as opposed to static bases of operations, contested air dominance, and enemy antiaccess/area denial (A2/AD).[18] The access problem challenges the Army behavioral health paradigm of bringing the soldier to a behavioral health provider or bringing a behavioral health provider to the soldier. This problem suggests that leaders will have longer wait times to get their soldiers to a behavioral health professional, necessitating leader-driven, unit-level approaches to addressing behavioral health matters within units.

Leader-driven efforts at behavioral health stabilization will likely be informed by Army Techniques Publication (ATP) 6-22.5, *A Leader's Guide to Soldier Health and Fitness*.[19] ATP 6-22.5 lists some relaxation exercises leaders or soldiers could employ to stabilize combat stress reactions, but the recommendations

focus more on preventative measures or referring the soldier to a combat and operational stress control team for definitive care. The ATP acknowledges that cohesion and morale, confidence in leaders, and confidence in the unit are important for reducing combat stress reactions. Although of some utility, the relaxation techniques listed in ATP 6-22.5 by themselves would not satisfy the behavioral health demand in theater during Operations Iraqi Freedom and Enduring Freedom, so it stands to reason it will not suffice during a LSCO scenario. The ATP's focus on prevention, preparation, and resilience may be the leader's best option for anticipating behavioral health casualties.

Prevention begins with proper screening. Many behavioral health conditions and treatments are prima facie deployment limiting or service disqualifying.[20] Close contact with a behavioral health officer will help the leader determine who will not be good candidates for deployment. This would be no different than deployments during the Global War on Terrorism. Despite assiduous screening, however, combat stress casualties will occur in combat. The significant difference with the Global War on Terrorism in this regard would be the relative ease with which a leader could get a soldier access to behavioral health. A behavioral health provider was always a forward operating base (FOB) away or even on the same FOB or combat outpost as the soldier. Since LSCO will not be FOB-centric, leaders will have to travel farther for behavioral health support. Travel around the battlespace will not be permissive during LSCO due to lack of U.S. air superiority and adversary A2/AD capabilities; hence, the importance of prevention.

Leaders may begin preventative efforts by investing in cohesive teams that have clear meaning and purpose. Instilling meaning and purpose is an uphill battle for leaders who are accountable to corporate processes. Nevertheless, the author has observed how certain units could be tasked with some of the more arduous missions in theater, take casualties, and continue with their mission unabated. These units cultivated esprit de corps well before they were deployed into theater. This was evident by unit members proudly wearing their unit shirts, soldiers competing and winning in brigade and division competitions, and leaders accounting for their soldiers. Whereas behavioral health providers become indirectly familiar with leaders of "that unit" described above, behavioral health providers become directly familiar with leaders of these units because of the swiftness with which they appear to absorb the soldier back into the unit with little-to-any continued adjustment problems. The pride, cohesion, and shared identity is evident in those units and serves as a buffer to combat stress in theater.

Leaders may benefit from continued innovation in group cohesion to buffer stress and facilitate positive mission outcomes. One novel approach to group cohesion is harnessing charismatic aspects of leadership.[21] Notable military leaders exhibited charismatic qualities, which likely influenced their success on the battlefield. Two such leaders were Chesty Puller and Douglas MacArthur. A leader's charisma may help facilitate group cohesion. Group cohesion is essential to safety and security on the battlefield.[22] Group cohesion will also work against anomie, which is a driver of adjustment problems. More research is needed to understand how the Army can best utilize charismatic leadership.

Conclusion

Leadership has a central role in preventing soldier maladjustment to the Army. Army leaders must work to create cohesive teams that have a sense of meaning and purpose. This requires a constant presence to know the soldiers, earn their trust, and teach them about the Army. Leaders do well in encouraging their soldiers to go to behavioral health when it appears that it would benefit the soldier, but the leader's work does not end there. Leaders may be uniquely positioned to alleviate soldier distress, particularly if the distress emanates from the leader's unit.

Engaged leadership that fosters cohesive teams begins to establish a social support network among the soldiers that may be an important buffer of stress in future combat. Future combat may not permit regular access to behavioral health assets. As such, greater cohesion and social support among soldiers will be important source of stress management in austere environments.

Adjustment to the stress of the Army does not mean that there must be no stress. It would be a grave disservice to soldiers if leaders shielded them from high levels of stress during training because doing so would leave them unprepared for the stress of combat. Leaders can, however, reduce the levels of perceived stress associated with non-mission-essential activities.

Oftentimes, perception of stress is idiosyncratic, so leaders must be proactively involved with their soldiers to provide a reality check for their soldiers if needed.

Limitations

This article does not assume a naïve monocausality about the source of soldier stress and mental health problems. Soldiers' perception of stress and associated mental health disorder are likely multiply determined. Several factors, such as genetic predisposition, personality disorder, or a desire to leave the Army, may fuel soldier adjustment problems. Notwithstanding this observation, leadership and unit dynamics play an integral role in soldiers stress levels and must be recognized as an important factor driving adjustment problems in the Army. ■

Notes

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