



# Leadership and Post Traumatic Stress Symptoms

Lieutenant Colonel Mary E. Card-Mina, U.S. Army

*Living in a war zone is an experience that leaves no one untouched.<sup>1</sup>*

**T**HE DRINKING BEGAN the night Sally Jones received her first counseling statement. In the past, she had been considered one of the best officers in her brigade. Captain Jones was organized, energetic, and dedicated to her job. Quick to volunteer, she could be counted on to organize formal and informal unit social functions. However, this was before Sally's combat deployment.

When Sally returned from her 15-month deployment, she was promoted and sent to another unit on the same large installation. At her new unit, she was often late to work. Her attention to detail began to suffer, and she made a serious error by transposing numbers on a set of reports. After scoring 80 points below her previous average on the Army Physical Fitness Test (APFT), she obtained the reputation for being the officer who put in the bare minimum. For the unit's organizational sports day, not only did Sally not volunteer to organize any of the events, she did not even attend.

Sally's new boss, Major Sam Smith, was disappointed in her duty performance. He assumed, incorrectly, that Sally held a desk job while deployed and, therefore, could never be affected by post traumatic stress disorder (PTSD). Smith assumed she had always been on the forward operating base and was a "Fobbit," and that, because Sally was a female, she had not been in "combat situations" but was "in the rear with the gear." Smith did not question Sally about her deployment when he counseled her for the serious work error and her lateness.

Did Major Smith do the right thing? Did he have any biases about women in combat or soldiers who worked "inside the wire" that affected his actions? What significance is an 80-point drop in Captain Jones' APFT score? What information could Jones' former unit share about her previous performance?

*Lieutenant Colonel Mary E. Card-Mina is currently serving as the chief of Army Judge Advocate Recruiting. She holds an MMAS from the Command and General Staff College; a J.D. from the Columbus School of Law, The Catholic University of America; and an LLM from the Judge Advocate General's Legal Center and School. She served as the brigade judge advocate for the 2nd Brigade Combat Team, 4th Infantry Division, at Fort Hood and FOB Kalsu, Iraq.*

*PHOTO: PFC Joseph Dwyer, from Mt. Sinai, NY, carries a young Iraqi boy who was injured during a battle between the U.S. Army's 7th Cavalry Regiment and insurgent forces on 25 March 2003 near Al Faysaliyah, Iraq. (AP Photo/Warren Zinn, Army Times)*

Should Smith have questioned why Captain Jones chose not to participate in organizational day?

Jones exhibited post traumatic stress symptoms, and early leader recognition of her symptoms may have prevented a later, more severe condition of PTSD. During her deployment, Jones routinely went out on dangerous combat patrols as part of her duties. She witnessed several traumatic events, including the death of a fellow soldier. These experiences caused her to suffer hypervigilance and lose sleep at night. The resulting fatigue caused her chronic lateness and inability to focus on detailed work. She began experiencing symptoms of depression; she chose not to exercise or socialize because she found little pleasure in these activities. Eventually, she started drinking to mask her pain. If Jones' leaders had recognized and understood her symptoms, could she possibly have thrived post-deployment? The answer is yes.

## Frequent Deployments

The nature of deployments and their frequency in support of the War on Terrorism require military leaders to recognize and better understand post traumatic stress symptoms (PTSS) and PTSD. Across the military, service members returning from deployment may be branded malcontents or malingers when, in fact, they are afflicted with PTSS or PTSD.

The Army's Comprehensive Soldier Fitness program calls for developing a cohesive plan "based upon the five dimensions of strength: physical, emotional, social, spiritual, and family."<sup>2</sup> One of the program's aims is to reduce PTSD.<sup>3</sup> Leaders and service providers in the mental health field are the definitive proponents to assure success in this endeavor.

Leadership, as defined in Army Field Manual 6-22, is "influencing people by providing purpose, motivation, and direction while operating to accomplish the mission and improve the organization."<sup>4</sup> By understanding and recognizing PTSD and its symptoms, leaders in every military branch and at every rank can help those suffering from post traumatic stress by motivating and guiding those persons to seek resources and treatment. Leadership doctrine and practice requires that a leader be a person of character, presence, and intellect. By applying these

attributes, leaders can have a tremendous impact on identifying PTSS and PTSD in their peers, their subordinates, and their superiors.

## What are PTSD and PTSS?

As defined by the President's Commission on Care for America's Returning Wounded Warriors, post traumatic stress disorder is among the signature injuries for service members who currently serve in Afghanistan and Iraq.<sup>5</sup> It has been defined as "an anxiety disorder that occurs after a traumatic event in which a threat of serious injury or death was experienced or witnessed, and the individual's response involved intense fear, helplessness, or horror."<sup>6</sup> While events of longer duration increase the chances for PTSD, brief exposure to an extreme event can also lead to it.<sup>7</sup>

Post traumatic stress disorder is characterized by "extreme general physical arousal" because the nervous system has become sensitized to an overwhelming trauma. When general arousal becomes elevated, the nervous system then overreacts to even minor stressful events. Signs of arousal include trouble falling asleep, trouble staying asleep, irritability or outbursts of anger, difficulty concentrating or remembering, hypervigilance, and exaggerated startle responses. Someone suffering from PTSD might also experience an elevated heart rate, elevated blood pressure, hyperventilation, and lightheadedness. Post traumatic stress disorder can cause physical, emotional, mental, and even spiritual fatigue during which the service member experiences discouragement, hopelessness, and despair.<sup>8</sup>

There are several other features of the disorder. Many service members feel shame and guilt about a traumatic event whether or not they were responsible for it. Some service members experience many forms of mood disturbances such as depression, anxiety, and hostility, and sometimes report chronic and often unexplained pain as well as fatigue. Some of those suffering from PTSD rely on alcohol or drugs to relieve pain and start on a path of addiction. In more severe cases, self-mutilation and other self-destructive behaviors can develop.

Many service members experience night terrors or nightmares. During night terrors, one can wake up terrified but cannot remember a dream;

in nightmares, one might feel as though he or she is reliving the event or may feel the same fear, helplessness, or rage experienced during the event.<sup>9</sup> Night terrors and nightmares are the brain's way of processing a stressful experience. Many veterans try to avoid nightmares by turning to drugs or alcohol or by avoiding sleep altogether. According to the authors of *Strategies for Managing Stress After War*, "These attempted solutions only lead to new problems such as substance dependence and sleep deprivation. This also results in more irritability and depression, poorer memory, and increased stress and anxiety."<sup>10</sup>

Typically, PTSD is diagnosed after one experiences its symptoms for three months or more. Before the onset of PTSD, service members can experience isolated symptoms, or PTSS. If not treated, PTSS can develop into PTSD, so it is paramount that leaders recognize the symptoms. In understanding the basics of PTSD and PTSS, it is vital to recognize that individuals meet traumatic events with varying

degrees of preparedness. Some service members might have a history of previous trauma such as child abuse or sexual abuse. Some might have underdeveloped protective and problem-solving skills or low self-esteem. Some might have had habitually negative personality and habitually negative thought patterns or a biologically overactive nervous system before the onset of PTSD.

There are differences between the genders regarding PTSD and PTSS. Women are more than twice as likely to develop PTSD: statistically, 10 percent of women and 4 percent of men. Studies note that some PTSD symptoms are more common in women than in men. According to a study published by the National Center for PTSD, women tend "to have more trouble feeling emotions, and to avoid things that remind them of the trauma than men. Men are more likely to feel angry and to have trouble controlling their anger than women."<sup>11</sup> Women may take longer to recover from PTSD



DOD, Cherie Cullen

**Secretary of Defense Robert M. Gates tours the Restoration and Resilience Center at Fort Bliss, TX, 30 April 2008. The center, which is a volunteer program for U.S. soldiers, was designed as a local initiative to help treat soldiers who return from combat with post traumatic stress disorder.**

and are four times more likely to have long-lasting PTSD than men.<sup>12</sup> Women with PTSD are more likely to feel depressed and anxious, while men with PTSD are more likely to have problems with alcohol or drugs.<sup>13</sup> Both men and women who experience PTSD may develop physical health problems. The National Center for PTSD noted that about 15 percent of all military personnel in Iraq are women and that future studies are necessary to understand the effects of combat on women.<sup>14</sup>

One way in which PTSD might manifest itself in the workplace is through power and control issues. Service members do what is expected of them in wartime, but they also understand that “what happens next” may be beyond their personal control.<sup>15</sup> Upon returning home, some service members continue to feel helpless or to feel that they cannot control their life or take charge as they once did. Sometimes, service members have the opposite response and try to control everything in their lives. Along this line, “some veterans come to possess a sense of indestructibility” or “stop listening to authority figures, since those in command weren’t able to stop bad things from happening during war.”<sup>16</sup>

Leaders must understand that barriers, real or imagined, exist when it comes to seeking help for PTSD. A 2006 survey from the Office of the Surgeon General’s Mental Health Advisory Team asked soldiers and marines about barriers to receiving mental health care services in theater. Approximately half of the service members who screened positive for mental disorders cited concerns about appearing weak, being treated differently by leadership, and losing the confidence of members of the unit as barriers to receiving behavioral health care. More than a third of the respondents stated that seeking mental health treatment would have a harmful effect on his or her career.<sup>17</sup>

## The Role of Leadership

A true leader has the ability to give meaning to a crisis event and turn it into an opportunity for

growth.<sup>18</sup> Leadership involves emotion; therefore, leaders need emotional intelligence to provide meaning in times of crisis and post-crisis recovery. Leaders at all levels are the first line of defense against PTSS and PTSD. Sound leadership is essential to ensure resiliency and recovery from the mental damage of combat experiences.<sup>19</sup> The most effective leaders, then, are leaders of character with emotional depth, leaders of presence demonstrating resiliency, and leaders of intellect with the understanding of how to help.

**Leaders of character.** Three major factors determine a leader’s character: values, empathy, and the Warrior Ethos. In the context of understanding the complex issues of PTSS and PTSD, empathy enables a leader to assist a peer, a subordinate, or a superior officer more than any other factor. Empathy is “the ability to see something from another person’s point of view, to identify with and enter into another person’s feelings and emotions.”<sup>20</sup> According to Lieutenant Colonel Joe Doty, former deputy director of the Army’s Center of Excellence for the Professional Military Ethic, empathy is “literally trying to put yourself in someone else’s shoes.”<sup>21</sup> It is “understanding something from another person’s foxhole.”<sup>22</sup>

Doty asserts, “To truly understand something from someone else’s perspective, the leader must genuinely care for the subordinate, and not just from a mission accomplishment perspective.” He gives the following suggestions on ways for leaders to demonstrate empathy: practice active listening techniques, encourage the person to open up, let the service member express how he is feeling and why he is feeling that way, and actively try to monitor the service member’s feelings and emotions.<sup>23</sup>

Comprehensive Soldier Fitness aims to sustain and build emotionally strong soldiers. By being empathetic, a leader can ensure he is doing all he can to take care of his subordinates, peers, and superiors. For example, a male may not be

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U.S. Army photo by SPC. Michael J. MacLeod



**CSM Lawrence Wilson, the highest-ranking enlisted soldier of Multi-National Forces–Iraq, accompanies 1SG Mike Schlitz returning to Iraq as part of Operation Proper Exit, 29 December 2009, at Camp Ramadi, Iraq. Operation Proper Exit returns severely wounded veterans to the battlefields where they were wounded to help them find psychological closure.**

able to understand every issue that confronts a female service member and vice versa, but if he is empathetic, he will attempt to gain greater understanding. Those suffering from PTSS and PTSD are in need of empathetic leaders.

**Leaders of presence.** The Army and the military call on leaders to be resilient and to develop a resilient force. Numerous deployments in quick succession test the physical and emotional resiliency of the force. Service members suffering from PTSS or PTSD need assistance strengthening their individual resiliency.

Resiliency is defined in FM 6-22, *Army Leadership: Competent, Confident, and Agile*, as the “tendency to recover quickly from setbacks, shock, injuries, adversity, and stress while maintaining a mission and organizational focus.”<sup>24</sup> If leaders quickly recognize post traumatic stress symptoms in themselves, their peers, their superiors, and their subordinates, then the process of working toward resiliency can more quickly

begin. Symptoms that are ignored, left unchecked, or minimized only lead to greater difficulties in the long term. For example, if a leader recognizes that a subordinate is constantly tired and gets him help for sleep issues, the subordinate might not spend as much time in the downward spiral of sleeplessness, drug or alcohol use, or sleep avoidance. To foster resiliency in the force, leaders need to be resilient themselves and seek help when they need it, as well as being vigilant and encouraging others to get help.

**Leaders of intellect.** According to FM 6-22, a leader’s intellectual capacity is what allows him or her to “conceptualize solutions and acquire knowledge to do the job.”<sup>25</sup> It is the leader’s intellectual capacity that applies “agility, judgment, innovation, interpersonal tact, and domain knowledge.”<sup>26</sup> Domain knowledge “encompasses the tactical and technical knowledge as well as cultural and geopolitical awareness.”<sup>27</sup> A leader of intellect knows that there are resources available to assist with PTSS and PTSD.

All military leaders should be aware of Military OneSource, a DOD website and resource center, staffed 24 hours a day for help with counseling and locating services.<sup>28</sup> Additionally, if a leader is unsure whether he is experiencing PTSS or PTSD or if he has a subordinate with unexplainable symptoms, a mental health self-assessment is available to identify the most beneficial resources.<sup>29</sup>

The Army Family Action Plan (AFAP) is another successful and longstanding program that enables soldiers, civilians, and family members to communicate with leaders about issues affecting quality of life, including concerns regarding PTSD and PTSS. One of the outcomes of the AFAP process was the recognition of a shortage of behavioral health services. As a result of innovative and aggressive recruitment efforts in 2010, the Army now employs more than 3,900 behavioral health providers, including psychologists, psychiatrists, psychiatric nurses, and social workers. This increase of almost 400 health professionals helps provide services that Army community members need for treatment and recovery.

In addition, the Army's Medical Command has established a new Tele-Health Division, which provides behavioral health services such as tele-psychiatry, tele-psychology, medical evaluation boards, mental status evaluations, tele-neuropsychology and a school-based mental health program. These real-time services are provided via video-conference through a network of sites across five Regional Medical Commands. More information on AFAP can be found at the Army OneSource website under the Family Program and Services menu.

Through the National Center for PTSD, the Veterans Administration (VA) offers extensive information on stress-related health problems and coping, and provides educational materials for service members, family members, providers, and researchers.<sup>30</sup> The VA's Women Veterans Program manager coordinates comprehensive health care services for female veterans on issues specific to women.<sup>31</sup>

Resilience Training, formerly known as Battlemind Training, is another key program available.<sup>32</sup> Battlemind was the creation of Colonel Carl Castro of the Walter Reed Army Institute of

Research in response to the mental health needs of service members returning from deployment. This training focuses on a unique mental skill that troops use to help them survive in combat but that can be problematic when carried over to life at home with family and friends.<sup>33</sup> Information is available online to encourage service members to do a Battlemind check for themselves and their colleagues.<sup>34</sup> Resilience Training also now contains modules for spouses, timed within the deployment cycle.

Leaders of intellect understand that PTSD affects service members differently and could be the result of one or several significant experiences. A service member's prior trauma experience combined with his or her gender and personal bias regarding mental health treatment makes each case of PTSD and each symptom of PTSS unique. In addition, leaders of intellect must also examine their own biases on mental health treatment and ensure they remove any personal barriers they might have toward encouraging mental health assistance.

## Conclusion

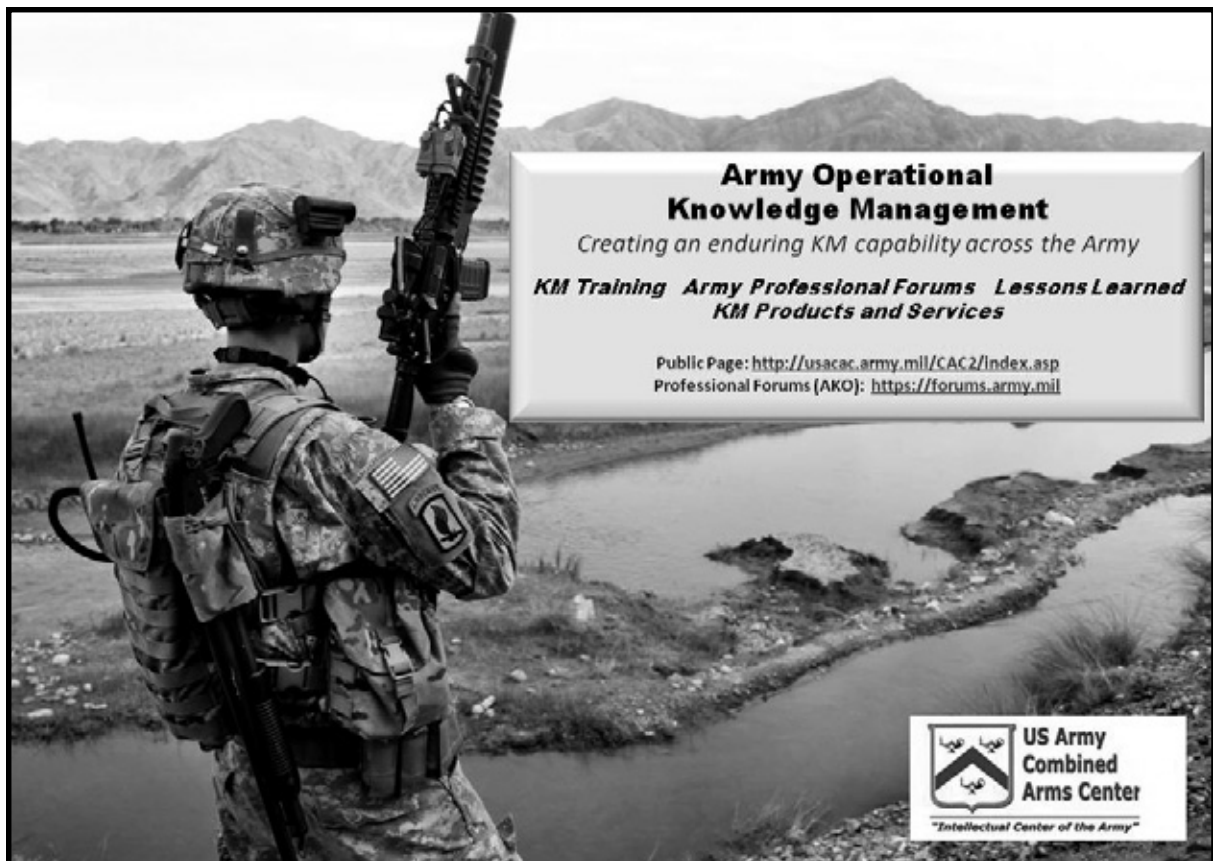
Leaders are expected to be a part of the solution and not part of the problem for those impacted by PTSD. In the opening vignette, Major Smith could have initiated Captain Jones' recovery by asking a few questions, challenging some assumptions, and making a few calls to Captain Jones' former unit. The Army's Comprehensive Soldier Fitness program includes developing a comprehensive and cohesive program for soldier wellness. Astute leaders can contribute to this program by recognizing PTSS and helping soldiers find treatment before they develop PTSD. There is no doubt that leaders must emphasize treatment of PTSS and PTSD as a way to "return to normal." Openly encouraging the use of mental health services would go a long way toward lessening the perceived negative consequences.<sup>35</sup> Specifically, a leader can assist with PTSS and PTSD by striving to serve as a person of character, presence, and intellect. Finally, a leader should pursue the wisdom to know when service members need counseling and a few more caring and probing questions. **MR**

## NOTES

1. Laurie B. Slone and Matthew J. Friedman, *After the War Zone: A Practical Guide for Returning Troops and Their Families* (Philadelphia: Da Capo Press, 2008), 65.
2. BG Rhonda Cornum, "Comprehensive Service Member Fitness," lecture, U.S. Army Command and General Staff College, 13 February 2009. BG Cornum elaborated that the vision for comprehensive service member fitness is an Army of balanced, healthy, self-confident service members, families, and civilians whose resilience and total fitness enables them to thrive in an era of high-operational tempo and persistent conflict. The mission is to develop and institute a comprehensive service member fitness program to build such resilience.
3. Ibid.
4. Field Manual (FM) 6-22, *Army Leadership: Competent, Confident, and Agile* (Washington, DC: Government Printing Office, October 2006), A-1.
5. M. Audrey Burnam, Lisa S. Meredith, Todd C. Helmus, Rachel M. Burns, Robert A. Cox, Elizabeth D'Armico, Laurie T. Martin, Mary E. Vaiana, Kayla M. Williams, and Michael R. Yochelson, "Systems of Care: Challenges and Opportunities to Improve Access to High-Quality Care," in *Invisible Wounds of War*, edited by Terri Tanielian and Lisa H. Jaycox (Santa Monica, CA: RAND Corporation, 2008), 305.
6. Ibid.
7. Glenn R. Schiraldi, *The Post-Traumatic Stress Disorder Sourcebook* (New York: McGraw-Hill Publishing, 2000), 36.
8. Ibid., 13.
9. Julia M. Whealin, Lorie T. Decarvalho, and Edward M. Vega, *Strategies for Managing Stress After War* (Hoboken, NJ: John Wiley and Sons, 2008), 47.
10. Ibid.
11. Dawn Vogt, *Women and PTSD*, National Center for PTSD Factsheet, <[http://www.ncptsd.va.gov/ncmain/ncdocs/fact\\_shts/fs\\_women\\_lay.html](http://www.ncptsd.va.gov/ncmain/ncdocs/fact_shts/fs_women_lay.html)> (18 March 2009).
12. Ibid.
13. Ibid.
14. Ibid.
15. Ibid. IEDs, sniper attacks, physical injuries, and deaths are some of the chaotic events that are beyond a service member's control.
16. Ibid.
17. M. Audrey Burnam, et al., 277.
18. Britta Stomayer, *Human Dynamics of Crisis Leadership*, 3 February 2009 <[http://employee-management-relations.suite101.com/article.cfm/human\\_dynamics\\_of\\_crisis\\_leadership](http://employee-management-relations.suite101.com/article.cfm/human_dynamics_of_crisis_leadership)> (18 March 2009).
19. Leadership is further illustrated in the Leadership Requirements Model, which centers on what a leader is in terms of attributes and what a leader does in terms of

core leader competencies. In dealing with and recognizing PTSS and PTSD, it is a leader of character, a leader of presence, and a leader with intellectual capacity that can then lead, develop and achieve victory in the war against PTSD.

20. FM 6-22, 4-9.
21. Joe Doty, "Empathy as a Leadership Trait," U.S. Army Combined Arms Center Blog, entry posted 11 February 2009, <[https://courses.leavenworth.army.mil/webapps/portal/frameset.jsp?tab\\_id=\\_14\\_1](https://courses.leavenworth.army.mil/webapps/portal/frameset.jsp?tab_id=_14_1)> (7 April 2009).
22. Ibid.
23. Ibid.
24. FM 6-22, Glossary.
25. Ibid.
26. Ibid.
27. Ibid.
28. Military OneSource.com, <<http://www.militaryonesource.com/skins/MOS/home.aspx>> (19 March 2009). The Department of Defense provides Military OneSource at no cost to active duty, Guard, and Reserve service members and their families. The telephone number for Military OneSource is 1-800-342-9647.
29. *The Military Mental Health Assessment*, <[www.militarymentalhealth.org](http://www.militarymentalhealth.org)> (19 March 2009). The website begins with the following introduction: "Military life, especially deployments or mobilizations, can present challenges to service members and their families that are both unique and difficult. Some are manageable, some are not. Many times we can successfully deal with them on our own. In some instances, matters get worse and one problem can trigger other more serious issues. At such times, it is wise to check things out and see what is really happening. That's the purpose of these totally anonymous and voluntary self-assessments."
30. The Veterans Administration National Center for Post Traumatic Stress Disorder, <[www.ncptsd.va.gov](http://www.ncptsd.va.gov)> (19 March 2009).
31. The Veterans Administration, Women's Veteran Health Care, <[www.va.gov/vwhp](http://www.va.gov/vwhp)> (19 March 2009).
32. Slone and Friedman, 77.
33. Ibid., 57. "Battlemind" is treated as an acronym formed as follows: B=Buddies vs. Withdrawal, A=Accountability vs. Controlling, T=Targeted vs. Inappropriate Aggression, T=Tactical Awareness vs. Hypervigilance, L=Lethally Armed vs. Locked and Loaded, E=Emotional Control vs. Detachment, M=Mission Operational Security vs. Secretiveness, I=Individual Responsibility vs. Guilt, N=Non-Defensive Driving vs. Aggressive Driving, D=Discipline and Ordering vs. Conflict.
34. Information can be found online at <<https://www.resilience.army.mil/>>.
35. Burnam, et al., 282.




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