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CHAPTER 5

Understanding and Mitigating Post-Traumatic Stress Disorder

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First Sergeant Spock, in Afghanistan during his fourth deployment after 9/11, recalls a mission from June 2007 in Iraq. Improvised explosive devises (IEDs) had become the unsuspecting killer in his area, and his infantry platoon was on a mission to capture a key insurgent responsible for emplacing them. They had killed one of his soldiers and wounded eighteen other comrades. It was so likely that his platoon was going to hit an IED during the mission that his commander assigned a route clearance team (RCT) to his platoon.

The RCT gave Spock some comfort, but it quickly faded when he received word that an RCT vehicle had broken down. His platoon faced the dilemma of having to wait for mechanics to fix the vehicle and jeopardize the mission or to move on and run the risk of hitting an IED explosion. Spock describes how he knew that his decision might cost him his life and the lives of his fellow soldiers, but he knew the mission was too important to delay. If anyone was going to take the additional risk, it was going to be him, so with his heart racing, he looked at his driver with as much confidence as he could muster and said, "Take the lead. We are going to the objective." Spock recalls that his driver didn't show the slightest doubt or fear in his face. Without hesitation, his driver stepped on the gas and their vehicle raced to the objective, first in the order of movement. Fortunately, Spock's platoon captured its target, without injury, which greatly reduced the number of IEDs for the remainder of the deployment.

If you are reading this, then the probability is high that you will face a similar situation as First Sergeant Spock in the future (or you already have) based on your chosen profession. The probability is also high that you will tell subordinates that you need them to perform a critical task that they may appraise as a potentially traumatic event (PTE), a threat to their physical or psychological health. Specific to leading in dangerous contexts, PTEs primarily consist of single or repeated experiences that may ultimately lead to death or serious injury for subordinates, their unit members, or a third party (i.e., a perpetrator, an innocent bystander, or an enemy).

A number of critical factors determine how PTEs affect psychological health. Two of them are discussed here. The first factor is how a subordinate cognitively appraises the PTE—that is, as a challenge or as a threat—and the second factor is the level of his or her coping flexibility, or ability to apply situation-appropriate coping styles after the event. When a subordinate appraises the PTE as a threat and then demonstrates coping inflexibility, post-traumatic stress disorder (PTSD) is a likely outcome. PTSD is a severe anxiety disorder that consists of persistent physiological, emotional, cognitive, and behavioral symptoms (related to facing a PTE) that cause significant distress or impairment in social, occupational, or other functional areas.[1] When a subordinate appraises the PTE as a challenge and is able to flexibly cope, then it is most probable that he or she will experience resilience. In such a case, the subordinate might have temporary reactions to the PTE, but these then return to baseline levels.[2]

One of the variables that helps determine how subordinates appraise PTEs and cope afterward is the strength of their "psychological body armor." This armor protects against PTSD and primarily depends on levels of social support, hardiness, and leadership. It is argued here that leadership is the most important component because leaders can greatly affect the social support and hardiness of subordinates. Thus it is essential that leaders understand how certain leadership behaviors can help minimize the number of subordinates on a PTSD trajectory and maximize those on a resilience trajectory. This is critical since researchers have recently associated PTSD with completed suicides and reduced health.[3] In addition, few would refute that PTSD negatively impacts the performance of small units that face the majority of trauma for their profession (i.e., the platoon level and below for most militaries, the shift or team level for the police, and company level and below for firefighters). Related to the opening scenario, it appears that the leadership behaviors of First Sergeant Spock before and during the PTE enabled his driver to view the situation as a challenge. The work to keep the driver on a resilience trajectory began after the PTE.

There is no perfect remedy for PTSD. Mitigating PTSD is extremely complex. More advances are needed before researchers can truly understand and alleviate PTSD in dangerous contexts. In the meantime, however, it is hoped that the framework presented here will help leaders improve the psychological health and performance levels of their units when PTEs occur.

PREVALENCE AND SYMPTOMS OF PTSD

Research conducted during the first decade of the 2000s on the prevalence of PTSD—determined by the number of individuals at the time experiencing it or who had experienced it within the year—found it among 16.7 percent of U.S. active-duty soldiers who had returned from Iraq,[4] 19 percent of police officers and 22 percent of firefighters who had worked in the aftermath of Hurricane Katrina,[5] and 25 percent of firefighters in Taiwan who had assisted with disasters.[6] Although accurately measuring PTSD is a difficult endeavor, the rate of prevalence for individuals working in dangerous contexts appears to be significantly higher than the average rates of 1.8 percent for American males in the general population and 0.5 percent for European males.[7] A plausible explanation for this disparity is that dangerous context professionals face more PTEs than civilians, and there is a positive relationship between the number of PTEs and resulting PTSD symptoms.[8] For example, N. Pole and colleagues found that cadets who had graduated from police academies in New York and California faced an average of seven PTEs during their first year of service.[9] This is compared to only 67 percent of European men who faced at least one PTE during their lifetime.[10] The same relationship was evident in a study that assigned soldiers to three exposure categories (low, middle, and high combat) and found that soldiers in the high group were 3.5 times more likely to screen positive for PTSD compared to the low group—that is, a prevalence rate of 28 percent versus 8 percent.[11] Since individuals in dangerous contexts face numerous PTEs that put them at greater risk for PTSD, it is important for leaders to be able to identify the symptoms of the disorder. It is natural for subordinates to temporarily experience PTSD symptoms, but leaders should become concerned when they experience them for more than thirty days after the PTE.[12]

Physical Symptoms

James Ness and colleagues highlight the adaptive nature of the body to return to homeostasis, or a stable state, in a discussion of allostatis (see Chapter 3 in this volume). As individuals face PTEs, they experience an inevitable imbalance

Table 5.1 Symptoms of Post-Traumatic Stress Disorder

Physical Symptoms	Cognitive and Emotional Symptoms	Behavioral Symptoms
▸ Difficulty breathing ▸ Profuse sweating ▸ Rapid heart rate ▸ Elevated blood pressure ▸ Migraines ▸ Exaggerated startle response ▸ Difficulty sleeping	▸ Easily agitated ▸ Trouble concentrating ▸ Negative expectations about oneself or distorted blame ▸ Inability to experience positive emotions ▸ Nightmares or flashbacks of the PTE with strong emotional response ▸ Feeling overwhelmed	▸ Avoidance of feelings, thoughts, people, places or events related to the PTE ▸ Being hyperalert ▸ Being detached and withdrawn ▸ Alcohol consumption ▸ Drug use ▸ Change in activities or loss of interest in hobbies ▸ Disciplinary issues

of hormones. If this imbalance persists for an extended period of time, physical symptoms can ensue. Some individuals may not be able to bring their bodies back to homeostasis for two inter-related reasons. First, fear conditioning occurs when the amygdala (which meditates the body's emotions) interprets neutral stimuli as threatening because the hippocampus (which plays a critical role in long-term memory) contains a memory of the neutral stimuli being paired with a threatening event. These threat-laden memories influence the amygdala's interpretation of these once-neutral stimuli as being the threatening PTE itself (for example, trash on the road paired with an IED).[13] Fear conditioning can be adaptive while dangerous contexts individuals perform their professional duties, but maladaptive in everyday life. Second, if the prefrontal cortex (which executes higher cognitive functions and regulates the body's responses) is unable to properly regulate an exaggerated response of the amygdala, physical symptoms can result.[14] Thus individuals with extensive fear conditioning and a diminished prefrontal cortex may experience an increased amount of physical symptoms of PTSD (see Table 5.1).

Cognitive and Emotional Symptoms

When people who have had a PTE experience physical symptoms from not being able to sleep at night, it is highly likely that they may become easily agitated or have trouble concentrating at work. They may also be struggling with strong emotions related to the PTE. When individuals cognitively appraise PTEs as threats, primary emotions, such as fear and anger, may be present. When

they are not able to make meaning of the PTE or they experience a conflict between the consequences of the PTE and their existing belief systems, then secondary emotions, such as guilt, shame, and sadness, may result. Individuals might try to resolve this conflict by irrationally blaming themselves—"It's all my fault" or "I'm worthless." Although individuals may be able to avoid normal and everyday emotional experiences, secondary emotions cannot be easily avoided.[15] Therefore, images of the original PTE may emerge as flashbacks during the day or at night in the form of nightmares, thus resulting in the experience of strong cognitive and emotional symptoms (see Table 5.1).

Behavioral Symptoms

The symptoms of PTSD noted above can become intense and overwhelming, so individuals may believe that the only way to function in everyday life is to completely avoid things that might trigger them. This helps explain why sleep can be so difficult; it means giving up control and inevitably re-experiencing the PTE in dreams. So, from the perspective of someone suffering from PTSD, their options are don't sleep, sleep and face the nightmares, or drink enough alcohol or take enough drugs to shut down the brain to suppress dream states (see Table 5.1).

THE DEVELOPMENT OF PTSD

First Factor—Cognitive Appraisal

It appears that approximately 30 percent of subordinates may experience the symptoms of PTSD within a year after facing PTEs. It is important to note, however, that PTSD is not the only trajectory of psychological health and that most subordinates will experience a resilience trajectory. Two critical factors differentiate the two trajectories. The first factor is a person's "in the moment" reaction, or immediate psychological reaction, to the PTE as it is occurring. E. Ozer and colleagues found this to be the most robust factor in determining the later development of PTSD.[16] M. Olff and colleagues also concluded that the "in the moment" cognitive appraisal of the PTE is an important predictor of the later onset of PTSD.[17] Consistent with this research, V. Florian and colleagues found that Israeli soldiers who cognitively appraised their four-month basic military training as a threatening experience exhibited a significant decline in their psychological health by the end of the training.[18]

Although not involving dangerous contexts, the research of J. Blascovich and colleagues with collegiate athletes showed that an individual's reaction

to a "threat appraisal" differs from a "challenge appraisal." In fact, a challenge appraisal predicted greater confidence in completing a task, greater energy mobilization, and better performance during a collegiate season. They found that individuals consider events to be a challenge or a threat based on a sequential appraisal of relevant demands and resources. In an initial demand appraisal, individuals assess the effort required of them to complete the task, the level of danger to themselves or others to complete the task, and the potential consequences of them completing or not completing the task. Next, individuals assess their resources—e.g., knowledge, skills, abilities, and the amount of external support available—to meet the demands of the situation. Based on this sequential appraisal, individuals perceive a challenge when evaluated resources meet or exceed demands, but a threat when demands exceed resources.[19]

The research presented here draws upon Patricia Resick's work with military veterans to add another variable to the threat-versus-challenge appraisal—the personal meaning that individuals take from the PTE. Resick points out that if a PTE is consistent with an individual's deeply held belief system, then he or she will quickly assimilate the consequences of the PTE into that system. In contrast, a PTE that shatters an existing belief system will cause an individual to see the PTE as a threat and increase the probability of following a PTSD trajectory.[20]

Second Factor—Coping Flexibility

Researchers contend that an individual's perceived ability to integrate certain coping styles after PTEs plays a crucial role in determining resulting trajectories of psychological health. They have attempted to identify the superior coping style for increasing psychological health but results have been inconsistent.[21] In response, G. Prati and colleagues posited that coping styles are not inherently good or bad, but their adaptive qualities depend on the contexts of specific situations.[22]

George Bonanno and colleagues concur with Prati and colleagues and introduced the construct of coping flexibility to identify individuals who are able to perceive themselves as flexible enough to engage in two different styles of coping based on the demands of the situation. The first style is forward focus coping, which emphasizes such means as maintaining goals and plans, attending to others, thinking optimistically, being able to laugh, reducing painful emotions, and remaining calm and serious. The second style of coping is emotional processing and consists of such means as fully experiencing the emotions related to the traumatic event and reflecting upon the

meaning of it. In contrast to forward focus coping, emotional processing is more demanding and time consuming as individuals may need to temporarily suspend normal obligations to reflect upon and work through the traumatic experience. The researchers found that coping flexibility was related to reduced PTSD symptoms in American and Israeli college respondents, especially when the individuals had experienced high levels of trauma. In addition, they found that a perceived ability in only one of the coping styles predicted increased PTSD symptoms.[23] Acknowledging the limitations of research with college samples, some of the authors of this chapter are currently researching the impact of coping flexibility on the psychological health of soldiers in Afghanistan.

Trajectories Resulting from Cognitive Appraisal and Coping Flexibility

T. deRoon-Cassini and colleagues identified four distinct trajectories—PTSD, recovery, delayed PTSD, and resilience—of psychological health that result after individuals face a PTE.[24] Through introducing the two factors of cognitive appraisal and coping flexibility, it is proposed here that an interaction of these two factors contributes to subordinates experiencing one of the four trajectories. In particular, a cognitive appraisal of threat combined with coping inflexibility greatly contributes to the PTSD trajectory and detracts from optimal performance (e.g., inability to focus and concentrate on the task at hand) (see Figure 5.1). The recovery trajectory occurs when an individual experiences symptoms of PTSD for an extended period of time, from several months after the PTE or as long as one or two years. This occurs when individuals appraise an event as a threat but then later exhibit coping flexibility to ameliorate their situation. The delayed PTSD trajectory occurs when individuals experience minimal symptoms immediately after the PTE but the symptoms significantly worsen over time, which occurs when individuals appraise a PTE as a challenge and then experience coping inflexibility as they attempt to deal with the symptoms. DeRoon-Cassini and colleagues associate the resilience trajectory with individuals who may experience temporary symptoms of PTSD (e.g., several weeks of temporary preoccupation with the PTE or disturbance of sleep) but then are able to maintain relatively stable and healthy levels of psychological health. These individuals see PTEs as challenges and then employ coping flexibility after the event, which improves their performance during PTEs and gives them improved self-efficacy—an individual's feeling of confidence to execute intended actions—to face the next PTE.[25]

MITIGATING PTSD

Knowing the different trajectories that may result from an interaction of two key factors—cognitive appraisal and coping flexibility—what can leaders do to help subordinates appraise inevitable PTEs as challenges instead of threats and to integrate coping flexibility after the PTE to ensure that they follow a resilience trajectory? One important response is to strengthen the psychological body armor of subordinates, which consists of at least three protective components—social support, hardiness, and leadership. These components interact to strengthen the psychological body armor, which maximizes their appraisal of the resources available to them when they face PTEs and gives them the self-efficacy to flexibly cope after PTEs. As noted above, it is suggested here that leadership is the most important component because leaders can significantly impact the hardiness and social support of individuals in their units.

Social Support

Social support for subordinates is the perceived helpfulness of their social interactions within and outside their units. Researchers have found it to protect against PTSD.[26] In fact, Vietnam Veterans with high levels of social support were 180 percent less likely to develop PTSD than those with lower levels.[27] Lieutenant General Hal Moore (Ret.) captures the essence of social support after his experience as the commander for the 1st Battalion, 7th Cavalry, during the Vietnam War. In the Battle of Ia Drang, his unit was encircled by a numerically superior enemy. He later wrote that "we discovered in that depressing, hellish place, where death was our constant companion, that we loved each other."[28] These sentiments of social support are reminiscent of that conveyed by the Australian military term "mateship," which can be traced back to early settlers who endured the difficult conditions of the Outback and then to Australian servicemen in World War I who placed "more importance on 'not letting down their mates' than on their own well-being."[29]

Hardiness

Over the last thirty years, researchers have utilized the personality characteristic of hardiness to differentiate individuals—that is, Gulf War veterans, Israeli soldiers, Norwegian cadets, and Iraq and Afghan war veterans—with reduced levels of PTSD symptoms from those with elevated levels of PTSD symptoms. They define the construct of hardiness as a constellation of personality characteristics that function as a resistance resource as individuals face stressful life events. In addition, researchers have found that hardy individuals have a

higher sense of commitment to such things as their work, activities, and relationships, gained from having a strong purpose in their lives; have a great sense of control over their surroundings, as well as their reactions to events; and appraise events as challenges (as already discussed).[30] (Please see Chapter 4 for a more in-depth discussion on hardiness.)

Leadership

At least since World War II, researchers have recognized the protective value of leadership and have found that units with good morale and leadership have fewer combat stress casualties than those without good morale and leadership.[31] Research confirms that this relationship also existed during the Iraq War: 20 percent of soldiers who rated their leaders as "high quality" screened positive for a psychological disorder in the high combat group, but among those high combat soldiers who rated their leaders as "low quality," 40 percent tested positive.[32]

D. Campbell and colleagues approach the component of leadership by describing it as a process of social influence that involves subordinates voluntarily accepting the influence of their leader and then willingly executing tasks that they otherwise might not have been inclined to do. This explains why First Sergeant Spock's driver did not show doubt or fear on his face. Leaders influence their subordinates not only through their observable personal characteristics (who they are) but also through their behaviors (what they do).[33] For more than forty years, researchers have reported that effective, or high quality, leaders influence subordinates primarily through task-oriented and relational-oriented behaviors.[34]

Task-oriented behaviors focus on accomplishing a mission and consist of such actions as leaders' defining tasks and work roles, ensuring that subordinates meet clearly established standards of task performance, and coordinating the efforts of subordinates in their unit. (Task-oriented behaviors are similar to transactional leadership behaviors.) Relational-oriented behaviors focus more on establishing supportive environments based on strong interpersonal relationships, such as showing concern and respect for subordinates, treating subordinates as equals, and focusing on the welfare of subordinates.[35] (Relational-oriented behaviors are similar to transformational leadership behaviors.) The execution of leadership can be complex. For example, dangerous context leaders must be able to shift between task- and relational-oriented leadership behaviors "depending on the phase of the mission and/or changing environmental demands."[36]

LEADERSHIP ACTIONS TO STRENGTHEN SUBORDINATES' PSYCHOLOGICAL BODY ARMOR

Preparation for PTEs

As noted above, a challenge appraisal results when individuals assess that their own resources (internal and external) will enable them to meet the demands of a PTE. Leaders help to increase this later assessment of resources by assisting individuals during the "preparation for PTEs" phase (see Figure 4.1). In this phase, leaders can improve subordinates' hardiness by utilizing task-oriented behaviors that increase their self-efficacy to successfully address the demands of PTEs. This occurs through leaders instilling discipline and providing rigorous training that replicates the dangerous context (e.g., elevated but safe levels of risk and stress). Such training enables individuals to hone their profession-specific skills and teaches them to appraise PTEs as challenges. A. Bandura refers to such experiences as mastery experiences and states that they enable individuals to "adopt strategies and courses of action designed to change hazardous environments into more benign ones."[37] For example, M. Perrin and colleagues found that emergency service workers less trained for the specific PTEs that they faced at the World Trade Center on 9/11 were more likely to later develop PTSD. Some of the highest rates of PTSD were among those who engaged in firefighting.[38]

Another benefit of rigorous and profession-specific training is that it provides an opportunity for leaders to demonstrate and improve their tactical competence levels (e.g., decision making and technical and tactical expertise), thus increasing subordinates' assessment of their external resources. This can occur through succeeding in difficult training exercises and through establishing and training on "battledrills" that capture and synchronize the actions of unit members in anticipation of the most threatening PTEs (i.e., dealing with an insurgent sniper attack for the military, confronting an armed and barricaded suspect for a police force, and being a firefighter injured in a burning building). P. Sweeney found that leaders in Iraq who had demonstrated competence during pre-combat operations enhanced the subsequent level of subordinates' trust in them during combat, while leaders who had failed to demonstrate competence did not engender as much trust.[39] As subordinates put their lives at risk to follow the orders of leaders, as First Sergeant Spock's driver did in the opening vignette, they watch their leaders closely and ask themselves, "Do I trust my leader with my life?" (The leader here is an external resource.) Sweeney's research suggests that part of the answer depends on the leader's tactical competence as demonstrated in the preparation phase. (See Chapter

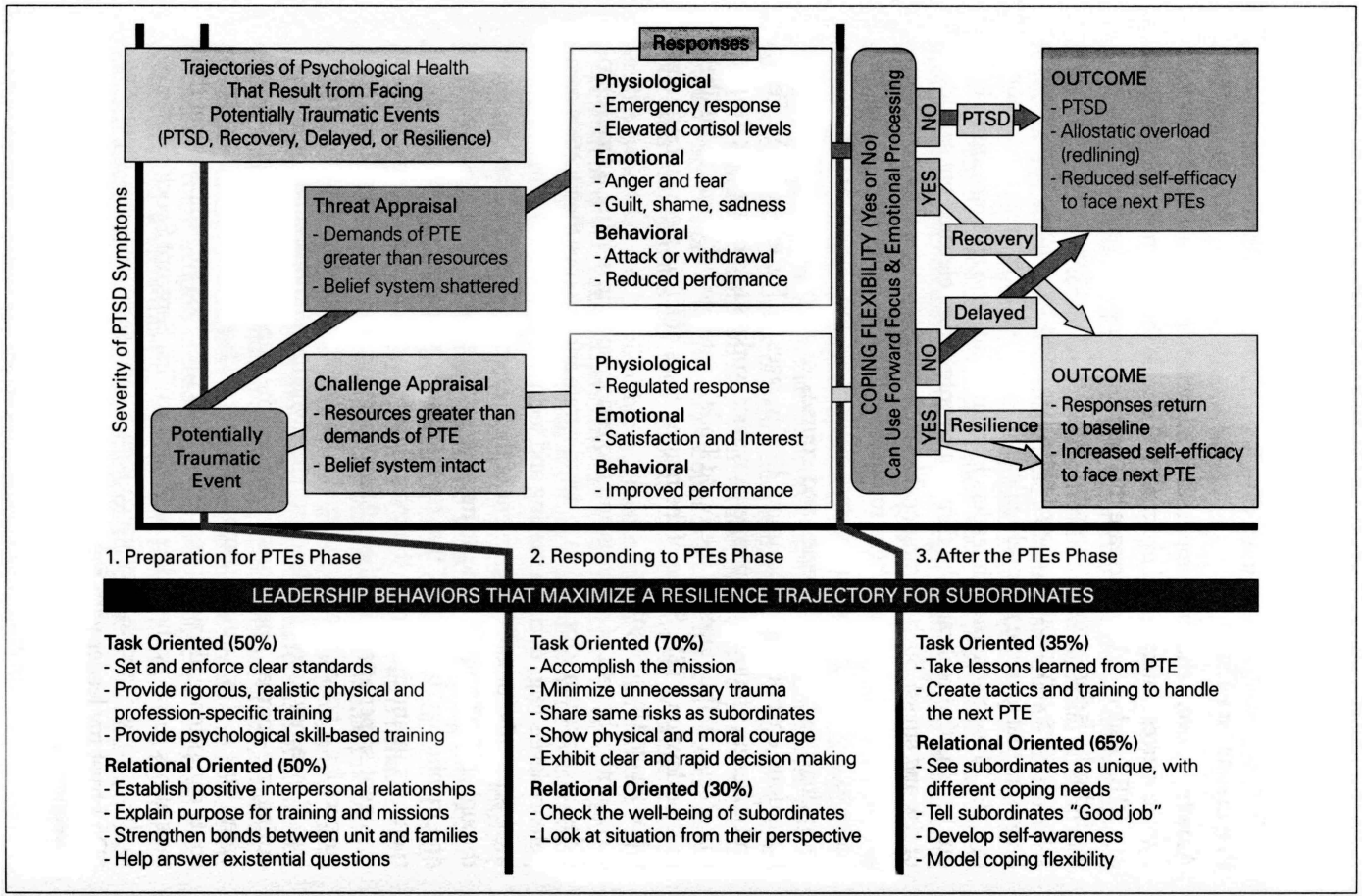

FIGURE 5.1 Understanding and mitigating post-traumatic stress disorder

9 for an in-depth discussion on how leaders can build trust among followers.) Other ways to help subordinates develop hardiness are through a rigorous and regular physical exercise program and in-depth psychological training focused on understanding and managing how the body responds to PTEs.[40]

An indirect effect of profession-specific training is that it can instill social support in units because it pushes individuals to their limits and forces them to pull together. This also enhances their assessment of their external resources. Through relational-oriented leadership behaviors, leaders can further develop this social support by establishing positive interpersonal relationships with their subordinates and learning about their lives, their families, and their aspirations. This will help to create a sense of family within the units and strengthen the bonds between the unit and subordinates' family members. (See Chapter 10 for more insight on how leaders can build strong teams.) Leaders can also utilize these relationships to help their subordinates reach their full potential to face PTEs through regular formal and informal counseling. Carl Rogers asserts that if dangerous contexts leaders are able to integrate three essential characteristics of positive interpersonal relationships—genuineness (being honest and real with subordinates), unconditional positive regard (loving every aspect of subordinates and being nonjudgmental), and empathy (taking on the worldview of subordinates to fully understand them)—then they will create subordinates who are "more self-responsible, more creative . . . and . . . better able to adapt to new problems."[41]

As part of subordinates' realistic and demanding training, it is recommended that leaders integrate the realism of PTEs by simulating wounded or injured subordinates and requiring other subordinates to provide them actual medical treatment (i.e., administer IVs as vehicles race to medical treatment facilitates). This training can save the lives of injured or wounded subordinates in the next phase and also help subordinates begin to answer such difficult and existential questions as "What would it be like if I was injured or if someone on my team died?" It is important for leaders to use their relational-oriented behaviors in this preparation phase to sit down, one-on-one, and help subordinates answer such questions and to explain the purpose of the training and of future missions. Leaders help to increase the hardiness of subordinates and their ability to make meaning out of the future consequences of PTEs when they help them to understand these purposes.

Leader competence in the preparation phase affects the level of trust that subordinates have in their leader in the "responding to PTEs" phase. Another critical component to this trust is a subordinate's evaluation of the level of care that he or she receives from the leader during this phase and that this evaluation is maximized when leaders establish positive interpersonal relationships

with each subordinate. (See Chapter 9 in this volume.) Following a competent and caring leader who one trusts into the responding to PTEs phase can greatly increase subordinates' appraisal of the resources available to face the demands of PTEs. Given the importance of leadership behaviors during the preparation for PTEs phase, it is proposed that leaders can optimize the psychological body armor of subordinates when they establish a balance between task-oriented and relational-oriented behaviors. The comments below from First Sergeant Spock highlight this balance:

> As a leader on the back of a helicopter during Operation Anaconda, I was thinking tactically—"If this happens" or "If this happens." Then I asked myself, "Do my subordinates really trust me?" From that operation, I learned that the two most important things to help prepare your soldiers for such situations is training them and getting to know them. If you can do both, then you gain the soldiers' trust. It culminates to a point, even when you know that everyone is probably not going to come back okay, where they are still going to follow you. The soldier doesn't have a doubt in his mind about it. He just knows that I trust my leader.

Responding to PTEs

If leaders are able to successfully integrate both leadership behaviors during the preparation for PTEs phase, their subordinates will be more hardy, be more likely to perceive a strong sense of social support from their family and their unit, and be more trusting of their leader, because he or she had previously demonstrated competence and had established a positive interpersonal relationship with them. As a result, the leaders will have maximized the resources of their subordinates as they face the demands of PTEs in this phase, thus increasing the probability that they will see PTEs as challenges and experience a resilience trajectory. An absence of any of these protective components may create cracks in the psychological body armors of subordinates and place them at greater risk for appraising PTEs as threats and experiencing a PTSD trajectory. When discussing the leadership behaviors necessary during this phase, it is important to remember that dangerous contexts professionals provide key services for society, and it is their professional obligation to complete their profession-specific tasks. It is, therefore, critical for them to utilize task-oriented behaviors during this phase and accomplish their mission.

Given that PTEs can create situations that are time-sensitive, ambiguous, and potentially deadly, it is also important to utilize task-oriented behaviors to reduce the number of unnecessary and avoidable traumatic events that subordinates face during this phase. In addition, while responding to PTEs, subordinates anticipate their leaders to lead by example by sharing in the risks,

exhibiting physical courage in the face of danger, and demonstrating their competence.[42] In these situations, there is considerable evidence to support the assumption that leaders speed up their decision-making process and that "a leader who can react quickly in emergencies will be judged better by followers than one who cannot."[43]

During PTEs, there is probably little time to integrate relational-oriented leader behaviors, thus necessitating that leaders rely on the positive interpersonal relationships built in the previous phase. These relationships will directly influence the level of social support and resulting assessment of resources available to subordinates as they deal with PTEs.[44] If there is time available, however, it may be beneficial for leaders to take a momentary pause and check on subordinates to assess their well-being and to see the situation from their perspective.

It is proposed that leaders continue to maximize the psychological body armor of subordinates during this phase by prioritizing task-oriented behaviors over relational-oriented behaviors (about 70 percent to 30 percent). This ratio is consistent with the work of Fiedler, who states that more task-oriented leadership behaviors are needed when situations are extremely ambiguous, dangerous, and unstructured.[45]

After the PTEs

To maximize the number of subordinates on a resilience trajectory, leaders are encouraged to facilitate coping flexibility in their units during this phase. Each individual is unique and will need different styles of coping after facing PTEs. Many subordinates may only need to integrate a forward focus coping style to continue on a resilience trajectory. Certain task-oriented leader behaviors, for instance, helping subordinates learn lessons from the responding to PTEs phase, may facilitate this; leaders can assist subordinates in developing new tactics and training to help the unit prepare for future PTEs. A shift leader for the German police who the authors interviewed in Afghanistan highlighted this point: "It is important to talk after a heavy duty or when a comrade is wounded. Talk about it and learn from it. Everyone has a right to say what went right and wrong. It is important for leaders to learn from mistakes."

One of the characteristics of PTEs is that they may "shatter" subordinates' beliefs about themselves, the world, or other people, thus requiring that they integrate an emotional processing coping style. As suggested by Resick, many of the initial symptoms of PTSD can be reduced if individuals are able to process and make meaning of secondary emotions and the consequences of facing PTEs.[46] In fact, research has shown that one form of psychotherapy, cognitive processing therapy (developed by Resick), significantly reduced PTSD

symptoms among veterans compared to a control group.[47] To facilitate this emotional processing, the leadership style needed "in the heat of battle may be qualitatively different than that needed to help a unit psychologically recover from catastrophic losses after the battle ends."[48] Therefore, it is recommended that leaders utilize a leadership style in this phase that favors relational-oriented behaviors over task-oriented behaviors (about 65 percent to 35 percent), so they can address the individual needs of their subordinates. The following comments from a SWAT leader highlight this point: "I don't look at someone as a tool. They are individuals; each one of them is a unique person. For me, it is important to address the needs of the people. You have your 'human being' face on and you ask how they are doing. You need to be perceived as caring and sincere . . . believable. It is one of the duties and traits of a true leader."

As noted by the SWAT leader, it is important for leaders to create an environment that is nonjudgmental and safe for individuals to freely and flexibly cope. Leaders should talk one-on-one with subordinates in order to maintain the positive interpersonal relationships established with subordinates in the preparing for PTEs phase and strengthened in the "responding to PTE" phase. Leaders can educate subordinates about the different coping styles, as well as help them identify the one beneficial to them, and discuss things the leader can do to help them integrate these styles. Of course, some leaders will probably have subordinates who need to integrate a combination of the two coping styles.

Two of the most important ways for leaders to increase coping flexibility in their units is through developing their own self-awareness and modeling coping flexibility for their subordinates. This will be especially important for subordinates who might need to integrate the emotional processing coping style because the stigma against employing such a coping style is quite strong in dangerous contexts professions.[49] It is highly likely that if leaders enable themselves to utilize and demonstrate an emotional processing style, especially when it is not needed, then these leaders will greatly increase the coping flexibility available to their subordinates. Therefore, it may be helpful for leaders to discuss the impact of PTEs upon themselves and how they are flexibly coping with it. Such disclosures can "give permission" to subordinates to employ the full range of coping styles. The leader must also be able to flexibly transition back to forward focus coping in preparation for the next, inevitable PTE.

CONCLUSION

Dangerous contexts professionals will continue to face death given the nature of their work. As a result, they will experience elevated risks for developing PTSD compared to the general population. This does not mean, however, that they will inevitably experience a PTSD trajectory. In fact, strong psychological body armor can put them on a resilience trajectory by helping them cognitively appraise PTEs as challenges and to apply coping flexibility afterward. Leadership is the most important protective component of the body armor, and leaders can integrate specific leadership behaviors that maximize subordinates experiencing a resilience trajectory. In particular, leaders should establish a balance between task-oriented and relational-oriented behaviors in preparation for PTEs, prioritize task-oriented behaviors while responding to PTEs, and prioritize relational-oriented behaviors after the PTEs. Fortunately, for small-unit leaders—and those who train them—these leadership behaviors can be learned and developed.[50]

KEY TAKE-AWAY POINTS

1. Dangerous contexts professionals will continue to face PTEs, which increases their risk of developing PTSD. This elevated risk does not, however, mean that they will inevitably develop PTSD. In fact, most will experience resilience.
2. Leaders should be able to identify the physical, cognitive and emotional, and behavioral symptoms of PTSD in their subordinates and themselves.
3. Two of the critical factors that contribute to the resulting trajectories of psychological health (PTSD versus resilience) are the initial cognitive appraisal of PTEs and the coping flexibility individuals demonstrate afterward.
4. There are certain leadership behaviors that positively affect cognitive appraisal and coping flexibility, and the importance of these leadership behaviors (task- versus relational-oriented) vary based on the phase of PTEs: (1) preparation for PTEs, (2) responding to PTEs, and (3) after the PTEs.

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