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**March 2009**

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**COMBAT AND OPERATIONAL STRESS CONTROL  
MANUAL FOR LEADERS AND SOLDIERS**

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**Headquarters, Department of the Army**

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# **Combat and Operational Stress Control Manual for Leaders and Soldiers**

## **Contents**

	<b>Page</b>
<b>PREFACE .....</b>	<b>v</b>
<b>INTRODUCTION.....</b>	<b>vi</b>
<b>Chapter 1    <b>Combat and Operational Stress Reaction Identification.....</b></b>	<b>1-1</b>
<b>Section I — Introduction and Historical Perspective.....</b>	<b>1-1</b>
Introduction.....	1-1
Historical Perspective.....	1-1
<b>Section II — Reactions to Combat and Operational Stress.....</b>	<b>1-2</b>
Stress Behaviors in Full Spectrum Operations .....	1-2
<b>Section III — Forms of Combat and Operational Stress .....</b>	<b>1-3</b>
Potentially Traumatic Event.....	1-3
<b>Section IV — Observing and Recognizing Common Reactions to     Combat and Operational Stress.....</b>	<b>1-6</b>
Combat and Operational Stress Reactions May Affect Soldiers in all Types of Military Operations.....	1-6
<b>Section V — Role of the Unit Ministry Team.....</b>	<b>1-11</b>
Unit Ministry Team Support.....	1-11
<b>Section VI — Role of Unit Behavioral Health Assets.....</b>	<b>1-12</b>
Mental Health Sections .....	1-12
<b>Section VII — Referrals of Soldiers Experiencing Combat and     Operational Stress Reaction and/or Other Stress-Related Disorders .....</b>	<b>1-14</b>
Recognize Severe Stress Reactions.....	1-14
<b>Chapter 2    <b>Combat and Operational Stress Prevention, Management, and Control ...</b></b>	<b>2-1</b>
<b>Section I — Introduction and Factors Which Influence Combat and     Operational Stress and Leader Actions.....</b>	<b>2-1</b>
Introduction.....	2-1

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	Combat and Operational Stress Control Risk Factors or Stressors and Preventive Measures or Leader Actions.....	2-1
	<b>Section II — Preventing and Managing Combat and Operational Stress ...</b>	<b>2-6</b>
	Cohesion and Morale.....	2-6
	<b>Section III — Stress-Reduction Techniques for Leaders.....</b>	<b>2-7</b>
	Preventive Actions .....	2-7
	<b>Section IV — Performance Degradation Prevention Measures .....</b>	<b>2-9</b>
	Effectively Sustain Performance .....	2-9
	<b>Section V — Effective Leadership.....</b>	<b>2-11</b>
	Leaders are Competent and Reliable .....	2-11
	<b>Section VI — Managing Soldiers In Distress .....</b>	<b>2-12</b>
	Guidance and Tools for Leaders .....	2-12
	Leader Actions to Manage and Prevent Deployment Distress.....	2-15
	Family Readiness Group .....	2-16
	<b>Section VII — Traumatic Event Management, Cool-Down Meetings, and Leader-Led After-Action Debriefing.....</b>	<b>2-21</b>
	Traumatic Event Management.....	2-21
	Cool-Down Meetings.....	2-23
	Leader-Led After-Action Debriefing .....	2-23
<b>Chapter 3</b>	<b>Command Leadership Actions and Combat and Operational Stress Control Programs .....</b>	<b>3-1</b>
	<b>Section I — Unit Behavioral Health Needs Assessment Survey.....</b>	<b>3-1</b>
	Introduction .....	3-1
	Using an Assessment Tool .....	3-1
	<b>Section II — Effective Combat and Operational Stress Control Program ..</b>	<b>3-2</b>
	Minimize Stress.....	3-2
	Mobilization .....	3-2
	Deployment.....	3-5
	<b>Section III — Combat and Operational Stress Control Resiliency Training .....</b>	<b>3-8</b>
	Battlemind Training—Building Soldier Resiliency.....	3-8
	<b>Section IV — Battlemind Warrior Resiliency and Combat and Operational Stress Control .....</b>	<b>3-9</b>
	Peer-Support Program.....	3-9
	<b>Section V — Leadership Actions and Interventions for Combat and Operational Stress Reactions.....</b>	<b>3-10</b>
	Leader Intervention .....	3-10
	<b>Section VI — Combat and Operational Stress Reaction.....</b>	<b>3-11</b>
	Guidelines for the Management of Combat and Operational Stress Reaction	3-11
	<b>Section VII — Safety Considerations .....</b>	<b>3-13</b>
	Soldier and Unit Safety Comes First.....	3-13
<b>Chapter 4</b>	<b>Sleep Deprivation.....</b>	<b>4-1</b>
	<b>Section I — Introduction and Sleeping in the Operational Environment....</b>	<b>4-1</b>
	Introduction .....	4-1
	Sleeping Environment Information and Related Factors .....	4-1

	<b>Section II — Maintaining Performance During Sustained Operations/Continuous Operations</b> .....	<b>4-3</b>
	Countermeasures to Maintain Performance .....	4-3
	<b>Section III — Understanding the Effects and Misconceptions of Sleep Loss and Sleep Loss Alternatives</b> .....	<b>4-5</b>
	Specific Sleep Loss Effects .....	4-5
<b>Chapter 5</b>	<b>Potentially Life-Threatening Thoughts and Behaviors</b> .....	<b>5-1</b>
	<b>Section I — Introduction and Threat of Suicide</b> .....	<b>5-1</b>
	Introduction .....	5-1
	Threat of Suicide and Potential Suicide Risk .....	5-1
	<b>Section II — Threat of Violence to Others and the Risk of Unlawful Behaviors</b> .....	<b>5-2</b>
	Dangerousness to Others .....	5-2
<b>Appendix A</b>	<b>Mild Traumatic Brain Injury and Posttraumatic Stress Disorder</b> .....	<b>A-1</b>
<b>Appendix B</b>	<b>Behavioral and Personality Disorders</b> .....	<b>B-1</b>
	<b>GLOSSARY</b> .....	<b>Glossary-1</b>
	<b>REFERENCES</b> .....	<b>References-1</b>
	<b>INDEX</b> .....	<b>Index-1</b>

## Figure

Figure 1-1. Combat and operational stress effect model .....	1-3
--	-----

## Tables

Table 1-1. Combat stressors and operational stressors .....	1-2
Table 1-2. Adaptive stress reactions.....	1-4
Table 1-3. Mild stress reactions .....	1-7
Table 1-4. Severe stress reactions .....	1-7
Table 2-1. Combat and operational stress control risk factors or stressors and preventive measures or leader actions.....	2-1
Table 2-2. Environmental and physical risk factors or stressors and preventive measures or leader actions .....	2-2
Table 2-3. Unit casualties and other potentially traumatic event risk factors or stressors and preventive measures or leader actions.....	2-2
Table 2-4. Adjustment and transitional issues (predeployment) risk factors or stressors and preventive measures or leader actions.....	2-3
Table 2-5. New Soldier integration risk factors or stressors and preventive measures or leader actions .....	2-3

## Contents

---

Table 2-6. Perceived threat or actual use of chemical, biological, radiological, and nuclear weapons risk factors or stressors and preventive measures or leader actions .....	2-4
Table 2-7. Home front issues risk factors or stressors and preventive measures or leader actions .....	2-4
Table 2-8. Loss of confidence, lack of cohesion, and decreased morale risk factors or stressors and preventive measures or leader actions.....	2-5
Table 2-9. Adjustment and transitional issues (postdeployment) risk factors or stressors and preventive measures or leader actions .....	2-6
Table 4-1. Basic sleep scheduling factors.....	4-2
Table 4-2. Basic sleep environment and related factors .....	4-3
Table 4-3. Using caffeine under various conditions of sleep deprivation .....	4-4
Table A-1. Healing and management of symptoms.....	A-2
Table A-2. Symptoms that may be experienced from posttraumatic stress disorders .....	A-3

## Preface

The focus of this publication is to inform leaders and Soldiers of the stressors of combat (offense and defense), stability, and civil support operations and to provide information on combat and operational stress control (COSC). It provides guidance on how to prevent, reduce, identify, and manage combat and operational stress reactions (COSRs) in the Soldier's own unit to the maximum extent possible. This publication identifies risk factors/stressors associated with military operations and leader actions/preventive measures required to reduce or eliminate them. It is the intent of this publication to provide COSC management tools that will maximize the combat effectiveness of an organization or element. Leaders must focus their efforts on the management of COSR and mitigating factors to control COSR and shape the long-term reaction of their organization and individual Soldiers. These COSC management tools will facilitate healthy and adaptive resolutions of stress issues resulting from combat and operational engagements while conducting military operations. Using these tools, leaders should assist junior personnel in managing their stress. This publication discusses the application of unit needs assessment (UNA), COSC management techniques, and traumatic event management (TEM) that help prevent, identify, and treat stress casualties in forward areas and minimize the long-term effects of a COSR.

The COSC doctrine presented in this publication is based on and supported by the Department of Defense (DOD) policy, DOD Directives (DODDs) 6490.1, 6490.02E, and 6490.5, and DOD Instruction (DODI) 6490.03; and Title 10, Subtitle A, Part II, Chapter 47 of the United States (US) Code as well as Field Manual (FM) 4-02.51 and doctrine and lessons learned from recent contingency operations.

This publication applies to the Active Army, the Army National Guard/Army National Guard of the US, and the US Army Reserve (USAR) unless otherwise stated.

Users of this publication are encouraged to submit comments and recommendations to improve the publication. Comments should include the page, paragraph, and line(s) of the text where the change is recommended. The proponent for this publication is the US Army Medical Department (AMEDD) Center and School (USAMEDDC&S). Comments and recommendations should be forwarded, in letter format, directly to **Commander, USAMEDDC&S, ATTN: MCCS-FCD-L, 1400 East Grayson Street, Fort Sam Houston, Texas 78234-5052** or by using the e-mail address: [Medicaldoctrine@amedd.army.mil](mailto:Medicaldoctrine@amedd.army.mil).

Unless this publication states otherwise, masculine nouns and pronouns do not refer exclusively to men.

Use of trade or brand names in this publication is for illustrative purposes only and does not imply endorsement by the DOD.

# Introduction

Current combat operations in support of the war on terrorism (WOT) and US Army transformation have resulted in an institutional shift in how leaders view, approach, and manage the effects of combat and operational stress. Combat and operational stress control has always been a commander's program. To be successful, commanders must fully understand and appreciate the magnitude of a potentially traumatic event (PTE) as it affects exposed organizations and individuals. It is a harsh reality that combat and operational stress affects everyone engaged in full spectrum operations. No Soldier or Family member will remain unchanged. It should be viewed as a continuum of possible outcomes that each person will experience with a range from positive growth behaviors to negative and sometimes disruptive reactions. Effective leadership shapes the experience that they and their Soldiers go through in an effort to successfully transition units and individuals, build resilience and promote posttraumatic growth (PTG), or increased functioning and positive change after enduring trauma. Combat and operational stress control does not take away the experiences faced while engaged in military operations, it attempts to mitigate those experiences so that Soldiers and units remain combat-effective and ultimately provide the support and meaning that will allow Soldiers to maintain the quality of life to which they are entitled.

Postcombat and operational stress (PCOS) describes the range of possible outcomes along a continuum of stress reactions that are experienced weeks or even years after combat and operational stress exposure. Postcombat and operational stress includes adaptive resolution to the stressors of combat operations (PTG), mild adjustment reactions, and the more severe negative symptoms that are often associated with posttraumatic stress disorder (PTSD). Leaders must understand this continuum and know the difference between adaptation, adjustment, and PTSD. Most Soldiers adapt, but some will struggle with COSRs and, if unresolved, result in a diagnosis of PTSD.

This publication outlines the effects of combat and operational stress as a manageable leader function. It describes various types of combat and operational stress behaviors (COSBs) and resulting PCOS as a function of engaging in and returning from military operations. There are many new tools and resources at the leader's disposal to address this issue and provide successful transition and appropriate roles of care to the Soldiers and organizations entrusted in their care. This manual is designed to provide the unit leader with information and techniques to recognize and mitigate the effects of combat and operational stress. However, effective programs and solid leadership are sometimes not enough. The leadership should know the extended resources available to them and the appropriate mechanisms to utilize them.

The application of COSC management techniques helps conserve the fighting strength, maintain combat effectiveness in sustained military operations, and promotes resilience and facilitates growth and management for individuals exposed to PTEs. Combat and operational stress control literally can be the deciding factor in successfully executing full spectrum operations and winning combat engagements.

# Chapter 1

## Combat and Operational Stress Reaction Identification

### SECTION I — INTRODUCTION AND HISTORICAL PERSPECTIVE

#### INTRODUCTION

1-1. Combat and operational stress reactions refer to the adverse reactions personnel may experience when exposed to combat or combat-like situations. Other names that have been used in the past to describe this reaction include *shell shock*, *Soldier's heart*, *battle fatigue*, and *battle exhaustion*.

1-2. Combat and operational stress control falls under the force health protection mission and must not be overlooked or minimized when planning and conducting tactical operations. It is important for Soldiers and leaders to understand that the effects of combat and operational stress are experienced by all Soldiers in full spectrum operations. Recognizing and managing the effects of combat and operational stress is equally important during routine training missions as it is during combat. It is the leaders that have the greatest impact in successfully implementing a COSC program. Leaders must create conditions where their Soldiers can talk about and make sense of their experiences. They prepare Soldiers before combat by training them, talking to them, sharing experiences, and making sure they understand the rules of engagement and the factors that lead to combat and operational stress. The COSC teams and behavioral health (BH) and medical personnel should be integrated into training and predeployment exercises with units preparing to deploy.

1-3. Once in theater, leaders should reinforce the mission's purpose, importance of communicating stress, and involve chaplains by encouraging them to be available to the troops. Leaders should remember that the more the troops know about normal reactions to extremely abnormal experiences, the more resilient they will be at dealing with the stress of combat and other military operations. Leaders should not underestimate their influence on the morale and well-being of Soldiers in their command.

#### HISTORICAL PERSPECTIVE

1-4. There have been high rates of COSR casualties in all wars over the past 100 years. When the recent Southwest Asia military operations, (Operation Desert Storm, 1991 and Operation Iraqi Freedom, 2003); the Afghanistan (Operation Enduring Freedom) and Balkans operations in 2001; or the stability operations in the Western Hemisphere are compared to World War I or World War II, we notice different types of conflicts. The levels of intensity in which those conflicts were waged are essentially the same; however, the lethality of the modern conflicts is potentially greater and the way that conflicts are waged is more asymmetrical.

1-5. Historically, within US military operations, COSRs have accounted for up to half of all battlefield casualties, depending upon the difficulty of the conditions. As a result of COSC being recognized as one of the ten AMEDD functions that is required for support of full spectrum operations, losses due to COSR have significantly decreased. In today's operational environment, leaders can expect to retain and have returned to duty over 95 percent of the Soldiers who have COSR. Combat and operational stress control is a tactical consideration that must not be overlooked or minimized.

## SECTION II — REACTIONS TO COMBAT AND OPERATIONAL STRESS

### STRESS BEHAVIORS IN FULL SPECTRUM OPERATIONS

1-6. Combat and operational stress behavior is the term that is used to describe the full spectrum of combat and operational stress that Soldiers are exposed to throughout their military experience.

1-7. Soldiers—especially leaders—must learn to recognize the symptoms and take steps to prevent or reduce the disruptive effects of combat and operational stress.

1-8. Combat and operational stress is a reality of all military missions. It is important to understand that combat and operational experiences affect all Soldiers and reflect all activities that Soldiers are exposed to throughout the length of their military service whether it is a complete career or a single enlistment. Combat and operational stress can occur during missions in both garrison and deployed assignments.

1-9. Combat stressors include singular incidents that have the potential to significantly impact the unit or Soldiers experiencing them. They may come from a range of possible sources while performing military missions. Operational stressors may include multiple combat stressors or prolonged exposures due to continued operations in hostile environments. Combat and operational stressors have a combined effect that results in COSRs. See Table 1-1 for examples of both combat stressors and operational stressors.

**Table 1-1. Combat stressors and operational stressors**

<i>Combat stressors</i>	<i>Operational stressors</i>
Personal injury. Killing of combatants. Witnessing the death of an individual. Death of another unit member. Injury resulting in the loss of a limb.	Prolonged exposure to extreme geographical environments such as desert heat or arctic cold. Reduced quality of life and communication resources over extended period of time. Prolonged separation from significant support systems such as Family separation. Exposure to significant injuries over multiple missions such as witnessing the death of several unit members over the course of many combat missions.

1-10. Most Soldiers are resilient and work through their COSB experiences. The resiliency displayed by these Soldiers is what we refer to as mental toughness or Battlemind.

1-11. Battlemind skills, developed in military training, provide Soldiers and leaders the inner strength to face fear, adversity, and hardship during combat with confidence and resolution and the will to persevere and win.

1-12. No amount of training can totally prepare a Soldier for the realities of combat. Sometimes even the strongest Soldiers are affected so severely that they will need additional help. Combat and operational stress behavior experiences will impact every Soldier in some way. Just because a Soldier may not be affected by a specific event, it does not mean that every Soldier in the unit is handling the stress in the same way.

1-13. Soldiers surveyed in Iraq indicated that those who experienced the most combat were the most likely to screen positive for a BH problem, including PTSD. Nearly one-third of Soldiers operating outside the wire may be experiencing severe negative symptoms related to combat and operational stress exposure. This can potentially affect the unit's mission capability.

1-14. In fact, current research shows Soldiers continue to struggle with negative PCOS symptoms long after redeployment. Soldiers do not reset quickly after coming home and up to 17 percent of returned veterans may continue to struggle with negative PCOS effects even 12 months after coming home.

1-15. Leaders and Soldiers must recognize the continued effects of combat and operational exposure. Understanding these effects will help Soldiers to plan accordingly to support each other and those entrusted

to them. This is especially important while sustaining prolonged or multiple deployment rotations as well as combat operations (see Figure 1-1). This model identifies PTEs related to combat and operational stressors. It looks at COSBs—both adaptive reactions and COSRs—and then looks at PCOS that includes either PTG or PTSD.

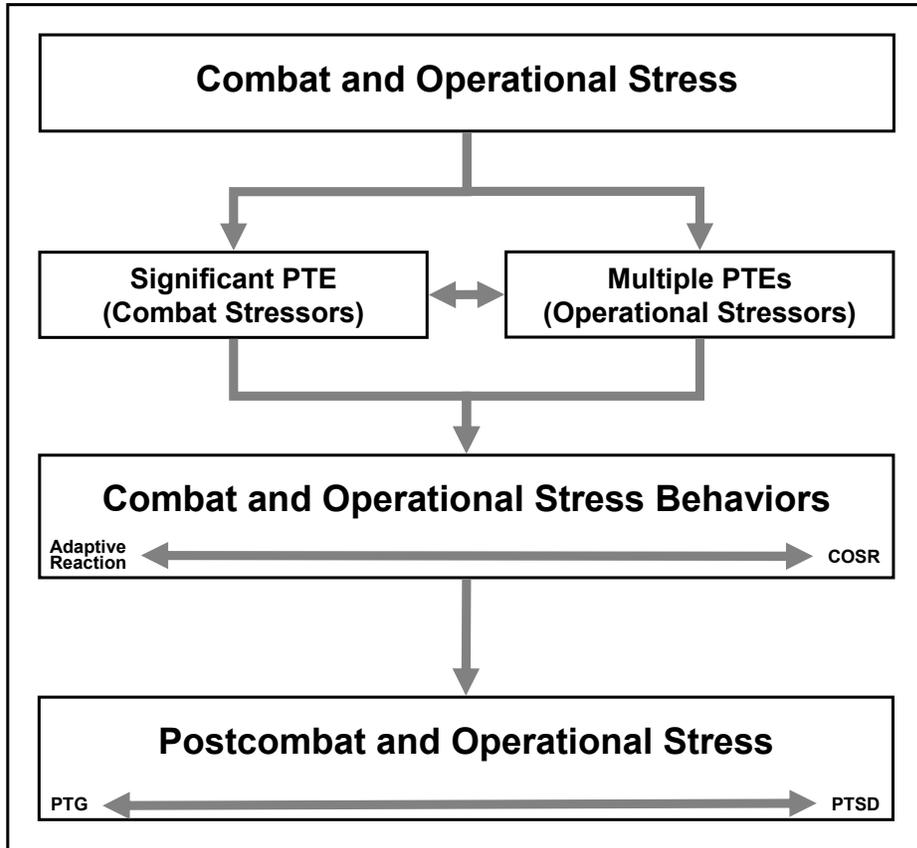


Figure 1-1. Combat and operational stress effect model

## SECTION III — FORMS OF COMBAT AND OPERATIONAL STRESS

### POTENTIALLY TRAUMATIC EVENT

1-16. Units and Soldiers deploy and execute military missions which continuously expose them to military-specific stressors. The effects of these stressors are experienced prior to, during, and after conducting military operations and missions. Sometimes these stressors are related to a significant or multiple PTEs. A PTE is an event which causes an individual or group to experience intense feelings of terror, horror, helplessness, and/or hopelessness. It is an event that is perceived and experienced as a threat to one's safety or to the stability of one's world. Units and Soldiers are exposed to or experience PTEs during both combat and operational military missions.

### COMBAT AND OPERATIONAL STRESS BEHAVIORS

1-17. Combat and operational stress behaviors cover the range of reactions found in full spectrum operations. It covers the range of reactions from adaptive to maladaptive behaviors.

## Adaptive Stress Reactions

1-18. Stressors, when combined with effective leadership and strong peer relationships, often lead to adaptive stress reactions which enhance individual and unit performance. Examples of adaptive stress reactions are provided in Table 1-2.

**Table 1-2. Adaptive stress reactions**

<b>Horizontal bonding</b>	The strong personal trust, loyalty, and cohesiveness which develops among peers in a small military unit.
<b>Vertical bonding</b>	Personal trust, loyalty, and cohesiveness that develops between leaders and their subordinates.
<b>Esprit de corps</b>	Defined as a feeling of identification and membership in the larger, enduring unit with its history and intent. This may include the unit (such as battalion, brigade combat team [BCT], regiment, or other Army organization), the branch (such as infantry, artillery, or military police), and beyond the branch to the US Army level.
<b>Unit cohesion</b>	<p>The binding force that keeps Soldiers together and performing the mission in spite of danger and adversity.</p> <ul style="list-style-type: none"> <li>● Cohesion is a result of Soldiers knowing and trusting their peers and leaders and understanding their dependency on one another.</li> <li>● It is achieved through personal bonding and a strong sense of responsibility toward the unit and its members.</li> <li>● The ultimate adaptive stress reactions are acts of extreme courage and almost unbelievable strength. They may even involve deliberate heroism resulting in the ultimate self-sacrifice.</li> </ul>

## Combat and Operational Stress Reaction

1-19. The Army uses the DOD-approved term/acronym *COSR* in official medical reports. This term can be applied to any stress reaction in the military unit environment. Many reactions look like symptoms of mental illness (such as panic, extreme anxiety, depression, and hallucinations), but they are only transient reactions to the traumatic stress of combat and the cumulative stresses of military operations. Some individuals may have behavioral disorders that existed prior to deployment or disorders that were first present during deployment and may need BH intervention beyond the interventions for COSR.

1-20. The COSR casualties are Soldiers who become combat ineffective due to unresolved negative COSRs.

1-21. Misconduct stress behavior is a form of COSR and most likely to occur in poorly trained, undisciplined units. Even so, highly trained, highly cohesive units, and individuals under extreme combat and operational stress may also engage in misconduct. Generally, misconduct stress behaviors—

- Range from minor breaches of unit orders or regulations to serious violations of the Uniform Code of Military Justice (UCMJ) and of the Law of Land Warfare.
- May also become a major problem for highly cohesive and proud units. Such units may come to consider themselves entitled to special privileges and, as a result, some members may relieve tension unlawfully when they stand-down from their military operations. For example, they may lapse into illegal revenge when a unit member is lost in combat.
- Can be prevented by stress control measures and sound leadership, but once serious misconduct has occurred, Soldiers must be punished to prevent further erosion of discipline. Combat stress, even with heroic combat performance, cannot justify criminal misconduct and does not remove responsibility from anyone who commits such an act.

## Postcombat and Operational Stress

1-22. Postcombat and operational stress describes a range of possible outcomes along the continuum of stress reactions which may be experienced weeks or even years after combat and operational stress exposure. Postcombat and operational stress includes the adaptive resolution (PTG) to the stressors of

combat operations, mild COSR, and the more severe symptoms that are often associated with PTSD. Leaders, Soldiers, and health care providers must understand this continuum and know the difference between adaptation, COSR, and PTSD.

### Posttraumatic Growth

1-23. Posttraumatic growth refers to positive outcomes that result from stress exposure and traumatic experiences that include improved relationships, renewed hope for life, an improved appreciation of life, an enhanced sense of personal strength, and spiritual development.

### Posttraumatic Stress Disorder

1-24. Posttraumatic stress disorder is a psychiatric illness that can occur following a traumatic event (such as combat exposure) in which there was a threat of injury or death to you or someone else.

## COMBAT AND OPERATIONAL STRESS REACTION AND POSTTRAUMATIC STRESS DISORDER

1-25. Leaders must understand the difference between COSR and PTSD. Combat and operational stress reaction is not the same as PTSD. Combat and operational stress reaction represents the broad group of physical, mental, and emotional signs that result from combat and operational stress exposure which includes—

- Combat and operational stress reaction which is considered a subclinical diagnosis with a high recovery rate if provided appropriate attention and time.
- Posttraumatic stress disorder which is an anxiety disorder associated with serious traumatic events and characterized by such symptoms as survivor guilt, reliving the trauma in dreams, numbness and lack of involvement with reality, or recurrent thoughts and images. Posttraumatic stress disorder is a clinical diagnosis as defined by the *Diagnostic and Statistical Manual of Mental Disorders* and the *International Statistical Classification of Diseases and Related Health Problems (ICD-10) in Occupational Health*.

1-26. Combat and operational stress reaction and PTSD may share some common symptoms, however, COSR is recognizable immediately or shortly after exposure to traumatic events and captures any recognizable reaction resulting from exposure to that event or series of events. Posttraumatic stress disorder is different from COSR because of its specific chronological requirements and symptom markers that must be satisfied in order to diagnose. Posttraumatic stress disorder is only diagnosable by a trained and credentialed health care provider. See Appendix A for additional information on PTSD and mild traumatic brain injuries (MTBIs).

## CONTINUUM OF COMBAT AND OPERATIONAL STRESS REACTIONS

1-27. The distinctions among adaptive stress reactions, misconduct stress behaviors, COSR casualties, PTG, and PTSD are not always clear. Indeed, the categories of COSBs may overlap. Soldiers with COSR may show misconduct stress behaviors and vice versa. Soldiers with adaptive stress reactions may also suffer from COSR. Soldiers exposed to danger may experience physical and emotional reactions that are not present in their daily activities. Some reactions sharpen abilities to survive and win; other reactions may produce disruptive behaviors and threaten individual and unit safety. Excellent combat Soldiers that have exhibited bravery and acts of heroism may also commit misconduct stress behaviors.

1-28. Postcombat and operational stress may develop after someone has experienced or witnessed an actual or threatened traumatic event. If PCOS interferes with the ability to do jobs and enjoy life, and it seems to continually get worse, it could lead to an actual BH diagnosis known as PTSD. Most Soldiers will do well but for some, persistent symptoms of PCOS may need support or medical care.

1-29. Soldiers in combat experience a range of emotions, but their behavior influences immediate safety and mission success. Combat and combat-related military missions can also impose combinations of heavy physical work; sleep loss; dehydration; poor nutrition; severe noise, vibration, and blast exposure; exposure

to heat, cold, or wetness; poor hygiene facilities; and perhaps exposure to infectious diseases and toxic fumes or substances.

1-30. This range of emotions and mission-related conditions in combination with other influences—such as concerns about problems back home—affect the ability to manage the perceived or real danger and diminish the skills needed to accomplish the mission. Additional factors that may influence stress levels and leader considerations include—

- Environmental stressors often play an important part in experiencing adverse or disruptive COSR. The leader must work to keep each Soldier's perception of danger balanced by the sense that the unit has the means to prevail over it.
- When troops begin to lose confidence in themselves and their leaders, adverse stress reactions are most likely to occur. The leader must keep himself and his unit working at the level of stress that enhances performance and confidence.
- The importance of leaders to recognize COSRs in order to intervene promptly for the safety of the Soldier and organization.
- Combat and operational stress behaviors may take many forms and can range from subtle to dramatic. Trying to memorize every possible sign and symptom is less useful than being alert for sudden, persistent, or progressive changes in a Soldier's behavior, especially if the Soldier is a threat to himself or the functioning and safety of the unit.

## **SECTION IV — OBSERVING AND RECOGNIZING COMMON REACTIONS TO COMBAT AND OPERATIONAL STRESS**

### **COMBAT AND OPERATIONAL STRESS REACTIONS MAY AFFECT SOLDIERS IN ALL TYPES OF MILITARY OPERATIONS**

1-31. Mild stress reaction may be signaled by changes in behavior and discernible only by the individual Soldier or by close comrades. Without self-report, it can be difficult to observe stress-related changes. The unit leader and medical personnel depend on information from the Soldier or his comrades for early recognition of COSR to provide prompt and appropriate help. Some mild stress reactions (physical and emotional) that the small-unit leader should look for are listed in Table 1-3.

1-32. Severe stress reactions may prevent the individual from performing his duties or create a concern for personal safety or the safety of others. More serious reactions or warning signs are listed in Table 1-4.

1-33. The reactions that are listed in Table 1-4 do not necessarily mean that the person must be relieved from duty, but warrant immediate evaluation and help by leadership. If not provided support, Soldiers may become COSR casualties.

**Table 1-3. Mild stress reactions**

<i>Physical</i>	<i>Emotional</i>
Trembling Jumpiness Cold sweats, dry mouth Insomnia Pounding heart Dizziness Nausea, vomiting, or diarrhea Fatigue <i>Thousand-yard stare</i> Difficulty thinking, speaking, and communicating	Anxiety, indecisiveness Irritability, complaining Forgetfulness, inability to concentrate Nightmares Easily startled by noise, movement, and light Tears, crying Anger, loss of confidence in self and unit

**Table 1-4. Severe stress reactions**

<i>Physical</i>	<i>Emotional</i>
Constantly moves around Flinches or ducks at sudden sound or movement Shakes, trembles Cannot use part of body (hand, arm, or leg) for no apparent physical reason Inability to see, hear, or feel Is physically exhausted, cries easily Freezes under fire or is totally immobile Panics, runs under fire, socially withdrawn	Talks rapidly and/or inappropriately Argumentative; acts recklessly Indifferent to danger Memory loss Stutters severely, mumbles, or cannot speak at all Insomnia; severe nightmares Sees or hears things that do not exist Apathetic, hysterical outbursts, frantic, or strange behavior

1-34. The most common stress reactions include—

- Fatigue:
  - Slow reaction time.
  - Difficulty sorting out priorities.
  - Difficulty starting routine tasks.
  - Excessive concern with seemingly minor issues.
  - Indecision and difficulty focusing attention as evidenced by a tendency to do familiar tasks and preoccupation with familiar details. These reactions may reach a point where the person becomes very passive or wanders aimlessly.
  - Loss of initiative with fatigue and exhaustion.
- Muscular tension:
  - Often increases strain on the scalp and spine (backache) and often leads to headaches, pain, and cramps.
  - The inability to relax because of prolonged muscular tension wastes energy and leads to fatigue and exhaustion. Muscles must relax periodically to enable free blood flow, waste product flushing, and nutrient replenishment.
- Shaking and tremors:
  - During incoming rounds, the individual may experience mild shaking. This symptom appears and disappears rapidly and is considered a normal physiological reaction to conditions of great danger.

- A common postbattle reaction, marked or violent shaking can be incapacitating if it occurs during the action. If shaking persists long after the precipitating stimulus ceases or if there was no stimulus, the individual should be checked by medical personnel.
- It is normal to experience either mild or heavy sweating (perspiration) or sensations of chilliness under combat stress.
- Digestive and urinary systems:
  - Nausea (*butterflies in the stomach*) is a common stress feeling. Vomiting may occur as a result of an extreme experience like that of a firefight, shelling, or in anticipation of danger.
  - Appetite loss may result as a reaction to stress. It becomes a significant problem if rapid weight loss occurs or the person does not eat a sufficiently balanced diet to keep his muscles and brain supplied for sustained operations.
  - Acute abdominal pain (*knotted stomach*, heartburn) may occur during combat. Persistent and severe abdominal pain is a disruptive reaction and may indicate a medical condition.
  - Frequent urination may occur, especially at night.
  - During extremely dangerous moments, the inability to control bowel and/or bladder functions (incontinence) may occur. Incontinence is embarrassing, but it is not abnormal under these circumstances.
- Circulatory and respiratory systems:
  - Rapid heartbeat (heart palpitations), a sense of pressure in the chest, occasional skipped beats, and sometimes chest pains are common with anxiety or fear. Very irregular heartbeats need to be checked by medical personnel.
  - Hyperventilation is identified by rapid respiration, shortness of breath, dizziness, and a sense of choking. It is often accompanied with tingling and cramping of fingers and toes. Simple solutions are increased exercise and breathing with a paper bag over the nose and mouth or breathing slowly using abdominal muscles (called abdominal breathing).
  - Faintness and giddiness reactions occur in tandem with generalized muscular weakness, lack of energy, physical fatigue, and extreme stress. Brief rest should be arranged, if possible.
- Sleep disturbance:
  - Sometimes a Soldier who has experienced intense battle conditions cannot fall asleep even when the situation permits or when he does fall asleep, he frequently wakes up and has difficulty getting back to sleep (refer to Chapter 4 for a complete discussion on sleep deprivation).
  - Terror dreams, battle dreams, and nightmares of other kinds cause difficulty in staying asleep. Sleep disturbances in the form of dreams are part of the coping process. This process of working through combat experiences is a means of increasing the level of tolerance of combat stress. The individual may have battle-related nightmares or dreams that a close relative (such as a spouse or parent) or another person important in his life has been killed in the battle. As time passes, the nightmares tend to occur with less intensity and less frequency. In some cases, a Soldier, even when awake, may experience the memory of the stressful incident as if it were recurring (called a *flashback*). This is usually triggered by a smell, sound, or sight, and is not harmful as long as the Soldier realizes it is only a memory and does not react inappropriately or feel overwhelmed. However, if it happens frequently or is very distressing, help should be sought from the chaplain or medical personnel.
  - When a person is asleep, the sleep is not restful sleep if the person is constantly being half-wakened by noise, movement, or other stimuli. Heavy snoring often indicates poor quality sleep. The individual wakes up as tired as when he went to sleep. Finding a more comfortable position, away from distractions, can help.
  - Individuals exhibiting a need for excessive sleep may be exhibiting symptoms of combat stress; however, excessive sleep is also a sign of substance abuse or depression. (Persistent insomnia is a more common indicator of possible depression.)

- Visual and hearing problems and partial paralysis:
  - Stress-related blindness, deafness, loss of other sensations, and partial paralysis are not true physical injuries, but physical symptoms that unconsciously enable the individual to escape or avoid a seemingly intolerably stressful situation. These symptoms can quickly improve with reassurance and encouragement from comrades, unit medical personnel, or physician.
  - If they persist, the physician must examine the Soldier to be sure there is not a physical cause; for example, laser hazards (such as laser range finders) can cause temporary or partial blindness and nearby explosions can cause ear damage. Individuals with these physical conditions are unaware of the causative relationship with their inability to cope with stress. These cases are genuinely concerned with their physical symptoms and want to get better. They are willing to discuss them and do not mind being examined. This is contrary to malingerers faking a physical illness, who are often reluctant to talk, or who over-dramatize their disability and refuse an examination.
  - Visual problems include blurred vision, double vision, difficulty in focusing, or total blindness.
  - Hearing problems include the inability to hear orders and/or nearby conversations or complete deafness occurs.
  - Paralysis or loss of sensation is usually confined to one arm or leg. Prickling sensations or rigidity of the larger joints occur. However, temporary complete immobility (with normal breathing and reflexes) can occur. If these reactions do not recover quickly with immediate reassurance, care must be taken in moving the casualty to medical treatment facility (MTF) for an evaluation to avoid making a possible nerve or spinal cord injury worse.
- Bodily arousal: Not all emotional reactions to stress are necessarily negative. For example, the body may become aroused to a higher degree of awareness and sensitivity.
- Threat:
  - In response to threat, the brain sends out chemicals arousing the various body systems. The body is ready to *fight or take flight*.
  - The alerting systems of the experienced combat veteran become finely tuned, so that he may ignore loud stimuli that pose no danger (such as the firing of nearby friendly artillery). However, he may awaken from sleep at the sound of an enemy mortar being fired and take cover before the round hits.
  - The senses of vision and smell can also become very sensitive to warning stimuli. The Soldier may instantly focus and be ready to react.
- Hyperalert:
  - This refers to being distracted by any external stimuli that might signal danger and overreacting to things that are, in fact, safe. The hyperalert Soldier is not truly in tune with his environment, but is on a hair trigger.
  - The hyperalert Soldier is likely to overreact and consequences can range from firing at an innocent noise to designating an innocent target as hostile, or misinterpreting reassuring information as threats, and reacting without adequate critical thinking.
- Startle reactions:
  - This is part of an increased sensitivity to minor external stimuli (on-guard reactions).
  - Leaping, jumping, cringing, jerking, or other forms of involuntary self-protective motor responses to sudden noises are noted. The noises are not necessarily very loud.
  - Sudden noise, movement, and light cause startle reactions; for example, unexpected movement of an animal (or person) precipitates weapon firing.
- Anxiety:
  - Fear of death, pain, and injury causes anxiety reactions. After witnessing the loss of a comrade in combat, a Soldier may lose self-confidence and feel overly vulnerable or incapable.

- The death of a buddy leads to serious loss of emotional support. Feelings of *survivor guilt* are common.
- The survivors each brood silently, second-guessing what they think they might have done differently to prevent the loss. While the Soldier feels glad he survived, he also feels guilty about having such feelings. Understanding support and open grieving shared within the unit can help alleviate this.
- Irritability:
  - Mild irritable reactions range from angry looks to a few sharp words, but can progress to more serious acts of violence. Mild irritability is exhibited by sharp, verbal overreaction to normal, everyday comments or incidents; flare-ups involving profanity; and crying in response to relatively slight frustrations.
  - Severe irritability includes sporadic and unpredictable explosions of aggressive behavior (violence) which can occur with little or no provocation. For example, a Soldier tries to pick a fight with another Soldier. The provocation may be a noise (such as the closing of a window, an accidental bumping, or just normal verbal interaction).
- Short attention span:
  - Persons under pressure have short attention spans.
  - Soldier finds it is difficult to concentrate.
  - Soldier has difficulty following orders.
  - Soldier does not easily understand what others are saying.
  - Soldier has difficulty following directions, aiding others, or performing unfamiliar tasks.
- Depression:
  - Soldier responds to stress with protective defensive reactions against painful perceptions.
  - Emotional dulling or numbing of normal responsiveness is a result.
  - The reactions are easily observed changes from the individual's usual self.
- Low energy level:
  - Decreased effectiveness on the job, decreased ability to think clearly, excessive sleeping or difficulty falling asleep, and chronic tiredness can occur.
  - Emotions such as pride, shame, hope, grief, and gratitude no longer matter to the person.
- Social withdrawal:
  - The Soldier is less talkative than usual and shows limited response to jokes or cries.
  - He is unable to enjoy relaxation and companionship, even when the tactical situation permits.
- Change in outward appearance:
  - If the Soldier is in a depressed mood, he may be observed to exhibit very little body movement and to have an almost expressionless mask-like face.
  - The Soldier may present disheveled in appearance, with reduced personal hygiene, and with little military bearing.
- Substance abuse:
  - Some Soldiers may attempt to use substances such as alcohol or drugs as a means of escaping combat and operational stress.
  - The use of substances in a combat area makes some Soldiers less capable of functioning on the job. These Soldiers are less able to adapt to the tremendous demands placed on them in combat.
- Loss of adaptability:
  - Less common reactions include uncontrolled emotional outbursts such as crying, yelling, or laughing.
  - Some Soldiers may become withdrawn, silent, and try to isolate themselves.
  - Uncontrolled reactions can appear singly or in combination with a number of other symptoms. In this state, the individual may become restless, unable to keep still, and move aimlessly about.

- The Soldier may feel rage or fear (which he demonstrates by aggressive acts [angry outbursts or irritability]).
- Disruptive reactions:
  - Soldiers with disruptive COSR cannot function on the job.
  - In some cases, stress produces signs and symptoms often associated with head injuries. For example, the person may appear dazed and may wander around aimlessly. He may appear confused and disoriented and exhibit either a complete or partial memory loss.
  - Soldiers exhibiting this behavior should be removed from duties until the cause for this behavior can be determined.
  - These Soldiers may compromise their own safety—in a desperate attempt to escape the danger that has overwhelmed them.
  - An individual Soldier may panic and become confused. The term *panic run* refers to a person rushing about without self-control. In combat, such a Soldier can easily compromise his safety and could possibly get killed. His mental ability becomes impaired to the degree that he cannot think clearly or follow simple commands. He stands up in a firefight because his judgment is clouded and he cannot understand the likely consequences of his behavior. He loses his ability to move and seems paralyzed. A person in panic is virtually out of control and needs to be protected from himself. More than one person may be needed to exert control over the individual experiencing panic. However, it is also important to avoid threatening actions, such as striking him.
  - They may compromise the safety of others—if panic is not quelled early, it can easily spread to others.

1-35. Although the more serious or warning behaviors described in the preceding paragraphs usually diminish with help from comrades and small-unit leaders and time, some do not. Soldiers can improve when their basic needs are met and they are given the opportunity to express their thoughts.

1-36. If a Soldier's signs and symptoms do not improve within 1 to 2 days or when symptoms endanger the Soldier or organization, leadership should immediately consult with the unit chaplain or medical personnel. Consultation with BH/COSC personnel is recommended when available.

## SECTION V — ROLE OF THE UNIT MINISTRY TEAM

### UNIT MINISTRY TEAM SUPPORT

1-37. This section addresses the general role of the unit ministry team (UMT) in the commander's program of COSC and in COSR ministry. The UMT is assigned to a command or designated by higher headquarters to be responsible for the direct UMT support to the command. The UMT provides professional ministry support to leaders in fulfilling their combat and operational stress identification and intervention responsibilities. The UMT can also assist in training leaders to recognize combat stress symptoms.

1-38. The unit is organic to Army units at all echelons from battalion and above. The UMT's primary mission is to provide for the personal delivery of religious support to Soldiers and other authorized personnel. Because the UMT is an integral part of the unit, it is a resource immediately available to the commander to assist with COSC.

1-39. The UMT consists of at least one chaplain and one chaplain's assistant. The UMT also provides area religious support in their unit's area of operations for assigned or attached units without organic religious support assets.

1-40. During combat operations, the UMT often collocates with the battalion aid station in order to provide religious support to casualties and to be with Soldiers who are most likely to experience COSR. Using their professional training, skills, knowledge, and relationship with the Soldiers, chaplains provide religious and spiritual support focusing on the prevention of mild and severe COSR. Chaplains also provide religious support to COSR casualties as an important part of the replenishment process.

1-41. In addition to being a spiritual/religious mentor for Soldiers, chaplains are trained in the TEM process and are able to assist the TEM facilitator. Chaplains are effective TEM team members as well as trainers of small-unit leaders (such as platoon leaders, noncommissioned officers [NCOs], senior combat medics, and health care specialists) in TEM team member skills and stress management techniques. (See FM 1-05, for further information on the role and functions of the UMT.)

1-42. The UMT can assist commanders in the identification of Soldiers experiencing COSR. Chaplains work closely with the unit medical personnel and are trained to recognize the signs of combat and operational stress and provide religious support to Soldiers experiencing COSR. Chaplains assess the Soldier's religious needs and then provide the appropriate religious support. Chaplains are also trained to evaluate Soldiers experiencing COSR for possible referral to medical, BH, or COSC unit personnel. When advising commanders on COSR among Soldiers, chaplains must ensure that they do not violate Soldier's rights to privileged communications.

1-43. The UMT can help Soldiers regain their emotional, psychological, and spiritual strength. The chaplain's ability to relate religious and spiritual aspects of life to the Soldier's situation is an essential element of the replenishment process. Chaplains contribute to replenishment by ensuring the following types of religious support:

- Providing worship services, sacraments, rites, and ordinances.
- Providing memorial services and/or ceremonies honoring the dead.
- Assisting with the integration of personnel replacements.
- Providing personal counseling to assist Soldiers dealing with the grief process.
- Requesting religious resources as required for reinforcing the Soldier's sense of hope.
- Supporting TEM by providing opportunities for Soldiers to talk about their combat experiences and to facilitate integration of the combat experience into their lives.
- Providing leadership training and supervision of TEM.
- Reconnecting the Soldier to the foundational principles of his personal faith.
- Assisting in resolving spiritual, moral, and ethical dilemmas presented by the circumstances of war.

## **SECTION VI — ROLE OF UNIT BEHAVIORAL HEALTH ASSETS**

### **MENTAL HEALTH SECTIONS**

1-44. Mental health (MH) sections are located in medical companies assigned to brigade and echelons above brigade medical units. The primary warfighting units for the Army are the modular brigades that include infantry, heavy brigade, and the Stryker BCTs (see FM 3-90.6 for definitive information on the modular BCTs).

1-45. Each BCT medical company has a two-person MH section consisting of one area of concentration 67D (either a psychologist or a social work officer) and one enlisted MH specialist (military occupational specialty 68X10).

1-46. The MH section coordinates, supervises, and provides the primary COSC functions for the BCT through vigorous prevention, consultation, training, education, and Soldier restoration programs. These programs are designed to provide COSC expertise to unit leaders and Soldiers where they serve to sustain their mission focus and effectiveness under heavy and prolonged stress.

1-47. The MH section has a primary responsibility for assisting leaders with COSC by implementing the brigade COSC program. The MH section—

- Is the consultant to the commander, staff, and others involved with providing prevention and intervention services to unit Soldiers and their Families.
- Is responsible for assisting the brigade surgeon with establishing brigade policy and guidance for the prevention, diagnosis, treatment, management, and return to duty (RTD) of stress-related casualties. This is accomplished under the guidance and in close coordination with all of the maneuver battalions and the brigade support medical company (BSMC) physicians.
- Is qualified to conduct command consultations per DODD 6490.1 (refer to Section VII below). Consultation should not be confused with evaluation. Only physicians and doctoral-level providers are qualified to conduct command directed evaluation.

1-48. The BH officer (either a clinical psychologist or social work officer) and MH specialist are especially concerned with assisting and training of—

- Small-unit leaders.
- Unit ministry teams and staff chaplains.
- Battalion medical platoons.
- Patient-holding squad and treatment squad personnel of the medical company.

1-49. They work closely with unit leaders and chaplains to control organizational stress and rapidly identify and intervene with those Soldiers that may need assistance. Unit leaders should seek the expertise of the BSMC BH personnel and include them in their planning processes prior to deployment.

1-50. All MH sections regardless of their organizational assignment are tasked with providing COSC for their supported units. In all of these units, COSC is accomplished through vigorous prevention, consultation, training, education, and Soldier restoration programs. These programs are designed to provide BH expertise to unit leaders and Soldiers where they serve and sustain their mission focus and effectiveness under heavy and prolonged stress.

1-51. The MH sections identify Soldiers with COSRs who need to be provided rest/restoration within or near their unit area for rapid RTD. These programs are designed to maximize the RTD rate of Soldiers who are either temporarily impaired, have a diagnosed behavioral disorder, or have stress-related conditions.

1-52. The MH section has a primary responsibility for assisting commanders with COSC by implementing the brigade COSC program and serves as a consultant to the commander, staff, and others involved with providing prevention and intervention services to unit Soldiers and their Families.

1-53. In garrison, BH personnel assigned to the BSMC and to echelons above brigade medical units continue to perform the same staff and outreach functions with supported units as they do in a field environment. An increase in the BH treatment functions may be possible as a result of consolidating BH care providers. The BH providers make available their consultation skills and clinical expertise to Soldiers of supported units and their Family readiness groups (FRG). Clinical care of Family members and Soldiers that require longer-term care beyond crisis intervention, brief treatment, and medication follow up is the responsibility of the medical department activity/medical center. The MH section personnel should focus their clinical work primarily on Soldiers with problems amenable to brief treatment.

1-54. Clinical services may be provided as part of a consolidated BH activity that is normally coordinated and established by a senior medical headquarters by using brigade BH support personnel and personnel from the medical detachment, combat stress control, or by augmenting an existing medical department activity/medical center BH staff.

1-55. Mental health sections should work closely with unit leaders and chaplains to control organizational stress and rapidly identify and intervene with those Soldiers having BH disorders. This close relationship through command consultation will reduce the stigma and lead to a better outcome for both the leadership and Soldiers. See Appendix B for additional information on behavioral and personality disorders.

1-56. When the medical company or its battalion deploys on training exercises, assigned BH personnel deploy with them to provide COSC training and support. In addition, they train to improve their own technical and tactical skills.

## **SECTION VII — REFERRALS OF SOLDIERS EXPERIENCING COMBAT AND OPERATIONAL STRESS REACTION AND/OR OTHER STRESS-RELATED DISORDERS**

### **RECOGNIZE SEVERE STRESS REACTIONS**

1-57. Although the more serious or warning behaviors described in the preceding paragraphs usually diminish with help from peers, unit leaders, and time; some do not. An individual usually improves when basic need and comforts are met. Examples of these are warm food, rest, and an opportunity to share his feelings with comrades or a small-unit leader. If the symptoms endanger the individual, others, or the mission or if they do not improve within a day or two, or seem to worsen, get the individual to talk with the unit chaplain, health care providers, or BH/COSC asset. Access to MH specialists may be sought, if available. Do not wait too long to see if the Soldier's behavior is better with time. Specialized training is not required to recognize severe stress reactions. The unit leader can usually determine if the individual is not performing his duties normally, not taking care of himself, behaving in an unusual fashion, or acting out of character.

1-58. Unit leaders have multiple levels of COSC support services available to them, some organic to their organizations, some attached, and some area or garrison support. It is up to the small-unit leader to identify what resources are available in their local and extended area. The following assets are generally available to leadership, in tactical environments—

- Organic medical assets to include physicians, physician assistants, health care specialists, and combat medics.
- Chaplains.
- Behavioral health assets organic and/or attached to the organization.
- Combat and operational stress control team that is working in the unit's area of operation.

### **VOLUNTARY REFERRALS**

1-59. When there are signs of distress that may be negatively impacting a Soldier's functioning, commands can encourage the individual to voluntarily seek help. Active duty Soldiers who voluntarily seek help will be evaluated and offered appropriate treatment. With some exceptions, information provided will be kept private. These exceptions include—

- Removal from weapon-bearing duties or access to classified information is recommended.
- Significant risk of danger to self or others is present.
- The Soldier represents a significant security risk.
- Hospitalization is necessary.
- Domestic violence or child abuse is suspected or reported or a diagnosis of substance abuse or dependence is made (Family Advocacy Program restricted reporting policy may apply).
- The Soldier's BH has deteriorated to the point that it may significantly affect work or Family function.

### **COMMAND-DIRECTED EVALUATION**

1-60. The commander may direct Soldiers to undergo a command-directed evaluation (CDE) according to DODD 6490.1 and DODI 6490.4 for a BH evaluation. A CDE is appropriate whenever the commander believes that the Soldier's mental state renders him a risk to himself or others or may be affecting his ability to carry out the mission. A CDE can provide the commander with information needed to initiate the appropriate administrative action. Examples of questions commanders may pose include—

- Does the Soldier have a BH or neuropsychiatric condition that is contributing to his current difficulty?
- What is the potential for the Soldier to return to full functioning given successful treatment?
- Is the Soldier suitable for carrying a weapon at the current time?
- Is it appropriate for the Soldier to have access to classified information?
- Is the Soldier qualified for deployment?
- Is this an emergency or can the CDE be accomplished on a routine basis?

### **Routine Command-Directed Evaluation**

1-61. Once a decision has been made to request a routine/nonemergency CDE, commanders are required to—

- Consult with a privileged BH provider. Commanders should communicate the behaviors that they believe warrant the evaluation and what information they would like from an evaluation. The BH provider will make recommendations about whether a CDE is appropriate and if the situation warrants an emergency CDE. The BH provider will also discuss other options that may be appropriate. If a CDE is necessary, the commander should inform the provider as to when the Soldier will be notified about the referral so that a time and date for the evaluation can be determined.
- Provide a written letter or counseling statement to the Soldier. This should be provided to the Soldier at least two working days prior to the evaluation. The letter will include—
  - The date, time, and location of the evaluation.
  - The name and grade or rank of the BH professional who will be conducting the evaluation.
  - The name and grade or rank of the BH professional with whom the command has consulted.
  - A brief factual description of the behavior that gave rise to the need for a referral.
  - A listing of the Soldier's rights.
  - The names and telephone numbers of the resources on-post that can assist the Soldier.
  - The name and signature of the commander.
  - Soldier's acknowledgement of receipt of letter by signing or commander's annotation of Soldier's refusal.

1-62. Most BH assets will have copies of templated sample CDE request forms. Leaders should contact their supporting BH asset to request a copy of this form.

1-63. Forward a request for a CDE to the provider. It is vital for the Soldier's command to provide all available documentation concerning the problem behaviors. This may include, as available, Article 15s, letters of reprimand, letters of counseling, and enlisted performance reports/officer performance reports. The documentation is necessary for a comprehensive evaluation.

1-64. Provide a copy of the letter to the BH provider conducting the CDE. If the provider believes that the evaluation has been requested improperly, he will contact the command to clarify issues about the process or procedures used. The provider conducting the evaluation will provide both written and verbal feedback on the results of the evaluation. Be aware the evaluation may require more than one appointment to complete.

### **Emergency Command-Directed Evaluations**

1-65. Emergency CDEs are conducted upon recommendation of the BH provider or when in the judgment of the command an emergent situation exists. In general the following constitute grounds for an emergency referral:

- A severe mental or substance use disorder.
- Intent to inflict harm to self or others.
- Actual, attempted, or threatened violence.

1-66. When an emergency CDE is determined to be necessary, adhere to the following steps:

- Ensure safety of the Soldier and others by—
  - Observing the Soldier and never leaving him alone.
  - Taking away all weapons, knives, medication, or other objects that could harm him or others.
  - Taking all reasonable precautions to notify and protect others who have been identified as intended targets of violence or harm.
  - Consulting with BH or other privileged health care provider prior to sending a Soldier for an emergency CDE, if at all possible. If the circumstances do not permit such a consultation, contact other supporting medical personnel as soon as possible.
- Take action to safely transport the Soldier to the nearest BH care provider, or if unavailable, another privileged health care provider as soon as is practical. Provide—
  - The Soldier with a letter stating the reasons for emergency referral as soon as practical. If the Soldier is seen before the letter can be provided, the letter and statement of rights must be provided as soon as is practical. If a BH provider was not consulted prior to ordering the CDE, the reason why should be explained in the letter to the Soldier.
  - A letter to the evaluating provider. A letter requesting a CDE must be sent to the treating BH provider documenting command concerns, the Soldier's circumstances, and the observations that led to refer emergency referral. This should be done as soon as possible.

### **Rights of Soldiers Pertaining to a Command-Directed Evaluation**

1-67. Legal protections for the rights of Soldiers prohibit a command from improperly referring for a CDE. It is improper to refer a Soldier for a CDE to buy time, as a disciplinary tool, or as a reprisal for the individual's attempt or intent to make a lawful communication (see DODD 6490.1). When referred for a nonemergency CDE when deployed in theater, the following rights prior to the evaluation apply. The Soldier may—

- Have two working days waiting period between the CDE notification and evaluation.
- Consult with and get advice from an attorney (judge advocate).
- Consult with the inspector general if he believes the CDE violates policy.
- Request a second BH evaluation by another BH provider of the Soldier's choice and expense, if reasonably available.
- Not have his rights restricted from communicating with the inspector general, members of Congress, or any others concerning the BH referral.

### **Coordination Between the Commander and Behavioral Health Provider for a Command-Directed Evaluation**

1-68. A commander can expect the BH provider to keep him informed and to request additional information following a CDE request which may include—

- Requesting documents supportive of the request for a CDE (documentation of problem behaviors, letters of reprimand or counseling, Article 15s, and past performance reports).
- Requesting interviews with unit leaders, immediate supervisors, or other appropriate personnel to obtain collateral information on the individual.
- Performing psychological testing or conducting clinical interviews with the Soldier.

1-69. The commander will be notified by the BH provider when the Soldier—

- Requires hospitalization.
- Requires evacuation out of theater.
- Has any limitations placed on his duty status.

1-70. Verbal and written reports summarizing findings and recommendations will be discussed with both commander and the Soldier. Recommendations may include suggestions for support, changes in special duty status, and/or separation from the Army.

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## Chapter 2

# Combat and Operational Stress Prevention, Management, and Control

### SECTION I — INTRODUCTION AND FACTORS WHICH INFLUENCE COMBAT AND OPERATIONAL STRESS AND LEADER ACTIONS

#### INTRODUCTION

2-1. The previous chapter defined combat and operational stress and how to utilize additional resources to aid in the management of Soldiers with significant COSR. The rest of this manual will provide information, recommendations, and tools for the leader in preventing and managing combat and operational stress. There are key risk factors that have the potential to create significant distress for the Soldier that small-unit leaders must be aware of. Each factor is presented below with recommendations on how to mitigate the potential COSR resulting from the specific stressor

#### COMBAT AND OPERATIONAL STRESS CONTROL RISK FACTORS OR STRESSORS AND PREVENTIVE MEASURES OR LEADER ACTIONS

2-2. The following tables (Tables 2-1 through 2-9 on pages 2-1 through 2-7) identify risk factors or stressors and preventive measures or leader actions that are required to reduce or eliminate the risk factors or stressors. Subsequent sections of this chapter provide additional guidance and tools for Soldiers and leaders in the prevention and management of combat and operational stress.

**Table 2-1. Combat and operational stress control risk factors or stressors and preventive measures or leader actions**

<i>Risk factor or stressor</i>	<i>Preventive measure or leader action</i>
Intense or heavy combat.	Consider coordinating a unit BH needs assessment survey (UBHNAS) to assess BH of unit at a scheduled point in the deployment cycle (midpoint, quarterly, or so forth). This will allow visibility of BH of unit as a whole, especially if compared to UBHNAS results prior to deployment. Allows the refinement of the unit COSC program to address relevant issues.
Under attack and unable to strike back.	Ensure that unit understands the rules of engagement (ROEs) and behavior expectations. Remind Soldiers of the intent to <i>return with honor</i> .
Troops may feel like helpless victims of pure chance.	Conduct activities that allow continued bonding and development of unit cohesion and <i>esprit de corps</i> .
Immobility—during static, heavy fighting.	Conduct rugged and realistic training.
Pinned down in bunkers, trenches, or ruins. Armored troops on restrictive terrain. Close quarters during urban combat.	Train troops in active defense against these threats. Institute protective measures for trench, bunker, or urban operations. Understand that stress in response to threatening or uncertain situations is a normal reaction. Recognize that battle duration and intensity increases the potential for COSR. Convey this message to Soldiers. Impart unit pride and identity.

**Table 2-2. Environmental and physical risk factors or stressors and preventive measures or leader actions**

<i>Risk factor or stressor</i>	<i>Preventive measure or leader action</i>
<p>Lengthy, ongoing deployments creating cumulative stress.</p> <p>Extreme temperatures.</p> <p>Precipitation.</p> <p>Austere conditions.</p> <p>Sand and windstorms.</p> <p>Poor air quality.</p> <p>Dietary changes.</p> <p>Exposure to disease.</p> <p>Crowded living conditions and lack of privacy.</p> <p>Jet lag upon arrival.</p> <p>Physical demands.</p> <p>Fatigue-producing events and activities.</p>	<p>Conduct rugged and realistic training.</p> <p>Ensure every effort is made to provide for Soldiers' health and welfare.</p> <p>Promote regular and proper hygiene.</p> <p>Provide Soldier's with appropriate equipment for weather-related conditions.</p> <p>Institute sleep management program.</p> <p>Ensure proper nutrition and hydration.</p> <p>Initiate and support stress management program.</p> <p>Develop and supervise safety policies and procedures.</p> <p>Promote individual and unit physical training.</p> <p>Consult with preventive medicine and other force health protection personnel.</p> <p>Consult with BH and COSC teams.</p> <p>Encourage Soldiers to self-refer.</p> <p>Foster a command climate that encourages seeking help for problems.</p> <p>Encourage use of sick call when physical symptoms are present.</p> <p>Prohibit the use of self-medication; only use medication if prescribed and monitored by health care providers.</p>

**Table 2-3. Unit casualties and other potentially traumatic event risk factors or stressors and preventive measures or leader actions**

<i>Risk factor or stressor</i>	<i>Preventive measure or leader action</i>
<p>Soldiers in the unit being killed and wounded are the strongest indicator of <i>combat intensity</i> and are usually accompanied by increased COSR.</p> <p>Heavy casualties naturally shake Soldiers' confidence in their own chance of survival.</p> <p>Loss of a leader or buddy is an emotional shock and threat.</p>	<p>Provide unit updates on status of injured or deceased Soldiers. Provide as many details as known about Family support issues and expected recovery of injured Soldiers. It is critical to inform the unit of both the known and unknown, with updates as appropriate so rumors and disinformation do not materialize.</p> <p>Utilize unit peer support system to provide internal decompression of PTE and to help prevent or assist with any COSR casualties.</p> <p>Recognize that grief is a normal response that is expected.</p> <p>Encourage Soldiers to talk about their grief and loss.</p> <p>Conduct TEM assessment utilizing UMTs, COSC teams, and BH assets to provide the appropriate level of supportive services.</p> <p>Consider event-driven Battlemind psychological debrief if TEM assessment warrants.</p> <p>Consider conducting routine time-driven Battlemind psychological debriefings preplanned and scheduled throughout the deployed phase of an operation as a way of capturing all PTEs throughout the rotation as part of the planning process.</p> <p>Conduct memorial services.</p> <p>Promote confidence in the Army Health System and its medical treatment capabilities.</p>

**Table 2-4. Adjustment and transitional issues (predeployment) risk factors or stressors and preventive measures or leader actions**

<i>Risk factor or stressor</i>	<i>Preventive measure or leader action</i>
<p>Lack of information.</p> <p>Limited time for addressing personal issues.</p> <p>Anxiety and concern regarding upcoming Family separation.</p> <p>Anxiety and concern regarding Family functioning after the Soldier has deployed.</p> <p>Interpersonal relationship difficulty.</p> <p>Children may act out and or misbehave.</p>	<p>Consider coordinating a UBHNAS to assess the BH of unit prior to entering the operational environment. Will also aid in the development and execution of the unit COSC program.</p> <p>Ensure that unit understands the ROEs and behavior expectations. Remind Soldiers of the intent to return with honor.</p> <p>Ensure Family readiness is a priority function of unit readiness.</p> <p>Ensure command involvement and support for Families before deployment.</p> <p>Articulate readiness goals and the vision for Family readiness.</p> <p>Establish a functioning, command endorsed and funded FRG Program.</p> <p>Provide information about the mission, as permitted by operations security (OPSEC).</p> <p>Effective communication; provide upward, downward, and lateral information.</p> <p>Single Soldiers without children are often underrecognized as an at-risk population. However, all Soldiers are at risk for developing adjustment and transitional problems. Utilize the <i>Military OneSource</i> which is able to coordinate counseling services for Soldiers and Families who need assistance with deployment-related issues at their Web site (<a href="http://www.militaryonesource.com">http://www.militaryonesource.com</a>).</p> <p>Foster a command climate that encourages seeking help for problems.</p> <p>Utilize Battlemind training system modules.</p> <p>Conduct additional briefings with small groups of Soldiers.</p> <p>Allow as much time as possible for Soldiers to address personal and Family readiness issues during their predeployment preparation and utilize garrison UMTs and BH assets to assist the individual, Family, and unit with predeployment concerns.</p> <p>Discuss the plan for linking Soldiers and Family members to available resources.</p>

**Table 2-5. New Soldier integration risk factors or stressors and preventive measures or leader actions**

<i>Risk factor or stressor</i>	<i>Preventive measure or leader action</i>
<p>Unestablished trust and cohesion.</p> <p>Replacements might have limited experience.</p> <p>New Soldier feeling like an <i>outsider</i>.</p> <p>Difficult transition (for personal reasons or as the result of a group dynamic).</p>	<p>Foster unit cohesion and integration of all Soldiers equally to enhance <i>esprit de corps</i> and bonding of peer groups.</p> <p>Impart unit pride and identity.</p> <p>Ensure that new arrivals are welcomed into the unit, helping them to become known and trusted.</p> <p>Assign sponsor to new Soldier.</p> <p>Encourage experienced unit members to teach, coach, and mentor.</p> <p>Ensure new unit members understand their jobs and are properly trained.</p> <p>Conduct team-building activities, such as unit physical training or small group activity.</p>

**Table 2-6. Perceived threat or actual use of chemical, biological, radiological, and nuclear weapons risk factors or stressors and preventive measures or leader actions**

<i>Risk factor or stressor</i>	<i>Preventive measure or leader action</i>
Invisible, pervasive nature of many of these weapons creates a high degree of uncertainty and ambiguity with fertile opportunity for false alarms, rumors, and maladaptive stress reactions.	<p>Conduct rugged and realistic training.</p> <p>Prepare Soldiers for chemical, biological, radiological, and nuclear threat contingencies.</p>

**Table 2-7. Home front issues risk factors or stressors and preventive measures or leader actions**

<i>Risk factor or stressor</i>	<i>Preventive measure or leader action</i>
<p>Worrying about what is happening back home distracts Soldiers from focusing their psychological defenses on combat and operational stressors. It creates internal conflict over performing their combat duty and resolving the uncertainties and issues at home.</p> <p>The home-front problem may be a negative one—marital or financial problems, illness, uncertainty, job security (if a reserve component or Army National Guard Soldier), or it may be something positive—newly married or a new baby.</p> <p>All Soldiers face greater potential problems and uncertainties with personal matters if the military conflict is not popular at home.</p>	<p>Family readiness is a critical component of unit readiness.</p> <p>Help Soldiers to prepare themselves and their Families for the disruption and stress associated with deployment.</p> <p>Encourage Families to maximize their resources and support during all phases of the deployment cycle and utilize the resources that include—</p> <ul style="list-style-type: none"> <li>Family readiness groups.</li> <li>Army Family team building.</li> <li>Army community services (ACS) and Family support group.</li> <li>American Red Cross.</li> <li>Army Emergency Relief.</li> <li><i>Military OneSource</i>.</li> <li>Chaplains and BH assets.</li> </ul> <p>Ensure involvement of rear detachment.</p> <p>Provide regular updates to the home front from the deployed unit. Adopt a comprehensive communication plan that may include a unit newsletter or a unit Web site.</p> <p>Coordinate with postal support unit for incoming and outgoing mail and packages.</p> <p>Provide access to the telephone and computers, when available.</p> <p>Consult with UMTs, BH teams, and COSC teams.</p> <p>Encourage Soldiers to self-refer.</p>

**Table 2-8. Loss of confidence, lack of cohesion, and decreased morale risk factors or stressors and preventive measures or leader actions**

<b><i>Risk factor or stressor</i></b>	<b><i>Preventive measure or leader action</i></b>
<p>Insufficient information and failure of expected support.</p> <p>Lack of confidence in—</p> <ul style="list-style-type: none"> <li>Leaders.</li> <li>Training.</li> <li>Unit.</li> <li>Equipment.</li> </ul>	<p>Conduct rugged and realistic training.</p> <p>Effective communications; provide upward, downward, and lateral information.</p> <p>Plan operations carefully and thoroughly.</p> <p>Commit unit to missions commensurate with training, experience, and capabilities.</p> <p>Demonstrate effective leadership to earn the confidence, loyalty, and trust of subordinates.</p> <p>Be decisive and assertive.</p> <p>Ensure leaders make expectations clear.</p> <p>Impart unit pride.</p> <p>Encourage Soldiers to identify meaning and purpose in relation to their service and mission.</p> <p>Let every Soldier know that he is valued and appreciated and his contributions are invaluable.</p> <p>Demonstrate and promote the Army Values and the Warrior Ethos.</p> <p>Keep Soldiers productive (when not resting) through recreational activities, equipment maintenance, and training to preserve perishable skills.</p> <p>Initiate and support stress management and unit COSC programs.</p> <p>Understand that stress in response to threatening or uncertain situations is a normal response. Convey the message to each Soldier that having additional stress is a normal reaction.</p> <p>Consult with UMTs, BH teams, and COSC teams.</p> <p>Encourage Soldiers to self-refer for any stress problems.</p> <p>Consider conducting time-driven Battlemind psychological debrief near midpoint of deployment cycle.</p> <p>Utilize a unit peer support system to allow decompression of significant events and internal monitoring of individuals and sections.</p> <p>Foster a command climate that encourages seeking help for problems.</p> <p>Ensure all leaders know their jobs and work together to promote <i>esprit de corps</i> through building unit confidence, integrity, and unit cohesion.</p>

**Table 2-9. Adjustment and transitional issues (postdeployment) risk factors or stressors and preventive measures or leader actions**

<i>Risk factor or stressor</i>	<i>Preventive measure or leader action</i>
Reintegration problems. Reunion problems and interpersonal relationship difficulty. Children may act out and or misbehave.	Consider coordinating a UBHNAS to assess unit needs and refine support services provided. Reintegration and reunion briefings for Soldiers and Families prior to arrival home. Reintegration and reunion activities for Soldiers and Families upon return home. Recommend to the maximum extent possible that commanders allow time (through half-day workdays) for returning Soldiers to <i>decompress</i> from their battlefield experience. Utilize all deployment cycle support programs available at the home station. Utilize the Battlemind training system modules. Utilize garrison UMTs and BH assets to assist the individual, Family, and unit with postdeployment concerns. Promote use of <i>Military OneSource</i> Web site. The <i>Military OneSource</i> Web site is able to coordinate counseling services for Soldiers and Families who need assistance with deployment-related issues at the Web site ( <a href="http://www.militaryonesource.com">http://www.militaryonesource.com</a> ). Encourage the use of block leave. Conduct Battlemind postdeployment psychological debrief.

## SECTION II — PREVENTING AND MANAGING COMBAT AND OPERATIONAL STRESS

### COHESION AND MORALE

2-3. Unit cohesion and morale is the best predictor of combat resiliency within a unit or organization. Units with high cohesion tend to experience a lower rate of COSR casualties than units with low cohesion and morale. High cohesion and morale enhance adaptive stress reactions in Soldiers and organizations. The foundation for any stress-reduction program includes trust and confidence in—

- Leaders.
- Training.
- Unit.
- Equipment.

### CONFIDENCE IN LEADERS

2-4. Leaders must demonstrate effective leadership to earn their subordinates' confidence, loyalty, and trust. Leaders are responsible for—

- Committing the unit to missions commensurate with their abilities and training.
- Planning operations carefully and thoroughly.
- Preparing the unit to accomplish the mission.
- Leading and guiding the unit to mission accomplishment.
- Showing consistent good leadership that convinces subordinates their leaders know best what should be done, how it should be done, who should do it, and how long the task should take. Authority accompanies leadership beyond the automatic authority given by military rank and

position. Authority and respect are earned based on confidence in a leader's ability to guide the unit to success.

### CONFIDENCE IN TRAINING

2-5. Training helps Soldiers develop the skills required to do their jobs. Confidence is the result of knowing they have received the best possible training for combat and are fully prepared. This confidence results from—

- Realistic training that ends with successful mastery.
- Relevance of training to survival and success on the modern battlefield.
- Refresher training and cross-training.
- Systematic training development process for individual and collective training.

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*Note.* An occupational therapist, a member of the COSC team, can assist in selecting realistic training to match abilities and result in success.

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### CONFIDENCE IN UNIT

2-6. Each Soldier in a unit needs to become confident of the other unit members' competence. Individuals must stay and train together to gain that personal trust. Unless absolutely necessary, teams should not be disbanded or scrambled. Subunits in the same larger unit should have the same standing operating procedures (SOPs) and training standards, so members can fit in quickly if teams have to be cross-leveled or reorganized after casualties occur.

2-7. History has shown that most Soldiers *stay and fight* primarily as a direct correlation to the bonding and identity they have established with unit personnel. Soldiers fight for the battle buddy next to them. It is imperative that leadership make every effort to develop this relationship in a healthy, cohesive way to ensure unit integrity in high-stress environments.

2-8. Mission accomplishment is the unit's highest priority.

### CONFIDENCE IN EQUIPMENT

2-9. Soldiers who learn to operate and maintain assigned equipment develop confidence in their ability to employ it. This, in combination with an individual's belief in his personal capabilities, raises overall confidence in his fighting ability.

## SECTION III — STRESS-REDUCTION TECHNIQUES FOR LEADERS

### PREVENTIVE ACTIONS

2-10. The same leadership skills that apply to troop welfare and warfighting can effectively reduce or prevent COSR. Leaders should take preventive actions and address stress symptoms. Ignoring the early warning signs can increase the severity of COSRs.

2-11. Positive action to reduce combat and operational stress also helps Soldiers cope with normal, everyday situations and enhance adaptive stress reactions. The following are stress management techniques:

- Assure every effort is made to provide for the Soldiers' welfare.
- Be decisive and assertive; demonstrate competence and fair leadership.
- Whenever possible provide sleep and/or rest, especially during continuous operations, and ensure sleep for decisionmaking personnel.
- Set realistic goals for progressive development of the individual and team.
- Systematically test the achievement of these goals.

- Recognize that battle duration and intensity increase stress.
- Be aware of environmental stressors such as light level, noise level, temperature, and precipitation.
- Recognize that individuals and units react differently to the same stressors.
- Learn the signs of stress in yourself and others.
- Recognize that fear is a normal part of combat and operational stress.
- Rest minor stress casualties briefly, keeping them with their unit.
- Be aware of background stress sources prior to combat; for example, Family concerns and/or separation or economic problems.
- Allow open communication with Soldiers and provide an upward, downward, and lateral information flow of communication.
- Understand that stress in response to threatening or uncertain situations is normal.
- Create a spirit to win under stress.
- Realistic training is a primary stress-reduction technique which assures Soldiers' maximum confidence in their skills and their belief that their leaders are doing their best for them.
- Ensure training includes understanding of combat and operational stress and how to deal with it.
- Practice stress control through cross-training, task allocation, tasks matching, and task sharing.
- Look for stress signs and a decreased ability to tolerate stress.
- Practice and master stress-coping techniques.
- Train Soldiers to recognize the stressors of full spectrum operations and how to manage them, since it is unhealthy to deny the stresses.
- Ensure the best possible shelters are available.
- Keep Soldiers well-supplied with food, water, and other essentials.
- Provide mail, news, and information avenues.
- Provide the best medical, logistical, human resource, and other available support.
- Maintain high morale, unit identity, and *esprit de corps*.
- Keep unit members together and build cohesion.
- Encourage experienced unit members to mentor and teach new members.

## COPING WITH INDIVIDUAL STRESS

2-12. Stress pushes the body to its limits and causes tension; relaxation reverses this process. Coping with personal stress is essential.

2-13. Stress-coping skills should be incorporated into unit training activities and given command support in practicing them. Once Soldiers receive a block of instruction on stress-coping techniques, they should then be incorporated into daily unit operations.

2-14. Once routine unit operational tempo is established Soldiers relax easier and more quickly, even under highly stressful conditions. The Soldiers should be able to naturally control stomach fluttering, heart rate, blood pressure, and stress.

2-15. Stress-coping exercises include deep breathing, muscle relaxation, and cognitive exercises. Deep breathing is the simplest to learn and practice; the others require longer instruction and more practice time.

2-16. On request, the COSC team or BH assets can provide instructional materials and assistance.

## Deep-Breathing Exercise

2-17. Breathing exercises consist of slow, deep inhaling (which expands the chest and abdomen) holding it for 2 to 5 seconds and then exhaling slowly and completely through the mouth (which pushes out the used air). This can be done for five breaths as a quick, mind-clearing exercise, or continuously to promote sleep.

2-18. Abdominal or diaphragmatic breathing (making the stomach move the air, rather than the upper chest) is especially effective for stress control and, with practice, can be done simultaneously with tasks that require full attention.

### Muscle-Relaxation Exercises

2-19. Relaxation exercises are more complex. They generally consist of concentrating on various muscle groups and the tensing and relaxing of limbs to relax the entire body. Quick versions for use in action consist of tensing all muscles simultaneously, holding for 15 seconds or more, and then letting them relax and *shaking out the tension*. Deep relaxation versions start in the feet and work up (or start in the head and work down), body part by body part (muscle group by muscle group), tensing and then relaxing each in turn, while noticing how each part feels warm after it relaxes.

### Cognitive Exercises

2-20. Cognitive exercises consist of self-suggestion (positive self-talk); imagery (imagine being fully immersed in a deeply relaxing setting); rehearsal (imagine performing the stressful or critical task under pressure and doing it perfectly); and meditation (clearing the mind of all other thoughts by focusing on every breath and silently repeating a single word or phrase).

2-21. These techniques involve creating positive mental images that reduce the effects of stressful surroundings, redirecting mental focus, and learning to detach from stress. Soldiers are encouraged to practice stress management techniques and discuss their use in combat and other stressful situations.

#### CAUTION

It is important not to use deep relaxation techniques at times when you need to be alert to dangers in your surroundings. Practice the quick relaxation techniques so you can use them automatically without distraction from the mission.

2-22. To reduce stress, the small-unit leader should—

- Lead by inspiration, not fear or intimidation.
- Initiate and support stress management programs.
- Provide information to focus stress positively.
- Ensure each Soldier has mastered at least two stress-coping (relaxation) techniques, a slow one for deep relaxation and a quick one for on the job.

## SECTION IV — PERFORMANCE DEGRADATION PREVENTION MEASURES

### EFFECTIVELY SUSTAIN PERFORMANCE

2-23. Every Soldier, team, and unit must learn to effectively sustain performance in continuous operations. This requirement applies especially to leaders.

2-24. While it is an important ingredient, the determination to endure does not ensure effectiveness. Gaining the required capability goes beyond a high level of proficiency in combat skills and technical specialties. It means learning to identify the adverse conditions of continuous operations, cope with them, and overcome their effects. It also means learning how to slow the rate of performance degradation.

2-25. Units (leaders and personnel) must prepare and execute plans and train to sustain performance. Adverse conditions progressively degrade Soldier effectiveness. Fortunately, long-term remedies exist for slowing the rate of performance decline. These remedies, which must be introduced prior to combat, include safety, food intake, combat load, and physical fitness.

## SAFETY

2-26. Safety, which encompasses such factors as using proper lifting techniques and staying alert and careful, is influenced by fatigue. Overly tired Soldiers are more vulnerable to injury than those who are rested. After 72 hours of continuous combat, the tendency to seek shortcuts is very strong and accident rates increase 50 percent. Fatigued Soldiers operating equipment and other military systems is hazardous but it is especially hazardous when weapon systems are involved. Catastrophic accidents can occur when fatigued (and underexperienced) crews man weapon systems. Ways to safeguard Soldiers include developing and following unit safety SOPs and increasing supervision during extended operations.

## FOOD INTAKE

2-27. If Soldiers are too busy, stressed, and/or tired to eat adequate rations during continuous operations, their caloric intake will be reduced. This may lead to both physical and mental fatigue and degraded performance. For example, in accidents judged to involve aviator fatigue, there is some indication that before the accidents occurred, the pilots had irregular eating schedules or missed one or more meals.

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*Note.* Leaders need to emphasize the importance of eating, especially the easily digestible items such as the special supplements (for example, power bars) in the meal, ready-to-eat (MRE), because nutritional demands may exceed caloric intake of the meal.

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2-28. Nutrition is an essential element in the management of COSC. Decreased nutrition can lead to a higher susceptibility to stress-related problems and overall reduction in performance and efficiency. The ability to sustain nutritional intake not only increases stress-coping capability and performance output, it can be a morale enhancer and source of positive reinforcement. An example of this might be the ability to offer hot meals versus MREs or special meals during significant achievements or holiday activities. Good nutrition is very important. Eating all meals in the field will usually provide the body's requirements for salts. The MREs meet the daily requirements for minerals and electrolytes. Do not take extra salt in meals unless medically indicated.

2-29. An inadequate diet degrades performance, reduces resistance to disease, and prolongs recuperation from illness and injury. When unitized group rations-A and unitized group rations-heat and serve become available, leaders must ensure that Soldiers eat food that has the nutritional value commensurate with the physical activity and stress of battle. The MREs may be consumed as the sole source of subsistence for 21 days (see Army Regulation [AR] 30-22). After 21 days, they must be enhanced with authorized enhancements, as identified in Department of the Army (DA) Pamphlet (Pam) 30-22, or alternate rations will be served. Leaders must remind and encourage Soldiers to eat and drink properly.

2-30. The excitement, stress, and rapid pace of events associated with field preparations can cause Soldiers to forget to drink liquids. Soldiers may enter the early part of the field scenario inadequately hydrated. Dehydration may result, especially if the early scenario calls for assault of a position or rapid air/land deployment.

2-31. Contributing to developing dehydration is the relative lack of moisture in MREs. In addition, Soldiers experiencing dehydration lose their appetite and reduce their food intake. This, in combination with dehydration, leads to degraded performance. Leaders must reemphasize drinking regimens to ensure that Soldiers are properly hydrated going into battle. Leaders must remind Soldiers to drink liquids in both hot and cold climates and must monitor fluid intake. If personnel drink only when thirsty, they will become dehydrated. See FM 21-10 for additional information on hydration.

## COMBAT LOAD

2-32. In combat, the load carried by a Soldier may often exceed optimum recommended weights. In the case of an infantry Soldier, the combat load may be double the recommended load. Physical conditioning cannot compensate for this degree of excess. Soldiers tire faster and, in continuous combat, recovery from fatigue becomes more time-consuming. The effects of increased physical demands and fatigue can amplify

stress-related responses and increase the rate of COSR experienced by the individual and the unit. Employing a load echelonment concept should be considered to ease the strain on Soldiers. In this concept, the unit separates an individual's equipment into two loads—fighting and existence (see FM 90-5). As the unit closes on the objective, the heavier existence load is dropped and the Soldier continues with the lighter fighting load.

## PHYSICAL CONDITIONING

2-33. Physical fitness can affect the ability to resist combat and operational stress. Good physical conditioning has physical and psychological benefits. Good physical conditioning delays fatigue, builds confidence, and shortens recovery times from illness and injury. Improved physical conditioning enhances self-esteem and builds individual capabilities to accomplish demanding tasks. Being in good physical condition prepares individuals to better cope with the physiological demands of stress. Rigorous physical conditioning helps protect against the stress of continuous operations. A regular program of physical fitness to increase aerobic endurance, muscular strength, and flexibility is essential to combat readiness. Aerobic fitness increases work capacity and the ability to withstand stress.

## PHYSICAL TRAINING

2-34. The ability to quickly recover from physically strenuous workloads is maintained by physical training that is performed consistently and routinely. However, there is no evidence that good physical conditioning significantly reduces normal sleep requirements or compensates for the deleterious impact of sleep deprivation on cognitive functioning. (Sleep deprivation is discussed in greater detail in Chapter 4.) Unit training must include regular physical conditioning. This increases the Soldiers' tolerance to all types of stressors. The program should be geared to the unit's combat mission and the exercises tailored to meet the environment where the unit operates. The pace, length, and types of runs, road marches, and other activities should be commensurate with the unit's need. Infantry units need more demanding, longer road marches than maintenance units. Activities should include team athletics, which capitalize on the cohesion-building aspects, as well as physical benefits. The benefits of such a program include developing endurance through aerobic exercises and enhancing strength through weight training and deprivation/physical stress training. As physical conditioning improves, Soldiers feel better about themselves and have greater confidence in each other.

# SECTION V — EFFECTIVE LEADERSHIP

## LEADERS ARE COMPETENT AND RELIABLE

2-35. The effective leader in combat is competent and reliable. He knows his job without question and he can be counted on to do it regardless of the situation or circumstances. Effective small-unit leadership reduces the impact of stress in several ways. The fact that a leader is recognized by his subordinate Soldiers as effective will inspire confidence in them, giving them one less thing to worry about in a potentially stressful situation. Leaders must understand the effects of COSR and must—

- Focus on the immediate mission.
- Expect Soldiers to perform assigned duties.
- Remain calm, in command, and in control at all times.
- Normalize Soldiers' stress reactions.
- Keep Soldiers productive (when not resting) through recreational activities, equipment maintenance, and training to preserve perishable skills.
- Ensure Soldiers maintain good personal hygiene.
- Ensure Soldiers eat, drink, and sleep.
- Let the Soldiers express their thoughts. Do not ignore or make light of expressions of grief or worry. Give practical advice and put emotions into perspective.

2-36. A unit builds confidence, *esprit de corps*, integrity, and cohesion when the *leaders know their jobs*.

## SECTION VI — MANAGING SOLDIERS IN DISTRESS

### GUIDANCE AND TOOLS FOR LEADERS

2-37. This section is designed to provide guidance and tools to leaders on what to look for, what to do, and specific resources for helping Soldiers who are in distress.

2-38. Although there are many reasons that a Soldier may be in distress, this section only provides guidance on more common areas likely to be experienced within units and organizations. Specifically, deployment, Family, personal, harassment, substance abuse, and emotional distress are discussed. Leaders should attempt to identify the local resources available to manage these types of distress.

2-39. Problems that Soldiers face whether deployment-related, financial, or personal can all be detrimental not only to the readiness of the individual, but to the entire unit as well. These issues can occupy a great amount of the leader's time and personnel and can have significant consequences for the command and Soldier if the issues are not quickly addressed and handled effectively.

2-40. Even the most motivated and well-trained Soldiers can find themselves in difficult situations. These situations, while infrequent, can weigh heavily on each Soldier's mind. Some Soldiers handle these problems well on their own, but others may not. These Soldiers will look to their leaders for guidance.

### FORCE PROJECTION PROCESSES

2-41. Leaders should be aware of the common risk factors in deployment distress resulting from the force projection process. Force projection encompasses a range of processes including mobilization, deployment, employment, sustainment, and redeployment.

2-42. These processes have overlapping timelines, are continuous and can repeat throughout an operation. Force projection operations are inherently joint and require detailed planning and synchronization. Decisions made early in the process directly impact the success of an operation.

- Mobilization is the process of assembling and organizing resources to support national objectives in time of war and other emergencies. Mobilization includes bringing all or part of the industrial base and the US Armed Forces to the necessary state of readiness to meet the requirements of the contingency.
- Deployment is the movement of forces to an operational area in response to an order.
- Employment prescribes how to apply force and/or forces to attain specified national strategic objectives. Employment concepts are developed by the combatant commands and their component commands during the planning process. Employment encompasses a wide array of operations—including but not limited to—entry operations, decisive operations, and postconflict operations.
- **Sustainment** is the provision of human resources, logistics, and Army Health System and other support necessary to maintain and prolong operations or combat until successful accomplishment or revision of the mission or national objective.
- **Redeployment** involves the return of forces to home station or demobilization station.

2-43. Each force projection activity influences the other. Deployment and employment cannot be planned successfully without the others. The operational speed and tempo reflect the ability of the deployment pipeline to deliver combat power where and when the joint force commander requires it. A disruption in the deployment will inevitably affect employment. Poor planning for any part of the force projection process can negatively impact Family stability, individual readiness, unit readiness, cohesion, and, ultimately, the ability to meet the mission. If Soldiers are not confident that their spouses and Family are cared for and personal affairs are in order, then Soldiers will not be fully ready to contribute to the unit and cannot be considered mission ready or reliable. Proper planning will cover basic issues that affect Family life such as home, finances, automobile, communications, and other similar issues. If Soldiers do not accept the responsibility of adequately preparing their Family prior to departure or are not provided the time to do so, then they may negatively impact overall unit readiness and mission capability.

## **DEPLOYMENT**

2-44. Deployment encompasses all activities from origin or home station through destination, including predeployment events, as well as intracontinental US, intertheater, and intratheater movement legs. This combination of dynamic actions supports the combatant commander's concept of operations for employment of the force. Deployments and separation are expected functions of military life and can be divided into four distinct but interrelated deployment phases. The four phases, predeployment, fort-to-port, port-to-port, and reception, staging, onward movement, and integration, are always sequential and could overlap or occur simultaneously. All four phases within the deployment cycle are distinct and pose their challenges and needs for preparation.

2-45. See the Army G-1 Deployment Cycle Support Process Homepage for additional information and current support documentation and presentations on the Army G-1 deployment cycle support process at Web site (<http://www.armyg1.army.mil/dcs/default.asp>). Specifically, this guidance refers to the deployment cycle support for mobilization, deployment and employment, and redeployment and postdeployment.

## **Mobilization**

2-46. Proper mobilization preparation is not something that can be accomplished in a short time and the extra time a Soldier may have to put towards the necessary activities is often redirected to accomplish the additional duties associated with the upcoming deployment.

### ***Inadequate Mobilization Education***

2-47. Unit mobilization education can vary depending on the unit and the amount of time allotted prior to deployment. Mobilization briefs are regularly provided to outbound units but are often given only a short time prior to departure, possibly too late. The extra duties on the job associated with deployment do not leave a Soldier time to adequately follow up on mobilization responsibilities.

### ***Lack of Individualized Attention by Command***

2-48. There is no mechanism to ensure a Soldier has taken the time and actions necessary to properly prepare for deployment. Units are able to track unit requirements prior to deployment but unless personal attention is provided (one-on-one conversations or smaller reinforcement briefs by NCOs and officers) there is no guarantee all things are in order.

### ***Lack of Prioritizing Family Readiness as a Form of Unit Readiness***

2-49. Inadequate mobilization education of the spouses may occur as the spouses may be unable or unwilling to participate in the mobilization brief or process. Obstacles such as child care, transportation, conflict with work schedule, feeling unconnected to the unit, or denial of departure may prohibit a spouse from becoming educated or involved. The Soldier may not feel confident or comfortable in turning over all Family matters to his spouse so he refrains from educating his spouse about responsibilities. The spouse may not want to take on those additional chores or responsibilities (for example, bill paying).

2-50. Family mobilization education can vary depending on the unit and the amount of time allotted prior to deployment. Families need to have time to prepare prior to a unit deployment. More than one mobilization briefing is suggested at least six or more weeks ahead of time, but this is not always practical from a unit perspective. The Soldier does not always inform his spouse of upcoming mobilization briefings, readiness education, or benefits of the unit FRG. Unit commanders must ensure maximum participation by unit spouses. The fact is that the Soldier is not prepared if the spouse is not prepared. Command leadership should intervene and inquire when spouses do not attend mobilization briefings. Families who do not reside in the same area as the unit may not feel as connected or informed about the mobilization process and, therefore, take a less active role. Depending on the distance, they may not travel to attend any mobilization briefings or unit functions. One possible benefit, should a Family live elsewhere, is they may have already planned for and resolved separation-related issues that are very similar to deployment issues.

2-51. Newly married spouses (or very young spouses) are still acclimating the military lifestyle and may feel additionally challenged if asked to adapt to a new environment without their spouses to help them. For obvious reasons, spouses with English as a second language will have problems translating the volume of information they will receive in connection to a deployment (both written and oral). Comprehension may be a challenge that could then become a readiness challenge as well. This category of spouse can have similar challenges as those who are inexperienced or new to the Service.

2-52. Depending on time and availability, individual mobilization augmentee personnel (in the Reserve Component [RC]) may not receive valuable mobilization information and readiness education. Ideally, the Family of the individual mobilization augmentee personnel will be absorbed by the gaining unit's FRG who can provide timely official information and support, but this is not always the case. Efforts must be made to contact and assist these individual mobilization augmentee Families and incorporate them into existing unit readiness planning. The unit contact roster plays a major role in Family readiness. It is the primary source of Family information for unit FRG members and must be accurate and updated in a timely manner. Many Soldiers may not (purposely or otherwise) list their correct home address and telephone numbers (landline and cellular telephones) for use in the command recall roster. This may also apply to those Families who are in transitional housing (sharing a house or an apartment with another Family or living in a hotel until the Soldier deploys). Without proper personal information, command and FRG communication are significantly delayed. The unit FRG may not be notified when a married Soldier checks into the unit. Procedures for ensuring the FRG is notified should be established in the unit SOP.

2-53. Alerting the FRG would mean the new Family receives a welcome to the unit. Unit point of contact (POC) information is also then provided to the Family for future use. Soldiers who get married may not have their new contact or Family information updated on the unit recall roster. The newly married (or about to be married) Soldiers must be educated about the proper administrative requirement once married. The unit must be made aware of the Soldiers' new situation/status. The same can be said of a Soldier getting divorced.

## Deployment and Employment

2-54. During the deployment and employment process of force projection, a breakdown in communications between the Soldier and his Family and between unit and the Family may result from—

- Changes of Family telephone numbers and addresses.
- Out-of-date rosters.
- Blackout periods at unit level when deployed.
- Inadequate contact by the Soldier due to deployment circumstances.
- Family moving *back home*.
- Emotional barriers.
- Timeliness of communications.
- Losing touch with FRG.
- Information on unit Family support programs not being passed from the older, more experienced officer and NCO spouses to the more junior or younger/newer spouses.

2-55. Families may decide to move out of the area while a Soldier is deployed or simply break contact with the unit. Either of these actions results in Families being less informed. The FRG is the first POC with these Families and is responsible for updating Families through telephone calls, personal contact, and electronic/regular mail. If the FRG is not able to link with the Families they lose personal touch and connection, as well as the opportunity to bond the Family to the unit and the other Families. The opportunity to have a shared experience is the greatest factor in bonding—if that goes, so does the opportunity for affiliation. Isolation can also result from spouses who are very active in their careers or at work, with Family obligations, attending school, or are otherwise so busy that they do not have time for unit functions, FRG, or any other command-sponsored functions.

2-56. Excessive media coverage can challenge all concerned. Families dealing with real-time coverage will sometimes be drawing on false conclusions from the media reports heightening their already elevated stress level. Official information being passed through the FRG, on unit answering machines, and posted

on unit Web sites is generally considered more accurate and verified information, but may not reach the unit Families as quickly as the command would like. Families will need guidance on putting media reports in perspective and handling the excessive and dramatic nature of some reporting.

2-57. Unit personnel who are remaining behind to support Families must be thoroughly educated and capable of handling a wide variety of technical, emotional, and supportive issues.

## REDEPLOYMENT

2-58. The return and reunion at the end of deployments is a significant challenge for Soldiers and their Family members, regardless of experience, length of service or deployment, and environment (battlefield or otherwise). A standardized structured program has been developed by DOD for Soldiers and their Families to help ease the stress, emotional flux, and reunion challenges which the transition to the home environment can produce.

2-59. Policy that encompasses return and reunion requires commands to ensure Soldiers receive adjustment time, education, and counseling. Families are also offered the opportunity to attend return and reunion education and may access counseling (individual or Family) as needed.

2-60. Poor communication between a Soldier and his spouse and the potential of combat and operational stress impacting Family relationships are additional stressors that the command should be aware of in postdeployment support operations. Commands must be knowledgeable of available resources existing both in garrison and through extended care avenues (internet-based *Military OneSource*, for example) so that they can refer Soldiers and their Family members for care.

## LEADER ACTIONS TO MANAGE AND PREVENT DEPLOYMENT DISTRESS

2-61. Deployments may include combat, stability, and civil support operations. Distress is seen during all phases of deployments and with proper training and deployment preparation it may be decreased. Unmanaged stressors have been linked with poor work performance, depression, predisposition to injury, spousal abuse, and other coping difficulties.

2-62. The unit leaders and commanders can manage deployment-related distress utilizing the following recommendations and resources, organized by deployment cycle phase, that include—

- Setting the example and prioritizing Family readiness. This is a crucial part of unit readiness for any command.
- Becoming familiar with overriding military policies, programs, and services concerning Family readiness. Command involvement and readiness support for Families before, during, and after a deployment can have a direct impact on the success of the unit's Family readiness efforts and overall unit readiness. It is vital that the commander articulate readiness goals, the vision for Family readiness, information about the mission, and the plan to link Soldiers in the unit, Family members, and available resources. The common goal is to enable Families to be self-sufficient and prepared. There are many resources, including individual counseling and guidance available. Some of these include—
  - Establishing a functioning, command endorsed and funded FRG program. The unit FRG serves as the official communication link between a deployed command and its Families. The FRG is primarily a spouse-to-spouse connection that commanders use to pass important, factual, and timely information on the status and welfare of the operational unit. Standardized training for individual volunteers and unit FRG leaders, as well as guidance on establishing and maintaining a FRG, is available at each military installation.
  - Encouraging participation in FRG from all ranks.
  - Providing spouses with the skills needed to meet the challenges of the military lifestyle, including instruction on coping with deployment.
  - Educating unit leaders on all available support resources.

## FAMILY READINESS GROUP

2-63. Unit leaders must continually ensure that lines of communications with unit, Soldiers, and Family members remain open and are routinely used while the unit is in a deployed status. Leaders must—

- Assign, educate, and empower rear party personnel to assist FRG members.
- Adopt a comprehensive communications plan that may include unit newsletter, unit answering machine, a unit Web site, a current [FRG](#) telephone tree, e-mail/message traffic, and coordination with rear detachment personnel.
- Educate senior leaders, Family readiness personnel, and rear detachment about comprehensive resource information (*Military OneSource*).
- Address specific unit concerns by providing or coordinating *just in time counseling*. For those times of heightened stress, the command is able to request stress management support from the installation counseling staff. They may also be able to tailor briefings relative to the needs of the unit and Families who may require help coping with a suicide in the unit, training accident, or combat loss. Contact your local Soldier and Family Assistance Center and local COSC team (if available) to coordinate.

2-64. Care for the caregivers is a facilitated discussion for those who actively support the unit and their Families. Over time, the stress and demands of caring for others and responding to their needs becomes a drain on those key volunteers supporting the unit. Chaplains are a good resource to facilitate the discussions and provide the volunteers the opportunity for focusing on themselves and rejuvenate their energy and spirit.

2-65. Family team building or other post-support services may be actively involved with support groups from Families and children for those dealing with issues surrounding deployment.

## POSTDEPLOYMENT ACTIVITIES

2-66. The command should provide comprehensive return and reunion programs and services to both the Soldiers and Families. Should one or the other not receive timely adequate reintegration education, it could negatively affect the reunion process, the relationship, and the Soldier's future readiness. Though the focus of this section is on Families, it is important to remind commanders of the specific reintegration requirements for Soldiers returning from combat experiences and the need to provide proper adjustment time in addition to stated services. The command should—

- Provide return and reunion briefs for spouses.
- Plan postdeployment education/briefings for Soldiers and Families to include topics such as domestic violence, alcohol abuse, stressors of combat, and anger management. Spouses can receive a version of the above-targeted briefings for them. They may also benefit from information concerning changes to leave and earnings statements, budgeting issues, and child-related issues. Together, the Soldiers and their spouses may attend these sessions and receive couples counseling as needed through Soldiers and Family services and *Military OneSource*.

2-67. *Military OneSource* is able to coordinate counseling services for Soldiers and Families in need of counseling support to help cope with deployment-related issues, reunion concerns, parenting, child care, and other everyday issues. Soldiers and Family members are authorized six face-to-face counseling sessions per incident with a civilian BH practitioner for free. A Soldier or Family member will call a *Military OneSource* consultant who will determine if there are on-post resources readily available to assist the caller. If post resources are not available, the *Military OneSource* consultant will provide the caller an immediate referral to counseling assistance and, using their nationwide network of providers, will find a licensed BH practitioner near the caller. Utilizing *Military OneSource* is ideal for active duty Soldiers and RC Soldiers (and their Families) who need counseling services. Those who are not located near an installation may go online to the Web site (<http://www.militaryonesource.com>).

2-68. The DOD has funded a program directing the MH network, one of the nation's leading mental and substance abuse health care organizations, to provide counseling specialists to individual units that are remotely located and unable to access local services or to utilize mental health network to augment local

counseling providers. The mental health network is available to assist with mobilization briefings, deployment issues and especially, redeployment, and reunion/reintegration issues.

2-69. Upon arrival at the home location, unit commanders should ensure that Soldiers are aware of the supportive services available through the chaplains, ACS, and MTF.

## FAMILY RELATIONSHIPS

2-70. Many life stressors stem from relationships. Whether in a dating relationship or married, relationship problems leading to distress may result from difficulties in communication, parenting, sexual intimacy, finances, or immaturity. There is a tendency among some leaders not to interfere in a Soldier's personal life. However, relationship problems can quickly interfere with duty performance. Relationship problems have been identified as a significant risk factor associated with suicide in the military. The military takes a proactive stance in supporting healthy marital relationships. Most leaders are keenly aware of how relationships can impact mission readiness. When Soldiers are confident that their relationships are in good standing and their spouses are supportive, they are able to focus on the mission at hand. Counseling services for relationships can come in two forms in the military; premarital and marital counseling—

- Statistics show that marriage is much more successful and enjoyable when couples go through counseling prior to saying *I do*. Many chaplains have organized premarriage seminars that teach skills to help couples prepare for a lifetime together. To find out about premarriage seminars available in your area, including Prevention and Relationship Enhancement Program courses, check with your chaplain or installation Family Life Chaplain.
- Counseling or *talking therapy* involves a trained professional assisting a member in resolving problems or making changes. Counseling can be done one-on-one or as couples or groups. It can be helpful for a number of concerns such as stress symptoms, poor sleep, nervousness, tension headaches, relationship difficulties, work problems, depression, and anxiety disorders.

2-71. Leader actions to manage Family-related distress include being aware of and monitoring the following common marital conflict risk factors:

- Isolation or geographic separation from friends and extended Family.
- Peer group is either unmarried or unhappily married.
- Financial problems.
- New baby in the home.
- Differences in the level of commitment.
- Sexual problems.
- Child discipline problems or disagreements.
- Young age at the time of marriage.
- Different or unrealistic expectations of marriage.
- Short engagement or no premarital counseling.
- Cultural or religious and spiritual differences.
- Poor communication and problem-solving skills.
- Chronic unresolved life stressors.
- Dual career demands.

2-72. Leaders can support Soldiers and their spouses by becoming familiar with the many programs on the installation and in the community that support marriages.

2-73. Services on installations may include—

- Premarital workshops.
- Relationship enhancement classes.
- Family advocacy programs for prevention and intervention related to emotional/physical abuse.
- Chaplain for counseling and support related to relationship difficulties.
- Medical treatment facility for individual or couples therapy.

- Behavioral health for individual therapy.

2-74. Other sources of support include—

- Community-based support groups where personal difficulties can be shared with others experiencing similar problems.
- Rebuilding one's faith. Many churches, synagogues, and other religious organizations are actively concerned for the needs of people in the divorce process. Learning to adjust to a crisis can be enhanced through a spiritual process.
- Social activities, sports, and academic endeavors. These provide opportunities for building new friendships.

## PERSONAL CHALLENGES

2-75. Financial challenges can arise from unanticipated emergencies or financial mismanagement. Financial hardships (difficulty paying bills), usually a result of poor financial literacy, are commonly found in demographic groups such as: junior enlisted Soldiers; single parents; newly divorced or separated individuals; Soldiers with dependents having physical problems; newlyweds; and individuals who have recently relocated. Financial strain may cause behavioral changes in an individual and has been linked to depression, which can impact duty performance, mission readiness, and interpersonal relationships. If a Soldier is at risk for personal problems, marital problems, or suicide, that risk is exacerbated in times of financial stress.

2-76. Legal problems may be civil or criminal in nature. Civil legal problems take many forms (from being served with a notice of a lawsuit to a letter from home) and can involve a wide range of issues, such as lawsuits, divorce, separation, debt collection, taxes, citizenship issues, landlord-tenant problems, estate planning, and literally hundreds of other issues. A common element is that such problems can have a devastating effect on a Soldier's state of mind and readiness if these problems are not adequately addressed. Judge advocates are trained to help Soldiers solve these problems and are familiar with military-specific laws that are designed to address many problems unique to the military community.

2-77. Leaders must monitor assigned personnel routinely and become familiar enough with unit members to assess the personal risk factors of—

- Financial problems.
- Alcohol misuse.
- Immaturity.
- Relationship problems.

2-78. Although factors such as financial problems, alcohol abuse, and lack of life experience can invite legal problems, even the most experienced officer or enlisted Soldier is likely to face the business end of a legal problem during his career. In many cases, the difference between relative success and failure in a matter rests in how well and quickly the individual reacts to the problem.

2-79. A majority of the crimes that Soldiers commit involve the use or abuse of alcohol. Alcohol clouds one's judgment. Additionally, financial problems and relationship problems can also lead Soldiers to commit criminal acts.

2-80. Leaders can assist Soldiers assigned to their organization by offering the following resources:

- Most civil legal problems can be prevented through education and counseling. Soldiers need to be educated about their rights and the resources available to them. Legal assistance attorneys are available to teach Soldiers in these areas.
- Soldiers need to be informed that defense counsel, medical staffs, and chaplains are outlets for help and are provided for the specific purpose of helping in these situations. These personnel are obligated to pursue the interests of their client and are insulated from command influence. Soldiers need to be educated about their rights and the resources available to them.

2-81. For many Soldiers, separation or retirement may be welcome or agreeable to them. However, for others, there may be ambivalence or outright resistance. Most Soldiers will get through this process without any problems, but some will not.

2-82. Separation from the military is a general term which includes dismissal, dropping from the rolls, revocation of an appointment or commission, termination of an appointment, release from active duty, release from custody and control of the military, or transfer from active duty to the individual ready reserve, the RC, the retired list, the temporary or permanent disability list, or the retired Reserve and the similar changes in an active or reserve status.

2-83. Retirement is the process of separating from the US military after at least 20 years of satisfactory service and, as a result, drawing appropriate retirement pay, allowances, and benefits.

2-84. The uncertainty involved in transition from military to civilian life can be stressful to almost anyone, but some Soldiers may have issues that increase the stress of that transition and their mixed feelings toward separation or retirement, including—

- Military service has been more of their identity than they realized.
- Difficulty finding a job as separation/retirement approaches.
- Marital problems.
- Financial problems.
- Exceptional Family member.

2-85. Outright resistance will be more likely for Soldiers facing involuntary separation. Risk factors making this process worse may include those listed in the paragraph above plus—

- Adverse characterization of discharge.
- Physical or mental disability that may impair the Soldier's ability to support himself.
- Personality disorder.

2-86. Some type of command involvement can minimize most of the problems listed. For Soldiers who are voluntarily separating, proper adherence to the separation process will greatly ease the transition. In addition, the outprocessing checklists will ensure that all milestones are hit in a timely manner. For Soldiers who are attempting to stay in the service against involuntary separation, it becomes more imperative that the leaders are ensuring that all legislated actions are taking place and, if they are not, that the individual Soldier is held accountable.

## **HARASSMENT**

2-87. The organizational climate of a unit is the responsibility of the commander. Sound leadership is the key to eliminating all forms of discrimination and those in supervisory positions must foster an environment free of inappropriate behavior. All individuals in the unit must be treated fairly and with mutual respect. Sexual harassment is a form of discrimination that erodes morale and negatively impacts unit cohesion. Commanders, supervisors, managers, and all others in leadership positions will neither tolerate nor fail to correct sexual harassment by their subordinates, nor will they allow the existence of hostile work environments. The impact of sexual harassment affects the individual through stress in the workplace, physical fitness, and reenlistment intentions. Sexual harassment affects the unit's productivity, readiness and cohesion, and mission accomplishment.

2-88. Sexual assault is a criminal act. It is incompatible with the core values of military service. Sexual assault impedes units' or Soldiers' morale, effectiveness, efficiency, and negatively impairs the ability of the military to function smoothly. Victims can be male or female. Perpetrators can also be male or female. In recognition of the seriousness of sexual assault, the military has initiated policy and guidance for commanders for handling these cases. For definitive information, see AR 600-20.

## **SUBSTANCE ABUSE**

2-89. Combating the debilitating threat posed by alcohol abuse and alcohol dependency on both Soldiers and mission readiness requires a total commitment from all levels of leadership. Leaders must be alert to

characteristics of alcohol abuse and with the symptoms of the disease of alcohol dependency. All leaders must not, in any way, promote or condone alcohol misuse.

2-90. The use of illegal drugs undermines the effective performance of Soldiers and is contrary to the military's mission. Use, possession, trafficking, or distribution of illegal drugs or drug paraphernalia will not be tolerated. These offenses must be dealt with swiftly and effectively to the fullest extent provided for by law and regulations. Civilians engaging in such acts will be detained and turned over to a local law enforcement agency for prosecution under the applicable criminal statutes.

2-91. There are established policies and guidelines available to leaders in the identification, management, and treatment of substance abuse. Leaders must be aware of these policies and adhere to them accordingly.

## EMOTIONAL

2-92. Behavioral health is a critical component of personal and unit readiness. Behavioral health is more than just the absence of mental illness; it is mental resilience, flexibility, and the capacity to deal with problems as they occur (to adapt, to innovate, and to overcome). Some Soldiers are able to do this better than others. A large component of this is personality or character traits, which are fairly fixed in an individual from early adulthood onward. These traits are affected by a Soldier's mental state, which can vary according to circumstances or illness. When BH is in jeopardy, a Soldier may have ongoing problems getting along in the unit, may seem to be functioning below usual capacity, or may seem *weird* or *crazy*. Any of these problems can affect a Soldier's personal readiness, as well as the overall readiness of the unit. Early identification, evaluation, and treatment are essential to all concerned.

2-93. People who are mourning the death of a loved one experience a myriad of emotions and responses. Different kinds of losses dictate different responses, so not all of the suggestions for dealing with those in a grief situation will suit everyone. Likewise, no two people grieve alike, what works for one may not work for another. So whatever the response you see and what the mourner feels may be normal for that specific situation and the Soldier. There are many moods and expressions of grieving. There is even acute grief that causes a person to feel like *he is going crazy*. Helping a Soldier understand that acute grief reactions are normal reactions to significant losses can be very helpful. This is not something that the Soldier can snap out of in a hurry. It will usually take some time and the amount of time is different for everyone and every situation.

2-94. Loss includes not just the death of a Family member, but the loss of any treasured person (for example, a friend or even a pet). It might be the loss of a spouse through divorce or separation or even the end of a relationship due to a geographical move. Loss may also include separation from a job, retirement from the Service, losing an object such as a home or car to fire, a repossessed car, filing for bankruptcy, or having a pet euthanized (*putting a pet to sleep*) because of unrecoverable illness or injury.

2-95. Grief is the inner experience of someone who has experienced a loss. It may include emotions, thoughts, and even behavioral symptoms, such as crying or arguing. Severe symptoms of grief are considered normal following a loss, but can also be considered *abnormal grief* when the symptoms persist for long periods of time.

2-96. Mourning is the coping process, sometimes stages, one goes through after a difficult loss. It overlaps with grief, but can be defined more as the recovery process of which grief symptoms are a part. It is often defined as the public display of grief through one's behaviors.

2-97. Risk factors for complicated or severe grief reactions include—

- Sudden or unexpected death or loss.
- Traumatic or violent death or loss.
- Death or loss was perceived as preventable.
- Soldier is usually a loner.
- Tendency to generalize or catastrophize losses or changes.
- Disconnection from normal support network.
- Tendency toward self-destructive or suicidal behaviors.

- Use of drugs or alcohol.
- Unresolved past losses.
- History of mental illness.
- Deterioration in ability to care for self or others.

2-98. Leaders have a significant role in emotional distress and the grief process and can assist in the following ways:

- Present a command environment that values life, service, and respect for those who have gone before and remembering what they accomplished.
- Seek help from the chaplain or BH professional to train Soldiers in how to handle loss and grief.
- Foster a command climate that encourages seeking help for problems before they start to affect job performance and BH.
- Make sure Soldiers feel free to avail themselves of the opportunities to attend and discuss combat and operational stress prevention programs such as the Warrior transition and Battlemind training.
- Ensure they have access to worship materials, services of worship, and the opportunity to learn more about their faith.
- Discuss with the chaplain the process to handle deaths both in the unit and in the Families of Soldiers.

2-99. Participation in the ritual and history of the military services is crucial to understand the process of moving on after loss or death but at the same time valuing and remembering. These lessons will help Soldiers know what is expected and what is valued in life and in death and will correspond to any loss experience they have in life. Encourage discussion and exchange of stories, memories, and thoughts of those who have died. Soldiers no longer spend weeks together on ships returning from deployments, so commands may need to find other ways to get them to accomplish this.

## **SECTION VII — TRAUMATIC EVENT MANAGEMENT, COOL-DOWN MEETINGS, AND LEADER-LED AFTER-ACTION DEBRIEFING**

### **TRAUMATIC EVENT MANAGEMENT**

2-100. Combat and operational stress control is a commanders program mandated by DOD (DODD 6490.5) and established in the US Army through FM 4-02.51. Traumatic event management is a commander's responsibility and he is assisted by COSC personnel. Traumatic event management is a blend of all the mission tasks belonging to the COSC functions that are used to create a flexible set of interventions specifically focused on stress management for units and Soldiers following a PTE. Commanders are not alone in delivering TEM. Commanders are supported by all Army COSC assets and specified TEM facilitators to address PTE exposure and provide appropriate support activities. Like COSC, TEM is focused on the BH of the organization and the ability of the exposed individuals to continue to function in the roles they have been tasked to perform.

2-101. Traumatic event management is the approved US Army term used to define any support activities taken to assist in the transition of military units and Soldiers who are exposed to PTE. The goal of TEM is to successfully transition units and individuals, build resilience and promote PTG, or increased functioning and positive change after enduring a trauma (refer to FM 4-02.51).

2-102. An event is considered potentially traumatic when it causes individuals or groups to experience intense feelings of terror, horror, helplessness, and/or hopelessness. Guilt, anger, sadness, and dislocation of world view or faith are potential emotional/cognitive responses to PTEs. Studies of Soldiers in Operation Iraqi Freedom and Operation Enduring Freedom have shown a correlation between exposure to combat experiences and BH disorders, most particularly acute stress disorder and PTSD. Examples include:

- Heavy or continuous combat operations.

- Death of unit members.
- Accidents.
- Serious injury.
- Suicide and/or homicide.
- Environmental devastation and/or human suffering.
- Significant home front issues.
- Operations resulting in the death of civilians or combatants.

2-103. It is an inevitable fact that *all* organizations and Soldiers will be affected in some way when exposed to PTEs. Most organizations and individuals will adjust to these events and successfully transition through them; capable of continuing the missions and tasks they are assigned. However, some organizations and/or individuals may show signs of reduced performance and dysfunction as a result of traumatic exposure. It is the goal of the TEM facilitator to assist leaders in assessing the impact of the PTE exposure and provide supportive measures as appropriate in an effort to enhance adaptive functioning and promote PCOS.

2-104. The TEM facilitators include any trained individual designated to assess the potential impact of PTE exposure to military units and personnel. Traumatic event management facilitators assist in crafting a support plan and executing measures to enable successful transition through the PTE incident and promoting resilience, adaptive functioning, and PTG. Specifically, TEM facilitators include all COSC providers and Army chaplains. Traumatic event management facilitators may also include specially trained medical and unit personnel designated to provide TEM and UNAs and assist in TEM support activities. There is no specified restriction on who can be trained to assess and render support to units and individuals in response to PTE exposure.

2-105. For military units, TEM is active in all phases of the deployment cycle and across full spectrum operations. It is a process that can and should be used in garrison and in deployed environments.

2-106. The main value of TEM is to quickly restore unit cohesion and readiness to return to action, through clarifying what actually happened and clearing up harmful misperceptions and misunderstandings. It may also reduce the possibility of long-term distress through sharing and acceptance of thoughts, feelings, and reactions related to the PTE.

2-107. In the event a unit experiences a PTE, leadership may request a TEM UNA to assess its potential impact. When requested, the identified TEM team coordinates a TEM UNA resulting in specific recommendations to address the identified PTE as effectively and efficiently as required.

2-108. The TEM UNAs differ from COSC UNAs in the scope and tools utilized to gather the required information. The COSC UNAs are global assessments of the unit, with consideration to multiple variables that may affect leadership, performance, morale, and combat effectiveness of the organization. The COSC UNAs are generally not restricted in terms of time or techniques utilized in compiling the necessary data to obtain the desired results. The COSC UNAs lend themselves to the use of objective measurement tools such as the UBHNAS.

2-109. The TEM UNAs, however, are a focused assessment of the PTE incident with specific consideration as to the potential disruption or dysfunction that the event may have caused to individuals or the entire organization. Collateral data is limited to only information that is relevant to the overall impact of the PTE exposure (such as previous combat injuries when responding to a unit casualty). The TEM UNAs are generally time-limited and rely on more subjective data-gathering techniques rather than formal objective measurements.

2-110. It is recommended that leadership request TEM UNAs as close to the specific PTE as practically possible. However, there are no time limitations to conducting assessments and implementing TEM support activities in response to current or past PTE exposure that have had a significant impact on the performance, morale, and cohesion of the effected unit or organization.

2-111. The TEM process incorporates multiple support exercises to aid the leader in managing and mitigating the impact of PTE exposure that units and Soldiers may experience while executing military

operations. Traumatic event management is tailored to the PTE and operational needs and requirements of the effected unit or organization. Traumatic event management responses include—

- Unit needs assessment of the impact of the identified PTE.
- Command consultation and education.
- Unit and individual education.
- Individual supportive intervention and counseling.
- Psychological debriefs.

2-112. In the event TEM facilitators are not available to assist with TEM, leaders may use alternative methods to address PTEs, including cool-down meetings and leader-led after-action debriefing (LLAAD), as described in the proceeding paragraphs.

## **COOL-DOWN MEETINGS**

2-113. An immediate, short meeting when a team or larger unit/group returns from the battlefield or other mission is referred to as a cool-down meeting. These cool-down meetings are held after heavy/intense battles with the enemy or a shift in the mission has occurred which is highly arousing and/or distressing. This is especially important after PTEs. The cool-down meeting is an informal event and occurs before the participants fully replenish their bodily needs and precedes any other activities including LLAADs, COSC interventions, or return to the mission.

### **COMPONENTS OF A COOL-DOWN MEETING**

2-114. Components of a cool-down meeting may include—

- Assembling all of the unit personnel at a safe and relatively comfortable location for a brief period of time (about 15 minutes).
- Receiving or sharing nonstimulating beverages and convenience food (comfort foods if available).
- Providing personnel the opportunity to talk among themselves.
- Giving recognition and praise for the difficult mission they have completed.
- Providing information to unit personnel on where and how they will rest and replenish.
- Previewing the immediate agenda for the unit on what will happen after the cool-down meeting including plans for further debriefing and/or other available stress control or morale and welfare intervention.
- Providing announcements pertaining to further preparations and expected time of return to the mission.

## **LEADER-LED AFTER-ACTION DEBRIEFING**

2-115. A LLAAD is led by a platoon, squad, or team leader and is not normally conducted above platoon level. The LLAAD should be conducted after all missions especially when the maneuvers did not go according to plan.

2-116. A LLAAD may even be sufficient for PTEs involving injury or death. The best time to conduct this debriefing is as soon as is feasible after the team/squad/platoon has returned to a relatively safe place and members have replenished bodily needs and are no longer in a high state of arousal.

2-117. Usually a well-conducted LLAAD is the best option to manage PTEs during a mission. The exception to this type of debriefing is when the event evoked reactions that seriously threaten unit cohesion and/or have a high likelihood of arousing disruptive behavior and emotions. In these situations the leader should ask himself the following:

- Should I conduct the debriefing?
- Should a trained facilitator be present?
- Should a request for COSC TEM be submitted for his team/squad/platoon?

## CONDUCTING A LEADER-LED AFTER-ACTION DEBRIEFING

2-118. These debriefings require the leader to extend the lessons-learned orientation of the standard after-action review. He uses the event reconstruction approach or has the individuals present their own roles and perceptions of the event, whichever best fits the situation and time available. Refer to Training Circular (TC) 25-20 for definitive information on after-action reviews. When individuals express or show emotions, the leader and the teammates recognize and normalize them; they agree to talk with them later and support the distressed Soldier through personal interactions. The group then returns to determining the facts. A lessons-learned discussion is deferred until all the facts are laid out. The leader may provide education about controlling likely reactions or referral information at the end, depending on his knowledge and experience.

2-119. When a PTE is likely to create individual or collective guilt, distrust, or anger, the unit leader should be encouraged to request COSC assistance. Either a COSC or a UMT Soldier trained in TEM sits in with the leader-led debriefing as a familiar and trusted friend of the unit. The COSC or UMT facilitator helps the unit/team leader rehearse and mentors the leaders on the debriefing process. The leader conducting the debriefing must be attentive to identify individuals needing COSC follow-up. Leaders in positions above platoon level also have a role in LLAAD. Company commanders and first sergeants may conduct after-action debriefings similar to LLAAD with their subordinate leaders. Battalion commanders may also conduct similar type debriefings with their staffs after distressing actions and may include subordinate leaders when time allows bringing them together.

## COMPONENTS OF LEADER-LED AFTER-ACTION DEBRIEFING

2-120. Do not go it alone. Consult your BH assets or chaplain to discuss the event (PTE) and use of this guideline before arranging for a LLAAD.

2-121. Give enough advance notice so the unit has time to eat, sleep, and make arrangements to be present. Leader-led after-action debriefings are best utilized with small groups, specifically at platoon level and below. Although LLAADs should not be mandatory, it is recommended that the entire unit be in attendance, regardless if they were directly involved in the incident (such as the entire platoon). It is not recommended to conduct LLAADs for organizations larger than traditional platoon configurations or around 30 Soldiers in size. Instead, provide an information briefing to larger organizations focused on facts and details only. Find a quiet, private room with a door that can be locked to avoid interruptions.

2-122. Conduct a LLAAD using the following:

- Open the LLAAD with an introduction that—
  - Identifies the goals of the debriefing and establishes the climate and the ground rules.
  - Explains that the LLAAD is designed to be given by the leader and focuses on the emotional impact of a PTE.
  - Explains that the LLAAD is not intended to be a traditional after-action review or fact-finding event.
- Explain that a LLAAD is like a standard after-action review or *hot wash* with its focus on details of what happened. It is not a fault finding or an investigation but addresses the human responses to the event. The purpose of the LLAAD is to—
  - Provide the most current information, facts, and details so everyone is clear on what happened and resolve any misperceptions.
  - Provide an opportunity for those involved to discuss their responses to the event.
  - Provide emotional support to other group members.
  - Educate participants about normal physical reactions, feelings, and where to go for help for any future problems.
- Share the most current known details regarding the PTE that occurred. The leader should address issues such as the status of wounded Soldiers and review any specifics that occurred during the PTE exposure. The focus is on facts and to resolve any developing rumors so

everyone is clear, as far as OPSEC permits, on what happened during the PTE. It is a good opportunity to provide positive feedback for successful actions taken by unit members. Leaders should point out what was done right according to SOP (quick response time and so forth). Any real deficiencies can be addressed later.

- Acknowledge thoughts and reactions resulting from the PTE exposure. Leaders are encouraged to normalize the range of possible emotions that may occur as a result of the particular incident (such as feelings of guilt, anger, or sadness). Specifically address the tendency to *second guess* alternate actions that may or may not have *made a difference*. It is common for Soldiers to review their actions and assign personal blame for events due to perceived inaction or decisions during the PTE. Leaders should remind Soldiers that this is a common response, combat is not predictable and sometimes bad outcomes occur. The leader can indicate that the individuals involved did the best that they could under the circumstances. Leaders should focus on the realities of the event and the immediate loss.
- Focus on peer support in managing the PTE impact on both the unit and its individual Soldiers. Leaders must give permission to their Soldiers that it is acceptable to show reactions to PTEs. Soldiers are often the best support system available to rely on in transitioning through this experience. The focus is on supporting each other through a difficult event with the expectation of continued military operations and execution of assigned missions.
- Reinforce the Battlemind principles and leave the unit with a healthy, positive perspective to continue the mission. Leaders should reinforce available resources for continued support such as chaplains, BH, and COSC assets.

2-123. Leaders should meet with trusted helpers after the LLAAD to review the process and identify individuals who might need more help or referral right away. Leaders should follow up individually with group participants within a few days after the LLAAD and periodically thereafter for status check/help as needed.

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## Chapter 3

# Command Leadership Actions and Combat and Operational Stress Control Programs

### SECTION I — UNIT BEHAVIORAL HEALTH NEEDS ASSESSMENT SURVEY

#### INTRODUCTION

3-1. An effective COSC program starts with early planning and assessment then continues during deployment and extends beyond the return home. A key instrument in establishing and conducting a successful unit COSC program is utilizing effective assessment tools to determine the health of the organization and to identify key components that may require some level of support or intervention to enhance the overall effectiveness of the unit.

#### USING AN ASSESSMENT TOOL

3-2. Utilizing a systematic and periodically deliverable assessment tool will allow unit leadership to monitor the longitudinal health of their organizations and offer the ability to identify and address any BH or stress-related concerns that may exist within the organization. Such a tool exists and has been developed specifically for use in the military.

3-3. There are key considerations when utilizing this tool—

- The survey is anonymous. When administering the survey, the anonymity of every Soldier is maintained by not asking for any identifying information, by not asking to turn in the surveys to other members of the unit who may read individual responses, and by not looking at the surveys until all of the surveys have been collected.
- Soldiers need to feel confident that their answers are anonymous or they may not be fully truthful on the survey.
- Key leaders public efforts to maintain this anonymity will also send Soldiers the message that leadership takes the situation seriously and can be trusted to maintain this confidentiality if later needed for personal problems.

3-4. Although the UBHNAS may be a command-directed initiative, completing the survey should always be voluntary. Units may require Soldiers to attend the survey administration; however, Soldiers may choose not to complete the survey or to hand it in blank. Leadership should not coerce or order a Soldier to complete the survey; because they may not answer truthfully, thus making the results less meaningful.

3-5. It is important for leadership to note that the data obtained from the UBHNAS belongs to the commander of the organization that is being assessed, at the level it is conducted (for example, companies will have ownership of the individual company and battalions will have ownership of battalion roll up—not individual companies). These surveys are not for research purposes; there is no institutional review board oversight or informed written consent process. The data and findings should not be published or presented in any forum except to the unit commander. Further, the unit commander must give written permission to utilize the data for any purpose other than to assess and inform the unit leadership about the unit's BH needs. Results may be disclosed to military BH personnel for the purposes of consultation and/or resource allocation. They may also be provided to BH personnel assigned or attached to higher units for the purposes of rolling up the results as part of a larger UNA.

3-6. Only consolidated data from the UBHNAS should be presented to commanders. Brigade commanders should be briefed on the status of the brigade; battalion commanders should be briefed on the status of their respective battalions. However, brigade commanders should not be briefed on the results of individual subordinate battalions without the consent of the respective battalion commanders.

3-7. The survey is solely meant to help BH and unit leaders understand the BH needs of the unit as a whole in order to develop unitwide BH prevention and early intervention plans targeting identified problems and allocating limited BH resources. As a rule of thumb, 50 Soldiers per company or 100 Soldiers per battalion should be sufficient, as long as some Soldiers from each subordinate unit are included in the sample. Examples of when to conduct the UBHNAS would include change of commands, as part of a quarterly assessment plan, during predeployment/deployment/redeployment operations. For additional information on UBHNAS, see Web site ([www.battlemind.army.mil](http://www.battlemind.army.mil)).

## SECTION II — EFFECTIVE COMBAT AND OPERATIONAL STRESS CONTROL PROGRAM

### MINIMIZE STRESS

3-8. Having an active unit COSC program can have a decisive effect. A sound COSC program can minimize stress-related reactions and enhance mission accomplishment capabilities. The key element that COSC programs should focus on is unit morale and cohesion, which can be accomplished by integrating team-oriented training exercises that are conducted on at least a quarterly basis within the unit training calendar. Stress protection is achieved by providing realistic training focusing on team building and unit cohesion. An effective unit COSC program should include all of the different areas of the force projection process. The force projection process was discussed in Chapter 2. For definitive information on deployment and redeployment and the force projection process, see FMI 3-35.

3-9. For current information on the deployment cycle support, see the Army G-1 Deployment Cycle Support Process Homepage for information and current support documentation and presentations on the Army G-1 deployment cycle support at Web site (<http://www.armyg1.army.mil/dcs/default.asp>).

### MOBILIZATION

3-10. Mobilization is one of the processes of force projection when units or individuals are alerted for possible deployment and commence preparation. During the mobilization stage, force projection tasks consisting of administrative actions, briefings, training, counseling, and medical evaluations are completed to ensure all Soldiers and their Families are prepared for extended deployments.

3-11. Mobilization stressors experienced by Soldiers include long working hours, preparation for training, fear of the future, Family worries, and anxiety about the unit's readiness.

3-12. Signs of poor coping include insomnia, increased use of alcohol, marital problems, and increased bickering in the unit, irritability, and suicidal feelings. Important preparatory steps to take during the mobilization phase is to—

- Conduct unit behavioral needs assessment.
- Conduct unit training and mission rehearsals.
- Prepare for changed sleep schedules and jet lag.
- Attend to task assignments and allocations.
- Conduct equipment and supply maintenance checks.
- Attend to personal and Family matters. (Call the ACS.)
- Integrate new members into the unit positively and actively.
- Welcome *significant others* (not just entitled beneficiaries) in the Family support network information tree.
- Brief as much information about the operation as possible, consistent with OPSEC measures.

- Familiarize the unit members with the stressors they may encounter.
- Arrange for mobilization training and education, especially for refresher training of stress reduction techniques from chaplains, local BH professionals, or COSC team, if available.

### **UNIT TRAINING**

3-13. Because unit leaders have experienced the stressors associated with garrison living and peacetime training, they should have had the opportunity to better understand their Soldiers and what affects their performance.

3-14. It is important that Soldiers have a positive perception of their unit's personnel and equipment capabilities to accomplish the mission given. This is achieved through the development of realistic training that fosters unit cohesion and *esprit de corps*.

3-15. Realistic mission rehearsal helps desensitize Soldiers against potential combat and operational stressors. For example, wearing and realistically training in protective gear is important. By doing so in mobilization training, Soldiers may become less distressed in the operational environment, should it be necessary to wear it.

3-16. Given OPSEC limitations, leadership should make every effort to disclose as much information as possible regarding mission-specific operational requirements. This includes known enemy tactics and techniques. Soldiers who are informed and knowledgeable regarding mission specifics tend to exhibit less anxiety and experience less stress.

3-17. It is important during such training to talk realistically about enemy strengths and weaknesses, as well as those of their own units. While inspirational pep talks are also important at this time, they should not include biased, inaccurate information. Leaders earn trust and respect if their troops perceive them as accurate, dependable sources of information.

### **Stress-Coping Skills Training**

3-18. During preparation for deployment, the leaders should direct the unit to practice stress-coping and relaxation techniques and can be positive role models by demonstrating use of these techniques. If necessary, the chaplain and BH personnel available to the unit can provide additional training.

### **Sleep Discipline**

3-19. Before deployment, unit leaders must consider fatigue and sleep loss occurring during combat. The enforcement of work and rest schedules begins early in mobilization training. During continuous operations, fatigue caused by lack of sleep is a major source of stress. Breaks in combat are irregular, infrequent, and unscheduled (refer to Chapter 4).

### **Task Allocation and Management**

3-20. Overloading Soldiers with tasks or responsibilities is another major source of stress. Allocating tasks fairly among available Soldiers improves unit effectiveness as well as decreases stress. Proper allocation of tasks include—

- Selecting the right person for the job. The right person is fitted to the right task according to the task requirement and the individual's talents, abilities, and training.
- Duplicating critical tasks. Two Soldiers are assigned to a critical task requiring behavioral alertness and complete accuracy. They check each other's work by performing the same task independently.
- Cross-training. Each Soldier (other than medical Soldiers who can only cross-train in positions with the same MOS requirements) is trained in a secondary duty position to ensure competently stepping into the position of another.
- Developing performance supports. Develop SOPs, checklists, or other behavioral aids to simplify critical tasks during periods of low alertness.

- Maintaining equipment maintenance and supply. During mobilization, the unit maintains its equipment and manages needed supplies. Once deployed for combat, Soldiers require confidence that supplies are ample and equipment is dependable. The following questions are important:
  - Does the unit provide ample training in equipment maintenance and troubleshooting?
  - Has the unit's equipment been field-tested under realistic conditions?
  - Have Soldiers fired and cleaned their weapons while wearing full combat gear or protective clothing?
  - Does the unit have sufficient ammunition, food, water, and other essential supplies?
  - Does the unit have contingency plans for procuring and managing critical supplies if normal channels are disrupted?

### PERSONAL AND FAMILY MATTERS

3-21. Family stress adds to combat-imposed stress and causes distraction, interference with performance of essential duties, and a negative impact on stress-coping abilities. This will result in the unit's inability to perform at peak potential.

3-22. The unit should help the Soldiers resolve important Family care matters before deployment and develop methods for helping Families when Soldiers are deployed. Soldiers are encouraged to—

- Generate or update their wills.
- Finalize power of attorney for spouses.
- Update life insurance policies, including Servicemember's Group Life Insurance.
- Ensure Family automobiles are in good repair.
- Develop lists of telephone numbers of reliable POCs for specific problems (mechanics, emergency transportation, babysitters, sources of emergency money, and health care).
- Resolve major legal issues such as alimony payments, property settlements following divorces, and child support payments.

### ROLE OF LEADERS

3-23. Small-unit leaders should—

- Brief Families as a group before deployment or as soon as possible after deployment into the theater. Within the bounds of OPSEC, explain the mission's nature. Even if a mission is highly confidential, Families benefit from such a meeting by being told of the support available to them while separated. They begin to solve problems and form support systems with other Families. This includes an opportunity to discuss Family questions and concerns. The ACS, post BH service, or the chaplain's office assists in staging this briefing.
- Establish POCs (for example, the key volunteer network) to assist with Family problems. These volunteers possess good working relations with the chaplain and BH personnel to assist with the management of complex problems.
- Establish key volunteer communication and support networks. Commanders' spouses or spouses of sergeants majors are often good resources for developing and running such networks; however, the involvement of junior Soldiers' spouses is also crucial. Some of the most enthusiastic participants are tasked to make outreach visits and encourage shy or depressed spouses to participate.
- Have BH professionals conduct meetings to discuss mobilization problems. For example, some children have difficulty adjusting to a parent's absence. Behavioral health professionals give Families valuable information on these normal reactions and suggest ways to prepare for them.

## DEPLOYMENT

3-24. Deployment occurs when units or individuals deploy from the continental US or outside the continental US installations into the designated theater. Recurring administrative actions are completed during the deployment stage.

3-25. During the deployment stage is when units or individuals perform their assigned mission in support of the joint force commander for a prescribed period of time. Deployment stage tasks include recurring administrative actions and briefings, training, and counseling for Soldiers departing theater on emergency leave, rest and recuperation, and medical evacuation.

3-26. In addition to the normal stress associated with moving to a combat zone, Soldiers in these phases start worrying about their survival and performance under fire. Their thoughts become centered on fear of the unknown.

3-27. Unit leaders should emphasize that stress under these circumstances and conditions are expected and are a natural reaction. This will help prevent *normal* stress reactions from escalating into extreme reactions.

3-28. Unit leaders should provide as much information as necessary to their survival and mission success, reinforce stress control techniques, and help their subordinates understand what happens to them when stressors occur.

## DEPLOYMENT VEHICLE

3-29. The deployment vehicle—in most cases, an airplane—is a stressor by itself. If it is a commercial aircraft, in-flight problems are usually minor. However, if the unit deploys on a military aircraft, leaders should accomplish the following—

- Designate areas for light exercise and stretching to counter seating discomfort.
- Ensure Soldiers drink enough fluids to prevent dehydration and have access to the latrine.
- Adopt the activity schedule of the new time zone. If the unit is in the sleep cycle or is already in or about to enter the sleep cycle, cover windows, reduce lighting, and issue earplugs, blankets, and pillows.
- Allow uninterrupted sleep. If a stopover occurs during a sleep cycle, do not waken Soldiers to eat or partake in activities. If the stopover occurs during an activity period, take full advantage of it by having Soldiers take washcloth baths, stretch, and perform head-and-shoulder rotations.
- Upon arrival in the area of operations, follow the schedule of the new time zone. Eat the next meal and go to bed on the new schedule. Doing so helps the Soldiers' bodies adjust.

## KEEP SOLDIERS INFORMED

3-30. Since uncertainty about the future is a major source of stress, timely and accurate information becomes vital. Lines of communications are clearly defined and kept open. Issuing warning, operation, and fragmentary orders is critical to ensuring adequate information flow. Informational meetings are conducted at regular intervals, even when there is no new information to disseminate.

3-31. This reinforces the organizational structure and the importance of unit meetings as the source of current, accurate information. Reliable sources of information are especially important for countering rumors.

3-32. Soldiers also need information or performance feedback after mission completion. Engaging in a firefight or completing a mission without procedural feedback is insufficient with respect to COSC management. Soldiers must be told how they performed as a group. The knowledge of mission accomplishment and progress builds unit cohesion, develops a winning attitude, and reduces the effects of stress. Leaders should consider utilizing routine cool-down meetings and conducting LLAADs as described in Chapter 2 of this manual.

## FAMILY SUPPORT

3-33. The ACS, installation Family Life Chaplain, and Family support groups provide Family support throughout deployments. The Army Emergency Relief, American Red Cross, ACS, and other community agencies also provide direct assistance to Family members. *Military OneSource* provides 24-hour assistance for Soldiers and Families seeking assistance for a variety to problems at Web site (<http://www.militaryonesource.com>).

3-34. The FRG and the American Red Cross continue to function as conduits for emergency information between Soldiers and their Families.

3-35. Unit leaders need to educate Soldiers about these programs and agencies that are available to serve the needs of the community.

3-36. Effective communication and caring support networks help to prevent anxiety while Soldiers are deployed and/or in combat.

## FAMILY CARE

3-37. Soldiers entering a full spectrum operational environment with financial worries or Family problems risk breaking down under the additional operational stress. Even positive but unfinished changes on the home front, such as a recent marriage or parenthood, can distract the Soldiers' focus on combat missions with worries that they will not live to fulfill their new responsibilities at home. Leaders must be aware of this risk and assist members in handling personal matters before deployment.

3-38. When Soldiers know their Families are cared for, they are better able to focus on their military duties.

## PHYSICAL AND RECREATIONAL ACTIVITIES

3-39. It is imperative that leadership maintain some avenues for physical and recreational activities. Good physical health in conjunction with routine, team-building activities optimizes individual stress-coping capabilities and builds unit cohesion. Most current WOT operations have developed extensive physical fitness facilities and morale, welfare, and recreation activities in almost every location that Soldiers are deployed. When the tactical situation permits, leadership should maximize the ability for Soldiers to utilize these services. In fact, units should attempt to organize activities, if possible, in an effort to maintain cohesion and enhance the bonds formed when deployed.

3-40. The ability to conduct personal hygiene is another key factor in stress protection. If and when available, Soldiers should be given routine access to these resources. Doing so maximizes the potential psychological benefits to Soldier and unit.

3-41. Redeployment refers to units/individuals reposturing in theater; transfer forces and materiel to support other operational requirements; or return personnel, equipment (if it not left in theater for the incoming unit to use during their deployment), and materiel to the home station or demobilization station. The redeployment stage continues the process of reintegrating Soldiers and DA civilians into their predeployment environments. Redeployment stage tasks include administrative actions, briefings, training, and counseling for Soldiers and DA civilians departing theater and Family members at home station.

3-42. Postdeployment activities occur when personnel, equipment, and materiel arrive at home station or demobilization station. The postdeployment activities consist of administrative actions, briefings, training, counseling, and medical evaluations to facilitate the successful reintegration of Soldiers and DA civilians into their Families and communities.

3-43. Soldiers who have returned from deployments in support of Operation Enduring Freedom and Operation Iraqi Freedom have often been involved in significant combat experiences. Assimilating back into their home life and Family routines may be more difficult than expected and may complicate the reunion process. To ease the transition from the battlefield to home, the Families are provided information on the stressors and problems they may encounter in readjusting to a normal military family. Soldiers will, as part of their end-of-tour stress management debriefing and BH screening, receive homecoming-reunion

educational briefings and training to prepare them for their Family reunion and avoidance of domestic strife. Soldiers with any BH problems are referred for treatment by the installation MTF. All Soldiers and Families are informed of Family support services available to them.

3-44. The period after combat can be difficult. Today's rapid transportation enables Soldiers to travel from the battlefield to their hometowns in as little as 48 to 72 hours. Decompression periods are now mandatory throughout the Services.

3-45. This short time often does not give them reflection with their comrades. Units should therefore set aside time in the last few days before leaving the theater to conduct their own *end-of-tour* debriefing in which they start at predeployment and talk about whatever stands out in their memories, good or bad, as they recount the operation up to its end. The Army has developed a postdeployment debriefing process that may be helpful in achieving this goal. Leaders should consult with existing chaplain and BH assets to coordinate conducting Battlemind postdeployment psychological debriefings shortly after returning to home station installations.

3-46. There should also be appropriate memorial ceremonies and rituals that formally bring the operation to a close. Awards, decorations, and other recognition must be allotted fairly by the commanders.

3-47. Unit officers and NCOs, assisted by the chaplains and BH/COSC teams, prepare the Soldiers for problems encountered during Family reunion. For example, most Soldiers expect to resume roles and responsibilities they had prior to separation. However, their spouses often resist giving up their new roles as decisionmakers and primary home managers.

3-48. Spouses may feel that their sacrifices during the Soldiers' absence have gone unrecognized. This feeling becomes an additional source of tension. If at all possible, the Families should receive the same briefings or written materials.

3-49. Families need to be reassured of their contribution. Key volunteer networks and Family team-building programs and corresponding organizations for the Army continue to help manage problems with reunion and adjustment.

3-50. Soldiers are briefed that startle reactions to sudden noises or movements, combat dreams and nightmares and occasional problems with sleeping, and feeling bored, frustrated and out of place are common when first returning from operational environment to a peacetime, civilian setting. The leaders, chaplains, and the COSC team emphasize the normalcy of such reactions. Soldiers are also advised on resources available to help deal with such symptoms if they are persistent and become upsetting.

3-51. The same leadership skills that apply to troop welfare and warfighting can effectively reduce or prevent COSRs. Small-unit leaders should take preventive actions and address stress symptoms as they appear.

3-52. Ignoring the early warning signs can increase the severity of stress reactions.

### **ARMY FORCE GENERATION CYCLICAL READINESS PROCESS RESET/TRAIN**

3-53. Units returning from long-term operations are placed in the reset/train cycle. Active Army units typically stay in this pool for 6 to 9 months, while RC units will probably stay up to 4 years. It is during this cycle that replacement personnel are assigned to the unit. The reset/train cyclical readiness process begins after completing postdeployment recovery and administrative requirements. The reset/train process involves unit reorganization and the training of individual skills. Administrative actions, briefings, training, counseling, and medical evaluations are completed during the reset/retrain process to ensure all Soldiers, DA civilians, and their Families are prepared for extended deployments.

3-54. The reset/train process will also include all organizational and leadership activities that occur in between deployment orders. Typically this will be located at the installation where the organization is based or garrisoned during peacetime activities. This includes all BH support activities provided to Soldiers assigned to the organization, Family support activities, routine assessments, and preventive activities that occur during routine unit operations (to include field training and situational training exercises) not resulting from pending deployment instructions or orders.

3-55. Unit leadership must be familiar with garrison-based BH care resources available to address unit and individual Soldier concerns while garrisoned.

3-56. There is no better time to utilize BH resources and to refit the organization than when it is garrisoned awaiting future deployments. Additionally, garrison operations exert unique stressors on the organization and assigned personnel that are not existent when deployed. Key concerns include routine living problems experienced by assigned personnel, social, and off-duty activities.

3-57. Unit leaders have a unique opportunity during garrisoned activities to initiate cohesion-building activities and observe the unique individual traits of each Soldier under them. The bonding and *esprit de corps* that is developed during this phase is essential to the unit's ability to sustain high-stress environments that exist during deployment operations. Additionally, the small-unit leader can foster a relationship with his subordinates that will allow the ability to recognize signs of distress exhibited through behavioral changes.

### **READY**

3-58. Units determined to be at a ready level are capable of beginning their mission preparation and collective training with other operational headquarters. They are eligible for sourcing; may be mobilized if required; and can be trained, equipped, resourced, and committed, if necessary, to meet operational requirements. It is during this cycle that the individual training that could not be accomplished during reset/train is completed and collective training is undertaken.

### **AVAILABLE**

3-59. Units are capable of conducting a mission under any geographical combatant commander. All Active Army and US Army Reserve (USAR) units pass through a 1-year available force pool window. Generally, Active Army units will rotate through this pool 1 in every 3 years; USAR units 1 in every 5 years; and Army National Guard units 1 in every 6 years. Upon notification of a deployment, the unit begins the force projection process.

## **SECTION III — COMBAT AND OPERATIONAL STRESS CONTROL RESILIENCY TRAINING**

### **BATTLEMIND TRAINING—BUILDING SOLDIER RESILIENCY**

3-60. Battlemind refers to the US Army psychological resiliency building program. This term describes the Soldier's inner strength and courage to face fear and adversity during combat and speaks to resiliency skills that are developed to survive. It represents a range of training modules and tools under three categories—the deployment cycle, life cycle, and Soldier support.

3-61. Although war affects all Soldiers, most make a successful transition home after combat duty. Some Soldiers, however, experience persistent symptoms such as sleep disturbance, hypervigilance, detachment, anger, or risky behaviors such as alcohol misuse or aggression. These problems can seriously affect their military duty and Family functioning if not addressed early. Prior to the war in Iraq there were no empirically validated strategies to build resilience or methods to prevent combat-related BH problems. Battlemind training is designed to prevent or reduce the severity of combat-related BH problems through a strength-based approach. This approach focuses on the strengths and the skills that helped Soldiers to survive in combat instead of focusing on the negative effects of combat.

### **PREDEPLOYMENT BATTLEMIND**

3-62. The predeployment Battlemind training program is designed to build Soldier resiliency by developing his self-confidence and mental toughness. The training focuses on Soldier strengths and identifies specific actions that Soldiers and leaders can engage in to meet the challenges of combat and

address stress reactions that may occur. The predeployment training consists of unique modules for Soldiers, leaders, and USAR Soldiers. There are also parallel materials for Families.

## POSTDEPLOYMENT BATTLEMIND

3-63. The postdeployment Battlemind training focuses on transitioning from combat to home. The word *Battlemind* when used as an acronym, identifies 10 combat skills that include—

- Buddies (cohesion).
- Accountability.
- Targeted aggression.
- Tactical awareness.
- Lethally armed.
- Emotional control.
- Mission operational security.
- Individual responsibility.
- Nondefensive (combat) driving.
- Discipline and ordering.

3-64. These Battlemind skills will facilitate the transition home, if adapted. The postdeployment *Battlemind* training consists of two training modules to be conducted at different times during postdeployment. The first training module is intended to be given within the first two weeks of returning home. The focus of this initial transition training is on safety, relationships, as well as normalizing common reactions and symptoms from combat. The second training module is designed to be given at 3 to 6 months postdeployment. This follow up postdeployment training is designed so Soldiers can conduct their own Battlemind *check* of themselves, as well as that of their buddies, allowing them to know when to seek help. The training ends by addressing those barriers which prevent Soldiers from seeking help. The Battlemind training is designed to be given in small groups to encourage interaction and discussion requiring approximately 35 to 40 minutes to complete. For additional information on Battlemind training, go to Web site ([www.battlemind.army.mil](http://www.battlemind.army.mil)).

## SECTION IV — BATTLEMIND WARRIOR RESILIENCY AND COMBAT AND OPERATIONAL STRESS CONTROL

### PEER-SUPPORT PROGRAM

3-65. Management of COSR through peer support is a significant factor in the mitigation of COSR within the organization. Soldiers identify with peers who are viewed as trusted and needed. A determining factor in treating COSR is when Soldiers perceive that their peers support them. The higher the level of cohesion and bonding within a unit, the more likely peers are to support each other thus the more successful the unit as a whole is in dealing with COSR.

3-66. The US Army has designed a peer-support training program leveraging existing Army BH assets and health care specialist/combat medics. All health care specialists (military occupational specialty 68W) will be provided Battlemind Warrior Resiliency training as part of their basic and advanced individual training. The skills they receive will reinforce the ability to institute peer-support networks within unit structures and provide the ability to conduct preliminary TEM UNAs and limited support activities in response to unit and individual PTE exposure. This program is designed to enhance existing buddy aid and battle buddy support concepts that currently are utilized by the US Army. It specifically addresses unit-level COSBs that Soldiers and small groups may exhibit while executing military operations. Battlemind Warrior Resiliency is designed to use a peer-driven psychological risk management and support system with military personnel and units to provide the earliest possible identification, mediation, and referral for family, operational, and combat and operational environment-related BH and stress management.

3-67. A peer-delivered system that operates in concert with more formal BH assets has certain advantages over one delivered exclusively by the latter. In the military, adequate BH support may be difficult to deliver because of logistical constraints, difficult terrain, wide dispersal of personnel, combat contingencies, and a limited number of BH practitioners who may not always be as well-integrated with their specific brigades.

3-68. Under the Battlemind Warrior Resiliency program, identification of cases and uncomplicated intervention begin at the unit level, by unit members (health care providers/combat medics), preserving unit self-reliance and cohesion without the previously mentioned logistical concerns.

3-69. A peer-support program normalizes stressful events at the peer level. This peer-support program helps neutralize Soldiers' combat and operational stress responses and also allows for the delivery of vital services at the earliest possible time. Successful uses of the peer-support program help reduce the potential of further stressing personnel. The program is a useful extension of effective personnel management. Leaders may further reduce the added stress of carrying out military operations by incorporating Battlemind Warrior Resiliency into the organizational structure.

3-70. It is highly recommended that leaders utilize Battlemind Warrior Resiliency-trained medics in developing and implementing a peer-support program within their organization. Command should contact local BH assets to consult and establish a peer-support program. Maintaining peer-support programs internally is a vital part of the command COSC program and is a significant benefit in the normalization of PTEs and support delivery for Soldiers within an organization.

## **SECTION V — LEADERSHIP ACTIONS AND INTERVENTIONS FOR COMBAT AND OPERATIONAL STRESS REACTIONS**

### **LEADER INTERVENTION**

3-71. When a Soldier requires medical attention to rule out a possible serious physical cause for his symptoms or because his inability to function endangers himself, the unit, and the mission, he should be transported to the battalion aid station or the nearest MTF. Refer to Chapter 1 and DODD 6490.1.

### **LEADER ACTIONS FOR COMBAT AND OPERATIONAL STRESS REACTION**

3-72. Interventions at the small-unit level may be required if a Soldier is upset. The leader should let him talk about what is upsetting him, listen, and then try to reassure him. Intervention may also be required if a Soldier's—

- Behavior endangers the mission, himself, or others. The leader should take appropriate measures to control him.
- Reliability becomes questionable—
  - Unload the Soldier's weapon.
  - Remove the weapon if there is a serious concern.
  - Physically restrain the Soldier only when safety is a concern or during transport.
  - Reassure unit members that the signs are probably a normal COSR and will quickly improve.

3-73. If the COSR signs continue—

- Get the Soldier to a safer place.
- Do not leave the Soldier alone. Keep someone he knows with him.
- Notify the senior NCO or officer.
- Have the Soldier examined by medical personnel.

3-74. If the tactical situation permits, give the Soldier simple tasks to do when not sleeping, eating, or resting and assure the Soldier that he will return to full duty as soon as possible.

3-75. The most effective treatment for COSR is to normalize the symptoms presented by the Soldier. It is imperative that the small-group leader also verbally and nonverbally illustrate that the expectation is for the Soldier to improve and rejoin his organization as a fully functioning member. Soldiers need to perceive that their unit expects and wants them to rejoin the organization and continue to be a part of the team. The most important thing a small-group leader can do is to project this message. When COSRs are normalized and the unit demonstrates a desire to retain the individual, there is a significant chance of improvement in the Soldier.

3-76. When COSR casualties cannot be managed in place, they should be moved to a safer, quieter place and be provided rest and work for several hours up to one to two days in a place controlled by the unit. If the unit cannot wait for the Soldier to recover, he must be moved to the Role 1 MTF. From there, every effort is made to move the Soldiers to a nonmedical unit or area (a tent or building of opportunity could suffice) for rest, replenishment, and reassurance. Leaders should consider, as an alternative to complete weapons removal, disabling the weapon system (remove the bolt from the Soldier's weapon). This will facilitate the Soldier being able to retain a weapon system without losing the identity associated with being a Soldier (and carrying a weapon system of issue).

3-77. It should be made clear that the Soldiers are tired and in need of an opportunity to talk, sleep, eat, and replenish fluids; they are not patients.

3-78. Each Soldier is accounted for and every effort is made to ensure strong lines of communications are in place and maintained between Soldiers and their original unit.

3-79. Key to successful treatment is the return of the Soldier to his original unit. Actions to be taken for severely combat-stressed Soldiers are the same as those for the moderately combat-stressed, with one exception, medical personnel at the battalion aid station level should evaluate severely combat-stressed Soldiers as soon as possible. Casualties will be treated and released within hours, held for rest and replenishment, or evacuated for further Soldier restoration. Soldiers who recover from COSR return to their original units, (same company or platoon) and are welcomed upon their return are less likely to suffer recurrence. Once rested and returned, they usually become healthy again. Accordingly, risk is reduced when Soldiers recovering from COSR return to the same unit where their combat experience is known and welcomed. In rare instances, however, it is in the best interest of the individual to be reassigned to other jobs or units.

## **SECTION VI — COMBAT AND OPERATIONAL STRESS REACTION**

### **GUIDELINES FOR THE MANAGEMENT OF COMBAT AND OPERATIONAL STRESS REACTION**

3-80. Guidelines in the treatment and management of COSR are summarized in the memory aid—Brevity, Immediacy, Contact, Expectancy, Proximity, and Simplicity (BICEPS). Using BICEPS is extremely important in the management of Soldiers with COSR and/or behavioral disorders.

#### **BREVITY**

3-81. Initial rest and replenishment at COSC facilities located close to the Soldier's unit should last no more than 1 to 3 days. Those requiring further treatment are moved to the next role of care. Since many require no further treatment, commanders should expect their Soldiers to RTD rapidly.

#### **IMMEDIACY**

3-82. It is essential that COSC measures be initiated as soon as possible when operations permit. Intervention is provided as soon as symptoms appear.

## CONTACT

3-83. The Soldier must be encouraged to continue to think of himself as a Soldier, rather than a patient or a sick person. The chain of command remains directly involved in the Soldier's recovery and RTD. The COSC team coordinates with the unit's leaders to learn whether the overstressed individual was a good performer prior to the COSR. Whenever possible, representatives of the unit or messages from the unit tell the Soldier that he is needed and wanted back. The COSC team coordinates with the unit leaders, through unit medical personnel or chaplains, any special advice on how to assure quick reintegration when the Soldier returns to his unit.

## EXPECTANCY

3-84. The individual is explicitly told that he is reacting normally to extreme stress and is expected to recover and return to full duty in a few hours or days. A military leader is extremely effective in this area of treatment. Of all the things said to a Soldier suffering from COSR the words of his small-unit leader have the greatest impact due to the positive bonding process that occurs. A simple statement from the small-unit leader to the Soldier stating that he is reacting normally to excessive stress and that he is expected back to duty soon will have positive impact. Small-unit leaders should tell Soldiers that their comrades need and expect them to return. When they do return, the unit treats them as every other Soldier and expects them to perform well.

## PROXIMITY

3-85. Soldiers requiring observation or care beyond the unit level are evacuated to facilities in close proximity to, but separate from, the medical or surgical patients at the battalion aid station or medical company nearest the Soldier's unit. It is best to send Soldiers who cannot continue their mission and require more extensive intervention to a facility other than a hospital, unless no other alternative is possible. Combat and operational stress reactions are often more effectively managed in areas close to the Soldier's parent unit. On the noncontiguous battlefield characterized by rapid, frequent maneuver and continuous operations, COSC personnel must be innovative and flexible in designing interventions which maximize and maintain the Soldier's connection to his parent unit.

## SIMPLICITY

3-86. Indicates the need to use brief and straightforward methods to restore physical well-being and self-confidence.

3-87. The actions used for COSR control (commonly referred to as the six Rs) involve the following actions:

- Reassure of normality.
- Rest (respite from combat or break from the work).
- Replenish bodily needs (such as thermal comfort, water, food, hygiene, and sleep).
- Restore confidence with purposeful activities and contact with his unit.
- Return to duty and reunite Soldier with his unit.
- Remind the Soldier as appropriate before, during, and after combat that—
  - He is an American Soldier here to complete a lawful mission.
  - An American Soldier behaves honorably because it is the right thing to do.
  - Harming or killing noncombatants dishonors him and his fellow Soldiers (living and dead).
  - Stepping down to revenge helps the enemy to discredit him and his unit.
  - The ultimate objective is to *return home with honor*.

## SECTION VII — SAFETY CONSIDERATIONS

### SOLDIER AND UNIT SAFETY COMES FIRST

3-88. Leaders should be aware of emergency procedures to take in the event that a Soldier presents with questionable safety concerns. Emergency BH evaluations should be a part of every organization's SOP.

3-89. Standing operating procedures should include the use of escorts, proper form templates to execute command referrals, buddy watch protocols, and weapons removal guidelines. If SOPs do not exist, consult with organic BH assets to establish policies that are compatible with the specific unit structure.

3-90. Confiscation of a Soldier's weapon should only be considered when it is clearly apparent that the Soldier is unreliable and a safety hazard to himself and others. Soldiers that have immobilized weapons systems should not be considered for participation in combat missions.

3-91. A distressed Soldier perceived to be a danger to himself or to unit personnel should always be escorted until an evaluation is conducted by medical personnel. The escort should be sufficient in grade and number to successfully stabilize the Soldier if required.

3-92. Consult BH assets immediately in all matters concerning safety assessments and risk management of unit personnel. Detailed command consultation procedures are provided in Chapter 1; also, refer to a chaplain, a physician, a physician assistant, a BH professional, the COSC team, or other health care provider.

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## Chapter 4

# Sleep Deprivation

### SECTION I — INTRODUCTION AND SLEEPING IN THE OPERATIONAL ENVIRONMENT

#### INTRODUCTION

4-1. This sleep guidance is provided by the Walter Reed Army Institute of Research and supported by extensive research. This guidance is based on current research as of September 2007 and applies to all levels of military operations, to include both training and tactical environments. Unit sleep plans should be based on this guidance.

4-2. Sleep is a biological need, critical for sustaining the mental abilities needed for success on the battlefield. Soldiers require 7 to 8 hours of good quality sleep every 24-hour period to sustain operational readiness. Soldiers who lose sleep will accumulate a *sleep debt* over time that will seriously impair their performance. The only way to *pay off* this debt is by obtaining the needed sleep. The demanding nature of military operations often creates situations where obtaining sleep may be difficult or even impossible for more than short periods. While essential for many aspects of operational success, sheer determination or willpower cannot offset the mounting effects of inadequate sleep. This concept is applicable for all levels of military operations including basic training and in all operational environments.

4-3. For this reason, sleep should be viewed as being as critical as any logistical item of resupply, like water, food, fuel, and ammunition. Commanders need to plan proactively for the allocation of adequate sleep for themselves and their subordinates.

4-4. Individual and unit military effectiveness is dependent upon initiative, motivation, physical strength, endurance, and the ability to think clearly, accurately, and quickly. The longer a Soldier goes without sleep, the more his thinking slows and becomes confused, and the more mistakes he will make. Lapses in attention occur and speed is sacrificed in an effort to maintain accuracy. Degradation in the performance of continuous work is more rapid than that of intermittent work.

4-5. Tasks such as requesting fire, integrating range cards, establishing positions, and coordinating squad tactics are more susceptible to sleep loss than well-practiced, routine physical tasks such as loading magazines and marching. Without sleep, Soldiers can perform the simpler and/or clearer tasks (lifting, digging, and marching) longer than more complicated tasks requiring problem solving, decisionmaking, or sustained vigilance. For example, Soldiers may be able to accurately aim their weapon, but not select the correct target. Leaders should look for erratic or unreliable task performance and declining planning ability and preventive maintenance not only in subordinates, but also in themselves as indicators of lack of sleep.

4-6. In addition to declining military performance, leaders can expect changes in mood, motivation, and initiative as a result of inadequate sleep. Therefore, while there may be no outward signs of sleep deprivation, Soldiers may still not be functioning optimally.

#### SLEEPING ENVIRONMENT INFORMATION AND RELATED FACTORS

4-7. For optimal performance and effectiveness, 7 to 8 hours of good quality sleep per 24 hours is needed. As daily total sleep time decreases below this optimum, the extent and rate of performance decline increase.

4-8. Basic sleep scheduling information for planning sleep routines during all activities (predeployment, deployment, precombat, combat, and postcombat) is provided in Table 4-1. Basic sleep environment information and other related factors are provided in Table 4-2.

**Table 4-1. Basic sleep scheduling factors**

<i>Factor</i>	<i>Effect</i>
Timing of sleep period.	<ul style="list-style-type: none"> <li>• Because of the body's natural rhythms (called "circadian" rhythms), the best quality and longest duration sleep is obtained during nighttime hours (2300-0700).</li> <li>• These rhythms also make daytime sleep more difficult and less restorative, even in sleep-deprived Soldiers.</li> <li>• The ability to fall and stay asleep is impaired when bedtime is shifted earlier (such as from 2300 to 2100 hours).</li> <li>• This is why eastward travel across time zones initially produces greater deficits in alertness and performance than westward travel.</li> </ul>
Duration of sleep period.	<ul style="list-style-type: none"> <li>• <b>IDEAL</b> sleep period equals 7 to 8 hours of continuous and uninterrupted nighttime sleep each and every night.</li> <li>• <b>MINIMUM</b> sleep period—there is no minimum sleep period. Anything less than 7 to 8 hours per 24 hours will result in some level of performance degradation.</li> </ul>
Napping.	<ul style="list-style-type: none"> <li>• Although it is preferable to get all sleep over one sustained 7 to 8 hour period, sleep can be divided into two or more shorter periods to help the Soldier obtain 7 to 8 hours per 24 hours. Example: 0100-0700 hours plus nap 1300-1500 hours.</li> <li>• Good nap zones (when sleep onset and maintenance is easiest) occur in early morning, early afternoon, and nighttime hours.</li> <li>• Poor nap zones (when sleep initiation and maintenance is difficult) occur in late morning and early evening hours when the body's rhythms most strongly promote alertness.</li> <li>• Sleep and <i>rest</i> are not the same. While <i>resting</i> may briefly improve the way the Soldier feels, it does not restore performance the way sleep does.</li> <li>• There is no such thing as <i>too much sleep</i>—mental performance and alertness always benefit from sleep.</li> <li>• Napping and sleeping when off duty are not signs of laziness or weakness. They are indicative of foresight, planning, and effective human resource management.</li> </ul>
Prioritize sleep need by task.	<ul style="list-style-type: none"> <li>• <b>TOP PRIORITY</b> is leaders making decisions critical to mission success and unit survival. Adequate sleep enhances both the speed and accuracy of decisionmaking.</li> <li>• <b>SECOND PRIORITY</b> is Soldiers who have guard duty, who are required to perform tedious tasks such as monitoring equipment for extended periods, and those who judge and evaluate information.</li> <li>• <b>THIRD PRIORITY</b> is Soldiers performing duties involving only physical work.</li> </ul>
Individual differences.	<ul style="list-style-type: none"> <li>• Most Soldiers need 7 to 8 hours of sleep every 24 hours to maintain optimal performance.</li> <li>• Most leaders and Soldiers underestimate their own total daily sleep need and fail to recognize the effects that chronic sleep loss has on their own performance.</li> </ul>

Table 4-2. Basic sleep environment and related factors

<b>Factor</b>	<b>Effect</b>
Ambient noise.	<ul style="list-style-type: none"> <li>• A quiet area away from intermittent noises/disruptions is <b>IDEAL</b>.</li> <li>• Soldiers can use earplugs to block intermittent noises.</li> <li>• Continuous, monotonic noise (such as a fan or <i>white noise</i>) also can be helpful to mask other environmental noises.</li> </ul>
Ambient light.	<ul style="list-style-type: none"> <li>• A completely darkened room is <b>IDEAL</b>.</li> <li>• For Soldiers trying to sleep during daytime hours, darken the sleep area to the extent possible.</li> <li>• Sleep mask/eye patches should be used if sleep area cannot be darkened.</li> </ul>
Ambient temperature.	<ul style="list-style-type: none"> <li>• Even small deviations above or below comfort zone will disrupt sleep.</li> <li>• Extra clothing/blankets should be used in cold environments.</li> <li>• Fans in hot environments (fan can double as source of white noise to mask ambient noise) should be used.</li> </ul>
Stimulants (caffeine, nicotine).	<ul style="list-style-type: none"> <li>• Caffeine or nicotine use within 4 to 6 hours of a sleep period will disrupt sleep and effectively reduce sleep duration.</li> <li>• Soldier may not be aware of these disruptive effects.</li> </ul>
Prescription sleep-inducing agents (such as Ambien®, Lunesta®, and Restoril®).	<ul style="list-style-type: none"> <li>• Sleep inducers severely impair Soldiers' ability to detect and respond to threats.</li> <li>• Sleep inducers should not be taken in harsh (for example, excessively cold) and/or unprotected environments.</li> <li>• Soldiers should have <i>nonwork</i> time of at least 8 hours after taking a prescribed sleep inducer.</li> </ul>
Things that do not improve or increase sleep.	<ul style="list-style-type: none"> <li>• Foods/diet—no particular type of diet or food improves sleep, but hunger and thirst may disrupt sleep.</li> <li>• Alcohol induces drowsiness but actually makes sleep worse and reduces the duration of sleep.</li> <li>• Sominex®, Nytol®, melatonin, and other over-the-counter sleep aids induce drowsiness but typically have little effect on sleep duration and are, therefore, of limited usefulness.</li> <li>• Relaxation tapes, music, and so forth may help induce drowsiness but they do not improve sleep.</li> </ul>

## SECTION II — MAINTAINING PERFORMANCE DURING SUSTAINED OPERATIONS/CONTINUOUS OPERATIONS

### COUNTERMEASURES TO MAINTAIN PERFORMANCE

4-9. Cold air, noise, and physical exercise may momentarily improve a Soldier's feeling of alertness, but they do not improve performance.

4-10. The only countermeasures that effectively improve performance during sleep loss are stimulants (caffeine and prescription stimulants including Dexedrine® and Provigil®). However, these countermeasures are only effective in restoring performance for short periods (2 to 3 days) and they do not restore all aspects of performance to normal levels. Caffeine is just as effective as the prescription stimulants.

#### CAFFEINE COUNTERMEASURES

4-11. Pharmacological countermeasures such as caffeine are for short-term use only (2 to 3 days) and **do not replace sleep**.

4-12. Caffeine occurs in varying content in a number of drinks, gums, and nonprescription stimulants such as—

- 12 ounces (oz) caffeinated soda: 40 to 55 milligrams (mg).
- No-Doz®: 1 tablet: 100 mg.
- Vivarin®: 1 tablet/caplet: 200 mg.
- Caffeine gum (StayAlert®): 1 piece: 100 mg.
- Jolt® cola: 71 mg.
- Red Bull® Energy Drink (8.3 oz): 80 mg.

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*Note.* Liquids will increase urine output, which may result in interrupted sleep. To avoid this, caffeine should be ingested in pill, tablet, or other nonliquid forms.

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4-13. Sleep loss effects are most severe in the early morning hours (0600—0800). Countermeasures against sleep loss, such as caffeine, are often required and are very effective during this early morning lull.

4-14. Table 4-3 below summarizes advice on using caffeine to maintain performance when there is no opportunity for sleep. Clock times provided are approximate and can be adapted to individual circumstances.

**Table 4-3. Using caffeine under various conditions of sleep deprivation**

<i>Condition under which caffeine is used</i>	<i>Guidelines for use</i>
Sustained operations (no sleep).	<ul style="list-style-type: none"> <li>● 200 mg starting at approximately midnight.</li> <li>● 200 mg again at 0400 hours and 0800 hours, if needed.</li> <li>● Use during daytime hours only if needed.</li> <li>● Repeat for up to 72 hours.</li> </ul>
Night shifts with daytime sleep.	<ul style="list-style-type: none"> <li>● 200 mg starting at beginning of nighttime shift.</li> <li>● 200 mg again 4 hours later.</li> <li>● Last caffeine dose: no less than 6 hours before sleep (for example, last dose at 0400 hours if daytime sleep is anticipated to commence at 1000 hours).</li> </ul>
Restricted sleep.	<ul style="list-style-type: none"> <li>● 200 mg upon awakening.</li> <li>● 200 mg again 4 hours later.</li> <li>● Last caffeine dose: no less than 6 hours before sleep.</li> </ul>

**SLEEP RECOVERY**

4-15. Ultimately, the Soldier must be allowed recovery sleep. Following a single, acute (2 to 3 days) total sleep loss, most Soldiers will usually recover completely if allowed a 12-hour recovery sleep period, preferably during the night.

4-16. Following chronic, restricted sleep during continuous operations, Soldiers may need several days of 7 to 8 hours nightly sleep to fully recover.

**WORK SCHEDULES**

4-17. Usual work schedules are 8 hours on/16 hours off. Sixteen hours off allows enough time to attend to maintenance duties, meals, personal hygiene, and so forth, while still obtaining 7 to 8 hours of sleep.

4-18. To the extent possible, commanders should attempt to consolidate their own and Soldiers’ off-duty times into a single, long block to allow maximum sleep time. If the usual 8 hours on/16 hours off schedule is not possible, the next best schedule is 12 hours on/12 hours off. In general, 12 hours on/12 hours off is

superior to 6 hours on/6 hours off, and 8 hours on/16 hours off is superior to 4 hours on/8 hours off. This is true because time off is consolidated into a single, longer block.

4-19. On/off shifts should total 24 hours. Shifts that result in shorter or longer days (such as 6 hours on/12 hours off—an 18-hour day) will impair the Soldiers alertness and performance.

### Night Shift Work

4-20. In general, Soldiers will not adapt completely to night shift work, even if they are on a fixed night shift.

4-21. To protect Soldiers' daytime sleep, the commander should not attempt to schedule briefings, meals, and Soldiers' routine maintenance duties during the Soldiers' sleep time.

4-22. Caffeine can be used during the night shift to improve performance.

4-23. Morning daylight exposure in night shift workers coming off shift should be avoided by wearing sunglasses from sunrise until the Soldier commences daytime sleep.

### Time Zone Travel

4-24. Trying to *preadapt* sleep and performance to a new time zone by changing sleep/wake schedules ahead of time to fit the new time zone is of little benefit.

4-25. During travel, Soldiers should not be awakened for meals (for example, while in flight to a new location). This sleep time should be protected.

4-26. After deploying to a new time zone, sleep and performance will not adapt for several days. During this time, Soldiers might also experience gastrointestinal disturbances and find it difficult to fall asleep and stay asleep at night.

4-27. When reaching the new time zone, Soldiers should—

- Immediately conform to the new time zone schedule (for example, for those on day work, sleep only at night).
- Avoid daytime naps. Sleeping during the day will make it more difficult to sleep that night and to adapt to the new time zone.
- Use caffeine during the day (morning and only through early afternoon) to help maintain performance and alertness.
- Stay on a fixed wake-up and lights-out schedule, to the extent possible.

## SECTION III — UNDERSTANDING THE EFFECTS AND MISCONCEPTIONS OF SLEEP LOSS AND SLEEP LOSS ALTERNATIVES

### SPECIFIC SLEEP LOSS EFFECTS

4-28. Sleep loss makes the Soldier more susceptible to falling asleep in an environment with little stimulation (such as guard duty, driving, or monitoring of equipment). This is especially important when considering tasking sleep-deprived Soldiers for guard duty during evening and early morning shifts. Leaders should be aware that putting Soldiers on guard duty that are sleep-deprived or in a sleep deficit, places those Soldiers at high risk of falling asleep while conducting this mission-critical duty. Commanders should consider the level of their Soldiers' sleep deprivation when establishing guard duty rosters. When significant sleep loss exists, leaders should consider altering the length of duty or manning guard posts with *teams* of two or more to maximize security efforts.

4-29. Even in high tempo environments, sleep loss directly impairs complex mental operations such as (but not limited to)—

- Orientation with friendly and enemy forces (knowledge of the squad's location).
- Maintaining camouflage, cover, and concealment.

- Coordination and information processing (coordinating firing with other vehicles and dismounted elements).
- Combat activity (firing from bounding vehicle, observing the terrain for enemy presence).
- Force preservation and regrouping (covering disengaging squads and conducting reconnaissance).
- Command and control activity (directing location repositioning, directing mounted defense, or assigning fire zones and targets).

4-30. Soldiers suffering from sleep loss can perform routine physical tasks (for example, loading magazines and marching) longer than more complex tasks (for example, requesting fire and establishing positions), but, regardless of the Soldier's motivation, the performance of even the simplest and most routine task will eventually be impaired.

4-31. With long-term (weeks, months) chronic sleep restriction, mood, motivation, and initiative decline. The Soldier may neglect personal hygiene, fall behind on maintaining equipment, be less willing to work or less interested in work, and show increased irritability or negativity.

4-32. Sleep-deprived commanders and Soldiers are poor judges of their own abilities.

4-33. Sleep loss impairs the ability to *quickly* make decisions. This is especially true of decisions requiring ethical judgment. If given enough time to think about their actions, Soldiers will tend to make the same decision when sleep-deprived that they would make when fully rested. However, when placed in a situation in which a snap judgment needs to be made, such as deciding to fire on a rapidly approaching vehicle, sleep deprivation may negatively impact decisionmaking.

#### **DETERMINING SLEEP LOSS IN THE OPERATIONAL ENVIRONMENT**

4-34. Sleep can be measured by having Soldiers keep a sleep log, but compliance is likely to be very low and reliability is poor.

4-35. The best way to evaluate a Soldier's sleep status is to observe his behavior. Indications of sleep loss include, but are not limited to, increased errors, irritability, bloodshot eyes, difficulty understanding information, attention lapses, decreased initiative/motivation, and decreased attention to personal hygiene.

4-36. Sleep loss can be confirmed by asking the obvious question: "When did you sleep last and how long did you sleep?" or "How much sleep have you had over the last 24 hours?" The commander or leader should direct this question not only to his Soldiers, but to himself as well.

4-37. Sleep-deprived Soldiers may be impaired despite exhibiting few or no outward signs of performance problems, especially in high tempo situations. The best way to ensure that Soldiers are getting enough sleep is for leaders to establish schedules that provide at least 7 to 8 hours of sleep in 24 hours.

#### **COMMON MISCONCEPTIONS ABOUT SLEEP AND SLEEP LOSS**

4-38. It is commonly thought that adequate levels of performance can be maintained with only 4 hours of sleep per 24 hours. In fact, after obtaining 4 hours of sleep per night for 5 to 6 consecutive nights a Soldier will be as impaired as if he had stayed awake continuously for 24 hours.

4-39. Another misconception is that Soldiers who fall asleep at inappropriate times (for example, while on duty) do so out of negligence, laziness, or lack of willpower. In fact, this may mean that the Soldier has not been afforded enough sleep time by his unit leaders.

4-40. It is common for individuals to think that they are less vulnerable to the effects of sleep loss than their peers either because they *just need less sleep* or because they are better able to *tough it out*. In part, this is because the Soldier who is sleep-deprived loses the self-awareness of how his performance is impaired. Objective measures of performance during sleep loss in such persons typically reveal substantial impairment.

4-41. Some individuals think that they can *sleep anywhere* and that they are such *good sleepers* that external noise and light do not bother them. However, it has been shown that sleep is invariably lighter and more fragmented (and thus less restorative) in noisy, well-lit environments (like the tactical operations

center). Sleep that is obtained in dark, quiet environments is more efficient (more restorative per minute of sleep).

4-42. Although it is true that many people habitually obtain 6 hours of sleep or less per night, it is not true that most of these people only *need* that amount of sleep. Evidence suggests that those who habitually sleep longer at night tend to generally perform better and tend to withstand the effects of subsequent sleep deprivation better than those who habitually obtain less sleep.

### **SLEEP LOSS ALTERNATIVES**

4-43. Ways to overcome performance degradation include—

- Upon signs of diminished performance, find time for Soldiers to nap, change routines, or rotate jobs (if cross-trained).
- Have those Soldiers most affected by sleep loss execute a self-paced task.
- Have the Soldiers to execute a task as a team, using the buddy system.
- Do not allow Soldiers to be awakened for meals while in flight to a new location, especially if the time zone of the destination is several hours different than that of point of departure.
- Insist that Soldiers empty their bladder before going to bed. Awakening to urinate interrupts sleep and getting in and out of bed may disturb others and interrupt their sleep.
- Allocate sleep by priority. Leaders, on whose decisions mission success and unit survival depend, must get the highest priority and largest allocation of sleep. Second priority is given to Soldiers that have guard duty and to those whose jobs require them to perform calculations, make judgments, sustain attention, evaluate information, and perform tasks that require a degree of precision and alertness.

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## Chapter 5

# Potentially Life-Threatening Thoughts and Behaviors

### SECTION I — INTRODUCTION AND THREAT OF SUICIDE

#### INTRODUCTION

5-1. Soldiers and leaders need to know what changes in behavior to look for when addressing Soldiers who may be suicidal. The junior leader and battle buddy are the closest on the ground to Soldiers and have the best visibility to what is happening in their daily lives. Soldiers contemplating suicide tend to be thinking impulsively and are often not in the best position to help themselves. They are looking for a way to end the pain. The most common risk factors resulting in suicidal behaviors for Soldiers generally are some type of relationship problem, closely followed by financial, administrative, or legal problems. These issues are also highly associated with alcohol abuse and compounded by combat and operational stress issues.

#### THREAT OF SUICIDE AND POTENTIAL SUICIDE RISK

5-2. Some of the common symptoms Soldiers may experience relating to suicide are: sleep problems, impulsivity, and not having the ability to sit still or concentrate. Other indicators are feelings of worthlessness and guilt and feeling trapped. Often those who commit suicide feel as though the deep emotional pain or depression they experience will never go away. They feel cornered with no way out. Soldiers in distress may show a range of behaviors as they struggle with the issues in front of them. What buddies and leaders need to do is recognize behaviors that are different from the Soldier's normal behavior. They must be aware when the Soldier begins to act in ways that are uncommon. When behavior is very different from what his normal behavior is like and it is known that the Soldier is in the middle of one of the primary risk factors (divorce or financial or legal difficulties) that leaders and buddies may need to act. Leaders and buddies must recognize the indicators and make every effort to assist.

5-3. Leaders must establish a command climate which acknowledges that Soldiers may become overwhelmed with the personal issues they struggle with. One of the tenets of Battlemind is *earlier treatment leads to faster recovery*. The only way Soldiers will be open to receive help is if the environment in which they work endorses getting help is okay. Leaders must create a trusting environment so Soldiers will feel it is okay to ask for help when needed.

5-4. Leaders and battle buddies have to be willing to talk to Soldiers and listen to what they have to say. They have to send the message that they are interested in hearing about the problems Soldiers are facing and dealing with each day. It is important to emphasize that seeking help in times of distress displays courage, strength, responsibility, and good judgment. These are the cornerstones of Battlemind skill development. Advise Soldiers to seek needed counseling either through the chaplain's office or BH services.

5-5. The Army has developed a tool for Soldiers and leaders to use to provide some guidelines on how to approach a distressed Soldier. The tool is called ACE (which stands for Ask, Care, and Escort) and outlines how you can provide buddy aid for Soldiers in distress. You should—

- **Ask** your buddy how he is doing and whether or not he feels suicidal. It is a myth that talking about suicide will make someone more suicidal. Actually, asking someone about suicide is often what is needed most and serves as a starting point for getting your buddy help. Talking about suicide may be awkward, intimidating, and difficult. Overcoming this requires every leader to practice and educate subordinates that your Army strength and courage should guide

you. The best way to ask someone if he is suicidal is to do just that. Ask the question: Are you suicidal? It is that simple.

- **Care** for your buddy. Upon recognition that your buddy is feeling suicidal, calmly remove any weapons or other items which may increase risk. It is extremely important to *remain calm*, as your anxiety will have an impact on your ability to calm the Soldier. Remaining calm will also increase your effectiveness at intervening. Once any weapons or other potentially dangerous items are removed, be there for the Soldier. Never leave him alone. Remember, we never leave a fallen comrade and these situations are no different.
- **Escort** the Soldier to help and assistance staying at his side. Failure to stay involved can have a devastating impact on the Soldier and his ability to drive on. Failure to act increases the risk of the Soldier impulsively acting on his suicidal intent.

5-6. When a Soldier is experiencing problems, the leaders should not hesitate to refer that Soldier to a chaplain or BH for intervention before it becomes a larger issue. Remember that earlier treatment leads to faster recovery. Leaders must—

- Establish a climate where seeking help is not a character flaw but a sign of strength.
- Know the chaplain and BH providers. Request outreach BH services for your unit as required.
- Use ACE to assist Soldiers.

For further information refer to Training Aid (TA)-059-0107, Soldiers' Redeployment Information (Trifold) (<https://www.us.army.mil/suite/doc/7374750>); TA-056-1206, Soldier Combat Stress Reaction: *A Pocket Guide for Spouse and Loved Ones* (Trifold) (<https://www.us.army.mil/suite/doc/7374749>); Staying Healthy Guide (SHG) 046-0206, Redeployment Health Guide: *A Service Member's Guide to Deployment-Related Stress Problems* (Trifold) (<https://www.us.army.mil/suite/doc/7374862>); ACE Suicide Intervention Card (<https://www.us.army.mil/suite/doc/11137929>); and Suicide Prevention Training Tip Card located at <https://www.us.army.mil/suite/doc/12786310>.

## SECTION II — THREAT OF VIOLENCE TO OTHERS AND THE RISK OF UNLAWFUL BEHAVIORS

### DANGEROUSNESS TO OTHERS

5-7. Thoughts of impulsive violent acts, to include injury to others, may be stress reactions that can be expected during intense combat and other military operations. Horrific Soldier and civilian deaths may lead Soldiers to feel vengeful and perhaps homicidal. Soldiers may verbalize a desire to kill or harm civilians they believe to be aiding the enemy or their own leaders they hold responsible for the death of their friends. Vengeful thoughts and premisconduct behaviors may occur in individuals or groups of individuals within a unit. Poorly trained and undisciplined Soldiers are at highest risk, but highly cohesive units and those with high *esprit de corps* are also susceptible during times of extreme combat and operational stress.

5-8. Early identification of unit and individual risk factors and behaviors that precede misconduct and preventive measures can minimize the risk of Soldiers committing acts that are not in conformance with the Law of Land Warfare and the UCMJ. Soldiers and leaders at every level must be able to identify risk factors and behaviors that may lead to violent and uncontrolled reactions and employ interventions to prevent misconduct that must be punished.

### UNIT RISK FACTORS

5-9. The unit risk factors are higher for unlawful behaviors and may precede violent inhumane acts or injuries to unit members when—

- There is an incidence of multiple Soldier and civilian deaths occurring in the same area of operation and over a short period of time.
- There is a high operation tempo with little respite between engagements.
- There is a rapid turnover of unit leaders.

- There is a manpower shortage.
- There is overly and unreasonably restrictive or confusing ROE.
- There is an enemy that is indistinguishable from innocent civilians.
- There is a perception of lack of support from higher command.

### INDIVIDUAL RISK FACTORS AFFECTING SOLDIERS

5-10. Individual risk factors that may precede violent acts or injury to others not in conformance with the Law of Land Warfare and the UCMJ include—

- Poor social support.
- Home front or unit problems.
- History of reacting impulsively in past.
- History of disciplinary actions and UCMJ proceedings.
- Suffering a combat loss (friend or a team member who was wounded in action or killed in action).
- Personally witnessing the injury or death or being involved in the medical evacuation of friend/unit member.
- Witnessing a particularly gruesome or horrific loss of life.

### INDIVIDUAL BEHAVIORS OF SOLDIERS AT RISK

5-11. Individual behaviors that may precede committing acts not in conformance with the Law of Land Warfare may include—

- Verbalization of thoughts about—
  - Anger toward or lack of support from higher command.
  - Indiscriminate revenge.
- Appearance and/or behavior changes which may include—
  - Lax military dress/bearing.
  - Appearing *on edge*.
  - Being subject to angry outbursts.
  - Taking excessive and/or intentional risks.
  - Appearing to be depressed and having minimal or no contact with others.
  - Changes in sleep patterns and appetite.
  - Pushing the ROE to the maximum extent.
  - Alcohol use or substance abuse.

5-12. Leaders are not immune to the individual risk factors, individual behaviors, or hostile thoughts. They must be alert to and address their *own* thoughts and feelings and how these may be transmitted to their Soldiers. In addition to self-awareness and early recognition of risk factors and behaviors that might indicate future misconduct, small-unit leaders and Soldiers of all ranks can intervene to prevent these types of thoughts from becoming behaviors that escalate to uncontrolled violence. Specific interventions require leaders to—

- Know the Soldier and recognize changes in baseline behavior that seem like more than normal grieving.
- Remind the Soldier that horrific injury and death occur in combat.
- Remind each Soldier after engagements that he is an American Soldier and that—
  - He is here to complete a lawful mission.
  - He is required by law to behave honorably and because it is the right thing to do.
  - To do otherwise dishonors him and his fellow Soldiers (both living and dead).
  - Stepping down to revenge could not only help the enemy to achieve his goals but could result in disciplinary action be taken against the Soldier involved.
  - To *return home with honor* is his final objective.

- Remind the Soldier that violent thoughts and thinking about harming or killing is a very common reaction to the sadness and anger that are part of combat, but acting on those impulses is misconduct that can and will be punished.
  - Ask the Soldier if he is struggling with violent thoughts or when the leaders suspect that the Soldier may commit acts that are not in conformance with the Law of Land Warfare and the UCMJ they should—
    - Never leave the Soldier alone.
    - Never permit the Soldier to continue to carry a loaded weapon.
    - Never keep a dangerous situation with a Soldier a secret. Locate help immediately (NCO, chaplain, combat medic, health care provider, or COSC/BH personnel).
    - Always inform the chain of command.
- 5-13. If the Soldier returns to duty—
- Obtain advice and ongoing assistance from BH or COSC assets.
  - Consider rotation of individual or small unit (squad) to less intense duties for a period of time.
  - Assign the Soldier a battle buddy.
  - Frequently check back with the Soldier and remind him that he can get help as identified above throughout the mission.

## Appendix A

# Mild Traumatic Brain Injury and Posttraumatic Stress Disorder

### SECTION I — MILD TRAUMATIC BRAIN INJURY (CONCUSSION)

#### INTRODUCTION

A-1. Mild traumatic brain injury (also referred to as a concussion) and PTSD have become known as the *signature* combat injuries associated with current and ongoing WOT operations. In July 2007, the US Army released to all Army activities (ALARACT) 153-2007, date/time group 171457Z July 2007 (available at <https://www.us.army.mil/suite/doc/8195435>) directing all Soldiers (Active Duty, USAR, and Army National Guard) to participate in training on MTBI and PTSD. This chain-teaching program provided leaders and Soldiers information and resources on MTBIs (concussions) and PCOS.

#### CONCUSSION

A-2. This section provides information about MTBI, or concussion, and does not address moderate or severe traumatic brain injury which is more serious. It is important to recognize that the term *MTBI* means exactly the same thing as concussion. The term *concussion* is commonly used by health care providers because it is more familiar to most people and is less apt to be confused with more serious traumatic brain injuries. Concussions are different than other forms of traumatic brain injury. Concussions are mild head injuries that temporarily affect brain functioning.

A-3. Concussions are most accurately diagnosed as soon as possible after the injury event. A concussion is defined as a blow or jolt to the head that causes a brief loss of consciousness (*being knocked out*) or a change in consciousness (such as feeling *disoriented* or *confused*), without any visible brain damage. Concussions can occur during combat or military training, as well as during sports or as a result of an accident. Concussions can cause temporary gaps in memory and/or symptoms such as headaches, irritability, fatigue, nausea or vomiting, slurred speech, balance difficulties, dizziness, ringing in the ears, blurred vision, and attention or concentration problems starting at or near the time of the injury. The specific symptoms a leader or his Soldier might experience are hard to predict and it is important to get evaluated by a health care provider as soon as possible after an injury event.

A-4. The brain heals itself rapidly after a concussion. Concussions from sports injuries or accidents are common and almost everyone who has had a concussion recovers completely within a few hours or days. There is no evidence that healing from concussions caused by explosions or improvised explosive devices are any different than healing from concussions caused by sports or other accidents. Full recovery is also expected if more than one concussion is experienced during a deployment, although this may take longer.

#### WHEN TO SEEK MEDICAL ADVICE

A-5. All Soldiers should seek medical advice from the nearest local MTF as soon as possible after any blow to their head in which there may have been a concussion. It is important to seek care as soon as possible. Sometimes Soldiers think they are fine after a concussion when they have actually suffered a more severe brain injury that needs immediate treatment. Also, the health care provider will determine when it is safe for the Soldier to RTD. Usually this is just a few hours to a few days, but it is important to let the health care provider decide this because hitting the head for a second time before fully healed from a

concussion could place the Soldier at risk for a more serious injury. If a Soldier displays signs of concussion, make sure he is seen by a health care provider right away.

**RECOVERY FOLLOWING A CONCUSSION**

A-6. Rest is the best way to heal from a concussion. Recovery usually occurs in a few hours or days. Some over-the-counter and prescription drugs may relieve headache pain or sleep difficulties, but talk to your health care provider before taking any medications. Acetaminophen is the best initial treatment for headaches. Do not take aspirin or ibuprofen without speaking to your doctor, because these medications may contribute to bleeding. In addition, using drugs or alcohol before your brain has recovered can complicate healing. A summary of recommendations for treating and managing symptoms of a concussion is presented in Table A-1.

**Table A-1. Healing and management of symptoms**

<i>Things that can help</i>	<i>Things that can hurt</i>
<p>Let others know when you have had a head injury so that they can also be on the lookout for concussion symptoms.</p> <p>Make sure you are evaluated by a health care provider as soon as possible after a concussion.</p> <p>Let your health care provider decide when it is time to RTD.</p> <p>Get plenty of rest and sleep.</p>	<p>Another concussion before the first one has healed.</p> <p>Aspirin and other over-the-counter medications.</p> <p><i>Caffeine</i> or energy-enhancing products because they may increase symptoms.</p> <p>Alcohol and drugs that can slow healing of the injury.</p> <p>Sleeping aids should be avoided unless instructed by a health care provider since these products can slow thinking and memory.</p>

A-7. Occasionally, symptoms following a concussion persist longer than a few days or weeks. Common concussion symptoms such as fatigue, headaches, irritability, concentration difficulties, sleep disturbance, and ringing in the ears are often experienced after combat and can be due to other injuries or medical problems, as well as PTSD or depression. If these symptoms persist a Soldier should see a health care provider to discuss his symptoms and treatment options. For more information, go to Web site <http://www.pdhealth.mil>.

**SECTION II — POSTTRAUMATIC STRESS DISORDER**

**POSTTRAUMATIC STRESS DISORDER AND POSTCOMBAT AND OPERATIONAL STRESS**

A-8. All Soldiers have reactions after combat. These reactions are normal and usually resolve quickly. Some Soldiers go on to have more persistent reactions to combat. Posttraumatic stress disorder is a medical condition that can develop in some Soldiers after experiencing combat or other life-threatening events. Soldiers need time to transition home from a combat deployment, but if reactions persist then they may need to get help. See Table A-2 for common symptoms of PTSD.

**Table A-2. Symptoms that may be experienced from posttraumatic stress disorder**

<p><b><i>Soldier experiences the event over and over again:</i></b></p> <ul style="list-style-type: none"> <li>Cannot put it out of his mind no matter how hard he tries.</li> <li>Has repeated nightmares about the event.</li> <li>Has a vivid memory of the event, almost like it was happening all over again.</li> <li>Has a strong reaction when he encounters reminders, such as the smell of diesel fuel.</li> </ul>
<p><b><i>Soldier avoids people, places, or feelings that remind him of the event:</i></b></p> <ul style="list-style-type: none"> <li>Works hard to put it out of his mind.</li> <li>Feels numb and detached.</li> <li>Avoids people or places that remind him of the event.</li> </ul>
<p><b><i>Soldier feels keyed up or on edge all the time:</i></b></p> <ul style="list-style-type: none"> <li>May be startled easily by loud noises.</li> <li>May be irritable or angry for no apparent reason.</li> <li>Is always aware of the possibility of threats.</li> <li>May have trouble relaxing or getting to sleep.</li> </ul>

A-9. It is important for Soldiers to get help if PTSD symptoms are interfering with their ability to live their lives or do their jobs. Most Soldiers do not develop PTSD. It also is important to remember that a Soldier can experience some PTSD symptoms without having a diagnosis of PTSD and there are many other reactions to combat for which he may need counseling (for example, relationship problems or depression). The good news, however, is that PTSD is treatable. Therapy involving talking to a counselor has proven to be very effective in reducing and even eliminating the symptoms. Medication can also help. Early treatment leads to the best outcomes. So, when a Soldier, Family member, or a team member thinks a Soldier has PTSD, they should seek or request help with referring for treatment right away.

A-10. It is important to note that every Soldier will experience some type of PCOS resulting from their military experience. Postcombat and operational stress describes the range of possible outcomes along a continuum of common stress reactions to more serious BH problems. Postcombat and operational stress is not a BH diagnosis, but a term used to describe the effects of combat and operational exposure experienced by Soldiers performing military duties. Combat can also lead to personal growth such as increased confidence, spirituality, relationships with others, and/or ability to appreciate what is important in life.

A-11. Soldiers and leaders should seek help if they are having symptoms that are interfering with their ability to function at home, at work, or while out with others or if their symptoms are leading to dangerous thoughts or behaviors. Assistance is available through the unit chaplain, the installation department of BH, social work service, or the Soldier's primary care physician. Additional information is also available at Web sites <http://www.behavioralhealth.army.mil>, <http://www.militaryonesource.com>, or you can do an anonymous online survey at <http://www.militarymentalhealth.org>. For information on MTBI (concussions), visit the Defense and Veterans Brain Injury Center Web site at <http://www.dvbic.org>

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## Appendix B

# Behavioral and Personality Disorders

### SECTION I — INTRODUCTION AND MEDICAL READINESS RESPONSIBILITIES

#### INTRODUCTION

B-1. Serving in the Army requires the physical and mental fitness necessary to plan and execute missions involving combat, as well as stability and civil support operations. Any health condition that limits the physical or psychological ability of a Soldier to plan, train, or execute the mission represents a risk to that individual, the unit, and mission success. Any condition or treatment for that condition that negatively impacts on the mental status or behavioral capability of an individual must be evaluated to determine the potential impact both to the individual Soldier and to the mission.

#### MEDICAL READINESS RESPONSIBILITIES

B-2. Medical readiness is a shared responsibility of commanders, medical personnel, and Soldiers. It is essential that this triad work seamlessly in an integrated effort to ensure that our Soldiers are ready to fight and win our nation's wars while taking all practical measures to minimize the risk of harm to individuals and to the mission.

#### BEHAVIORAL HEALTH POLICY GUIDANCE

B-3. Recovery, amelioration of symptoms, and reduction of behavioral impairment are always goals associated with BH treatment, as psychiatric disorders, including PTSD, are treatable. Diagnosed conditions that are not amenable or anticipated not amenable to treatment and restoration to full functioning within one year of onset of treatment should generally be considered unacceptable or unsuitable for military duty and referred to a medical evaluation board or to the personnel system.

B-4. Early identification and treatment are keys to continuation of or RTD for Soldiers who experience BH disorders. All Soldiers, both in the active Army and RC, should be actively encouraged to seek treatment for BH concerns.

B-5. Leaders and health care providers who conduct Army medical readiness assessments for individuals with psychiatric disorders must consider the following criteria. These criteria should be applied across each assessment event in the Army medical readiness/deployment life cycle (periodic/recurring health assessment/physicals for predeployment, deployment, and postdeployment assessments, and normally after 90 to 120 days for a postdeployment health reassessment [PDHRA]). Leaders and health care providers who monitor the Army medical readiness for individuals must consider that—

- All conditions that do not meet retention requirements or that render an individual unfit or unsuitable for duty should be appropriately referred for a medical evaluation board or for administrative actions as appropriate.
- Psychotic and bipolar disorders are considered disqualifying factors for deployment.
- Soldiers with a psychiatric disorder in remission or whose residual symptoms do not impair duty performance may be considered for deployment duties.
- Disorders not meeting the threshold for a medical evaluation board should demonstrate a pattern of stability without significant symptoms for at least 3 months prior to deployment.

- The availability, accessibility, and practicality of a course of treatment or continuation of treatment in theater should be consistent with practice standards.
- Soldiers should demonstrate behavioral stability and minimal potential for deterioration or recurrence of symptoms in a deployed environment, to the extent this can be predicted by positive strengths, skills, training, motivation, and previous operational experience. This should be evaluated considering potential environmental demands and individual vulnerabilities.
- The environmental conditions and mission demands of deployment should be considered: the impact of sleep deprivation, rotating schedules, fatigue due to longer working hours, and increased physical challenges (including heat stress) with regard to a given BH condition.
- The occupational specialty in which the individual will function in a deployed environment should be considered. However, when deployed, individuals may be called upon to function outside their military training, as well as outside their initially assigned deployed occupational specialties. Therefore the primary consideration must be the overall environmental conditions and overall mission demands of the deployed environment rather than a singular focus on anticipated occupation-specific demands.

B-6. Behavioral health disorders are most often treated with either a course of psychotherapy, pharmacotherapy, or a combined therapeutic protocol. Medications prescribed to treat psychiatric disorders vary in terms of their effects on cognition, judgment, decisionmaking, reaction time, psychomotor functioning and coordination, and other psychological and physical parameters that are relevant to functioning effectively in an operational environment. In addition, psychotropic medications may be prescribed for a variety of conditions that are not assigned a psychiatric diagnosis.

B-7. Caution is warranted in beginning, changing, stopping, and/or continuing psychotropic medication for deploying and deployed personnel. Across every assessment event in the medical readiness life cycle and during routine clinical care both in garrison and in deployed settings, use of psychotropic medication should be evaluated for potential limitations to deployment or continued service in a deployed environment.

B-8. There are few medications that are inherently disqualifying for deployment for all military occupational specialties, to all potential operational locations, and at all times during the conduct of operations. Clinical care proximity, procedures availability, tempo, and demands of operations at the deployed location, and time during the deployment rotation must be considered when determining use of psychotropic medications prior to deployment, as well as in the operational environment.

B-9. A psychiatric condition controlled by medication should not automatically limit deployment. Soldiers with a controlled psychiatric illness can still deploy. The recommendation on deployability rests with the clinical judgment of the treating physician or other privileged provider, in consultation with the unit commander. If there are any questions on the safety of psychiatric medication, a psychiatrist should be consulted.

B-10. Medical readiness follows the Army force generation (ARFORGEN) model which is a structured progression of increased unit readiness over time resulting in recurring periods of availability of trained, ready, and cohesive units. This cyclical readiness allows commanders to recognize that not all units have to be ready for war all the time and units must build their readiness over time. See Chapter 2 for the force projection processes and FMI 3-35 for definitive information pertaining to ARFORGEN. Psychological readiness must be assessed at each phase of the force projection process with determinations made regarding limitations or restrictions for military occupational specialty requirements or deployment locations. Special consideration must be given to limitations affecting those under the DOD Personnel Reliability Program (see DODI 5210.42, DODI 5210.65, AR 50-5, and AR 50-6) and specific operational standards such as for aviation, Army Special Operations Forces, or other high risk occupational categories.

B-11. Medical readiness assessments are conducted for reconstitution operations, train up, and preparation period of the ARFORGEN process through the annual periodic health assessment, PDHRA, as well as routine health care visits. These medical readiness assessments may include—

- Recurring/periodic health assessment for the predeployment, deployment, and PDHRA processes which are designed to provide a global health assessment that includes assessment for

BH disorders, BH risks, and physical health conditions that may impact on mental status or emotional well-being. Any conditions, concerns, symptoms, or prescribed psychotropic medications identified through these assessment procedures must be documented. Self-reported symptoms should be clarified through standard clinical procedures by the reviewing health care provider to determine clinical significance and the need for further evaluation and treatment. If the health care provider determines that a concern or condition demonstrates a potential negative impact on performance in an occupational specialty or fitness for military service, the individual will be referred for further evaluation. If the concern or condition meets retention standards, but nevertheless represents a potential risk to health or mission execution in a deployed setting, that limitation should also be referred to the appropriate health care professional for further evaluation and definitive recommendation. The reason for the referral and the request for evaluation for deployment limitations should be clearly documented for future follow up.

- Health care visits for evaluation of potential deployment-limiting conditions which should include a thorough assessment of the current status and potential long-term status of the presenting condition and any associated medications or therapeutic procedures. Any limitations, either temporary or permanent, should be appropriately documented in the Soldiers official military personnel file. In addition, notations must be documented in the medical record for future deployment-related reviews.
- Recurring/periodic health assessment and PDHRA procedures which are designed to both identify and facilitate access to care for health risks and conditions. The advantage of these procedures for medical readiness includes the opportunity and available time to identify, implement, and conclude a treatment protocol for identified conditions and concerns prior to deployment. All medications and/or other therapeutic procedures implemented for identified health concerns that create additional changes to the mental or behavioral status of the individual should be appropriately noted. Most importantly, at the conclusion of the course of treatment, a termination notation must clearly document either the removal of deployment limitations or the initiation of permanent duty limitations.

### **Mobilization**

B-12. The Department of Defense (DD) Form 2795 (Pre-Deployment Health Assessment Questionnaire) is designed to identify health concerns that would preclude deployment or require a brief course of treatment immediately prior to deployment. The predeployment health assessment includes self-reported information of health status, medical record review, and a review of the Soldier's health concerns by a health care provider. It is the responsibility of the Soldier to report past or current physical or BH conditions or concerns and associated treatments, including prescribed medications. The assessing health care provider must review all medical readiness information and documentation to determine disposition. If the recommended clinical course of action is not clear, a referral is warranted for further medical evaluation and disposition. Soldiers followed by nonbehavioral health care providers whose condition fails to improve after 3 months of management, must have BH specialty review or consultation. This is done to determine deployability limitations and recommendations.

### **Deployment**

B-13. When personnel are diagnosed with a psychiatric disorder in theater, the provider will assess the patient's condition, treatment regimen, and risk level. The clinical decision to maintain or evacuate personnel diagnosed with psychiatric disorders in theater is based upon: the severity of symptoms and/or medication side effects; the degree of functional impairment resulting from the disorder and/or medications; the risk of exacerbation if the Soldier were exposed to trauma or severe operational stress; the estimation of the Soldier's ability and motivation to psychologically tolerate the rigors of the deployed environment; and the prognosis for recovery. Soldiers with conditions that are determined to be at significant risk for performing poorly or relapse in the operational environment or whose condition does not significantly improve within two weeks of treatment initiation, will be clinically recommended for return to their home station, in consultation with their commander.

## Postdeployment

B-14. The Post-Deployment Health Assessment (PDHA), DD Form 2796, is used to document the assessment. The PDHA is conducted immediately at the end of a deployment to determine any changes in health status resulting from deployment. Conditions that require immediate treatment will be stabilized at the point of administration of the PDHA. Other conditions will be referred back to the servicing MTF at the Soldier's station of assignment. Currently established medical processing procedures will be followed for USAR personnel that are subject to release from active duty upon return. Any resultant treatment and final disposition will be documented clearly in the military health record for future medical records review.

## SECTION II — PERSONALITY DISORDERS

### BEHAVIORAL HEALTH STATUS

B-15. Commanders must understand the impact BH status may have on unit readiness. Specifically, the role personality disorders may play in effecting the organization's ability to engage in military operations. Personality disorders are BH diagnoses that reflect long-standing maladaptive behavioral patterns that are unlikely to adapt to the roles of military service. Personality disorders are not the same as personality traits. All Soldiers will display various personality traits that are prominent aspects of their personality and are exhibited in a wide range of important social and personal contexts.

B-16. Personality disorders are clinical diagnoses that characterize the following:

- Inflexible and maladaptive personality traits which are pervasive across a broad-range of situations.
- Deviates from expectations of the individual's culture.
- Causes significant impairment in social, occupational, or other important areas of functioning or causes significant subjective distress.
- Pattern is stable and of long duration (onset traced back to adolescence or early adulthood).
- Not due to substance use or general medical condition or another mental disorder.
- Manifested in two areas of the following: cognition, affectivity, interpersonal functioning, or impulse control.

B-17. It is imperative that leaders document patterns of misconduct or administrative disturbances resulting from personality-related maladaptive behavior. Specifically, leaders must document patterns of maladjustment to military life in order to support a diagnosis of personality disorder so that appropriate administrative considerations can be determined. For information on administrative considerations for separation of Soldiers that are unsuited for military life, see AR 635-200.

## SECTION III — PERSONALITY DISORDERS AND POSTTRAUMATIC STRESS DISORDER

### DOCUMENTING MALADAPTIVE PATTERNS OF BEHAVIOR AND PERFORMANCE

B-18. As discussed in earlier chapters of this manual, PTSD is a psychiatric illness that can occur following a traumatic event in which there was a threat of injury or death to the Soldier or someone else. The nature of military duty can routinely place a Soldier in situations that expose him to significant traumatic events. If left unresolved, the negative effects of this exposure can result in degraded performance and functioning with the ultimate result in a diagnosis of PTSD. It is also important for leaders to understand that Soldiers having significant personality traits or even personality disorders can also be affected by PTE exposure. Personality disorders and PTSD can coexist; however, they are not the same thing.

B-19. In order to determine which takes priority in providing disposition, it is imperative that commanders have the appropriate collateral information available to determine the best administrative and treatment actions available to Soldiers and organizations. Without adequate evidence of maladaptive patterns of behavior related to personality disorders (such as counseling statements or nonjudicial punishment) that occurred prior to traumatic event exposure, it is difficult to support a personality disorder diagnosis and subsequent utilization of appropriate administrative considerations available to commanders resulting from such a diagnosis.

B-20. Commanders must document service-related maladaptive performance throughout all areas of the ARFORGEN and force projection processes. This documentation may be used to determine the extent of personality-related adaptive functioning versus reaction to significant traumatic events. Accurate documentation and assessment will allow for the appropriate disposition channels and treatment avenues that Soldiers are entitled to and organizations can leverage.

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# Glossary

## SECTION I — ACRONYMS AND ABBREVIATIONS

<b>ACE</b>	ask, care, escort
<b>ACS</b>	Army community services
<b>AMEDD</b>	Army Medical Department
<b>AR</b>	Army regulation
<b>ARFORGEN</b>	Army force generation
<b>BCT</b>	brigade combat team
<b>BH</b>	behavioral health
<b>BICEPS</b>	brevity, immediacy, contact, expectancy, proximity, simplicity
<b>BSMC</b>	brigade support medical company
<b>CDE</b>	command-directed evaluation
<b>COSB</b>	combat and operational stress behavior
<b>COSC</b>	combat and operational stress control
<b>COSR</b>	combat and operational stress reaction
<b>DA</b>	Department of the Army
<b>DD</b>	Department of Defense (official forms only)
<b>DOD</b>	Department of Defense
<b>DODD</b>	Department of Defense directive
<b>DODI</b>	Department of Defense instruction
<b>FM</b>	field manual
<b>FMI</b>	field manual interim
<b>FRG</b>	Family readiness group
<b>G-1</b>	Assistant Chief of Staff, Personnel
<b>LLAAD</b>	leader-led after-action debriefing
<b>mg</b>	milligram
<b>MH</b>	mental health
<b>MRE</b>	meal, ready-to-eat
<b>MTBI</b>	mild traumatic brain injury
<b>MTF</b>	medical treatment facility
<b>NCO</b>	noncommissioned officer
<b>OPSEC</b>	operations security
<b>oz</b>	ounce
<b>pam</b>	pamphlet
<b>PCOS</b>	postcombat and operational stress
<b>PDHRA</b>	postdeployment health reassessment
<b>POC</b>	point of contact
<b>PTE</b>	potentially traumatic event

<b>PTG</b>	posttraumatic growth
<b>PTSD</b>	posttraumatic stress disorder
<b>RC</b>	Reserve Component
<b>ROE</b>	rules of engagement
<b>RTD</b>	return to duty
<b>SOP</b>	standing operating procedure
<b>TA</b>	training aid
<b>TC</b>	training circular
<b>TEM</b>	traumatic event management
<b>UBHNAS</b>	unit behavioral health needs assessment survey
<b>UCMJ</b>	Uniform Code of Military Justice
<b>UMT</b>	unit ministry team
<b>UNA</b>	unit needs assessment
<b>US</b>	United States
<b>USAMEDDC&amp;S</b>	United States Army Medical Department Center and School
<b>USAR</b>	United States Army Reserve
<b>WOT</b>	war on terrorism

## SECTION II — TERMS AND DEFINITIONS

### **Battlemind**

The United States Army psychological resiliency program, based on the Soldier's inner strength during combat to face fear and adversity with courage. It speaks to resiliency skills that are developed to survive and represents a range of training modules and tools under the categories of development cycle, life cycle, and Soldier support.

### **Battlemind warrior resilience**

Basic traumatic event management and peer-support training to all United States Army Soldier combat medics/health care specialists and other health care professionals, allowing for the start of social- and peer-support systems within assigned units, basic traumatic events management, and assistance to the commander in establishing unit resiliency programs.

### **BICEPS**

A memory aid used for the management of combat and operational stress reaction: **brevity**—usually less than 72 hours; **immediacy**—as soon as symptoms are evident; **contact**—chain of command remains directly involved in the Soldier's recovery and return to duty; **expectancy**—casualties will recover; **proximity**—treatment at or as near the front as possible; **simplicity**—use of simple measures, such as rest, food, hygiene, and reassurance.

### **combat and operational stress behavior**

The behavioral reactions resulting from exposure primarily experienced while conducting the full spectrum of operations, reflecting the full range of behavior from adaptation to combat and operational stress reaction.

**combat and operational stress control**

Programs developed and actions taken by military leadership to prevent, identify, and manage adverse combat and operational stress reactions in units; optimize mission performance; conserve fighting strength; prevent or minimize adverse effects of combat and operational stress on members' physical, psychological, intellectual and social health; and to return the unit or Service member to duty expeditiously. (JP 4-02)

**combat and operational stress control unit needs assessment**

Global assessment of the unit with consideration of multiple variables that may affect leadership, performance, morale, and combat effectiveness of the organization.

**combat and operational stress reaction**

Negative adaptation to high-stress events and potentially traumatic event exposure.

**postcombat and operational stress**

Long-term stress reactions resulting from military combat and operational exposure.

**posttraumatic growth**

The increased functioning and positive change after enduring a trauma, which may include changes in personal strength, spirituality, relationships with others, and/or ability to appreciate life.

**potentially traumatic event**

An event that causes individuals or groups to experience intense feelings of terror, horror, helplessness, and/or hopelessness. It is an event that is perceived and experienced as a threat to one's safety or to the stability of one's world.

**six Rs**

Actions used for combat and operational stress control: **reassure** of normality; **rest** (respite from combat or break from work); **replenish** bodily needs (thermal comfort, water, food, hygiene, sleep); **restore** confidence with purposeful activities and contact with unit; **return** to duty and reunite Soldier with his unit; and **remind** Soldier that he behaves honorably because it is the right thing to do; that harming or killing noncombatants dishonors him and his fellow Soldiers; that revenge helps the enemy to discredit him and his unit; that the ultimate objective is to *return home with honor*.

**Soldier restoration and reconditioning program**

An intensive program of replenishment, physical activity, therapy, and military retraining for combat and operational stress casualties, including alcohol and drug abuse.

**stabilization**

The initial short-term management and evaluation of Soldiers exhibiting severely disturbed behavior caused by an underlying combat and operational stress reaction, behavioral health disorder, or alcohol and/or drug abuse.

**traumatic event management unit needs assessment**

A focused assessment of a potentially traumatizing event, with specific consideration of the potential disruption or dysfunction that the event may have caused to an individual or the entire organization.

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# Index

References are to paragraph numbers unless otherwise stated.

## A

adaptive stress reaction, 1-18,  
Table 1-2, 1-27, Table 2-6,  
2-3, 2-11

after-action debriefing, 2-112—  
113, 2-115—116, 2-118—  
123, 3-32

Army Health System, Table  
2-3, 2-42

## B

battlemind, 1-10—11, Tables 2-  
3 and 2-4, Tables 2-8 and 2-  
9, 2-98, 2-122, 3-45,  
3-60—64, 3-66, 5-3—4,  
Glossary

Warrior Resiliency, 3-66,  
3-68—70, Glossary

behavioral health, 1-2, 1-13,  
1-19, 1-28, 1-36, 1-42,  
1-48—50, 1-53—69, 2-16,  
2-67, 2-73, 2-92, 2-98,  
2-100, 2-102, 2-120, 2-122,  
Tables 2-1—4, Tables 2-7—  
9, 3-2, 3-4—5, 3-7, 3-12,  
3-18, 3-23, 3-43, 3-45, 3-47,  
3-54—56, 3-61, 3-66—67,  
3-70, 5-4, 5-6, 5-12—13,  
A-10—11, B-3—6, B-11—  
12, B-15

## C

combat and operational stress  
behaviors, vi, 1-6, 1-10,  
1-12, 1-14—15, 1-17,  
1-27, 1-30, 3-66,  
Glossary

control, v—vi, 1-2, 1-5,  
1-36—38, 1-42, 1-46—  
47, 1-50, 1-52, 1-56—58,  
Tables 2-1—4, Tables 2-7  
and 2-8, 2-5, 2-16,  
2-28, 2-63, 2-100, 2-104,  
2-108, 2-113, 2-117,  
2-119, 2-122, 3-1, 3-8,  
3-12, 3-32, 3-47, 3-50,  
3-70, 3-81—85, 3-92,  
5-12—13

reactions, v—vi, Table 1-2,  
Tables 1-4 and 1-5, 1-9,

1-15, 1-19—22, 1-25—  
27, 1-30—31, 1-33—34,  
1-37, 1-39—40, 1-42,  
1-51, 2-1, Tables 2-3 and  
2-4, 2-3, 2-10, 2-32, 2-35,  
3-51, 3-65, 3-72—73,  
3-75—76, 3-79—80,  
3-83—85, 3-87, 5-6—7,  
A-10, Glossary

command-directed evaluation,  
1-14, 1-47, 1-60—68

concussion, 1-26, Appendix A

## F

Family readiness, Tables 2-4  
and 2-7, 2-49—50, 2-52,  
2-62—63

group, 1-53, Tables 2-4 and  
2-7, 2-50—56, 2-62—63,  
3-34

## H

health assessment, B-5, B-11  
deployment, B-5, B-7, B-11  
postdeployment, B-5  
predeployment, B-5, B-11—  
12

## L

leader-led after-action de-  
briefing, 2-112—113,  
2-115—116, 2-118—123,  
3-32

## M

medical evaluation board, B-3,  
B-5

mental health section, 1-44—  
47, 1-50—55

mild traumatic brain injury,  
1-26, Appendix A

misconduct stress behavior,  
1-21, 1-27, 5-7—8, 5-12, 5-  
17

## P

personality disorder, 1-55,  
2-87, Appendix B

postcombat and operational  
stress, vi, 1-14—15, 1-28,

1-51, 2-103, A-1, A-10,  
Glossary

postdeployment health re-  
assessment, B-5, B-11

posttraumatic  
growth, vi, 1-15, 1-22—23,  
2-101, 2-104, Glossary  
stress disorder, vi, 1-15, 1-  
22—28, 2-102, A-1,  
A-7—9, B-3, B-18

potentially traumatic event, vi,  
1-4, 1-15—16, Table 2-3,  
2-100—104, 2-106—113,  
2-116—117, 2-119—120,  
2-122, 3-66, 3-70, B-18,  
Glossary

## S

stress  
common, 1-34  
mild, 1-22, 1-31, 1-34, Table  
1-3, 1-40  
severe, 1-32, Table 1-4,  
1-40, 1-57, B-13

substances abuse, 1-34, 1-59,  
2-38, 2-68, 2-89, 2-91, 5-11

## T

traumatic event management,  
v, 1-41, 1-43, Table 2-3,  
2-100, 2-101, 2-103—112,  
2-117, 2-119, 3-66

## U

unit  
behavioral health needs  
assessment survey,  
Table 2-1, Table 2-4,  
Table 2-9, 2-108, 3-1—7

ministry team, 1-37—43,  
1-48, Table 2-3, Table 2-  
4, Table 2-7, Tables 2-8  
and 2-9, 2-119

needs assessment, v, 2-104,  
2-107—111, 3-5, 3-66

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**18 March 2009**

By order of the Secretary of the Army:

**GEORGE W. CASEY, JR.**  
*General, United States Army*  
*Chief of Staff*

Official:

A handwritten signature in black ink that reads "Joyce E. Morrow". The signature is written in a cursive, flowing style.

**JOYCE E. MORROW**  
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