

***ATP 6-22.5**

A LEADER'S GUIDE TO SOLDIER HEALTH AND FITNESS

FEBRUARY 2016

DISTRIBUTION RESTRICTION. Approved for public release; distribution is unlimited.

*This publication supersedes FM 6-22.5, Combat and Operational Stress Control Manual for Leaders and Soldiers, dated 18 March 2009.

Headquarters, Department of the Army

This publication is available at Army Knowledge Online
(<https://armypubs.us.army.mil/doctrine/index.html>).

To receive publishing updates, please subscribe at
http://www.apd.army.mil/AdminPubs/new_subscribe.asp

Army Techniques Publication (ATP)
No. 6-22.5

Headquarters
Department of the Army
Washington, DC, 10 February 2016

A Leader's Guide to Soldier Health and Fitness

Contents

	Page
PREFACE.....	v
INTRODUCTION	vi
Chapter 1 READY AND RESILIENT CAMPAIGN.....	1-1
Section I — Medical Readiness.....	1-1
Behavioral Health	1-1
Posttraumatic Stress Disorder	1-2
Traumatic Brain Injury	1-2
Pain Management	1-3
Polypharmacy	1-4
Section II — Personnel Readiness	1-4
Suicide Prevention.....	1-5
Comprehensive Soldier and Family Fitness Program	1-5
Deployment Health Assessment Program	1-5
Individual Medical Readiness.....	1-6
Chapter 2 PERFORMANCE TRIAD	2-1
Section I — Sleep	2-1
Sleep Management in the Operational Environment	2-1
Sleep Environment and Critical Factors Related to Good Sleep Hygiene	2-2
Sleep Loss	2-5
Section II — Activity	2-7
Physical Training Programs.....	2-7
Functional Fitness Program.....	2-8
Section III — Nutrition	2-8
Nutritional Guidance	2-8
Dietary Supplements	2-9
Hydration	2-10

Distribution Restriction: Approved for public release; distribution is unlimited.

*This publication supersedes FM 6-22.5, Combat and Operational Stress Control Manual for Leaders and Soldiers dated 18 March 2009.

Contents

Chapter 3	COMPREHENSIVE SOLDIER AND FAMILY FITNESS PROGRAM	3-1
	Section I — Overview	3-1
	Section II — Educational Resources.....	3-2
Chapter 4	POTENTIALLY LIFE THREATENING THOUGHTS AND BEHAVIORS	4-1
	Section I — Threat of Suicide	4-1
	Section II — Threat of Violence to Others and the Risk of Unlawful Behavior.....	4-2
	Unit Risk Factors.....	4-2
	Individual Risk Factors Affecting Soldiers.....	4-3
	Individual Behaviors of Soldiers at Risk.....	4-3
Chapter 5	ARMY HEALTH PROMOTION PROGRAM.....	5-1
	Section I — Health Promotion Program	5-1
	Section II — Behavioral Health	5-2
	Behavioral Health Promotion	5-2
	Stress Management.....	5-2
	Combat and Operational Stress Control.....	5-3
	Suicide Prevention	5-3
	Responsible Sexual Behavior.....	5-3
	Army Substance Abuse Program.....	5-4
	Tobacco Cessation	5-4
	Section III — Physical Health.....	5-4
	Physical Fitness	5-5
	Injury Prevention	5-5
	Ergonomics	5-5
	Oral Health	5-6
	Body Composition Program	5-6
Chapter 6	FIELD HYGIENE AND SANITATION.....	6-1
	Section I — Health Threats to Soldiers in the Field.....	6-1
	Section II — Soldier Preventive Medicine Measures.....	6-2
	Personal Hygiene.....	6-2
	Arthropods, Rodents, and Other Animal Threats.....	6-3
	Section III — Field Sanitation Teams	6-3
	Field Sanitation Team Protection and Sanitation Duties	6-4
	Field Sanitation Team Arthropod and Rodent Control Duties	6-4
	Section IV — Commander and Leader Preventive Medicine Measures	6-5
Chapter 7	COMBAT AND OPERATIONAL STRESS REACTION IDENTIFICATION, PREVENTION, MANAGEMENT AND CONTROL.....	7-1
	Section I — Reactions to Combat and Operational Stress.....	7-1
	Section II — Forms of Combat and Operational Stress	7-3
	Potentially Traumatic Events	7-3
	Combat and Operational Stress Behaviors	7-3
	Section III — Combat and Operational Stress Reactions	7-5
	Section IV — Referral of Soldiers Experiencing Combat and Operational Stress Reactions and Other Stress-Related Disorders.....	7-10

Voluntary Referrals.....	7-11
Command-Directed Evaluation.....	7-11
Section V — Preventing and Managing Combat and Operational Stress	7-13
Cohesion and Morale	7-13
Stress-Reduction Techniques for Leaders	7-14
Performance Degradation Preventive Measures	7-17
Section VI — Role of Religious Support	7-18
Section VII — Role of Unit Behavioral Assets.....	7-19
Mental Health Sections.....	7-19
Mental Health Section Functions.....	7-20
Chapter 8 COMMAND LEADERSHIP ACTIONS AND COMBAT AND OPERATIONAL STRESS CONTROL PROGRAMS	8-1
Section I — Unit Behavioral Health Needs Assessment	8-1
Section II — Effective Leadership.....	8-2
Leaders are Reliable and Confident.....	8-2
Family Readiness Group	8-6
Section III — Traumatic Event Management and Leader-Led After Action Debriefing	8-11
Traumatic Event Management	8-11
Cool Down Meetings	8-13
Leader-Led After Action Debriefing	8-13
Effectively Sustain Performance	8-15
Section IV — Effective Combat and Operational Stress Control.....	8-17
Minimize Stress	8-17
Mobilization.....	8-17
Deployment	8-20
Section V — Soldier Resiliency and Combat and Operational Stress Control.....	8-22
Section VI — Leadership Actions and Interventions for Combat and Operational Stress Reactions	8-23
Section VII — Combat and Operational Stress Reaction Management Guidelines	8-24
Brevity.....	8-24
Immediacy	8-24
Contact	8-25
Expectancy	8-25
Proximity	8-25
Simplicity.....	8-25
Section VIII — Safety Considerations	8-25
Chapter 9 BEHAVIOR AND PERSONALITY DISORDERS.....	9-1
Section I — Medical Readiness Responsibilities	9-1
Section II — Personality Disorders.....	9-4
Behavioral Health Status	9-4
Documenting Maladaptive Patterns of Behavior and Performance	9-4
Chapter 10 POSTTRAUMATIC STRESS DISORDER	10-1

Contents

Chapter 11	MILD TRAUMATIC BRAIN INJURY/CONCUSSION.....	11-1
	Section I — Mild Traumatic Brain Injury Overview	11-1
	Educate	11-2
	Train	11-2
	Treat.....	11-2
	Track	11-3
	Section II — Commander's Guidance for Management of Mild Traumatic Brain Injury	11-3
	GLOSSARY	Glossary-1
	REFERENCES.....	References-1
	INDEX	Index-1

Figures

Figure 7-1. Combat and operational stress effect model	7-2
--	-----

Tables

Introductory Table-1. Rescinded Army terms	vii
Table 1-1. Symptoms of closed head injuries.....	1-3
Table 2-1. Basic sleep scheduling information	2-2
Table 2-2. Basic sleep environment and related factors.....	2-3
Table 2-3. Using caffeine under various conditions of sleep deprivation	2-4
Table 7-1. Combat stressors and operational stressors	7-1
Table 7-2. Adaptive stress reactions.....	7-3
Table 7-3. Mild stress reactions	7-6
Table 7-4. Severe stress reactions	7-6
Table 10-1. Symptoms of posttraumatic stress disorder	10-1
Table 11-1. Effects of mild traumatic brain injuries, or concussions, on the Soldier and combat mission.....	11-1
Table 11-2. Injury, evaluation, and distance checklist	11-3
Table 11-3. Common mild traumatic brain injury, or concussion, signs and symptoms....	11-4

Preface

Army Techniques Publication (ATP) 6-22.5 provides commanders, leaders, and Soldiers with doctrine and techniques to establish a climate that supports and encourages a holistic and collaborative effort to improve Soldier readiness and resilience. This publication includes physical and psychological health information and references pertaining to the United States (U.S.) Army Ready and Resilient Campaign, Performance Triad, Comprehensive Soldier and Family Fitness Program, and other behavioral health programs. Information and guidance is provided to establish a command climate that reduces the stigma associated with Soldiers seeking assistance with behavioral health issues, mild traumatic brain injury, and suicide or life-threatening thoughts. Continuous operations health issues are discussed to minimize Soldier performance degradation, sleep deprivation, and nutritional deficits. This publication provides essential leader and Soldier information on behavioral health issues including combat and operational stress control (COSC); combat and operational stress reaction identification, prevention, management, and control; command and leadership tools to minimize stress and build resilience; and information pertaining to the management of posttraumatic, postcombat, and operational stress. The publication assists leaders in identifying risk factors and stressors associated with military operations and describe leader actions and preventive measures designed to reduce or eliminate associated risks and stressors. The publication covers the application of unit needs assessments, COSC management techniques, and traumatic event management that help prevent, identify, and treat stress casualties in forward areas and minimize the long-term effects of combat and operational stress reactions. The inclusion of field hygiene and sanitation information is intended to provide leaders with a foundation to plan and execute field hygiene and sanitation practices to mitigate health threats and minimize personnel losses to disease and nonbattle injury.

The principal audience for ATP 6-22.5 is commanders, their staffs, command surgeons, leaders, Soldiers, and Army civilian personnel at all levels to ensure the health and fitness of the force.

Commanders, staffs, and subordinates ensure their decisions and actions comply with applicable United States, international, and in some cases, host-nation laws and regulations. Commanders at all levels ensure their Soldiers operate in accordance with the law of war and the rules of engagement (see Field Manual [FM] 27-10).

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

Army Techniques Publication 6-22.5 uses joint terms where applicable. Selected joint and Army terms and definitions appear in both the glossary and the text. For definitions shown in the text, the term is italicized and the number of the proponent publication follows the definition. This publication is not the proponent for any Army terms.

Army Techniques Publication 6-22.5 applies to the Active Army, Army National Guard, Army National Guard of the United States, and United States Army Reserve unless otherwise stated.

The proponent and the preparing agency of this publication is the United States Army Medical Department Center and School, United States Army Health Readiness Center of Excellence. Send comments and recommendations on a DA Form 2028 (Recommended Changes to Publications and Blank Forms) to **Commander, United States Army Medical Department Center and School, United States Army Health Readiness Center of Excellence, ATTN: MCCS-FDL, (ATP 6-22.5), 2377 Greely Road, Building 4011, Suite D, JBSA Fort Sam Houston, Texas 78234-7731**; by e-mail to usarmy.jbsa.medcom-ameddcos.mbx.ameddcs-medical-doctrine@mail.mil; or submit an electronic DA Form 2028. All recommended changes should be keyed to the specific page, paragraph, and line number. A rationale should be provided for each recommended change to aid in the evaluation of that comment.

Introduction

Current combat operations and a U.S. Army transformation resulted in an institutional shift in how leaders view, approach, and manage the effects of Soldier health, readiness, and resilience. Commanders are responsible to establish and maintain an environment that encourages holistic efforts from leaders, Soldiers and Family to improve health, readiness, and resilience. Combat and operational stress control has always been a commander's program and to be successful, commanders must fully understand and appreciate the magnitude of a potentially traumatic event and its effect on exposed organizations and individuals. It is a harsh reality that combat and operational stress affects everyone engaged in unified land operations. No Soldier or Family member remain unchanged. It should be viewed as a continuum of possible outcomes that each person's experience with a range from positive growth behavior 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, 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 allowing Soldiers to maintain the quality of life to which they are entitled.

Army Techniques Publication 6-22.5 consists of 11 chapters as follows:

Chapter 1 provides an overview of the Army's Ready and Resilient Campaign that integrates and synchronizes multiple Army health promotion and behavioral health initiatives. It provides leaders with information and resources specific to the medical aspects of the program.

Chapter 2 is a new chapter that provides leaders with the resources and information on the Army's Surgeon General's Performance Triad initiative to transform the Army Medical Department's health care system to a system of health emphasizing wellness and preservation of health. This chapter discusses the three major components of the program—sleep, activity, and nutrition.

Chapter 3 discusses the Comprehensive Soldier and Family Fitness Program and provides information and resources to assist leaders in improving the Soldier's physical and psychological health.

Chapter 4 provides information and resources pertaining to potentially life threatening behavioral changes that may be present when a Soldier, Family member, or Army Civilian may be exhibiting suicidal behavior.

Chapter 5 provides leaders with information and resources pertaining to the Army Health Promotion Program. This chapter focuses on the integration of preventive and public health practices to maximize readiness, resilience, and performance.

Chapter 6 provides information and references for leaders to prevent disease and nonbattle injury with effective preventive medicine measures and command involvement.

Chapter 7 provides leaders with information and references to successfully implement a COSC program. This chapter discusses combat and operational stress reaction identification and techniques for leaders to prevent or manage stress.

Chapter 8 describes leadership requirements and actions to support combat and operational stress control programs. It provides information on unit behavioral health needs assessments and methods to techniques to minimize stress within the organization with an effective COSC program.

Chapter 9 discusses behavior and personality disorders that may represent a health condition that limits the Soldier's physical or psychological ability to plan, train, or execute their mission.

Chapter 10 provides leaders with information pertaining to posttraumatic stress disorder (PTSD). Leaders are provided information on symptoms of PTSD and resources to assist Soldiers in obtaining assistance.

Chapter 11 provides leaders with an overview on mild traumatic brain injuries programs, policy guidance, mild traumatic brain injury identification, and medical guidance.

Introductory Table-1. Rescinded Army terms

<i>Term</i>	<i>Remarks</i>
battlemind	Deleted
battlemind warrior resilience	Deleted

This page intentionally left blank.

Chapter 1

Ready and Resilient Campaign

This chapter discusses the U.S. Army Ready and Resilient Campaign's objective to integrate and synchronize multiple Army health promotion and behavioral health initiatives. The campaign's objective is to enhance unit and individual readiness and resilience by improving upon the physical, emotional and psychological resilience of Soldiers, Families, and Army Civilians. The campaign integrates and synchronizes multiple Armywide initiatives such as the Performance Triad program, Comprehensive Soldier and Family Fitness, and other health and behavioral health programs, discussed in later chapters of this book, to enhance unit readiness and improve Soldier readiness and resilience.

SECTION I — MEDICAL READINESS

1-1. The physical and psychological health of Soldiers, Family and Army Civilians is a significant part of the U.S. Army Ready and Resilient Campaign. The Army Medical Department provides resources to assist Soldiers, Families, and Army Civilians to obtain treatment and provide guidance in matters including behavioral health, PTSD, traumatic brain injury, pain management, and polypharmacy.

BEHAVIORAL HEALTH

1-2. The Army's current behavioral health system is in the process of transforming its model of care to an enhanced proactive and integrated patient-centered system of care. The transformation to a behavioral health system of care provides standardized naming and function alignment, centralized resource management, continuous improvement through standardized metrics, and provides a review and analysis process. The new behavioral health system of care provides the following resources:

- Embedded Behavioral Health—Behavioral health personnel are aligned with units delivering behavioral health services in close proximity to the Soldier's unit. For additional information on this subject refer to the Army Medicine, Embedded Behavioral Health Web site identified in the references section of this publication.
- Tele-Behavioral Health—Provides behavioral health services through the use of technology to deliver clinical behavior health services at a distance via electronic communication systems. For additional information on this subject refer to the Army Medicine, Tele-Behavioral Health Web site identified in the references section of this publication.
- Addictions Medications Residential Treatment—Provides residential care for individuals with substance abuse disorders.
- Addictions Medications Intensive Outpatient Program—Provides treatment for substance abuse disorders that exceed the treatment capability of outpatient care in the Army Substance Abuse Program. *Outpatient* is a person receiving medical/dental examination and/or treatment from medical personnel and in a status other than being admitted to a hospital. Included in this category is the person who is treated and retained (held) in a medical facility (such as Role 2 facility) other than a hospital (FM 4-02). For additional information on the subject refer to the Army Substance Abuse Program Web site identified in the references section of this publication.
- Psychological Health Intensive Outpatient Program—Provides treatment for patient that display psychological conditions exceeding the outpatient treatment capabilities but does not require inpatient hospitalization. A *patient* is a sick, injured or wounded Soldier who receives medical care or treatment from medically trained personnel (FM 4-02).

- Multi-Disciplinary Outpatient Behavioral Health Clinic—Provides routine outpatient behavioral health services, neuropsychology, forensics, and support to Warrior Transition Units, and other outpatient missions.
- Inpatient Behavioral Health—Provides inpatient behavioral health service to address acute crisis and rapid symptom resolution to support safe transfer of care to outpatient settings.
- School Behavioral Health—Provides early intervention of behavioral health service to military children.
- Child and Behavioral Health Services—Provides outpatient behavioral health care and consultation and education to active duty Family members to create a behavioral health system of care promoting healthy, strong children and Families. For additional information on this subject refer to the Army Medicine, Child, Adolescent, and Family Behavioral Health Service Web site identified in the references section of this publication.
- Family Advocacy Program—Prevents and provides care for victims of domestic violence or neglect and provides marriage and Family therapy programs. This resource may also provide behavioral health personnel trained in sexual assault response and victim treatment. For additional information on this subject refer to the Army Medicine, Family Advocacy Program Web site (identified in the references section of this publication) and Army Regulation (AR) 608-18. For doctrinal information pertaining to the employment and capabilities of behavioral health resources in brigade combat teams as well as COSC detachments refer to ATP 4-02.3.

POSTTRAUMATIC STRESS DISORDER

1-3. Posttraumatic stress disorder is an anxiety disorder that can occur following a traumatic event such as combat, disasters, accidents or other life threatening events in which there was a threat of injury or death to you or someone else. All Soldiers have reactions after combat. These reactions are normal and usually resolve quickly. Typical symptoms include hypervigilance, intrusive thoughts, flashbacks, numbness, avoidance, and nightmares. Posttraumatic stress disorder is treatable and with the proper care the Soldier or patient returns to a healthy, productive and satisfying life. For additional information on this subject refer to Chapter 10 of this publication and the Army Medicine, Behavioral Health Web site identified in the references section of this publication.

TRAUMATIC BRAIN INJURY

1-4. Traumatic brain injuries are often referred to as the invisible wounds of war and are defined as a disruption of brain function resulting from a blow or jolt to the head or penetrating head injury. Soldiers are exposed to combat-related traumatic brain injuries by blast exposures from improvised explosive devices, mines, mortars, rocket-propelled grenades, other projectiles and motor vehicle accidents. Traumatic brain injuries represent a significant health issue that is not restricted to the confines of the battlefield. Soldiers, Family members, as well as Army Civilians are exposed to possible off the battlefield traumatic brain injuries during physical training, sports activities, leisure activities, motorcycle and motor vehicle accidents, playground accidents, falls and accidents at home.

1-5. Traumatic brain injuries are categorized as closed or penetrating head injuries. A closed head injury is caused by a blow or jolt to the head that does not penetrate the skull. Penetrating, as the word infers, occurs when an object goes through the skull and enters the brain. Closed head injuries are further classified as mild (also known as a concussion), moderate, and severe.

1-6. A diagnosis of mild traumatic brain injury, or concussion, would include symptoms of a confused or disoriented state that lasts less than 24 hours; loss of consciousness for up to 30 minutes; memory loss lasting less than 24 hours; and structural brain imaging by magnetic resonance imaging or computed tomography yielding normal results. This type of traumatic brain injury is the most prevalent of all the closed head injuries and with appropriate medical care, rest, nutrition, and sleep has a significantly high return to duty rate. This injury may also be one of the most difficult head injuries for leaders to identify, which if undiagnosed, may lead to significant degradation of Soldier performance. *Return to duty* is a patient disposition which, after medical evaluation and treatment when necessary, returns a Soldier for duty

to his unit (FM 4-02). Additional information on mild traumatic brain injury is referenced in Chapter 11 of this publication.

1-7. Moderate traumatic brain injury is defined as a confused or disoriented state more than 24 hours; loss of consciousness for more than 30 minutes and memory for more than 24 hours but less than seven days.

1-8. Severe traumatic brain injury is defined as a confused or disoriented state which lasts more than 24 hours; loss of consciousness for more than 24 hours; memory loss for more than seven days; and structural brain imaging yielding normal or abnormal results.

1-9. The Department of Defense (DOD) and the U.S. Department of Veterans Affairs recognize traumatic brain injury as a significant health issue affecting the Soldier, their immediate and extended Family, unit readiness, and limited medical resources. In a collaborative effort the agencies developed the Defense and Veterans Brain Injury Center to provide information to Service members and veterans on traumatic brain injury. The Defense and Veterans Brain Injury Center Web site, identified in the references, provides current information for Service members, veterans, Family, and medical providers pertaining to the latest research on traumatic brain injuries, treatment locations and outreach numbers for immediate assistance.

1-10. The Army Medical Department implemented comprehensive policies and medical management systems to mitigate the short- and long-term effects of traumatic brain injuries. Army medicine collaborates with, and leverages its partnerships with key DOD and civilian organizations to improve its ability to diagnose, treat and care for those affected by traumatic brain injury.

1-11. The Army's policies and management systems leads the nation in recognition and treatment of traumatic brain injuries through aggressive research and clinical capability. Because Army medicine is at the cutting edge of identifying brain injuries with a comprehensive policy and medical management system, most Soldiers are medically cleared and ready to return to duty due to early identification and treatment regimens. Research shows that traumatic brain injuries, especially concussions, are overwhelmingly treatable; however, receiving prompt care, regardless of severity, is essential in maximizing recovery.

1-12. Table 1-1 differentiates the symptoms of each type of head injury by defining the injury by time increments and three major head injury symptoms—confusion, loss of consciousness, and memory loss.

Table 1-1. Symptoms of closed head injuries

	Confusion	Loss of consciousness	Memory loss
Mild traumatic brain injury	< 24 hours	≤ 30 minutes	< 24 hours
Moderate traumatic brain injury	> 24 hours	> 30 minutes	> 24 hours < 7 days
Severe traumatic brain injury	> 24 hours	> 24 hours	> 7 days

1-13. Penetrating traumatic brain injury is defined as a head injury in which the skull and dura mater, the first of three membranes surrounding the brain, are penetrated. Penetrating brain injuries require immediate medical attention and evacuation to a Role 3 or Role 4 medical treatment facilities. A *medical treatment facility* is any facility established for the purpose of providing medical treatment. This includes battalion aid stations, Role 2 facilities, dispensaries, clinics and hospitals (FM 4-02).

1-14. Refer to the Defense and Veterans Brain Injury Center Web site identified in the references for additional information on closed head injuries treatment and support resources.

PAIN MANAGEMENT

1-15. The Army's Surgeon General chartered an Army Pain Management Task Force in 2009 to initiate the development of a comprehensive pain management strategy that improved and optimized the quality of life for Soldiers and other patients with acute and chronic pain. The study resulted in recommendations to design and implement a pain management program that integrates conventional medical treatments with complementary therapies to include acupuncture, medical massage, movement therapy, and bio-feedback. The intent of the program is to manage pain, promote health and decrease the need for medications.

1-16. The pain management program addresses issues related to overuse and abuse of prescription medications. The abuse of prescription medications and their association with behavioral changes, occupational difficulties, accidental overdose, disciplinary problems, and suicide are concerns for both the health care providers and commanders. The pain management program intent is not to vilify opioids but manage pain with a synchronized, educational, and proactive intervention program between health care providers, commanders, and Soldiers.

POLYPHARMACY

1-17. The increased use of prescription drugs, specifically psychotropic medications and central nervous system drugs, is a public health concern and one of many factors that contribute to medication overdoses. Risks associated with some of the medications include misuse and abuse, physical and psychological dependence, possible withdrawal and cognitive impairment. Members of the health care team should carefully consider these risk factors when prescribing from one or more of these classes of drugs.

1-18. The Army Medical Department developed guidance for managing polypharmacy and preventing medication overdose in Soldiers prescribed psychotropic medications and central nervous system depressants in the OTSG/MEDCOM Policy Memorandum 13-032. The policy and programs are based on the identification of the following three conditions defining polypharmacy:

- Prescriptions for four or more of any type medication, including one or more opioids within the previous 30 days.
- Prescriptions for four or more medications from seven categories of psychotropic, and central nervous system depressants (opioid, stimulant, anxiolytic, antidepressant, antipsychotic, anticonvulsant, or sleep medication) within the previous 30 days.
- Three or more emergency room visits in the past year in which an opioid was prescribed at each visit.

1-19. The Army has recognized an increased use of prescription drugs to include psychotropic and central nervous system depressants. Risks associated with this type of medication include misuse, abuse, physical as well as psychological dependence, potential for withdrawal, and cognitive impairment. To manage the risks associated with some of these medications the Army Medical Department developed and implemented the OTSG/MEDCOM Policy Memorandum 13-032. The policy was developed to manage adverse events, optimize clinical outcomes among Soldiers receiving care in the Military Health System, and enhance polypharmacy screening, management, and education.

1-20. The policy defines the responsibilities of commands, primary care managers, health care providers, and clinical support staff, nursing personnel, pharmacists, the Soldier and Soldier's commander. The Soldier must take an active responsibility for their care through open communication with their primary care physician, health care providers, and commanders. Soldiers interact and coordinate with their primary care physician to establish and adhere to treatment and health goals. Commanders actively communicate with the Soldier and the Soldier's primary care physician on issues of medical concern and consider limitations established due to medication related profiles.

1-21. Soldier deployments, relocations and emergencies add challenges to managing polypharmacy programs. A primary physician or other medical provider should monitor a patient's prescriptions, over-the-counter medications, and herbal medications to manage the risks associated with their pharmaceutical interactions, side effects, and potential for misuse.

SECTION II — PERSONNEL READINESS

1-22. The Army Medical Department supports personnel readiness with medical resources and programs in support of the Army's Suicide Prevention Program, Comprehensive Soldier and Family Fitness Program, Deployment Health Assessment Programs, and individual medical readiness.

SUICIDE PREVENTION

1-23. Suicide prevention is a commander's program and has shared responsibilities between leaders, Soldiers, Family members, and Army Civilians. The program encourages and challenges all members to recognize the suicidal warning signs, intervene, eliminate the stigma for seeking assistance, and act to save lives.

1-24. Soldiers, Family members, and Army Civilians, may deal with the pressures of persistent conflicts, deployments, financial and relationship problems, substance abuse, PTSD, injuries, pain and legal issues. Although many have the resilience to work through their issues, some may need assistance to manage the stressors associated with their issues. The Army's goal is to prevent suicides through a suicide risk reduction program to lower the probability that an individual engages in self-destructive behavior.

1-25. The Army Deputy Chief of Staff and Army Medical Department are committed to providing the tools and resources for commanders and leaders to educate and train Soldiers in suicide risk reduction. For additional information refer to the Department of the Army Pamphlet (DA Pam) 600-24, and the Army Public Health Center (Provisional), Suicide Prevention Program Web site identified in the references section of this publication. Additional information on suicide prevention is available in Chapter 4 of this publication as well as AR 600-63, AR 350-1, and DA Pam 600-24.

COMPREHENSIVE SOLDIER AND FAMILY FITNESS PROGRAM

1-26. The Comprehensive Soldier and Family Fitness Program is a key component of the United States Army Ready and Resilient Campaign and is a training program designed to improve physical and psychological health, build resilience, and enhance performance of Soldiers, Families, and Army Civilians. Chapter 3 of this publication provides detailed program and medical information on the Comprehensive Soldier and Family Fitness Program.

DEPLOYMENT HEALTH ASSESSMENT PROGRAM

1-27. The Deployment Health Assessment Program provides commanders with resources to identify physical or behavioral health concerns of Soldiers, Army Civilians, and contractors during the deployment cycle. The assessment is designed to increase the Soldier and Army Civilian well-being and resilience through early detection of health concerns and to assist the individual in accessing medical or behavioral health resources. The program was designed to address deployment health conditions such as PTSD, traumatic brain injury, depression, combat-related injuries, and substance abuse. For additional information on the conduct, time lines and regulatory requirements of this program refer to the Deployment Health Assessment Program Web site (identified in the references section of this publication) and to Department of the Defense Instruction (DODI) 6490.03.

1-28. Deployment health assessments are required for all Soldiers, Army Civilians, and contractors deployed in support of a contingency operation outside the U.S. The deployment health assessments are comprised of three individual assessments administered during different phases of the deployment as follows:

- Predeployment Health Assessment—Provides demographic and medical information on the individual prior to deployment. The information is recorded on a DD Form 2795 (Pre-Deployment Health Assessment) and reviewed with the individual by a trained health care provider. A trained health care provider assesses the individual and information for early identification of physical or behavioral health concerns. For additional information on the health assessments refer to the Deployment Health Clinical Center Web site and Army Medicine, Behavioral Health Web site identified in the references section of this publication.
- Postdeployment Health Assessment—Provides demographic and medical information on the individual returning from deployment and concentrates on physical and behavioral concerns from the deployment. The information is recorded on a DD Form 2796 (Post Deployment Health Assessment [PDHA]) and reviewed with the individual by a trained health care provider. The assessment documents health issues and identifies medical or behavioral health referrals. For additional information on the postdeployment health assessment refer to the Deployment

Health Clinical Center Web site and Army Medicine, Behavioral Health Web site identified in the references.

- Postdeployment Health Reassessment—Provides demographic and medical information on the individual 90 to 180 days after returning from deployment and screens for health issues that may not have been apparent during the postdeployment assessment or evolve over time. The information is recorded on a DD Form 2900 (Post Deployment Health Re-Assessment [PDHRA]) and reviewed with the individual by a trained health care provider. The issues include behavioral health concerns, traumatic brain injuries, PTSD, physical injuries, environmental expositors, suicidal thoughts, and substance abuse. For additional information on the Postdeployment Health Reassessment, refer to the Deployment Health Clinical Center Web site and Army Medicine, Behavioral Health Web site identified in the references.

1-29. For information on the conduct, time lines, and regulatory requirements of this program refer to the Deployment Health Assessment Program Web site identified in the references.

INDIVIDUAL MEDICAL READINESS

1-30. Soldiers are responsible for maintaining their health and fitness, meeting individual medical readiness requirements, and reporting medical and behavioral health issues that may affect their readiness to deploy or fitness requirements to serve in an active status. Soldiers are responsible to verify the documentation of this information during their periodic health assessment and predeployment health assessment. Soldiers also authorize and facilitate the release of health care information from non-DOD health care providers and transfer of this information to the Military Health System. Defined and measurable medical elements are developed to report and monitor individual medical readiness. They include the following:

- Personnel health assessments.
- Deployment-limiting medical and dental conditions.
- Dental assessments.
- Medical readiness and laboratory studies.
- Individual medical equipment.

1-31. Commanders are authorized to have access to individual medical readiness data to monitor the Soldier's medical readiness and deployability and initiate preventive services as warranted. The specific requirements of the health and dental assessments and individual medical readiness categories are described in DODI 6025.19.

Chapter 2

Performance Triad

The Performance Triad Program supports The Army Surgeon General's initiative to transform the Army Medical Department's focus from a health care system to a system of health that emphasizes wellness and preservation of health. The program supports the Army's commitment to assist Soldiers, Families, retirees and Army Civilians to live healthier lives by attaining a restful sleep pattern, increasing their activity, and making informed nutritional choices. This chapter discusses the three major components of the Performance Triad—sleep, activity, and nutrition. Additional information on the Performance Triad Program and is available on the Army Public Health Center (Provisional) and on the Army Medicine, Performance Triad Web site listed in the references section of this publication.

SECTION I — SLEEP

2-1. 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 and applies to all levels of military operations, to include both training and tactical environments. This section assists commanders, leaders, and Soldiers in developing, managing, and executing a comprehensive and effective sleep plan.

SLEEP MANAGEMENT IN THE OPERATIONAL ENVIRONMENT

2-2. 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 accumulate a sleep debt (the difference between the amount of sleep you should have received and the amount of sleep you actually received) over time that seriously impairs their performance. The only way to eliminate or reduce the sleep 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 model is applicable for all levels of military operations including basic training and in all operational environments.

2-3. 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.

2-4. 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 becomes prone to making mistakes. 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.

2-5. 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 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.

2-6. 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.

SLEEP ENVIRONMENT AND CRITICAL FACTORS RELATED TO GOOD SLEEP HYGIENE

2-7. 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.

2-8. Basic sleep scheduling information for planning sleep routines during all activities (predeployment, deployment, precombat, combat, and postcombat) is provided in Table 2-1. Basic sleep environment information and other related factors are provided in Table 2-2 on page 2-3.

Table 2-1. Basic sleep scheduling information

Factor	Effect
Timing of sleep period	<ul style="list-style-type: none"> Because of the body's natural rhythms (called <i>circadian</i> rhythms), the best quality and longest duration sleep is obtained during nighttime hours (2300 to 0700). These rhythms also make daytime sleep more difficult and less restorative, even in sleep-deprived Soldiers. The ability to fall and stay asleep is impaired when bedtime is shifted earlier (such as from 2300 to 2100 hours). This is why eastward travel across time zones initially produces greater deficits in alertness and performance than westward travel.
Duration of sleep period	<ul style="list-style-type: none"> IDEAL sleep period equals 7 to 8 hours of continuous and uninterrupted nighttime sleep each and every night. MINIMUM sleep period—there is no minimum sleep period. Anything less than 7 to 8 hours per 24 hours results in some level of performance degradation.
Napping	<ul style="list-style-type: none"> Although it is preferable to get all sleep over one sustained 7 to 8 hours 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 to 0700 hours plus nap 1300 to 1500 hours. Good nap zones (when sleep onset and maintenance is easiest) occur in early morning, early afternoon, and nighttime hours. 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. 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. There is no such thing as <i>too much sleep</i>—mental performance and alertness always benefit from sleep. Napping and sleeping when off duty are not signs of laziness or weakness. They are indicative of foresight, planning, and effective human resource management.
Prioritize sleep need by task	<ul style="list-style-type: none"> TOP PRIORITY is leaders making decisions critical to mission success and unit survival. Adequate sleep enhances both the speed and accuracy of decisionmaking. SECOND PRIORITY 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. THIRD PRIORITY is Soldiers performing duties involving only physical work.
Individual differences	<ul style="list-style-type: none"> Most Soldiers need 7 to 8 hours of sleep every 24 hours to maintain optimal performance. Most leaders and Soldiers underestimate their own total daily sleep need and fail to recognize effects that chronic sleep loss has on their own performance.

Table 2-2. Basic sleep environment and related factors

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

COUNTERMEASURES TO MAINTAIN PERFORMANCE DURING PERIODS OF INADEQUATE SLEEP

2-9. Cold air, noise, and physical exercise may momentarily improve a Soldier's feeling of alertness, but they do not improve performance.

2-10. The only countermeasures that effectively improve performance during sleep loss are stimulants (caffeine and prescription stimulants). 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

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

2-12. Caffeine occurs in varying content in a number of drinks, gums, and nonprescription stimulants such as—

- Caffeinated soda.
- Caffeine tablets.
- Caffeine gum.
- Energy drinks.

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

2-13. Sleep loss effects are most severe in the early morning hours (0600 to 0800). Countermeasures against sleep loss, such as caffeine, are often required and are very effective during this early morning lull.

2-14. Table 2-3 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 2-3. Using caffeine under various conditions of sleep deprivation

Condition under which caffeine is used	Guidelines for use
Sustained operations (no sleep)	<ul style="list-style-type: none">• 200 milligrams starting at approximately midnight.• 200 milligrams again at 0400 hours and 0800 hours, if needed.• Use during daytime hours only if needed.
Night shifts with daytime sleep	<ul style="list-style-type: none">• 200 milligrams starting at beginning of nighttime shift.
Restricted sleep	<ul style="list-style-type: none">• 200 milligrams upon awakening.• 200 milligrams again 4 hours later.• Discontinue or reduce caffeine intake for the last 4 to 6 hours before initiating sleep.

SLEEP RECOVERY

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

2-16. Following chronic, restricted sleep during continuous operations, Soldiers may need several days of 7 to 8 hours nightly sleep to fully recover.

WORK SCHEDULES

2-17. Usual work schedules are 8 hours on and 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.

2-18. 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 with 16 hours off schedule is not possible, the next best schedule is 12 hours on and 12 hours off. In general, 12 hours on and 12 hours off is superior to 6 hours on and 6 hours off, and 8 hours on and 16 hours off is superior to 4 hours on and 12 hours off. This is true because time off is consolidated into a single, longer block.

2-19. On and off shifts should total 24 hours. Shifts that result in shorter or longer days (such as 6 hours on and 12 hours off—an 18-hour day) impair the Soldiers alertness and performance.

NIGHT SHIFT WORK

2-20. Soldiers experience difficulties adapting completely to night shift work, even if they are on a fixed night shift. To protect Soldiers' daytime sleep, the commander should not attempt to schedule briefings, meals, and Soldiers' routine maintenance duties during the Soldiers' sleep time. Caffeine can be used during the night shift to improve performance. Morning daylight exposure in night shift workers coming off shift should be avoided by wearing sunglasses or tinted military combat eye protection from sunrise until the Soldier begins daytime sleep.

2-21. Trying to preadapt sleep and performance to a new time zone by changing sleep and wake schedules ahead of time to fit the new time zone is of little benefit.

2-22. During travel, a Soldier's sleep time should be protected. Avoid interruption of sleep during travel by proactive planning that minimizes any sleep interruptions including feeding.

2-23. After deploying to a new time zone, sleep and performance adaption are effected for several days. During this time, Soldiers might also experience gastrointestinal disturbances and find it difficult to fall asleep and stay asleep at night.

2-24. When reaching the new time zone, Soldiers should—

- Immediately conform to the new time zone schedule (for example, for those on day shift, sleep only at night).
- Avoid daytime naps. Sleeping during the day makes 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.

SLEEP LOSS

2-25. Sleep loss may result in the impairment of mental and physical activities and is dependent upon many individual factors. Commanders and Soldiers need to understand the impact of sleep loss and may have on an individual ability to perform assigned tasks and missions.

ASPECTS OF PERFORMANCE IMPAIRED BY SLEEP LOSS

2-26. 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.

2-27. 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).
- Mission command activity (directing location repositioning, directing mounted defense, or assigning fire zones and targets).

2-28. 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 are eventually impaired.

2-29. 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. Sleep-deprived commanders and Soldiers are poor judges of their own abilities.

2-30. Sleep loss may impair a Soldier's ethical judgment. Soldiers experiencing sleep loss are hindered in their ability to respond quickly and appropriately when faced with an ethical dilemma. If given enough

time to think about their actions, Soldiers 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

2-31. Sleep can be measured by having Soldiers keep a sleep log, but compliance is likely to be very low and reliability is poor. 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 and motivation, and decreased attention to personal hygiene.

2-32. Sleep loss can be confirmed by asking the obvious question: "When did you sleep last and how long did you sleep?" or "How many hours of 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.

2-33. 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

2-34. 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 experiences the same impairment as if he had stayed awake continuously for 24 hours.

2-35. 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.

2-36. 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.

2-37. 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 command post). Sleep that is obtained in dark, quiet environments is more efficient (more restorative per minute of sleep). 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. *Train as you fight* does not work for sleep loss—training in a sleep-deprived state reduces learning and training effectiveness.

SLEEP LOSS ALTERNATIVES

2-38. Ways to overcome performance degradation include—

- Find time for Soldiers to nap, change routines, or rotate jobs (if cross-trained), if signs of diminished performance are evident.
- 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.
- Allocate sleep by priority.

2-39. 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. Third priority is Soldiers performing duties involving only involving physical work.

SECTION II — ACTIVITY

2-40. Activity is a major component of the Performance Triad. The emphasis on Soldier's activity and resultant physical fitness enhancement are important aspect of the United States Army Ready and Resilient Campaign. Physical activity builds strength and increases stamina resulting in improved individual and unit readiness. Regular exercise and physical activity can lead to long-term health benefits and reduce your risk for many chronic diseases, such as depression, diabetes, heart disease, high blood pressure, obesity, stroke and some forms of cancer. Additional information on physical readiness training is referenced in FM 7-22 and AR 350-1.

PHYSICAL TRAINING PROGRAMS

2-41. Commanders should develop and implement physical training programs with the intent to improve on the physical conditioning of the Soldier but also with the intent to avoid injuries. Injuries from physical activities (such as physical training and sports) are the third leading cause for Soldier hospitalizations. Although it is not feasible to prevent every injury, commanders should consider the following factors in developing physical fitness and activity programs:

- Gradually increase intensity and duration of workouts as conditioning improves.
- Vary activities to include activities combining strength, endurance, and mobility training.
- Wear the appropriate protective gear when participating in high risk activities, such as combatives, football, basketball, boxing, soccer, and extreme sports.
- Design training calendars considering total daily physical demands and recovery time.
- Request assistance of a physical therapist to analyze injury risk, minimize injuries, and optimize human performance.
- Coordinate with health care providers to ensure temporary profiles include alternative and prohibited physical activities.

2-42. Physical readiness training provides the opportunity to train Soldiers to meet the physical demands of combat or their duty positions and to accomplish the unit mission. Physical readiness training builds strength, power, speed, and agility preparing the Soldier to perform wartime tasks throughout the range of military operations.

2-43. Three principles of readiness training commanders need to consider when developing and conducting the training are—

- Precision. Train proper techniques to reduce injury.
- Progression. Gradually increase training intensity and duration to allow the body to adapt to the activity.
- Integration. Includes a variety of activities to achieve balance in the development of strength, endurance, and mobility.

2-44. The training requires emphasis on the three major components of the program—strength, endurance, and mobility. When combined, these components increase muscular strength and endurance, aerobic and anaerobic conditioning, endurance, and mobility.

2-45. Physical readiness training requires activities that minimize the risk of injuries while maximizing Soldier performance. Technical Bulletin Medical (TB MED) 592, details the roles for health care providers in reducing the risk of physical training injuries. Health care providers—

- Assist commanders and leaders with alternative physical activities to minimize Soldier's risk of injury.
- Provide training in injury risk factors, signs and symptoms of musculoskeletal injuries, and self-treatment techniques.
- Assist commanders in analyzing sick call and profile rates, injury-incidence, and trends and advises commanders of changes in the health status of the command.

- Monitor the types of injuries and prescribed medications.
- Provide medical recommendations pertaining to training restrictions and alternate exercises for Soldiers recovering from injuries or illness.

FUNCTIONAL FITNESS PROGRAM

2-46. Functional fitness is a commander's training program designed with specific exercises and activities that correlate to the physical movement, and skills required when performing specified Soldier tasks. Functional fitness emphasizes exercises in movement, endurance and strength for mission accomplishment, core stability and reduction in musculoskeletal injuries.

2-47. Developing and maintaining a functional fitness program requires a coordinated effort between the commander, health care providers, and master fitness trainers. The program should be designed to provide the endurance or strength training required to perform Soldier tasks and scalable to allow for different levels of fitness and physical conditioning.

2-48. Department of the Army civilians are encouraged to maintain their fitness and health by participating in exercise programs and maintaining healthy lifestyles. Selected civilian occupational specialties requiring physical strength and stamina may have a physical exercise program as part of the job and the employee may be authorized to participate in an exercise program during duty hours. Army Regulation 600-63 provides commanders and supervisors with the authority to approve up to three hours administrative leave weekly for civilians participating in command-sponsored physical exercise and training for a period of no more than six months in duration. The regulation also provides that Army Civilians, not subject to mandatory physical fitness standards, may use physical fitness and other recreational facilities on a space available basis at no cost to the government.

2-49. For additional information and specifics and administration of Army Civilian fitness and health programs refer to the Army Civilian Personnel Office Web site identified in the references section of this publication.

SECTION III — NUTRITION

2-50. Nutrition and hydration have a direct impact on Soldier fitness and endurance. Nutrients, derived from food sources, provide the essential substances to maintain the functioning of the body while proper hydration provides a balance between the body's water and electrolyte requirements. Commanders and Soldiers need to recognize the correlation between proper nourishment and hydration with positive performance benefits and conversely the performance detriments caused by poor nutrition and hydration habits.

NUTRITIONAL GUIDANCE

2-51. There are three main sources of nutrients that provide the body with energy; carbohydrates, fats, and proteins. These nutrients are referred to as macronutrients, which are essential nutrients required by the body in relatively large amounts to produce energy as follows:

- Carbohydrates—Preferred food for endurance and resistance training.
- Fat—Provides taste to food, satisfies hunger, and absorbs certain vitamins.
- Protein—Provides for building new tissue and tissue repair.

2-52. A Soldier's nutritional management or choices can be influenced by nutritional education and the availability of healthy food selections. Soldiers are provided training and educational tools to make well-informed choices in their nutritional selection and consumption of food. The Army has implemented programs to assist Soldiers in making better nutritional choices and offers healthy options in dining facilities, commissaries, fitness centers, fast food restaurants, snack shops, convenience stores, vending machines, and worksites. One of the programs is the Military Nutrition Environment Assessment Tool (see Web site in the references section of this publication), which measures the availability of healthy nutritional choices and healthy environmental factors associated with healthy eating. This is an installation leadership tool assessing the support and success of the policies and practices supporting a healthy

nutritional program. Commanders at all levels are encouraged to create worksite policies and environments that promote healthier food and beverage choices.

2-53. Go for Green is another nutritional program providing Soldiers eating in a dining facility with a food recognition labeling system that details the nutritional value of menu offerings. The menu offering are green (eat often) amber (eat occasionally) and red (eat rarely) based on the impact under this system that food can have on a Soldier. Green labels identify high performance foods while amber labels identify moderate performance foods. Red labels identify foods that are low performance or empty calories. The Go for Green Program provides information on entrees, starches, vegetables, desserts, beverages, dairy, and condiments. All food groups should be eaten in moderation and should also represent a balanced meal with appropriate hydration. Army Regulation 30-22 prescribes commander and leaders roles in support of nutritional programs.

2-54. Eating for performance maximizes a Soldiers cognitive, physical performance and resiliency without compromising long-term health. Performance nutrition can increase energy and endurance and decrease recovery time between activities. Proper nutritional management supports muscle growth and recovery, tissue repair, immune function, reduction in the risk of chronic diseases, and weight management. Performance nutrition combined with nutrient timing, eating, and hydrating, according to the work performed, helps the body recover from physical activity and ensures the brain and muscles receive the energy they need to perform. Soldiers require additional high performance nutrients every 3 to 5 waking hours and within 30 to 60 minutes after exercising or completing a mission. The nutrients are essential to rebuilding muscle and tissues as well as replenishing the body's energy. Commanders should plan for Soldier nutritional requirements before and after training or missions and provide Soldiers sufficient time to—

- Eat and provide a healthy selection of high performance nutritional food.
- Recover from training or missions with high performance snacks and hydration.

2-55. Army Regulation 40-25/BUMEDINST 10110.6/AFI 44-141, directs The Surgeon General, in collaboration with the other Services, to establish the nutritional standards for meals served to military personnel and the requirement to provide Soldiers nutrition education as part of human performance optimization. This regulation establishes DOD menu standards that are minimum guidelines required for use by military food service programs during menu planning, food procurement, food preparation, and meal service programs. The regulation establishes military dietary reference intakes, which are nutritional-standards designed specifically to meet the unique needs of military personnel in an operational area.

2-56. The four major categories of rations include individual, assault, group, and special purpose rations. Information on each ration's purpose, characteristics, nutritional content, and preparation requirements are described in the U.S. Army Natick Soldier Systems Center Natick Pamphlet 30-25.

2-57. Proper planning and execution of feeding practices in garrison and the field impacts physical and cognitive performance as well as morale. Military leaders must understand basic nutrition as well as available ration options to ensure Soldiers are properly nourished for successful mission completion. Additionally, leaders must ensure Soldiers know the importance of nutrition in maintaining health and optimizing performance.

DIETARY SUPPLEMENTS

2-58. Dietary supplements are products consumed orally and contain dietary ingredients such as minerals, vitamins, enzyme supplements, amino acids, herbs, or other products. The supplements are used by Soldiers for a variety of reasons to include body building, weight loss, and controlling the effects of diseases. The supplements do not require Food and Drug Administration approval, but they do recommend consulting with a health care provider prior to using the dietary supplement. Using dietary supplements improperly can be harmful and actually decrease a Soldiers performance. Some of the supplements may have an adverse effect when taken with medications or when used as a substitute for prescribed medication. Some dietary supplements have potential side effects of bleeding and increasing the effects of anesthetics.

2-59. If Soldiers take dietary supplements they should—

- Consult with health care professional prior to using the supplement.
- Read the labels for product safety.
- Understand the significance of combining supplements with other supplements or medicine.
- Research supplements for benefits, alerts and government warnings, safety alerts, and other resources. For additional information refer to the Human Performance Resource Center Web site identified in the references section of this publication.

HYDRATION

2-60. Proper hydration is essential to a Soldier's performance. Performance may be affected by as little as a one percent dehydration (measured as change in body weight). This water loss degrades a Soldier's cognitive functions, increases tension, anxiety, and fatigue, and increases errors in visual vigilance. Two percent dehydration has a definite effect on cognitive functions, mood and fatigue. A Soldier can easily become dehydrated when performing physical exercise or activities in extreme environments through sweat, respiration and urination. For additional information on hydration refer to the nutrition and dietary supplement sections of the Human Performance Resource Center Web site.

2-61. Dehydration prevention is both the commander's and Soldier's responsibility. The first step in this prevention program is educating the Soldier on the steps to prevent dehydration. Soldiers can prevent dehydration by—

- Monitoring their fluid loss (weighing before and after physical activity, urine color).
- Drinking water before, during, and after exercise or other strenuous activity.
- Selecting plain water to replenish fluids if the activity is 60 minutes or less.
- Selecting a sports drink for water replenishment if exercising continuously between 60 to 90 minutes.
- Consuming water throughout the day.

Chapter 3

Comprehensive Soldier and Family Fitness Program

The Comprehensive Soldier and Family Fitness Program as a key component of the U.S. Army Ready and Resilient Campaign and is designed to increase resilience and enhance the performance of Soldiers, Families, and Army Civilians. This chapter provides an overview of the Army Medical Department's health promotion policies, resources and educational materials integrated within the on-line assessment and resources available to support the program.

SECTION I — OVERVIEW

3-1. The Army established the Comprehensive Soldier and Family Fitness Program to increase resilience and enhance the performance of Soldiers, Families, and Army Civilians. Effectively trained, resilient and fit individuals have enhanced skills that enable them to adapt to adversity, change, and recover and grow from setbacks. Resilient and fit individuals have the ability to use mental, physical, emotional, and behavioral characteristics to promote enhanced performance and optimize long-term health.

3-2. The Comprehensive Soldier and Family Fitness Program emphasizes the use of hands-on training and self-development tools to enhance an individual's ability to cope with adversity, enhance performance in stressful situations, and thrive in the military and civilian sector to meet a wide range of operational demands. The program assesses and trains specific physical and psychological resilience and performance enhancement techniques and skills.

3-3. The Global Assessment Tool 2.0 is an online survey designed, when combined with other health and fitness metrics, to provide an assessment of the Five Dimensions of Strength. The assessment combines objective health data with health survey based questions to provide the individual with scores and training resources to improve their physical and psychological health. The Five Dimensions of Strength include—

- Physical dimension—Performance activities requiring aerobic conditioning, endurance, strength and flexibility as well as a healthy body composition. The physical dimension also includes the Performance Triad initiative of sleep, activity, and nutrition to improve individual performance, and resilience.
- Emotional dimension—Demonstrating self-control, stamina and good character with choice and actions during life challenges. Emotional control is critical to the development and sustainment of resilience and psychological health.
- Social dimension—Developing and promoting quality relationships with Soldiers, Family members and Army Civilians to strengthen trust and esprit de corps promoting individual, Family and organizational resilience.
- Spiritual dimension—Identifying purpose, values, beliefs, identity, and life vision define the spiritual dimensions.
- Family dimension—Supporting a nurturing Family unit that is safe, supportive, loving and provides resources required for all members to live in a healthy and secure environment.

3-4. The Global Assessment Tool 2.0 is focused on behaviors that are adaptable and with training can be improved or changed. Less emphasis is placed on traits that are difficult to change. The assessment measures are as follows:

- Psychological strengths.
- Catastrophic thinking or cognitive flexibility.
- Good and bad coping strategies.
- Spiritual fitness.
- Quality of friendships and loneliness.
- Optimism.
- Work engagement.
- Social factors.
- Depression.
- Family fitness.
- Positive and negative affectivity.

3-5. For additional information on the Five Dimensions of Strength refer to AR 350-53.

SECTION II — EDUCATIONAL RESOURCES

3-6. The Army Medical Department provides educational resources and professional services that support and compliment the ArmyFit and Comprehensive Soldier and Family Fitness initiative. The Global Assessment 2.0 includes a Performance Triad assessment providing the individual with specific recommendations relating to sleep, activity, and nutrition designed to motivate the individual towards behavioral change to improve psychological and physical health, increase resilience, and performance enhancement skills.

3-7. The ArmyFit Program provides numerous organizational resources to support the Comprehensive Soldier and Family Fitness Program. The military and civilian support organizations are varied and provide Soldiers, Families, and Army Civilians with information on personal and family physical and psychological health resources. Each organization includes specific information on the organization, mission, links to other Web sites, frequently asked questions, and in some instances a social interface providing periodic updates and discussions. For detailed information on participating organizations refer to the ArmyFit and the Comprehensive Soldier and Family Fitness Web sites identified in the references section of this publication. The Army Medical Department provides significant number of resources to support this initiative Performance Triad assessment and recommendations, Patient and Family-Centered Care Program, Soldier Centered Medical Home Program, Tricare, healthy living videos, and numerous educational Web sites for healthy lifestyle modifications. For additional information on responsibilities and objectives of this program refer AR 350-53, as well as the ArmyFit and the Comprehensive Soldier and Family Fitness Web sites identified in the references section of this publication.

Chapter 4

Potentially Life Threatening Thoughts and Behaviors

This chapter addresses the threats, risks and possible violence to others related to suicidal behaviors. Information and resources are provided to assist Commanders, leaders, Soldiers, Family members, and Army Civilians to recognize signs and risks of suicidal behavior and how to provide immediate and sustaining assistance. We must identify persons at-risk, reduce or mitigate the stress and intervene as necessary to save lives and encourage them to seek help.

SECTION I — THREAT OF SUICIDE

4-1. 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 behavior 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.

4-2. 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, guilt, and feeling trapped. Often those who commit suicide feel as though the deep emotional pain or depression they experience never goes away. They feel cornered with no way out. Soldiers in distress may show a range of actions 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 a person's behavior changes and/or is different from what their normal behavior leaders and buddies need to act and reach out to the individual and offer help. Leaders and buddies must recognize the indicators and make every effort to assist the person in need.

4-3. Leaders must establish a command climate which acknowledges the difficult personal issues that Soldiers may face. The U.S. Army Ready and Resilience Program promotes early treatment, which leads to faster recovery. Establishing a caring environment that encourages Soldiers to open up and seek help is critical to combating the threat of suicide. One of the tenets of Resilience is earlier treatment leads to faster recovery.

4-4. 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 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 resilience skill development. Advise Soldiers to seek needed counseling either through the chaplain's office or behavioral health services.

4-5. Leaders, Soldiers, and Family members should remember three important words ask, care and escort to 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 makes 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 impacts on your ability to calm the Soldier. Remaining calm increases 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.

4-6. When Soldiers experience problems, leaders should promptly refer them to chaplains and behavioral health for intervention. 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.
- Collaborate with the chaplain and behavioral health providers. Request outreach behavioral health services for your unit as required.
- Develop and use a command philosophy understand and use the process of ask, care, and escort to assist fellow Soldiers, Family, and Army Civilians.

4-7. For additional information on suicide prevention refer to the Suicide Prevention Web site identified in the references section.

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

4-8. 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 warning signs or behavior indicating possible misconduct 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.

4-9. Early identification of unit and individual risk factors and behavior 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 (FM 27-10) and U.S. Code, Title 10, Armed Forces, Chapter 47, Uniform Code of Military Justice. Soldiers and leaders at every level must be able to identify risk factors and behavior that may lead to violent and uncontrolled reactions and employ interventions to prevent misconduct that must be punished.

UNIT RISK FACTORS

4-10. The unit risk factors are higher for unlawful behavior 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.
- Is a high operating tempo with little respite between engagements.

- Is a rapid turnover of unit leaders.
- Is a manpower shortage.
- Are overly and unreasonably restrictive or confusing rules of engagement.
- Is an enemy that is indistinguishable from innocent civilians.
- Is a perception of lack of support from higher command.

INDIVIDUAL RISK FACTORS AFFECTING SOLDIERS

4-11. Individual risk factors that may precede violent acts or injury to others not in conformance with the Law of Land Warfare and the Uniform Code of Military Justice include—

- Poor social support.
- Home front or unit problems.
- History of reacting impulsively in past.
- History of disciplinary actions and Uniform Code of Military Justice 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 a friend or unit member.
- Witnessing a particularly gruesome or horrific loss of life.

INDIVIDUAL BEHAVIORS OF SOLDIERS AT RISK

4-12. Individual behavior 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 or behavior changes which may include—
 - Lax military dress or bearing.
 - Appearing on edge.
 - Being subject to angry outbursts.
 - Taking excessive or intentional risks.
 - Appearing to be depressed and having minimal or no contact with others.
 - Changes in sleep patterns and appetite.
 - Pushing the rules of engagement to the maximum extent.
 - Alcohol use or substance abuse.

4-13. Leaders are not immune to the individual risk factors, individual behavior, 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 behavior that might indicate future misconduct, small-unit leaders and Soldiers of all ranks can intervene to prevent these types of thoughts from becoming behavior 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 being 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 is can be punishable.
- 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 Uniform Code of Military Justice 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 (noncommissioned officer, chaplain, combat medic, health care provider, COSC or other behavioral health personnel).
 - Always inform the chain of command.
- If the Soldier returns to duty—
 - Obtain advice and ongoing assistance from behavioral health 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.

Chapter 5

Army Health Promotion Program

The Army Health Promotion Program is any combination of health education and medical program interventions to ensure the health and well-being of the Soldier and Army community. It focuses on the integration of preventive and public health practice into a community and organizational structures ensuring health and well-being are integral parts of the Army. This chapter describes and provides reference material for the health programs included in AR 600-63.

SECTION I — HEALTH PROMOTION PROGRAM

5-1. The goal of the Army Health Promotion Program is to maximize readiness, warfighting ability, and work performance of Soldiers, Family members, Army Civilians, and retirees. The program encourages lifestyles that improve and protect physical, behavioral, and spiritual health. It integrates primary prevention and public health practice into community and organizational structures ensuring health and well-being are integrated within the Army community.

5-2. A health promotion program identifies the community's needs, assesses existing programs and develops a supporting plan to reduce risk and enhance medical and behavioral health, and spiritual well-being. The program must consider a wide range of health-related factors, and should encompass the following areas:

- Health education and the health promotion process raising individual and community health awareness.
- Behavioral health interventions improving psychological health and reducing self-destructive behavior.
- Physical programs optimizing physical wellness.
- Spiritual programs fostering spiritual awareness.
- Environmental and social programs promoting and sustaining healthy lifestyles, strengthening community actions, and encouraging proactive public health policies.

5-3. Army Regulation 600-63 prescribes the Army health promotion responsibilities from the U.S. Army Deputy Chief of Staff through the commander and leaders of a military unit. The delineation of responsibilities and coordinating activities establishes an encompassing program that involves—

- Identifying community health needs and establishing priorities.
- Developing and implementing health promotion programs to meet identified requirements.
- Evaluating the effectiveness of programs.
- Resiliency.
- Quality of life.
- Wellness.

5-4. The Community Health Promotion Council promotes the health and well-being of Soldiers, Family members, and Army Civilians. The council is implemented and managed at the community level through a community health promotion council. The council supports the health and well-being of Soldiers. The council membership is comprised of multidisciplinary representatives of the community consisting of the garrison commander, staff and community program officers, and selected garrison tenant organizations. Each member of the council is selected for one year and represents a major activity within the program. Mandatory community health promotion council membership and charter responsibilities are outlined in AR 600-63.

5-5. The community health promotion council is organized to provide a comprehensive approach to health promotion, and be concerned with the environment and its relationship to people at the individual, organizational, and community levels. All tenant organizations fall under the community health promotion council for health promotion policy and programs. The community health promotion council identifies and eliminates redundancies and voids in programs and services by evaluating population needs, assessing existing programs, and coordinating targeted health interventions and programs.

SECTION II — BEHAVIORAL HEALTH

5-6. Behavioral health issues have a significant impact on the readiness of the Army. While treatment options are available and effective, prevention and behavioral health promotion are more efficient strategies in supporting a healthy and ready force.

BEHAVIORAL HEALTH PROMOTION

5-7. Behavioral health promotion involves a wide network of social and programmatic areas. A successful behavioral health promotion program includes a sectoral approach and address the challenge of promoting behavioral health in differing aspects of an individual's life. This could include areas such as medical, housing, finance, and social services. The three cornerstones of effective strategies to promote optimal behavioral health include—

- Strengthening individuals by focusing on increasing the number of quality resources available. Examples include housing, stress inoculation interventions, installation briefings, and relationship enhancement programs.
- Strengthening communities by enhancing connections between individuals and community organizations and enhancing community organization cooperation. Examples include community health affairs, partnerships between medical activities and units, and partnerships between youth services and behavioral health services.
- Reducing structural barriers to behavioral health services to increase service availability and decrease behavioral health stigmas. Examples include public awareness campaigns to educate the community on availability of behavioral health services, establishing after-duty hours behavioral health services, and establishing behavioral health promotion activities.

STRESS MANAGEMENT

5-8. Stress is a physical and psychological reaction to internal and external pressures. Stress affects individuals in different ways; it can stimulate to action or cause someone to become despondent. Behavioral health services offer stress management programs to Soldiers, Family members, Army Civilians, and retirees. The programs are designed to assist clients in developing coping skills to deal with real or perceived stress within the work or Family environment.

5-9. Behavioral health resources are available to implement stress-related treatment regimens for clients and to develop and conduct training programs for commanders and supervisors. The training programs are designed to recognize and counter stress reactions from differing sources. Develop and conduct training to teach commanders and supervisors how to counteract the effects of work- and Family-related stress.

5-10. Stress pushes the body to its limits and causes tension; relaxation reverses this process. Coping with personal stress is essential. 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. Incorporate unit ministry team personnel in the stress prevention efforts to increase Soldier, Family, and Army Civilian's ability to cope positively with stress.

5-11. Once routine unit operating 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 with stress-coping exercises such as 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.

5-12. Stress management and combat and operational stressors are discussed in detail in Chapter 7 of this publication.

COMBAT AND OPERATIONAL STRESS CONTROL

5-13. *Combat and operational stress control* is a coordinated program for the prevention of and actions taken by military leadership to prevent, identify, and manage adverse combat and operational stress reactions in units (FM 4-02). Combat and operational stress reaction is a negative adaption to high stress events and potentially traumatic event exposure. It is an event that is perceived and experienced as a threat to one's safety or to the stability of one's world. The stress of active combat often leads to a combat and operational stress reaction. The treatment of combat and operational stress reactions is often completed by behavioral health personnel that are deployed to provide combat and operational stress interventions.

5-14. Combat and operational stress efforts are preventive in nature and consist of three primary prevention services including—

- Combat and operational stress universal prevention. Surveillance and mitigation activities to reduce or avoid stressors and increase Soldiers' tolerance and resilience to severe stress.
- Combat and operational stress indicated prevention. Surveillance and mitigation activities involving behavioral health personnel with individual Soldiers identified as having possible warning signs of combat and operational stress reactions.
- Combat and operational stress treatment prevention. Mitigation and stabilization activities to reduce long-term morbidity and complications in Soldiers with one or more diagnosable psychiatric or mental disorders.

5-15. Commanders, supervisors and Soldiers should be aware that behavioral health service providers in the COSC units implement the behavioral health recovery aspects of combat stress. The members of this unit can also provide assistance in developing and implementing Soldier and leadership training on coping with the demands of deployments and combat and operational stressors.

SUICIDE PREVENTION

5-16. The Army Suicide Prevention Program supports the Army's goal to minimize suicidal behavior by reducing the risks of suicide for Soldiers, Family members, and Army Civilians. The program implements control measures to address and minimize suicide risk factors and strengthen the factors that mitigate suicide risk factors. The Suicide Prevention Program focus is on a community approach to reduce suicides by integrating the multidisciplinary capabilities within the Community Health Promotion Council who in turn assist the commander in developing and implementing a suicide prevention program.

5-17. The key to prevention of suicide is based on command suicide prevention training, policies, and action and interaction of leaders and Soldiers. Suicide prevention is a commander's program and a responsibility of every leader. Leaders must demonstrate positive leadership skills and honest concern for Soldiers, Family members, and Army Civilians who are at increased suicide risk.

5-18. It is the Army's goal to prevent Soldiers, Family members and Army Civilian suicides. However, in some people the intent to commit suicide is not easily identified or predictable and an organization may experience an unexpected suicide attempt or suicide. Therefore, the Army has redefined its goal of suicide prevention to suicide risk reduction. Suicide risk reductions programs are based on reasonable actions taken to lower the probability that an individual commits acts of self-destructive behavior.

5-19. For detailed information on the Army Suicide Prevention Programs and training requirements refer to AR 600-63, AR 350-1, and DA Pam 600-24.

RESPONSIBLE SEXUAL BEHAVIOR

5-20. Commanders and leaders at all levels are responsible to promote and maintain a culture in which responsible sexual behavior is encouraged, supported, and expected. Commanders should coordinate with their servicing medical center or medical department activity to provide education on responsible sexual

behavior and assist the medical treatment facilities in developing and implementing training for Soldiers, Families, and other health care beneficiaries in the community.

5-21. Responsible sexual behavior includes the ability to understand and weigh the risks of individual actions and behavior. It includes understanding the responsibilities of both participants and the outcome or impacts of sexual actions, to include sexual assault. Unprotected sexual intercourse exposes individuals to sexually transmitted diseases and unintended pregnancies. Unintended outcomes of unprotected sexual intercourse have a direct impact on unit readiness, the Soldier's physical and behavioral health, and military Family.

5-22. Additional information on sexually transmitted diseases and resource materials can be found in DA Pam 40-11 and the Army Public Health Center (Provisional) Web site identified in the references section.

ARMY SUBSTANCE ABUSE PROGRAM

5-23. Army Regulation 600-85 defines the Army Substance Abuse Program as a commander's program to prevent and control substance abuse through programs for prevention, identification, education, and rehabilitation services including inpatient and outpatient treatment. The Army Substance Abuse Program is designed to strengthen the overall fitness and effectiveness of the Army workforce, conserve manpower, and enhance the readiness of the Soldier.

5-24. Commanders at all levels must ensure that there is an active testing program and it is maintained and administered within regulatory requirements. Commanders must support the program and take prompt action if an individual is suspected of alcohol abuse or use of illicit drugs. Soldiers that are identified as potential alcohol abusers or illicit drug users must be processed in accordance with AR 600-85 for retention or considered for separation.

5-25. Army Civilians, military Family members, and military retirees are encouraged to seek assistance for alcohol and drug abuse through the Employee Assistance Program as defined in DA Pam 600-85. Enrollment in the program is voluntary. Family members of Army Civilians and military retirees are also eligible to use the Employee Assistance Program.

TOBACCO CESSATION

5-26. The Army encourages the cessation of using any form of tobacco products by Soldiers, Family members, Army Civilians, and retirees. Commanders and supervisors at all levels are responsible to encourage appropriate anti-tobacco activities through education, utilization of tobacco cessation programs, and prohibiting the use of tobacco products in the work area. See AR 600-63 for additional information on the policy to control tobacco use in the work environment. The regulation specifies the workplace parameters, specific restrictions to tobacco use and establishment of outdoor smoking areas.

5-27. Numerous tobacco cessation and education programs are presented by health care providers to advise the individual of risks associated with use, the health benefits of abstinence, and where to obtain help to eliminate use of tobacco products. Medical and dental personnel assessments include inquiring about the usage of tobacco products and offering of assistance or providing guidance on where to obtain cessation assistance.

5-28. Installations provide tobacco cessation programs for all health care beneficiaries and as resources permit, for civilian employees. If cessation programs are not available through military medical treatment facilities, commanders are responsible to coordinate assistance through local resources. Guidance is provided in AR 600-63 if cessation programs are not available at military treatment facilities.

SECTION III — PHYSICAL HEALTH

5-29. Physical health and wellness have a direct correlation to readiness and performance. This section provides information and resources on physical fitness and health, injury prevention, ergonomics, oral health, and body composition.

PYHICAL FITNESS

5-30. Physical readiness training is a commander's program designed to emphasize a Soldier's strength, stamina, agility, resiliency, and coordination. Physical fitness is a set of attributes that one must have or achieve that relates to the ability to perform physical activity including muscular strength and endurance; aerobic and anaerobic conditioning and endurance; mobility (agility, balance, coordination, flexibility, posture, power, speed, and stability); body composition; and a healthy lifestyle.

5-31. Army Regulation 350-1 and FM 7-22 provide a commander with prescribed policy and procedures and guidance to design and implement a physical readiness training program. Army Regulation 350-1 specifies that commanders and supervisors must establish physical readiness training programs consistent with the regulation, unit mission and guidance in FM 7-22. The Soldier is responsible for maintaining their personal physical fitness and standards outlined within AR 350-1 and FM 7-22 as well as pass the Army Physical Fitness Test.

5-32. Civilians employed by the Army are encouraged to engage in a regular program of exercise and in other positive health habits. Commanders and supervisors may approve up to 3 hours administrative leave per week to allow employees to participate in command sponsored physical exercise training, monitoring, and education, provided these activities are an integral part of a total fitness program and are time-limited to six months in duration. For additional information on Army Civilian wellness programs refer to the Army Civilian Personnel Office Web site identified in the references section.

INJURY PREVENTION

5-33. Commanders, leaders, and Soldiers are responsible for injury prevention. Although it is a commander's program, it is everyone's responsibility to reduce risks associated with work, training and mission essential task accomplishment. Commanders are responsible for establishing interventions and monitoring their effect. The commander receives support from the Community Health Promotion Council by recommending, coordinating, and ensuring the integration of injury prevention programs for units, Soldiers, Family members, and Army Civilians in their area of responsibility. Medical treatment facilities and safety professionals provide subject matter experts to consult with commanders in developing and implementing risk reduction programs.

5-34. Unit commander, medical treatment facilities and safety professional responsibilities for injury prevention are detailed in AR 600-63. Additional information on injury prevention, health risk management and program resources can be found at the Army Public Health Center (Provisional), Injury Prevention Program Web site identified in the references section.

ERGONOMICS

5-35. Ergonomics is the field of study that seeks to fit the job to the person rather than the person to the job. Ergonomics involves the evaluation and design of workplaces, environments, jobs, tasks, equipment, and processes in relationship to human capabilities and interactions in the workplace.

5-36. Commanders should review their work and training environments and implement efficient ergonomics programs to prevent work-related musculoskeletal injuries or illnesses. The injuries are often associated with exposure to ergonomic workplace risk factors such as—

- Repetitive, forceful, or prolonged exertions.
- Frequent heavy lifting; pushing, pulling, or carrying heavy objects.
- Fixed or awkward work posture and contact stress.
- Localized or whole-body vibration.
- Temperatures.
- Inadequate lighting.

5-37. Department of Defense Instruction 6055.01, AR 40-5 and DA Pam 40-21 provide commanders with prescribed and detailed information on the responsibilities and policies of the ergonomics program. For

additional information on ergonomics policy and programs refer to the Army Public Health Center (Provisional) Ergonomics Program Web site identified in the references section.

ORAL HEALTH

5-38. Unit commanders, Soldiers and the dental care system share responsibility for dental health and readiness, oral health, and health promotion. Commanders are responsible for dental readiness making their personnel available for appointments and maintaining surveillance over the program. Unit commanders are responsible to require and enforce mouth guard use during the following training: pugil stick, bayonet and rifle, obstacle or confidence course, and hand-to-hand combat. Commanders are responsible to require mouth guard use during physical training or unit sports activities that may involve injury to the face or mouth as a result of head-to-head contact, falls, tooth clenching, or blows to the mouth.

5-39. Dental readiness programs are designed to reduce the risk that a Soldier negatively impacts unit and individual readiness by becoming a noncombat dental casualty. Dental readiness programs are designed to associate a dental classification of risk to a Soldier from being worldwide deployable at fitness Class 1 to normally not being worldwide deployable at Class 4. The Dental Readiness Program is defined in AR 40-35. The program includes requirements for annual dental examinations to ascertain the Soldier's dental classification, monthly dental readiness reports of unit the dental risk profile and priority dental appointments for high risk Soldiers. It describes the four dental classifications and correlation of the classifications to worldwide deployment readiness. For additional information on dental readiness refer to DODI 6025.19.

5-40. Clinical oral health and health promotion programs are provided to prevent injury, oral disease and promote health. The programs include clinical preventive services to include oral prophylaxis, (includes caries, tobacco, periodontal and oral cancer risk assessment), fluoride prescription and counseling on oral hygiene, tobacco cessation, and nutrition. For additional information on oral health refer to the Army Public Health Center (Provisional), Oral Fitness/Dental Readiness Web site identified in the references section.

BODY COMPOSITION PROGRAM

5-41. Army Regulation 600-9 replaces the Army Weight Control Program with the Army's Body Composition Program. The regulation redefines many of the standards governing weight and body fat standards in the Army and defines commanders, leaders and Soldiers responsibilities to meet the prescribed Army body fat standards. Soldiers are screened with the height and weight tables outlined in AR 600-9 every six months to determine if they are in compliance with the standards of the regulation.

5-42. Commanders and supervisors are responsible to implement the Army Body Composition Program to include evaluation of military appearance of all Soldiers under their command or jurisdiction. Additional command responsibilities including the policies for the Soldier weigh-in, body fat assessment, personnel actions, standards of measurements, and reporting is contained within this regulation.

5-43. Soldiers that do not meet the screening standards are flagged in accordance with AR 600-8-2 and enrolled in the Army Body Composition Program. Enrolled Soldiers are provided exercise guidance by the unit master fitness trainer or unit fitness training noncommissioned officer, nutrition counseling, and assistance in behavioral modification to assist them in obtaining the weight and fat standards. Soldier counseling and notification procedures are prescribed within this regulation.

5-44. Underweight and overweight Soldiers are at risk of their weight adversely impacting or compromising their health. Underweight Soldiers can be associated with excessive weight loss due to a medical condition, stressful life situations that interfere with typical eating habits or eating disorders. Underweight Soldiers should be referred to medical personnel for evaluation and nutrition assistance.

5-45. Overweight or Soldiers that do not meet the body fat standards may be referred for a medical evaluation by their commander or may request a medical evaluation to ensure that the Soldier can participate in the Army Body Composition Program and rule out underlying medical conditions that may cause significant weight gain or directly prohibit weight or body fat loss. If a temporary medical condition

exists, the health care provider initiates treatment, prepares a temporary profile, and refers the individual for nutritional and exercise counseling. If a medical condition exists that does not meet retention standards the health care provider initiates the referral of the Soldier to a medical evaluation board.

5-46. Overweight Soldiers are at risk of developing Type 2 diabetes, coronary heart disease, high blood pressure, stroke, gallbladder disease, sleep apnea, respiratory problems, and some types of cancer. The Army Body Composition Program assists Soldiers in maintaining their weight and fat standards and reduces the health risks associated with being overweight.

This page intentionally left blank.

Chapter 6

Field Hygiene and Sanitation

This chapter provides commanders, leaders, Soldiers, and field sanitation teams with information and references to prevent disease and nonbattle injury with effective preventive medicine measures and command involvement. Disease and nonbattle injury casualties are defined as a Soldier lost to an organization by reason of disease or injury and who is not a battle casualty. Historically, disease and nonbattle injury casualties have made a significant impact on unit readiness and in many instances dramatically decreased unit combat effectiveness. Commanders, leaders and Soldiers should not overlook the importance of preventive medicine measures to maintain the health of the command and combat effectiveness of the unit. This chapter outlines field sanitation operations, preventive medicine measures and personal protective measures to protect the Soldier and maintain unit personnel readiness.

SECTION I — HEALTH THREATS TO SOLDIERS IN THE FIELD

6-1. Health threats are significant factors for commanders to consider during the planning process. The impact of casualties caused by disease and nonbattle injury has been a prominent and continuous feature of military operations. Casualties from disease and nonbattle injury have historically been up to three times the number of casualties resulting from enemy actions and have decimated a unit's capabilities to the extent that they cannot perform their mission.

6-2. There are three major components of the health threat to field forces; adverse environmental factors, disease caused by zoonotic or animal bites, and diseases endemic to the area of operation. Commanders, leaders, and Soldiers should recognize health threats and be trained in preventive medicine measures to preclude or minimize exposure to health threats. *Preventive medicine* is the anticipation, prediction, identification, prevention, and control of communicable diseases (including vector-, food-, and waterborne diseases), illnesses, injuries, and diseases due to exposure to occupational and environmental threats, including nonbattle injury threats, combat stress responses, and other threats to the health and readiness of military personnel and military units. (FM 4-02). Detailed information on preventive medicine measures to mitigate the health threat is included in Training Circular (TC) 4-02.3 and ATP 4-25.12.

6-3. Health threats to Soldiers in the field include—

- Endemic diseases.
- Food and waterborne diseases.
- Hazardous plants and animals.
- Entomological hazards (nuisance pests and disease-carrying vectors).
- Toxic industrial materials (industrial and agricultural).
- Deployment-related stress.
- Hazardous noise.
- Climatic or environmental extremes (heat, cold, wind-blown sand, or other particulates).

6-4. Health threats cannot be totally eliminated but can be managed and minimized with command emphasis on planning, training, enforcing hygiene and sanitation, and implementation of preventive medicine measures.

SECTION II — SOLDIER PREVENTIVE MEDICINE MEASURES

6-5. Preventive medicine measures are simple, common sense actions that every Soldier can perform. Adhering to basic field hygiene and sanitation practices combined with the application of preventive medicine measures significantly reduces the spread of disease and greatly reduces or eliminates the incidence of disease and nonbattle injury.

Note. Implementation and supervision of preventive medicine measures must be an item of command interest and must be constantly observed and reinforced at all levels of leadership.

6-6. The principles of preventive medicine measures are—

- Soldiers perform individual techniques of preventive medicine measures.
- Field sanitation teams train Soldiers in preventive medicine measures and advise the commander and unit leaders on implementation of unit-level preventive medicine measures.
- Chain of command plans for and enforces preventive medicine measures.

6-7. Army Regulation 40-5 states that every Soldier is responsible for his own well-being and is required to implement and employ all protective measures possible to preserve his health. Maintaining sufficient sleep, physical activity, and a balanced nutritional diet enhances a Soldiers performance and reduces the risk of disease and injuries. Each Soldier, as a minimum, is required to protect against—

- Heat injury in hot and sunny climates by following work, rest, and water consumption guidelines, by properly adhering to uniform wear policies, and by using sunscreen on exposed body parts. Detailed information on prevention of heat injuries is contained in TC 4-02.3 and ATP 4-25.12.
- Cold injury in cold climates by wearing proper cold-weather clothing and frequently changing socks to keep feet dry, by careful handling of gasoline-type liquids, and by avoiding contact between skin and cold metal. Detailed information on prevention of cold injuries is contained in TC 4-02.3 and ATP 4-25.12.
- Mosquito, fly, tick, and other arthropodborne diseases by using insect repellents, netting, and insecticide aerosols; by taking approved chemoprophylaxis; and by wearing the uniform properly.
- Enteric diseases by using water purification tablets whenever water quality is uncertain and by avoiding foods prepared by unapproved food vendors, and by properly disposing of bodily wastes.
- Skin diseases by washing the body as often as practicable.

PERSONAL HYGIENE

6-8. While in garrison, Soldiers generally maintain high standards of personal hygiene. This is due in part to the availability of latrine facilities that are kept at comfortable temperatures and have hot and cold running water. However, these conveniences might not be as readily available in the field, which may lead usually well-groomed Soldiers to be less inclined to maintain their personal grooming standards. Poor personal hygiene in the field is a difficult problem to overcome because it requires a sense of responsibility on the part of each Soldier to maintain personal hygiene practices regardless of the difficulties involved. Leadership must be proactive in this matter making sure that Soldiers have regular access to shower facilities and that Soldiers are using them.

HANDWASHING AND SANITIZING

6-9. One of the most effective practices that Soldiers can perform to protect themselves and others from the spread of disease is to thoroughly wash or sanitize their hands frequently. Regular washing and sanitizing of the hands denies disease-causing bacteria and viruses from gaining easy entry into the body. Soldiers who fail to wash their hands frequently increase the risk of spreading germs picked up from other sources and possibly infecting themselves when touching their eyes, nose, or mouth. One of the most

common ways Soldiers catch a cold is by rubbing their nose or their eyes with an unwashed hand which has been contaminated with a cold-causing virus.

6-10. Germs can be spread directly to others or onto surfaces that others might touch which may cause other Soldiers around you to become sick. The important thing to remember is that, in addition to colds, serious diseases like infectious diarrhea and meningitis can easily be prevented when Soldiers make a habit of frequently washing their hands.

6-11. Hands can be cleaned or sanitized by the use of—

- Soap and potable water.
- Alcohol-based hand sanitizing solutions when soap and water are not available.
- Alcohol wipes to clean hands.
- Commercial cleansing wipes.

SHOWERING IN THE FIELD

6-12. Regular showering is important because a clean body is less susceptible to disease especially skin infections. If a shower is not available, Soldiers should wash daily with a washcloth emphasizing the cleaning of the genital area, armpits, feet, and other areas of the body where you sweat. Prevent genital and urinary tract infections by washing the genital area daily. See ATP 4-25.12 for additional information reference shower requirements.

ORAL HYGIENE

6-13. Soldiers should floss at least once a day and brush their teeth, gums and roof of the mouth a minimum of two times a day. Oral hygiene is critical to maintain Soldier health and is one of the easiest preventive medicine activities to accomplish. If possible, brush twice a day with fluoridated toothpaste and toothbrush. If a tooth brush is not available Soldiers can rinse their mouth and use a piece of cloth wrapped around their finger to wipe the surface of the teeth.

ARTHROPODS, RODENTS, AND OTHER ANIMAL THREATS

6-14. Of the 80 diseases said to be of military importance, over two-thirds are caused by pathogens transmitted by arthropods, rodents, and other animals. In addition to disease, these pests can inflict severe physical, psychological, and economic stresses that threaten the military mission. For example, arthropod bites can be painfully distracting and can lead to secondary infections, dermatitis, or allergic reactions.

6-15. Soldiers can avoid the incidence of vectorborne diseases and the associated discomfort caused by stinging and biting arthropods by adhering to established preventive medicine measures. Army Technical Publication 4-25.12 provides additional information on animal threats to include feral dogs, cats, and snakes.

6-16. Pests are defined by the DOD as arthropods, birds, rodents, nematodes, fungi, bacteria, viruses, algae, snails, marine borers, snakes, weeds, and other organisms (except for human or animal disease-causing organisms) that adversely affect readiness, military operations, or the well-being of personnel and animals; attack or damage real property, supplies, equipment, or vegetation; or are otherwise undesirable. For more information refer to DODI 4150.07.

6-17. Pest management is the prevention and control of disease vectors and pests that may adversely affect the DOD mission or military operations; the health and well-being of people; or structures, materiel, or property.

SECTION III — FIELD SANITATION TEAMS

6-18. Commanders, leaders, and Soldiers must counter health threats by implementing and enforcing unit-level field hygiene and sanitation practices. They must provide emphasis on the importance of field hygiene and sanitation preventive medicine measures, train and equip the team, and enforce standards for preventive medicine measures. Commanders of company-sized units are required to establish and employ

manned, trained and equipped unit field sanitation teams. Establishing and employing field sanitation teams is covered in AR 40-5, AR 350-1, DA Pam 40-11, and ATP 4-25.12.

FIELD SANITATION TEAM PROTECTION AND SANITATION DUTIES

6-19. The role of the field sanitation team is to assist the commander in protecting the health of the command. The team members act as advisors to the commander on individual and unit preventive medicine measures that prevent disease and nonbattle injury. The team provides instruction and supervision, inspections and reports to ensure that the appropriate field sanitation facilities are established and maintained; that effective sanitary control measures are applied; and that effective preventive medicine measures are practiced.

6-20. Army Regulation 350-1, directs commanders of all company sized units to appoint and train two unit fields sanitation teams (a primary and an alternate) prior to deployment. Field sanitation team consists of a minimum of two Soldiers, one of whom is a noncommissioned officer when organic medical personnel are not available. If available, the leader of the field sanitation team should be a medical noncommissioned officer. Selected team members should have a minimum of six months service remaining with their unit. The team members are appointed by the commander based on their skills and duties that are allowed sufficient time to devote to field sanitation activities. The commander establishes the duties of the field sanitation team including basic sanitation and protection and arthropod and rodent control.

6-21. Field sanitation teams assist the commander in basic protection and sanitation duties by—

- Supervising the disinfection of water in the unit area. Instructing Soldiers, as necessary, in individual water purification methods.
- Advising food service personnel in the prevention and elimination of deficiencies in food service sanitation. Instructing Soldiers in methods of washing individual eating utensils and dangers of consuming unapproved foods and drinks.
- Supervising the construction of garbage and soakage pits and assisting the unit commander in inspections for proper disposal of garbage.
- Supervising the construction of field latrines and urinals and assisting the unit commander in inspections for proper sanitation.
- Assisting the unit commander in the guidance and inspection of personnel and facilities to ensure a high level of personal hygiene.
- Providing guidance as needed in the use of protective measures to prevent arthropod borne disease and heat and cold injuries.
- Reporting deficiencies to the unit commander.
- Reporting possible toxic industrial chemicals and toxic industrial materials contamination to the unit commander.
- Reporting existing noise sources in the unit and posting *Noise Hazard* signs near noise hazard areas and equipment which presents a noise hazard.
- Advising unit commander of potential hazards within selected sites.

6-22. Refer to ATP 4-25.12 for detailed information on the performance and training of field sanitation teams.

FIELD SANITATION TEAM ARTHROPOD AND RODENT CONTROL DUTIES

6-23. Field sanitation teams assist commanders in arthropod and rodent control by—

- Ensuring that practice of proper waste disposal is followed. It is essential for arthropod and rodent control and is in compliance with applicable environmental laws.
- Explaining to the Soldier the ways that arthropods may affect their health and providing instructing them in the use of preventive medicine measures.

- Supervising the application of or applying approved pesticides as required for arthropod control.
- Inspect to ensure the elimination of food and shelter for rodents.
- Supervising the use of traps and authorized rodenticides as required in control of rodents.
- Reporting deficiencies to the unit commander.

6-24. Refer to ATP 4-25.12 for detailed information on the performance and training of field sanitation teams.

SECTION IV — COMMANDER AND LEADER PREVENTIVE MEDICINE MEASURES

6-25. Commanders and leaders are responsible for the readiness of their command to include medical and dental readiness of every Soldier in their charge. It is imperative that health be an integral part of the planning process.

6-26. It is equally important that commanders and leaders Commanders and leaders at every level must remember that the most effective preventive medicine measure that they can implement is to set the example for their Soldiers. Leaders accomplish this by personally employing all of the individual preventive medicine measures discussed throughout this publication. For leaders to ensure that Soldiers are adhering to established preventive medicine measures, they must strictly enforce unit policies regarding implementation and adherence to preventive medicine measures and standards of personal hygiene.

6-27. Commanders can ensure the welfare, safety, and health of their Soldiers by—

- Ensuring that the best and safest water, food, equipment, shelter, sanitation, and sleep possible are provided.
- Educating Soldiers to maintain professional pride and personal caring for themselves, each other, and their equipment.
- Knowing the personal backgrounds and the military skills of your Soldiers. Chat with them informally about themselves. Be attentive and understanding while listening to Soldiers.
- Utilizing group support and counseling for Soldiers who may have problems at home.
- Assigning jobs to maintain a balance between having qualified Soldiers in key positions while sharing the load, hardship, and risks fairly.
- Using challenging and difficult environments during training to increase the unit's coping skills and confidence.

6-28. Commanders and leaders should incorporate planning and enforcement of preventive medicine measures in their operational plans. The planning should include—

- Planning for the construction of field sanitation devices for human waste disposal.
- Planning for the maintenance and disposal of human waste.
- Planning and enforcing personal hygiene in the field.
- Planning and enforcing sleep discipline, activity, and nutrition.
- Planning for safe water.
- Planning for safe food.
- Planning for arthropod, rodent and other animal threats.
- Planning for environmental threats such as heat, cold, and blowing dust.
- Planning for toxic industrial materials that may be encountered in the operational area.
- Planning for noise hazards in the area of operation.

6-29. Refer to ATP 4-25.12 for detailed information on commander and leader preventive medicine responsibilities.

This page intentionally left blank.

Chapter 7

Combat and Operational Stress Reaction Identification, Prevention, Management, and Control

This chapter provides information and resources for commanders, leaders, and Soldiers to recognize and manage the effects of combat and operational stress. Leaders 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.

SECTION I — REACTIONS TO COMBAT AND OPERATIONAL STRESS

7-1. Combat and operational stress behavior is the term that is used to describe the range of combat and operational stress that Soldiers are exposed to throughout their military experience. Other names that have been used in the past to describe this reaction include shell shock, battle fatigue, and battle exhaustion.

7-2. Leaders and Soldiers must recognize the symptoms and take action to prevent or reduce the disruptive effects of combat and operational stress. 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 unified land operations.

7-3. 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 combat and operational stress reactions. See Table 7-1 for examples of both combat stressors and operational stressors.

Table 7-1. Combat stressors and operational stressors

Combat stressors	Operational stressors
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 stressors over multiple missions such as witnessing the death of several unit members over the course of many combat missions.

7-4. Most leaders and Soldiers are resilient and work through their combat and operational stress behavior experiences and have the psychological and physical capacity to recover from life's stressors and thrive in an area of high operating tempo. Resilience rests on a Soldier's will, which is the inner drive that compels them to keep going, even when exhausted, hungry, afraid, cold, and wet. Resilience is built through a set of core competencies that enable mental toughness, optimal performance, strong leadership, and goal achievement.

7-5. 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 require additional help. Combat and operational stress behavior experiences 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. Combat and operational stress control units, behavioral health and medical personnel should be integrated into training and predeployment exercises with units preparing to deploy.

7-6. Soldiers surveyed in Iraq indicated that those who experienced the most combat were the most likely to screen positive for a behavioral health 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.

7-7. In fact, current research shows Soldiers continue to struggle with negative post combat operational stress symptoms long after redeployment. Soldiers do not reset quickly after coming home and a percentage of returned veterans may continue to struggle with negative postcombat and operational stress symptoms months and years after coming home.

7-8. Leaders and Soldiers must recognize the continued effects of combat and operational exposure. Understanding these effects help leaders and 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 7-1). This model identifies potentially traumatic events related to combat and operational stressors. It looks at combat and operational stress behaviors—both adaptive reactions and combat and operational stress reactions—and then looks at postcombat and operational stress that includes either posttraumatic growth or PTSD. Postcombat and operational stress is defined as long-term stress reactions resulting from military combat and operational exposure.

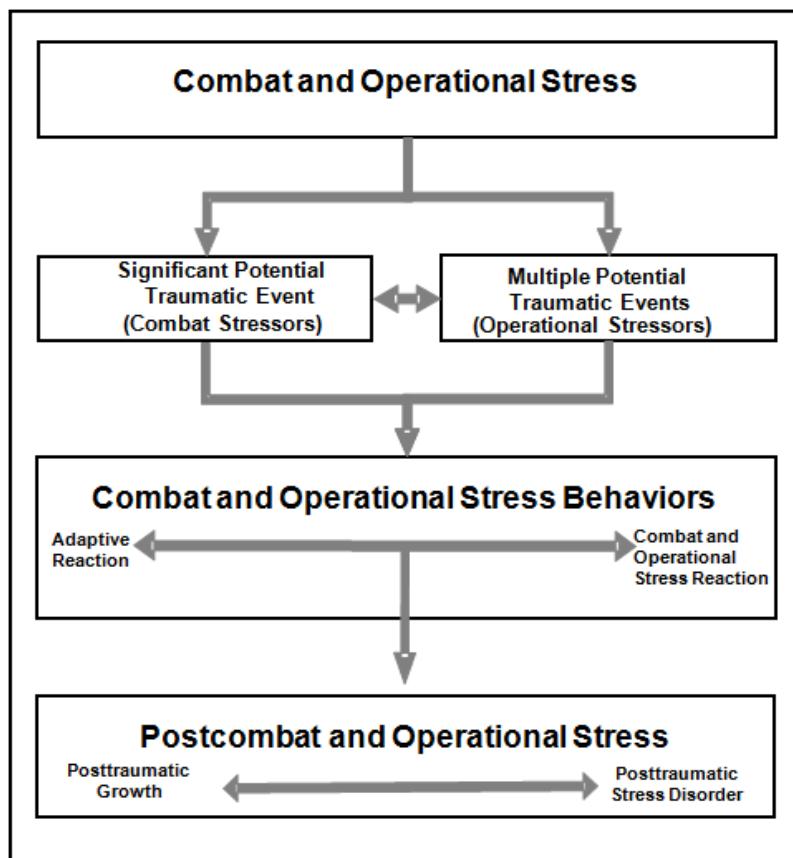


Figure 7-1. Combat and operational stress effect model

SECTION II — FORMS OF COMBAT AND OPERATIONAL STRESS

7-9. Combat and operational stress is a reality of all military missions. It is important to understand that combat and operational experiences affect all leaders and Soldiers and reflect all activities that they are exposed to throughout the length of their military service whether it is a complete career or a single enlistment. This section describes stressors that impact and relate to operational stress control.

POTENTIALLY TRAUMATIC EVENTS

7-10. 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 potentially traumatic events. A potentially traumatic event is an event that causes an individual or group to experience intense feelings of terror, horror, helplessness, and 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 potentially traumatic events during both combat and operational military missions.

COMBAT AND OPERATIONAL STRESS BEHAVIORS

7-11. Combat and operational stress behavior cover the range of reactions found in unified land operations. It covers the range of reactions from adaptive to maladaptive behaviors.

ADAPTIVE STRESS REACTIONS

7-12. 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 7-2.

Table 7-2. Adaptive stress reactions

Horizontal bonding	The strong personal trust, loyalty, and cohesiveness which develops among peers in a small military unit.
Vertical bonding	Personal trust, loyalty, and cohesiveness that develops between leaders and their subordinates.
Esprit de corps	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 or other Army organization), the branch (such as infantry, artillery, or military police), and beyond the branch to the United States Army level.
Unit cohesion	<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"> • Cohesion is a result of Soldiers knowing and trusting their peers and leaders and understanding their dependency on one another. • It is achieved through personal bonding and a strong sense of responsibility toward the unit and its members. • 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.

COMBAT AND OPERATIONAL STRESS REACTION

7-13. Combat and operational stress reaction is a term 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 may only be transient reactions to the traumatic stress of combat and the cumulative stresses of military operations. Some Soldiers may have behavioral disorders that

existed prior to deployment or disorders that were first present during deployment and may need behavioral health intervention beyond the interventions for combat and operational stress reactions.

7-14. Combat and operational stress reaction casualties are Soldiers who become combat ineffective due to unresolved negative combat and operational stress reactions.

MALADAPTIVE BEHAVIORS

7-15. Maladaptive behaviors include—

- Misconduct stress behaviors.
- Postcombat and operational stress.
- Posttraumatic growth.

Misconduct Stress Behavior

7-16. Misconduct stress behavior is a form of combat and operational stress reactions 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 behavior—

- Range from minor breaches of unit orders or regulations to serious violations of the Uniform Code of Military Justice 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

7-17. 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 to the stressors of combat operations, mild combat and operational stress reactions, 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, combat and operational stress reactions, and PTSD.

Posttraumatic Growth

7-18. Posttraumatic growth is defined as the increased functioning and positive change after enduring a trauma, which may include changes in personal strength, spirituality, relationships with others and ability to appreciate life. 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.

COMBAT AND OPERATIONAL STRESS REACTION AND POSTTRAUMATIC STRESS DISORDER

7-19. Leaders must understand the difference between combat and operational stress reactions 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 responses 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 a mental health disorder associated with serious traumatic events and characterized by reliving the trauma in dreams, numbness and lack of involvement with reality, or recurrent thoughts and images.

7-20. Combat and operational stress reaction and PTSD may share some common symptoms, however, combat and operational stress reactions are 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 combat and operational stress reactions 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.

CONTINUUM OF COMBAT AND OPERATIONAL STRESS REACTIONS

7-21. The distinctions among adaptive stress reactions, misconduct stress behavior, combat and operational stress reactions casualties, posttraumatic growth, and PTSD are not always clear. Indeed, the categories of combat and operational stress behaviors may overlap. Soldiers with combat and operational stress reactions may show misconduct stress behavior and vice versa. Soldiers with adaptive stress reactions may also suffer from combat and operational stress reactions. 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 behavior and threaten individual and unit safety. Excellent combat Soldiers that have exhibited bravery and acts of heroism may also commit misconduct stress behavior.

7-22. Postcombat and operational stress may develop after someone has experienced or witnessed an actual or threatened traumatic event. If postcombat and operational stress interferes with the ability to do jobs and enjoy life, and it seems to continually get worse, it could lead to an actual behavioral health diagnosis known as PTSD. Most Soldiers do well but for some, persistent symptoms of postcombat and operational stress may need support or medical care.

7-23. 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.

7-24. 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 combat and operational stress reactions. 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.
- The importance of leaders to recognize combat and operational stress reactions in order to intervene promptly for the safety of the Soldier and organization.
- Combat and operational stress behavior 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 III — COMBAT AND OPERATIONAL STRESS REACTIONS

7-25. 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 combat and operational stress reactions 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 7-3.

7-26. 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 7-4.

7-27. The reactions that are listed in Table 7-4 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 combat and operational stress reactions casualties.

Table 7-3. Mild stress reactions

Physical reaction	Emotional reaction
Trembling. Jumpiness. Cold sweats, dry mouth. Insomnia. Pounding heart. Dizziness. Nausea, vomiting, or diarrhea. Fatigue. Thousand-yard stare. 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 7-4. Severe stress reactions

Physical reaction	Emotional reaction
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 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.

7-28. 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.

- Shaking and tremors—
 - During or prior to combat operations 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 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 (referred to as 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 Soldiers who have experienced intense operations cannot fall asleep even when the situation permits or when they do fall asleep, they frequently wake up and have difficulty getting back to sleep (refer to Chapter 2 for additional 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 operations. 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, behavioral health 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 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 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 may lead 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 combat and operational stress reactions 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.

7-29. 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 and education with behavioral health COSC personnel is recommended when available.

SECTION IV — REFERRAL OF SOLDIERS EXPERIENCING COMBAT AND OPERATIONAL STRESS REACTIONS AND OTHER STRESS-RELATED DISORDERS

7-30. 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 operational environments:

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

7-31. It is imperative that commanders, leaders and Soldiers recognize stress reactions and other related disorders and obtain the appropriate health care treatment or assistance.

7-32. Although the more serious or warning behavior described in the preceding paragraphs usually diminish with help from peers, unit leaders, and time; some do not. An individual usually improves when basic needs 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 behavioral health COSC asset. Access to mental health 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.

VOLUNTARY REFERRALS

7-33. 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 are evaluated and offered appropriate treatment. With some exceptions, information provided is 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 behavioral health has deteriorated to the point that it may significantly affect work or Family function.

COMMAND-DIRECTED EVALUATION

7-34. The commander may direct Soldiers to undergo a command-directed evaluation according to DODI 6490.04 for a behavioral health evaluation. A command-directed evaluation 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 command-directed evaluation 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 behavioral health 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 command-directed evaluation be accomplished on a routine basis?

ROUTINE COMMAND-DIRECTED EVALUATION

7-35. Once a decision has been made to request a routine or nonemergency command-directed evaluation, commanders are required to consult with a behavioral health provider. Commanders should communicate the behavior that they believe warrant the evaluation and what information they would like from an evaluation. The behavioral health provider makes recommendations about whether a command-directed evaluation is appropriate and if the situation warrants an emergency command-directed evaluation. The behavioral health provider discusses other options that may be appropriate. If a command-directed evaluation is necessary, the commander should inform the provider as to when the Soldier is notified about the referral so that a time and date for the evaluation can be determined.

7-36. 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 includes—

- The date, time, and location of the evaluation.
- The name and grade or rank of the behavioral health professional conducting the evaluation.
- The name and grade or rank of the behavioral health 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.

7-37. Most behavioral health assets have copies of template sample command-directed evaluation request forms. Leaders should contact their supporting behavioral health asset to request a copy of this form.

7-38. Forward a request for a command-directed evaluation to the provider. It is vital for the Soldier's command to provide all available documentation concerning the problem behavior. This may include, as available, Article 15s, letters of reprimand, letters of counseling, and enlisted and officer performance reports. The documentation is necessary for a comprehensive evaluation.

7-39. Provide a copy of the letter to the behavioral health provider conducting the command-directed evaluation. If the provider believes that the evaluation has been requested improperly, he contacts the command to clarify issues about the process or procedures used. The provider conducting the evaluation provides 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 EVALUATION

7-40. Emergency command-directed evaluations are conducted upon recommendation of the behavioral health 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.

7-41. When an emergency command-directed evaluation 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 behavioral health or other privileged health care provider prior to sending a Soldier for an emergency command-directed evaluation. 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 behavioral health care provider, or if unavailable, another 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 behavioral health provider was not consulted prior to ordering the command-directed evaluation, the reason should be explained in the letter to the Soldier.
 - A letter to the evaluating provider. A letter requesting a command-directed evaluation must be sent to the treating behavioral health 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

7-42. Legal protections for the rights of Soldiers prohibit a command from improperly referring for a command-directed evaluation. It is improper to refer a Soldier for a command-directed evaluation to buy time, as a disciplinary tool, or as a reprisal for the individual's attempt or intent to make a lawful

communication (see DODI 6490.04). When referred for a nonemergency command-directed evaluation when deployed in area of responsibility, the following rights prior to the evaluation apply. The Soldier may—

- Have two working days waiting period between the command-directed evaluation notification and evaluation.
- Consult with and get advice from an attorney (judge advocate).
- Consult with the inspector general if he believes the command-directed evaluation violates policy.
- Request a second behavioral health evaluation by another behavioral health 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 behavioral health referral.

COORDINATION BETWEEN THE COMMANDER AND BEHAVIORAL HEALTH PROVIDER FOR A COMMAND-DIRECTED EVALUATION

7-43. A commander can expect the behavioral health provider to keep him informed and to request additional information following a command-directed evaluation request which may include—

- Requesting documents supportive of the request for a command-directed evaluation (documentation of problem behavior, 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.

7-44. The commander is notified by the behavioral health provider when the Soldier—

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

7-45. Verbal and written reports summarizing findings and recommendations are discussed with both commander and the Soldier. Recommendations may include suggestions for support, changes in special duty status, or separation from the Army.

SECTION V — PREVENTING AND MANAGING COMBAT AND OPERATIONAL STRESS

7-46. A commander should use all of his resources to develop and manage the unit's combat and operational stress program. This section describes the relationship of morale and cohesion, stress reduction techniques, and performance combat and operational stress and their impact on the combat and operational stress programs.

COHESION AND MORALE

7-47. 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 combat and operational stress reactions 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

7-48. 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.

7-49. Showing consistent good leadership that convinces subordinates their leaders are competent— know 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

7-50. 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.

Note. Occupational therapist, are members of the COSC team, and can assist in selecting realistic training to match abilities and result in success.

CONFIDENCE IN UNIT

7-51. 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. Subunits in the same larger unit should have the same standard operating procedures and training standards, so members can fit in quickly if teams have to be cross-leveled or reorganized after casualties occur.

7-52. 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.

7-53. Mission accomplishment is the unit's highest priority.

CONFIDENCE IN EQUIPMENT

7-54. 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.

STRESS-REDUCTION TECHNIQUES FOR LEADERS

7-55. The same leadership skills that apply to Soldier welfare and warfighting can effectively reduce or prevent combat and operational stress reactions. Leaders should take preventive actions and address stress symptoms. Ignoring the early warning signs can increase the severity of combat and operational stress reactions.

PREVENTIVE ACTIONS

7-56. 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 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 duration and intensity of an operation 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 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 unified land 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

7-57. Stress pushes the body to its limits and causes tension; relaxation reverses this process. Coping with personal stress is essential.

7-58. 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.

7-59. Once routine unit operating 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.

7-60. 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.

7-61. On request, the COSC team or behavioral health assets can provide instructional materials and assistance.

Deep Breathing Exercise

7-62. 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.

7-63. 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

7-64. 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

7-65. 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).

7-66. 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.

7-67. 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.

7-68. 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.

PERFORMANCE DEGRADATION PREVENTIVE MEASURES

7-69. Every Soldier, team, and unit must learn to effectively sustain performance in continuous operations. This requirement applies especially to leaders.

7-70. 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.

7-71. 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

7-72. 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 under experienced) crews man weapon systems. Ways to safeguard Soldiers include developing and following unit safety standard operating procedures and increasing supervision during extended operations.

FOOD INTAKE

7-73. If Soldiers are too busy, stressed, or too tired to eat adequate rations during continuous operations, their caloric intake is 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.

Note. Leaders need to emphasize the importance of eating, especially the easily digestible items such as the special supplements (for example, energy bars) in the individual rations, because nutritional demands may exceed caloric intake of the meal.

7-74. 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 meal, ready-to-eat individual or special meals during significant achievements or holiday activities. Good nutrition is very important. Eating all meals in the field usually provides the body's requirements for salts. The meal, ready-to-eat individual meet the daily requirements for minerals and electrolytes. Do not take extra salt in meals unless medically indicated.

7-75. An inadequate diet degrades performance, reduces resistance to disease, and prolongs recuperation from illness and injury. When unitized group rations 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 operations. The meal, ready-to-eat individual may be consumed as the sole source of subsistence for 21 days (see AR 40-25/BUMEDINST 10110.6/AFI 44-141).

7-76. After 21 days, they must be enhanced with authorized enhancements, as identified in DA Pam 30-22, or serving alternate rations is required. Leaders must remind and encourage Soldiers to eat and drink properly.

7-77. 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 and land deployment.

7-78. Contributing to developing dehydration is the relative lack of moisture in the meal, ready-to-eat individual. 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 prior to initiating operations. Leaders must remind Soldiers to drink liquids in both hot and cold climates and must monitor fluid intake. If Soldiers drink only when thirsty, they become dehydrated. For additional information on hydration refer to TC 4-02.3.

COMBAT LOAD

7-79. 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 combat and operational stress reactions experienced by the individual and the unit. Employing a load echelonnement 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. As the unit closes on the objective, the heavier existence load is dropped and the Soldier continues with the lighter fighting load.

PHYSICAL CONDITIONING

7-80. 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

7-81. 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. 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 or physical stress training. As physical conditioning improves, Soldiers feel better about themselves and have greater confidence in each other.

SECTION VI — ROLE OF RELIGIOUS SUPPORT

7-82. This section addresses the role of religious support in the commander's program of COSC and in combat and operational stress reactions ministry. Army chaplains and chaplain assistants constitute a unit ministry team, in organizations at brigade and below, and a chaplain section in organizations at echelons above brigade.

7-83. Commanders provide opportunities for the free exercise of religion through their chaplains and chaplain assistants. Unit ministry teams and chaplain sections provide religious support and advise

commanders, staff and leaders. The chaplain is a personal staff officer who advises the commander and staff on religion, morals, morale, and ethical issues, both within the command and throughout the operational environment.

7-84. Unit ministry teams and chaplain sections provide professional ministry support to leaders in fulfilling their combat and operational stress identification and intervention responsibilities. Chaplains and chaplain assistants recognize the signs of combat and operational stress and work closely with the unit medical personnel. Unit ministry teams evaluate and refer Soldiers experiencing combat and operational stress reactions to medical, behavioral health, or COSC unit personnel. During combat operations, unit ministry teams care for the wounded, often collocating with the battalion or brigade aid stations, and to be with Soldiers who are most likely to experience combat and operational stress reactions.

7-85. Chaplains support the prevention of mild and severe operational stress reactions through their professional training, skills, knowledge and relationships with Soldiers. Chaplains provide—

- Leadership training and supervision of traumatic event management for small-unit leaders in identifying Soldier's experiencing combat and operational stress reactions, stress management techniques, and skills development.
- Religious support to Soldiers experiencing combat and operational stress reactions.
- Opportunities for Soldiers and leaders to talk about combat experiences.
- Reinforcement of the Soldier's sense of hope and faith group expression.

7-86. Under the supervision of the chaplain, the chaplain assistant—

- Assists in religious support planning, preparation, execution, and training (movement, sustainment, rehearsals, and survivability).
- Coordinates for and supervises section activities (equipment maintenance, sustainment support, classified data systems and access).
- Assesses Soldier morale and advises the chaplain accordingly.
- Assists the chaplain in conducting Soldier nurture and care (precounseling interviews and traumatic event management).

7-87. Chaplains and chaplain assistants live out the shared experiences of the Army Family and provide dedicated skills to resolve conflict, foster faith, and enhance unit readiness and individual Soldier and Family resiliency. Through nurturing, caring and honoring, unit ministry teams and chaplain sections help Soldiers to resolve spiritual, moral, and ethical dilemmas presented by the circumstances of war. For additional information on refer to FM 6-0 and ATP 1-05.01, ATP 1-05.02, ATP 1-05.03.

SECTION VII — ROLE OF UNIT BEHAVIORAL ASSETS

MENTAL HEALTH SECTIONS

7-88. The mental health 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. The mental health 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 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 physicians.
- Is qualified to conduct command consultations per DODI 6490.04. Consultation and education should not be confused with evaluation. Only physicians and doctoral-level providers are qualified to conduct command-directed evaluation.

7-89. The mental health sections are located in medical companies assigned to brigade and echelon above brigade medical units. Each brigade support medical company has a four-person mental health section consisting of two behavioral science officers (area of concentration 67D00, one behavioral health noncommissioned officer (military occupational specialty 68X20) and one behavioral health-specialist (military occupational specialty 68X10).

MENTAL HEALTH SECTION FUNCTIONS

7-90. The mental health section coordinates, supervises, and provides the primary COSC functions for the brigade combat teams through vigorous prevention, consultation and education, training, and Soldier restoration programs. These programs are designed to provide COSC expertise to unit leaders and Soldiers where they serve to sustain their focus and effectiveness under heavy and prolonged stress.

7-91. The behavioral health officer (either a clinical psychologist or social work officer) and mental health behavioral health noncommissioned officer and behavioral health specialist are especially concerned with the assisting and training of—

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

7-92. 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 brigade support medical company behavioral health personnel and include them in their planning processes prior to deployment.

7-93. All mental health 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 and education, training, and Soldier restoration programs. These programs are designed to provide behavioral health expertise to unit leaders and Soldiers where they serve and sustain their focus and effectiveness under heavy and prolonged stress. The mental health sections identify Soldiers with combat and operational stress reactions that need to be provided rest and restoration within or near their unit area for rapid return to duty. These programs are designed to maximize the return to duty rate of Soldiers who are either temporarily impaired, have a diagnosed behavioral disorder, or have stress-related conditions.

7-94. In garrison, behavioral health personnel assigned to the brigade support medical company 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 behavioral health treatment functions may be possible as a result of consolidating behavioral health care providers. The behavioral health providers make available their consultation and education skills and clinical expertise to Soldiers of supported units and their Family readiness groups. 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 or medical center. The mental health section personnel should focus their clinical work primarily on Soldiers with problems amenable to brief treatment.

7-95. Clinical services may be provided as part of a consolidated behavioral health activity that is normally coordinated and established by a senior medical headquarters by using brigade behavioral health support personnel and personnel from the medical detachment, COSC, or by augmenting an existing medical department activity or medical center behavioral health staff.

7-96. Mental health sections should work closely with unit leaders and chaplains to control organizational stress and rapidly identify and intervene with those Soldiers having behavioral health disorders. This close relationship through command consultation and education reduces the stigma and lead to a better outcome for both the leadership and Soldiers.

Chapter 8

Command Leadership Actions and Combat and Operational Stress Control Programs

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.

SECTION I — UNIT BEHAVIORAL HEALTH NEEDS ASSESSMENT

8-1. The unit behavioral health needs assessment is a systematic and periodically deliverable assessment tool allowing unit leadership to monitor the longitudinal health of their organizations and offer the ability to identify and address any behavioral health or stress-related concerns that may exist within the organization.

8-2. It is important that leadership recognize and understand 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 sends Soldiers the message that leadership takes the situation seriously and can be trusted to maintain this confidentiality if later needed for personal problems.

8-3. Although the unit behavioral health needs assessment 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.

8-4. It is important for leadership to note that the data obtained from the unit behavioral health needs assessment belongs to the commander of the organization that is being assessed, at the level it is conducted (for example, companies have ownership of the individual company and battalions 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 behavioral health needs. Results may be disclosed to military behavioral health personnel for the purposes of consultation and education or resource allocation. They may also be provided to behavioral health personnel assigned or attached to higher units for the purposes of rolling up the results as part of a larger unit needs assessment.

8-5. Only consolidated data from the unit behavioral health needs assessment 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.

8-6. The survey is solely meant to help behavioral health and unit leaders understand the needs of the unit as a whole in order to develop unit-wide behavioral health prevention and early intervention plans targeting identified problems and allocating limited health 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 unit behavioral health needs assessment would include change of commands, as part of a quarterly assessment plan, during predeployment, deployment, and redeployment operations.

SECTION II — EFFECTIVE LEADERSHIP

8-7. Leaders should not underestimate their influence on the morale and well-being of Soldiers in their command. Leaders should remember that the more the troops know about normal reactions to extremely abnormal experiences, the more resilient they are at dealing with the stress of combat and other military operations. This section provides information to for leaders to use in their planning process for predeployment, deployment, and redeployment operations.

LEADERS ARE RELIABLE AND CONFIDENT

8-8. 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 inspires confidence in them, giving them one less thing to worry about in a potentially stressful situation. Leaders must understand the effects of combat and operational stress reactions 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.

8-9. A unit builds confidence, esprit de corps, integrity, and cohesion when the *leaders know their jobs*.

FORCE PROJECTION PROCESSES

8-10. Leaders should be aware of the common risk factors in deployment distress resulting from the force projection process. Army Techniques Publication 3-35 discusses this process in detail and defines the phases to include mobilization, deployment, employment, sustainment, and redeployment.

8-11. These processes have overlapping timelines, are continuous and can repeat throughout an operation. Force projection operations are inherently joint operations and require detailed planning and synchronization. Decisions made early in the process directly impact the success of an operation.

8-12. 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 inevitably affects 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 may not be fully ready to contribute to the unit and cannot be considered mission ready or reliable. Proper planning covering basic issues that affect Family life such as home, finances, automobile, communications, and other similar issues are essential in preparing Soldiers

for deployment and employment. 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

8-13. Deployment encompasses all activities from origin or home station through destination, including predeployment events, as well as intracontinental U.S., 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 phases within the deployment cycle are distinct and pose their challenges and needs for preparation.

Mobilization

8-14. 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

8-15. 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

8-16. 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 noncommissioned officers and officers) there is no guarantee all things are in order.

Lack of Prioritizing Family Readiness as a Form of Unit Readiness

8-17. 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).

8-18. 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 Family readiness groups. 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.

8-19. Newly married spouses (or very young spouses) are still adjusting to 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 experience problems translating the volume of information they 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.

8-20. Depending on time and availability, individual mobilization augmentee personnel (in the Reserve Component) may not receive valuable mobilization information and readiness education. Ideally, the Family of the individual mobilization augmentee personnel are absorbed by the gaining unit's Family readiness groups 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 Family readiness group's 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 Family readiness group's communication are significantly delayed. The unit Family readiness groups may not be notified when a married Soldier checks into the unit. Procedures for ensuring the Family readiness groups are notified should be established in the unit standard operating procedures.

8-21. Alerting the Family readiness groups would mean the new Family receives a welcome to the unit. Unit point of contact 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 and status. The same can be said of a Soldier getting divorced.

Deployment and Employment

8-22. 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 Family readiness groups.
- Information on unit Family support programs not being passed from the older, more experienced officer and noncommissioned officer spouses to the more junior or younger spouses.

8-23. 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 Family readiness groups is the first point of contact with these Families and is responsible for updating Families through telephone calls, personal contact, and electronic or regular mail. If the Family readiness groups are 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, Family readiness groups, or any other command-sponsored functions.

8-24. Excessive media coverage can challenge all concerned. Families dealing with real-time coverage sometimes draw on false conclusions from the media reports heightening their already elevated stress level. Official information being passed through the Family readiness groups, 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 need guidance on putting media reports in perspective and handling the excessive and dramatic nature of some reporting.

8-25. 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

8-26. 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.

8-27. 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.

8-28. 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 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

8-29. Deployments may include combat, stability, and defense support of civil authorities. Distress is seen during all phases of deployments and with proper training and deployment preparation it may be reduced. Unmanaged stressors have been linked with poor work performance, depression, predisposition to injury, spousal abuse, and other coping difficulties.

8-30. 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 Family readiness groups program. The unit Family readiness groups serves as the official communication link between a deployed command and its Families. The Family readiness groups are 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 Family readiness groups leaders, as well as guidance on establishing and maintaining a Family readiness groups, is available at each military installation.
 - Encouraging participation in Family readiness groups 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

8-31. 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 Family readiness group's members.
- Adopt a comprehensive communications plan that may include unit newsletter, unit answering machine, a unit Web site, a current Family readiness group's telephone tree, e-mail or message traffic, and coordination with rear detachment personnel.
- Educate senior leaders, Family readiness personnel, and rear detachment about the availability of comprehensive educational information and professional military and civilian resource availability.
- 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 assistance. For additional resource information refer to the Military OneSource Web site identified in the references section.

8-32. 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.

8-33. 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

8-34. 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.

8-35. 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 behavioral health practitioner for free. A Soldier or Family member can call a Military OneSource consultant determines if there are on-post resources readily available to assist the caller. If post resources are not available, the Military OneSource consultant provides the caller with an immediate referral to counseling assistance and, using their nationwide network of providers, finds a licensed behavioral health practitioner near the caller. Utilizing Military OneSource is ideal for active duty Soldiers and reserve component Soldiers (and their Families) who need counseling services.

8-36. The DOD has funded a program directing the mental health 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 and reintegration issues.

8-37. Upon arrival at the home location, unit commanders should ensure that Soldiers are aware of the supportive services available through the chaplains, Army community services, and medical treatment facility.

FAMILY RELATIONSHIPS

8-38. 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.

8-39. Chaplains provide counseling and training that teach relationship skills to Soldiers, authorized civilians, and their Families. Unit chaplains and chaplain assistants coordinate with installation chaplains and Family life chaplains for additional unit resources and Soldier support.

8-40. Counseling involves a trained professional assisting a member in resolving problems or making changes and be conducted one-on-one, as couples or in groups. Counseling is helpful in a number of areas to include stress symptoms, poor sleep, nervousness, tension headaches, relationship difficulties, work problems, depression, and anxiety disorders.

8-41. 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.

8-42. Leaders can support Soldiers and their spouses by becoming familiar with the many programs on the installation and in the community that support marriages.

8-43. Services on installations may include—

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

8-44. Other sources of support include—

- Community-based support groups where personal difficulties can be shared with others experiencing similar problems.
- Social activities, sports, and academic endeavors. These provide opportunities for building new friendships.

PERSONAL CHALLENGES

8-45. 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.

8-46. 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.

8-47. 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.

8-48. 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.

8-49. 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.

8-50. 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 staff, 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.

8-51. 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 get through this process without any problems, but some do not and experience personal problems during or after the transition.

8-52. 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 reserve component, the retired list, the temporary or permanent disability list, or the retired Reserve and the similar changes in an active or reserve status.

8-53. 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 or retirement approaches.
- Marital problems.
- Financial problems.
- Exceptional Family member.

8-54. Outright resistance is 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.

8-55. Some type of command involvement can minimize most of the problems listed. For Soldiers who are voluntarily separating, proper adherence to the separation process greatly ease and enhances the transition experience. In addition, the outprocessing checklists 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.

SEXUAL HARASSMENT AND ASSAULT

8-56. 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 neither tolerate nor fail to correct sexual harassment by their subordinates, nor do 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.

8-57. Sexual assault is a criminal act. It is incompatible with the core values of the 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 additional information on prevention of sexual harassment and the Army sexual assault prevention and response refer to AR 600-20.

SUBSTANCE ABUSE

8-58. 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.

8-59. 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 is cannot 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 are to be detained and turned over to a local law enforcement agency for prosecution under the applicable criminal statutes.

8-60. 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. For additional information refer to the Army Substance Abuse Program Web site identified in the references section.

EMOTIONAL RESPONSE TO LOSS AND GRIEF

8-61. 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 is appropriate for 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 may not be mentally stable. 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 usually takes some time and the amount of time is different for everyone and every situation.

8-62. 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 because of unrecoverable illness or injury.

8-63. 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.

8-64. 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 behavior.

8-65. 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 behavior.
- Use of drugs or alcohol.
- Unresolved past losses.
- History of mental illness.
- Deterioration in ability to care for self or others.

8-66. 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 behavioral health 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 behavioral health.
- Make sure Soldiers feel free to avail themselves of the opportunities to attend and discuss combat and operational stress prevention programs such as the Psychological Debriefing developed and implemented by the Walter Reed Army Institute of Research and Resilience

Training (foundational skill training and deployment-cycle training modules provided by master resilience trainers) additional information is provided on the Resilience Training Web site identified in the references.

- Discuss with the chaplain the process to handle deaths both in the unit and in the Families of Soldiers.

8-67. 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 assist Soldiers to understand what is expected and what is valued in life and in death and how to 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 III — TRAUMATIC EVENT MANAGEMENT AND LEADER-LED AFTER ACTION DEBRIEFING

8-68. Traumatic event management is a commander's responsibility and is focused on the behavioral health of the organization and the ability of the individual Soldiers to continue to function in their assigned duties after exposure to a potentially traumatic event.

TRAUMATIC EVENT MANAGEMENT

8-69. Traumatic event management includes any support activities taken to assist in the transition of military units and Soldiers who are exposed to potentially traumatic event. The goals of traumatic event management are to—

- Successfully transition units and individuals to full-mission readiness.
- Build resilience.
- Promote posttraumatic growth.
- Quickly restore and enhance unit cohesion and effectiveness.

8-70. 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 potentially traumatic event. Commanders are not alone in delivering traumatic event management. Commanders are supported by all Army COSC assets and specified traumatic event management facilitators to address potentially traumatic event exposure and provide appropriate support activities. The goal of traumatic event management is to successfully transition units and individuals, build resilience and promote posttraumatic growth, or increased functioning and positive change after enduring a trauma.

8-71. An event is considered potentially traumatic when it involves exposure to threat of perceived or actual death or serious injury. Guilt, anger, sadness, and dislocation of world view or faith are potential emotional and cognitive responses to potentially traumatic events. Studies of Soldiers in Operation New Dawn and Operation Enduring Freedom have shown a correlation between exposure to combat experiences and behavioral health disorders, most particularly acute stress disorder and PTSD. Examples include—

- Participation in heavy or continuous combat operations.
- Death of unit members.
- Accidents.
- Serious injury.
- Death of unit members due to suicide or homicide.
- Environmental devastation or human suffering.
- Significant home front issues.
- Operations resulting in the death of civilians or combatants.
- Mass casualty producing events.

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

8-72. The traumatic event management facilitators include any trained individual designated to assess the potential impact of potentially traumatic event 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 potentially traumatic event incident and promoting resilience, adaptive functioning, and posttraumatic growth. Specifically, traumatic event management facilitators include all COSC providers and Army chaplains. Traumatic event management facilitators may also include specially trained medical and unit personnel designated to provide traumatic event management and unit needs assessment and assist in traumatic event management support activities. There is no specified restriction on who can be trained to assess and render support to units and individuals in response to potentially traumatic event exposure.

8-73. For military units, traumatic event management is active in all phases of the deployment cycle and across unified land operations. It is a process that can and should be used in garrison and in deployed environments.

8-74. The main value of traumatic event management 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 potentially traumatic event.

8-75. In the event a unit experiences a potentially traumatic event, leadership may request a traumatic unit needs assessment. Traumatic event management is a focused assessment of a potentially traumatizing event, with specific consideration of the potential disruption or dysfunction that may have caused to an individual or the entire organization. When requested, the identified traumatic event management team coordinates a traumatic event management unit needs assessments resulting in specific recommendations to address the identified potentially traumatic event as effectively and efficiently as required.

8-76. The traumatic event management unit needs assessments differ from COSC unit needs assessments in the scope and tools utilized to gather the required information. The COSC unit needs assessments 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 unit needs assessments are generally not restricted in terms of time or techniques utilized in compiling the necessary data to obtain the desired results. The COSC unit needs assessments lend themselves to the use of objective measurement tools such as the unit behavioral health needs assessment survey.

8-77. The traumatic event management unit needs assessments, however, are a focused assessment of the potentially traumatic event 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 potentially traumatic event exposure (such as previous combat injuries when responding to a unit casualty). The traumatic event management unit needs assessments are generally time-limited and rely on more subjective data-gathering techniques rather than formal objective measurements.

8-78. It is recommended that leadership request traumatic event management unit needs assessments as close to the specific potentially traumatic event as practically possible. However, there are no time limitations to conducting assessments and implementing traumatic event management support activities in response to current or past potentially traumatic event exposure that have had a significant impact on the performance, morale, and cohesion of the effected unit or organization.

8-79. The traumatic event management process incorporates multiple support exercises to aid the leader in managing and mitigating the impact of potentially traumatic event exposure that units and Soldiers may experience while executing military operations. Traumatic event management is tailored to the potentially

traumatic event 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 potentially traumatic event.
- Command consultation and education.
- Unit and individual education.
- Individual supportive intervention and counseling.
- Psychological debriefs.

8-80. In the event traumatic event management facilitators are not available to assist with traumatic event management, leaders may use alternative methods to address potentially traumatic events, including cool down meetings and leader-led after action debriefings, as described in the proceeding paragraphs.

COOL DOWN MEETINGS

8-81. An immediate, short meeting when a team or larger unit or group returns from the battlefield or other mission is referred to as a cool down meeting. These cool down meetings are held after heavy or intense battles with the enemy or a shift in the mission has occurred which is highly arousing or distressing. This is especially important after potentially traumatic events. The cool down meeting is an informal event and occurs before the participants fully replenish their bodily needs and precedes any other activities including leader-led after action debriefings, COSC interventions, or return to the mission.

8-82. 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 rest and replenish.
- Previewing the immediate agenda for the unit on what happens after the cool down meeting including plans for further debriefing 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

8-83. A leader-led after action debriefing is led by a platoon, squad, or team leader and is not normally conducted above platoon level. The leader-led after action debriefing should be conducted after all missions especially when the maneuvers did not go according to plan.

8-84. A leader-led after action debriefing may even be sufficient for potentially traumatic events involving injury or death. The best time to conduct this debriefing is as soon as is feasible after the team, squad, or platoon has returned to a relatively safe place and members have replenished bodily needs and are no longer in a high state of arousal.

8-85. Usually a well-conducted leader-led after action debriefing is the best option to manage potentially traumatic events during a mission. The exception to this type of debriefing is when the event evoked reactions that seriously threaten unit cohesion 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 traumatic event management be submitted for his team, squad or platoon?

CONDUCTING A LEADER-LED AFTER ACTION DEBRIEFING

8-86. 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. 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.

8-87. When a potentially traumatic event 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 unit ministry team Soldier trained in traumatic event management sits in with the leader-led debriefing as a familiar and trusted friend of the unit. The COSC or unit ministry team facilitator helps the unit and 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 leader-led after action debriefing. Company commanders and first sergeants may conduct after action debriefings similar leader-led after action debriefing with their subordinate leaders. Battalion commanders may also conduct similar type debriefings with their staff after distressing actions and may include subordinate leaders when time allows bringing them together.

COMPONENTS OF LEADER-LED AFTER ACTION DEBRIEFING

8-88. Do not go it alone. Consult your behavioral health assets or chaplain to discuss the event (potentially traumatic event) and use of this guideline before arranging for a leader-led after action debriefing.

8-89. 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 leader-led after action debriefings 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 leader-led after action debriefings 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.

8-90. Conduct a leader-led after action debriefing using the following:

- Open the leader-led after action debriefing with an introduction that—
 - Identifies the goals of the debriefing and establishes the climate and the ground rules.
 - Explains that the leader-led after action debriefing is designed to be given by the leader and focuses on the emotional impact of a potentially traumatic event.
 - Explains that the leader-led after action debriefing is not intended to be a traditional after action review or fact-finding event.
- Explain that a leader-led after action debriefing 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 leader-led after action debriefing 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 potentially traumatic event that occurred. The leader should address issues such as the status of wounded Soldiers and review any specifics that occurred during the potentially traumatic event exposure. The focus is on facts and to

resolve any developing rumors so everyone is clear, as far as operations security permits, on what happened during the potentially traumatic event. 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 standard operating procedures (quick response time and so forth). Any real deficiencies can be addressed later.

- Acknowledge thoughts and reactions resulting from the potentially traumatic event 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 potentially traumatic event. 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 potentially traumatic event impact on both the unit and its individual Soldiers. Leaders must give permission to their Soldiers that it is acceptable to show reactions to potentially traumatic events. 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 resilience training 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, behavioral health, and COSC assets.

8-91. Leaders should meet with trusted helpers after the leader-led after action debriefing to review the process and identify individuals who might require additional assistance or referral right away. Leaders should follow up individually with group participants within a few days after the leader-led after action debriefing and periodically thereafter for status check or help as needed.

EFFECTIVELY SUSTAIN PERFORMANCE

8-92. Every Soldier, team, and unit must learn to effectively sustain performance in continuous operations. This requirement applies especially to leaders.

8-93. 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.

8-94. 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

8-95. 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 under experienced) crews man weapon systems. Ways to safeguard Soldiers include developing and following unit safety standard operating procedures and increasing supervision during extended operations.

FOOD INTAKE

8-96. If Soldiers are too busy, stressed, or too tired to eat adequate rations during continuous operations, their caloric intake is 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.

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 individual, because nutritional demands may exceed caloric intake of the meal.

8-97. 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 meal, ready-to-eat individual or special meals during significant achievements or holiday activities. Good nutrition is very important. Eating all meals in the field usually provide the body's requirements for salts. The meal, ready-to-eat individual meet the daily requirements for minerals and electrolytes. Do not take extra salt in meals unless medically indicated.

8-98. An inadequate diet degrades performance, reduces resistance to disease, and prolongs recuperation from illness and injury.

8-99. 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 deployment.

8-100. Contributing to developing dehydration is the relative lack of moisture in the meal, ready-to-eat individual. 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 Soldiers drink only when thirsty, they become dehydrated. For additional information on hydration refer to TC 4-02.3.

COMBAT LOAD

8-101. 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 combat and operational stress reactions experienced by the individual and the unit. Employing a load echelonnement 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. As the unit closes on the objective, the heavier existence load is dropped and the Soldier continues with the lighter fighting load.

PHYSICAL CONDITIONING

8-102. 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

8-103. 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. 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 or physical stress training. As physical conditioning improves, Soldiers feel better about themselves and have greater confidence in each other.

SECTION IV — EFFECTIVE COMBAT AND OPERATIONAL STRESS CONTROL

8-104. An effective combat and operational stress control program starts with the proper command climate that supports and accepts all the aspects of stress management. It is imperative that leaders, Soldiers, Family members, and Army Civilians understand the program and know where to obtain the resources to maximize the program's effectiveness.

MINIMIZE STRESS

8-105. 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 7. For more information on deployment and redeployment and the force projection process, see ATP 3-35.

MOBILIZATION

8-106. 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.

8-107. 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.

8-108. 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 Army community services.)
- 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 operational security 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 behavioral health professionals, or COSC team, if available.

UNIT TRAINING

8-109. 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.

8-110. 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.

8-111. 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, should it be necessary to wear it.

8-112. Given operational security 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.

8-113. 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

8-114. 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 behavioral health personnel available to the unit can provide additional training.

Sleep Discipline

8-115. 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.

Task Allocation and Management

8-116. 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 military occupational specialty requirements) is trained in a secondary duty position to ensure competently stepping into the position of another.

- Developing performance supports. Develop standard operating procedures, 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

8-117. 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 results in the unit's inability to perform at peak potential.

8-118. 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 Service member's Group Life Insurance.
- Ensure Family automobiles are in good repair.
- Develop lists of telephone numbers of reliable points of contact 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

8-119. Small-unit leaders should—

- Brief Families as a group before deployment or as soon as possible after deployment into the area of responsibility. Within the bounds of operational security, 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 Army community services, post behavioral health service, and the chaplain section or unit ministry team assists in staging this briefing.
- Establish points of contacts (for example, the key volunteer network) to assist with Family problems. These volunteers possess good working relations with the chaplain and behavioral health personnel to assist with the management of complex problems.
- Establish key volunteer communication and support networks. Commanders' spouses or spouses of sergeant 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 behavioral health 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

8-120. Deployment occurs when units or individuals deploy from the continental U.S. or outside the continental U.S. installations into the designated area of responsibility. Recurring administrative actions are completed during the deployment stage.

8-121. 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 area of responsibility on emergency leave, rest and recuperation, and medical evacuation. *Medical evacuation* is the process of moving any person who is wounded, injured, or ill to and/or between medical treatment facilities while providing en route medical care (FM 4-02).

8-122. 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.

8-123. Unit leaders should emphasize that stress under these circumstances and conditions are expected and are a natural reaction. This helps prevent *normal* stress reactions from escalating into extreme reactions.

8-124. 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

8-125. 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

8-126. 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.

8-127. 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.

8-128. 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 leader-led after action debriefings.

FAMILY SUPPORT

8-129. Soldiers entering an operational area 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 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. When Soldiers know their Families are cared for, they are better able to focus on their military duties.

8-130. The Army community services, installation Family life chaplain, and Family support groups provide Family support throughout deployments. The Army Emergency Relief, American Red Cross, Army community services, and other community agencies also provide direct assistance to Family members. For additional information and 24-hour assistance refer to the Military OneSource Web site identified in the references section of this publication. The Family readiness groups and the American Red Cross continue to function as conduits for emergency information between Soldiers and their Families. Unit leaders need to educate Soldiers about these programs and agencies that are available to serve the needs of the community. Effective communication and caring support networks help to prevent anxiety while Soldiers are deployed or in combat.

PHYSICAL AND RECREATIONAL ACTIVITIES

8-131. 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. During some operations extensive physical fitness facilities and morale, welfare, and recreation activities may be available 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.

8-132. 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.

8-133. Redeployment refers to the rotation of forces in an area of responsibility; transfer forces and materiel to support other operational requirements; or return personnel, equipment (if it not left in area of responsibility 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 Army Civilians into their predeployment environments. Redeployment stage tasks include administrative actions, briefings, training, and counseling for Soldiers and Army Civilians departing area of responsibility and Family members at home station.

8-134. 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 Army Civilians into their Families and communities.

8-135. Soldiers who have returned from deployments in support of Operation Enduring Freedom, Operation Iraqi Freedom and Operation New Dawn 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, as part of their end-of-tour stress management debriefing and behavioral health screening, receive homecoming-reunion educational briefings and training to prepare them for their Family reunion and avoidance of domestic strife. Soldiers with any behavioral health problems are referred for treatment by the installation medical treatment facility. All Soldiers and Families are informed of Family support services available to them.

8-136. 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. 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 area of responsibility 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 chaplain and behavioral health assets to coordinate postdeployment psychological debriefings shortly after returning to home station installations.

8-137. Unit officers and noncommissioned officers, assisted by the chaplains and behavioral health 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.

8-138. 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.

8-139. 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.

8-140. 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 the operational area 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.

8-141. The same leadership skills that apply to troop welfare and warfighting can effectively reduce or prevent combat and operational stress reactions. Small-unit leaders should take preventive actions and address stress symptoms as they appear. Ignoring the early warning signs can increase the severity of stress reactions.

SECTION V — SOLDIER RESILIENCY AND COMBAT AND OPERATIONAL STRESS CONTROL

8-142. Although war affects all Soldiers, most make a successful transition home after combat duty. Some Soldiers experience persistent symptoms such as a sleep disturbance, hypervigilance, detachment anger, or risky behaviors such as alcohol misuse or aggression. Resilience programs are designed to prevent or reduce the severity of combat related behavioral health issues. They are based on coordinated efforts of strength-based approach emphasizing the strength and skills that helped Soldiers to survive combat instead of focusing on negative effects of combat.

8-143. Management of combat and operational stress reactions through peer support is a significant factor in the mitigation of combat and operational stress reactions within the organization. Soldiers identify with peers who are viewed as trusted and needed. A determining factor in treating combat and operational stress reactions 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 combat and operational stress reactions.

8-144. The U.S. Army has designed a peer-support training program leveraging existing Army behavioral health assets and health care specialist and combat medics. All health care specialists (military occupational specialty 68W) are provided resilience training as part of their basic and advanced individual training. The skills they receive reinforce the ability to institute peer-support networks within unit structures and provide the ability to conduct preliminary traumatic event management unit needs assessments and limited support activities in response to unit and individual potentially traumatic event exposure. This program is designed to enhance existing buddy aid and battle buddy support concepts that currently are utilized by the U.S. Army. It specifically addresses unit-level combat and operational stress behaviors that Soldiers and small groups may exhibit while executing military operations. Psychological first-aid 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 behavioral health and stress management.

8-145. A peer-delivered system that operates in concert with more formal behavioral health assets has certain advantages over one delivered exclusively by the latter. In the military, adequate behavioral health support may be difficult to deliver because of logistical constraints, difficult terrain, and wide dispersal of personnel, combat contingencies, and a limited number of behavioral health practitioners who may not always be as well-integrated with their specific brigades.

8-146. Under the psychological first-aid program, identification of cases and uncomplicated intervention begin at the unit level, by unit members (health care providers and combat medics), preserving unit self-reliance and cohesion without the previously mentioned logistical concerns.

8-147. 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 the incorporating psychological first-aid program into the organizational structure.

8-148. It is highly recommended that leaders utilize psychological first-aid program-trained medics in developing and implementing a peer-support program within their organization. Command should contact local behavioral health 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 potentially traumatic events and support delivery for Soldiers within an organization.

SECTION VI — LEADERSHIP ACTIONS AND INTERVENTIONS FOR COMBAT AND OPERATIONAL STRESS REACTIONS

8-149. 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 escorted to the battalion aid station or the nearest medical treatment facility as soon as possible. Additional information for commanders and leaders on mental health evaluations of members of the military services can be found in DODI 6490.04.

8-150. 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 normal combat and operational stress reactions and they normally improve quickly.

8-151. If the combat and operational stress reactions signs continue—

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

8-152. If the tactical situation permits, give the Soldier simple tasks to do when not sleeping, eating, or resting and assure the Soldier that he can return to full duty as soon as possible.

8-153. The most effective treatment for combat and operational stress reactions 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 combat and operational stress reactions are normalized and the unit demonstrates a desire to retain the individual, there is a significant chance of improvement in the Soldier.

8-154. When combat and operational stress reactions 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 medical treatment facility. 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 facilitates 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).

8-155. 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. 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.

8-156. 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 are normally treated and released within hours, held for rest and replenishment, or evacuated for further Soldier restoration. Soldiers who recover from combat and operational stress reactions 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 combat and operational stress reactions 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 VII — COMBAT AND OPERATIONAL STRESS REACTION MANAGEMENT GUIDELINES

8-157. Guidelines for treatment and management of combat and operational stress reactions are based on a standardized process to treat as far forward as possible and return the Soldier to duty as soon as possible. This process is the following process based on brevity, immediacy, contact, expectancy, proximity and simplicity.

8-158. Guidelines in the treatment and management of combat and operational stress reactions are summarized in a memory aid to define brevity, immediacy, contact, expectancy, proximity, and simplicity (BICEPS). The BICEPS is a memory aid for the management of combat and operational stress reaction: brevity—usually last 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—casualty recovery; proximity—treatment at or as near the front as possible; simplicity—use of simple measures, such as rest, food, hygiene, and reassurance. Using BICEPS is extremely important in the management of Soldiers with combat and operational stress reactions or behavioral disorders.

BREVITY

8-159. 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 return to duty rapidly.

IMMEDIACY

8-160. It is essential that COSC measures be initiated as soon as possible when operations permit. Intervention is provided as soon as symptoms appear.

CONTACT

8-161. 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 return to duty. The COSC team coordinates with the unit's leaders to learn whether the overstressed individual was a good performer prior to the combat and operational stress reactions. 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

8-162. 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 combat and operational stress reactions 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 has a 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

8-163. 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

8-164. Indicates the need to use brief and straightforward methods to restore physical well-being and self-confidence.

8-165. The actions used by health care providers to combat and operational stress reaction control are commonly referred to as the 6 Rs. The 6 Rs describe actions used for combat and operational stress reaction control: 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 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.

SECTION VIII — SAFETY CONSIDERATIONS

8-166. Soldier and unit safety considerations come first. Leaders should be aware of emergency procedures to take in the event that a Soldier presents with questionable safety concerns. Emergency behavioral health evaluations should be a part of every organization's standard operating procedure. Standard operating procedures should include the use of escorts, proper form templates to execute command referrals, buddy watch protocols, and weapons removal guidelines. If standard operating procedures do not exist, consult with organic behavioral health assets to establish policies that are compatible with the specific unit structure.

8-167. 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.

8-168. 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. Consult behavioral health assets immediately in all matters concerning safety assessments and risk management of unit personnel.

Chapter 9

Behavior and Personality Disorders

Serving in the Army requires the physical and mental fitness necessary to plan and execute missions involving combat, as well as stability and defense support of civil authorities 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. This chapter addresses behavioral and personality disorders and what impact they may have on unit readiness.

SECTION I — MEDICAL READINESS RESPONSIBILITIES

9-1. 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.

9-2. Recovery, amelioration of symptoms, and reduction of behavioral impairment are always goals associated with behavioral health 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.

9-3. Early identification and treatment are keys to continuation of or return to duty for Soldiers who experience behavioral health disorders. All Soldiers, both in the active Army and reserve component, should be actively encouraged to seek treatment for behavioral health concerns.

9-4. 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 and deployment life cycle (periodic or recurring health assessment and physicals for predeployment, deployment, and postdeployment assessments, and normally after 90 to 120 days for a postdeployment health reassessment). 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 area of responsibility 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 behavioral health condition.
- The occupational specialty in which the individual functions 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.

9-5. 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, decision-making, reaction time, psychomotor functioning and coordination, and other psychological and physical parameters that are relevant to functioning effectively. In addition, psychotropic medications may be prescribed for a variety of conditions that are not assigned a psychiatric diagnosis.

9-6. Caution is warranted in beginning, changing, stopping, 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.

9-7. Commanders should work closely with medical personnel to identify any Soldier that receives 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. 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 and education with the unit commander. If there are any questions on the safety of psychiatric medication, a psychiatrist should be consulted.

9-8. Medical readiness follows the Army Force Generation 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 ATP 3-35 for definitive information pertaining to Army force generation model. 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.

9-9. Medical readiness assessments are conducted for reconstitution operations, train up, and preparation period of the Army force generation model process through the annual periodic health assessment, postdeployment health reassessment, as well as routine health care visits. These medical readiness assessments may include—

- Recurring and periodic health assessment for the predeployment, deployment, and postdeployment health reassessment processes which are designed to provide a global health assessment.
- Behavioral health disorders, behavioral health 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 is 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 Soldier's official military personnel file. In addition, notations must be documented in the medical record for future deployment-related reviews.
- Recurring and periodic health assessment and postdeployment health reassessment 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 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

9-10. The DD Form 2795 is designed to identify health concerns that would preclude deployment or require a brief course of treatment immediately prior to deployment. This includes self-reported information of health status, medical record pre-deployment health assessment 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 behavioral health 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 behavioral health specialty review or consultation. This is done to determine deployability limitations and recommendations.

DEPLOYMENT

9-11. When personnel are diagnosed with a psychiatric disorder in the area of responsibility, the provider assesses the patient's condition, treatment regimen, and risk level. The clinical decision to maintain or evacuate personnel diagnosed with psychiatric disorders in the area of responsibility is based upon: the severity of symptoms or medication side effects; the degree of functional impairment resulting from the disorder or medications; the risk of exacerbation if the Soldier 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 or whose condition does not significantly improve within two weeks of treatment initiation, are to be clinically recommended for return to their home station, in consultation with their commander.

POSTDEPLOYMENT

9-12. The DD Form 2796 is used to document the assessment. The post-deployment health assessment is conducted immediately at the end of a deployment to determine any changes in health status resulting from deployment. Conditions that require immediate treatment are stabilized at the point of administration of

the post-deployment health assessment. Other conditions are referred back to the servicing medical treatment facility at the Soldier's station of assignment. Currently established medical processing procedures followed for United States Army Reserve personnel that are subject to release from active duty upon return. Resultant treatments and final disposition are documented clearly in the military health record for future medical records review.

SECTION II — PERSONALITY DISORDERS

9-13. Commanders must understand the impact behavioral health status may have on unit readiness. Specifically, the role personality disorders may play in effecting the organization's ability to engage in military operations.

BEHAVIORAL HEALTH STATUS

9-14. Personality disorders are behavioral health 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 display various personality traits that are prominent aspects of their personality and are exhibited in a wide range of important social and personal contexts.

9-15. 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.

9-16. 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.

DOCUMENTING MALADAPTIVE PATTERNS OF BEHAVIOR AND PERFORMANCE

9-17. As discussed in Chapter 10 of this manual, PTSD is an anxiety disorder 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 potentially traumatic event exposure. Personality disorders and PTSD can coexist; however, they are not the same thing.

9-18. 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.

9-19. Commanders must document service-related maladaptive performance throughout all areas of the Army force generation 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 allows for the appropriate disposition channels and treatment avenues that Soldiers are entitled to and organizations can leverage.

This page intentionally left blank.

Chapter 10

Posttraumatic Stress Disorder

Posttraumatic stress disorder is an anxiety disorder with potentially debilitating implications. This chapter provides leaders with information on the symptoms of the disorder and resources to obtain assistance for the Soldier experiencing this reaction. Leaders and Soldiers need to recognize these symptoms, seek assistance, and provide support and encouragement to the Soldier or individual experiencing PTSD.

10-1. 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 such as PTSD. It isn't clear why some people develop PTSD and others do not. Posttraumatic stress disorder 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 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.

10-2. Posttraumatic stress disorder does not restrict itself to Soldiers as this disorder can be experienced by anyone including Family members (spouse, children, relative and some cases a close friend), Army Civilians and the general population. Traumatic events such as accidents, medical emergencies, or an event in which the person perceives their life or the lives of others are in danger may trigger this stress disorder.

10-3. 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) (see Table 10-1). 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.

Table 10-1. Symptoms of posttraumatic stress disorder

Soldier experiences the event over and over again— Cannot put it out of his mind no matter how hard he tries. Has repeated nightmares about the event. Has a vivid memory of the event, almost like it was happening all over again. Has a strong reaction when he encounters reminders, such as the smell of diesel fuel.
Soldier avoids people, places, or feelings that remind him of the event— Works hard to put it out of his mind. Feels numb and detached. Avoids people or places that remind him of the event.
Soldier feels keyed up or on edge all the time— May be startled easily by loud noises. May be irritable or angry for no apparent reason. Is always aware of the possibility of threats. May have trouble relaxing or getting to sleep.

10-4. It is important to note that every Soldier experiences some type of postcombat and operational stress resulting from their military experience. Postcombat and operational stress is not a behavioral

health 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, or ability to appreciate what is important in life.

10-5. 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 behavioral health, social work service, or the Soldier's primary care physician. Additional information is also available on the Behavioral Health, Military OneSource, and the Defense Center of Excellence for Psychological Health and Traumatic Brain Injury Web sites identified in the references.

Chapter 11

Mild Traumatic Brain Injury

Mild traumatic brain injury, or concussion, is an invisible injury resulting from not only the signature weapons of Operation Enduring Freedom and Operation New Dawn—improvised explosive devices and rocket-propelled grenades—but also from blows to the head during physical training, sports activities, motorcycle or motor vehicle accidents, falls and accidents at home. This chapter describes commander's and leader's responsibilities in identifying, reporting, and assisting Soldiers who have been exposed to a potential concussive event while deployed or in a garrison setting.

SECTION I — MILD TRAUMATIC BRAIN INJURY OVERVIEW

11-1. Mild traumatic brain injury, or concussion, is a disruption in brain function as a result of an external force, typically from a blow or jolt to the head. Concussions are usually treatable and the overwhelming majority of Soldiers fully recover; however, receiving prompt care regardless of injury severity is essential in maximizing recovery. The diagnosis of concussion is made when two conditions are met. In the absence of documentation, both conditions are based on self-reported information. An injury event must have occurred and the individual must have experienced one of the following:

- Alteration of consciousness lasting less than 24 hours.
- Loss of consciousness, if any, lasting for less than 30 minutes.
- Memory loss after the event, called posttraumatic amnesia, that lasts for less than 24 hours.
- Normal structural neuroimaging.

11-2. The brain needs rest and time to recover after a concussion and it is extremely important to avoid a second injury while the brain is healing. Recovery time after concussion varies based on injury circumstances, the Soldier's medical history, and recovery from prior injuries. Leaders at all echelons need to recognize the effects of mild traumatic brain injury or concussion and how factors such as sleep-deprivation, nutrition, emotional trauma, and musculoskeletal injury influence concussion recovery.

11-3. Early intervention, education, and treatment are the cornerstones to maximizing full recovery. Mild traumatic brain injury or concussion symptoms can significantly impact not only personal and unit safety, but also operational effectiveness. Table 11-1 describes how the symptoms of mild traumatic brain injury or concussion can affect the Soldier and impact the combat mission.

Table 11-1. Effects of mild traumatic brain injuries, or concussions, on the Soldier and combat mission

Symptoms	Manifestation	Operational impact
Headache.	Decreased energy.	Marksmanship difficulties.
Sleep disturbance.	Difficulty sleeping.	Decreased awareness.
Difficulty finding words.	Slower reaction time.	Difficulty performing quickly under time pressures.
Balance difficulties.	Change in walking patterns.	Difficulty navigating uneven terrain.
Light sensitivity, ringing in the ears.	Easily distracted.	Difficulty multitasking.
Slowed thinking, poor concentration.	Difficulty processing multiple sources of information.	Difficulty in performing in certain environments.
Irritability, mood swings, anxiety.	Interpersonal problems.	Performance difficulties can affect confidence and self-esteem.

EDUCATE

11-4. Education is the overarching line of effort in the mild traumatic brain injury management strategy to increase awareness and decrease the stigma of seeking care for invisible injuries. In September 2012, the Secretary of Defense issued DODI 6490.11. This instruction established the requirement for the Services to develop and support effective training programs for early detection by commander's, leaders and Soldiers as well as educating medical personnel in mild traumatic brain injury, or concussion, treatment algorithms.

11-5. Extensive educational materials are available from Defense and Veterans Brain Injury Center, Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury Web sites identified in the references. These Web sites have multiple educational documents and graphics cards for the Soldiers and their Families. Education and positive expectation for recovery is well supported in the literature for treating mild traumatic brain injury, concussion patients. For additional information on the programs and resources provided by the referenced agencies refer to their Web site links in the references section of this publication.

TRAIN

11-6. Specialized training is provided to medics and health care providers both for deployed and garrison settings, as well as to senior leaders for general traumatic brain injury awareness and leadership expectations. Traumatic brain injury training required by DODI 6490.11 is available via the training network. This document provides policy guidance for management of mild traumatic brain injury, or concussion, in the deployed setting. Specifically it delineates training requirements through the echelons of agencies and leader positions to manage an effective and efficient training program.

TREAT

11-7. The goal of treatment programs is to deliver integrated care and services from the point of injury or wounding to return to duty or transition from active duty and maximizing function and quality of life. Numerous initiatives are under development to treat and manage mild traumatic brain injury, concussed patients including—

- Implementation of deployed medical algorithms and dissemination of clinical practice guidelines.
- Designation of providers and special clinics to support the mild traumatic brain injury mission at some Roles 2 and 3 medical treatment facilities in Operation Enduring Freedom.
- Dissemination of the mild traumatic brain injury rehabilitation toolkit to assist providers with assessment and treatment. Rehabilitation toolkits and other information sources can be located at the Defense Centers of Excellence Web site identified in the references.
- Evaluation by a Role 4 facility of all medically evacuated patients for mild traumatic brain injury.
- Employment of interdisciplinary mild traumatic brain injury teams at high troop density installations.
- Provision of state-of-the-art equipment for assessment and treatment.
- Collaboration with the U.S. Department of Veterans Affairs and local resources to meet individual Soldier needs.
- Implementation of traumatic brain injury telehealth programs to ensure patients have access to professionals from remote sites. The Mobile Care Program provides Soldiers mobile phones for our community-based Warriors in transition unit programs to facilitate communication with their health care team. The deployed providers can send e-mail inquiries to contact a subject matter expert in the continental U.S. support base or other locations to the Defense and Veterans Brain Injury Center.

TRACK

11-8. The goal of tracking mandatory events is to facilitate identification of Soldiers at potential risk, provide awareness to health care providers and leaders, and improve medical care with knowledge of involvement in potentially concussive events.

11-9. In accordance with DODI 6490.11, units are required to document mandatory events in a significant activity report. This information is transferred through command channels to the Combined Information Data Network Exchange in the Blast Exposure and Concussion Incident Report module. This information is then transferred to the Joint Trauma Analysis and Prevention of Injury in Combat Program.

11-10. Department of Defense policy guidance is transmitted in DODI 6490.11. This directive establishes policy, assigns responsibilities, and provides procedures for the management of mild traumatic brain injury or concussion, in the deployed setting. It standardizes terminology, procedures, leadership actions, and medical management to provide maximum protection of the Soldier.

11-11. The specifics of the DOD policy guidance are provided in DODI 6490.11. Commanders and leaders have a responsibility to—

- Identify, track, and ensure the appropriate protection of Soldiers exposed to potential concussive events, including blast events.
- Direct a medical assessment for any Soldier exposed to possible concussive events as close to the time of the injury as possible.
- Identify, treat, and manage concussion in Soldier by following approved clinical guidance.
- Address recurrent concussions in a manner appropriate to its emerging clinical significance.

SECTION II — COMMANDER'S GUIDANCE FOR MANAGEMENT OF MILD TRAUMATIC BRAIN INJURY

11-12. Commanders, leaders, and Soldiers are trained to identify potential concussion events requiring mandatory rest periods, medical evaluations and reporting of exposure of all involved personnel. Mild traumatic brain injury or concussions can occur in combat, training, and in garrison or homes. Leaders, Soldiers, Family members, and Army Civilians should recognize potential concussive events, reporting and medical treatment guidelines outlined in this publication.

11-13. Potential concussive events that could lead to mild traumatic brain injury include, but are not limited to—

- Involvement in a vehicle blast event, collision, or rollover.
- Presence within 50 meters of a blast (inside or outside).
- Direct blow to the head or witnessed loss of consciousness.
- Exposure to more than one blast event (the Soldier's commander shall direct a medical evaluation).

11-14. Commanders or their representatives are required to assess all Soldiers involved in potentially concussive events, including those without apparent injuries, as soon as possible using the injury, evaluation, and distance checklist (Table 11-2).

Table 11-2. Injury, evaluation, and distance checklist

Injury	Physical damage to the body or body part of the Soldier?	(Yes/No)
Evaluation	H – Headaches and or vomiting? E – Ears ringing? A - Amnesia, altered consciousness, and or loss of consciousness? D – Double vision and or dizziness? S – Something feels wrong or is not right?	(Yes/No)
Distance	Was the Soldier within 50 meters of the blast? Record the distance from the blast.	(Yes/No) Not Applicable

11-15. If a Soldier is involved in a potentially concussive event and any of the injury, evaluation, and distance checklist is answered yes, or demonstrate any listed symptoms, the Soldier is referred for a medical evaluation.

11-16. Upon completion of the injury, evaluation and distance checklist record the results of all the Soldier's involved in the event and submit as part of a significant activities report required for blast-related events or other events outlined in paragraph 11-9 of this chapter.

11-17. Commanders are required to report the following as soon as possible, preferably within 24 hours, as operational conditions permit—

- Date of potentially concussive event.
- Type of potentially concussive event triggering the evaluation.
- Significant action number.
- Personal identifier (DOD identification or roster number).
- Soldier's name.
- Unit name, unit identification code, and home duty station.
- Combatant command in which the event occurred.
- Soldier's distance from the blast when applicable.
- The dispositions following the medical evaluation (return to duty after 24 hours, commander's justification to return to duty prior to 24 hours, or did not return to duty after 24 hours).

11-18. The common signs and symptoms of mild traumatic brain injury, or concussion, are detailed in Table 11-3. The signs and symptoms may manifest individually or be combined. Medical examinations, diagnosis, and treatment plans assists the Soldier's recovery and return-to-duty.

Table 11-3. Common mild traumatic brain injury, or concussion, signs and symptoms

Physical	Cognitive	Emotional
Headache.	Concentration problems.	Irritability.
Sleep disturbance.	Temporary gaps in memory.	Anxiety.
Dizziness.	Attention problems.	Depression.
Balance problems.	Slowed thinking.	Mood swings.
Nausea or vomiting.	Difficulty finding words.	
Fatigue.		
Visual disturbance.		
Sensitivity to light.		
Ringing in the ears.		

11-19. Commanders should recognize these symptoms and be cognoscente of increasing complications such as worsening headaches, worsening balance, double vision, decreased alertness or disorientation, seizures, repeated vomiting, seizures and memory problems. Increased complications require immediate medical attention.

11-20. All deployed medical personnel must use and commander's must follow the most current clinical practice guidelines for deployed personnel. Medical guidance is provided at the Defense Center of Excellence for Psychological Health and Traumatic Brain Injury and the Defense and Veterans Brain Injury Center Web sites identified in the references section of this publication.

11-21. Sample medical guidance is provided below—

- Potential Concussive Event—Soldiers involved in a potential concussive event are required to rest for 24 hours, beginning at the time of the event. Commanders may determine that mission requirements supersede the rest period in certain circumstances. If the 24-hour rest period is delayed the commander must document the circumstances on their monthly reports.
- First Diagnosed Concussion—Soldiers diagnosed with a mild traumatic brain injury, or concussion must have a minimum of 24-hour recovery and the recovery period may be extended based on a medical evaluation for return-to-duty.
- Second Diagnosed Concussion—Two diagnosed concussions within a 12-month period prescribe a delay the Soldier's return-to-duty for seven days following the symptoms resolution.
- Recurrent Concussion—Three diagnosed mild traumatic brain injuries, or concussions, within a 12-month period delays the Soldier's return to duty until a recurrent concussion evaluation has been completed. A neurologist or other qualified practitioner is required to determine the Soldier's return-to-duty status.

This page intentionally left blank.

Glossary

This glossary lists acronyms and terms with Army or joint definitions. Where Army and joint definitions differ, (Army) preceded the definition. The proponent publication for other terms is listed in parentheses after the definition. This publication is not the proponent for any Army terms.

SECTION I – ACRONYMS AND ABBREVIATIONS

AR	Army regulation
ATP	Army techniques publication
BICEPS	brevity, immediacy, contact, expectancy, proximity, simplicity
COSC	combat and operational stress control
DA	Department of the Army
DA Pam	Department of the Army pamphlet
DOD	Department of Defense
DODI	Department of Defense instruction
FM	field manual
JP	joint publication
PTSD	posttraumatic stress disorder
TC	training circular
U.S.	United States Army

SECTION II – TERMS

combat and operational stress control

A coordinated program for the prevention of and actions taken by military leadership to prevent, identify, and manage adverse combat and operational stress reactions in units. (FM 4-02)

medical evacuation

The process of moving any person who is wounded, injured, or ill to and/or between medical treatment facilities while providing en route medical care. (FM 4-02)

medical treatment facility

Any facility established for the purpose of providing medical treatment. This includes battalion aid stations, Role 2 facilities, dispensaries, clinics, and hospitals. (FM 4-02)

outpatient

A person receiving medical/dental examination and/or treatment from medical personnel and in a status other than being admitted to a hospital. Included in this category is the person who is treated and retained (held) in a medical facility (such as a Role 2 facility) other than a hospital. (FM 4-02)

patient

A sick, injured, or wounded Soldier who receives medical care or treatment from medically trained personnel. (FM 4-02)

Glossary

preventive medicine

The anticipation, prediction, identification, prevention, and control of communicable diseases (including vector-, food-, and waterborne diseases), illnesses, injuries, and diseases due to exposure to occupational and environmental threats, including nonbattle injury threats, combat stress responses, and other threats to the health and readiness of military personnel and military units. (FM 4-02).

return to duty

A patient disposition which, after medical evaluation and treatment when necessary, returns a Soldier for duty to his unit. (FM 4-02)

References

REQUIRED PUBLICATIONS

These documents must be available to intended users of this publication.

This publication is available online at (www.apd.army.mil). Accessed on 9 December 2015.

ADRP 1-02, *Terms and Military Symbols*, 7 December 2015.

This publication is available online at (<http://www.dtic.mil/doctrine>). Accessed on 9 December 2015.

JP 1-02, *Department of Defense Dictionary of Military and Associated Terms*, 8 November 2010.

RELATED PUBLICATIONS

These documents contain relevant supplemental information.

DEPARTMENT OF DEFENSE PUBLICATIONS

Department of Defense publications are available online at (<http://www.dtic.mil/whs/directives>). Accessed on 7 December 2015.

DODI 4150.07, *DOD Pest Management Program*, 29 May 2008.

DODI 5210.42, *Nuclear Weapons Personnel Reliability Program (PRP)*, 16 July 2012.

DODI 5210.65, *Minimum Security Standards for Safeguarding Chemical Agents*, 12 March 2007.

DODI 6025.19, *Individual Medical Readiness (IMR)*, 9 June 2014.

DODI 6055.01, *DOD Safety and Occupational Health (SOH) Program*, 14 October 2014.

DODI 6490.03, *Deployment Health*, 11 August 2006.

DODI 6490.04, *Mental Health Evaluations of Members of the Military Services*, 4 March 2013.

DODI 6490.11, *DOD Policy Guidance for Management of Mild Traumatic Brain Injury/Concussion in the Deployed Setting*, 18 September 2012.

UNITED STATES CODES

These documents are available online at <http://uscode.house.gov>. Accessed on 19 January 2016.

Title 10, Armed Forces, Chapter 47, *Uniform Code of Military Justice*.

MULTISERVICE PUBLICATIONS

Most multiservice doctrinal publications are available online at (<http://www.apd.army.mil>). Accessed on 7 December 2015.

AR 40-25/BUMEDINST 10110.6/AFI 44-141, *Nutrition Standards and Education*, 15 June 2001.

ARMY PUBLICATIONS

Most Army doctrinal publications are available online at (<http://www.apd.army.mil>). Accessed on 7 December 2015.

AR 30-22, *Army Food Program*, 24 July 2012.

AR 40-5, *Preventive Medicine*, 25 May 2007.

AR 40-35, *Dental Readiness and Community Oral Health Protection*, 2 August 2004.

AR 50-5, *Nuclear Surety*, 1 August 2000.

AR 50-6, *Chemical Surety*, 28 July 2008.

AR 350-1, *Army Training and Leader Development*, 19 August 2014.

AR 350-53, *Comprehensive Soldier and Family Fitness*, 19 June 2014.

AR 600-8-2, *Suspension of Favorable Personnel Actions (Flag)*, 23 October 2012.

References

- AR 600-9, *The Army Body Composition Program*, 28 June 2013.
- AR 600-20, *Army Command Policy*, 6 November 2014.
- AR 600-63, *Army Health Promotion*, 14 April 2015.
- AR 600-85, *The Army Substance Abuse Program*, 28 December 2012.
- AR 608-18, *The Army Family Advocacy Program*, 30 October 2007.
- AR 635-200, *Active Duty Enlisted Administrative Separations*, 6 June 2005.
- ATP 1-05.01, *Religious Support and the Operations Process*, 12 May 2014.
- ATP 1-05.02, *Religious Support to Funerals and Memorial Ceremonies and Services*, 29 March 2013.
- ATP 1-05.03, *Religious Support and External Advisement*, 3 May 2013.
- ATP 3-35, *Army Deployment Redeployment*, 23 March 2015.
- ATP 4-02.3, *Army Health System Support to Maneuver Forces*, 9 June 2014.
- ATP 4-25.12, *Unit Field Sanitation Teams*, 30 April 2014.
- DA Pam 30-22, *Operating Procedures for the Army Food Program*, 6 February 2007.
- DA Pam 40-11, *Preventive Medicine*, 22 July 2005.
- DA Pam 40-21, *Ergonomics Program*, 15 August 2003.
- DA Pam 600-24, *Health Promotion, Risk Reduction, and Suicide Prevention*, 14 April 2015.
- DA Pam 600-85, *Army Substance Abuse Program Civilian Services*, 15 October 2001.
- FM 4-02, *Army Health System*, 26 August 2013.
- FM 6-0, *Commander and Staff Organization and Operations*, 5 May 2014.
- FM 7-22, *Army Physical Readiness Training*, 26 October 2012.
- FM 27-10, *The Law of Land Warfare*, 18 July 1956.
- TB MED 592, *Prevention and Control of Musculoskeletal Injuries Associated with Physical Training*, 1 May 2011.
- TC 4-02.3, *Field Hygiene and Sanitation*, 6 May 2015.

OTHER PUBLICATIONS

- NATICK Pamphlet 30-25, *Operational Rations of the Department of Defense*, February 2015 (http://nsrdec.natick.army.mil/media/print/OP_Rations.pdf). Accessed on 7 December 2015.
- OTSG/MEDCOM Policy Memorandum 13-032, *Guidance for Managing Polypharmacy and Preventing Medication Overdose in Soldiers Prescribed Psychotropic Medications and Central Nervous System Depressants*, 21 May 2013. ([http://pec.ha.osd.mil/PMART/Polypharmacy%20POLICY%2013-032%20\(2\).pdf](http://pec.ha.osd.mil/PMART/Polypharmacy%20POLICY%2013-032%20(2).pdf)). Accessed on 7 December 2015.

WEB SITES

- Army Civilian Personnel Office. <http://cpol.army.mil/library/general/wellness>. Accessed on 7 December 2015.
- Army Medicine, Behavioral Health. <http://armymedicine.mil/Pages/behavioralhealth.aspx>. Accessed on 7 December 2015.
- Army Medicine, Child, Adolescent and Family Behavioral Health Service. <http://armymedicine.mil/Pages/CAFBHS.aspx>. Accessed on 7 December 2015.
- Army Medicine, Embedded Behavioral Health (EBH). <http://armymedicine.mil/Pages/EBH.aspx>. Accessed on 7 December 2015.
- Army Medicine, Family Advocacy Program (FAP). <http://armymedicine.mil/Pages/FAP.aspx>. Accessed on 7 December 2015.
- Army Medicine, Performance Triad. <http://armymedicine.mil/Search/Pages/Results.aspx?k=performance%20triad>. Accessed on 10 December 2015.

- Army Medicine, Tele-Behavioral Health (TBH). <http://armymedicine.mil/Pages/TeleBH.aspx>. Accessed on 7 December 2015.
- Army Public Health Center (Provisional), Ergonomics Program. <http://phc.amedd.army.mil/topics/workplacehealth/ergo/Pages/default.aspx>. Accessed on 8 December 2015.
- Army Public Health Center (Provisional), Injury Prevention Program. <http://phc.amedd.army.mil/topics/healthsurv/ip/Pages/InjuryPreventionInitiatives.aspx>. Accessed on 9 December 2015.
- Army Public Health Center (Provisional), Oral Fitness/Dental Readiness. <http://phc.amedd.army.mil/topics/healthyliving/of/Pages/default.aspx>. Accessed on 9 December 2015.
- Army Public Health Center (Provisional), Performance Triad. <http://phc.amedd.army.mil/topics/campaigns/perftriad/Pages/default.aspx>. Accessed on 7 December 2015.
- Army Public Health Center (Provisional), Sexually Transmitted Diseases Prevention. <http://phc.amedd.army.mil/topics/healthyliving/rsbwh/Pages/HIVandSTDPrevention.aspx>. Accessed on 7 December 2015.
- Army Public Health Center (Provisional), Suicide Prevention. <http://phc.amedd.army.mil/topics/healthyliving/bh/Pages/SuicidePreventionEducation.aspx>. Accessed on 7 December 2015.
- Army Substance Abuse Program (ASAP). <https://acsap.army.mil/>. Accessed on 7 December 2015.
- ArmyFit. <https://armyfit.army.mil/Protected/>. Accessed on 7 December 2015.
- Comprehensive Soldier and Family Fitness (CSF2). <http://csf2.army.mil/index.html>. Accessed on 7 December 2015.
- Defense and Veterans Brain Injury Center. <http://dvbic.dcoe.mil/>. Accessed on 7 December 2015.
- Defense Center of Excellence for Psychological Health and Traumatic Brain Injury. <http://www.dcoe.mil>. Accessed on 7 December 2015.
- Deployment Health Assessment Program (DHAP). <http://www.armyg1.army.mil/hr/dhap/index.html>. Accessed on 7 December 2015.
- Deployment Health Clinical Center (DHCC). http://www.pdhealth.mil/dcs/pre_deploy.asp. Accessed on 7 December 2015.
- Human Performance Resource Center. <http://hprc-online.org/dietary-supplements>. Accessed on 7 December 2015.
- Military Nutrition Environment Assessment Tool. <http://phc.amedd.army.mil/topics/healthyliving/n/Pages/HealthyEatingEnvironment.aspx>. Accessed on 7 December 2015.
- Military OneSource. <http://www.militaryonesource.mil>. Accessed on 9 December 2015.
- Resilience Training. <https://www.rto.wrair.army.mil>. Accessed on 8 December 2015.

PRESCRIBED FORMS

This section contains no entries.

REFERENCED FORMS

Unless otherwise indicated, DA forms are available on the Army Publishing Directorate (APD) Web site (www.apd.army.mil).

Department of Defense (DD) forms are available on the Office of the Secretary of Defense (OSD) Web site (www.dtic.mil/whs/directives/infomgt/forms/index.htm).

DA Form 2028, *Recommended Changes to Publications and Blank Forms*.

DD Form 2795, *Pre-Deployment Health Assessment*.

References

DD Form 2796, *Post Deployment Health Assessment (PDHA)*.

DD Form 2900, *Post Deployment Health Re-Assessment (PDHRA)*.

Index

References are to paragraph numbers except where otherwise specified.

A

- after action debriefing, Chapter 8 (Section III), 8-128
activity, Chapter 2 (Introduction), 2-40—41, 2-43, 2-54, 2-61, 3-3, 3-6, 5-30, 6-7, 6-28, 7-75
Army Health Promotion Program, Chapter 5
Army Substance Abuse Program, 1-2, 5-23—25, 8-60

B

- behavioral health disorder, 7-96, 8-71, 9-3, 9-5, 9-9
evaluation, 7-34, 7-42, 8-166
intervention, 5-2, 7-13
promotion, 5-6—7

C

- combat and operational stress behavior, 7-1, 7-4—5, 7-8, 7-11—24, 8-144
control, Preface, Introduction, 1-2, 4-13, 5-13, 5-16, Chapter 7 (Introduction), 7-2, 7-5, 7-29—30, 7-32, 7-50, 7-61, 7-74, 7-82, 7-84, 7-88, 7-90, 7-93, 7-95, Chapter 8 (Introduction), 8-31, 8-70, 8-72, 8-76, 8-81, 8-85, 8-87, 8-90, 8-97, 8-104—105, 8-108, 8-128, 8-137, 8-140, 8-148, 8-159—161, 8-163
command-directed evaluation, 7-34—35, 7-37—43, 7-88

- Comprehensive Soldier and Family Fitness, Preface, Introduction, Chapter 1 (Introduction) 1-22, 1-26, Chapter 3 (Introduction), 3-1—2, 3-6—7

- concussion, 1-5—6, 1-11, Chapter 11 (Introduction), Table 11-1, 11-1—6, 11-9—12, 11-18, Table 11-3, 11-21

D

- dental readiness, 5-39—40, 6-25
classification, 5-40

F

- Family readiness groups, 7-94, 8-18, 8-20—24, 8-30, 8-130
field hygiene and sanitation, Preface, Chapter 6 (Introduction), 6-5, 6-18

G

- Global Assessment Tool 2.0, 3-3—4

H

- health assessment deployment, 1-22, 1-27—30, 9-10, 9-12
postdeployment, 1-28, 9-4, 9-9, 9-12
predeployment, 1-28, 1-30, 9-4, 9-9—10

L

- leader-led after action debriefing, 8-83—91, 8-128

M

- mental health section, 7-88—90, 7-93—94, 7-96
mild traumatic brain injury, Preface, Introduction, 1-6, Table 1-1, Chapter 11

N

- nutrition, Preface, Introduction, 1-6, Chapter 2 (Introduction) 2-50—57, 2-60, 3-3, 3-6, 5-41, 5-44—46, 6-7, 6-28, 7-23, 7-73—75, 8-96—97, 11-2

P

- Performance Triad, Preface, Introduction, Chapter 1 (Introduction), Chapter 2 (Introduction), 2-40, 3-3, 3-6—7

- personality disorder, Introduction, 8-54, Chapter 9 (Introduction), 9-13—18

- postcombat and operational stress, Preface, 7-7—8, 7-15, 7-17, 7-22, 10-4

- posttraumatic stress disorder, Introduction, 1-1, 1-3, 1-24, 1-27—28, 7-6, 7-8, 7-17, 7-19—22, 8-71, 9-17, Chapter 10 (Introduction), 10-1—3, Table 10-1

- potentially traumatic event, Introduction, 5-13, Figure 7-1, 7-8, 7-10, 8-68—81, 8-84—88, 8-90, 8-144, 8-148, 9-17

S

- sleep, Preface, Introduction, 1-6, Chapter 2 (Introduction), 2-1—39, 3-3, 3-6, 4-2, 4-12, 6-7, 6-27—28, 7-23, 7-28, 7-56, 7-62, 7-81, 8-8, 8-40, 8-89, 8-103, 8-108, 8-115, 8-125, 8-140, 8-142, 8-155, 8-165, 9-4, Table 10-1, 11-2, Table 11-1, Table 11-3

- stress reaction, Preface, 4-8, 5-9, 5-13—14, 7-3, 7-8, 7-13—14, 7-16—17, 7-19—21, 7-24—27, Table 7-3—4, 7-28, 7-31—32, 7-47, 7-55, 7-84—85, 8-8, 8-101, 8-123—124, 8-141, 8-143, 8-150—158, 8-161—165

- adaptive, 7-12, 7-21, 7-47, 7-56, Table 7-2

- maladaptive behavior, 7-11, 7-15, 9-14, 9-15—16

- substance abuse, 1-2, 1-24, 1-27—28, 4-12, 5-24, 7-28, 7-33, 8-36, 8-60

- suicide, Preface, 1-16, 4-1—3, 4-5, 5-17—19, 8-31, 8-38, 8-45, 8-71

- prevention, 1-22—23, 1-25, 4-7, 5-17—20

- risk, 1-24—25, 5-17—19

- suicidal behavior, Introduction, Chapter 4 (Introduction), 4-1, 5-17, 8-55

Index

T	U	
traumatic brain injury, Preface, Introduction, 1-1, 1-4—14, Table 1-1, 1-27, 10-5 traumatic event management, Preface, 7-85—86, 8-68—80, 8-85, 8-144	unit behavioral health needs assessment, Introduction, 8-1, 8-3, 8-6, 8-76 ministry team, 5-10, 7-82—84, 7-87, 7-91, 8-87, 8-119	United States Army Ready and Resilient Campaign, Preface, Chapter 1, 2-40, Chapter 3 (Introduction)

ATP 6-22.5
10 February 2016

By Order of the Secretary of the Army:

MARK A. MILLEY
General, United States Army
Chief of Staff

Official:



GERALD B. O'KEEFE
*Administrative Assistant to
the Secretary of the Army*
1602702

DISTRIBUTION:

Active Army, Army National Guard, and United States Army Reserve: Distributed in electronic media only (EMO).

PIN: 106036-000