

CHAPTER 1

OVERVIEW OF COMBAT STRESS CONTROL

1-1. Introduction

This chapter presents the concept and scope of combat stress control. It reviews historical experiences with stress casualties in different intensities of conflict and looks at the potential stressors in high-tech battles. It lists the responsibilities for combat stress control of all junior (direct) and senior (organizational) leaders, staffs, chaplains, and health care providers. It also discusses the responsibilities of specialized combat stress control/mental health personnel.

NOTE

Battle fatigue and misconduct stress behaviors are preventable with strong effective leadership.

1-2. Combat Stress Control

a. Controlling combat stress is often the deciding factor—the difference between victory and defeat—in all forms of human conflict. Stressors are a fact of combat and soldiers must face them. It is controlled combat stress (when properly focused by training, unit cohesion, and leadership) that gives soldiers the necessary alertness, strength, and endurance to accomplish their mission. Controlled combat stress can call forth stress reactions of loyalty, selflessness, and heroism. Conversely, uncontrolled combat stress causes erratic or harmful behavior that disrupts or interferes with accomplishment of the unit mission. Uncontrolled combat stress could impair mission performance and may bring disgrace, disaster, and defeat.

b. The art of war aims to impose so much stress on the enemy soldiers that they lose their will to fight. Both sides try to do this and at times accept severe stress themselves in order to

inflict greater stress on the enemy. To win, combat stress must be controlled.

c. The word *control* has been chosen deliberately to focus thinking and action within the Army. Since the same word may have contrasting connotations to different people, it is important to make its intended meaning clear. The word *control* is used (rather than the word *management*) to emphasize the active steps which leaders, supporting personnel, and individual soldiers must take to keep stress within the acceptable range. This does not mean that control and management are mutually exclusive terms. Management is, by definition, the exercise of control. Within common usage, however, and especially within Army usage, management has the connotation of being a somewhat detached, number-driven, higher echelon process rather than a direct, inspirational, leadership process.

d. Stress is the body's and mind's process for dealing with uncertain change and danger. Elimination of stress is both impossible and undesirable in either the Army's combat or peacetime missions.

e. The objectives of stress control areas follows:

(1) To keep stress within acceptable limits for mission performance and to achieve the ideal (optimal) level of stress when feasible.

(2) To return stress to acceptable limits when it becomes temporarily disruptive.

(3) To progressively increase tolerance to stress so that soldiers can endure and function under the extreme stress which is unavoidable in combat.

f. How can stress be controlled? Stress is controlled in the same ways other complex processes are controlled.

(1) Monitor the signs of stress and recognize when and if they change. To be effective, this recognition should come well before the stress becomes disruptive and causes dysfunction.

(2) Identify and monitor the causes of stress; that is, the stressors. Stress and stressors are defined in detail in Chapter 2.

(3) Classify the stressors into those which can be controlled (increased, decreased, avoided, or otherwise changed) versus those which cannot be controlled.

(4) Control those stressors which can be changed by focusing the stress in the desired direction, either up or down.

(5) Help soldiers adapt to the stressors which cannot be changed.

(6) Learn (and teach) how to directly lower (or raise) the stress level within the individual soldier as needed, at specific times, in specific situations.

1-3. Scope of Combat Stress Control

Combat stress control is much more than just a few stress reduction techniques which busy leaders are supposed to learn from books or mental health workers and use now and then when the stress seems intense. Army combat stress control activities must be a part of everything the Army does. Combat stress control must be a natural part of the three continuums of Army life: *responsibility*, *location*, and *Army mission*. Note that a weakness or gap anywhere in these three continuums can cause weaknesses, overloads, or breakdowns in other aspects of Army life.

a. Responsibility. Responsibility for combat stress control requires a continuous interaction that begins with every soldier and his

buddies. It also involves the soldier's family members. The interaction continues through the small team's combat lifesaver (when there is one) and the combat medic. Stress control requires special involvement from direct (small unit) leaders. The responsibility extends up through the organizational leaders and their staffs (both officers and noncommissioned officers [NCOs]) at all echelons. Appendix A describes combat stress risk factors and prescribes leaders' actions to control them. Leaders, staffs, and individual soldiers all receive assistance from the supporting chaplains, the medical personnel, and combat stress control/mental health personnel (see Appendix B for information pertaining to combat stress control units). If any link in the chain of responsibility is weak, it is the responsibility of the other members of the chain to strengthen it.

b. Location. The location for combat stress control extends continuously—

- From the site of battle, disaster, or rigorous duty.
- Through the unit's forward and rearward support areas.
- Through the communications zone (COMMZ), if present.
- To the continental United States (CONUS).
- To the unit's home station.
- To the rear detachment.
- To the family support group.
- To the Army hospitals and medical centers.

The location even extends to the Department of Veterans Affairs and veterans organizations after

the soldiers' discharge, medical separation, or retirement. Preventive efforts, and also treatment for stress dysfunction, should be actively accomplished at each location. If stress control is weak at any one location, this can cause stress and breakdown not only there, but elsewhere in other locations.

c. *Army Missions.* The Army operations that require combat stress control are all-inclusive. They extend continuously—

- From garrison maintenance activities.
- To peacetime training exercises.
- To operations other than war.
- To war.
- To the integrated battlefield.

The same basic stress control principles apply across the entire range of Army operations. Within our rapidly changing world, many Army units have had their missions shift across a wide range of operations in a matter of weeks, sometimes with little advance warning. Individual soldiers, family members, unit leaders and staffs, chaplains, and medics (including the mental health/combat stress control teams) must be involved and work together continuously. They must practice stress control against the frequent minor stressors and the occasional severe stressors of peacetime. This, and only this, enables them to be ready on short notice for the extreme stressors of war.

1-4. Historical Experience

a. *Origins of the Combat Stress Control Concept.*

(1) Combat stress control is not new. The basic leadership techniques which this manual

will review were discovered and taught by successful military leaders through the centuries and have long been cornerstones of US Army leadership training. Combat stress control medical doctrine for preventing and treating stress casualties is sometimes mistakenly said to have originated from the Israeli Defense Force experiences in the 1970s and 1980s. Quite the contrary, the US Army learned that basic doctrine from its allies during World War I (WWI).

(a) *The French and British* discovered that if stress casualties were evacuated far to the rear, many became chronic psychiatric cripples. If treated quickly close to their units, most recovered and returned to duty. The US Army Surgeon General of that time recommended that we adopt a three-echelon system for prevention, triage, treatment, and return to duty of stress casualties.

1. *First echelon.* The US Army attached a trained psychiatrist to each division. The psychiatrist's role was to advise command in the prevention of stress casualties, to screen out the unsuitable, and to assure that overstressed soldiers were rested and returned to duty within the division whenever possible. Following British practice, stress casualties in the division were labeled "Not Yet Diagnosed, Nervous" (NYDN). This avoided even the suggestion of physical injury implied by the dramatic popular label "shell shock" or the implication of psychiatric illness conveyed by the official diagnosis of "war neurosis." Under good conditions, 70 percent of stress casualties were returned to duty within the division.

2. *Second echelon.* Behind the divisions in WWI, the US Army had specialized neurological hospitals (150 beds) whose sole function was to provide additional brief rest and rehabilitation to those NYDN cases whom the division psychiatrist was unable to return to duty. These neuropsychiatric facilities also provided brief

rest and rehabilitation to persistent cases of “gas mania” or “gas hysteria” who believed they had suffered chemical injuries, even though they had not been truly injured. About 55 percent of the cases sent to these facilities returned to duty in an average of two weeks.

3. *Third echelon.* Further to the rear was a specialized base hospital which provided several weeks of additional treatment for cases who failed to improve in the neurological hospital. It returned many of those cases to useful duty.

(b) The three-echelon system worked well, but on occasions when the tactical situation interfered with forward treatment, it clearly showed the superiority of the forward-deployed part of the program.

(2) The experience of WWI was forgotten between wars. It had to be rediscovered in World War II (WWII) after several disastrous experiences when large numbers of psychiatric casualties were overevacuated in the early battles. By late WWII in the European and Mediterranean theaters, all divisions again had a division psychiatrist with mental health assistants. The psychiatrist supervised a Training and Rehabilitation Center in the division rear. The psychiatrists trained and supervised the regimental and battalion surgeons in recognizing and treating combat exhaustion or battle fatigue cases. Most regimental combat teams (equivalent to our brigades) had an exhaustion center in the regimental trains area. Many battalions maintained a rest area at the battalion field kitchens. The surgeons supervised these facilities to assure that soldiers who were rotated back to them recovered quickly and returned to duty. Behind the division there were specialized clearing companies commanded and staffed by psychiatrists. These clearing companies provided additional treatment for nonresponders or problem cases. Specialized base hospitals were located in the COMMZ.

(3) Following WWII, the lessons learned were embodied in a table of organization and equipment (TOE) unit, the mobile psychiatric detachment, or “KO” team. These teams functioned very effectively in Korea.

b. *Experience in War.*

(1) In the WWII Mediterranean and European theaters, the average incidence of combat exhaustion casualties was one case requiring medical holding and treatment for every four wounded in action (WIA) (a 1:4 ratio). In really intense or prolonged fighting, the ratio rose to 1:2. On the Gothic line in Italy, the 1st Armored Division suffered 137 combat exhaustion casualties for 250 WIA (a 1:1.8 ratio). Overall, with the correct treatment, 50 to 70 percent of combat exhaustion casualties returned to combat within 3 days, and most of the remainder returned to useful duty within a few weeks.

(2) During WWII the 6th Marine Division was involved in the Battle of Okinawa. They fought day after day and were up against a determined, dug-in Japanese resistance, rain and mud, and heavy artillery. The division suffered 2,662 WIA and had 1,289 combat exhaustion casualties (a ratio to WIA of 1:2). Many of the combat exhaustion cases were evacuated to Navy ships offshore and few of those cases ever returned to duty.

(3) In the Pacific theater in WWII, there was about one neuropsychiatric casualty evacuated from the theater for every one WIA (a 1:1 ratio). Many of these troops appeared psychotic (bizarrely out of touch with reality). Most of these, however, did not come from the combat units or areas. They were combat service support (CSS) troops left behind by the war on the hot jungle or coral islands or the cold, damp Aleutian Islands. The stressors were the combination of isolation, monotony, boredom, chronic discomfort, and low-grade illness from the environment, plus fear of

disease, injury, and surprise attack. In retrospect, it was realized that evacuating these bizarre stress reaction cases home only encouraged more soldiers to "go crazy" when they temporarily reached their limit of tolerance to stress. It would have been better to have sent them to rest camps close to their units. This might have returned the majority quickly to duty, as was done with the combat exhaustion cases in the European and Mediterranean theaters.

(4) It was also shown in WWII that tough training and esprit de corps prevented many battle fatigue casualties. Elite units, such as the ranger and airborne units, had less than one battle fatigue casualty for every ten WIA. This unit cohesiveness prevailed even in combat assaults, such as Normandy and Arnhem, where extremely high casualties were suffered. Unit cohesiveness also prevailed during prolonged fighting like the Battle of the Bulge.

(5) During the Yom Kippur War (1973), the Israeli experience confirmed the risk of stress casualties in the modern, high-tech, continuous operations (CONOPS) battle. The Israelis counted on the high cohesion and training of their troops and leaders to keep stress casualties to a minimum. They were caught, however, by strategic and tactical surprise and were forced to mobilize on a religious (fasting) holiday. They sent their reserves piecemeal into battle. Their Arab opponents, whom they had previously discounted as inefficient, used massed artillery, armor, and wire-guided missiles. The Arab units followed the Soviet CONOPS, echeloned-attack doctrine. Israeli estimates of stress casualties suggest that large numbers of Israeli soldiers, including veterans and leaders, became unable to function solely because of stress. Stress casualties were frequent in the Golan Heights fighting, in the initial defense of the Sinai, and during the recrossing of the Suez Canal. Since the Israeli Defense Force had no plans for treatment and return to duty, all such cases were evacuated to hospitals in Israel. True

to the experience of WWI and WWII, many of these Israeli soldiers who were evacuated remain psychiatrically disabled today.

(6) After the 1973 war, the Israelis instituted a model program of leadership training and medical/mental health support. This was intended to prevent combat stress casualties and to treat those cases which occurred in the brigade and division support areas. However, in the 1982 Lebanon invasion, many cases were inadvertently evacuated by helicopter to Israel in the initial haste of the invasion. Few of these cases returned to full duty, while 60 to 80 percent of those treated in Lebanon did.

(7) One Israeli armored battalion trapped in a desperate night action against the Syrians had approximately 30 combat stress cases and 30 WIA (a 1:1 ratio). A combat engineer battalion which was accidentally bombed by an Israeli fighter-bomber had approximately 25 killed in action (KIA) and 200 WIA. This same battalion soon had 20 immediate combat stress casualties. Approximately 25 other soldiers developed delayed stress reactions over succeeding days (a ratio to WIA of 1:4.4). Even the Israelis' strong preventive program could not completely prevent battle fatigue casualties in a high-tech war.

c. *Experience in Vietnam.*

(1) In Vietnam, battle fatigue casualty rates rarely exceeded one per ten WIA. The reasons for the few battle fatigue casualties included the sporadic nature of fighting and our air and artillery superiority. Other factors were well-supplied fire bases, scheduled rest and recuperation (R&R), and a fixed combat tour. All these factors kept most battle fatigue cases at levels which could be treated in their units and did not require medical holding or hospitalization.

(2) Other behavioral problems related to loneliness and frustration, however, were

associated with combat stress in Vietnam. Serious incidents of poor discipline occurred, including commission of atrocities at My Lai (March 1968), combat refusal, and even “fragging” (murder) of leaders. These events threatened unit cohesion and the chain of command. By 1970–1971, when US ground forces were rarely committed to offensive operations, “neuropsychiatric casualties,” especially drug and alcohol abuse and addiction, became epidemic. By September 1971, neuropsychiatric cases accounted for over 60 percent of all medical evacuations from the theater. Today those misconduct problems are recognized as having contributed to the high incidence of delayed post-traumatic stress disorder (PTSD) in Vietnam veterans. Due to the different nature of the stress, these types of misconduct stress behaviors are more likely than battle fatigue in operations other than war (conflict). These misconduct stress behaviors can seriously undermine the objectives and successes of the mission.

d. Experience in Catastrophic Events During Peacetime and Operations Other Than War. Within the past few years, numerous accidents and hostile incidents have demonstrated the value of crisis stress control for soldiers, their families, and civilians caught in the turmoil of peacetime operations. Some recent historical events are listed in Table 1-1. Unit leaders aided by post and hospital mental health personnel, chaplains, and others played key roles in providing crisis stress control for many of these tragic incidents. In the peacetime military, as in civilian police, fire, and disaster relief, stress debriefing of critical incidents has proved its value in preventing and treating disabling PTSD.

1-5. Effects of Battle on Soldiers, Units, and Leaders

a. War is fundamentally a contest of wills fought by men, not machines. Ardant Du Picq, a 19th century French officer and student of

men in battle, reminded us that, “You can reach into the well of courage only so many times before the well runs dry.” Even before that, Marshall De Saxe, writing in the 18th century, pointed out that, “A soldier’s courage must be reborn daily,” and went on to say that the most important task of leaders was to understand this, to care for and prepare soldiers before battle, and to use tactics during battle which recognize that courage must be renewed.

b. Commanders must understand that in battle men and units are more likely to fail catastrophically than gradually. Commanders and staffs, assisted by combat stress control personnel, medics, chaplains, and others, must be alert to subtle indicators of fatigue, fear, poor discipline, and reduced morale. They must take measures to deal with these symptoms before their cumulative effects cause a unit to collapse. Staffs and commanders at higher levels must be advised about the impact of intense or prolonged combat on subordinate units. Military organizations can fight at peak efficiency for only so long. Prolonged demands of combat cause efficiency to drop even when physical losses are not great.

c. A unit may not be capable of performing its mission adequately if soldier resources are depleted because—

- Vigilance deteriorates.
- Determinations and calculations become inaccurate.
- Reports become faulty.
- Decisions become slow and inaccurate.
- Orders are misunderstood/forgotten.
- Weapons are misused/under-used.

Table 1-1. Examples of Catastrophic Events During Peacetime and Operations Other Than War—Historic Incidents

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- THE CRASH AT GANDER, NEWFOUNDLAND, OF A CONTRACT AIRLINER CARRYING HOME ONE-THIRD OF A BATTALION OF THE 101ST AIRBORNE DIVISION FROM THE SINAI PEACEKEEPING MISSION.*
 - THE CAR-BOMBING BY SHIITE FANATICS OF THE MARINE BATTALION'S BARRACKS AT BEIRUT AIRPORT, LEBANON,** AND OF THE AMERICAN EMBASSY IN BEIRUT.
 - THE DEATH BY BURNING OF MANY FORT KNOX SCHOOL CHILDREN WHEN A DRUNK DRIVER CRASHED INTO THEIR SCHOOL BUS.
 - THE HIJACKING OF THE OCEAN LINER *ACHILLE LAURO** AND OF SEVERAL AIRLINERS* BY PALESTINIAN TERRORISTS.
 - THE SERIOUS DAMAGING OF THE DESTROYER USS *STARK* BY AN ACCIDENTALLY LAUNCHED IRAQI MISSILE IN THE PERSIAN GULF.*, **
 - THE SHOOTING DOWN OF AN IRANIAN CIVILIAN AIRLINER IN THE PERSIAN GULF BY THE CRUISER *VINCENNES****
 - THE CRASH OF TWO ITALIAN JETS INTO THE CROWD OF SPECTATORS AT AN AIR SHOW IN RAMSTEIN, WEST GERMANY.****
 - THE EXPLOSION OF A GUN TURRET ON THE BATTLESHIP *IOWA* DURING TARGET PRACTICE,** AND SEVERAL FATAL FIRES AND CRASHES ABOARD SUBMARINES AND AIRCRAFT CARRIERS.**
 - THE CRASH OF TWO CALIFORNIA ARMY NATIONAL GUARD (CAARNG) HELICOPTERS WHILE ON DRUG INTERDICTION SERVICE.#
 - DISASTER RELIEF TO SOUTH FLORIDA FOLLOWING HURRICANE ANDREW.**,## AND OPERATION RESTORE HOPE IN SOMALIA,###
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- * 17th Medical Command, US Army, Europe, sent its Stress Management Team.
 - ** The Navy SPRINT (Special Psychiatric Rapid Intervention Team) was deployed.
 - *** The Board of Inquiry cited "combat stress" as primary cause of the error.
 - **** The mental health debriefing assisted survivors and care givers.
 - # The CAARNG Medical Brigade sent a special Stress Control Team.
 - ## The 10th Mountain, 24th Infantry, and 82nd Airborne Divisions' Mental Health Sections played important parts.
 - ### The 10th Mountain Division's Mental Health Section and a new Combat Stress Control Detachment were deployed and debriefed Army and Marine units.
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- Maintenance and preplanning are forgotten.
- Motivation to perform duties decreases.
- Leaders' effectiveness decreases.
- Training becomes ineffective.

d. Degradation of soldiers' performance means that they lose a portion of their normal effectiveness. Continuous, unrelieved operations and excessive stress degrade performance and erode soldier resources. Combat capability is cut whether the unit is at 50 percent strength or at full strength with soldiers who are only 50 percent effective. As individual and unit capabilities fall, battle fatigue may contribute not only to more battle fatigue casualties but also to higher rates of wounds and disease and nonbattle injuries (DNBI).

e. The skill and courage of leaders at all levels are critical to success in operations across the full range of conflict. The chaos of combat places a premium on initiative, unit cohesion, and mental and physical preparedness of soldiers and units. While the importance of winning the first battle is great, the ability to fight sustained campaigns is vital to deterrence and to victory. In war, temporary battle fatigue casualties are inevitable but can be treated and returned to duty in or close to their units. In operations other than war (conflict), the enemy threat counts on psychological stress and misconduct stress behaviors to disable the defender. In operations other than war (conflict), drug and alcohol abuse, other violations of military discipline, and criminal acts must be prevented by strong leadership. Misconduct stress behaviors are dealt with through the legal system. Medical care and treatment are provided when, necessary.

1-6. The Potential High-Tech Battlefield

United States Army planners have predicted what future high-tech combat could entail. This was demonstrated in the recent past with the world's confrontation with Iraq over the seizure of Kuwait. Based on the current world situation, such future battles are not unthinkable. The unprecedented debilitating effects of battlefield in the twenty-first century will demand even more attention to the preparation of soldiers, crews, and leaders for combat hardships. In such battlefields, the soldier will face many challenges.

a. *Challenge of Isolation.* The first challenge is isolation. Units may experience periods of combat where forces are intermixed and lines of communication are broken. Units will experience feelings of uncertainty and helplessness from unpredictable strikes by long-range weapon systems. To make matters worse, these strikes may be inflicted by one's own forces in the confusion of battle. The certain use of smoke and obscurants will limit soldiers' vision, promoting feelings of separation, abandonment, and vulnerability.

b. *Challenge of Higher Rates of Casualties from Conventional, Nuclear, Biological, and Chemical Weapons/Agents.* The increased rate of destruction of potential future weaponry has both physical and psychological effects. Losing 40 to 60 percent of an entire unit in minutes or hours could leave the remaining soldiers incapacitated. The rapid and horrible death of their comrades and leaders could have a definite and detrimental effect on the mental stability of the unit. Surviving soldiers will have to be prepared to overcome the experience of mass human destruction. They will need to be trained to take over from those lost and to reshape units that can continue to fight.

c. *Challenge of Human-Technological Imbalance.* The emergence of new technologies

has significantly increased the range of weapons, reduced reaction time, and changed conditions over which battles are fought. This new technology has the potential to exceed the capacity of human crews to fight.

- All-weather, day-and-night-capable vehicles which can operate for extended periods without resupply are limited only by the crews' need for sleep.

- High-probability-of-kill, direct-fire systems will be degraded over time by the stress and fatigue levels of the men aiming those weapons.

- Improved sensors and longer range weapons could exceed the capabilities of a tactical headquarters to plan and execute battles fought over expanded areas of operations.

- Short engagement times and the increased lethality of new weapons could overwhelm the ability of staffs to control and coordinate the overall battle.

Soldiers, leaders, and staffs will face problems of reduced efficiency and effectiveness when fighting over extended periods. These conditions will tend to neutralize the potential gains of new war-fighting technologies and force new approaches to the preparation and employment of soldiers, leaders, and staffs.

d. Challenge of the Mental Rigors of Combat. Armies must initiate training programs to help precondition soldiers to the mental rigors of combat. This is of vital importance as the potentially catastrophic effect of battle stress in future warfare becomes evident. The military force that does this best will have a decided edge in any war. Future combat will strain human endurance to unprecedented levels. If these challenges are left unchecked by poor mental and physical conditioning of soldiers, they could result in the disastrous

failure of entire units. Failure to consider the human factors in an environment of increased lethality and uncertainty could cause a nation's concept of warfare to be irrelevant. With the miniaturization and spread of high-tech (and perhaps even of nuclear, biological, and chemical [NBC]) weapons, this can be just as true in operations other than war (conflict) as in war.

1-7. Responsibilities for Controlling Combat (Conflict) Stress

a. Unit Cohesiveness Development. Rigorous, realistic training for war must go on continuously to assure unit readiness. Emphasis must be placed on establishing and maintaining cohesive units. Unit training and activities must emphasize development of soldier skills. This development should focus on building trust and establishing effective communication throughout the unit.

b. Senior (Organizational) Leaders' Responsibilities. The chain of command must ensure that the standards for military leadership are met. Senior leaders must provide the necessary information and resources to the junior leaders to control combat stress and to make stress work for the US Army and against the enemy. Senior leaders' responsibilities are listed in Table 1-2.

c. Junior (Direct) Leaders' Responsibilities. Junior leaders, and especially the NCOs, have the crucial business of applying the principles of stress control day-by-day, hour-by-hour, minute-by-minute. These responsibilities overlap with senior leaders' responsibilities but include parts that are fundamentally "sergeants' business," supported by the officers. See Table 1-3, page 1-11, for junior leaders' responsibilities.

d. Staff Section Responsibilities. Each element of the commander's staff (adjutant, intelligence, operations, logistics, and civil and

public affairs [if present]) has its own area of responsibility that has particular relevance to stress control (see Table 1-4, pages 1-12—13). For example, the adjutant’s responsibility for mail and decorations is more than just “nice to have.” These are

important stress control measures. Morale, welfare, and recreation opportunities, and even the use of Army bands, are valuable ways to sustain morale and combat readiness. For additional information on the role of Army bands, see Appendix C.

Table 1-2. Senior Leaders’ Responsibilities

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- BE COMPETENT, COMMITTED, COURAGEOUS, CANDID, AND CARING.
 - PLAN TO ACCOMPLISH THE MISSION WITH AS FEW LOSSES AS POSSIBLE.
 - SET THE POLICY AND COMMAND CLIMATE FOR STRESS CONTROL, ESPECIALLY TO BUILD TEAMS WITH HIGH UNIT COHESION.
 - SERVE AS AN ETHICAL ROLE MODEL.
 - MAKE “THE BUREAUCRACY” WORK FOR THE TROOPS.
 - ASSURE RESOURCES TO “TAKE CARE OF THE TROOPS.”
 - PLAN FOR AND CONDUCT TOUGH, REALISTIC TRAINING TO INCLUDE LIVE FIRES.
 - PROVIDE AS MUCH INFORMATION AS POSSIBLE TO THE TROOPS.
 - ASSURE THAT MEDICAL AND MENTAL HEALTH/COMBAT STRESS CONTROL PERSONNEL ARE ASSIGNED AND TRAINED WITH THEIR SUPPORTED UNITS.
 - PLAN FOR COMBAT STRESS CONTROL IN ALL OPERATIONS.
 - PROVIDE THE JUNIOR LEADERS/NCOs WITH THE NECESSARY GUIDANCE.
 - ENSURE RISK ASSESSMENTS ARE CONDUCTED PRIOR TO ALL TRAINING AND COMBAT OPERATIONS.
 - SUPERVISE THE JUNIOR LEADERS/NCOs AND REWARD THEIR SUCCESS.
 - BE VISIBLE.
 - LEAD ALL STRESS CONTROL MEASURES BY GOOD EXAMPLE.
 - MAINTAIN (THROUGH POSITIVE LEADERSHIP AND, WHEN NECESSARY, WITH DISCIPLINARY ACTION) THE HIGH STANDARDS OF THE INTERNATIONAL LAW OF LAND WARFARE.
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*Table 1-3. Junior Leaders' Responsibilities—Combat Stress Control**

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- BE COMPETENT, COMMITTED, COURAGEOUS, CANDID, AND CARING.
 - BUILD COHESIVE TEAMS; INTEGRATE NEW PERSONNEL QUICKLY.
 - CROSS-TRAIN SOLDIERS WHEREVER AND WHENEVER POSSIBLE.
 - PLAN AND CONDUCT TOUGH REALISTIC TRAINING THAT REPLICATES COMBAT CONDITIONS, ESPECIALLY LIVE FIRES.
 - TAKE CARE OF THE TROOPS (INCLUDING THE LEADERS).
 - ASSURE PHYSICAL FITNESS, NUTRITION, HYDRATION, ADEQUATE CLOTHING AND SHELTER, AND PREVENTIVE MEDICINE MEASURES.
 - MAKE AND ENFORCE SLEEP PLANS.
 - KEEP ACCURATE INFORMATION FLOWING DOWN TO THE LOWEST LEVEL (AND BACK UP AGAIN); DISPEL RUMORS.
 - ENCOURAGE SHARING OF RESOURCES AND FEELINGS.
 - CONDUCT AFTER-ACTION DEBRIEFINGS ROUTINELY.
 - MAINTAIN (THROUGH POSITIVE LEADERSHIP AND, WHEN NECESSARY, WITH DISCIPLINARY ACTION) THE HIGH STANDARDS OF THE INTERNATIONAL LAW OF LAND WARFARE.
 - RECOMMEND EXEMPLARY SOLDIERS FOR AWARDS AND DECORATIONS.
 - RECOGNIZE EXCESS STRESS EARLY AND GIVE IMMEDIATE SUPPORT.
 - KEEP THOSE STRESSED SOLDIERS WHO CAN STILL PERFORM THEIR DUTIES IN THE UNIT, AND PROVIDE EXTRA SUPPORT AND ENCOURAGE THEM BACK TO FULL EFFECTIVENESS.
 - SEND THOSE STRESSED SOLDIERS WHO CANNOT GET NEEDED REST IN THEIR SMALL UNIT BACK TO A SUPPORTING ELEMENT FOR BRIEF SLEEP, FOOD, HYGIENE, AND LIMITED DUTY, TO RETURN IN 1 TO 2 DAYS.
 - REFER TEMPORARILY UNMANAGEABLE STRESS CASES THROUGH CHANNELS FOR MEDICAL EVALUATION AND TREATMENT.
 - WELCOME RECOVERED BATTLE FATIGUE CASUALTIES BACK AND GIVE THEM MEANINGFUL WORK AND RESPONSIBILITIES.
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* Note that every soldier ultimately must be a junior (direct) leader. Each soldier must exercise self-leadership and control stress for self and others.

Table 1-4. Staff Responsibilities for Combat Stress Control

S1/G1 PERSONNEL

- ASSURE SOLDIERS' PAY, MAIL, AND THE AVAILABILITY OF TELEPHONES WHEN FEASIBLE.
- ASSURE PERSONNEL REPLACEMENT, PREFERABLY WITH COHESIVE TEAMS.
- RETURN RECOVERED CASUALTIES TO ORIGINAL UNITS WHENEVER POSSIBLE.
- ASSURE RAPID, ACCURATE CASUALTY REPORTING.
- ASSIST PLANNING FOR MEDICAL CARE AND EVACUATION.
- ASSURE BATH, LAUNDRY, CLOTHING REPLACEMENT, COMFORT KITS, AND OTHER LIKE AREA/ITEMS WITH THE S4.
- PLAN MORALE/WELFARE/REST AND RECREATION OPPORTUNITIES AND FACILITIES.
- UTILIZE ARMY BANDS TO SUSTAIN ESPRIT, MORALE.
- MONITOR IN COORDINATION WITH THE S3/G3 CUMULATIVE STRESS IN UNIT SUCH AS SLEEP LOSS, CASUALTIES, AND NUMBER OF NEW PERSONNEL REPLACEMENTS.
- RECOMMEND ROTATION OF UNITS INTO RESERVE OR FORMAL RECONSTITUTION.
- KEEP INFORMATION FLOW OPEN WITH REAR DETACHMENTS AND FAMILY SUPPORT GROUPS.
- COLLATE STATISTICS ON MISCONDUCT BEHAVIORS (DISCIPLINARY AND MILITARY POLICE ACTIONS) WHICH COULD BE DUE TO COMBAT OR OTHER STRESS.
- PROCESS TIMELY AWARDING OF INDIVIDUAL AND UNIT DECORATIONS AND CITATIONS.
- KNOW LOCATIONS AND CAPABILITIES OF COMBAT STRESS CONTROL TEAMS AND COORDINATE WITH THEM AS REQUIRED.

S2/G2 INTELLIGENCE

- DISSEMINATE INFORMATION ON ENEMY WEAPONS' CAPABILITIES, TACTICS, AND ACTIONS.
 - DISSEMINATE INFORMATION OF WEATHER, TERRAIN, AND OTHER POTENTIAL STRESSORS.
 - DISSEMINATE INFORMATION ON ENEMY TROOP CONCENTRATION, CAPABILITIES, AND LIKELY COURSES OF ACTION.
 - ENSURE ISSUE OF APPROPRIATE CLOTHING AND EQUIPMENT.
 - PREVENT UNPLEASANT SURPRISES.
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Table 1-4. Staff Responsibilities for Combat Stress Control (Continued)

S3/G3 OPERATIONS

- ENCOURAGE MAXIMUM DISSEMINATION OF INFORMATION ABOUT THE TACTICAL AND OPERATIONAL PLAN, LIMITED ONLY BY ESSENTIAL OPERATIONAL SECURITY.
 - CONSIDER STRESS ISSUES AND CUMULATIVE STRESS OF UNITS WHEN MAKING OPERATIONAL PLANS WITH S1.
 - PLAN ROTATION OF UNITS TO ALLOW SLEEP/RESPIRE.
 - SCHEDULE LIVE FIRE AND MISSION REHEARSAL TRAINING IN THE COMBAT ZONE WHEN FEASIBLE.
 - INTEGRATE COMBAT STRESS CONTROL AND PSYCHOLOGICAL OPERATIONS INTO THE OPERATIONAL PLAN.
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S4/G4 LOGISTICS

- ASSURE ADEQUATE FOOD, WATER, AMMUNITION, AND FUEL.
 - KEEP WEAPONS SYSTEMS AND COMMUNICATION EQUIPMENT FUNCTIONING.
 - ASSURE BATH, LAUNDRY, CLOTHING, AND OTHER LIKE AREAS/ITEMS WITH S1/G1.
 - ASSURE RESPECTFUL HANDLING OF THE DEAD.
 - ASSIST WITH TRANSPORT OF BATTLE FATIGUE CASUALTIES IN GENERAL PURPOSE VEHICLES.
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S5/G5 CIVIL AFFAIRS

- RECOGNIZE AND MEDIATE STRESS ISSUES BETWEEN US PERSONNEL AND THE LOCAL POPULATION.
- COORDINATE FOR HOST-NATION SUPPORT.

PUBLIC AFFAIRS

- ASSURE THE UNIT GETS PROPER RECOGNITION FOR ITS ACHIEVEMENTS IN THE US MEDIA.
 - ASSIST THE COMMANDER IN DETERMINING INFORMATION NEEDS OF SOLDIERS.
 - ASSIST THE COMMANDER IN MESSAGE AND PRODUCT DEVELOPMENT.
 - FACILITATE COMMUNICATIONS CHANNELS.
 - SERVE AS PRIMARY INTERFACE BETWEEN THE MILITARY AND CIVILIAN MEDIA.
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e. *Chaplains' Responsibilities.* Chaplains, especially those in unit ministry teams, have extremely important responsibilities. See Table 1-5 for chaplains' responsibilities. For additional information on the unit ministry teams, see Appendix D.

f. *Unit Medical Personnel's Responsibilities.* Unit medical personnel assist commanders and NCOs in the control of stressors. See Table 1-6, page 1-16, for combat stress control responsibilities.

1-8. Primary Responsibility—Combat Stress Control/Mental Health Personnel

Combat stress control is the primary responsibility—in peace as well as in war—of the mental health team. While the chain of command and NCO chain of support have ultimate responsibility for stress control, the unit leaders must give primary attention to accomplishing their unit's mission. Headquarters staffs and unit chaplains and medical personnel also have other primary missions which must come first. Sustaining military performance, preventing stress casualties, and treating stress symptoms are the primary missions for Army combat stress control units and personnel.

a. *Combat Stress Control Organization.* As defined in Army Regulation (AR) 40-216, the mental health team consists of Army psychiatrists, clinical psychologists, social work officers, occupational therapy officers, psychiatric nurses, and their enlisted counterparts. Mental health personnel are organized into organic mental health sections in the main support medical companies of divisions and the medical companies of separate brigades. In both the corps and the COMMZ, the mental health sections are organic to the area support medical battalion. Mental health staff sections in the medical command, medical brigade,

and medical group monitor and coordinate combat stress control support. The medical combat stress control units (companies and detachments) are a corps and COMMZ asset. They are designed to divide into mobile, modular combat stress control teams. The teams provide combat stress control support throughout the corps and routinely deploy forward to reinforce mental health section personnel in the division and brigade areas. The philosophy and the organizational and operational concept for combat stress control are reviewed in Appendix B.

b. *Combat Stress Control/Mental Health Team Responsibilities.* Table 1-7, page 1-17, summarizes the mission and responsibilities of combat stress control/mental health personnel in combat stress control.

1-9. Effective Combat Stress Control Program

Without an effective combat stress control program, combat stress can be a "war-stopper" for our soldiers. This may be by way of a high number of battle fatigue casualties during and after intense critical battles. It may be by way of misconduct stress behaviors which undermine the objectives and the will to persist in operations other than war (conflict). Maximizing the amount of combat stress experienced by our forces is one of the main objectives of the enemy. An effective combat stress control program requires participation at all levels. It is implemented by command authority. It is supported by commanders, leaders, staffs, chaplains, physicians, and health care providers and should be facilitated by mental health/combat stress control personnel and units. Through these actions we can control the effects combat stress has on the accomplishment of unit missions by—

- Identifying and controlling stress factors (stressors).

- Reducing number of battle fatigue casualties and misconduct stress behaviors.
- Reducing recovery time for battle fatigue casualties.

An effective combat stress control program focuses the effects of combat stress toward increasing positive stress responses while decreasing disruptive stress. It reduces the possibilities of stress becoming a war-stopper for the US.

Table 1-5. Chaplains' Responsibilities for Combat Stress Control

<ul style="list-style-type: none"> ● PROVIDE RELIGIOUS SUPPORT AND THE MINISTRY OF PRESENCE (BEING WITH THE SOLDIERS) TO ALL SOLDIERS IN THE UNIT. ● ADVISE COMMAND ON SPIRITUAL, MORAL, AND MORALE ISSUES AS A SPECIAL STAFF OFFICER. ● HELP SOLDIERS TO BE SPIRITUALLY STRONG TO FACE THE MORAL AND ETHICAL DILEMMAS AND PARADOXES OF HUMAN COMBAT. ● ENCOURAGE SOLDIERS TO SHARE FEELINGS AFTER COMBAT. ● ENCOURAGE CONTINUED PERFORMANCE OF DUTY. ● RECOGNIZE STRESS SYMPTOMS, PROVIDE IMMEDIATE SOLACE, AND RECOMMEND FURTHER EVALUATION AND TREATMENT WHEN APPROPRIATE. ● KNOW AND PROVIDE INFORMATION TO UNIT LEADERS ON COMBAT STRESS CONTROL TEAM LOCATIONS AND CAPABILITIES. ● PROVIDE ASSISTANCE WITH INTEGRATING RECOVERED STRESS CASUALTIES BACK INTO THEIR UNITS. ● MINISTER TO THE SICK AND DYING. ● ASSIST SURVIVORS WITH GRIEF AND BEREAVEMENT.
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Table 1-6. Unit Medical Personnel's Responsibilities for Combat Stress Control

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- ADVISE AND INFORM LEADERS AND SOLDIERS/PATIENTS ON STRESS.
 - ENCOURAGE HEALTHY FITNESS OF THE SOLDIERS; ASSIST LEADERS WITH AFTER-ACTION DEBRIEFINGS, SLEEP PLANS, HYGIENE, NUTRITION, AND HYDRATION.
 - DETECT EXCESS STRESS EARLY AND INTERVENE. WHEN FEASIBLE, TREAT AND RELEASE SOLDIERS BACK TO THE SMALL UNIT OR TO REST IN THE SMALL UNIT'S HIGHER HEADQUARTERS (1 TO 2 DAYS MAXIMUM) BEFORE RETURNING TO DUTY.
 - HOLD THE STRESS CASES WHO CANNOT RETURN IMMEDIATELY TO THEIR UNITS AND GIVE BRIEF (1 TO 3 DAY) RESTORATION IN MEDICAL HOLDING FACILITIES.
 - REFER (EVACUATE) TEMPORARILY UNMANAGEABLE STRESS CASES BUT ONLY TO THE NEXT MEDICAL ECHELON OR TO THE NEAREST COMBAT STRESS CONTROL TEAMS.
 - KNOW AND PROVIDE INFORMATION TO UNIT LEADERS ON COMBAT STRESS CONTROL TEAM LOCATIONS AND CAPABILITIES.
 - PROVIDE TRANSPORTATION, IF POSSIBLE, FOR COMBAT STRESS CONTROL PERSONNEL WHEN THEY PROVIDE CONSULTATION TO UNITS.
 - BE ALERT FOR STRESS SYMPTOMS IN ALL PHYSICALLY INJURED AND ILL SOLDIERS (BOTH RETURN-TO-DUTY AND EVACUATED-TO-CONUS CASES) AND INITIATE IMMEDIATE TREATMENT.
 - PROVIDE QUALITY HEALTH SERVICE SUPPORT IN THE FORM OF PREVENTIVE ACTIONS, ROUTINE CARE, EMERGENCY TREATMENT, AND CONVALESCENT CARE FOR RETURN TO DUTY OR EVACUATION.

NOTE: When soldiers know that they will receive timely medical care if wounded, injured, or ill—that is a powerful stress controller.

Table 1-7. Combat Stress Control Unit and Mental Health / Combat Stress Control Personnel's Responsibilities

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- BE THE ARMY'S ORGANIZATIONAL MEMORY AND ADVOCATE FOR STRESS CONTROL ISSUES.
 - BE PROACTIVE AND MOBILE AND PRESENT WITH THE TROOPS.
 - BE IDENTIFIED WITH SUPPORTED UNIT AND TRUSTED BY ITS LEADERS.
 - PROVIDE CONSULTATION TO LEADERS, CHAPLAINS, MEDICAL PERSONNEL, AND STAFFS INCLUDING—
 - TECHNICAL SUPERVISION AND TRAINING.
 - CASE EVALUATION AND ADVICE.
 - PERSONNEL RELIABILITY SCREENING.
 - INFORMATION BRIEFINGS.
 - IDENTIFICATION OF STRESSORS.
 - ANALYSIS OF STRESSORS.
 - STRESS CONTROL TECHNIQUES.
 - SLEEP PLANNING.
 - SUICIDE PREVENTION.
 - SUBSTANCE ABUSE PREVENTION.
 - FAMILY ISSUES.
 - OTHER AREAS AS REQUIRED.
 - STAFF PLANNING FOR COMBAT STRESS CONTROL IN ALL OPERATIONS, INCLUDING PEACETIME.
 - SURVEYS OF STRESS IN THE UNIT, ITS COHESION, AND READINESS.
 - TRANSITION WORKSHOPS; ENHANCED ORGANIZATIONAL FUNCTION.
 - COORDINATION FOR UNIT, FAMILY SUPPORT GROUPS, AND SUPPORT AGENCIES.
 - EMPHASIS ON PREVENTION OF STRESS CASUALTIES AND ON TREATMENT IN OR CLOSE TO THE UNIT.
 - ASSISTING THE RETURN TO DUTY AND REINTEGRATION OF RECOVERED CASUALTIES INTO THEIR ORIGINAL OR NEW UNITS AND JOBS.
 - PROVIDE REORGANIZATION/RECONSTITUTION SUPPORT FOR SEVERELY ATTRITED UNITS.
 - PROVIDE CRITICAL EVENTS DEBRIEFINGS FOLLOWING DISASTERS OR ACCIDENTS.
 - PROVIDE PROXIMATE NEUROPSYCHIATRIC TRIAGE (SORTING BASED ON HOW FAR FORWARD THE OVERSTRESSED SOLDIER CAN BE TREATED); SEPARATE OTHER CASES WITH SERIOUS PHYSICAL OR MENTAL ILLNESS FOR EVACUATION.
 - SUPERVISE OR PROVIDE 1- TO 3-DAY RESTORATION TREATMENT FOR BATTLE FATIGUE CASUALTIES AT MEDICAL FACILITIES CLOSE TO THE SOLDIER'S UNITS.
 - PROVIDE LONGER RECONDITIONING FOR SLOW-TO-IMPROVE CASES AT A SECURE LOCATION, USUALLY IN THE CORPS (FOR 4 TO 14 DAYS) AND COMMZ (FOR UP TO 28 DAYS) DEPENDING ON THE THEATER EVACUATION POLICY.
 - SUPERVISE OR PROVIDE STABILIZATION FOR ACUTELY DISRUPTIVE CASES AND EVALUATE FOR FURTHER TREATMENT AND EITHER RETURN TO DUTY OR EVACUATE TO CONUS.
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