



AUSTRALIAN DEFENCE FORCE PUBLICATION

HEALTH SERIES

ADFP 714

OPERATIONAL STRESS
MANAGEMENT

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AUSTRALIAN DEFENCE FORCE PUBLICATION

HEALTH SERIES

OPERATIONAL STRESS MANAGEMENT

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J.S. BAKER
General
Chief of the Defence Force

June 1997

Headquarters
Australian Defence Force
CANBERRA ACT 2600

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HEALTH SERIES

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FOREWORD

1. ADFP 714 - *Operational Stress Management* describes the principles, procedures and techniques for the management of operational stress in the Australian Defence Force.
2. This publication is complemented by ADFP 53 - *Health Support* and ADFP 709 - *Casualty Treatment Regimes*.
3. Surgeon General Australian Defence Force is the approval authority and publication sponsor for ADFP 714. Director Operational Health Policy and Doctrine (Surgeon General Australian Defence Force) is responsible for continued development, amendment and production. Further information on Australian Defence Force publications is promulgated in Defence Instruction (General) ADMIN 20-1 - *Production and Control of Australian Defence Force Publications* .
4. Every opportunity should be taken by the users of this publication to examine constructively its contents, applicability and currency. If deficiencies or errors are found, amendment action should be taken. Surgeon General Australian Defence Force welcomes any assistance, from whatever source, to improve this publication.
5. The general basis for distribution of ADFP 714 is one copy per Australian Defence Force unit/ship for reference by commanders and their staffs, and multiple copies for Australian Defence Force health service staffs/facilities/units involved in the management of operational stress.
6. **ADFP 714 is not to be released to foreign countries without the written approval of the Assistant Chief of the Defence Force (Strategic Operations and Plans).**

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ACRONYMS AND ABBREVIATIONS

AOSI	Army Office Staff Instruction
APA	American Psychiatric Association
ASA	Australian Support Area
BASB	Brigade Administrative Support Battalion
C2W	Command and Control Warfare
CISD	Critical Incident Stress Debriefing
CISM	Critical Incident Stress Management
CMR	Central Medical Record
CSR	Combat Stress Reaction
DSM	Diagnostic and Statistical Manual of Mental Disorders
DVA	Department of Veterans Affairs
ECT	Electro Convulsive Therapy
EMDR	Eye Movement Desensitisation and Reprocessing
GAS	General Adaptive Syndrome
ICD	International Classification of Diseases
JFAO	Joint Force Area of Operations
JHQ	Joint Headquarters
MHP	Mental Health Professional
NBC	Nuclear, Biological and Chemical
NSA	National Support Area
PIES	Proximity, Immediacy, Expectancy, Simplicity
PO	Petty Officer
PSM	Peer Support Member
PsST	Psychological Support Team
PTSD	Post Traumatic Stress Disorder
QSTAG	Quadripartite Standardisation Agreement
SGADF	Surgeon General Australian Defence Force
TTCP	The Technical Cooperation Program
UMR	Unit Medical Record
UN	United Nations
VVCS	Vietnam Veterans Counselling Service
XO	Executive Officer

CHAPTER 1

INTRODUCTION

DEFINITIONS

Stress

101. Stress is the physiological and psychological reaction that occurs when individuals perceive an imbalance between the level of demand placed upon them and their capability to meet that demand. It is sometimes called the General Adaptive Syndrome, which recognises the human drive to return to homeostatic levels of stress, where there is no imbalance between the level of demand and the individual's capability to meet that demand. Stress responses are adaptive in that they enable an individual to concentrate their full attention on a particular threat, and to mobilise physical energy in response to the threat. Stress reactions can become maladaptive if they are sustained or inappropriately attended to.

Operations

102. Operations are military actions or the carrying out of strategic, tactical, Service, training or administrative military missions. Operations may also be further defined as being the process of carrying on combat, including movement, supply, attack, defence and manoeuvres needed to gain the objectives of any battle or campaign.

Operational Stress

103. Operational stress is a term which encompasses an array of effects caused by the stressors of operations, and refers to the temporary or lasting psychological upset causing a marked reduction in an individual's ability to function effectively. Operational stress encompasses the terms battle fatigue, battle shock, and critical incident stress, as well as the older terms such as shell shock, war neurosis, neuropsychiatric and combat exhaustion. It also encompasses the more recent concepts of Transient Stress Response, Acute Stress Disorder and Post Traumatic Stress Disorder (PTSD).

104. Operational stress may be a normal reaction to a very abnormal situation, and does not constitute a psychiatric illness, although it may become one. Operational stress may present as a psychiatric illness, such as depression, anxiety or psychosis, however this is not always necessarily the case.

Operational Stress Management

105. Stress management refers to assistance given at all levels and strategies used by individuals to deal with stress. This includes the application of good leadership by unit personnel to reduce or cope with operational stressors and facilitate recovery in those personnel exhibiting early signs of operational stress, as well as specific therapy given to the more serious cases by appropriately trained health personnel.

SCOPE OF OPERATIONAL STRESS

106. In considering the scope of operational stress, it is important to view the operational environment broadly - distinguishing between less severe or normal reactions to abnormal circumstances and reactions which may be considered pathological. The operational environment may include actual combat, humanitarian and peacekeeping operations, exposure to displaced

persons camps, massacre sites, or major accidents. Stress in these environments can arise from acute sources, such as combat or dealing with bodies, or from chronic sources such as stress from prolonged separation from family or living in isolated areas with the same people for long periods.

107. In this context, operational stress can be viewed in three categories:

- a. *A transient stress response* to the aversive stimuli of the operational environment. This is a mild Combat Stress Reaction. This stress, while distressing to the individual, is not dysfunctional to the extent that the person needs to be removed from the unit environment. Individuals can be taught to manage their own responses to abnormal circumstances to a certain extent. Further support comes from unit resources such as unit leaders and buddy psychological first aid.
- b. *A stress reaction which incapacitates in the short term* either during or immediately after exposure to stressors. This renders the person unable to function effectively in the unit role. Support for personnel experiencing such reactions comes in the first instance from unit leaders and buddy first aid, while subsequent specialist support is provided (from deployed combat support elements). In the case of those suffering these reactions the expectation is that they will return to normal unit duties within a relatively short period (eg 72 hours).
- c. A post trauma reaction which is incapacitating to the extent that the person is unable to perform normal unit duties and where *the symptoms are expected to last beyond the Joint Force Area of Operations medical holding policy*. These personnel are evacuated to the National Support Area. Under these circumstances the symptoms may well endure and these abnormal responses to stress may subsequently be diagnosed under categories such as PTSD, Depression or Anxiety Response.

HISTORICAL BACKGROUND

108. Operational military service is unique in the range, intensity and continuity of stressors likely to be encountered. The relationship between stressor and stress has been observed in previous wars, however the opportunity to develop effective stress management strategies has not been adequately grasped. Da Costa's Syndrome, the prototype stress reaction, was described in the American Civil War. Emphasis was given to the physiological accompaniments of hyperarousal. In World War I the same condition was called 'defective action of the heart'.

109. During World War I 'shell shock' was proposed as a diagnostic entity to describe a range of stress reactions including confusion, fatigue, anxiety, conversion states and obsessional states. Organic mechanisms to explain psychological disorders were popular at the time because of the work done on brain syndromes arising from syphilis. Shell shock embodied the notions that percussion, such as that produced by sustained artillery fire, could cause 'neuronal disruption', or that carbon monoxide inhalation accompanying munitions explosions could lead to neurotoxicity. Further, the term 'shell shock' implied a wound, and as such avoided the stigmatisation associated with psychiatric labelling. This was a particular problem during World War I because nervous stress and different forms of delinquent behaviour were seen as being points on a continuum. Sufferers of nervous stress were considered to have a predisposition to the condition - in other words, it was a sign of pre-existing weakness - which had an influential effect on the way they were managed.

110. There was no specific treatment available for shell shock beyond withdrawal from the front line, rest, reassurance and persuasion, which in many cases was quite efficacious. Some personnel however, even with prolonged rest, continued to show symptoms which caused marked impairment in their ability to carry out active duties. These personnel came under consideration for repatriation, although the development of objective criteria to determine the need for evacuation and longer-term hospital care for psychiatric cases, always remained problematic.

111. After World War I, Freudian theories impacted increasingly on psychiatry. Freud himself gave greater emphasis to aggression and destructive instincts as contributors to neurosis, partly in response to the large scale, apparently pointless, loss of life occurring during the war. The term 'Post Traumatic Neurosis', which was carried into World War II originated from the analytic view that trauma leads to repression, which can in turn generate nervous symptoms reinforced by various secondary gain factors. The individual predisposition to Post Traumatic Neurosis was seen as being determined by the presence of incompletely 'worked through' childhood conflicts.

112. The extensive personnel requirements of the global World War II forces precluded too permissive a response to psychological casualties - particularly so because the popular psychiatric treatments of the time were often prolonged and therapist intensive. Therefore, military staff preferred to de-emphasise psychiatric morbidity by encouraging terms such as 'battle fatigue', which carried the implication that simple rest was all that was necessary for restoration of a combatant's efficiency. The principles of proximity, immediacy and expectancy evolved from this view. Certainly, it was found that a policy of early return to active duty for psychological casualties removed some of the hitherto potent reinforcers of illness behaviour. Unfortunately, what followed in many instances was a failure to diagnose, understand, and hence offer appropriate treatment to many genuine cases.

113. During the Vietnam War, there was a general awareness of the unpopular nature of the conflict, with a variable level of support at home. As the war proceeded and in the early post-war years, psychiatric morbidity appeared to be minimal until the late 1970s when links were drawn between a range of symptoms and the possibility of exposure to toxic chemicals. The 'Agent Orange' controversy then ensued, where psychological syndromes with neurasthenia, cognitive deficits, anxiety and social withdrawal were described. Epidemiological studies were carried out in both the United States of America and Australia, which in most instances failed to establish clear connections between exposure to chemical defoliants, and the other chemicals extensively used in Vietnam, with subsequent nervous symptoms. The relatively low level of recorded psychiatric casualties in Vietnam may possibly be attributed to the fact that many Combat Stress Reaction casualties were diagnosed as having a disciplinary problem.

114. An alternative explanation was sought for what later on became an increasing number of Vietnam veterans presenting with psychopathology. Over this period the American Psychiatric Association (APA) had been carrying out an extensive review of the evidence supporting the validity of all psychiatric diagnoses, for a new system of classification - the Diagnostic and Statistical Manual of Mental Illness III (DSM III, now DSM IV). The APA's relevant committee noted the similarity in symptomatology between the disorders previously described in concentration camp survivors and currently occurring in many of the presenting Vietnam veterans. These symptoms included, as a result of exposure to extremely traumatic and distressing experiences, a continuing preoccupation with those experiences, different patterns of avoidance behaviour plus an unresolving state of hyperarousal. These clinical features were refined through further studies and became the diagnostic criteria for the entity PTSD as it is widely applied today. In addition, while the concept of PTSD was developed in a military context, the symptoms observed are the same following other traumatic stimuli, such as severe physical or sexual assault.

INCIDENCE OF OPERATIONAL STRESS

115. In World War II, about 23 per cent of American casualties suffered from psychological disorders. In combat units the figures were much higher, particularly when the fighting was intense. For example, the 2nd Armoured Division in Italy fighting for 44 days reported 54 per cent of total casualties were combat stress casualties.

116. Israeli psychological casualties in the 1973 Arab-Israeli War were estimated to be around 30 per cent of total battle casualties, although of the first 1500, 900 were psychological casualties, reflecting the intensity of combat in the first 48 hours of the war.

117. After the Vietnam War, about 30 per cent of veterans were estimated to have dysfunctional psychological reactions, and about 15 per cent still experience those today.

118. In preparations for the Gulf War, United States forces planned for 25 per cent of the force to be combat stress casualties. The fact that these did not occur does not necessarily reflect the fact that the war fighting was less intense than was expected. A decisive victory, the highly mobile nature of the war, popular support and the resultant high morale, a belief in technological superiority and the overwhelming success of the air campaign may have contributed to the relatively low numbers of operational stress casualties.

GENERAL APPROACH TO THE MANAGEMENT OF OPERATIONAL STRESS

119. Important lessons from history show that combat stress reactions are an inevitable consequence of military operations and that all individuals are susceptible. Effective leadership, unit cohesion, high morale, and realistic training produce considerable buffering against operational stress. In addition, many individuals displaying the symptoms of operational stress, if managed correctly, can quickly recover and return to useful function with a minimum risk of relapse. The ultimate aim of effective operational stress management is the conservation of manpower and maintenance of the Australian Defence Force's combat capability.

120. Commanders at all levels and their medical staff should work together in order to prevent, as far as possible, stress reaction casualties during the pre-deployment phase; maintain an awareness of personnel displaying early symptoms of operational stress while on deployment, and initiate treatment accordingly; and carry out psychological debriefings and post-deployment follow-ups for those who are returning from operations. These requirements will be addressed in more detail in later chapters.

RESPONSIBILITIES

Commanders

121. Commanders are responsible for the operational effectiveness, health and wellbeing of their personnel. Operational stress can reduce the performance of personnel remaining on operations and can severely reduce the number of personnel available for operations. In both instances operational effectiveness is degraded.

122. On operations, stress can lead to administrative problems, illness, malingering, self-inflicted wounds and refusal to obey orders. After operations, accumulated stress can be a contributor to poor work relationships, job dissatisfaction, increased turnover, marriage/relationship problems and anti-social behaviour. It can also result in psychiatric illness.

123. It is important that commanders, especially junior commanders, understand the type of stress that they and their personnel will encounter and the early warning signs so that they can intervene to pre-empt the development of operational stress. Where it cannot be pre-empted they must know the measures available to them to minimise the impact and initiate subsequent treatment.

Health Services

124. Health services advise and support the commander. They combine specialist medical, psychiatric and psychological advice with the provision of diagnostic, evaluation and treatment facilities.

CHAPTER 2

SOURCES OF STRESS IN AUSTRALIAN DEFENCE FORCE OPERATIONS

INTRODUCTION

201. Stress in Australian Defence Force (ADF) operations will be caused by a variety of situations, will manifest in various forms and will affect different people in different ways, even during peacetime. The ADF continues to exercise all forms of warfare which exposes personnel to operational situations during peacetime, and peacekeeping or humanitarian missions may involve combat type operations with the associated dangers. The focus of this chapter will therefore be on the stressors faced in operations during both peacetime and conflict. How these stressors are likely to effect personnel, how to recognise the symptoms and possible treatments or preventative measures are addressed later in this publication.

202. In discussing stressors linked to operations, it should be said that not all stress-related conditions will have their origins in operational circumstances. In some cases, the cause of stress will be related to events indirectly linked with an operation. For example, when subjected to extended absences, separation from family is likely to be a major cause of stress in itself. Individuals must face and deal with stress in their own way, however commanders must also address these factors collectively and be aware of the overall effect that stressors can have on individuals, particularly how these stressors can effect the success of operations. Commanders need to remain cognisant of the effects of various activities and situations on personnel and take these effects into account when formulating plans.

AUSTRALIA'S STRATEGIC GUIDANCE

203. Strategic guidance based on the geographic and political situation faced by Australia and the resultant roles and missions assigned to the ADF provide an indication of the stressors likely to be faced by defence personnel. Strategic guidance provides a focus for the ADF on the disposition of forces, their employment and the level to which they should prepare for operations. This in itself provides a guide into stressors likely to be experienced, in that certain conditions are prevalent in particular types of operations and their likely locale.

204. Guidance for the defence of Australia provides a focus for operations across the northern area of the continent (noting that maritime operations may be required to extend significantly beyond the northern area of Australia). The environment and population spread which is characteristic of northern Australia impacts upon operations and contributes to the type and level of stress experienced by personnel. This will include operating for extended periods in isolated and inhospitable areas, with little or no contact with personnel outside the immediate combat unit.

205. Operations conducted in foreign countries in humanitarian or peacekeeping roles will provide stressors unique to those roles. Exposing ADF personnel to environments and cultures alien to our own - in what are likely to be volatile and degrading conditions - will provide personnel with a range of stressors which may be either similar to, or distinctly different from, those experienced in combat operations. Stressors that may be experienced under these circumstances are detailed in paragraph 210.

STRESSORS IN MILITARY OPERATIONS

Common Stressors

206. A significant number of stressors will be common to all operations, whether they be during peacetime exercises, in actual combat, or peacekeeping situations. This list is not exhaustive as other factors come into consideration the longer an operation runs, or in the case of individuals, as their individual stress levels are reached. Poor communication, lack of information, poor leadership, risk/fear of injury or death to oneself or others, inexperience, duration of operation/deployment, definition of mission (or lack of), personality factors, living conditions, separation, lack of contact with home or family, emotional/sexual deprivation, boredom, changing plans and priorities are all stressors to be managed, and in some way alleviated, in nearly all operations.

207. The level of operational stress casualties depends on a number of interrelated factors. Risk is greater where one or more of the following potential operational stressors prevail:

- a. exposure to the operational stressor is of long duration and/or high intensity;
- b. there is high risk of physical injury, loss of one's own life, or where there is a sense of loss (such as comrades but also including loss of personally valued possessions, such as a house and belongings in a destructive conflict or natural disaster);
- c. there is exposure to human misery and atrocities, especially on a large scale such as in displaced persons camps or massacre sites;
- d. bodies are handled;
- e. there is a sense of isolation such as being far from home, family and friends, communications to home are poor, or the dominant culture is alien (cultural isolation);
- f. there is a perception of a lack of support for the operation from the government and/or society back home;
- g. there is a perception that leadership, equipment, tactics, or training are deficient;
- h. there is a prevalence of drug or alcohol misuse, which can be a sign of low morale, poor discipline or leadership, or a lack of self-confidence and is indicative of an inability to resolve emotional turmoil; and
- i. there is a risk or potential of being taken hostage or becoming a prisoner of war (POW).

Major Conflict

208. Major conflict will dramatically increase the amount of stress experienced by military personnel and add to the number of likely stressors. The extended duration of conflict, the unknown factors surrounding the operational requirement and the increased threat to the civilian population, including families of serving personnel if the conflict is taking place within Australia or its territories, will add to the amount and type of stress experienced. There will be a greater likelihood of major stress effects and an accumulation of the effects of minor stressors, which in themselves would not normally cause problems, but which could contribute to major problems over the long term.

Short-warning Conflict

209. The stressors linked to short-warning conflict will vary only from those experienced in major conflict early in the operation, while the intensity and short duration of the operation are anticipated. The transition from short-warning to prolonged major conflict may not be readily identifiable, especially for personnel at the tactical level of operations. The effects of long-term exposure to stressors for these personnel will become apparent as the duration of the operation or campaign increases.

Peacekeeping and Humanitarian Operations

210. Personnel involved in humanitarian or peacekeeping operations may be subjected to inconveniences, frustrations and dangers not normally experienced in combat operations. Media coverage will be an additional stress factor, particularly if negative and implying a lack of public support, creating doubt about the operation. Personnel are also likely to be exposed to foreign and alien cultures of which they have little or no understanding. They may be required to serve in operations where there is obvious injustice and suffering and be prohibited from intervening or reacting to atrocities against indigenous personnel. They also face the risk of capture and being held hostage by groups who are not readily identifiable from friendly groups within the area of operations.

'The killing was going on right under the UN noses. They especially took old women up and executed them 15 metres or so from the Australians. The Australians and Zambians, bound by rules of engagement and, in any case, vastly outnumbered, could do nothing. World War II soldiers who went into places like Belsen saw dead bodies...but these soldiers had actually treated them as patients, played with the kids, and then we saw them killed in the most graphic way. Then they had to count the bodies.'

George Gittoes
The Bulletin, June 6, 1995

Disaster Relief

211. Stressors peculiar to disaster relief operations may also have a significant impact upon individuals; possibly to the same degree as stressors encountered in military operations. A greater possibility of exposure to the suffering of civilians, the likelihood of being exposed to contagious diseases or human remains, and the general poor working and living conditions that would be found in these circumstances will differ from those usually experienced by these personnel. They are also likely to have to deal with hostile civilians who may be psychologically affected by the disaster they have experienced or perceive the presence of military personnel as a threat. There is also the possibility of security operations and the associated dangers when dealing with looters and/or organised criminal activity.

ENVIRONMENTAL CONSIDERATIONS

Maritime Operations

212. In the first instance, all personnel on maritime operations are exposed to isolated and cramped conditions, and in most cases a complete lack of privacy, not only during working hours, but also in leisure and sleep periods. Personnel are also exposed to sleep deprivation due to intensive watch cycles, while ambient noise, temperature variations, vibration, inadequate ventilation and constant movement can also have a debilitating effect. Added to this are the nausea and listlessness that comes with motion sickness, which not only affects the efficiency of personnel during working hours, but may also affect their physical wellbeing if not treated appropriately.

213. Being at sea on a ship or submarine exposes personnel to stressors which, as individual or isolated incidents, would not usually cause major psychological or physical problems. However, over a period of time their accumulative effect may cause problems for some personnel. A ship is in continuous motion and this motion can affect people by disrupting coordination and body stability. The aforementioned environmental variables, particularly noise, vibration and temperature, long irregular hours with sleep deprivation and working with hazardous machinery, could be factors influencing the rates of hospitalisation on board vessels.

214. Many of the threats faced at sea in a modern combat situation offer little or no warning to the ship or its crew. Mines or torpedoes can sink a ship without warning in a matter of minutes. Sea skimming or supersonic anti-ship missiles and modern attack aircraft offer little warning and can strike a ship hard enough to cripple or even sink it in a very short time frame. These vulnerability factors contribute significantly to operational stress levels during maritime operations.

'.....Morale remained high throughout but the pressure was beginning to take its toll: the tedium of maintaining high levels of alertness during twelve hours a day on watch plus off watch tasks that broke sleep patterns; the constant stress of having only minutes to react to a missile attack; of searching for floating mines, with the ever present fear of the world suddenly exploding and the sea rushing in, particularly for the majority of the crew who slept in mess-decks below the water line. We were not at the end of our tether but the strain was apparent. As we sailed back to the northern Gulf there was relief on board as a temporary cease fire was announced, however, the mines were still there.....'

Commanding Officer
HMAS SYDNEY
Operation DAMASK

Land Operations

215. Sources of stress for the individual in land operations will come from the environment, the enemy and the team. These are as follows:

- a. **Environment.** The physical environment is always a source of stress; be it darkness, cold, wet, wind, noise, heat, or excess exposure to the sun. Such stress may cause physical or mental exhaustion. These stressors can be reduced by provision of suitable clothing, equipment, shelter, and training to ensure troops have the skills and knowledge to operate in the appropriate environment.

'Physically the pathetically young warriors of the 39th were in poor shape. Worn out by strenuous fighting and exhaustive movement, and weakened by lack of food and sleep and shelter, many of them had literally come to a standstill. Practically every day torrential rains fell through the afternoon and night, soaking the clothes they wore - the only ones they had. In these, they shivered through the long chilly vigil of the lonely nights when they were required to stand awake and alert, but still silent.'

Dudley McCarthy, *Kokoda to Wau*

- b. **Enemy.** The stressors caused by the enemy can be categorised into the following two areas:
 - (1) **Contemplation of Enemy Action.** Troops may suffer anxiety before battle from contemplating the task ahead and imagining the worst case scenarios, such as unknown minefields, the strength of the enemy and being killed, maimed or captured. Such anxiety may have a degrading effect on performance and contribute to battle stress. These stressors can be reduced by realistic training, which will help to alleviate the fear of the unknown. As a

2-5

rule, troops who have confidence in both their leader's and their own abilities will suffer less anxiety prior to battle. Another way to counter this anxiety is to keep troops busy, preferably with meaningful military tasks.

'I found the best way to overcome fear in battle was to get involved and keep busy. I had to keep moving and not keep still. Once I was fully in the picture, and knew what we were up against, and could come up with a plan of action; I was OK. Until then I would have the fast pulse, the outbreak of sweat and other normal reactions to stress.'

Gary McKay, *In Good Company*
1987

- (2) **Actual Enemy Action.** Sustained or unexpected bombardment, observing comrades being killed or injured, and a sudden air or armoured attack can all have a devastating effect on the mind.

'Everybody reacts differently to the stresses of combat and soldiers cannot be lumped together and classified as having a certain reaction to combat. One theory I know now is that the harder men train for combat the better they will fight when it eventually comes.'

Gary McKay, *In Good Company*
1987

- c. **The Team.** During operations most troops will be part of a team. The team will be both a source of stress and counter-stress. A team that has bonded together, has complete trust and confidence in one another, and is well led, will be a formidable military organisation. Doubts about its leaders, or obstacles in the path of mutual trust and confidence will cause stress on all individuals in the team.

'For the full duration while we were out there by ourselves it was very well controlled. Everybody knew what the bloke next to him was doing and how he was reacting. It was like a very tight family. We all worked very well together. That control came from Sharp, down through the Section Commanders and after he was killed the control was still there in Bob Buick who took over the Platoon.'

Lex McCauley, *The Battle of Long Tan*
1986

'I look back on that six months jungle training as a vital part of my training for war, accidental though it was. Even though the Australian Army was very experienced in jungle operations, a lot of training time was devoted to work in the 'J'. To an unblooded officer or soldier it is a most daunting environment. Operations in the jungle are emotionally or spiritually draining and physically demanding. On the emotional side, there is the nervous tension engendered by poor visibility, by jungle noises - in fact by ignorance of one's environment. Also contributing to the mental strain are the restrictions that working in the jungle places on personal behaviour. You can't talk in a normal voice, cough or sneeze. You can never relax your personal vigilance. The physical demands are also very high and of course contribute to the emotional drain. One is constantly wet from either rain, ground water or sweat. On patrol, fatigue is great from heavy loads carried for long hours while moving slowly, twisting,

ducking and bending through dense undergrowth. Finally, the jungle provides a good assortment of non-human threats; in Vietnam anything from leeches to tigers craved your blood and sometimes, it seemed, in equal proportions...

An infantry platoon commander's recollections of service in Vietnam.

Air Operations

216. All aircrew are subject to a certain in-built stress due entirely to operating in the third dimension. The simple fact is that human beings were never designed to fly, and although they can adapt with the aid of heavier-than-air machines, and even enjoy it, there is always a certain residual tension. Aircrew in high-speed aircraft have the additional stress of amplified body weight and G force when these high-speed aircraft are manoeuvred briskly.

217. Superimposing operational stress with its mission demands, reaction times, long periods of waiting on high alert, sortie length, technical overload, working in extreme climatic conditions, conducting operations from bare bases and associated equipment problems will have a cumulative effect, which although it can be coped with, never becomes routine.

218. Aircrew in the fighter and strike roles are intrinsically subjected to high stress levels. This fact is both reflected in their historically higher accident rate, and a direct result of it. For example, in the 25 years the RAAF operated the Mirage 111-0 fighter, 45 aircraft were completely destroyed in accidents - resulting in the deaths of 15 pilots. This was in peacetime. Maritime and transport crews are also subjected to high levels of stress. Operational frustrations caused by the success or otherwise of a transport or maritime mission, and particularly the length of these types of sorties, are often exacerbated by the personalities as they try to cope with others in a large crew environment.

'I did not think much about it at the time, but life as an F111 pilot/navigator or instructor was extremely stressful. The demands of the job were very unusual - indeed, unique - in that just the environment (black, low, fast, wet, turbulent, lightning, hail, snow, birds, terrain) was very scary. No matter how experienced the crew, no-one ever got used to the worse nights. And that is even before loading real bombs and going against real, defended targets!

As an instructor, I vividly recall the students' reaction to their first night low level sortie: pure adrenalin. When it was all over and a beer was in the hand, every one of them turned into gibbering wrecks. The fact that one could see trees flash past the wingtips only by the illumination of the aircraft's lights never failed to impress. Nearly all learned to cope, but coping was more a process of understanding the aircraft's systems, trusting them, and monitoring them than becoming bolder or thicker of skin.'

F111 Pilot/Instructor

OPERATIONAL INFLUENCES

Warfare Systems

219. Operators of high technology military equipment will face stressors particular to their own equipment, Service and the environment they are operating in. In most cases they will be subject to close scrutiny from superiors who may be relying on information provided through use of the equipment, or the results of actions brought about by use of the equipment. Operators may be subject to technical overload due to working at a high intensity for extended periods of time. There will also be the frustration of having sophisticated equipment breakdown at inopportune moments and no parts or personnel may be available to rectify the problem. These personnel may also be the first to perceive that their unit is at or near a decisive point which is the key to the operation, and consequently, are susceptible to the principle focus of an enemy's main effort.

Endurance

220. Military forces have developed technology that give them the ability to conduct operations 24 hours a day. These innovations have contributed to the likelihood of continuous operations that have personnel operating around the clock for days, and possibly weeks, at a time. Sustained workload combines with fatigue - especially after one or more nights of complete sleep loss or longer periods of reduced or fragmented sleep - to degrade performance, productivity, safety and mission effectiveness. Sleep loss interacts with workload, resulting in reduced reaction time, decreased vigilance, and perceptual and cognitive distortions; all of which will vary according to individual reactions and experience. Endurance of personnel must be carefully monitored to minimise the effect of sleep loss in continuous operations, and therefore maintain higher levels of sustained performance and activity.

Command and Control Warfare

221. Command and control warfare (C2W) can be conducted during any sort of operation, from low-level peacekeeping to the highest level of open conflict. The actual form of a particular operation - its environment, the military aim, type of opposition likely to be encountered, level of threat to participants, etc - will dictate, to a certain extent, the stress that will be experienced.

222. The majority of the elements involved in C2W do not involve direct combat, but rather the combat support (electronic warfare, targeting) or rear area support (operational security, operational deception, psychological operations) to an operation. This allows participants a certain degree of separation from the actual results of combat operations, and thus predisposes personnel to the effects of a different range of stressors. This supporting role, for example, means that C2W operations will tend to be conducted over extended periods. These long-duration operations bring with them stressors, such as sleep deprivation, that have already been discussed. In addition, particularly on the modern battlefield, support personnel will be subject to the constant threat of missile attack or artillery fire from the outset of an operation. This will form part of an enemies' attempt to reduce the operational capability of an opponent by damaging, or at best eliminating, the command and control infrastructure. Even if this threat is never realised, it is sufficient in itself to trigger a high level of stress in personnel.

Psychological Operations

223. Psychological operations are a component of command and control warfare and have the potential to damage an enemy's, or one's own (when directed by the enemy), command and control system by lowering morale, instilling fear and fostering distrust. They may be directed toward enemy command and control systems or may be directed to protect friendly force command and control systems (when measures employed contribute to the cohesiveness of friendly forces).

224. External stimuli which bear directly on an individual's value system or physical wellbeing are of particular significance to psychological operations where target audiences are exposed to unfamiliar or extreme situations. The impact of these situations can often produce temporary emotional and behavioural responses which override pre-existing attitudes and behavioural patterns. These mood fluctuations can be exploited by psychological operations.

Nuclear, Biological and Chemical Warfare

225. Although the likelihood of nuclear, biological and chemical (NBC) weapons being used against personnel has diminished over the past few decades, new and more dangerous methods of destruction are still being developed and may be used in the future. Personnel must therefore be prepared for the possible eventuality of facing NBC weapons which, even if it remains as only a threat, will be a major cause of stress in itself. Using protective clothing and other defensive measures against NBC warfare adds to physical fatigue primarily because of heat, visibility restrictions and impeded movement. The necessity for these precautions will further reduce time

available for rest and sleep, thus contributing to the overall debilitating effect on personnel during operations. The associated fear of the unknown and the knowledge of the lethality of NBC weapons will add to the already significant stress being experienced.

NON-OPERATIONAL STRESSORS

Separation and Domestic Situation

226. A number of stressors will not be related to the ongoing operation, but may be prevalent in all circumstances. Separation from family or friends and the lack of support they usually provide will be felt by most personnel. Being unable to provide reciprocal support is also a problem, especially when situations arise where personnel are aware of problems at home, but due to separation, are unable to help. In addition, when members return home after a long separation, they may feel that their presence disturbs the usual household routine. Changes may also have taken place, such as fashion changes, family friends, neighbours, news of the day and cost of everyday items which may lead to a feeling of isolation.

Political Views

227. Some ADF personnel may hold views that disagree with Government policy or the Government's or ADF's stand on particular issues. This may cause problems if the depth of feeling is excessive, especially if individuals openly voice their opposition or try to subvert other personnel to their way of thinking. This may be dealt with by treating these personnel as conscientious objectors. However, given the potential breadth of operational locations and the diverse ethnic background of Australia's population reflected in its military forces, this problem may not have a readily apparent solution.

CHAPTER 3

THE CLINICAL NATURE AND PRESENTATION OF OPERATIONAL STRESS REACTION

VULNERABILITY AND RISK FACTORS

Young Age

301. Children and young adults are particularly susceptible to the effects of stress. An inexperience factor, combined with the tendency to distort the significance of a threat and an immature coping style, all contribute to increased susceptibility. The Australian Defence Force (ADF) has a high number of younger personnel in a transitive stage of development, and it is therefore important to remain cognisant of their vulnerability to the effects of operational stress.

Family History of Psychiatric Illness

302. A family history of Anxiety Disorder may indicate a familial factor for high trait anxiety. Similarly, a family history of Mood Disorder may foreshadow emergence of depression under stressful conditions. Familial Schizophrenia may also predict development of Psychosis when major changes are encountered.

Past Psychiatric History

303. Previous episodes of stress-related psychological illness, particularly clear Post Traumatic Stress Disorder (PTSD), are important indicators of an individual's vulnerability.

Individual History

304. Early separations, previous physical or sexual abuse and behavioural disturbance during childhood are important risk factors to be recognised.

Certain Personality Factors Increase the Vulnerability to Stressor Exposure

305. It is difficult to be specific in relation to these, however traits associated with neuroticism, dependence, avoidance, an external locus of control, and low self-esteem are all important factors.

NATURE OF THE STRESSOR

Stressors have Different Dimensions

306. A stressor's magnitude, duration and qualitative factors all need to be considered. Stressors are also highly subjective - in that they are directly related to an individual's perception of events - and an individual's response may be governed by personal aspects such as experience, expectation and symbolic meaning.

Duration

307. Prolonged exposure to a stressful event is more likely to be damaging than a brief encounter of the same magnitude.

Intensity

308. In an operational context, combat veterans are generally more likely to show adverse reactions than personnel employed in more supportive roles. The more intense the combat, measured in terms of degree of risk and actual casualties, the higher the likelihood of consequent stress reactions. Various psychological instruments are available to quantify combat stressors.

Qualitative Factors

309. There is evidence suggesting that human-induced stressors cause more difficulties with adjustment than natural events. Circumstances where there is a threat of physical injury, loss of life, or actual injury and loss of life, constitute the most adverse possibilities. In most circumstances, the closeness of the relationship between the victim and survivor intensifies the trauma. Being a prisoner of war, witnessing atrocities, being a victim of torture or handling human remains can have special effects.

310. Other aspects of operational service that potentially heighten the stressor effect include unfamiliarity with the environment, the need to cope with an alien culture, work performed in isolation, a perception of command incompetence, a lack of moral basis for the tasks associated with some operations and sensory overload arising out of high noise levels. Death of comrades can produce special difficulties where the nature of operations might provide restricted opportunities for bereavement.

311. There is a complex interaction between the death of comrades, restricted opportunities for mourning, the factors mentioned above, and the depersonalisation of the enemy that contribute to long-term effects.

PROTECTIVE FACTORS

312. Experience from previous conflicts, especially from the Vietnam War, has demonstrated that the incidence of adverse stress reactions can be reduced by maintaining a number of organisational characteristics, both during deployment and afterwards. These characteristics are high degrees of leadership, unit cohesion, morale, and unit social support. External social support can also act as a buffer to adverse stress reactions. These organisational characteristics are traditionally recognised as important to overall military effectiveness, and are emphasised again because of their demonstrated role in reducing adverse stress reactions.

313. Post deployment adjustment is assisted by allowing reasonable time to elapse between operational activities and a return to everyday community life. Adequate social supports need to be available within the community; this being optimally provided through an intact family structure. General community attitudes can also be a significant determinant. It has become clear that media hostility and negative reactions from some community groups hindered the adjustment of many veterans. If possible, there needs to be open discussion of all operational tasks at a community as well as at an individual (debriefing) level. Community analysis helps place operational events in proper historical context. Memorials and commemorative ceremonies also serve important functions in this regard. Appropriate counselling and treatment services should be made unconditionally available to individuals who, for whatever reason, may be having difficulty coping after trauma experiences.

314. Alcohol or other substance abuse can act against resolution of emotional issues arising out of stressor exposure. The anxiolytic (anxiety reducing) effect of sedative substances may appear to assist in the alleviation of short-term distress, post-trauma, only for important emotional issues to be reactivated at a later date. Intoxication facilitates denial and distortion of events and acts against effective longer-term problem-solving. Substance abuse leads to its own adverse emotional and social consequences which further complicates understanding, and proper handling, of primary trauma aspects.

TYPES OF OPERATIONAL STRESS REACTION

General

315. Many symptoms forming part of a stress reaction are experienced in mild and transient or temporary forms and may not develop into established psychological disorders. In general, after exposure to a stressor there is a shock phase characterised by disorganisation which is followed by an impact phase where specific nervous symptoms may develop. Fortunately, in most cases complete resolution of symptomatology occurs. In some instances, development of specific psychiatric syndromes can follow. Early warning signs of psychopathology includes continuing guilt about actions, shame over perceived failure, emotional lability, sleep disturbance, depressed mood, anxiety, anger, somatic complaints such as headache, nausea or fatigue, social isolation, poor concentration, irritability and a preoccupation with the trauma.

Acute Stress Disorder

316. Acute Stress Disorder first appeared as a recognised entity in the Diagnostic and Statistical Manuals of Mental Disorders (DSM IV) (the most recent revision of the Diagnostic Manual of the American Psychiatric Association). The features are essentially the same as those to be described for PTSD except that the symptoms resolve within a four-week period. While this diagnosis is acknowledging the need for early specific treatment, it is also indicating that acute stress reactions can resolve without invariably proceeding on to more chronic syndromes such as PTSD.

Post Traumatic Stress Disorder

317. PTSD first appeared as a diagnosis in 1980 by the inclusion in DSM III of a description of the reaction to a trauma of catastrophic proportions. In DSM II the closest equivalent was transient situational disturbance. There have been some changes in the diagnostic criteria from DSM III to DSM IV. A more specific definition of the stressor is now provided and other dimensions of PTSD are grouped into well delineated classes, each with their own characteristics:

- a. re-experiencing phenomena;
- b. avoidance aspects, including numbing of emotional responses; and
- c. symptoms of increased arousal.

318. A more detailed appraisal of PTSD is provided in chapter 8.

Combat Stress Reaction

319. Historically, there have been many labels given to the stress reactions arising from combat service. As explained in chapter 1, it was combat stress reactions (CSR) which were partly the origin of the diagnostic classification of PTSD which is now recognised as a general stress classification in the community, ie CSR is specific to the combat environment but Post Traumatic Stress is a more severe, enduring, and dysfunctional traumatic stress reaction which can be found across the entire community. While there is a clearly established link between CSR and PTSD, and it has been suggested in the research literature that untreated CSR leads to PTSD, the inevitability of this progression is not universally accepted. However, failure to treat CSR invites later PTSD. CSR is treated separately because the nature of the battlefield environment has given rise to specific treatment methods and support structures which have, at least in the ADF, subsequently been utilised to treat stress arising from other operational environments, eg peacekeeping operations and support to civil authorities.

Mood Disorder

320. Depression, either as a manifestation of an adjustment disorder from which recovery usually occurs fairly rapidly, or as a major depressive episode, can follow a stress reaction. Major depression in these circumstances is usually unipolar. However, in constitutionally predisposed individuals, it can be an episode of a bipolar process. Depression can also be a feature of the presentation of PTSD. Whether in these circumstances a diagnosis of primary depression or alternatively PTSD is made will depend on a comprehensive and thorough clinical assessment. The common symptoms of major depression are a lowered mood, negative thoughts, behavioural changes usually with social withdrawal, poor concentration, reduced energy and other somatic features including sleep disturbance, appetite change and loss of libido. Suicide is always a high risk with lowered mood states.

Other

321. Other specific psychiatric disorders developing in association with stress reactions are Generalised Anxiety Disorder, Obsessive Compulsive Disorder, Somatoform Disorder (often a Conversion Disorder) and occasionally Psychosis. Factitious disorders also need to be considered.

322. In Generalised Anxiety Disorder the traumatic origin of the symptoms is less evident. In Obsessive Compulsive Disorder there are recurrent ruminative thoughts which are experienced as inappropriate and not easily linked to a past traumatic event. A Conversion Disorder is a disturbance of physical functioning, which cannot be explained on an organic basis and where there is a reasonably clear link to stress. The physical changes in conversion disorder can take almost any form, but they always involve functions under voluntary control. Loss of motor or sensory capacities are common. The prominent flashbacks sometimes occurring in PTSD need to be distinguished from the hallucinations characteristic of Schizophrenia.

CO-MORBIDITY

323. Co-morbidity refers to two or more disorders that occur together at the same time. While the disorders can be distinctly different, they usually appear related in some way. Co-morbidity is the rule where a variety of reactions can occur post-trauma. There is a strong association between PTSD and substance abuse. In addition, depression and PTSD are often concomitant conditions. A range of symptoms can occur in some individuals suggesting different disorders. However, these 'symptomatic' states often settle with time. Therefore, it is important to avoid making early diagnoses which carry negative prognostic implications or which might lead to unnecessary stigmatisation.

324. The diagnosis may change over time. An Acute Stress Disorder can become PTSD even after a long interval of apparently normal functioning. This is the so called 'Delayed Onset' PTSD.

325. Alcohol Dependence Disorder is a common accompanying condition. Alcohol is frequently being taken as a self medication to try to alleviate personal distress. Intoxication can release accompanying anger, usually impacting adversely on the immediate social network.

326. Family psychopathology of different kinds can be produced through the family system failing to adjust to changed behaviour in a key member. Continuing family support may be a key factor in ultimate recovery, or conversely, a spouse who feels shut out by a traumatised partner can easily become depressed, hastening complete relationship breakdown.

CO-MORBIDITY (ASSOCIATED FACTORS)

327. The work group is another strong social group in which difficulty with relationships can have a dysfunctional outcome as the result of a member's exposure to stress on operations. This is particularly so where the member is posted to a unit where few others have operational experience. In this case there is often a lack of understanding of the member's situation, and sometimes there is jealousy of the member's operational experience. This may be coupled with lowered job satisfaction by the member following the operational deployment, and a lack of knowledge by others in the unit about how to approach those returning from operational service. As with family support, some adjustment, at least in the short term, may be necessary to ensure the Service person copes with the operational stress reactions and that the work group maintains its effectiveness.

CHAPTER 4

PREVENTION OF OPERATIONAL STRESS REACTION PRE-DEPLOYMENT ASPECTS

PSYCHOLOGICAL METHODS TO ASSIST IN PERSONNEL SELECTION

401. The first stage in the Australian Defence Force's (ADF) approach to the management of operational stress involves screening for susceptibility to stress at the time of selection for entry to the ADF. This is a complex stage of the process, because although there are known vulnerabilities and risk factors associated with a candidate's personality and background, evidence of these does not necessarily mean an individual will succumb to operational stress. Dysfunctional psychological stress is likely to be experienced, at varying intensities, by anyone subjected to a sufficient amount of stress. This is due to the fact that the development of stress reactions depends on how the individual experiences specific events, and as such, the same event can have a different impact upon different individuals. This in turn limits the effectiveness of standardised selection procedures, and hence, psychological methods are only partly effective in predicting personnel who are at higher risk of developing adverse operational stress.

402. In illustration of the difficulty faced, the application of psychology to selection underwent enormous development between the two world wars. During World War II, the United States applied this new information in an attempt to eliminate psychiatric casualties. Although 1 700 000 applicants were rejected prior to enlistment, about 9 per cent of those who served (over 900 000 soldiers) were treated and 300 000 were discharged for neuropsychiatric causes.

403. Key elements of pre-entry screening are assessments for motivation, emotional stability and training potential. Psychological methods used in screening include: aptitude and ability tests, personality questionnaires, structured interviews and performance tests.

STRESS MANAGEMENT TRAINING

404. Stress management training is an important strategy designed to prevent stress and mitigate traumatic stress reactions following serious accidents or incidents during operational deployments. Crises and traumatic events which have a stressful impact, sufficient enough to overwhelm the usually effective coping skills of either an individual or a group, are known as 'critical incidents'. These events are typically sudden, powerful events which are outside the range of ordinary human experiences. Because they are so sudden and unusual, they can have a strong emotional effect, even on well trained people, either at the time or later on. For example, a perception of helplessness after the event is considered a major contributor to dysfunctional stress. Stress management training can help military personnel to gain a sense of control by understanding that some stress reaction is normal, that it is usually of short duration, and that speedy return to normal duties can be expected. Training can also help them to recognise operational stress symptoms early and to take action to eliminate, or at least minimise, their impact. Education and training relating to the nature of stress and its symptoms (training in self-help and ways to assist others) creates confidence in the individual's ability to deal with operational stress when it arises.

405. Pre-deployment stress management training should occur with all operational deployments, other than routine operational training activities. This training should be designed to prevent stress and mitigate traumatic stress reactions following serious accidents or incidents during the operational deployment. Education and training relating to stress, stress management, and support mechanisms are relevant to all personnel deploying on operations. The concentration period is appropriate to this activity, but it should be remembered that competing priorities will inevitably detract from the attention and retention of information provided. This eventually should be catered

for by the command organisation during the operation, with reinforcement of operational stress recognition and management principles through ongoing group education and individual counselling as appropriate.

406. Pre-deployment stress management training should comprise:

- a. an introduction which discusses the nature of stress, its status as a normal reaction to abnormal events, and its influence on performance and quality of life;
- b. a discussion about symptoms, where the signs of stress are described under their categories - physical, mental/cognitive, emotional, interpersonal/behavioural and spiritual;
- c. a section on stressors reported on operational service such as various United Nations (UN) missions, with specific mention of hostage incidents involving UN personnel;
- d. a section on coping with stress employing both individual strategies for self-help and group strategies to aid both self and others;
- e. a section which covers separation from family and friends, ways to adjust more effectively, and to maintain relationships during absence; and
- f. a conclusion which discusses the nature of critical incidents, ways of minimising their impact and of coping.

IDENTIFICATION AND CONTROL OF STRESSORS

407. Operational stressors can be placed into two main categories:

- a. **Stressors Specifically Related to the Nature of the Operation.** Stressors specifically related to the nature of the operation may include combat exposure and the threat of death or capture, dealing with bodies and with wounded, exposure to mass human misery, prolonged separation from family and friends, foreign political views and military organisations, cultural isolation, or isolation from others by virtue of living and working locations.
- b. **Stressors which are More General.** Stressors which are more general may be less directly dependent on the specific operation. Examples are unit cohesion, morale, confidence in leadership, training and equipment, social support during and after the operation in the unit, home and community, and domestic situation.

408. Some stressors could be considered under either main category, but generally those related to the specific nature of the operation tend to be difficult to prevent while the more general ones can be minimised by action within Australia. For those which are difficult to prevent, training in coping with them when they occur is the key to minimising their impact. For those stressors which are more general in nature, training is also a key factor in modifying their impact, but others can be altered. Unit cohesion, morale and confidence in leadership can be modified by appropriate selection, training, experience and support by leaders at all levels. Policies can be developed to encourage social and community support for operations, and to ensure support for families left at home during operations.

TRAINING ASPECTS

409. Realistic combat training and other operational rehearsals should be used to develop both skills and confidence to reduce operational stress. The use of live ammunition, explosives and the simulation of the dangers involved, employed under appropriate training regimes, will enable the member to develop familiarisation with the situation and to develop appropriate coping skills for combat (often referred to as 'battle inoculation'). The more thorough the training, particularly the more rehearsed the drills to be implemented during combat or when encountering other critical events, the more automatic the reactions will become in real circumstances, and the less the cognitive demands on the individual. Cognitive functioning is usually the first ability to suffer under stress, and the more that procedures are learned as drills the less they are affected by stress. Prevention of stress should allow personnel to function at as high a level of effectiveness as is possible. Such realistic training should also be used to familiarise members with the stress they might encounter in combat and allow them to adjust to it and learn that such stress is normal under such conditions.

410. Operational rehearsals not only develop knowledge about specific plans and tasks which will be required for an operation, but when conducted successfully will develop self-confidence and confidence in leaders, tactics, equipment, training, and a sense of comradeship (which provides strong social support from within a member's unit). Such confidence assists in the reduction of stress. Operational rehearsals should aim to incorporate the expected intensity, duration and conditions which may be characteristic of future operations. In particular, they should not understate the real capacity of an enemy.

UNIT COHESION

411. Unit cohesion and its related factors of morale and confidence in leadership, training and equipment all help to reduce any feeling of helplessness in the face of severe stressors. They give knowledge about how to react, confidence that others will react appropriately and the expectations that courses of action will be successful. These reduce the likelihood of dysfunctional operational stress reactions. For example, Israeli research on the Arab-Israeli War and the Lebanon War shows that the levels of cohesion, leadership and morale are significant in predicting combat stress casualties and that units high in these characteristics were more combat effective.

SOCIAL SUPPORT SYSTEMS

412. Social support is a significant factor in reducing stress. A high level of social support will assist personnel after exposure to operational stress. Support systems should be established prior to operations so that they can be accessible when required.

413. Cohesion, morale and leadership within a unit may provide a social support system which gives a good opportunity for personnel to express themselves after intensely stressful experiences and may provide a cathartic mechanism in coping with stress. **Cohesion needs to be built before operations for it to be effective during and after stressful events.**

414. Formal support may be provided by chaplains, psychologists, medical officers, social workers and the like, while informal support may be found in colleagues, friends and family members.

COMMUNITY ATTITUDES

415. While there is evidence that the traumatic experience itself is more important in determining later psychopathology than either social support or subsequent life events, there is also evidence that the inhibition of emotional expression is associated with psychological distress. The history of labels for what is now known as Combat Stress Reaction is one example of how the label affected

people's preparedness to admit to stress. When the label 'shell shock' was employed the implied cause was physical and community attitudes were such that physical injuries were acceptable as reasons for not continuing to fight. When the label 'war neurosis', which had an implied emotional or psychological cause was used, community attitudes were such that these were not considered 'real' injuries and therefore were not acceptable reasons to be withdrawn from combat duties.

416. Community attitudes towards emotional expression have changed over recent decades and citizens are now more prepared to admit to emotional distress - and they expect to be able to seek assistance for this. In organisations such as emergency services, police and the military, where members have a cultural self-concept of mental toughness and ability to handle traumatic experiences, there is a reluctance to admit to emotional distress. This reluctance is clearly evident in the military, although there is an increasing expectation today that emotional injury will receive support from the organisation and society as does physical injury.

417. Operational stress can also be generated by community attitudes towards the operation. Policies need to be established and implemented to develop community support for specific operations as well as for the role of the military in general.

PREPARING UNIT LEADERS AND HEALTH STAFF

418. While it is important for all military personnel to be able to recognise operational stress symptoms in themselves as well as in others so that they can look after themselves and their mates, it is especially important for leaders to have this knowledge. Leaders have responsibility for the welfare of others and for making decisions which can have serious consequences for mission success and the safety of those they lead. Also, by virtue of their roles, leaders are more susceptible to stress and are more influenced by additional stressors than are subordinates. These different stresses cannot be as readily dealt with as those confronting subordinates. There are many areas where a leader's understanding of the influence of stress can improve unit performance (eg the Proximity, Immediacy, Expectancy principles and attention to the quality of leadership, unit cohesion and training, discussed earlier). The areas of decision making and leader behaviour following a unit crisis are used here as illustrations of the need for education and training in leader stress management.

419. Decision making, an assigned role, provides additional stress. Junior subordinates' roles tend to be more structured, with decision making constrained by clear direction and specific training, such as contact drills for soldiers. On the other hand, the leader's role is relatively unstructured with less clear directions, usually by radio, where rapid decisions are required about a scenario frequently typified by ambiguity and uncertainty. In making these decisions the leader is required to balance the needs of superiors and the mission against the safety and emotional wellbeing of subordinates. Although decision making aids such as the appreciation process are taught, the cognitive functions vital to effective decision making are usually among the first affected by stress. For example, in the appreciation process when courses of action are considered, instead of five or six being considered, under stress there is a tendency to consider fewer options and this reduction in effectiveness is accentuated by a tendency to consider options as more black-or-white than may be justified by the facts. Most military personnel who have been involved with a command post exercise will have noticed the effect that sleep loss (a stressor) has on people's performance. The following quote emphasises the cognitive impairment of stress:

'They were dull-eyed, bodily worn and too tired to think connectedly. Even a 30 minute flop on the turf with the stars for a blanket would have doubled the power of this body and quickened the minds of its leaders to ideas which they had blanked out. But no one thought to take that

precaution.' Said Captain Patch of his people on the right, 'They were so beat they could not even understand words even if an order was clearly expressed. I was too tired to talk straight. Nothing I heard made a firm impression on me. I spoke jerkily in phrases because I could not remember the thoughts which had preceded what I had said.'

S.L.A Marshall - *Night Drops: The American Airborne Invasion of Normandy*

420. Following a unit crisis the leader generally has two major concerns; dealing with the emotional needs of the unit members and restoring unit functioning. These should not normally be seen as separate issues because restoring unit functioning is good for the unit members. The following examples of actions and behaviour that leaders can take are adapted from research of various incidents and events, and can be summarised using findings from a major United States military aircraft accident:

- a. The leader should not be afraid to show personal grief. Grief is normal.
- b. Emphasise that returning to work is not a sign of disrespect for the dead. Unit members may be sensitive about the way in which they are told they should resume normal work. They may see emphasising the important job they do as patronising and they may resent being told that the time for grieving is over. It is preferable to emphasise that while they still grieve, including the leader, they must go on and do their job. Also emphasise that while the unit is not responsible for its present plight it is responsible for its own recovery.
- c. Group recovery can be facilitated by successfully meeting a challenge soon after.
- d. Small groups (work/social), left to their own initiative, talk through their own grief/trauma. Group discussion also buffers stress. Leaders can provide opportunities for the group to be together. Privacy from outside, especially the Press and curiosity seekers, is essential.
- e. Leaders need to mix with the group as much as possible soon after the event. They can observe, communicate and demonstrate concern.
- f. The group needs information, so deal with rumours and uncertainty.
- g. Rituals, formal and informal, are important. Groups usually have or develop their own rituals. They strengthen group bonds which helps recovery. Informal rituals will emerge within a group and they help as much as formal ones.
- h. Investigations, while necessary, prolong grief and can damage morale. Sometimes those who have started to deal effectively with the grief will be set back by an investigation which brings much of the incident back to present thoughts.
- i. Critical Incident Stress Debriefing can help fit experiences into personal schemas. While it may be sufficient for some group members it is not a treatment and should be considered as only a useful start point for most.
- j. The group itself is the best source of information about who may need special attention.
- k. People separated from the group at the time or soon after are at special risk. This includes those separated due to injury.

421. Leaders need to be familiar with the symptoms of operational stress so that they can recognise stress in themselves and in those they lead. They need to understand how personnel can look after their mates, ensure first line support to those affected and be able to arrange second

and third line support for those who require it. In addition, they have a responsibility to minimise stress in order to protect those for whom they are responsible and to maintain maximum combat effectiveness. Minimisation of stress occurs through practices such as good leadership, strong unit cohesion, confidence in equipment and tactics, and realistic training.

OPERATIONAL STRESS MANAGEMENT PREVENTIVE CAPABILITIES

Preventive and Educational Support

422. There are a number of preventive and educational capabilities designed to minimise the adverse impact of operational stress. These are:

- a. **Selection, Training and Cultural Affiliation.** Selection, training and cultural affiliation are discussed in chapter 10 and some considerations in the selection process are also detailed in chapter 3 where vulnerability and risk factors are discussed.
- b. **Pre-deployment Training.** Pre-deployment training is discussed in paragraphs 404 to 406 above.
- c. **Education, Counselling and other Personal Support.** Commanders, chaplains, medical officers, psychologists and community services personnel all have a preventative and educational role in the management of operational stress. Commanders are responsible for the welfare of their personnel; they are aided particularly by chaplains, medical officers, psychologists and community services personnel in meeting this responsibility. Psychologists are responsible for the provision of specialist Critical Incident Stress Management support, but in this they usually work in teams with chaplains, and in the RAAF with medical officers as well.

RESEARCH

423. Although Combat Stress Disorders have been documented going back to ancient history, research up until the late 1970s tended to concentrate on describing and classifying the disorders, particularly combat-related Post Traumatic Stress Disorder (PTSD). Little research however, was conducted on treatment approaches and their efficacy. Although PTSD treatment modes have been studied in more recent years, there are few studies which are based on universally agreed sound research design. In particular there is a dearth of research using subjects randomly allocated to treatment regimes. This is because of the ethical problem (and probably also a legal problem) of not providing people with what is believed to be the most effective treatment mode when their future wellbeing is at risk.

424. Another problem with research into stress inoculation training, debriefing techniques and PTSD is that research is usually post hoc. That is, information is gathered, usually by questionnaire or by interview, after the person has been exposed to critical incident stress. While providing useful information, problems with this research design usually arise from considerations of participation and recall. Why do people agree to participate in research and how objective is their recall after the event? Are these factors affected by the nature of any stress reaction?

425. Careful research design can minimise, but rarely eliminate, these potentially confounding factors. One such research program involving the ADF is being developed through The Technical Cooperation Program which is a formally mandated multinational program involving the United States, United Kingdom, Canada, New Zealand and Australia. It will be several years before results are available, but the multinational approach offers the opportunity to use systematic large scale studies rather than small scale and single case approaches usually reported in the literature.

CHAPTER 5

GENERAL TREATMENT AND EVACUATION OF OPERATIONAL STRESS CASUALTIES DURING DEPLOYMENT**GENERAL**

501. The effective management of operational stress casualties requires an awareness and understanding of the needs of the organisation as well as the individual. The process of treatment should proceed so as to maintain the balance between what sometimes appear to be competing needs. The personnel necessary to complete tasks involves more than just numbers. It is in fact the product of filled positions, level of training, attitude, motivation and personal health. Optimum mental health is an important determinant of general health, attitude and motivation.

IDENTIFICATION OF SYMPTOMS

502. The early identification of symptoms is important to successful treatment, because the common wisdom is that the more 'embedded' the stress symptoms become, the more difficult they are to relieve and the worse the expectation of full and speedy recovery.

503. In general, symptoms are grouped into five categories:

- a. **Physical.** Physical symptoms include being unable to wind down or rest, feeling particularly fatigued, experiencing sleep disturbances, indigestion, nausea, diarrhoea, dizziness, breathing difficulties, excessive sweating, muscle tension and/or sexual difficulties.
- b. **Mental or Cognitive.** Mental or cognitive symptoms include poor concentration, memory or judgment, being easily distracted, unable to make decisions and lowered confidence and self-esteem.
- c. **Emotional.** Emotional symptoms include fear, hyper-alertness, irritability/short temper, intolerance of noise or minor aggravations, rapid mood changes, anger, depression and anxiety.
- d. **Interpersonal/Behavioural.** Interpersonal/behavioural symptoms include problems dealing with people, social withdrawal, risk-taking, inability to express emotions effectively and over-reactions.
- e. **Values/Spiritual.** Symptoms include those which may or may not be associated with religious beliefs, but reflect the fact that operational service sometimes leads to a complete re-evaluation of basic beliefs and life values.

TREATMENT PRINCIPLES**General**

504. The principles employed by the Australian military for managing operational stress are consistent with those detailed in Quadripartite Standardisation Agreement 909 - *Principles of Prevention and Management of Combat Stress Reaction* for the treatment of Combat Stress Reaction, even though Australia is not yet a signatory to this agreement. These principles, often referred to as the 'PIES' principles, were developed and validated during World War I, and

although they have not always been applied, they remain valid. Although developed for the combat environment, they have also been successfully employed by Australia and other nations on United Nations peacekeeping and humanitarian operations. The principles are:

- a. proximity (P);
- b. immediacy (I);
- c. expectancy (E); and
- d. simplicity (S).

Proximity

505. *The further from the parent unit (and the stressor, such as combat) that individuals are evacuated, the less likely they are to return to duty.* The treatment principle of proximity arose out of the World War I experience, where it was found necessary to provide a treatment location for operational stress casualties close to the front, but nevertheless in a safe facility where rest and relief could be ensured. Proximity facilitates a continuing identification with the operational unit, and allows support to be provided by actual members of the unit. If removed from the immediate vicinity of the individual's unit, treatment should be in a military milieu; not integrated into a medical treatment facility such as a hospital. This reinforces the individual's self image as a military professional and not a patient. A proximate treatment location needs to be one however, where facilities are dedicated to psychological cases and where staff have the necessary expertise and appropriate attitude to deal with such cases. Proximity also minimises transportation requirements and decreases the likelihood of malingering which may occur if evacuated well rearward of the area. For more severe cases, appropriate health support may not be available at the first line; evacuation to second or third line may become necessary.

Immediacy

506. *Symptoms must be recognised early and dealt with promptly because the longer the delay the more the symptoms become resistant to change.* The principle of immediacy has two components. First, a system must be in place so that members can be quickly removed from stressor situations once it is apparent that stress levels have reached dysfunctional proportions. Second, once removal has been achieved, restorative treatment is immediately offered in a time frame where treatment will be completed within days, or at most, several weeks. There is good evidence that immediate therapy reduces the incidence of lasting symptoms, and similarly there is support for the view that brief treatment discourages inappropriate dependence. Also, immediate interventions also probably minimise the development of ongoing avoidance behaviours.

Expectancy

507. *It is important that the stress casualties always understand that they are experiencing a normal reaction to an abnormal situation and that, after a brief stay, return to normal duties in the parent unit is expected.* Everybody is aware of this; the command structure, the treatment provider and most importantly, the stress victim. The status during treatment, where possible, is not one of patient, but one of continuing member of an active unit. In some instances, it might even be possible for messing and accommodation arrangements to remain the responsibility of the parent unit during therapy. The importance of continuing to treat the person as a military member should not be underestimated, since this factor has been identified as the most important by Israeli researchers.

Simplicity

508. *Management should be short and simple, providing the individual with rest, food, sleep, clean clothes, an understanding listener and the expectation of return to normal duty.* Simplicity of treatment embraces the notions that treatment can be delivered over a short period of time, focus on support rather than deeper psychological change, and be provided by a range of personnel, including those who may not have received sophisticated training. The goal of simple treatment is the restoration of previous coping resources to enable speedy return to operational duties. Additional brief interventions, such as stress coping skills, may be taught.

TREATMENT COMPONENTS**General**

509. The components of treatment or the therapeutic strategies involved in providing optimum care for members with stress reactions will be influenced by the stage of the reaction, its severity and whether any of the specific stress-related psychiatric disorders are present. What will now be described are some of the important dimensions of acute treatment which are commonly offered in combination, as tailored management packages.

Attitude Towards Psychological Casualties

510. Victims of stress may be experiencing emotions such as guilt and fear which leave them vulnerable to further psychological assault. Self-esteem is often low, because many individuals tend to interpret anxiety as evidence of personal failure. To prevent compounding dysfunctional self-reproach, criticism either overt or implied needs to be avoided. Medical attendants should be particularly conscious of the importance of managing stress patients as legitimate casualties. At times, circumstances may require that priority is given to the management of physical trauma cases, however where possible this should be done with sensitivity to the special needs of those with emotional distress. Negative or pejorative labelling of persons with psychological symptoms should be avoided and for clinical and statistical purposes cases should be diagnosed and listed using an approved scientific classificatory system such as the Diagnostic and Statistical Manual of Mental Disorders IV or International Classification of Diseases 10.

511. At a command level the true incidence of operational stress casualties should be acknowledged and adequate resources provided to facilitate appropriate care. Senior commanders need to have a full understanding of the stress process, with its attendant reactions, so they can give balanced consideration to how this might impact on operational forces. The cohesion of a force can be an important factor in reducing the incidence of stress. Members are likely to cope more effectively if they feel they are being respected as individuals. In addition, it is helpful if all participants have a good understanding of where their particular tasks and roles stand in relation to overall strategic planning. *Vertical and horizontal cohesion is one of the most important factors that determine how well a unit recovers from stress reactions .*

Physical Measures

512. High standards of physical health ensure good psychological functioning, with optimum stress tolerance. Forces for special operations need to be especially screened in this regard. Good physical health is not only the absence of disease but includes high exercise tolerance, muscle tone and coordination which can only be improved through regular physical activity. Being physically fit, not overweight and not suffering substance abuse problems, makes it easier to maintain a positive self-image. For people already suffering stress reactions, supervised exercise and remedial gym programs can be important aspects of treatment.

Hygiene Aspects

513. Attending to personal cleanliness and maintaining a generally healthy physical environment probably adds considerably to psychological wellbeing. Personal grooming relates to self-esteem, which in turn can help reduce pessimism and depression. An orderly and controlled environment, where all members of the team make a contribution to wellbeing, assists in the development of necessary positive group identification.

Supportive Care

514. Recognising that a person has a reduced capacity to manage because of stress leads logically to the provision of additional temporary support. This may be all that is required to enable stress victims to re-establish their own coping skills. The aims of support are: relief from the immediate crisis; strengthening of psychological defences; suppression of the more distressing aspects of recent traumatic experiences; and general assistance with adaptation and social recovery. To help achieve this, simple strategies are used which might include listening uncritically, providing reassurance and clarifying the significance of symptoms. More specific educational information might also need to be provided. Supportive care is pursued with an attitude of understanding and positive expectation regarding recovery.

Behavioural and Cognitive Strategies

515. Behaviour therapy is concerned with modifying current unwanted behaviours with minimal attention being given to specific underlying causes. Stress is invariably associated with CNS hyperarousal accompanied by increased muscle tension and autonomic overactivity. These manifestations can be reduced by any behaviour helping to promote a reduction in anxiety. Teaching specific relaxation strategies can therefore be a potent tool for established stress states. There are many relaxation measures extending from bio-feedback and progressive muscle relaxation to hypnosis and meditation. Standard relaxation training usually includes:

- a. a didactic explanation of anxiety,
- b. teaching individuals to recognise their own anxiety symptoms,
- c. training in deep breathing,
- d. instruction in sequential muscle group relaxation,
- e. enhancement in relaxation using mental imaging or mental focus techniques, and
- f. regular rehearsal.

516. Relaxation manuals and relaxation courses can be provided to usefully assist this training.

517. Cognitive therapy focuses on altering the disturbing thoughts accompanying traumatic reactions. Although sometimes helpful in acute situations, cognitive strategies are probably more appropriately applied in the post-deployment phase.

Critical Incident Stress Management

518. Crises and traumatic events which have a stressful impact, sufficient enough to overwhelm the usually effective coping skills of either an individual or a group, are known as 'critical incidents'. Typically, critical incidents are life-threatening ones such as being involved directly in combat, or being mortared, shot at, held hostage, involved in mine incidents, aeroplane crashes or ship collisions, fatal motor vehicle accidents and those occasioning severe physical trauma, seeing bodies, gruesome sights or mass human misery. These incidents are 'critical' to the individual when linked to a strong emotional response. It is normal to feel shock, fear, anger, sadness, shame at feeling fear, or physical symptoms such as shaking, sweating or heart palpitations.

519. Critical Incident Stress Management (CISM) is a process which seeks to prevent or alleviate stress following exposure to a critical incident or series of incidents. Combat can be considered a special category of critical incidents.

520. CISM encompasses a wide range of programs and structured intervention strategies for use in Military and Emergency Services organisations. They are designed to assist personnel in managing and recovering from significantly stressful events. While most CISM interventions involve group work, the term CISM really encompasses a comprehensive approach to stress management.

521. The notion of acute psychological debriefing arose originally in major disasters, where the scope of the trauma and its special effects indicated clearly the degree to which all people involved could suffer damaging consequences. Alongside operational debriefing, ie looking at roles, tasks, technical aspects etc, it became clear that all persons affected by severe trauma might benefit from the opportunity for psychological counselling and emotional release.

522. CISM interventions allow the opportunity for catharsis, group and peer support, professional support, cognitive restructuring and appraisal of incidents, formalised follow-up, as well as education on stress responses and coping skills. CISM interventions provide early intervention with the opportunity to assess the need for referral. CISM aims at 'normalising' members' experiences. Anxiety is reduced through educating members that following Critical Incidents, some reactions are common and not a sign of generalised inadequacy or abnormality. As such, CISM intervention takes on a preventative, rather than treatment, orientation. Most CISM interventions are group interventions designed to augment pre-existing avenues of medical and psychological support.

523. CISM can range from first line buddy and leader psychological first aid through to second and third line medical and psychological support teams to evacuation to Australian Support Area fourth line support.

Pharmacotherapy

524. Drugs can be useful adjuncts to therapy for most stress-related disorders. By themselves, they rarely constitute complete treatment. Drugs with high addictive potential should be avoided as should agents tending to take away a sense of personal control.

525. Pharmacological agents where there is proven evidence of therapeutic value include:

- a. Tricyclic Antidepressants - which reduce intrusive thoughts and avoidance phenomena as well as elevate mood. Side effects can be a problem.
- b. Serotonin Specific Re-uptake Inhibitors - which have a similar effect to Tricyclics but usually cause less troublesome side effects.
- c. Monoamine Oxidase Inhibitors - which can be used in place of other antidepressants and may have additional anti-phobic benefits.
- d. Carbamazepine - which may be helpful for hyperarousal states and particularly when these are combined with aggression.
- e. Lithium Carbonate - which is mood stabilising and may be of benefit when impulse control is a problem.
- f. Beta blockers - which can be prescribed for accompanying hyperarousal.
- g. Clonazepam - a benzodiazepine, which can be considered for severe agitation.

Rehabilitation

526. Because lasting psychosocial dysfunction can arise from stress-related psychopathology, considerable effort should be focused on returning members to a useful social and occupational role. Involvement in regular social activities and the development of an interpersonal network with appropriate supports is important to reduce the risk of relapse. Special rehabilitation programs may therefore need to be provided and even during the acute phase of stress some preparation for this possibility might be helpful.

OPERATIONAL STRESS MANAGEMENT CAPABILITIES - AREA OF OPERATIONS

RAN Health Services

527. Operational stress management during maritime operations is carried out primarily by the Navy's CISM Program. Each CISM Team will comprise a mental health professional as Team Coordinator, other mental health professionals as necessary, peer support members, and should also include a Chaplain. Activation of a CISM Team occurs as soon as practicable after the incident. CISM interventions are not psychotherapy, or counselling, and are not to be confused with operational debriefings. They include group meetings or discussions designed to reduce stress, based on the principles of crisis intervention and education.

Australian Army Psychology Corps and Health Services

528. Operational stress management support within the unit on operations is provided primarily by unit resources through commissioned and noncommissioned officers, and by chaplains and medical officers if they are posted to the unit. On some deployments a psychologist is also attached for the duration of the operation. For other deployments, Psychological Support Teams (PsST) are deployed into the area of operations as required during the operation to provide psychological debriefing (in accordance with Army Office Staff Instruction 28/94 - *Army Stress Management Policy*) prior to return from operations. In the case of operations where small numbers of members are deployed, the psychological debriefing is conducted after the return from operations, although this is less effective and less well received by the members than is in-country debriefing before the return.

529. While the size of the deployed force and the level of activity dictates the structure of the stress management support, a chaplain and a medical officer are usually deployed on an operation and can provide initial support. Specialist support is provided by PsST which consist of a psychologist (officer) and a senior noncommissioned officer, although a single psychologist may be deployed if the expected demand is low. One PsST can normally provide operational stress management support to a brigade deployed on low-intensity operations.

RAAF Health Services

530. Critical incident stress debriefing can be conducted by RAAF personnel in deployed health care facilities. In particular, Air Transportable Health Centres and Air Transportable Hospitals include a psychiatrist to coordinate and control the provision of mental health support.

OPERATIONAL STRESS MANAGEMENT CAPABILITIES - NATIONAL SUPPORT AREA

531. Most stress-related disorders fall within the group of Minor Psychiatric Disorders and therefore, after appropriate treatment, a return to normal and usually unrestricted duties should be anticipated. Evacuation for special treatment of ongoing conditions might sometimes be necessary. The arrangements for evacuation will depend on the severity of the disorder. Appropriate chemical restraint with special nursing care should be considered in some instances. Psychotic reactions,

severe mood disorders and Post Traumatic Stress Disorder which is unresponsive to treatment, should invariably lead to a classification of permanent medical unfitness. Additional detail regarding the current operational stress management capabilities of the National Support Area are to be found in chapter 6.

RECOVERY OF HUMAN REMAINS DURING OPERATIONS

532. The recovery of human remains is a common task during military operations and can be a significant stressor. Effective preparation for the task, including preparatory training and counselling, can reduce adverse effects. An individual guide designed for personnel involved in such activities is attached at annex A. This guide can provide the basis for preparatory training and counselling.

Annex:

- A. Recovering Human Bodies - An Individual Guide

RECOVERING HUMAN BODIES - AN INDIVIDUAL GUIDE

(Adapted from: 'When the Mission Requires Recovering Human Dead Bodies', Combat Stress Actions Office, Department of Preventive Health Services, Fort Sam Houston, Texas, USA.)

1. Whether the mission is humanitarian, peacekeeping or war, military personnel from all types of units may be involved in recovering, processing, and perhaps burying bodies, including ones of those who died under tragic or horrible circumstances. The bodies may be those of friends or adversaries, combatants or non-combatants, the aged, women, or children. They may be relatively intact, or mutilated, few in number, or thousands. It is not a pleasant task, but experience has shown that if we know what to expect and follow some guidelines for working with human remains the job can be done and we can return to normal duties, career and family life without being unduly troubled by the memories, even when these include some very sad, unpleasant or distressing details.

2. On some body recovery missions there are no living survivors. Others are part of continuing rescue, medical care and survivor assistance activities. The reactions of the living victims may include grief, anger, shock, gratitude or ingratitude, numbness and indifference. Their reactions may interact with your own.

3. Bodies may be mutilated. This often invokes horror, though most of us quickly form a protective 'shell' so that we don't feel so badly. We may come to see the remains as objects, without reflecting that they were once people. On the other hand, the bodies may be unmarked and this is sometimes harder to adapt to because it is harder to form that 'shell'. You will often have to smell the bodies and other associated strong odours. You may have to touch the remains to move them, and to hear the sounds of autopsies or burial activities. These sensations may strain your capacity to do the work, and may trouble you in memories. There are things you can do to help.

4. Being exposed to large numbers of dead bodies is not a normal part of human experience, therefore you should not be surprised to feel things you are not used to:

- a. You may experience sorrow, regret, repulsion, disgust, anger, and futility. These are **normal** experiences given the situation in which you have been placed. It would be surprising if you did not experience at least some of these emotions.
- b. You may see similarities between yourself (or others you love) and those who died. This could lead to feelings of guilt ("Why wasn't it me?" or "Why can't I do more to stop it?") or anxiety ("It could have been me"). Again, these feelings are **normal** under the circumstances.
- c. Humour is a normal human reaction or 'safety valve' for very uncomfortable feelings. Don't be surprised at finding 'black humour' in yourselves or others.

5. It is better to be as prepared as possible for what you will be seeing and doing:

- a. Try to learn as much as you can about the history, culture or background to the tragedy. How did it come to happen? Try to understand it the way a neutral investigator would.
- b. Look at videos and photographs of the area and of the victims. If none are available of the current situation try to find similar ones. Share them as a group and talk about them.

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6. Understand the importance and value of what you are doing:
 - a. Remember that you are helping the deceased to receive a respectful burial, even if in some cases it is hasty and a mass burial. You are saving their remains the indignity of being left on the ground to decay.
 - b. In some cases you help survivors know their loved ones have died, rather than remain for years in uncertainty. These relatives or friends can take the bodies for private burial, or at least know that they are buried, and where.
 - c. Burying the dead provides a safer, healthier environment for those still living.
7. When you are seeing or working with bodies, think about the larger purpose you are serving, without attempting to relate to each individual who died:
 - a. Remember, the body is not the person, only the remains.
 - b. Some people find it helpful to think of the remains as wax models or mannequins, or as memorial models to which they are showing the respect due to the original person who is no longer there.
 - c. If your job requires that you collect personal effects from the bodies for identification, intelligence or other official purposes, do not let yourself look closely at or read the personal effects. (Those required to examine these effects are advised to do so remote from, and preferably without having seen, the body.)
 - d. Do not desecrate or take souvenirs from the bodies. (These are also criminal acts).
 - e. Humour, even black humour, is helpful if it remains on a witty and relatively abstract level. It is unhelpful when it becomes too gross, too personal (eg, comments or practical jokes which pick on members of the team who need support, not ridicule), or too disrespectful of the individual dead. Some members may become upset by excessive black humour, and even the joker may remember it with guilt years later.
 - f. Each of you can say prayers for the dead and conduct whatever ceremonies your own beliefs and background recommend. The unit chaplain or local clergy may also conduct rites or ceremonies. Even very brief rites at the time can help.
8. Take steps to limit exposure to the stimuli from the bodies:
 - a. Have screens, partitions, covers, body bags or barriers so that people don't see the bodies unless it is necessary to their job.
 - b. Wear gloves if the job calls for touching the bodies.
 - c. It may help to mask the odour with disinfectants, air-fresheners, or deodorants. Scents and perfumes are of little value in the presence of the bodies and are better saved for during breaks away from the work. Don't be surprised if the scents may bring back memories of the work for some time afterwards.
9. Take care of yourself and each other:
 - a. When possible, schedule frequent short breaks away from working with or around bodies.
 - b. Drink plenty of fluids, continue to eat well, and especially maintain good hygiene. Command should endeavour to provide facilities for washing hands, clothing, and hot showers after each shift.

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- c. Hold team after-action debriefings frequently to talk out the worst and best things about what has occurred, sharing thoughts, feelings and reactions with team mates.
 - d. A Psychological Support Team or chaplain may be able to lead a Critical Incident Stress Debriefing after a particularly bad event or at the end of an operation.
 - e. Plan team as well as individual activities to get your mind off the tragedy you are helping to correct. Do not feel guilty about this. You **must pace yourself** for the task and do what can be done, one step at a time.
 - f. Stay physically fit.
 - g. Make sure your family is aware of what is happening and that they are supported at home.
 - h. Take special care of new unit members, and those with recent changes or special problems back home.
- 10.** If the stress caused by working with the dead bodies begins to interfere with your performance or your ability to relax, or if you feel that you are becoming overwhelmed, **take action**. Do not ignore the stress. Seek out someone to talk with about how you are feeling. Others will be feeling as you are. It is important not to withdraw and become isolated. It could be a mate or someone else, eg, chaplain, doctor, psychologist. It needs to be someone who will listen and who will understand.
- 11.** Don't forget to help your mates. Give support and encouragement, and try to get the other person to talk through the problem they are having. You will both cope better with the situation.
- 12.** After the mission is completed and you are no longer working around bodies, you may experience a variety of feelings. These may include feeling bad about not treating each body as an individual, and needing to express the emotions that were pent up while you were doing the work of body recovery. **Do not keep these emotions inside** . They are normal:
- a. Take an active part in end-of-tour debriefing and pre-homecoming information briefings prior to leaving the operational area.
 - b. Follow through with activities which recognise and honour what the unit has done and share the experiences with families.
 - c. Don't be surprised if being back home brings back upsetting memories of the operation. You may find it hard to talk about them with those who were not there. This is very common. Try to talk about them anyway. Also, try to stay in touch with your mates from the operation.
 - d. If you still find yourself upset, don't hesitate to talk to the chaplain, psychologist, Defence Community Organisation worker or the doctor. This is wise "preventive maintenance".'

CHAPTER 6

POST-DEPLOYMENT MANAGEMENT OF OPERATIONAL STRESS

GENERAL

601. For many military personnel deployed on operations, the professional operational environment provides them with a 'frame of reference' within which they can interpret stressful experiences in the context of their self-concept as a military professional. They see themselves as trained to cope with critical events, and indeed, expect exposure to stressful events while on operations. As a direct result, personnel tend to emotionally process their experiences in this operational context.

602. For many, returning from operations to the familiar comfort and safety of family, work and Australian society is the time when they start to relax. When they do so, some personnel may also relax the coping mechanisms which provided defences against adverse stress reactions whilst on operations. Training can prepare them for this by teaching them to recognise symptoms and educating them about action they can take to assist themselves and others.

603. Many individuals require additional support systems because it is often life-events after returning which are the 'trigger' to unpleasant stress reactions. In particular, there is often a need to talk, to attest, or 'bear witness to' experiences. This need requires others who are available and willing to listen, people who are supportive in practical and emotional ways and who do not make the person feel worse. There is evidence that greater support from family and friends is associated with lower levels of Post Traumatic Stress Disorder (PTSD). There is evidence that such crisis support not only buffers the existing trauma but also assists to modify other negative life-events which may impede recovery from operational stress.

604. One post-operational life-event often not recognised as a potential stressor is that of returning to work. For many it is difficult to return from the 'real' operational environment, where tasks were considered to be of greater significance, to the 'training' environment of a peacetime military. Job satisfaction levels are often low on return to work and the members require understanding by their peers and superiors of this adjustment problem. Postings which offer significant challenge in relation to recent experience are very helpful in readjusting to work after operational service.

PSYCHOLOGICAL DEBRIEFING

605. Psychological debriefing prior to departure from the area of operations is vital to the wellbeing of all deployed members and should be clearly separated from operational debriefings. While specific interventions occur to minimise the impact of stressful events during operations, post operational psychological debriefing is an important process whether or not the individual has been exposed to critical events. This process is designed to deal with chronic stressors as well as scanning for stress from acute sources. It also provides general preparation for the Service person to return to family, friends, work and Australian society with a minimum of adverse impact from their operational service. In earlier conflicts, such as World War I and World War II, the slow return to Australia by ship gave Service personnel time to talk among themselves and to adjust their emotional states to the return home. During the Vietnam War this adjustment was impeded by the rapid transition from combat service to barracks service and even to civilian life. Furthermore, society's understanding of stress and expectations concerning support provided are now different from that during these earlier conflicts. These different expectations are in part met by post-deployment debriefing.

606. Psychological debriefing should not be confused with Critical Incident Stress Debriefing. Psychological debriefing is conducted either in the area of operations towards the end of a deployment (which is preferable) or as soon as possible after leaving the area of operations.

607. The aims of psychological debriefing are to:

- a. assist personnel to work through psychological reactions to accumulated stress and critical incident stress situations by:
 - (1) discussing members' stressful experiences and assisting in processing reactions,
 - (2) educating members on stress reactions and stress management, and
 - (3) discussing further reactions and support systems;
- b. identify personnel who may need further counselling;
- c. counsel individuals as required;
- d. facilitate members' return to non-operational life by making them aware of potential problems upon return to family and work;
- e. gain data on factors which caused stress and stress levels;
- f. demonstrate a genuine concern for personnel and that the Australian Defence Force (ADF) is taking steps to provide for their wellbeing;
- g. provide an independent link in the system where members can express emotions and opinions without fear of untoward circumstances;
- h. provide anonymous feedback to the organisation about members' perceptions on a range of issues;
- i. obtain a feeling for the nature of operational deployments to assist development of training and debriefing packages; and
- j. liaise with commanders and other elements (eg padres, community services) involved with members' welfare.

608. Psychological debriefing is part of a broad stress management program which assists personnel to deploy, perform their operational duties effectively and return to work and private lives with minimum disruption. This program starts with pre-deployment stress management training as detailed in paragraphs 404 to 406.

609. Psychological debriefings vary depending on judgment about the needs of the individuals, but in general, the following process has been used on recent operations:

- a. The debrief is introduced by an explanation of why it is conducted, and with reference to benefits reported through questionnaire responses from previous operational contingents.
- b. A reminder is given about the pre-deployment training, about the sources of stress (acute and cumulative) and that stress is viewed as a normal reaction.
- c. The 'rules' for the conduct of the debrief are given, including reference to confidentiality and records.

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- d. A deployment stressors questionnaire is completed (about 15 to 20 minutes).
- e. The deployment is placed in perspective. This includes a discussion of perceptions of mission achievement and positive and negative aspects of the deployment both personally and professionally. This section ends with an overall evaluation of whether the deployment has been 'worth it'.
- f. Stressors, reactions to these, and coping strategies used are discussed. Many of these have already been raised as negatives about the deployment.
- g. Critical incidents are defined and personal critical incidents are elicited. Where appropriate these lead straight to counselling or to an appointment for subsequent counselling.
- h. Returning to family and friends is then discussed, including education about potential difficulties and methods of coping.
- i. Next, returning to work, potential difficulties and methods of dealing with these are covered. This is an important area because most personnel experience difficulties with job satisfaction and/or peer relations for a while after returning from an area of operations.
- j. Education is also provided about 'flashbacks', dreams, intrusive thoughts, likely reactions and ways of dealing with these.
- k. There is a summary, with positives, negatives and the mission placed in perspective, together with a reminder that the ADF cares for its people. Follow-up contact names and numbers are provided and personnel are advised that they all would be routinely contacted at 12 and 26 weeks after returning from an area of operations.
- l. Finally, personnel suspected of being particularly vulnerable are identified for early follow-up after return from an area of operations (or before other routine follow-up).

POST-DEPLOYMENT FOLLOW-UP

610. Military people generally cope with stresses while on operations, perhaps because they expect to be involved in unpleasant incidents and deal with these within the mental framework of a professional doing a job. It is not uncommon that, after return from operations, problems arise as the veteran returns to life in peacetime, training military, to family and the comforts of society. A common characteristic of people suffering stress reactions is a reluctance to present with their problems. Historically, this has been especially common with emergency services workers, police and military personnel. Education about the nature of stress, its symptoms and their recognition, and ways of coping with stress is included in pre-deployment training and post-deployment psychological debriefing. Because of this reluctance on the part of some suffering stress reaction to initiate contact with support agencies, a routine follow-up process has been introduced for those returning from major operational deployments and following critical incidents in Australia. This will also assist in dealing with the possibility of delayed onset PTSD. In the case of those returning from major operational deployments, follow-up occurs at 12 and 26 weeks after return from operations.

611. The 12-week follow-up is normally by a letter and a short questionnaire from Service psychological staff. The aims are to:

- a. remind the members of the organisation's continued interest in them personally,
- b. obtain information about levels of stress symptoms,

- c. get feedback on the utility of the psychological debriefings together with suggestions about ways in which they could be improved, and
- d. invite members to contact support systems if they want to seek assistance about any matters which may be related to their deployment.

612. The 26-week follow-up is by a letter from Service psychological staff to members reminding them of the debriefing and earlier follow-up, inviting them to contact the writer if they have any matters to talk about, congratulating them on their operational service, and wishing them well for their career.

613. In addition to the 12- and 26-week follow-ups, every member returning from an area of operations is to undergo a medical examination within 12 weeks of return. This examination is to include an assessment of the risk of PTSD. See paragraphs 902 to 907.

614. In essence the principles of follow-up are those of educating about symptoms and support systems, reminding members of their access to assistance and encouraging their use. One key ingredient in successful stress treatment regimes is a sense of the member's own control over events. This approach seeks to develop this control.

615. When treatment is required, it can be conducted by:

- a. ADF medical officers, psychiatrists and psychologists;
- b. consultant psychiatrists or psychologists;
- c. admission to an in-patient or an outpatient treatment program, such as those approved by the National Centre for War Related PTSD;
- d. the use of support systems such as that offered by the Vietnam Veterans' Counselling Service; or
- e. the member electing to use a private consultant (paid for by the member).

OPERATIONAL STRESS MANAGEMENT CAPABILITIES - NATIONAL SUPPORT AREA

Australian Defence Force Facilities and Consultants

616. ADF health care facilities and psychology units in the National Support Area include professional staff specifically trained to manage operational stress. They can also refer personnel requiring more specialised support to consultants and can coordinate management with other civilian and military agencies including welfare agencies and Service chaplains.

Department of Veterans' Affairs

617. The Department of Veterans' Affairs has a number of facilities which can be utilised in the treatment of operational stress. The National Centre for War Related PTSD, a collaborative project of the Department of Veterans' Affairs, the University of Melbourne and the Austin Repatriation Medical Centre, has assisted in establishing specialised PTSD rehabilitation programs for veterans in each State of Australia. Programs are conducted at the Austin Repatriation Medical Centre, Melbourne; the St John of God Hospital, Richmond; the St John of God Hospital, Burwood; the Northside Clinic, Greenwich; the Lingard Hospital, Newcastle; The Greenslopes Private Hospital, Brisbane; the Daw Park Hospital, Adelaide; the Hollywood Private Hospital, Perth; and the Hobart Clinic, Hobart.

Other Civilian Capabilities

618. Most major civilian health care facilities provide professional staff specifically trained in stress management, although they will not necessarily be familiar with the nature of ADF service and the specific stressors of military operations.

CHAPTER 7

COUNSELLING MODELS

GENERAL

701. Anxiety is evoked when psychological defences are overwhelmed by external trauma or internal conflict, or by the psychological defences themselves becoming less efficient (such as from fatigue) and thus directly reducing an individual's coping capacity. Operational stress can arise from a combination of all these factors, although it most commonly develops in circumstances where the stressors are external and readily definable.

702. The goals of stress counselling are to: facilitate the member's rational appraisal of the external threat; optimise the member's own coping capacities; reduce distressing affects; and provide information so that all reasonable helping systems are made available. The evidence indicates that the probability of longer-term dysfunction is reduced if restoration of normal functioning can be achieved quickly. If handled appropriately, operational stress may even provide a catalyst for personal growth and general character development.

703. Counselling can focus primarily on: coping strategies (support); effect (ventilation); thinking (cognitive therapy); behaviour (behaviour therapy); helping assimilate memories (reminiscence); or on building up social supports (family techniques). In practice, management draws on all these techniques in offering combination treatments.

RANGE OF COUNSELLING INTERVENTIONS

704. These will vary in relation to whether they are primary, secondary or tertiary interventions. Acute treatments have already been discussed in some detail.

Stress Inoculation Training

705. This will be directed at helping prepare members for the tasks at hand. It will include informational briefing, stress rehearsal and also realistic training in the technical sense. Teaching behavioural methods of controlling anxiety may also be helpful at this stage.

Counselling for Acute Reactions

706. During operations, if evidence of stress in an individual is seen to develop, it needs to be acknowledged as a legitimate response to the situation and support immediately offered. If stress symptoms continue, and appear to be causing significant dysfunction, then more specific counselling may be required. It can be difficult to determine the point at which stress might make it impossible for a member to continue in an operational role. This assessment needs to be undertaken by available forward medical attendants who should consider the severity of the symptoms, the stress tolerance of the member and the exigencies of the circumstances. On-the-spot counselling could be provided which would include elements of support, catharsis and simple cognitive interventions. Identification of at-risk personnel is important at this stage and arrangements for appropriate follow-up put in place. If obvious dysfunction continues, evacuation to a less stressful location and more thorough medical examination will become necessary.

Critical Incident Stress Debriefing

707. One form of debriefing process which is popular in civilian settings for dealing with critical incidents is 'Critical Incident Stress Debriefing' (CISD). CISD was developed for use with emergency services personnel, but it has been assumed valid for application in a wide range of settings. A critical evaluation of the nature of emergency services organisations, particularly the

self-concepts of professionalism and risk-taking, and of the social support networks for the employee and family, suggests that the CISD process should be readily applicable to military forces in settings where group treatment processes are appropriate. CISD may be therapeutic (as indicated by the strong positive feelings that are expressed about the process after a debriefing) and it is a useful group intervention under certain circumstances, but it should be considered as only a part (often an important part) of a process designed to educate, identify and treat those with stress symptoms.

708. This model is useful because interventions extend to medical and Peer Support Members (PSM) as well as trauma victims. It needs to be provided by trained personnel in teams with designated leaders. The leader has the key coordinating role and should be an experienced Mental Health Professional (MHP). The team has broad responsibilities covering prevention, formal intervention being part of the referral network. PSM are usually trained senior noncommissioned officers, with some officers, who: gather information and provide assistance to the team leaders on the incident, provide counselling and basic services to personnel, co-facilitate Critical Incident Stress Management interventions, provide on-scene support and follow-up, and serve as a liaison between personnel and MHPs. As peers to the personnel they assist, PSM can often help overcome resistance from members who are uncomfortable with intervention by MHPs.

709. Debriefing aims to: reduce the intensity of stress reactions experienced following an incident, accelerate the normal recovery process of people who are experiencing normal but painful reactions to an abnormal event, and reduce the likelihood that Post Traumatic Stress Disorder (PTSD) will develop. It relies largely on a small group process with group debriefing sessions usually lasting two to three hours. The effectiveness of CISD, however, remains somewhat unproven and it must not be assumed that simply because debriefing has been provided, PTSD will not develop. A further difficulty with CISD relates to when it should be offered and to whom. With major trauma situations it is probably clear enough although with exposure to lesser stressors, too enthusiastic debriefing might be tying up treatment personnel more effectively employed on other tasks.

Supportive Counselling

710. Supportive counselling can be offered individually or in groups. There are probably special advantages to a group model such as learning that reactions are shared and the optimism that comes from seeing others recover. The leaders of supportive groups do not need the same level of specialised skills training as CISD leaders.

Behaviour Therapy

711. Several behavioural approaches such as relaxation training and graded exposure within a desensitisation program, have been utilised with good effect as treatment models for stress states. Established stress disorders often embody prominent phobic and avoidance features among the symptomatology. Behavioural desensitisation is probably the treatment of choice for most phobic states. In desensitisation programs, relaxation is taught as the initial step followed by graded exposure to the identified phobic stimulus. This can be achieved slowly as in classical systematic desensitisation or rapidly as in 'flooding' or 'implosion' therapies. There is some evidence that desensitisation in PTSD can be achieved more rapidly if relaxation is augmented by rapid rhythmic eye movements. The essence of this procedure is that the patient maintains an image of a traumatic scene, while tracking the repeated lateral movements of the therapist's finger. The movements are offered in sets and repeated as necessary.

Cognitive Models

712. Cognitive strategies are aimed at changing the beliefs and attitudes underlying a person's response to a traumatic event. Trauma is usually interpreted in terms of past experience. Prevailing attitudes may contain distortions which have the capacity to alter the way reality is perceived. Patients are encouraged to test their thoughts and beliefs about the trauma and replace them with more appropriate appraisals. An effective application of more general problem-solving strategies

may then be possible. Anxiety and a desire to escape invariably accompany thoughts of threat and danger. A perception of personal failure is likely to evoke feelings of guilt and depression. A perception of loss is similarly likely to be accompanied by an emotional state of depression. Anger can be evoked when a situation is considered to be the product of the wrong doing of others. Combat stress usually contains elements of all these factors - danger, personal failure, loss and wrongdoing by others. Cognitive reappraisal is a specific process facilitating the development of more appropriate and rational thoughts in relation to the original trauma experience. In cognitive therapy, using a systematic approach, patients are helped to identify their inappropriate cognitions and, through focused discussions, any underlying dysfunctional beliefs are corrected. Techniques such as self-disputation, displacement and thought-blocking are taught. Homework is an important aspect of treatment, where the design of appropriate assignments to test specific dysfunctional ideas is essential. Cognitive therapy for trauma victims has the advantages of being active, structured and most important for Defence Force applications, time limited.

Longer-term Dynamic Psychotherapy

713. Counselling for more established disorders can be a lengthy process, where adequate time needs to be given to working through important emotional issues and to rehabilitation aspects. Resistances preventing the development of an effective therapeutic alliance may also need to be dealt with. Hostility can be an early presentation, which frequently has to be understood as constituting part of the defensive style adopted by some stress victims. The counsellor's own counter hostile responses have to be prevented from adversely influencing the engagement phase of treatment. A further key aim of psychotherapy is to help stress sufferers come to accept significant responsibility for their responses with the realisation that they do in fact have a degree of control over their reactions. Wherever possible, as part of rehabilitation, it is important to work with other family members who may be having difficulty coping themselves. Rehabilitation should aim at complete social integration, which means dealing intensively with all avoidance behaviours and in addition helping with the reconstruction of a range of appropriate social skills.

FOLLOW-UP ACTIVITIES

714. Follow-up is important, even when there appears to be short-term resolution, because of the possibility of delayed or late onset syndromes. Annual medical assessments of personnel deployed in demanding locations should include a systematic evaluation for the presence of major PTSD symptoms. Members who develop stress-related disorders may require longer-term follow-up and treatment in special facilities. This requires resources beyond those available within the Australian Defence Force, some of which have been listed in paragraphs 617 and 618.

EVALUATION OF INTERVENTIONS

715. Systematic and controlled evaluation of all interventions for stress-related disorders is important. To date, there has been little reported in the scientific literature about the real benefits of many of the early interventions such as CISD.

716. The research literature indicates little consistency from one study to another in the measures employed to evaluate the long-term outcomes of interventions once the enduring dysfunctional stage, such as PTSD, is reached.

717. Despite this, there are many anecdotal accounts of early improvement and there is the commonsense proposition that the opportunity to talk about an experience will always help. The real need however is to know the degree of improvement achieved, and if this is significant, for what length of time the level of improvement is maintained.

718. Studies need to delineate issues such as pre-morbid functioning, quantification of stressor exposure, validity of diagnosis, standardisation of treatment measures, indicators of treatment response and adequate follow-up.

CHAPTER 8

CLINICAL MANAGEMENT OF SPECIFIC OPERATIONAL STRESS DISORDERS

POST TRAUMATIC STRESS DISORDER

General

801. Post Traumatic Stress Disorder (PTSD) is one of the more disabling long-term psychological complications following exposure to an extreme traumatic stressor involving direct personal experience of an event which includes actual or threatened death or serious injury. Many such events may be expected to be encountered on military operations and these are likely to produce PTSD in some individuals. Relief of distress, with restoration of personal and social functioning, are therefore the aims of treatment of PTSD.

Prevalence

802. The prevalence of PTSD for the general community ranges between one per cent and 15 per cent, and for at risk individuals, between five per cent and 50 per cent. Figures from the United States (US) estimate that at any given time, 15 per cent of Vietnam veterans have PTSD. The number of Australian Vietnam veterans with PTSD seems to be increasing and is probably approaching figures similar to US veterans. The prevalence for groups exposed to extreme stressors, such as concentration camp survivors, approximates 100 per cent.

Course

803. The disorder characteristically runs a relapsing course where exacerbations of symptoms might be precipitated by circumstances that resemble in some way the original trauma. Previously traumatised individuals are likely to suffer new episodes of PTSD when exposed to later events that either threatened their safety or in some way remind them of the original trauma. Similarities to the original trauma can be sensory, such as similar smells, sights, sounds etc, or symbolic, such as anniversaries of the original trauma. About 50 per cent of sufferers experience chronic dysfunction, making it difficult to return to earlier levels of social competence.

Diagnostic Criteria

804. According to the Diagnostic and Statistical Manual of Mental Disorders (DSM) IV, the diagnostic criteria are as follows:

- a. A traumatic event where there was:
 - (1) actual or threatened death or serious injury, or a threat to the physical integrity of self or others; and
 - (2) the person's response involved intense fear, helplessness, or horror.
- b. The traumatic event is persistently re-experienced as:
 - (1) recurrent and intrusive distressing recollections of the event,
 - (2) recurrent distressing dreams of the event,
 - (3) acting or feeling as if the traumatic events were recurring,

- (4) intense psychological distress at exposure to cues that resemble an aspect of the traumatic event, and
 - (5) physiological re-activity on exposure to cues that resemble an aspect of the traumatic event.
- c. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness:
- (1) efforts to avoid thoughts, or conversations associated with trauma;
 - (2) efforts to avoid activities that arouse recollections of the trauma;
 - (3) unable to recall key aspects of trauma;
 - (4) markedly diminished interest in significant activities;
 - (5) feeling of detachment from others;
 - (6) restricted range of affect; and
 - (7) sense of a foreshortened future.
- d. Persistent symptoms of increased arousal:
- (1) difficulty falling or staying asleep,
 - (2) irritability or outbursts of anger,
 - (3) difficulty concentrating,
 - (4) hyper-vigilance, and
 - (5) exaggerated startle response.
- e. Duration of the disturbance (symptoms in criteria b., c., and d.) is more than one month.
- f. The disturbance causes clinically significant distress or impairment in social, or occupational functioning.

May be: Acute (duration of symptoms is less than three months)
Chronic (duration of symptoms is three months or more)
Delayed (onset of symptoms after six months)

Special Treatment Programs

805. Dedicated programs for PTSD sufferers are now provided in all Australian States under the coordination of the National Centre for War Related PTSD which is based at the Austin and Repatriation Medical Centre in Victoria. The actual program offered at Heidelberg serves as a model for all the others. The program is based on principles drawn from the best available treatments world-wide. Currently both in-patient/outpatient and outpatient-only treatment programs are offered. Individuals are assessed prior to entry to the programs for the presence of PTSD and related problems to determine whether an in-patient or outpatient treatment approach is required. See paragraph 617 for facilities in other Australian States offering similar programs.

806. The in-patient/outpatient program has a four-week in-patient phase followed by an eight-week outpatient phase. Usually a group of patients complete the program together. Using an individual and group therapeutic and educational approach, the program addresses the following clinical problems: stress, PTSD symptoms, assertiveness, anger, problem-solving, social interaction, living skills, marital and family problems and physical health. Medications are used when indicated. Alcohol rehabilitation is provided for patients with alcohol problems. Partners are also offered group therapy while the patient is in the program. Following the in-patient phase of treatment, patients complete a course of outpatient treatment for one day a week for eight weeks. This phase of treatment is based on a group approach. It has three components addressing PTSD, alcohol rehabilitation and family support. This group treatment complements individual outpatient therapy.

807. Outpatient group therapy is also available for patients who do not require initial in-patient admission. Outpatient care can be tailored to the needs of each patient.

808. Referral can be made by contacting the Austin and Repatriation Medical Centre, Banksia St, Heidelberg West, Victoria 3081. Telephone: (03) 9496 2184.

DEPRESSION

General

809. Depression affects up to 5 per cent of the population and it is one of the more common clinical consequences of stressor exposure. It is particularly likely to develop where trauma involves some kind of loss - a companion, aspects of personal functioning or important possessions. Survivor guilt may be associated with a depressive reaction. Examples of the presentation of depression include foreshortened sense of future, feelings of hopelessness and generally feeling 'down'.

Presentation

810. Classical symptoms may be present, or insidious development may disguise the true affective nature of a disturbance. Depression is frequently under-diagnosed. Alcohol abuse is a common complication of a depressive disorder.

Management

811. Mood disorders usually respond well to appropriate interventions, although under-treatment must be avoided. Effective therapy usually involves pharmacotherapy, general support, cognitive strategies and strengthening of the social network. Antidepressant drugs available produce a good response, with the newer preparations causing less side effects. Doses must be in the therapeutic range and continued for at least four weeks before concluding that treatment has failed. Adequate doses of drugs may need to be maintained for periods of up to six months. In severe depression Electro Convulsive Therapy treatment may need to be considered. In managing depressed patients high suicide risk should be given attention in treatment planning.

CHAPTER 9

OPERATIONAL STRESS CASUALTY INFORMATION

INTRODUCTION

901. Australian Defence Force (ADF) personnel on operations do so under a wide range of circumstances. They may be subject to operational, climatic, disease and specific occupational hazards. The facilities for monitoring, treating and recording of illness and injuries, including operational stress exposure, vary with the nature of the operation and the availability of support services. It is essential that ADF personnel returning from operations are fit to resume their usual duties and lifestyle, and that any potential health problems arising as a result of the operation be recognised and appropriate management be promptly initiated.

POLICY

902. Medical reports and returns are central to the efficient and effective management and follow-up of personnel on operational deployments. For each operation Surgeon General Australian Defence Force will issue guidelines relating to the known health risks to ADF personnel, and where necessary, direct screening and testing requirements specific to the operation concerned.

903. Operational stress screening, follow-up as described at paragraphs 610 to 615, and effective clinical treatment are all integral components of the overall psychological management of personnel returning from operational deployments.

904. It is recognised that the ADF regularly has personnel serving overseas or at sea on duties which are considered operational, but which are not necessarily part of designated operations. In these circumstances, the requirements for medical examination and operational stress follow-up will be determined by the appropriate Command Medical Officer.

Reporting and Recording

905. Every member returning from operations is to be seen by a medical officer who, considering the location of the operation and the nature of the member's duties on the operation, is to take a history, conduct a medical examination and initiate any necessary management. Where the risk of suffering Post Traumatic Stress Disorder (PTSD) is significant, the examination is to be held 12 weeks after returning from operations to allow all appropriate follow-up to be done at the same time. The consultation which must be recorded on Form PM 105 - *Outpatient Clinical Record*, must include, in addition to all other relevant clinical information, the following:

- a. consideration of the specific stresses inherent in the operation and their potential consequences (annex A); and
- b. consideration of specific concerns which the member may have.

906. A record of psychological debrief (annex B) and psychological counselling (annex C) is to be placed in the member's Unit Medical Record and Central Medical Record to record the events have taken place. Detailed psychological records of counselling will be maintained in accordance with single Service psychology policies and practices.

Follow-up

907. In addition to the routine programmed follow-up, members returning to duty must be monitored (at 12 and 26 weeks as described in paragraphs 610 to 615) and offered further individual psychological debriefing, counselling or other assistance if there is:

- a. a request for assistance from the member, family or friends; or
- b. clinical evidence of stress-related illness or of any form of stress related to the deployment.

Responsibilities

908. Pre- and post-deployment briefings and debriefings as detailed in chapters 4 and 6 are to be arranged by the Joint Headquarters (JHQ) responsible for mounting the operation. It is also the responsibility of the mounting JHQ to initiate and advise the Services of the ongoing personnel management requirements, including the 12-weekly post-deployment assessment. It is then the Services' responsibility to undertake the examination, recording, monitoring and any follow-up treatment considered appropriate.

909. Service health and psychology resources, and policies and procedures are to be utilised for any follow-up action deemed necessary.

Monitoring and Feedback

910. Monitoring of operational stress for prevention and treatment purposes is important to the development and refinement of future management techniques and processes. Publishing the operational stress aspects of the operation, psychological insights, and 'lessons learned' in the post-operation report is central to the learning process for prevention. The overview report will allow any lessons learned to be implemented quickly while maintaining individual and group confidentiality. The mounting headquarters is to ensure that the post-operation report contains an adequate section on the operational stress and psychology aspects pertinent to the operation.

911. A centralised joint database of operational stress information is required to aid ongoing management and research of operational stress and its effects. An integrated, on-line, joint database linking the Services, and utilising data already held, will be established. Existing single Service data will form the baseline of information upon which the joint system will be developed.

Annexes:

- A. Post Traumatic Stress Disorder Indicators
- B. Psychological Debrief
- C. Psychological Counselling

POST TRAUMATIC STRESS DISORDER INDICATORS

1. ADF personnel returning from operational deployments will require careful monitoring, given the extreme harshness of the conditions they may have encountered.

2. Symptoms usually begin within the first three months after the traumatic experience although they may be delayed months or even years. The presence of any such problems may warrant specialist referral for assessment and appropriate management. The following list of symptoms should be used by medical officers, to actively seek evidence of distress in returning members:

- a. sleep disturbance: insomnia, fitful sleep, nightmares, night sweats;
- b. flashbacks, unwanted memories of the trauma or related events;
- c. anxiety;
- d. aggressive acts;
- e. emotional numbing;
- f. loss of interest in work and other activities;
- g. suicidal thoughts and feelings;
- h. fantasies of retaliation;
- i. feelings of alienation and problems with intimate and other relationships;
- j. cynicism and distrust of authority figures and public institutions;
- k. fits of rage or passivity (or alternating between the two);
- l. hyper-alertness;
- m. hyperventilation;
- n. over-protectiveness or fear of losing others;
- o. social isolation or emotional distance from others;
- p. survivor guilt;
- q. avoidance of activities which arouse memories of trauma;
- r. fear of the trauma returning;
- s. dissociation; trance states, denial, 'out of body' experiences;
- t. psychosomatic problems;
- u. mood swings; and
- v. difficulty concentrating.

3. The longer a person has suffered from untreated PTSD, and the longer and more severe the trauma, the more likely the member will present with secondary manifestations of PTSD. These problems do not present as the symptoms above, but are psychological syndromes and behaviours

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which have evolved to assist the individual in coping with the trauma. When treating the following problems, PTSD should be considered as a possible underlying factor and the member referred for specialist assessment and appropriate treatment:

- a. alcohol or drug abuse;
- b. eating disorders;
- c. compulsive gambling or spending;
- d. psychosomatic problems;
- e. homicidal, suicidal and self-mutilating behaviour;
- f. amnesia;
- g. phobias;
- h. panic disorders;
- i. delinquent or depressive symptoms;
- j. dissociation symptoms;
- k. fainting spells;
- l. psychotic episodes; and
- m. other psychological disorders (relating to mood, personality, anxiety etc).

PSYCHOLOGICAL DEBRIEF

SERVICE NO _____ SURNAME _____ INITIALS _____

1. The above member was part of the contingent serving with _____ in _____

during the period of _____ (inclusive).

2. The member underwent a psychological debriefing conducted by _____ of _____ (unit).

3. The debrief was conducted in (location) _____ during the period (date[s]) _____ (inclusive).

Entered by _____ (name, rank, position) on
(date) _____ from information gained
from _____ filed on _____.

PSYCHOLOGICAL COUNSELLING

SERVICE NO _____ SURNAME _____ INITIALS _____

1. The above member received Critical Incident Stress Management counselling in relation to:

_____ which occurred on (date[s]) _____ inclusive.

2. The counselling was conducted by _____

of _____ (unit).

3. The counselling was conducted in (location) _____ during

the period (date[s]) _____ (inclusive).

Entered by _____ (name, rank, position) on

(date) _____ from information gained

from _____ filed on _____.

CHAPTER 10

TRAINING IN OPERATIONAL STRESS MANAGEMENT

COMMANDERS

1001. Navy : Training in stress management and Critical Incident Stress Management (CISM) is given to Commanding Officer and Executive Officer Designate courses

1002. Army : Reserved.

1003. Air Force : Reserved.

OFFICERS AND SENIOR NONCOMMISSIONED OFFICERS

1004. Navy : Training in stress management and CISM principles is given to Junior Officers under training, Medical and Nursing Officer Entry course, Petty Officer Leadership and Management courses.

1005. Army : Reserved.

1006. Air Force : Training in stress management is provided during Basic Pilot and Navigator training, and is an integral part of Sergeant and Warrant Officer Promotion Courses. Training in combat stress management is given to all officers during attendance at Basic Staff Course with further stress management training during attendance at RAAF Command and Staff Course.

ALL RANKS

1007. Navy : Training in stress management and CISM principles is given to Leading Seaman Leadership and Management courses, Naval Police Coxswain and Medical Category courses, and New Entry course.

1008. Army : Reserved.

1009. Air Force : The CISM Peer Support Course has been conducted for health personnel including Medical Officers, Nursing Officers, Medical Assistants, Chaplains, Psychologists, and Social Workers since 1995. The course has recently been opened to members from any specialisation and mustering. Approval authority for the course is PMO HQTC. Training in stress management is also provided during all Firefighter, Police and Security Officer Courses.

HEALTH PERSONNEL

Surgeon General Australian Defence Force Policy on Training of Health Personnel in Stress Management

1010. Reserved.

CHAPTER 11

ASSOCIATED REFERENCES

COMBINED OPERATIONS POLICY

QSTAG 909 - *Principles of Prevention and Management of Combat Stress Reaction*

United Nations Stress Management Booklet

United Nations Field Operations Medical Support Manual

AUSTRALIAN DEFENCE FORCE POLICY

SGADF Bulletin 6/95 - *Policy Related to Medical Examination of Australian Defence Force Personnel Returning from Designated Overseas Locations*

SINGLE SERVICE POLICY

DI(N) PERS 5-7 - *Critical Incident Stress Management*

AOSI 12/91 - *Operational Stress Management of Army Personnel*

AOSI 28/94 - *Army Stress Management Policy*

DI(AF) PERS 54-20 - *The Management of Critical Incident Stress*

CLINICAL REFERENCES

American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (DSM IV), Washington DC (1994)

Mitchell, J.T. and Everly, G.S., *Critical Incident Stress Debriefing*, Chevron, Ellicott City MD (1993)

FOREIGN FORCES REFERENCES

Murphy, P.J., Major and Farley, K.M.J., Captain, *Hostage Survival Skills for CF Personnel, Operational Effectiveness Guide 97-1*, Personal Research Team, National Defence Headquarters, Ottawa, Canada, KIA OK2 (1997).

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		COMAUSSUBRON	1
		COMFLOT	1
		MHQ	4
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COONAWARRA	1	SASR	5
CRESWELL	1	ARMU (Army Malaria Research Unit)	1
CRESWELL Library (Staff College)	1		
DARWIN	1	LAND COMMAND UNITS	
HARMAN	1	LHQ	12
HAROLD E HOLT	1	HQ 1 Div	5
HC 723	1	HQ 2 Div	5
HS 816	1	HQ 1 Bde	3
HS 817	1	HQ 1 BASB	1
HOBART	1	HQ 3 Bde	3
KANIMBLA	1	HQ 3 BASB	1
KUTTABUL	1	HQ 4 Bde	1
MANOORA	1	HQ 5 Bde	1
MELBOURNE	1	HQ 6 Bde	1
NEWCASTLE	1	HQ 6 BASB	1
PENGUIN	1	HQ 7 Bde	1
PENGUIN Library (RANSC)	10	HQ 7 BASB	1
PENGUIN Medical Training School	5	HQ 8 Bde	1
PERTH	1	HQ 9 Bde	1
PLATYPUS Library	1	HQ 11 Bde	1
STIRLING	1	HQ 11 BASB	1
SUCCESS	1	HQ 13 Bde	3
SWAN	1	HQLSF	1
SYDNEY	1	HQ 1 LSG	1
TOBRUK	1	1 BASB (Fwd) (formally 7 Log Coy)	1
TORRENS	1	Land Command Battle School	1
WATERHEN	2	LCAUST Liaison Sect Butterworth	1
WATSON	1	1 Armd Regt	1
WATSON (RANSWARS)	3	1/15 RNSWL	1
WESTRALIA	1	2 Cav Regt	1
Navy Supply Centre	27	2/14 LH (QMI)	1
		3/9 LH (SAMR)	1
ARMY		4/19 PWLH	1
		12/16 HRL	1
ARMY HEADQUARTERS		A Sqn, 10 LH	1
OFFICE CGS	1	B Sqn, 3/4 Cav Regt	1
DALS	1	1 Fd Regt	1
DCOORD-A	1	2/10 Mdm Regt	1
DEME-A	1	4 Fd Regt	1
DGLWP-A (for ABCA Library)	2	7 Fd Bty, 3 Fd Regt	1
DLOG-A (incl DLD/DLC)	2	7 Fd Regt	1
DMI-A	2	8/12 Mdm Regt	1
DMOV&T	1	11 Fd Regt	1
DORD-A	1	13 Fd Bty, 5 Fd Regt	1
Gen Staff Div	1	16 AD Regt	2
Mat Div Coord	1	16 Fd Bty, 6/13 Fd Regt	1
		23 Fd Regt	1
ARMY HEADQUARTERS UNITS		48 Fd Bty, 6/13 Fd Regt	1
HQSF (G-1-18)	1	111 AD Bty (Lt)	1
HQ 1 Cdo Regt	1	131 Div Loc Bty	1
1 Cdo Coy	1	HQ LSF Engr	1
2 Cdo Coy	1	1 CER	1
HQ 1 GL Gp	1	1 Fd Sqn, 1 CER	1
66 GL Sect	1	1 Fd Tp, 1 Fd Sqn, 1 CER	1

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1 PC&R Gp	1	10/27 RSAR	1
2 CER	1	11/28 RWAR	1
3 CER	1	12/40 RTR	1
3 Fd Sqn	1	16 RWAR	1
4 FER	1	25 RQR	1
5 Fd Sqn, 4 FER	1	31 RQR	1
7 Engr Spt Regt, LSF Engr	1	41 RNSWR	1
7 Fd Sqn, 2 CER	1	42 RQR	1
10 Fd Sqn, 4 FER	1	49 RQR	1
11 Fd Sqn	1	51 FNQR	1
12 CE Wks	1	NORFORCE	1
13 Fd Sqn	1	Pilbara Regt	1
14 Fd Sqn, 4 FER	1	1 Avn Regt	1
17 Const Sqn, LC Engr	1	5 Avn Regt	1
18 Fd Sqn, 3 CER	1	161 Recce Sqn	1
19 CE Wks, LC Engr	1	162 Recce Sqn	1
20 Spt Sqn, 2 CER	1	171 Comd and Liaison Sqn	1
21 Const Regt, LC Engr	1	173 Gen Spt Sqn	1
22 Const Regt, LSF Engr	1	1 Div Int Coy	1
23 Spt Sqn, 1 CER	1	2 Div Int Coy	1
25 Spt Sqn, 3 CER	1	7 Int Coy	1
26 Div ESS	1	HQ 9 Tpt Regt	1
35 Fd Sqn	1	HQ 10 Tml Regt	1
38 Fd Sqn, 7 Engr Spt Regt	1	1 Tpt Sqn (Tpt Sqn 1 BASB)	1
39 E&M Sqn, 7 Engr Spt Regt	1	2 Tpt Sqn (Tpt Sqn 7 BASB)	1
91 RES Sqn, 7 Engr Spt Regt	1	3 Tpt Sqn	1
101 Const Sqn, 21 Const Regt	1	4 Tpt Sqn (Tpt Sqn 11 BASB)	1
102 Const Sqn, 21 Const Regt	1	5 Tpt Sqn (Tpt Sqn 6 BASB)	1
105 Const Sqn, 22 Const Regt	1	7 Tpt Sqn	1
106 Const Sqn, 22 Const Regt	1	8 Tpt Sqn	1
1 Topo Svy Sqn	1	9 Tpt Sqn (Tpt Sqn 3 BASB)	1
4 Fd Svy Sqn	1	10 Tpt Sqn	1
1 Sig Regt	1	11 MC Gp	1
7 Sig Regt (EW)	1	15 Tpt Sqn	1
8 Sig Regt	1	16 Tpt Sqn	1
103 Sig Sqn	1	26 Tpt Sqn	1
104 Sig Sqn	1	30 Tml Sqn	1
108 Sig Sqn	1	35 Water Tpt Sqn	1
109 Sig Sqn	1	44 Tpt Sqn	1
139 Sig Sqn	1	176 Air Dispatch Sqn	1
140 Sig Sqn	1	SAD HMAS TOBRUK	1
141 Sig Sqn	1	1 Fd Amb	2
144 Sig Sqn	1	1 Fd Hosp	2
152 Sig Sqn	1	1 PST (PST 1 BASB)	1
615 Sig Tp	1	2 Fd Hosp	2
Land Force Sig Unit	1	2 Fd Amb (Med Coy 3 BASB)	2
1 RAR	1	2 Pvnt Med Coy	1
1/19 RNSWR	1	3 Fd Amb	2
2/4 RAR	1	3 Fwd Gen Hosp	2
2/17 RNSWR	1	3 Pvnt Med Coy	1
3 RAR	1	4 Pvnt Med Coy	1
4/3 RNSWR	1	5 Fd Amb	2
5/6 RVR	1	6 Fd Amb	2
5/7 RAR	1	7 Fd Amb	2
6 RAR	1	9 Fd Amb (Med Coy 1 BASB)	2
8/7 RVR	1	10 Fd Amb	2
8/9 RAR	1	11 Fd Amb (Med Coy 6 BASB)	2
9 RQR	1	1 Fd Den Unit (Fd Den Unit 7 BASB)	1

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2 Fd Den Unit	1	PTS	1
3 Fd Den Unit	1	RMC	2
4 Fd Den Unit	1	RMC (Dental Unit)	1
5 Fd Den Unit	1	RMC (Med Cen)	1
6 Fd Den Unit	1	1 RTB (Kapooka Dental Unit)	1
15 Fd Den Unit (Fd Den Unit 11 BASB)	1	1 RTB (Kapooka Med Cen)	1
16 Fd Den Unit (Fd Den Unit 3 BASB)	1	Army Maritime School	1
33 Fd Den Unit (Fd Den Unit 6 BASB)	1	Army School of Transport	1
35 Fd Den Unit (Fd Den Unit 1 BASB)	1	RAAOC Centre	2
1 Amen Unit	1	RAEME Trg Centre	2
1 Combat Sup PI (Cbt Sup PI 1 BASB)	1	School of Armour	3
1 Fd Sup Coy (Fd Sup Coy 1 BASB)	1	School of Army Health	30
1 Petrol Coy	1	School of Artillery	2
2 Fd Log Bn	1	School of Army Aviation	2
3 Combat Sup PI (Cbt Sup PI 3 BASB)	1	School of Infantry	2
3 Fd Sup (Fd Sup Coy 3 BASB)	1	School of Military Engineering	2
4 Fd Sup Coy	1	School of Military Intelligence	2
5 Fd Sup Coy	1	School of Military Police	1
6 Combat Sup PI (Cbt Sup PI 6 BASB)	1	School of Military Survey	1
6 Fd Sup Coy (Fd Sup Coy 6 BASB)	1	School of Signals	1
7 Fd Sup Coy (Fd Sup Coy 7 BASB)	1	1 Trg Gp	1
8 Fd Sup Coy	1	2 Trg Gp	1
9 Combat Sup PI	1	3 Trg Gp	1
9 Fd Sup Coy	1	4 Trg Gp	1
11 Fd Sup Coy (Comp)	1	5 Trg Gp	1
13 Fd Sup Coy	1	6 Trg Gp	1
39 ADE Maint PI	1	7 Trg Gp	1
1 Avn Regt Wksp	1	11 Trg Gp	1
1 Sig Regt Wksp	1		
1 CER Wksp	1	LOGISTIC COMMAND	
2 CER Wksp	1	HQ Log Comd	5
3 CER Wksp	1	Bandiana Log Gp	1
3 Recov Coy	1	Brisbane Log Gp	1
5 Avn Regt Wksp	1	DNSDC	3
10 Tml Regt Wksp	1	Adelaide Log Bn	1
16 AD Wksp	1	Army Spt Unit Darwin	1
17 Const Sqn Wksp	1	Broadmeadows Log Bn	1
21 Const Sqn Wksp	1	Broadmeadows Log Bn (Med Sect)	1
101 Fd Wksp (Fd Wksp 1 BASB)	1	Oakey Log Bn	1
102 Fd Wksp (Fd Wksp 3 BASB)	1	Perth Log Bn	1
103 Fd Wksp	1	Puckapunyal Log Bn	1
104 Fd Wksp (Fd Wksp 7 BASB)	1	Hobart Log Bn	1
105 Fd Wksp	1	Marrangaroo Sup Coy	1
106 Fd Wksp (Fd Wksp 6 BASB)	1	Myambat Log Coy	1
107 Fd Wksp	1	Randwick Log Coy	1
108 Fd Wksp (Fd Wksp 11 BASB)	1	Wallangarra Log Coy	1
111 Fd Wksp	1	Sydney Log Coy	1
113 Fd Wksp	1	ACT Wksp PI	1
173 Gen Spt Sqn Wksp	1	1 MU	1
LSF Wksp	1	2 MU	1
1 MP Coy	1	3 MU	1
1 Psych Unit	1	4 MU	1
		5 MU	1
		6 MU	1
TRAINING COMMAND		7 MU	1
HQ Trg Comd	6	8 MU	1
C&SC	30	BASC Albury/Wodonga	1
LWC	30	BASC Darling Downs	1
LWC (Med Sect)	1		1

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BASC Enoggera	1	ASSAMB (BMF/BDF)	2
BASC Enoggera 1 Div RANLO	1	ASSAMB Library	1
BASC Enoggera (Den Unit)	1	RAAFSFS	1
BASC Enoggera (Med Cen)	1		
BASC Hunter Valley	1	Butterworth	
BASC Lavarack	1	92WG Det A	1
BASC Lavarack (Med Cen)	1	RSU Medical Flight	1
BASC Liverpool	1		
BASC Puckapunyal	1	Darwin	
BASC Puckapunyal (Med Cen)	1	HQ RAAF Northern Area	1
BASC Randwick	1	2CRU	1
BASC Randwick (Med Cen)	1	13SQN	1
BASC Rockhampton	1	301SQN	1
BASC Watsonia	1	35SQN Det A	1
BASC Watsonia (Med Cen)	1	BSDAR (BMF/BDF)	2
P&EE Graytown	1	BSDAR Library	1
P&EE Port Wakefield	1		
Dent Unit Karrakatta	1	East Sale	
Dent Unit Keswick	1	HQ RAAF East Sale	1
Dent Unit Latchford	1	32SQN	1
Dent Unit Puckapunyal	1	515SQN	1
Dent Unit Randwick	1	BSESL Library	1
Dent Unit Singleton	1	CFS	1
Dent Unit Watsonia	1	SAN	1
Med Centre Puckapunyal	1	SATC	1
1 Military Hospital	2	BSESL (BMF/BDF)	2
2 Military Hospital	1		
4 Camp Hospital	1	Edinburgh	
DFCE	1	HQMPG	1
3 MP Coy	1	92WG	1
Karrakatta Med Cen	1	BSWEDN	1
Keswick Med Sect	1	10SQN	1
Larrakeyah Med Sect	1	11SQN	1
Bandiana Log Gp	65	24SQN	1
		292SQN	1
AIR FORCE		504SQN	1
		ARDU	1
AIR FORCE HEADQUARTERS		ASSEDN (BMF/BDF)	2
DOCAS	1	ASSEDN (Library)	1
AFPOL3	1	EWSQN ARDU (WAS RAAFEWOSU)	1
DAFLS	1		
DGPP	1	Fairbairn	
DOMAT-AF	1	HQ RAAF FBN	1
RAAFSUCAN Library	2	28SQN	1
		34SQN	1
BASES		AHQIAC	1
		APSC	1
Amberley		BSFBN Library	1
HQSRG	1	BSFBN (BMF/BDF)	2
82WG	1	RAAFSC	10
501WG	1		
BSWAMB	1	Glenbrook	
1SQN	1	AHQ	5
2AFDS	1	RAAFSUGLEN	1
6SQN	1		
23SQN	1		
38SQN	1		
114MCRU	1		

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Pearce		Williamtown	
HQ RAAF Pearce	1	HQTFG	1
2FTS	1	41WG	1
25SQN	1	81WG	1
38 SQN Det A	1	BSWWLM	1
516SQN	1	2OCU	1
BSPEA Library	1	3CRU	1
BSPEA (BMF/BDF)	2	3SQN	1
		26SQN	1
Richmond		76SQN	1
HQALG	1	77SQN	1
86WG	1	ASSWLM Library	1
503WG	1	TFLMS	1
BSWRIC	1	ASSWLM (BMF/BDF)	2
3RAAF HOSP (BMF/BDF)	2		
22SQN	1	Williams	
33SQN	1	HQ RAAF Williams	1
36SQN	1	6RAAF HOSP (BMF/BDF)	2
37SQN	1	21 SQN	1
AMTDU	1	AVMED	1
ASSRIC Library	1	BSWIL Library	1
ATTU	1	RAAFCOL	10
MATU	1	ADF School of Languages	1
MOVCORDC	1		
		INDEPENDENT UNITS	
Tindal		HQLC	1
HQ RAAF Tindal	1	HQTC	1
1AFDS	1	1CAMD	1
75SQN	1	1OSU	1
302SQN	1	1SD	1
BSTD Library	1	7SD	1
BSTD (BMF/BDF)	2	RAAFPU	32
Townsville		Inquiries:	
HQOSG	1	SO1 LOPHS	
84WG	1	HQADF (SGADF)	
27SQN	1	CP4-6-18	
35SQN	1	Campbell Park Offices	
303SQN	1	CANBERRA ACT 2600	
304SQN	1	Tel: (06) 266 3899	
305SQN	1	DNATS 866 3899	
ASSTVL Library	1	Fax: (06) 266 3933	
ASSTVL (BMF/BDF)	2		
HQOSW	1		
Wagga			
BSWAG (BMF/BDF)	2		
BSWAG Library	1		