Treating PTSD in Veterans: When and why things go wrong and what we can do about it

Brad's story

Brad began an apprenticeship as an electrician when he left school in 2000, and left the trade before he qualified, citing difficulties with his boss. In 2004, after spending several months doing odd jobs, he was accepted into the Army Infantry. The Army appealed to him as it offered him a long-term career path.

Brad was medically discharged from the Army in 2016 (three years ago) after 12 years of service and two deployments to Afghanistan. He receives a Totally and Permanently Incapacitated (TPI) pension for injuries received when an IED exploded on his second deployment - he was blinded in one eye and sustained multiple fractures to his shoulder. Ever since the incident in 2015, he has been experiencing residual pain, for which he has been prescribed opioids. Brad has also been diagnosed with posttraumatic stress disorder (PTSD) and Major Depression.

Brad joined the Army as a single man and left as a married man, with three children under the age of ten. He met his wife Donna during home leave in 2009. They married after six months, when Donna was three months pregnant. Brad was delighted that Donna wanted to keep the baby. Brad had long yearned for his '*own family*'.

Brad and his younger sister grew up in a family characterised by family violence, his parents placing a priority on gambling and drinking rather than providing adequate care and protection for their children.

His parents divorced when he was nine and his sister was six years old. He does not have contact with his father and has a distant connection with his mother. He started drinking in his early teens.

Up until his discharge Donna and Brad had not spent a lot of time together, their relationship a whirlwind of home visits, pregnancies, long distance communication and young children. Since his discharge, their relationship has been challenged by financial stressors, '*Brad's many moods*' (Donna's words) and endless arguments over what Brad thinks are petty issues.

In parenting his children, Brad is a proud disciplinarian. He cannot tolerate noise and shouting during the children's playtime and becomes incensed if they do not do exactly as he says.

Brad has experienced panic attacks when out in public, and now avoids crowds at all costs. He does not like leaving the house and when forced to he becomes hyper-vigilant and aggressive with people he believes are staring at him. Brad had been seeing a psychiatrist on a monthly basis for several years for medication management.

As Brad has lost several jobs due to his aggressive behaviour towards his manager and colleagues, they both agreed that Donna should increase her hours to work full time while Brad is the primary stay at home carer.

As he does not sleep well, with nightmares a common occurrence, Brad struggles to get out of bed in the mornings to ensure the kids get to school. Some days Brad feels so hopeless that he does not bother showering or shaving.
He struggles in the role of primary care giver, in particular with their youngest, Bella, who is home all the time. Of all his children, Brad feels he should be better bonded with Bella. Hers was the only birth at which he was present, however there is something about her clinginess, the pitch of her cry, which he said '*drives me crazy'*.

Worried about his anger and sullen moods Donna convinced Brad to talk to his GP. Brad did not think he was angry, rather that he had a lot on his plate; however to please Donna he agreed. The GP referred him to a psychologist through the DVA gold card. Brad told the psychologist he could not see the point of therapy and could manage things himself; the psychologist responded by asking *'How is your approach working for you so far?'* and with that, Brad knew he could not get away with his usual bravado.

It took many sessions for the psychologist to convince Brad things could change, that he was feeling the way he was due to what has happened to him and not because of him as a person, and that there were good evidence-based treatments for working with trauma.

The psychologist introduced prolonged exposure therapy. Even though Brad attended weekly sessions, there was little reduction in PCL- 5 scores before and after treatment, as it was difficult to pinpoint specific index trauma to focus treatment. Imaginal exposure was very difficult for Brad to engage with as bringing up a particular scene was marked by triggers to a range of different traumatic events. EMDR was no better in reducing symptoms.

Around this time, his drinking and opioid use escalates. Brad is convinced that these are the only things he needs to help him. By day, he limits his drinking to up to four cans of beer '*just to take the edge off*'; at night, he does not monitor his drinking.

The only other time he has ever felt a sense of '*inner peace*' was when he was serving. He enjoyed the adrenalin rush, the team spirit, the purpose and the containment that the Army experience offered *'… you didn't want for anything, it was all there. No decisions to make, it's all done for you*'.

In the last two years he's been '*too busy*' to see his Army mates *'…is it really because I don't have time? Or something more? Resentment that they are still serving or shame that I couldn't handle it? Couldn't handle it and ended up banging myself up real bad.*'

Brad didn't know if he felt sad, relieved or angry about the way his army life had ended, but he knew he didn't feel proud.

Current situation

Some days Brad feels so overwhelmed *'...it's like everything is crashing down around me. Sometimes I have flashbacks to my childhood and then all this rage for what my old man did comes spilling out.*' He has never told anybody about this. Drinking provides him with some relief from these emotions.

From Brad's point of view, all of the '*issues*' identified by Donna, his GP, the psychologist and the psychiatrist can be put down to not being able to '*strike a blow*' since being discharged from the Army.

Recently, the Department of Child Safety visited Brad unannounced at the family home, investigating a report from a neighbour who thinks a child is being regularly locked out in the backyard. The neighbour has often heard a raised, angry male voice, slamming of doors and the sound of a young child in the backyard crying '*daddy, daddy*'.

The department arrange to return when Donna is home, expressing concerns that Brad is both unable to explain the neighbour's observations and seems to be alcohol affected, despite his denials.

Brad knows '*things*' are coming to a head. He doesn't know who to turn to but he feels like he is on the cusp of possibly losing everything.

He dreads facing Donna, his GP, his psychologist, his psychiatrist. In fact, he doesn't know if he feels safe with anyone, including himself.

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Speaker biographies:

Ms Lauren Eastaughffe
National Community and Peer Advisor, Open Arms, ACT

Lauren is the National Community and Peer Advisor with Open Arms – Veterans & Families Counselling.

She served for 14 years as a Commissioned Officer with the Royal Australian Air Force and has since worked in a range of management and consulting roles in private industry and government.

Lauren joined Open Arms as a member of a pilot project which trialled the employment of veteran Community and Peer Advisors as Mental Health Peer Workers within multi-disciplinary Community Engagement Teams. In this role she provided direct mental health peer support and recovery focussed role-modelling for veterans and their families, case management assistance, lived experience advisory within Open Arms and the Department of Veterans' Affairs, and worked with a range of Defence and ex-service organisations to promote Open Arms service options and access.

In her current role as the Open Arms National Community and Peer Advisor, Lauren is responsible for managing the national implementation of the Open Arms Community and Peer program. This program will see the recruitment, employment, training and mentoring of 42 veteran and carer Community and Peer Advisors at 13 Open Arms sites across Australia by the end of 2019. Lauren's team within Open Arms National Operations will also be responsible for the national management and coordination of specific portfolio project areas affecting veterans and their families.

Lauren is passionate about the utilisation of her lived experience of Defence service and mental illness and recovery to inspire and support positive, holistic physical and mental health outcomes for veterans and their family members.

Professor Richard A. Bryant AC
Scientia Professor and NHMRC Senior Principal Research Fellow, NSW

Richard Bryant is a Scientia Professor of Psychology at the University of New South Wales, Sydney.

Professor Bryant has researched the nature, course, and treatment of post-traumatic stress disorder (PTSD) for over 20 years. His work has identified key genetic, neural, and psychological factors underpinning PTSD. Much of his work has focused on early markers of recently trauma-exposed people who will develop PTSD. Through many longitudinal studies he has developed the world's leading screening tools for early identification of PTSD as well as development of the most commonly used early treatment protocols. These have been translated into over 15 languages and used in many countries. Professor Bryant has written five books, 70 book chapters, and 570 journal

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articles. He has served on major international committees to define PTSD internationally. In 2016 he received the Companion of the Order of Australia for services to research and management of traumatic stress.

Dr Andrew Khoo
Consultant Psychiatrist, Qld

Dr Andrew Khoo attained his fellowship from the Royal Australian and New Zealand College of Psychiatrists in 2002, receiving a College medal for his final year dissertation on Post Traumatic Stress Disorder. He has worked as a private psychiatrist in the Brisbane metropolitan area since 2002. He has worked in the Day Programs at the Toowong Private Hospital (TPH) for the last 18 years providing CBT based group therapy for PTSD, mood and anxiety disorders, and has held the position of Director of this unit since 2004.

In 2016, he was nominated to the position of Director of Medical Services and Chair of the Medical Council at TPH. He holds academic title with the University of Queensland within the School of Medicine and has published, and continues to publish, academic papers in peer reviewed psychiatric journals.

He is a member of the Department of Veteran's Affairs Clinical Reference Group, a national board tasked with advising on clinical issues and directions regarding veteran's mental health. He is the Deputy Chair of the Open Arms (formerly VVCS) National Advisory Committee and holds the Psychiatrist position on the Consultation Reference Group for Phoenix Australia's (Centre for Post-traumatic Mental health) Centenary of Anzac Centre. He is on the Working Group for the RANZCP Military and Veterans mental Health Network and has presented on behalf of the College to multiple Senate Inquiries and Productivity Commission public hearings. He is the Psychiatric Advisor to the Gallipoli Medical Research Foundation (GMRF) and is a member of the GMRF Strategic Oversight Committee. He is a current member of the Qcomp Medical Assessment Tribunals. He has chaired, been interviewed, presented or participated on panels around Australia and across all media platforms on Post Trauma psychological reactions and Military and Veteran's Mental Health issues.

Dr Phil Parker
General Practitioner, Qld

BAppSci (Hons1), BEd, MBBS, FRACGP

Dr Phil Parker is a Brisbane-based general practitioner with extensive expertise in veteran's health. He will provide consultation to practitioners about a wide range of veteran's health care issues, including post-traumatic stress disorder.

Phil served with the Australian Army for 28 years, which included roles in Signals, Infantry and Medical Corps. In 2012, he deployed to Afghanistan as the Task Force Surgeon. This role involved operational coordination of coalition health forces in Uruzgan, mentoring of senior Afghan Army, Police and civilian health staff, and treatment for trauma patients. Phil has also held senior medical officer roles within Army, with significant involvement in capability and policy development.

As a community general practitioner, Phil has a special interest in veterans' health. He is also actively involved in the advice and education to other practitioners about PTSD management. Phil is GP Ambassador for Gallipoli Medical Research Foundation and serves as a medical educator with General Practice Training Queensland.

Facilitator:

Professor Mark Creamer
Clinical Psychologist, Vic

Professor Mark Creamer is a clinical and consulting psychologist with over 30 years' experience in the field of posttraumatic mental health.

Mark is internationally recognised for his work in the field; providing policy advice, training and research consultancy to government and non-government organisations, with the aim of improving the recognition, prevention and treatment of psychological problems following stressful life events.

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Mark is a Professorial Fellow in the Department of Psychiatry at The University of Melbourne, and has an impressive research record with over 180 publications.

Mark is an accomplished speaker and has given numerous invited addresses at national and international conferences.