Australian Government
Department of Veterans' Affairs

Mental Health and the Military Experience

WEBINAR PANEL

mhpn Mental Health Professionals' Network

Responding to and Treating Posttraumatic Stress Disorder: What Works?

6:45 pm – 8:00 pm AEDT, Tuesday 25th October

Webinar panellists

Professor Mark Creamer, clinical psychologist

Mark Creamer is a clinical and consulting psychologist with over 30 years' experience in the field of posttraumatic mental health. He is internationally recognised for his work in the field. He provides 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. Mark is a Professorial Fellow in the Department of Psychiatry, 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 to national and international conferences.

Professor David Forbes, clinical psychologist

David Forbes is the Director of Phoenix Australia – Centre for Posttraumatic Mental Health and Professor in the Department of Psychiatry, the University of Melbourne.

He has over twenty years' experience in the assessment and treatment of mental health problems in trauma survivors, with a speciality in military and veteran mental health. He led the development of the inaugural 2007 Australian Guidelines for the Treatment of Posttraumatic Stress Disorder (PTSD) and the revision published in 2013 approved by the National Health and Medical Research Council and endorsed by the key health professional colleges. He is also the Vice Chair of the International PTSD Guidelines Committee developed by the International Society for Traumatic Stress Studies.

He has a strong track record in the conduct of research in the assessment and treatment of PTSD and the provision of policy and service development advice to government and agencies responsible for the care of veteran and military personnel, and trauma survivors across the community.

Professor Forbes also has a strong track record in the provision of training for health and mental health practitioners in evidence-based treatments for PTSD and related disorders in veterans. This has included the development of a mobile app and online resources for practitioners, and the current and ex-serving Defence community. He has published over 120 scientific papers in the international literature and sits on many Commonwealth government veteran and military policy panels, scientific advisory panels and academic journal editorial boards.

Dr Andrew Khoo, psychiatrist

Andrew Khoo completed his undergraduate medical degree from the University of Queensland in 1994, and received 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 presently divides his time between private practice and being the Director of Medical Services at the Toowong Private Hospital. His trauma recovery work at the Toowong Private Hospital has seen him assess and oversee the clinical management of more than 1,000 veterans/currently serving military personnel and close to 150 emergency services/civilians with PTSD. He is an active member on numerous national boards advising government on military and veteran mental health. He is a Senior Lecturer for the University of Queensland's School of Medicine and what time he finds for academic work is currently spent on various research foundations and committees, and compiling and publishing papers.

Webinar panellists continued

Dr Sam Hay, general practitioner

Sam is a practicing Australian GP and is regularly seen in the media. Sam has hosted Amazing Medical Stories on Channel Nine and was one of the charismatic presenters of Embarrassing Bodies Down Under. He regularly writes for popular parenting resource kidspot.com.au, and is the resident doctor for The Today Show on Sundays and the Kyle and Jackie O radio show on KIIS.

A former Senior Medical Officer in the Royal Australian Army Medical Corps, Dr Hay has been working in general practice since 2005 and is currently a partner in one of Sydney's most successful GP practices, Your Doctors™. He has also appeared as a medical expert on Studio 10 as well as on radio stations Sea FM and Triple M.

Dr Hay started his military career at the 1st Health Support Battalion with the Parachute Surgical Team – a small scale, highly mobile hospital, able to respond within hours to any emergency, anywhere in the world, specifically by parachute. He found his most challenging trip was to Afghanistan, where he led a small medical team that integrated with an American helicopter based retrieval team. They were responsible for retrieving injured soldiers from the combat zone and evacuating them back to the military hospitals.

Dr Hay is a self-confessed health and fitness advocate who can be found in the gym or the surf. He is also an ambassador for the Beer the Beautiful Truth campaign.

Responding to and Treating Posttraumatic Stress Disorder: What Works?

Case study

Rob's story

Rob is 36 years old, and the eldest of three children. His father died from liver failure when Rob was in his late teens. He *"….was a cop, a good one too, but he wasn't a good dad or husband. If he wasn't working he was boozing and starting fights left, right and centre; mainly with mum but really anyone who would get under his skin"*. Rob's mother is in supported accommodation with early onset dementia. Rob wonders if she has sustained a brain injury, given how many times *"…dad hit her around the head"*. His siblings are dispersed across the country and do not have a lot of contact with each other.

From a young age Rob vowed to never be addicted to anything. Despite not ever drinking or smoking, as a kid he always enjoyed the buzz from taking risks; that hit of adrenaline he got from driving fast, shoplifting, skateboarding, and any form of extreme sports.

Rob struggled academically and left school in Year 11 to work full-time in the group home for disabled teenagers, which was managed by his mother. As a support worker, he enjoyed the role, particularly helping the kids *"have a bit of fun, a laugh, like helping them do things they wouldn't normally do"*. He didn't like meetings or being part of a team, and would get frustrated easily over the administrative demands of the role.

Rob married Sophie when he was 20 and she was 19.

They had only been together for a couple of months when Sophie became pregnant. Lachlan, their son, was born just before Rob's 21st birthday. Rob was not a hands-on father; he worked shifts, which meant he was often absent for Lachlan's significant rites of passage.

He was settled in the group home job for about six years, but was challenged when his mother retired due to health issues and a new manager was recruited. Eventually, after a number of warnings for creating conflict within the team, he was fired.

Shortly after he was fired, Sophie announced she had met someone else and was taking Lachlan and moving interstate to be with her new partner. Despite being devastated, Rob managed to amicably negotiate ongoing child support and access arrangements.

Mindful that he needed stable employment, he joined the army; an idea he had toyed with since a young boy. He initially joined the infantry with the intent to become a medic and successfully undertook the relevant training to do so. He had a few deployments in Afghanistan working as a medic. He enjoyed the deployments; they satisfied his need for a "*thrill"* but also enabled him to use the skills he employed in the group home *"helping people who couldn't help themselves"*.

A couple of times on deployment, he questioned whether this was the right role for him. Sometimes the "*thrill"* was overwhelming. Once when his unit was attacked by the Taliban . . . *"I really thought I was going to die"*. He found it hard to throw this feeling. Then a couple of weeks later, he was in a vehicle driving in convoy. The vehicle in front drove over an improvised explosive device (I.E.D.). The occupants of the vehicle, as well as some civilians who had gathered on the road side to watch the convoy, were badly injured, some fatally. *"The impact! It was like a movie scene, just unreal. And then, when the dust settled, there were bodies everywhere. I didn't know where to start, who to look after. It was like everything stopped, including me. I froze. Who to help - the women, the children, my mates?"*

Rob couldn't settle after this incident. His relationships with his team mates had always been a bit feisty but now his short fuse was shorter than ever. A couple of months following the I.E.D. incident, Rob was administratively discharged for punching a senior officer in the jaw who was reprimanding him for starting a fight with a team member.

Upon his discharge, Rob took a job as a first aid officer on a mine in Mount Isa. Although he liked the isolation, the first time he had to attend to a worker who was bleeding following a minor cut, he experienced severe flashbacks of his time in Afghanistan.

He only stayed in the job couple of weeks before quitting, and over the following five year period, drifted into a range of unskilled jobs such as storeman and packer, bicycle courier and labourer. Each job tended to end in the same way, the result of conflict with team members, customers or managers. Either Rob would fly off the handle and leave impulsively or he was sacked. *"It's hard to hold down a job when I'm just tired all the time. I mean, I wake up exhausted – every night it's the same nightmare over and over, on repeat. Do you know what it's like to wake up exhausted and then have to act normal?"*

For the past year, he has been in a relationship with Marion; they met when he joined a local abseiling group. Rob initially went abseiling with Marion and the group, but he now goes alone as he finds the group holds him back. *"Abseiling is the only time I feel half alive. I get that thrill, that rush. Nothing is the same since I've come home. It's like things have gone from colour to black and white"*.

Since his discharge, Sophie was *"pretty understanding, happy to let child support payments slide, but as soon as she broke up with that boyfriend of hers she started hassling me to make payments I can't make"*. Rob can't help but feel the irony – over the years he has tried to maintain his relationship with his son but since becoming a teenager their relationship has become increasingly strained and distant.

Rob is currently unemployed. He knows he needs to find secure ongoing employment but he doubts his capacity to do so. He wouldn't say this out loud but thinks *"I blame myself; I couldn't help those people. I mean, I was a medic, but a useless one"*.

He knows he feels better when he isn't reminded of the war. Some things like loud noises or confronting images take him *"back there, in a flash"*. Marion has agreed to the ban on watching the news or bringing the newspaper home. Rob knows he has to calm down. He is trying – dabbling in yoga, natural therapies and other approaches that calm him down but don't *"zonk me out so much that I can't do anything else"*.

One night they were driving to Marion's mother's house for dinner. He was speeding again and Marion had had enough; his speeding was often a trigger for an argument but this time she really got angry. *"STOP IT! Slow down. How many times do I have to tell you? Do you want to kill us both? You are just too toey, you've gotta calm down. You've tried this, you've tried that – acupuncture, myotherapy – you don't stick at anything. If something doesn't change, I'm leaving!"*

He doesn't want to lose Marion and, for this reason, Rob finds himself waiting in his GP's office. When the GP asks *"what seems to be the problem?"* , he doesn't know where to start.

Responding to and Treating Posttraumatic Stress Disorder: What Works?

Frequently Asked Questions

1. **What are the current recommended evidence-based treatments for posttraumatic stress disorder (PTSD)?**

   Recommended treatments for PTSD focus on confronting the memories and reminders of the traumatic event or events, as well as addressing associated unhelpful thoughts and beliefs. They include trauma-focussed cognitive behaviour therapy, cognitive processing therapy and eye movement desensitisation and reprocessing.[1] These treatments can be delivered in a one-on-one consultation or a group therapy environment.

   Pharmacological treatments used to treat PTSD are intended to improve symptoms and functioning. While medications are not recommended as a routine first-line treatment for PTSD, they can assist in making a person less symptomatic, making it easier to 'work through' or confront traumatic memories. As such, medications are often used in conjunction with psychological treatment. Further information about medications is provided at question seven.

2. **Is eye movement desensitisation and reprocessing (EMDR) an effective treatment and when should it be used?**

   EMDR was first developed in the late 1980's and has been rigorously tested and researched

   through a number of randomised control trials. In EMDR the patient focuses on the trauma-related imagery, negative thoughts and emotions while moving their eyes back and forth in 20-30 seconds intervals. By repeating this process, it is proposed that this facilitates the processing of the traumatic memory into existing knowledge networks.[2]

   EMDR is a recommended treatment for PTSD under the *Australian Guidelines for Treatment of Acute Stress disorder and Posttraumatic Stress Disorder* and the World Health Organization's *Guidelines for the Management of Conditions Specifically Related to Stress*.[3] EMDR is accepted as an effective treatment by the Department of Veterans' Affairs.

   As an accepted first line treatment for PTSD, EMDR should be considered alongside cognitive processing therapy and trauma-focussed cognitive behavioural therapy as a treatment option. As EMDR does not require the patient to verbally relate details of the traumatic event or events, it may be an appropriate treatment

[1] Raphael, B. and Forbes, D., *Australian Guidelines for Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder*, Phoenix Australia – Centre for Posttraumatic Mental Health, Melbourne, 2013, pp. 68-71.
[2] Raphael, B. and Forbes, D., *Australian Guidelines for Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder*, Phoenix Australia – Centre for Posttraumatic Mental Health, Melbourne, 2013, p. 69.
[3] World Health Organization, *Guidelines for the Management of Conditions Specifically Related to Stress*, 2013, p. 8.

option for a patient who is exceptionally anxious about undergoing exposure therapy.

3. How to decide which treatment to use for an individual patient?

When deciding which treatment to use for an individual patient, a clinician should consider the aspects of the specific treatment modalities and how these are suited to the characteristics of the individual patient. A clinician should look for contraindications and prepare a treatment program to avoid these.

For example, if an individual displays dissociative tendencies, then it may not be effective to utilise a treatment modality that could potentially heighten this. Alternatively, if a client expresses an unwillingness or inability to talk about traumatic events, then a treatment requiring non-verbal processing of the traumatic memory should be considered.

4. How and when should second-line treatment options be used?

Some treatments that focus on calming or reducing stress levels (such as mindfulness or hypnotherapy) can be used as an adjunct to, or a precursor to, structured exposure therapy. These treatments can be effective in preparing a patient for dealing with the recollection of traumatic events.

Physical therapies such as acupuncture, can also be used in conjunction with a structured therapeutic treatment regimen, with an emphasis on reducing physical symptoms of stress that may inhibit the recovery process.

Psychosocial therapies (such as art therapy and equine therapy) can help an individual compensate for the negative effects of disability by reducing some of the problems associated with PTSD. The focus of psychosocial is to promote community integration and improved functioning, rather than reducing symptoms.

The Department of Veterans' Affairs (DVA) acknowledges that those with mental health concerns can benefit from a variety of wellbeing activities. These second-lined treatments can be considered as part of a broader evidence-based program. However, DVA only funds treatment which is evidence-based and in accordance with the *2013 Australian Guidelines for the Treatment of Adults with Acute Stress Disorder and PTSD*, endorsed by the National Health and Medical Research Council.

5. Should family members be involved in treatment? If so, how?

As in any family environment, mental health issues can have a significant impact upon individual family members and the functioning of the family unit. People with PTSD may avoid social situations, feel detached, and have trouble expressing their emotions. As a result, they might be less affectionate or withdraw from social outings or family gatherings. They may also show less intimacy with their partner or withdraw from their parenting responsibilities.

Research has shown that a veteran's PTSD can also affect their family members' mental health. Partners can experience anxiety, depression, social isolation and feelings of hopelessness, while younger children can develop behaviour problems such as acting out at school and adult children are more likely to suffer from mental health problems than their counterparts in the general population.[4] The Veterans and Veterans' Families Counselling Service offers free family counselling to eligible veterans and their immediate families. For more information, call 1800 011 046.

Clinicians are encouraged to engage family members early and provide them with information about PTSD and include them in the collaborative care and recovery plan as far as possible. However, some veterans may be fearful of the impact on their family relationships should family members find out the details of their military experiences and may resist the inclusion of family in their therapy.

On way to engage family members in a veteran's treatment is through family therapy. Family therapy may involve psychoeducation, psychosocial aspects, sharing some elements of the veteran's traumatic experiences and a focus on communication and support strategies.

The approach to psychosocial rehabilitation taken by the Department of Veterans' Affairs has a strong focus on helping a veteran to learn to self-manage their conditions and focus on recovery. This approach recognises the importance of reducing social isolation and

[4] Commonwealth of Australia, *Vietnam Veterans Health Study*. Volume 1*, Introduction and Summary of the Studies of Vietnam Veterans Families*, Department of Veterans' Affairs, Canberra, 2014.

building community connections to a veteran's recovery. Family members can play a key part in this process, especially if the veteran is comfortable with including family members in discussions about their rehabilitation goals and identifying activities to help them to reach these goals.

Many of the stories highlighted in DVA's rehabilitation success stories talk about the importance of family to recovery.

6. What is moral injury and how do you treat it?

Military personnel are often confronted with situations whereby they are required to make decisions, take action or are exposed to events that challenge their ethical and moral beliefs. Transgressions of ethical and moral beliefs and inner conflict can arise in these circumstances and lead to potential mental health problems. Research indicates that in addition to symptoms associated with PTSD, moral injury can manifest itself as shame, guilt, loss of trust, anger, demoralisation, self-handicapping behaviours, and desire for self-harm.[5]

Since 1980, PTSD has been conceptualised as an anxiety disorder emphasising the role of an exaggerated threat appraisal in the development of symptoms. This threat-based model of PTSD has shaped the development of effective treatments. Most first-line PTSD treatments include a form of exposure therapy, which assumes that emotional distress is underscored by a fear response. However, given that PTSD related to moral injury does not stem from a fear response, these treatments could conceivably be less effective when used in isolation. Instead, treatments involving a higher degree of cognitive reframing have been shown to be more effective in addressing distorted beliefs about guilt and worthlessness.

Direct evidence around the success of a modified approach to treating moral injury is relatively scant. However, indirect evidence strongly supports the approach. As such, a number of trials are underway with current and ex-serving personnel in the United States.

7. What are appropriate medications to use in treatment and when should they be used?

Medications used to treat PTSD are intended to improve symptoms and, as a result, enhance functioning. When the person is less symptomatic it may be easier to 'work through' or confront the traumatic memories, as such medications are often used in combination with psychological treatment.

A wide range of psychotropic (affecting a person's mental state) medications have been examined and used in clinical practice to treat PTSD. However, there is limited research on the effectiveness of these medications in treating PTSD. Selective serotonin reuptake inhibitor antidepressants have several possible side effects, however they tend to have fewer than older antidepressants, are relatively easy to use and are usually safe in overdose.

Monoamine oxidase inhibitor (MAOI) antidepressants are another drug used to treat patients with PTSD. MAOI antidepressants have been around for a long time, however they are very difficult to use and require careful dietary restrictions.

Although generally not supported by empirical data, several other classes of medication are often used in PTSD.[6]

8. What further training is available in understanding and/or treating PTSD?

The Department of Veterans' Affairs (DVA) have produced a range of resources for mental health professionals to assist them to deliver better outcomes for former ADF personnel.

The *PTSD-Psychological Interventions Program*, developed by DVA, is a free eLearning program which helps providers better understand the preferred treatments for PTSD through a combination of case studies, learning activities and video demonstrations. This program can be accessed through the *At Ease Professional* website, at http://at-

[5] Commonwealth of Australia, Evidence Compass *'What are effective interventions for veterans who have experienced moral injury?'*, Department of Veterans' Affairs, Canberra, 2015, pp.3-4.

[6] Raphael and Forbes, *Australian Guidelines*, p. 72.

ease.dva.gov.au/professionals/professionaldevelopment/.

DVA has also developed a one-hour eLearning program, *Working with Veterans with Mental Health Problems.* This program is designed to assist GPs to better understand common veteran mental health conditions, how military service can affect the mental health of serving and ex-serving personnel and referral pathways for DVA clients. The program is hosted on the Royal Australian College of General Practitioners' *gplearning* system.

The PTSD Coach Australia mobile app can be a helpful resource in assisting veterans to better understand and manage symptoms of PTSD. A clinician's guide has been developed to assist providers to integrate the PTSD Coach Australia app into their patient's treatment. A short video is also available on DVA's YouTube Channel.

Further information about courses and programs aimed at increasing knowledge about PTSD treatment interventions can be accessed through the *At Ease Professional* website (www.atease.dva.gov.au/professionals).

9. How important is vocational rehabilitation in treating PTSD?

There is a strong body of evidence about the health benefits of safe and meaningful work. Safe and meaningful work can be an important part of recovery for a veteran with PTSD, and indeed for their family. However, the key is that a return to employment is considered at the right time for an individual.

The Department of Veterans' Affairs (DVA) has a whole-of-person approach to rehabilitation. Our approach recognises that each veteran's needs and circumstances are different, so an individually tailored rehabilitation plan is developed for each veteran. DVA's rehabilitation approach means that veterans can access medical management, psychosocial and vocational rehabilitation assistance at a time that is right for them.

Vocational rehabilitation may assist a person with PTSD return to an optimal level of functioning and employment. Although the goal for many will be paid employment, it does not have to be the only goal. Voluntary work, retraining and additional study, including tertiary study, can be important steps along the way to a return to paid employment.

Depending on the current level of functioning, DVA interventions may involve support to stay in the person's current role or with the same employer, if they have been successful in finding work outside the Australian Defence Force. Recognition of prior learning, curriculum vitae and interview preparation, job seeking assistance, work trials, reasonable adjustments to a workplace or role, or a return to employment in a supported and graded fashion may be some of the activities included in a vocational rehabilitation plan.

For some veterans, a return to paid work may be a longer process, potentially involving retraining, or further study with a view to finding suitable, meaningful and sustainable employment for the person. The rehabilitation providers who work with DVA clients are expected to liaise regularly with a veteran's treating health professionals, to ensure a coordinated approach to supporting a safe return to work.

This document has been developed to assist health professionals, including medical practitioners, nurses, psychologists, social workers, counsellors and rehabilitation service providers, who care for veterans. The assessment and treatment of mental health problems requires the consideration of an individual's particular circumstances by a qualified health professional, practising within the limits of their competence and accepted standards at the time for their profession.

This document is not a substitute for such professional competence and expert opinion, and should not be used to diagnose or prescribe treatment for any mental health problem. The Australian Government does not accept liability for any injury, illness, damage or loss incurred by any person arising from the use of, or reliance on, the information and advice that is provided in this document.