Promoting Healthy Sleep: Recognising, Responding to and Treating Common Sleep Disorders in Veterans

Case study

Sally's story

Sally (48 years old) is a registered nurse and a nursing officer with the Army Reserve. She joined the Army Reserve following in the footsteps of her father, grandfather and great uncle all of whom were Reservists. Sally is an only child and often says to her Reservist mates *"… I was the son that Dad never had. He loved that I was in the army. I miss him lots. Being in the Reserves helps me feel connected to him"*. Over her 20 plus years as a Reservist, Sally has been on various deployments in the Middle East, as well as undertaken local disaster relief work. She has valued the work and opportunity to do something that is not only worthwhile, but also outside of her comfort zone.

Sally has been married to Cameron (51 years old) for ten years. Sally and Cameron met on a dating site and married shortly after. They do not have children "… *we tried but it just didn't happen for us. I did get sad about it a couple of years back, but you know what? It's ok now. I got some professional help and worked through it. I'm just ever so grateful for having what I have with Cam. Some people don't even have that*".

After graduating, Sally secured a permanent nursing position in the orthopaedic ward of a major metropolitan hospital where she stayed for about ten years, leaving to undertake casual agency work. She enjoyed the variety of this new employment arrangement, valuing in particular the flexibility to attend her regular Pilates classes. She'd never been one for physical activity, but a couple of years ago, while on deployment in the Middle East, she sustained a minor back injury which resulted in a niggling back pain that would not go way. She's not entirely sure the Pilates is effective, as the pain still niggles, but she enjoys the coffee dates after the class with her fellow class mates.

Sleep has never come easy to Sally; she's not ever felt she needed much, "*I've got a fast metabolism. Don't need much sleep, thin as a whippet, always positive, always busy*" she used to say, but not anymore.

Since her return from disaster relief work in the 2009 Victorian bushfires she has seemed to need more sleep or has been more tired than usual. Sally puts her newfound tiredness down to her sleep now being characterised by disturbing dreams and strange awakenings.

Her sleep patterns were always a tad random but now they are more predictable. She has difficulty getting off to sleep and is restless through the night (although often seems to fall more deeply asleep near morning). Recurring nightmares have become a feature with a couple that happen regularly, once or twice a week. The first takes her back to a particular day in the 2009 bushfires when she unexpectedly came across a very distressing scene that she has never shared with anyone, not even Cameron. The nightmare replays exactly what happened in vivid detail. The second nightmare is not as vivid, but just as disturbing, even though it is not something that actually happened to Sally. In this nightmare Cameron is seriously injured in a terrible accident of some kind and needs Sally's help, which she is unable to provide. Each time she'll wake at the point of the

‘story’ when she feels most helpless, confident that Cameron will die. Some nights she’ll just wake up startled, gasping for breath with her heart racing, not sure why she has woken or whether she has even been dreaming.

About eighteen months ago, impacted by Sally’s restlessness at night, Cameron moved into the spare room where he now sleeps.

The new sleep arrangements haven’t helped Sally’s sleep quality or patterns. She is spending more time in the bedroom but less time sleeping. She has moved the TV into the master bedroom, both bed side tables are cluttered with coffee cups, her iPad, books and old magazines with copies of cryptic crosswords, a long held habit of Sally’s for which she has her father to thank “*he was the cryptic crossword master! If nothing else, not sleeping helps me hone my crossword skills*!” She tends to go to sleep later now and if she’s had a bad night, sleeps in till late in the morning.

Sally, who rarely drank alcohol, now finds herself having a couple of wines with her evening meal. Cameron is a teetotaller and isn’t happy with this new routine and lets Sally know. Sally tells him “*it helps me get to sleep. It’s nothing to worry about … don’t go making a mountain out of a molehill*”.

Despite the frequency of the nightmares increasing over the years, Sally feels the best technique to deal with them is to not give them too much attention. Her father always said “*don’t sweat the small stuff*” and that has been her mantra in life.

Her irritability, constant tiredness, low self-esteem, all new to Sally, she attributes to peri-menopause. A woman in her Pilates class who is a bit older than her keeps warning her about “… *the ravages that menopause does to your body, your energy and your self-esteem*”.

Recently Sally had a minor car accident “… *it wasn’t serious, I just scraped some parked cars. I think I just lost concentration for a moment. You know usually I’m a good driver. I was just so tired today*”. Sally is surprised that Cameron seems to care more about her state of mind than the car. He shares with her his concerns about her functioning and the impact this is having on their relationship “… *you are not the same bubbly woman I married … you pick on me, you’re grumpy and tired all the time. Where is our old spark?* I *wonder if you, or in fact we, are happy anymore. We hardly see each other. More often than not you’re still asleep when I leave in the morning …”*

A couple of days later her boss at the agency tells her that the hospital where she did her last nursing shift lodged a complaint claiming that Sally had made significant errors in her handover notes “… *it’s not like you Sally. Frankly your attention to detail hasn’t been great of late. Why don’t you take some time off and have a rest*?”

Sally finally decides that she needs to do something about her sleep problems and makes an appointment with her GP to get a referral to a psychologist.

“OK, maybe I am a little under par. If I could just get a good night’s sleep. Problem is, I don’t know how to …”.

Frequently Asked Questions

1. How can military experience impact on sleep?

Aspects of military service which some individuals may find stressful, such as experiences on deployment, separation from family, have the potential to cause sleep disturbances.[1]

During deployment, the physical sleep environment for an individual is changed and the stress of both being away from home and being on deployment, compounded by frequent shift work and irregular sleep/wake cycles, can make the experience of deployment disruptive to normal sleep patterns.[2]

It remains unclear if deployment exacerbates a previously undiagnosed sleep disorder or causes sleep disorders in veterans.

2. What is the link between sleep disturbances and other mental health conditions, such as posttraumatic stress disorder?

Sleep disturbance is a key feature of many mental health disorders and has the potential to exacerbate the psychological symptoms that an individual is experiencing as a result of their disorder.[3]

Research has shown that insomnia is a potential risk factor for poor clinical outcomes for psychiatric disorders such as posttraumatic stress disorder (PTSD), depression and suicidality.[4] This relationship is found to be bi-directional, in that sleep disturbance can be an independent risk factor for developing depression, suicidal ideation and PTSD. [5]

Mental health conditions such as depression and PTSD are also highly comorbid with insomnia. It is therefore important to screen for depression, anxiety, PTSD and alcohol misuse if chronic sleep problems are detected.

[1] Commonwealth of Australia, Evidence Compass 'What are effective interventions for veterans with sleep disturbances?', Department of Veterans' Affairs, Canberra, 2014, http://www.dva.gov.au/sites/default/files/Question%206%20Sleep%20Technical%20Report%20November%202016.pdf [2] Commonwealth of Australia, Evidence Compass 'What are effective interventions for veterans with sleep disturbances?', Department of Veterans' Affairs, Canberra, 2014, http://www.dva.gov.au/sites/default/files/Question%206%20Sleep%20Technical%20Report%20November%202016.pdf

[3] The University of Melbourne, 'Military and Veteran Mental Health Annual Literature Scan: 2015', Phoenix Australia: Centre for Posttraumatic Mental Health, Melbourne, 2016, https://phoenixaustralia.org/wp-content/uploads/2016/06/Phoenix-2015-MMHLiterature-Scan.pdf

[4] Commonwealth of Australia, Evidence Compass 'What are effective interventions for veterans with sleep disturbances?', Department of Veterans' Affairs, Canberra, 2014, http://www.dva.gov.au/sites/default/files/Question%206%20Sleep%20Technical%20Report%20November%202016.pdf

[5] Commonwealth of Australia, Evidence Compass 'What are effective interventions for veterans with sleep disturbances?', Department of Veterans' Affairs, Canberra, 2014, http://www.dva.gov.au/sites/default/files/Question%206%20Sleep%20Technical%20Report%20November%202016.pdf

3. What are the current recommended evidence-based treatments for insomnia?

Clinicians are encouraged to promote self-management strategies, such as sleep hygiene, to their patients. These strategies are based on the premise that sleep problems can be developed and/or maintained by a series of problems or habits that are inherently disruptive to sleep. If insomnia persists after the patient has implemented self-management strategies, it may be necessary to consider more formal interventions.

Cognitive behavioural therapy for insomnia (CBTi) is the recommended first-line treatment. CBTi is designed to assist clients in developing healthy sleep habits through a range of behavioural interventions and in challenging the negative thoughts or cognitions that can play a role in maintaining and perpetuating sleep disturbance.

4. What are appropriate medications to use in the treatment of sleep disorders?

Medications for sleep disorders should not be used in isolation. If appropriate, medications should be used in conjunction with psychological treatments.

If medication is considered necessary, non-benzodiazepine hypnotic agents such as zolpidem (e.g. Stilnox) and zopiclone (e.g. Eryc) are the preferred first-line agents.[1] These are preferred as they have a cleaner profile of action, and do not have anxiolytic, muscle relaxant or anticonvulsant properties. They are less likely to distort normal sleep architecture or to cause rebound insomnia or withdrawal syndromes than benzodiazepines.

Benzodiazepine hypnotics are problematic because of the potential for tolerance and dependency, residual daytime cognitive impairment, interference with motor function and association with confusional states and falls in the elderly.[2]

As a general principle, short-term use (less than four weeks) is preferable when using hypnotic medication as this helps to prevent many potential complications. Longer-term use may be required if stopping the medication leads to greater impairment of the veteran's quality of life and if all other treatments have proven unsuccessful. In the longer-term situations, intermittent use is preferable to continuous use. Withdrawal from long-term use should always be tapered slowly.

5. What resources are available to assist clinicians in treating veterans experiencing sleep disturbances?

The Department of Veterans' Affairs (DVA) has developed a range of information and self-help resources to assist veterans in managing sleep disturbances.

The *High Res* website and mobile app can help serving and ex-serving military personnel and their families manage stress and build resilience. The *High Res* website and app include a tool called, Healthy Sleeping, that reviews users' sleep behaviours and tailors advice and tips for improving sleep.

The Open Arms website can help veterans, current serving military personnel and family members identify other symptoms of poor mental health, find self-help tools and advice, access professional support and learn about mental health treatment options.

Clinicians can refer their veteran clients to the Veterans and Veterans Families Counselling Service (VVCS). VVCS provides free and confidential, nation-wide counselling and support for war and service-related mental health conditions, such as PTSD, anxiety, depression, sleep disturbance and anger. Support is also available for relationship and family matters that can arise due to the unique nature of the military lifestyle.

Additionally, Open Arms offers the Sleeping Better program, which is an educational and skills-based group program assisting participants to understand the sleep process and more effectively manage disturbed sleep. The Open Arms

[6] Phoenix Australia: Centre for Posttraumatic Mental Health (2012). *Mental Health Advice Book for Practitioners Helping Veterans with Common Mental Health Problems*, Department of Veterans' Affairs, Canberra, pg 118.
[7] Phoenix Australia: Centre for Posttraumatic Mental Health (2012). *Mental Health Advice Book for Practitioners Helping Veterans with Common Mental Health Problems*, Department of Veterans' Affairs, Canberra, pg 118.

programs calendar provides program dates in locations across Australia. If you have a client you consider may benefit from VVCS support, please call 1800 011 046 to discuss (www.openarms.gov.au).

If clinicians are seeking upskilling training in the assessment and management of common sleep disorders, the APS Institute offers an e-learning Practice Certificate in Sleep Psychology, at http://www.psychology.org.au/APSinstitute/practice-certificate/#s2.

Panellists: Common Sleep Disorders in Veterans

7.15 pm – 8.30 pm AEDT, Tuesday 28 February 2017

Dr Andrea Phelps Clinical psychologist, BA (Hons) MPsych (Clin) PhD

Dr Andrea Phelps is the Deputy Director of Phoenix Australia. She has over 20 years of clinical experience in treating posttraumatic mental health problems. Andrea has led a number of major Phoenix Australia projects including the development of the Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder (2007, 2013). She has also undertaken several projects for the Departments of Veterans' Affairs and Defence, developing treatment programs and self-help resources for service and ex-service personnel with mental health concerns.

Andrea has a particular interest in sleep, including the understanding and treatment of posttraumatic nightmares of PTSD.

Dr Curtis Gray Psychiatrist

Dr Curt Gray is a fellow of the Royal Australian and New Zealand College of Psychiatrists (RANZCP) and has been a registered psychiatrist with the Medical Board of Queensland since 1993. From that time, he ran a successful Brisbane private practice in general adult psychiatry and attended the Princess Alexandra Hospital as a Visiting Medical Officer. From early 2007 to late 2010, he held positions including Clinical Director, and Senior Specialist, at the Gold Coast Hospital Consultation-Liaison Psychiatry Service, and Senior Specialist at The Prince Charles Hospital.

Dr Gray is now in private practice at New Farm Consulting Suites and mlcoa (mlcoa.com.au). He has a major clinical interest, and considerable experience, in the area of Sleep Disorders Medicine, especially the assessment and management of insomnia disorders, as well as a developing interest in trauma-related syndromes including PTSD and depressive disorders. He is a recent member of the RANZCP Federal Committee for Examinations and is a member of the Australasian Sleep Association, where he is involved in the Special Interest Group on Insomnia.

Dr David Cunnington Sleep physician

Dr David Cunnington is a sleep physician practicing exclusively in sleep medicine, managing a broad range of sleep problems including insomnia, snoring and sleep apnea, nightmare disorder and parasomnias. David has a particular interest in complex sleep problems and their interaction with physical and mental health. He trained in sleep medicine both in Australia and Harvard Medical School in the United States. In addition to his clinical work, David has developed the online sleep resource, SleepHub.com.au to provide evidence-based information in sleep for the public and health professionals.

Facilitator: **Professor Mark Creamer** MA (Clin), PhD, FAPS,

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