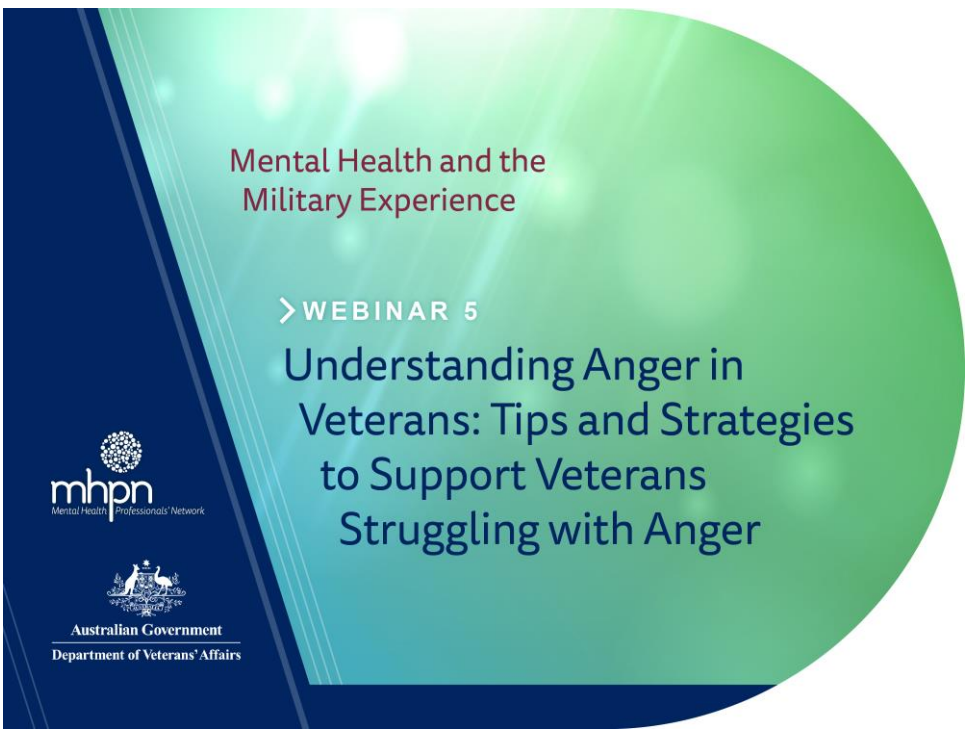

Mental Health and the Military Experience
WEBINAR SERIES
mhpn
Mental Health Professionals' Network
Australian Government
Department of Veterans' Affairs


Mental Health and the Military Experience
WEBINAR 5
Understanding Anger in Veterans: Tips and Strategies to Support Veterans Struggling with Anger
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## Tonight's panel

**Dr Monica Moore**
**General Practitioner**

**Dr Tony McHugh**
**Consultant Psychologist**

**Dr Jonathon Lane**
**Psychiatrist**

**Prof Mark Creamer**
**Clinical Psychologist**
**(Facilitator)**

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## This webinar series

This webinar is the fifth in a series of six and has been made possible through funding provided by the Department of Veterans' Affairs.

Learn more about the Department of Veterans' Affairs by visiting: www.dva.gov.au

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# Learning Outcomes

Through a facilitated panel discussion of Darren's story, at the completion of the webinar participants will be able to:

- better recognise the characteristics, prevalence and risks associated with anger amongst military personnel and veterans
- describe the evidence-based approaches which are most effective in supporting military personnel and veterans struggling with anger
- have increased confidence in supporting and managing military personnel and veterans challenged by anger.

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# GP Perspective

## Personality style

Style influences therapeutic relationship and prognosis.

- 'Inflexible'– responds well to structure, flounders in 'normal' adversity e.g. grief
- Difficulty seeing others' perspectives
- Very high expectations
- Black and white thinking

Dr Monica Moore

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# GP Perspective

## GP Tips

- Be punctual – e.g. schedule appointments at the beginning of the day or after lunch
- Explain rationale for questions, examination, investigations, diagnoses and treatment options
- Explain boundaries early – feelings are normal *internal* processes, some *behaviours* are not acceptable

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# GP Perspective

## First appointment

- Brief history including risk assessment, PTSD screening
- Targeted physical examination
- Relevant investigations (at least FBC, LFT's)
- Validation of experience
- Suggest *prolonged* second appointment

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# GP Perspective

## Second appointment

- GP Care Plan (701-705) – more detailed history
- Biopsychosocial model to plan care (patient decides where to start)
- Offer DVA services (e.g. anger management group, individual)
- Offer regular review

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# Psychologist Perspective

## Dysfunctional anger

- Anger is a normal human emotion. It is functional when expressed at the right time, in the right place and with the right intensity; dysfunctional anger (D/A) is a target for clinical intervention
- D/A's phenomenology is not well-established; among other things, it:
  - Diminishes intellectual performance, task completion & problem solving
  - Leads to mistakes, accidents and mishaps
  - Alienates its sufferers from others (blue singlet brigade)
  - Decreases relatedness across the board ("civilians are knobbers")

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# Psychologist Perspective

## Dysfunctional anger (cont.)

- Frequency, intensity, duration & absorption separate baseline anger from D/A
- Prevalence unclear - IED 4% (DSM-5); CVs >st angry mil. group yet (Elbogen et al., 2010)
- When present in an ongoing, smouldering form, anger is associated ++ with increased morbidity and mortality (ref. cardiac disease literature).
- These = key motivational points: "angry people" lose (but fail to understand this)

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# Psychologist Perspective

## Anger treatment works: the evidence base

| Author(s) | Sample | Studies | Effects | Comments |
|---|---|---|---|---|
| Tafrate (1995) | Adults | 17 | ESs fr 0.82 to 1.16 | Skills Training (ES = 0.82)<br>CT (ES = 0.93)<br>Multicomponent (ES = 1.00)<br>Relaxation (ES = 1.16) |
| Bowman-Edmondson & Cohen-Conger (1996) | Adults | 18 | ESs fr 0.64 to 0.80 | Social skills (ES = 0.90)<br>CT (ES = 0.96)<br>CT-relaxation (ES = 1.04)<br>Relaxation (ES = 1.19) |
| Beck & Fernandez (1998) | Adults | 50 | Weighted μ ES of 0.70 | Treated better than 76% of untreated |
| DiGiuseppe & Tafrate (2003) | Adults | 57 | Overall ES size of 0.71 | Various treatments had differential effects on specific aspects of anger |
| Del Vecchio & O'Leary (2003) | Adults | 23 | Medium to large ESs | Various treatments had differential effects on specific aspects of anger |
| Sukhodolsky, Kassinove & Gorman (2004) | Children & adolescents | 40 | Overall ES = .67 | All RXs had medium ESs - skills training, problem solving, affective education & multimodal Rx obtained *ds* of .79, .67, .36 & 0.74 respectively |

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# Psychologist Perspective

## The art of treatment

- Be knowledgeable (see "much is known about anger" slide)
- Be methodical & structured - manualised interventions maximise outcomes
- Adopt a model of anger in PTSD [*e.g., Taft/Berkowitz (network/neo-associationist model), Selye/Chemtob (dysregulation/survivor mode model); Bandura/Keane (learned behaviour modle), Greenburg/Feeny (avoidance model)*] that informs your work and the client

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# Psychologist Perspective

## The art of treatment (cont.)

- Persist in it: there are rarely quick fixes *(the 7 Ps / eyes on the prize versus what do I want and when do I want it)*
- Apply what works (see evidence base slide) - i.e., CT, relaxation training *(Peeking into the black box - MacKintosh et al., 2014)*, combination approaches and, above all, experiential interventions (no light bulb; beware of nature in vivos)
- Self Instruction Training (SIT; Meichenbaum/Novaco) has particular promise (but has recently been overlooked)

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# Psychologist Perspective

## Much is known about the nature of anger

- Anger is often an avoidance emotion and strongly related to other -negative emotions
- Anger is an externalising emotion and often not about the present – need to take account of pre, peri and posttraumatic factors to understand it *(the iceberg of emotion)*
- There is a neurobiology of anger that interacts with the mind
- Anger can be volitional & involuntary (each are associated with rumination)

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# Psychologist Perspective

## Much is known about the nature of anger (cont.)

- After trauma anger is most common where PTSD is present and predicts and prolongs PTSD (chronicity) and mediates its treatment efficacy (perhaps more so than anxiety or depression)
- Anger and intrusions are associated (by memory content and mental process variables)
- Lone US study suggests those who report PTSD SXs, but fail to meet diagnosis, show more trait anger, hostility and aggression than those who report no SXs (Jakupcek et al., 2007)
- None of this is well understood by clients - it is our job to facilitate

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# Psychologist Perspective

## Tips

- Declare your position(s) from the start (you are there to treat, not confirm views)
- Encourage clients to u/s being angry doesn't address underlying causes of distress (the elevator of affect)
- Know and work with common cognitions; e.g., those around
  - "Those who don't acquiesce are the enemy" (family included)
  - What people should or should not do (the six)
  - Rules must be obeyed, provocations and barbs abound (the world is full of idiots)
  - Risk
  - Disrespect and entitlement
  - Trauma specific themes (responsibility, teamwork)

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# Psychologist Perspective

## Tips (cont.)

- Work with inter-related emotions (esp. anxiety, depression and emotions of responsibility)
- Normalising experience by reference to quotable quotes is very useful
- Slowness and flexibility of thinking are key to remediation
- Choose language and metaphors carefully - do not be opaque
- Engage in supervision with someone with expertise in the area and look after yourself

Dr Tony McHugh

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# Psychiatrist Perspective

- Anger is a trained response for Military people
- It is one of the few 'safe' emotions veterans know and understand, along with satisfaction and pride in one's work or performance

Dr Jon Lane

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# Psychiatrist Perspective

- Anger is often about emotional dysregulation
- It is an emotional response to a situation or problem, which often leads to behaviours that increase the problems for the individual, and so it becomes a self-reinforcing negative feedback loop
- We need to identify the underlying problems, not just focus on the symptoms of anger

Dr Jon Lane

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## Questions and answers




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## Help guide tonight's discussion

The following themes were identified from the questions you provided on registration:

1. **Assessing & diagnosing anger**
2. **Managing risk/de-escalation techniques**
3. **Influence of military culture**
4. **Partners & families**
5. **Links with other conditions (including PTSD)**

A pop up will appear on your screen shortly listing the themes. Choose the one you'd most like the panel to discuss.

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## Local networking

- **Interested in leading a face-to-face network of mental health professionals with a shared interest in veterans' mental health in your local area?** MHPN can support you to do so.
- Provide your details in the relevant section of the feedback survey. MHPN will follow up with you directly.
- For more information about MHPN networks and online activities, visit www.mhpn.org.au.

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## Panellist and DVA recommended resources

- For access to resources recommend by the Department of Veterans' Affairs and the panel, view the supporting resources document in the documents tab at the bottom right of the screen.

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## Thank you for your participation

- Please complete the feedback survey before you log out (it will appear on your screen after the session closes).
- Attendance Certificates will be emailed within four weeks.
- You will receive an email with a link to online resources associated with this webinar in the next few weeks.
- The next webinar in the series will focus on families and partners of veterans and will be broadcast sometime in September/October 2017.

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