

Mental Health Advice Book

for treating veterans with common
mental health problems



MAXIMISING MENTAL HEALTH. MINIMISING MENTAL ILLNESS.



Australian Government
Department of Veterans' Affairs



Australian Centre for
Posttraumatic Mental Health



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Prepared for the Department of Veterans' Affairs by
the Australian Centre for Posttraumatic Mental Health

Revised in 2012.



Australian Government
Department of Veterans' Affairs

 Australian Centre for
Posttraumatic Mental Health

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DVD

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This book, its accompanying DVD and online resources (available from www.at-ease.dva.gov.au) have 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 book 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.

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Foreword

Veterans' mental health problems are as varied as the conflicts in which our ex-servicemen and women have served. Health practitioners may treat an ex-prisoner of war from World War II, a Vietnam veteran, a woman in her thirties who served as a peacekeeper in Rwanda and East Timor or a soldier having served multiple deployments in Afghanistan. While their problems and the treatment they receive may be unique, veterans share a common military culture. Although it has certainly changed over the years, an understanding of this culture will greatly assist all health practitioners provide the most appropriate treatment for veterans. At the same time, practitioners can be reassured that they can help veterans with mental health problems with much the same interventions as they use to help the general community, with an approach tailored to the veterans' needs.

Society's understanding and acceptance of mental health problems has improved dramatically since the men and women who served in World War I returned home to the care of dedicated repatriation hospitals. Views about where to provide mental health treatment have changed considerably since then. Like all of us, veterans benefit from being treated in the community, close to family and friends with as little disruption as possible to their daily routines.

This book provides information and advice to practitioners in all health services in recognising, assessing and treating veterans' common mental health problems. It will also increase practitioners' awareness and knowledge of more specialist mental health advice, services and referral options. Originally published in 2007, this publication has now been updated, drawing upon the latest Australian and international best practice guidelines.

Busy health practitioners can dip in and out of the different sections in this book, seeking information on, for example, anger management or to review treatment options for panic disorder or problem drinking. A tailored section for General Practitioners comprises brief summaries outlining screening, patient advice, evidence-based treatment and referral options. Regardless of particular interest or specialty, we strongly encourage everyone to read 'Understanding the Veteran Experience' in Part I, Chapter 2, for a comprehensive background into military experience and its potential impact on mental health and on families.

While there is a range of resources available to practitioners on specific mental health problems, we believe that this book is unique in bringing together information on the assessment and treatment of veterans' common mental health problems. We would like to thank the dedicated team of mental health professionals who produced this resource, as well as the working practitioners and members of the veteran community who reviewed it. Their insightful comments have served to strengthen the information provided.

The mental health of the servicemen and women who served our country is everybody's business. We are pleased to provide the foreword to this excellent resource and strongly commend it to all health practitioners with an interest in mental health.

Dr Graeme Killer AO

Principal Medical Adviser
Department of Veterans' Affairs

Major General Mark Kelly AO, DSC

Repatriation Commissioner

Contents

Foreword	iii
Acknowledgements	vi
Introduction	1
Part 1: Understanding veterans and their families	
Understanding the veteran experience	5
Impact of veterans' experiences on their families	12
Part 2: Advice for general practitioners	
Summary advice on screening and management of common mental health problems in general practice – including individual 'quick-reference' summary sheets	17
Part 3: Assessment, formulation and treatment of common mental health problems amongst veterans	
Depressive disorders	75
Anxiety disorders	80
Trauma- and stressor-related disorders	88
Somatic symptom disorders	93
Substance use disorders	97
Complicated grief	108
Associated complaints	111
Cognitive impairment	121
Comorbidity and case formulation	127
Appendices	
Appendix A: Overview of main interventions for the clusters of mental health problems	133
Appendix B: Key components of cognitive behavioural therapy for the treatment of veterans' mental health problems	135
Appendix C: Assessment measures	141
Appendix D: Psychoeducation script outline	156
Appendix E: Self-monitoring sheets	157
Appendix F: Pleasant events schedule	162
Appendix G: Progressive muscle relaxation	163
Appendix H: Breathing retraining instructions	165
Appendix I: 5A's smoking cessation framework	166
Appendix J: Where veterans can get more help	168
Appendix K: Case formulation template	169
Appendix L: Veteran education handouts	171
References	195
Acronyms	201

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Introduction

Purpose of this book

The Department of Veterans' Affairs (DVA) has developed this advice book to assist health practitioners to deliver the most effective mental health treatments for veterans. It draws upon the latest Australian and international best practice guidelines for the treatment of common mental health problems. The book aims to update practitioners who regularly treat veterans, as well as inform those who may be less familiar with veterans' mental health issues.

This book is designed to help most practitioners apply their existing mental health knowledge and expertise to veterans. General practitioners (GPs) and mental health professionals can help veterans with mental health problems using many of the same approaches used to help other people with similar conditions. However, practitioners may need to modify aspects of their treatment to take into account the influence of military experiences on veterans and their family.

Common concepts and terminology are provided to assist in engaging the veteran and his or her family in the development of a treatment plan and to facilitate communication among health practitioners about treatment goals and approaches.

This book has been developed to support all community services in Australia to be more sensitive and skilled in assessing and treating veterans' mental health needs and to increase awareness and knowledge of more specialist mental health advice and services.

How to use this book

Although the book can be read from cover to cover, it has been written so that practitioners can dip in and out of relevant chapters. As a result, there is some unavoidable repetition to ensure that readers can quickly obtain the information they require in the one place.

The book has been divided into sections to help guide different health professionals to the information most useful to them. Some sections are aimed primarily at GPs while others have been written with mental health practitioners such as psychologists and social workers in mind.

Part 1 Understanding veterans and their families provides background information about Australia's veteran community, the common mental health problems some may face and how these should be assessed.

Part 2 Advice for general practitioners is aimed primarily at GPs and comprises brief summaries outlining screening, patient advice, evidence-based treatment and referral options for common mental health disorders.

Part 3 Assessment, formulation and treatment of common mental health problems amongst veterans is aimed primarily at mental health practitioners and contains more detailed information on the assessment and treatment of common mental health disorders.

Diagnostic system used in this book

As a general rule, descriptions of mental health problems in this book are based on the Diagnostic and Statistical Manual (DSM) system. We are aware that some practitioners may be using other diagnostic systems. For example, Medicare treatment plans require an International Classification of Diseases (ICD) diagnosis. Therefore, our descriptions are intended to be as inclusive as possible and reflect the realities of day-to-day practice, and are not exact reproductions of DSM criteria. Note also that at the time of writing, the DSM was under revision, and while we have tried to be consistent with proposed changes, the final diagnostic criteria in DSM-5 may differ slightly to what is presented here.

Evidence for the advice in this book

This book is based upon evidence available up to the end of 2011, and has drawn on a number of best practice guidelines, as well as obtained evidence from evidence-based literature such as published reviews and meta-analyses.

The following best practice guidelines have been drawn from:

- Fourth edition of the *Management of Mental Disorders* (WHO 2004)
- Australian and New Zealand College of Psychiatry guidelines for the treatment of depression and panic disorder and agoraphobia (available from www.ranzcp.org)
- *Australian Guidelines for the Treatment of Adults with Acute Stress Disorder and Posttraumatic Stress Disorder, 2007* (available from www.acpmh.unimelb.edu.au)
- United Kingdom National Institute for Clinical Excellence guidelines for the treatment of depression, panic disorder and agoraphobia, posttraumatic stress disorder (PTSD) generalised anxiety disorder, alcohol use disorders, and drug misuse (available from www.nice.org.uk)
- American Psychiatric Association guidelines on the treatment of depression, panic and agoraphobia and PTSD (available from www.psych.org)
- United States Veterans' Administration/Department of Defence *Clinical Practice Guideline for Management of Post-traumatic Stress* (2010) (available from www.healthquality.va.gov)
- Canadian Psychiatric Association *Clinical Practice Guidelines for the Management of Anxiety Disorders* (2006) (available from www.cpa-apc.org)
- *Smoking Cessation Guidelines for Australian General Practice* (2004) (available from www.health.gov.au)
- National Health and Medical Research Council (NHMRC) *Australian Guidelines to Reduce Health Risks from Drinking Alcohol* (2009) (available from www.nhmrc.gov.au)
- Australian Government Department of Health and Ageing *Guidelines for the Treatment of Alcohol Problems* (2009) (available from www.health.gov.au)
- NHMRC *Guideline for Screening, Assessment and Treatment in Problem Gambling* (2011) (available from www.nhmrc.gov.au and www.med.monash.edu.au)

As there are no formal international or national guidelines in areas such as social phobia, problematic anger, cognitive impairment, or somatic symptom disorders, advice regarding these conditions is based on the published reviews and meta-analyses of the evidence-based literature. It is important to note that recommendations regarding somatic symptom disorders have been made on the basis of limited empirical evidence.

This information has been synthesised by expert clinicians with extensive experience in veterans' mental health from the Australian Centre for Posttraumatic Mental Health, a Centre of Excellence located at the University of Melbourne and supported by the Australian Government. The book was developed in liaison with the Mental Health Programs Section of the Department of Veterans' Affairs (DVA) and is endorsed by the Principal Medical Adviser, Dr Graeme Killer AO. The Royal Australian and New Zealand College of Psychiatry (RANZCP), Australian Psychological Society (APS), Australian Association of Social Workers (AASW), as well as representatives from VVCS - Veterans and Veterans Families Counselling Service (VVCS) and Defence Health Service were consulted during the review of this book. A range of metropolitan, rural and remote GP practices also tested relevant sections of the book, and the accompanying online resources developed for GPs (available from www.at-ease.dva.gov.au).

Limitations of this book

The advice in this book assumes that treatments are being provided by professionally qualified and competent health practitioners working in accordance with the National Practice Standards for the Mental Health Workforce, as well as discipline-specific practice standards and competencies.

The advice is not designed to substitute for the knowledge and skill of competent individual practitioners, which are best assessed against the professional standards prevailing at the time. It should not be used as an inflexible prescription concerning the content of treatment, but as a framework of best practice around which treatment should be structured. The advice is also not designed to limit treatment innovation and development based on scientific evidence, expert consensus and practitioner judgment for the needs of the client group concerned.

This book does not address less common mental health problems such as psychotic disorders, nor does it cover all of a veteran's psychosocial difficulties such as relationship, family, social or vocational problems. These problems are important in their own right and should be addressed in the context of the focussed mental health interventions outlined in the book.

The recommendations represent best practice as at the date of publication and, given the pace of advances in knowledge, will require review and updating at three-year intervals.

Understanding the veteran experience

For many veterans, military service and operational deployment lead to a strong sense of identity and belonging. For clinicians working with veterans, demonstrating an understanding of the military experience can greatly enhance the therapeutic alliance and the delivery of effective treatment. Veterans are more likely to engage with health care practitioners whom they feel understand, or seek to understand their mental health problems within the context of their military service. This chapter provides a demographic overview of Australia's veteran population, common mental health problems within the veteran community, and a summary of the military experience.

Australian veterans

Since federation, approximately 1.4 million Australian men and women have served with Australian military forces in wars and peacekeeping operations. Amongst those alive today, the majority are males aged 60 years and over. World War II veterans are the largest group (around 77,400), followed by Vietnam veterans (around 47,000) and approximately 14,700 veterans of the Korean War, Malayan Emergency, Indonesian Confrontation and other operations in Southeast Asia. The 1990s saw the Australian Defence Force (ADF) engaged in a new wave of overseas deployments, with approximately 1,200 personnel serving in the First Gulf War and an estimated 5,000 engaged in peacekeeping operations in places such as Cambodia, Somalia and Rwanda. Since 1999, it is estimated that a further 45,000 ADF personnel have served in peacekeeping operations and in areas of conflict, including East Timor, Afghanistan and Iraq (Department of Veterans' Affairs, 2011).

Practitioners may see veterans or ex-service personnel, either men or women, ranging in age from as young as 18 to over 80, with increasing numbers of women joining the veteran ranks. As the composition of the veteran population changes, so too have their mental health needs. At one end of the spectrum are the World War II, Korean and Vietnam veterans, for whom issues of ageing and chronic disease can be an important consideration. At the other end are currently serving and recently discharged ADF personnel who have engaged in a range of warlike, peacekeeping and peacemaking deployments, as well as disaster response operations. These younger, or 'contemporary' veterans are more likely to have experienced multiple, high tempo deployments. Apart from deployment cycles, frequent relocations within Australia can result in a sense of dislocation for the veteran and their family, and combined with the often remote locations of ADF bases, this can limit consistent access to medical and mental health services. Currently serving veterans may also be concerned about career progression and limited opportunities for re-deployment when mental health issues are identified.

Recent conflicts and peacekeeping missions arguably involve fundamentally different types of conflict to previous engagements. For example, deployment to the Middle East may involve the ongoing threat of insurgent combatants, urban conflict amongst non-combatants, and increased prevalence of Improvised Explosive Devices. Many veterans describe the extraordinary demands of constantly facing the threat of death or serious injury. Additionally, complex rules of engagement and lines of command within multinational forces can increase the level of stress on Defence members on deployment, particularly in peacekeeping and peacemaking operations.

Veterans' common mental health problems

The common mental health problems of veterans fall into five broad and overlapping clusters.

Common mental health problems amongst veterans

Depression problems	mood disorders, including major depressive disorder and dysthymia
Anxiety problems	e.g., generalised anxiety disorder, panic disorder with/without agoraphobia and social anxiety
Substance use problems	problem drinking, alcohol dependence, medication misuse, and illicit drug use
Adjustment problems	posttraumatic stress disorder (PTSD), complicated grief
Somatic problems	medically unexplained symptoms, e.g., psychogenic pain

While many of these presenting problems may be sufficiently significant to meet full diagnostic criteria, a large number of veterans are likely to present with partial syndromes of a disorder.

Comorbid mental health problems are common, particularly posttraumatic mental health problems, where substance use problems are present. For some veterans, many years may have elapsed between the time when mental health symptoms first appeared and when they were recognised and treated. This may have led to additional difficulties, as their relationships, their ability to participate in work and social activities, and their health may have been affected over long periods of time.

Many veterans present with more generic yet significant complaints such as sleep disturbance, problematic anger, vocational, parenting or relationship problems. Where practitioners identify such problems, they should investigate potential underlying mental health issues.

Impact of military service

A veteran's military experiences may have taken place many years in the past or more recently, and they may have been deployed to different types of operations. Some ex-ADF members may not have participated in deployment that involved war or peacekeeping duties but may have nonetheless been deeply affected by experiences such as humanitarian deployments (such as the one to Aceh following the 2004 tsunami) or training accidents (e.g., the 2006 Black Hawk training accident or the 1964 HMAS Melbourne-Voyager collision that resulted in 82 deaths). Regardless of their timing or nature, a veteran's experiences can have a lasting and profound influence. There are at least two readily identifiable reasons for this enduring impact. First, most veterans join the services as young adults, an important time in life for shaping values, beliefs and attitudes. Because they were socialised into military culture at a time when they were malleable, many will have adopted military values and ideals as their own. Second, during service, many of the highest impact experiences will have occurred during times of extreme stress, in some cases during life-threatening situations. What is learned under these conditions can be resistant to change because it is associated with survival.

There is a range of service-related experiences that may need to be considered when working with a veteran. While some of these experiences can help protect a veteran from the impact of stress and mental health problems, they can also lead to tension, particularly in a civilian setting. Others can contribute to, or exacerbate mental health problems. These experiences do not apply to all veterans, nor are the mental health problems described in this Advice Book an inevitable consequence of the events experienced. This summary includes recent research findings and subjective reports of many veterans with mental health problems. It is important to note that while some veterans readily identify the impact of service-related experiences on their current feelings and behaviours, for others, the connection may not be as evident, particularly if habits linked to their military experience were formed many years ago.

Military as family

An important component of socialisation into military culture is strong identification as a member of the group (often referred to as 'family') over and above an identity as an individual.

Veterans often describe this socialisation as being achieved by breaking down the individual identity through means such as:

- a regimented lifestyle
- having the same uniform and hair cut
- the inculcation of a common set of attitudes, beliefs and moral values.

Identity as a member of the group is then further reinforced through:

- group consequences for an individual's actions
- the emphasis on strength as a member of the group
- the inculcation of the belief that the survival of the individual and group are inter-dependent
- a perception of vulnerability as an individual
- a belief in the superiority of service personnel over civilians.

The legacy of military service can often be seen in a veteran's strong identification with other veterans, which brings with it a sense of personal identity and value, a sense of belonging and connectedness, as well as affording a sense of security or protection. The other side to this coin can be a mistrust of others who are not part of the 'group' and the uncritical adoption of attitudes and beliefs expressed by one or more of the group with whom the veteran may identify.

Standards and expectations

Military training promotes strict conformity to high standards of behaviour in terms of discipline, punctuality, orderliness, cleanliness, obedience and attention to detail. Lives may depend on these behaviours in the face of a military threat. Training also promotes aggression in the face of perceived threat. With the combination of these factors, veterans can react in what may be judged by others to be an 'over the top' way, for example, when they are kept waiting or when things do not run according to plan. These high standards of behaviour can influence parenting, for example, the veteran's expectations around 'normal/acceptable' child/teenage behaviour may differ from other parents. In addition, veterans may also have difficulty adapting to the less rigorous and less structured nature of non-military life.

The military culture privileges strength, competence and the ability to adapt and overcome. Veterans can strongly believe that they should be able to cope without assistance and that seeking help is a sign of weakness (Gibbs, Olmstead, Brown, & Clinton-Sherrod, 2011). For veterans who are still serving, there can be fears about the repercussions of seeking help and whether this will affect re-deployment, and these fears can transfer to another career path they may have chosen post separation (Hoge et al., 2004).

Exposure to inhumanity

Beyond military culture and training, many veterans have had experiences in the course of service which have led them to think of themselves as fundamentally different to civilians. Many of these experiences relate to their exposure to people's capacity to behave inhumanely towards others. In war, service people are required to overcome their natural reluctance to kill another human being, which requires, amongst other things, learning to 'dehumanise the enemy'. Many struggle within themselves to reconcile this with their personal values and beliefs, and feel that they have been changed as a result. This is often described as a 'loss of innocence'. Some peacekeepers refer to the 'soul-destroying' experience of witnessing atrocities of one group of people against another. They have the training to intervene, but often they do not have the authority.

This direct experience of inhumanity can result in veterans feeling different and misunderstood by civilians. Some are left with hatred and closely aligned fear of people from the ethnic group who were 'the enemy'. For some veterans, the sights and sounds associated with particular cultures can serve as powerful triggers to re-experiencing trauma.

Some veterans may question whether a non-military practitioner could help them without having experienced conflict themselves. Other veterans may fear that the practitioner will not be able to cope with the information provided to them about the veteran's experiences of conflict.

Entitlement

Service people deployed overseas in war zones or peacekeeping missions are required to 'put their lives on the line' for their country. While this is accepted as part of the job, it can become a source of bitterness and resentment for veterans who feel that the public or government have not appreciated their sacrifice, or the 'ultimate sacrifice' of mates who have been killed. Many veterans from both past and present conflicts feel let down by the government and society for whom they were prepared to die, when they are left with mental health problems following their service and feel that they have to fight for recognition. While they may indeed be entitled to care as defined in legislation, eligibility needs to be established in each case. Some veterans may have a low tolerance for the process of establishing entitlement.

Community attitudes

The experience of Vietnam veterans highlights the difficulties caused by public opposition to a conflict. The experience of many Vietnam veterans was that instead of being welcomed home as heroes, they were confronted with moratoriums, ostracised by their peers, and vilified as 'baby killers'. Many speak of leaving a war zone only to be confronted by another 'enemy at home'. While there were many locally organised welcome home parades for Vietnam veterans, there was no official national welcome home parade until 1987, almost 15 years after the war in Vietnam had ended. For many Vietnam veterans, this was a devastating experience, which reinforced their perception that there was a clear divide between 'them' (civilians) and 'us' (veterans) and the associated mistrust of those outside the group. Some Vietnam veterans do not, even now, disclose their service to others, for fear of negative judgment.

Due to the experience of Vietnam veterans, care has been taken by politicians and the public opposed to Australia's participation in war or peacekeeping missions, to separate their opposition to government policy from their opposition to the troops themselves. Although there has been more support for the veterans of recent deployments, these veterans can still experience difficulty reintegrating and redefining their role within the community and their family. Indeed, some veterans claim that reintegration can be more difficult than the experience of deployment. Similar to Vietnam veterans, veterans of more recent operations may also feel unable to discuss their military experiences with the general community, believing that their experiences would not be understood, or that the community may judge their actions.

First impressions and relationship building

Generally, military culture values strength and stoicism over 'softer' emotions such as fear or sadness. The acknowledgement of mental health problems can be seen as personal failure and associated with shame. However, this is unlikely to be acknowledged at the outset and may be concealed behind a shield of anger or blame. Difficult emotional, relationship or behavioural problems are also unlikely to be acknowledged at the start of treatment and may be concealed or minimised. In addition, veterans may hold a belief that the problems that they are experiencing will resolve over time without input from a health professional, or conversely, that their mental health issues will never resolve and that there is little to be done that can help.

Veterans may not present to a general practitioner or mental health professional with apparent mental health issues, instead they may present with physical health symptoms which may mask their mental health symptoms such as fatigue or difficulty sleeping (Cooper, Creamer & Forbes, 2006). In addition, it may be unclear that the person presenting to the service is a veteran. Practitioners should take notice of whether a client has a history with the Defence forces, or have accepted conditions or claims pending with DVA.

Practitioners who seek to understand the veteran's experience are much more likely to gain their trust. To varying degrees, demonstrating understanding can help to establish rapport, assist the development of an appropriate treatment plan via case formulation, and provide insights into potential barriers to treatment. Practitioners need to be prepared to give the process of engagement and assessment sufficient time, such as providing a longer initial consultation time. Veterans need to feel that practitioners have the time and inclination to listen and have the capacity to tolerate what veterans tell them whilst still maintaining a positive regard for them. It is important for practitioners to be aware of their own thoughts and biases about war and military service and to be mindful of the effect of these on their work with veterans.

The following are four important practices, derived from the principles of motivational interviewing (Miller & Rollnick 2002), for effectively helping people with mental health problems:

- Express empathy — acceptance and reflective listening facilitates change and ambivalence is normal.
- Promote awareness of the consequences of unhelpful behaviours — discrepancies between present behaviour and important goals will motivate behaviour. The veteran should ultimately present his or her own arguments for change.
- Avoid argument — arguments are counterproductive as defending breeds defensiveness. Take resistance as a signal to change strategies. Often labelling the veteran with a diagnosis is unnecessary. Offer, but do not impose new perspectives, as the veteran is the most valuable resource for finding solutions.
- Support a belief in the possibility of change — this is an important motivator. The veteran is responsible for choosing and carrying out most interventions, and there is a range of interventions available to choose from.

Veteran case studies

The following case studies illustrate the range and diversity of veterans' mental health problems and available treatments. The cases of Ron, Tim and Lisa can be found on the accompanying DVD, and are referred to on page 127 on comorbidity and case formulation.

Ron: 62 year old Vietnam veteran

Ron is presenting for counselling following his reaction to a television program commemorating the anniversary of the Battle of Long Tan. He has attended counselling intermittently over a number of years. Ron has been retired for the last six years after he had a claim accepted for alcohol abuse and PTSD in relation to several events in Vietnam involving deaths in his platoon and civilian deaths. He is highly avoidant of reminders of Vietnam. Ron has a long established pattern of dependent drinking, consuming between 10 and 20 standard drinks per day. He is on high levels of codeine in relation to a hip injury sustained in Vietnam. He has very high social anxiety and has experienced panic attacks, so he prefers to stay at home. He gets very upset at perceived criticism of having served in Vietnam. Ron and his wife have little interaction but no intention to separate. His relationship with his children is also distant. He has difficulty remembering the steps needed to accomplish tasks he used to do on a routine basis and this is the case even when he has not been drinking. He is easily frustrated when trying to complete these tasks.

Ron's diagnoses include PTSD, alcohol dependence, social anxiety and panic disorder. Ron's chronic hip pain is also a significant issue which leads to potential prescribed medication misuse and which may be exacerbating his PTSD symptoms. Although Ron has attended counselling intermittently for a number of years, his case notes indicate that he has not engaged particularly well and has experienced little change in presenting problems.

Adam: medically discharged army private

Adam is presenting to his GP seeking advice regarding further surgical options for his knee, which was injured during training. At 22 years of age, Adam was given a medical discharge from the army because he did not regain full use of his knee following reconstruction surgery.

Adam is unable to return to military duties even after his reconstruction surgery, and has been medically discharged from the ADF. He is struggling with his transition to civilian life. He is also feeling bitter and angry about his unsuccessful appeal against his discharge. He is angry and agitated by his inability to recover from his knee injury and to return to the army. He feels a loss of control about his future as he is now unable to pursue his chosen career. Contributing to Adam's distress is his concern about his financial security, future medical expenses and uncertainty about his career options.

Adam appears restless and irritable and says that he has not been sleeping well since the appeal decision. He has trouble enjoying any activity and he has become increasingly pessimistic.

Adam's diagnosis is of an adjustment disorder with both anxiety and depression. These problems have been caused by the stress associated with his knee injury and subsequent loss of function.

Adam is referred to a private psychologist who provides cognitive and supportive therapy and psychosocial rehabilitation. Adam discusses antidepressant medication with his GP, and they identify further psychological care as his symptoms are beginning to settle. Given the importance to Adam of being active and productive, he sets a treatment goal with his psychologist to be well enough to resume employment. After six further sessions his symptoms are sufficiently settled, allowing Adam's GP to refer him to the DVA Veterans' Vocational Rehabilitation Scheme. He is then sent to the Commonwealth Rehabilitation Service where active vocational rehabilitation begins.

Frank: World War II veteran

Frank is an 86-year-old married, retired boot maker presenting to his GP with breathing difficulties and chest pain. Recent medical investigations have cleared him of significant cardiac disease and he has mild emphysema because he is an ex-smoker. He had successful surgery five years ago to remove a bowel cancer, suffers tinnitus and has painful knees due to osteoarthritis. He is concerned he will have a heart attack and that his wife will not cope without him. She has arthritis in her hips and he doesn't want her to have joint replacement surgery in case she has to be away from home for too long. Frank also mentions his concerns about his 52-year-old daughter who has just gone through a divorce. Other fears are expressed, including his ability to pay bills, the future of the country, and worries about young people in general.

Frank's wife reports that her husband gets very panicky and agitated watching the television news, and has become increasingly forgetful. He lost his car at the shopping centre recently, muddles his medications and has forgotten his grandson's name. He has taken to reminiscing mainly about the war and his veteran mates who have died.

Examination reveals slightly increased heart and breathing rates, sweaty palms and a fine tremor. A mental state examination reveals memory impairment with 0/3 recall, disorientation in time, and two errors performing serial 7s. He is unchanged medically, but conveys considerable anxiety and excessive worry. Frank is diagnosed as having generalised anxiety disorder, health anxiety, cognitive decline and medical comorbidity.

Treatment is aimed at anxiety management, specifically his generalised and health-related anxiety. An aged care assessment will involve a home assessment to consider aids and services that may improve the couple's functioning. A referral to a memory clinic or geriatrician may lead to nootropic treatment if Alzheimer's dementia is diagnosed. Psychotherapy aiming to provide relaxation skills, psychoeducation and support can be complemented by suitable group therapy where socialisation, reminiscence and occupational therapy can be provided. Introduction of low-dose antidepressant medication, cautiously monitored and increased as required, may also reduce the severity of the anxiety.

Tim: 28 year old, ex-ADF

Tim is presenting for his first counselling session. He has served in Afghanistan and has witnessed multiple deaths, including that of a mate, and once felt threatened and trapped for several hours when under fire. Tim has had a claim accepted for PTSD. He experiences frequent nightmares and daytime intrusive images of events in Afghanistan in which feelings of helplessness and fear overwhelm him. He consumes 15 or more standard drinks over three to four hours several times a week. He tends to use alcohol when he is feeling vulnerable or frustrated. He smokes two to three cannabis joints daily. Occasionally he will use methamphetamine at a party.

Tim has intermittent bouts of extremely low mood associated with suicidal ideation. In fact, there have been a number of occasions when Tim was involved in self-destructive impulsive behaviours (e.g., driving at full speed towards a tree and stopping at the last minute) following a drinking bout. Angry outbursts are common for him. Tim has been involved in a few fights

outside nightclubs. On several occasions he has hit his girlfriend after she resisted his attempts to limit her access to friends or when he has been unable to contact her. Tim's diagnoses include PTSD, substance and alcohol abuse and depression.

Tim currently lives with his girlfriend, has limited contact with his sister and almost no contact with his mother and father. As a child, Tim was frequently "belted" by his veteran father for disobeying directives. Tim has presented at treatment after an ultimatum from his girlfriend to receive help or otherwise she will leave the relationship. Tim is adamant that he will be OK if other people do not "get on his case" or in his way.

Tim is easily frustrated, and he reports feeling generally negative and cynical, including being sceptical as to the value of treatment. Tim states that he is not interested in talking about his experiences in Afghanistan. He states that no amount of talking will change the way he feels and that only people who have served in Afghanistan can understand his experience.

An assessment of risk, both in terms of self-harm and harm to others, is one of the first steps in Tim's treatment. A separate interview with his girlfriend will need to be conducted in order to establish her safety. A treatment plan is developed which will initially focus on psychoeducation about PTSD and reducing Tim's substance and alcohol intake. By reducing Tim's substance and alcohol use, he will be better able to address his PTSD symptoms. To help prepare Tim to address his PTSD and to minimise the risk associated with his impulsive behaviours, the counsellor will also need to spend time helping Tim learn to manage and regulate his emotions. Tim will then begin confronting his traumatic memories through trauma-focussed therapy.

Lisa: 32 year old, ex-ADF peacekeeper

Lisa served in East Timor when she was 23 years old. She has presented for counselling to address poor sleep patterns. When she lies awake at night she thinks about her experiences in East Timor over and over again and sometimes has nightmares. In East Timor, she felt powerless to affect much change amidst what she saw as widespread devastation and need, and now feels guilty that she returned to Australia just when she felt some children had begun to trust her. She also becomes frustrated when faced with everyday concerns of civilians, stating that it distresses her greatly when Australians "complain about trivialities", when the people in Timor were facing very difficult conditions. She is unable to resume sleep for the night unless she takes a "sleeping tablet" prescribed by her GP. She is concerned about the fact that she has begun to use the medication to manage her anxiety during the day. She has started to doctor-shop to meet her increased need for medication. Her mood is low; she has a low energy level, and has lost interest in activities that used to be important to her.

All aspects of Lisa's life have been unravelling, leaving her without the support or sense of accomplishment she needs. Her difficulty in concentrating at work, and frequent absenteeism, is being "performance managed" by her supervisor, an experience she describes as "humiliating". Lisa lives alone in a small flat. Her relationship with her once close family (specifically her sister and her mother) is deteriorating; she does not return their calls. She now finds socialising very stressful, and tearfully said that it's "all becoming too much to bear".

Lisa's initial diagnosis includes depression characterised by difficulty sleeping, rumination, guilt, low mood and reduced energy. She is also showing strong indications of substance dependence.

Lisa is referred to her local VVCS where she receives cognitive behavioural therapy aimed at reducing her use of sleeping tablets and her depressive symptoms. Lisa agrees to ask her mother and sister to attend a counselling session to provide them with psychoeducation about depression and provide an insight into Lisa's experiences. She also agrees for the counsellor to talk to her workplace and organise support so that she does not lose her job and has a plan to return to more meaningful duties.

Impact of veterans' experiences on their families

The family experience within the Australian Defence Force

Having a family member in the Australian Defence Force (ADF) can involve a great deal of pride and provide a strong sense of community. Members and their families often describe the military in familial terms, due to the strong bonds, shared values and sense of belonging afforded by Defence careers. These positive identifications can also extend to ex-ADF members, veterans and their families.

Military life can also involve difficulties for families, particularly in managing the expectations of military and civilian cultures. Values that may be important in a military context such as discipline and obedience to authority may not always mesh with civilian behaviours and values, such as negotiation and compromise. The practical realities of military life have perhaps the most significant impacts on family functioning, including long absences during training and deployments, changes in roles and responsibilities, adapting to regular relocations, and managing upheavals in partners' careers and children's schooling. Military families have to cope with the potential for exposure to extraordinary risks, such as the injury or death in combat of a family member. A potentially challenging period for some is the transition out of the military. Separation from Defence can involve changes in location, finances and family roles (e.g., the partner of a veteran becoming the main income earner).

The emotional and physical impact of exposure to combat, humanitarian, peacekeeping and peacemaking experiences for veterans can have long-term consequences for many families. For example, recurring depression, chronic substance abuse or posttraumatic stress disorder (PTSD) may lead to long-term conflict or disengagement within the family. Anxiety about the veteran's mental health and taking on the role of carer can also take a toll on family members.

The difficulties encountered by military families have had varied impacts across generations and for different conflicts. For example, the Vietnam War involved conscription as well as deployment of full-time professional forces. Many families of conscripted veterans were shaped by the unexpected impact of the war and what often turned out to be well over 300 days of absence. It was not unusual for Vietnam veterans to have started a relationship or a family just before being conscripted, and to return markedly changed by their war experience. For more than half of recent veterans, their families have had to cope with multiple deployments, which can place significant strains on relationships, change parenting roles, and impact on the whole family's social networks.

There are significant generational differences in how families respond to service related stress. The divorce rate of Vietnam veterans is slightly lower than that of the general population, though high rates of depression, substance use and PTSD amongst Vietnam veterans have affected the subsequent mental health of their partners and children (Australian Institute of Health and Welfare, 1998). In contrast, the rate of marital separation is higher for recent veterans, who are also more likely to have blended families.

When working with veterans, it is important to consider the experiences of family members and their role in the veteran's recovery. A sense of connection and belonging is essential for recovery from mental health problems, and a treatment approach that includes family is likely to lead to more successful outcomes for veterans. It also mitigates risks associated with mental health problems, as relationship breakdown and social isolation are significant risk factors for suicidal behaviour (Van Orden et al., 2010).

The impact of training and deployment

When a serving member is deployed (or absent for long periods during pre-deployment training) the whole family is affected. During deployment, family members have to cope with the absence of the serving member and uncertainty around his or her safety. They also have to adapt by taking on new roles. For example, partners may have to take sole responsibility for managing budgets, and older children may have to care for their siblings. The nature of military postings may mean that additional support from friends or family is not readily available. These roles and relationships, as partners and parents, often have to be renegotiated once the serving member returns. Reintegration into family life can also be hampered by mental health issues exacerbated or developed since deployment.

Impact of mental health issues on family members

As in any family environment, mental health issues can have a significant impact upon individual family members and the functioning of the family unit.

Mental health issues can impact on a person's ability to parent effectively. For example, a parent with depression may find he or she has little motivation or energy, and therefore struggles to interact with the children; he or she may become irritable and less patient with children or may lack the confidence to set limits. Children who have a parent with a mental health issue are more likely to experience behavioural problems, difficulties in forming and maintaining relationships, poor coping skills, academic difficulties, and are more likely to develop mental health issues themselves. These issues can continue into adulthood. For example, adult children of Vietnam veterans have a higher rate of accidental death and suicide than other Australians (Australian Institute of Health and Welfare, 1999).

Veterans' mental health can also significantly impact upon partners. In addition to dealing with problems associated with mental health issues such as emotional withdrawal, substance abuse or suicide threats or attempts, partners may have to take on additional responsibilities in the family home, or adapt to unwanted lifestyle changes such as increased isolation from their friends and community (Evans et al., 2003). This can lead to strain in relationships, inhibit intimacy, and can isolate not only the veteran but the whole family from potentially valuable social support. Partners of veterans with a mental health problem are more likely to experience mental health problems (particularly anxiety disorders and severe depression) than the general population (O'Toole, Outram, Catts, & Pierse, 2010).

The impact of PTSD on relationships

The symptoms associated with PTSD (intrusive memories, hyperarousal and avoidance) can lead to particular difficulties in family relationships. Hyperarousal can contribute to aggression and domestic violence (Monson, Taft, & Fredman, 2009). Avoidance can inhibit intimacy between a veteran and their partner, and reduce satisfaction with the relationship (Evans, McHugh, Hopwood, & Watt, 2003). Partners of veterans have also been said to experience vicarious trauma as a result of being exposed to their partner's PTSD (Lambert & Morgan, 2009). Partners can also experience anxiety, depression, social isolation and feelings of hopelessness as a result of their partner's trauma and subsequent symptoms (Hutchinson & Banks-Williams, 2006). Partners have talked about 'walking on eggshells' around their veteran partner and being afraid of the veteran's symptoms.

Impact of being widowed or losing a parent

There are currently approximately 95,000 dependents of veterans, including widows and widowers of veterans and children who have lost a veteran parent, with the majority from the World War II generation. Widows and widowers and their children may have experienced the death of their veteran in quite different ways. They may have lost their family member during a deployment, or months or years later from a war-caused injury, physical illness or suicide.

The needs of widows, widowers and children of deceased veterans vary depending on the circumstances of their loss. If a veteran has died at a comparatively young age, especially under unexpected and sudden circumstances, their family will not only be experiencing intense grief, but may also have to face unplanned-for problems such as managing financial arrangements or adapting to a single-parent household. For many families, grief reactions may still be present years after the veteran has died, and mental health issues such as depression and anxiety associated with the death may be longstanding.

Veterans with mental health issues have an increased risk of death by suicide (Dunt, 2009). Families who experience the death of a family member by suicide may encounter additional difficulties due to the nature of the death. Family members may be angry that their parent, spouse or child has taken their own life and confused about why it happened. They may feel that they need to conceal the nature of the death and may feel stigmatised and ashamed (Sveen & Walby, 2008). Families of a veteran who has committed suicide may find it difficult to talk to other people about their experience and may find it difficult to access help to assist them in adjusting to life without their family member.

Providing care in a family sensitive way

The involvement of partners and family in the assessment and treatment of a veteran can have positive impacts on a veteran's recovery and helps identify the needs of family members so that they can be adequately supported or referred. Involvement of family members in assessment and treatment allows accurate, hopeful messages about support and treatment to be shared. Family members are invaluable sources of helpful information about the veteran's mental health, providing more objective assessments of changes in veteran's mood and behaviour. Families can also provide support and motivation to seek help and maintain involvement in treatment. In addition, veterans may be more likely to seek help and engage with mental health services alongside their families if they believe it is of benefit to their family (Batten et al., 2009). Veteran recovery from mental health issues can be significantly impeded by increased stress, poor relationships and lack of perceived social support. Conversely, being supported by family, whether in practical ways (e.g., partner coming to appointments with veteran) or emotional ways (e.g., being listened to, feeling part of the family), has been shown to lead to better mental health outcomes.

There are several ways of providing family sensitive mental health care. At the most basic level, it is important for the practitioner to ask questions about family members. Establishing family structures (who are the veteran's closest family members) is the first step, and this may include not only partners and children, but parents and siblings, especially with younger veterans. Asking general questions such as, "How are things with your partner and your children?" can help to provide important information about possible needs and sources of support. Sensitive assessment of potential for family violence (followed by a separate interview of a veteran's partner or children if there is an indication of violence) is particularly important given the higher incidence of family violence in veterans' families.

It may be useful to ask the veteran if they would like a family member to attend a session with them with the aim of helping conduct a thorough assessment and providing psychoeducation. A psychoeducation session with families usually involves assessing the impact of the veteran's symptoms on the family, providing education about mental health problems, addressing the beliefs family members may have about the veteran's symptoms, and exploring aims and goals of counselling.

Many mental health practitioners are comfortable involving partners at some point in their treatment of veterans but it is far less common to involve children. Mental health issues are often not discussed with children out of concern that the discussion may frighten or upset children. Children are astute observers of their environment and are often aware of even subtle differences in a parent's behaviour, but may not have the vocabulary to express their awareness. Discussing mental health problems with a child can reduce confusion and worry, enhance communication within the family and improve mental health outcomes for children. With regard to adult children of veterans, veterans can be sensitive about the possibility that their own mental health issues have harmed, or are harming their children, and may not want their mental health issues discussed with their children (Galovski & Lyons, 2004) even if their children are adults.

It is important to note that many veteran specific treatment and support programs, including inpatient programs, have specific programs for involving families in treatment. The VVCS - Veterans and Veterans Families Counselling Service (VVCS) has a family sensitive practice program which informs the provision of family consultations, family counselling, and the provision of individualised care to eligible partners and children of veterans. There are also community based family services and resources listed at the end of this chapter.

Case studies

The following case studies illustrate some of the common themes in the presenting problems of veterans' families, including concerns about the veteran's wellbeing, their relationships, the wellbeing of children and the family member's own mental health.

Amanda: 37 year old daughter of a Vietnam veteran and partner of a current serving member and veteran of Iraq/East Timor

Amanda is a stay at home mother who has sought counselling following deterioration in her mood, and difficulties with her relationship and parenting following a recent move from interstate. Amanda describes escalating feelings of anxiety and stress, sometimes manifesting as panic. At times she has difficulties managing her anger and is concerned that she is yelling at her children (three and six year old boys), and failing to manage what she terms "their acting out behaviours". Her eldest son has become aggressive at school, and her younger son more withdrawn at childcare. Amanda feels ashamed of having to speak frequently with the school counsellor.

She also describes estrangement from her partner, Sean, who also works long hours and has a demanding job with the ADF. Amanda explains that she understands the importance of his role and the sacrifices of military family life, as her father was a Vietnam veteran. She also values the positive role model her husband usually presents for their sons. However, she reports that, recently, Sean has become more avoidant of intimacy with the family, and appears to be relying on alcohol to manage stress.

Amanda describes recent difficulties with feeling isolated from her extended family who are located interstate, and has had difficulty navigating through the health system in the new area. Amanda is keen to involve her partner, Sean, in finding strategies to manage their sons' behaviour, but is doubtful that counselling will be able to help with their relationship.

Danielle: 28 year old widow of an Afghanistan veteran

Danielle is an accountant who has presented to a counsellor with difficulties coping following the death of her husband two years ago when he died in a car accident soon after returning from a deployment in Afghanistan. Danielle presents with difficulties getting to sleep and staying asleep, and reports she experiences significant stress managing a single-parent household and keeping on top of bills and other expenses.

Danielle is still unsure of how to manage her husband's death when discussing it with her nine year old son. Danielle says she has difficulty "finding the right words" to talk with her son about his father, and finds it difficult to talk about even positive memories involving her husband. Danielle also reports that her son used to be a "caring, sweet boy who always shared", and that since her husband's death, there has been a sharp increase in aggressive behaviour at school and at home. Danielle avoids news items on car accidents, and becomes distressed and tries to ignore significant days such as her husband's birthday or the date of his accident. When alone, Danielle reports repeatedly thinking about the way her husband may have died. She also experiences intense longing for him. Danielle is concerned that at times she can't stop thinking about his death, and reports she still has difficulty concentrating at work.

Danielle has sought solace by talking with her friends and other mothers from school. However, although she appreciates their support, she feels they are not able to identify with her situation.

John: a 65 year old father of an East Timor veteran deployed to Aceh

John is a software developer who has presented to his GP for advice regarding his son Matthew, who returned from Aceh after being deployed there for humanitarian efforts following the tsunami in 2004. John and his wife Linda live interstate, and their contact with Matthew is mainly over the phone. John is concerned that, since returning from Aceh, Matthew has been un-characteristically irritable and “moody” over the phone, and is less likely to return their phone calls. John is also aware that although Matthew used to smoke cannabis “every now and then”, his friends have told John that Matthew is smoking cannabis more regularly, and that Matthew becomes agitated when John enquires about his cannabis use. Matthew’s friends have also advised John that they are seeing “less and less” of Matthew and that, when Matthew does go out, he is withdrawn and appears disinterested in being with friends.

John is aware that whilst in Aceh, Matthew witnessed scenes of destruction and extreme poverty. Matthew’s fiancée also ended their relationship whilst he was deployed, and Matthew says he is still unsure why the relationship ended, and at times becomes tearful when discussing it with John.

John reports that he and Linda feel extremely helpless about Matthew’s changes in behaviour, and simply do not know what to do to help their son return to his “happy-go-lucky” self again. John stated that he was not sleeping well and was starting to have arguments with his wife about Matthew.

Resources and referral options

- **VVCS - Veterans and Veterans Families Counselling Service:** This service provides veterans and their families with counselling and group programs Australia-wide. VVCS can be contacted 24 hours a day on 1800 011 046.
- **Family violence programs:** A list can be found at www.relationships.org.au/what-we-do/services/family-violence-prevention.
- **At Ease website (www.at-ease.dva.gov.au)** has several resources about military families. In particular, you can order or download:
 - *Beyond the Call: Stories from veterans and their families.* This book provides an in-depth personal look at the impact of military service on families.
 - *Mental Health and Wellbeing after Military Service.* This booklet has a section on the impact of military service on families and how to get help.
- The Bouverie Centre provides information and resources on family sensitive practice: www.bouverie.org.au.
- The Child Family Community Australia Information Exchange run by the Australian Institute of Family Studies provides research and best practice updates for practitioners on family interventions and family violence: www.aifs.gov.au/cfca/.
- The Raising Children Network provides resources for parents such as tips for setting limits or helping children deal with separation: www.raisingchildren.net.au.

Summary advice on screening and management of common mental health problems in general practice

This chapter is designed to provide general practitioners with brief and practical information on common mental health presentations amongst veterans. It comprises a series of summaries that outline screening, advice and referral options. They can easily be used during a 15 minute consultation, or when you need to develop a mental health plan.

Common presenting problems

The most common mental health disorders among veterans include depressive disorders such as major depression and dysthymia, posttraumatic stress disorder (PTSD), anxiety disorders such as panic disorder, and alcohol abuse. Some veterans also experience difficulties with cannabis or prescribed medication use, but often go undiagnosed because they tend to underreport these problems.

More commonly, veterans present to general practices with more generic complaints such as sleep disturbance, problematic anger, relationship problems or unexplained medical symptoms.

Comorbid mental health problems are common, particularly when posttraumatic mental health and substance use problems are present.

When to screen

Whilst the K-10 is useful for screening for general psychological distress (a copy of which can be found on the adjacent page with scoring instructions), it is important to screen for specific disorders. The most prevalent disorders GPs will need to be prepared to screen for are:

- depression
- PTSD
- substance / alcohol abuse

General practitioners can use the list below to help prioritise disorders that may require screening:

Presenting, or observed complaint(s)	What to screen for:
history of trauma	depression, substance abuse, PTSD,
substance use problems	history of trauma, depression, substance abuse
anger	history of trauma, depression, substance abuse
low mood	history of trauma, depression
anxiety problems	history of trauma, generalised anxiety disorder (GAD), social anxiety
medically unexplained symptoms	history of trauma, depression, somatic symptom disorders

K10 questionnaire to measure psychological distress

Date (Day/Month/Year)					
In the past 4 weeks:	None of the time	A little of the time	Some of the time	Most of the time	All of the time
1. About how often did you feel tired out for no good reason?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. About how often did you feel nervous?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. About how often did you feel so nervous that nothing could calm you down?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. About how often did you feel hopeless?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. About how often did you feel restless or fidgety?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. About how often did you feel so restless you could not sit still?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. About how often did you feel depressed?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. About how often did you feel that everything is an effort?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. About how often did you feel so sad that nothing could cheer you up?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. About how often did you feel worthless?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

For all questions, please **fill in** the appropriate response circle. Please do not tick or cross the circles.

Scoring

The Kessler Psychological Distress Scale (K10) uses a five-value response option for each question – all of the time; most of the time; some of the time; a little of the time; and none of the time – which is scored from 5 through to one in that order. The numbers attached to the 10 responses are added up and the total is the score on the K10. The maximum score is 50, indicating severe distress and the minimum score is 10, indicating no distress.

Questions 3 and 6 are not asked if the answer to the preceding question was 'none of the time', in which case questions 3 and 6 automatically receive a score of one.

People seen in primary care who score:

- under 20 are likely to be well
- 20–24 are likely to have a mild mental health disorder
- 25–29 are likely to have moderate mental health disorder
- 30 and over are likely to have a severe mental health disorder.

Mental Status Examination Template

Appearance and General Behaviour Normal Other:	Mood (Depressed/Labile) Normal Other:
Thinking (Content/Rate/Disturbances) Normal Other:	Affect (Flat/Blunted) Normal Other:
Perception (Hallucinations, etc.) Normal Other:	Sleep (Initial Insomnia/Early Morning Wakening) Normal Other:
Cognition (Level of Consciousness/Delirium/Intelligence) Normal Other:	Appetite (Disturbed Eating Patterns) Normal Other:
Attention/Concentration Normal Other:	Motivation/Energy Normal Other:
Memory (Short and Long Term) Normal Other:	Judgement (Ability to make rational decisions) Normal Other:
Insight Normal Other:	Anxiety Symptoms (Physical and Emotional) Normal Other:
Orientation (Time/Place/Person) Normal Other:	Speech (Volume/Rate/Content) Normal Other:

Screening for risk of harm

Risk of self harm/suicide

The following questions can be used to assess risk:

- Are there times when things seem so hopeless that you think about killing yourself?
- Do you have a plan of how you might do this?
- Do you have access to ... (check means and opportunity)?
- Have you ever harmed yourself or tried to kill yourself in the past?
- Do you live alone (or unsupervised)?
- Do you use amphetamines, alcohol, or other substances?

Risk of harm to others

Where a veteran responds positively to self-harm questions, then also ask:

- Are there times when things seem so hopeless that you think about killing someone?
- Do you have a plan of how you might do this?
- Do you have access to ... (check means and opportunity)?
- Have you ever harmed someone else or tried to kill someone else in the past?
- Do you live alone (or unsupervised)?
- Do you use amphetamines, alcohol, or other substances?

Screening for a history of trauma

As the experience of trauma is common in veterans, routinely screening for a history of trauma is recommended. A good opening question for screening for trauma is:

- Have you experienced a particularly frightening or upsetting event?

Asking about specific events the veteran may have experienced is often useful, such as:

- car accidents
- being threatened with a weapon
- combat
- seeing somebody badly injured or killed
- torture or an act of terrorism
- any other extremely stressful or upsetting event, keeping in mind that it may not be related directly to being in a war zone or involved in military service.

It is important to be aware that if there is evidence to suggest trauma, it does not always warrant, or lead to a diagnosis of PTSD. The experience of trauma can lead to other mental health problems, and if trauma has been experienced by your patient, screening for the following disorders is recommended:

- depression
- PTSD
- substance abuse.

Other general considerations

Speaking to patients about their presenting issues

There is good evidence that the more people understand about the problem they are experiencing and its treatment, the better they adhere to treatment plans. Providing education will help veterans understand their difficulties and help facilitate a sense of hope and control over their wellbeing. Veterans are often reticent to disclose symptoms, as some disorders (e.g., anxiety disorders) tend to be associated with weakness. When providing education, it is important to make explicit any common misconceptions veterans may have about their disorder. Education should include the following information on the identified mental health problem(s):

- what the disorder is (avoid medical jargon)
- how common the disorder is
- what causes the disorder
- what symptoms the veteran has
- any complications or other problems.

Once information is delivered, it is important to:

- check if the information provided so far corresponds with the veteran's theories and beliefs about his/her problems
- discuss what factors may impede recovery
- encourage the veteran to ask questions.

Because of difficulties in retaining new information in general, and potential issues with concentration associated with most common mental health disorders, it is important to:

- repeat important information where feasible
- use both oral and written information — the combination is better than either alone
- check the veteran's comprehension regularly
- involve family members and significant others if appropriate.

Supporting self-management and prioritising social support

In a primary care setting, it can be helpful to offer advice on self-help strategies that a veteran can begin using immediately to reduce symptoms of their disorder. For veterans in particular, the following practical advice has strong evidence for promoting recovery:

- **Prioritise spending time and reconnecting with their social supports**, e.g., sympathetic family members and friends, community activities.
- **Maintain (or re-establish) their daily routine and current roles**, e.g., work, family.
- **Reduce substance use**. This is a significant issue amongst veterans given the high levels of comorbidity between depressive disorders, PTSD and substance use. Early advice on reducing substance use has been proven to be effective.

Referring to veteran-specific services

There are veteran-specific services that your patient, or their family member may be entitled to.

VVCS - Veterans and Veterans Families Counselling Service (VVCS) (1800 011 046 - 24 hours) offers counselling services for veterans and their families.

For patients who are at risk of harm, are isolated or have severe symptoms, referral to a tertiary facility such as a psychiatric hospital unit may be beneficial. The Department of Veterans' Affairs (DVA) offers inpatient programs specifically targeted to veterans, including specialist inpatient and outpatient programs that target alcohol-related problems, and PTSD (phone 133 251 or 1800 555 254).

DVA offers extensive rehabilitation services for entitled veterans (www.dva.gov.au/rehabilitation).

Mental status exam

Conducting a Mental Status Examination (MSE; see page 19) is good practice for all general practitioners who have patients with potential mental health problems. It serves the same function for mental health practitioners as a physical examination does for a general practitioner. A MSE is a documented summary of observations taken during a clinical interview and usually recorded in a structured format. It is essentially done by observation, although there are a few points that may be clarified by direct questioning.

Note that while an MSE is required for patients being referred through the Better Mental Health Outcomes initiative, veterans are eligible for DVA-funded services and do not need to access treatment through this initiative.

Depressive disorders

Approximately 15 per cent of Australians will experience a depressive disorder at some point in their lives.

- Depression can involve low mood, a loss of interest in usually enjoyable activities, changes in sleep and appetite, and low energy.
- Cognitive behavioural therapy (CBT) and interpersonal therapy (IPT) are the most effective treatments for depression.
- Where medication is required, newer antidepressants should be considered as the first choice.
A combination of CBT and pharmacotherapy is recommended.

Information, patient resources and assessment tools are available at www.at-ease.dva.gov.au or in the Appendices.

Screening for depressive disorders

The following questions can screen veterans for depressive symptoms:

- Over the past month, have you often been bothered by feeling down, depressed, or hopeless?
- Over the past month, have you often been bothered by little interest or pleasure in doing things?

If the veteran responds 'yes' to either question, assess for further symptoms of depression and dysthymia.

Screening for risk of harm to self or others

Depression is a significant risk factor for suicide. Impulsive, self-destructive and aggressive behaviours such as dangerous driving are more common among younger veterans. You can begin to screen for risk to self and/or others by asking the following questions:

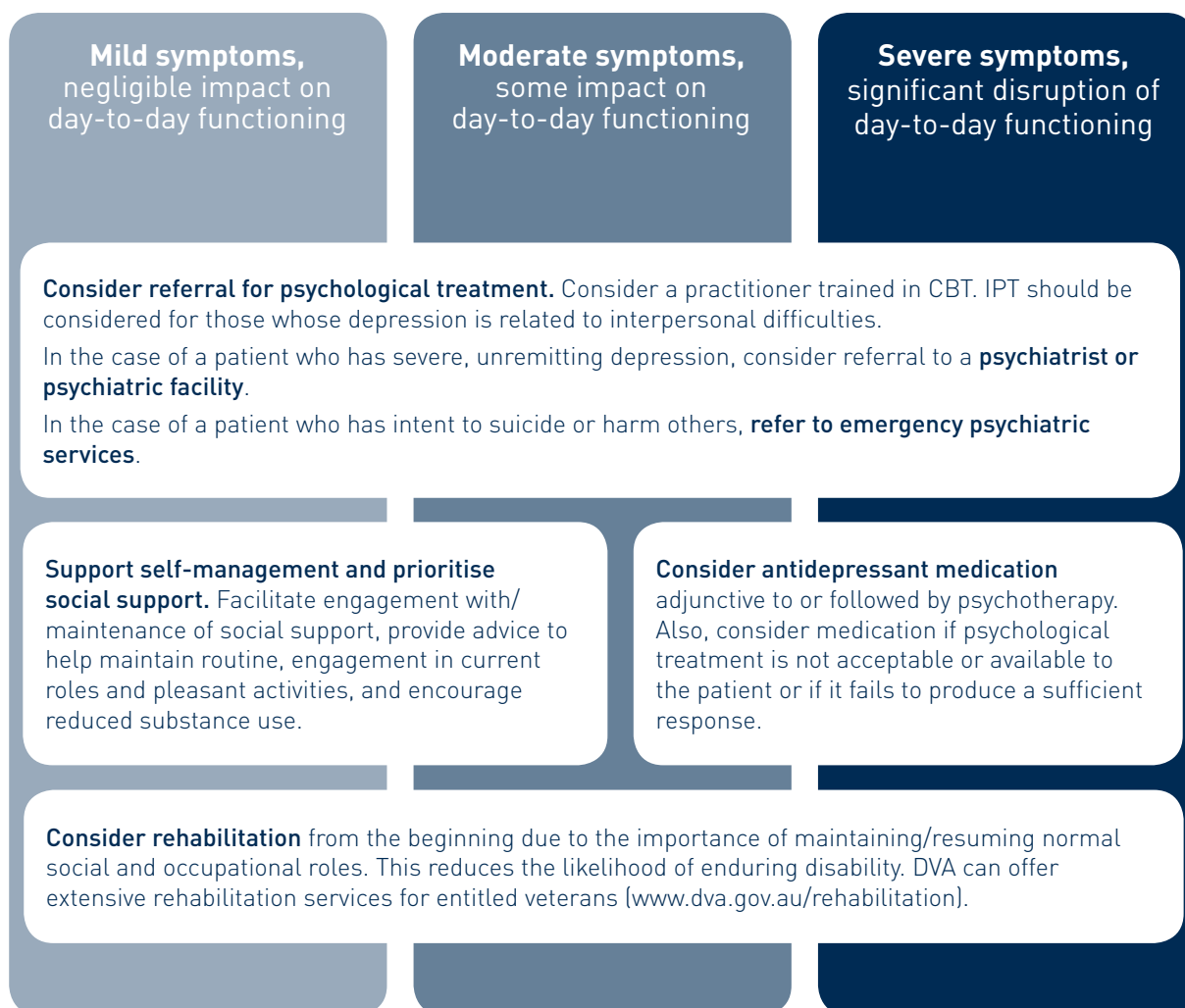
- Are there times when things seem so hopeless that you have thought about killing yourself or harming yourself in some way?
- Are there times when things seem so hopeless that you have thought about ending the lives of others around you?

If the veteran responds 'yes' to either question, check for intent to act on these thoughts and refer to emergency psychiatric services.

Assessment

Assess the patient's mental state, presence of comorbid mental and physical conditions, strengths, and cognitive impairments.

A freely available standardised assessment tool that can assist in developing a mental health plan, or assessing severity and outcomes, is the Depression Anxiety and Stress Scale (DASS-21; available at www.at-ease.dva.gov.au or Appendix C). This is not a diagnostic measure.



Elements that you may consider during a consultation

Self-management Strategies

Practitioners may talk through basic self-management strategies that the veteran can use to reduce their symptoms while undergoing more targeted psychological and/or pharmacological interventions. Encourage the patient to:

- Prioritise social supports e.g., sympathetic family members and friends, local interpersonal community activities. There is strong evidence that social support is a key factor in preventing deterioration of symptoms and in promoting recovery.
- Maintain (or re-establish) daily routine and current roles (e.g., work, family). Engaging in pleasant or meaningful activities is particularly important for veterans who have a lot of unstructured time.
- Reduce substance use. High comorbidity between depressive disorders and substance use is a significant issue amongst veterans. Early advice on reducing substance use is effective.

Self-management Resources

- At Ease website (www.at-ease.dva.gov.au) for veteran-specific information on mental health wellbeing including the Wellbeing Toolbox, anxiety management and alcohol resources. The DVA *Mental Health and Wellbeing after Military Service* booklet is available to order or download.
- Other useful websites include beyondblue (www.beyondblue.com.au) and MoodGYM (www.moodgym.anu.edu.au - an internet-based self-help program).
- Useful books include *Mind over Mood: A Cognitive Therapy Treatment Manual* (Padesky and Greenberger, 1995) and *Feeling Good: The New Mood Therapy* (Burns, 1999).

Psychological Treatment

- Cognitive behavioural therapy (CBT) is the treatment of choice for depression. Key components of CBT for depression include:
 - structured problem solving
 - activity scheduling
 - cognitive therapy
- Interpersonal therapy (IPT) should be considered for veterans whose depression is related to interpersonal difficulties.
- Depression is typically treated in an outpatient setting. Considerations for referral to emergency psychiatric services include the severity of depression and the risk of self-harm or suicide.
- Treatment for mild to moderate depression usually consists of six to eight one-hour sessions over 10 to 12 weeks. In complex cases, a longer intervention may be required.
- Patient information on effective treatments for depression is available at www.at-ease.dva.gov.au and in Appendix L, and an example script is provided below:

“One of the most effective treatments for depression is cognitive behavioural therapy, or CBT – this approach recognises that the way we think and act affects the way we feel. You will learn to challenge your negative thinking, which will have a positive impact on the way you feel. You will also learn strategies to help you get back to your routine and enjoying your usual activities. The therapy may involve 8-12 weekly sessions but may require longer depending on your needs.”

Pharmacological Treatment

- Antidepressants may be beneficial for veterans with moderate to severe depression. Newer antidepressants such as SSRIs and SNRIs are the preferred first line pharmacotherapy due to their favourable side-effect profile. When a veteran responds to antidepressants, they should be continued for at least 12 months before considering gradual withdrawal.
- If pharmacotherapy is commenced, the veteran's mental state should be monitored and adjunctive psychological therapy commenced when appropriate.

Referral Options

- WACS – Veterans and Veterans Families Counselling Service. Phone 1800 011 046 (24 hours).
- Mental health professionals can be accessed through Medicare. A list of psychologists can be found at www.psychology.org.au/findapsychologist. A list of mental health trained social workers can be found at www.aasw.asn.au/membersdirectory.
- Private psychiatrists: A list can be accessed by GPs at www.ranzcp.org/Resources/find-a-psychiatrist.aspx.
- If hospitalisation is required, there are veteran specific mental health wards and treatment programs. To find out their location call DVA on 133 254 or 1800 555 254.

Panic disorder with or without agoraphobia

Approximately one in thirty Australians will suffer from panic disorder at some point in their lives, while one in forty will experience agoraphobia.

- A **panic attack** is a sudden surge of intense fear that is accompanied by a number of somatic and cognitive symptoms e.g., racing heart, hyperventilation, fear of dying. Panic disorder is the experience of repeated unexpected panic attacks, combined with persistent concern about having another attack or the consequences of the attack.
- **Agoraphobia** involves marked fear and/or avoidance of situations (e.g., crowded places) where escape might be difficult or help might not be available in the event of a panic attack.

Cognitive behavioural therapy (CBT) is the most effective treatment for panic with/without agoraphobia.

Where medication is required, newer antidepressants should be considered as the first choice.

Information, patient resources and assessment tools are available at www.at-ease.dva.gov.au or in the Appendices.

Screening for panic disorder and agoraphobia

The following questions can be used to screen veterans for **panic disorder**:

- In the past month, have you on more than one occasion, had spells or attacks when you suddenly felt anxious, frightened, uncomfortable or uneasy even in situations where most people would not feel that way?
- Did the spells peak within 10 minutes?

If the veteran responds 'yes' to both questions, assess further for symptoms of panic disorder.

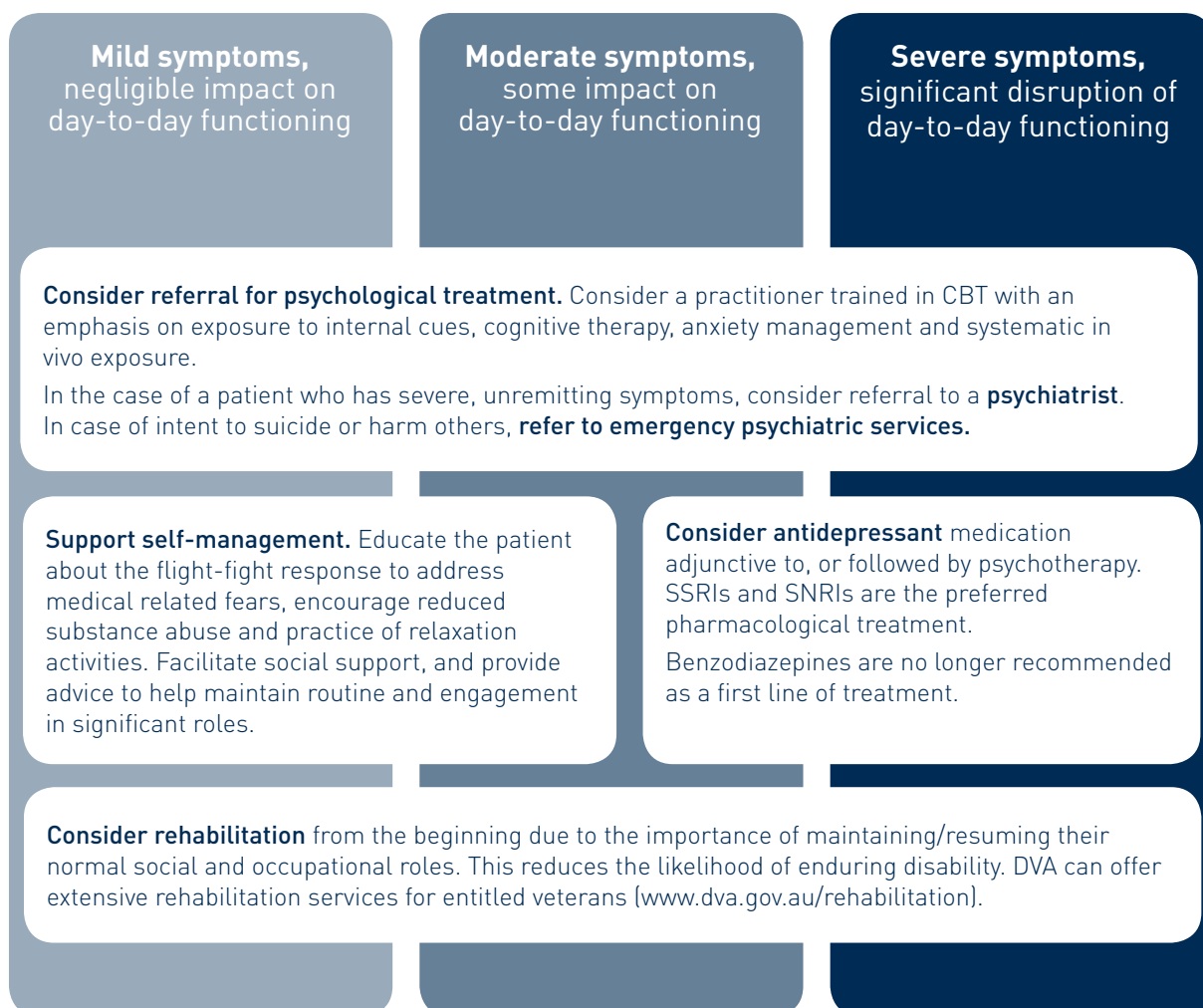
The following question can be used to screen veterans for **agoraphobia**:

- In the past month, have you felt anxious or uneasy in places or situation where you might have a panic attack or panic-like symptoms, or where help might not be available or escape might be difficult (e.g., being in a crowd, standing in a queue, when you are away from home or alone at home, or when crossing a bridge, travelling in a bus or train or car)?

If the veteran responds 'yes' to the above question, assess further for symptoms of agoraphobia.

Assessment

- Assess patient's mental state, presence of comorbid mental and physical conditions, strengths, and cognitive impairments.
- A freely available standardised assessment tool that can help you develop a mental health plan, or assess severity and outcomes, is the Depression, Anxiety and Stress Scale (DASS-21). The Fear Questionnaire (FQ) helps identify situations that trigger anxiety. Neither is a diagnostic measure for panic or agoraphobia. Both questionnaires are available in Appendix C or at www.at-ease.dva.gov.au.



Elements that you may consider during a consultation

Self-management Strategies

Practitioners may discuss basic self-management strategies with the veteran while more targeted psychological and/or pharmacological interventions take effect. Encourage the patient to:

- **Understand the flight-flight response** i.e., explain that although panic attacks may feel dangerous, they are not. Address any other medical-related fears the patient may have regarding their physiological panic symptoms.
- Use **anxiety management strategies** e.g., relaxation activities, breathing retraining. A useful patient resource is the Wellbeing Toolbox (www.wellbeingtoolbox.net.au).
- **Reduce substance use.** This is a significant issue as 20% of Australians with panic and 13% of those with agoraphobia also have an alcohol use disorder.
- Prioritise spending time and reconnecting with **social supports** e.g., sympathetic family members and friends, local interpersonal community activities.
- Maintain (or re-establish) daily **routine and current roles** (e.g., work, family).

Self-management Resources

- At Ease website (www.at-ease.dva.gov.au) for access to veteran-specific information on mental health wellbeing including the Wellbeing Toolbox, anxiety management and alcohol resources. The DVA *Mental Health and Wellbeing after Military Service* booklet is available to order or download.
- Useful materials are available from beyondblue (www.beyondblue.com.au), the Clinical Research Unit for Anxiety and Depression (www.crufad.org) and SANE (www.sane.org).
- Anxiety Online (www.anxietyonline.org.au) is an internet based treatment clinic affiliated with Swinburne University.

Psychological Treatment

- Cognitive behavioural therapy (CBT) has a strong evidence base for the treatment of panic disorder and/or agoraphobia. The key components of CBT are:
 - Exposure to internal cues – e.g., induce hyperventilation in order to challenge fear about its dangerousness.
 - Cognitive therapy – to address misinterpretations of symptoms such as fears of going mad or having a heart attack.
 - Anxiety management strategies – e.g., breathing retraining.
 - Exposure therapy – involves graded exposure to places and activities currently avoided due to fear of a panic attack and difficulty escaping e.g., being on public transport.
- Panic and/or agoraphobia is typically treated in an outpatient setting, at least once a week for 7 – 14 weeks depending on severity.
- Patient information on effective treatments is available online (www.at-ease.dva.gov.au) or in Appendix L, and an example script is provided below:

“One of the most effective treatments for anxiety is cognitive behavioural therapy, or CBT. CBT will teach you skills to help you manage your panic symptoms and overcome your avoidance of challenging situations e.g., crowded places, other places away from home. For example, you will learn ways to challenge your fears related to the physical symptoms, and ways to face your feared situations and physical symptoms in a gradual and manageable way. The therapy may involve 7 – 14 weekly sessions but may require longer depending on your needs.”

Pharmacological Treatment

- Newer antidepressants such as SSRIs and SNRIs are the preferred first line for pharmacological treatment due to their favourable side-effect profile.
- Benzodiazepines should be used with caution. Although they provide rapid control of severe physical symptoms, long term use is not indicated as they do not treat the underlying condition and involve risk of dependency.
- If pharmacotherapy is commenced, the veteran's mental state should be monitored and adjunctive psychological therapy commenced when appropriate.

Referral Options

- VVCS – Veterans and Veterans Families Counselling Service. Phone 1800 011 046 (24 hours).
- Mental health professionals can be accessed through Medicare. A list of psychologists can be found at www.psychology.org.au/findapsychologist. A list of mental health trained social workers can be found at www.aasw.asn.au/membersdirectory.
- Private psychiatrists: A list can be accessed by GPs at www.ranzcp.org/Resources/find-a-psychiatrist.aspx.
- DVA-funded inpatient and outpatient programs. Phone 133 254 or 1800 555 254.

Generalised anxiety disorder (GAD)

Approximately six per cent of Australians will experience GAD at some point in their lives.

GAD involves:

- persistent and excessive anxiety and worry about a range of events
- symptoms associated with anxiety such as restlessness, fatigue, irritability, concentration or sleep difficulties.

Cognitive behavioural therapy (CBT) is the most effective treatment for GAD.

Where medication is required, newer antidepressants should be considered as the first choice.

Information, patient resources and assessment tools are available at www.at-ease.dva.gov.au or in the Appendices.

Screening for generalised anxiety disorder

The following questions can be used to screen veterans for generalised anxiety disorder:

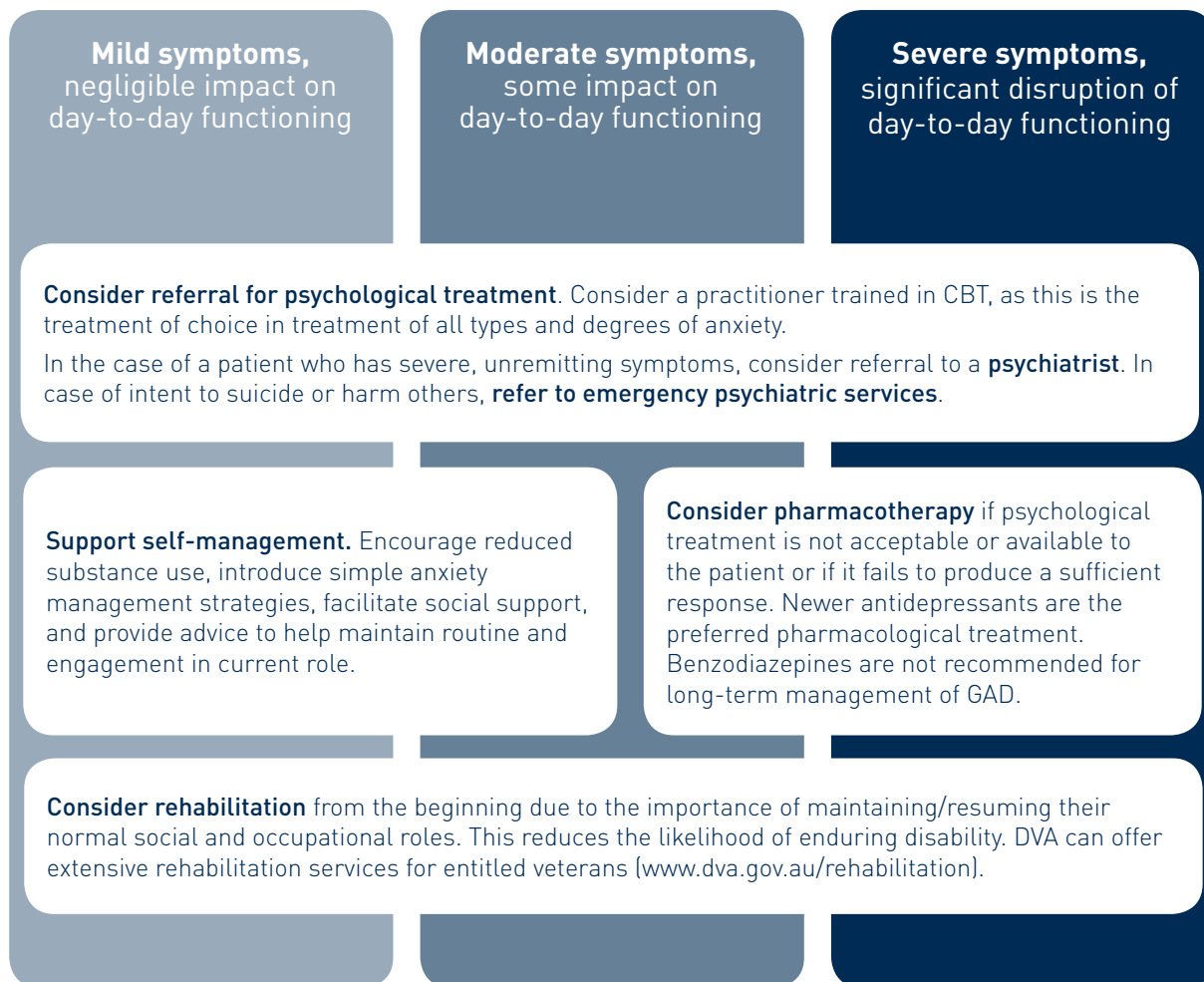
- Have you worried excessively or been anxious about several things over the past three to six months?
- (If yes) Are these worries present most days?

If the veteran responds 'yes' to each of these questions, assess further for symptoms of GAD.

Assessment

Assess the patient's mental state, presence of comorbid mental and physical conditions, cognitive impairments, strengths and resilience.

The Penn State Worry Questionnaire (PSWQ) is a specific measure of worry. It can be used help develop a mental health plan, or assess severity and outcomes. The Depression, Anxiety and Stress Scale (DASS-21) is a more general measure. Neither is a diagnostic measure for GAD. Both questionnaires are available in Appendix C or at www.at-ease.dva.gov.au.



Elements that you may consider during a consultation

Self-management Strategies

Practitioners may discuss basic self-management strategies that the veteran can use to reduce the symptoms while undergoing more targeted psychological and/or pharmacological interventions. Encourage the patient to:

- Use **anxiety management strategies** e.g., breathing retraining, problem solving etc. A useful resource for veterans is the Wellbeing Toolbox (www.wellbeingtoolbox.net.au).
- **Reduce substance use.** Approximately 17% of Australians with generalised anxiety disorder also have an alcohol use disorder, and early advice on reducing substance use is effective.
- Maintain (or re-establish) their daily **routine and current roles (e.g., work, family)**.
- Prioritise spending time and reconnecting with time with **social supports** e.g., sympathetic family members and friends, local community.

Self-management Resources

- At Ease website (www.at-ease.dva.gov.au) for access to veteran-specific information on mental health and wellbeing including the Wellbeing Toolbox, anxiety management and alcohol resources. The DVA *Mental Health and Wellbeing after Military Service* booklet is available to order or download.
- Useful materials are available from *beyondblue* (www.beyondblue.com.au), the Clinical Research Unit for Anxiety and Depression (www.crufad.org) and SANE (www.sane.org).
- Anxiety Online (www.anxietyonline.org.au) is an internet based treatment clinic affiliated with Swinburne University.

Psychological Treatment

- Cognitive behavioural therapy (CBT) is the most consistently effective psychological treatment for GAD. The key components of CBT for GAD include:
 - Cognitive therapy – to challenge the negative and catastrophic beliefs that trigger and maintain worry.
 - Structured problem solving – to address feared problems and consequences using a method other than worry.
 - Anxiety management – to help manage the physical consequences of worry.
- GAD is typically treated in an outpatient setting, and treatment duration may vary from 12 to 15 one hour weekly sessions depending on severity.
- Patient information on effective treatments is available online (www.gp-mh.com) or in Appendix L, and an example script is provided below:

“One of the most effective treatments for anxiety is cognitive behavioural therapy, or CBT. CBT will teach you practical skills to help manage your anxiety and worries such as problem solving, relaxation activities and strategies to improve your sleep. You will also learn to identify and challenge thoughts and beliefs that can keep your worries going. The therapy may involve 12 to 15 weekly sessions but may require longer depending on your needs.”

Pharmacological Treatment

- Evidence suggests that newer antidepressants, such as SSRIs and SNRIs, are the preferred pharmacological treatment due to their favourable side-effect profile.
- Benzodiazepines are sometimes used to stabilise patients, however long term use is not indicated as they do not treat the underlying condition and involve risk of dependency.
- If pharmacotherapy is commenced, the veteran’s mental state should be monitored and adjunctive psychological therapy commenced when appropriate.

Referral Options

- WCS – Veterans and Veterans Families Counselling Service. Phone 1800 011 046 (24 hours).
- Mental health professionals can be accessed through Medicare. A list of psychologists can be found at www.psychology.org.au/findapsychologist. A list of mental health trained social workers can be found at www.aasw.asn.au/membersdirectory.
- Private psychiatrists: A list can be accessed by GPs at www.ranzcp.org/Resources/find-a-psychiatrist.aspx.
- DVA-funded inpatient and outpatient programs. Phone 133 254 or 1800 555 254.

Social anxiety

Around one in twelve Australians will experience social anxiety at some point in their lives.

Social anxiety symptoms include:

- fear of social or performance situations in which a person worries about being scrutinised or negatively evaluated by others
- avoidance of the feared situation, or intense fear and anxiety when exposed to it.

Commonly feared situations include meeting new people, speaking, eating or drinking in public.

Cognitive behavioural therapy (CBT) is the most effective treatment for social anxiety.

Where medication is required, newer antidepressants should be considered as the first choice.

Information, patient resources and assessment tools are available at www.at-ease.dva.gov.au or in the Appendices.

Screening for social anxiety

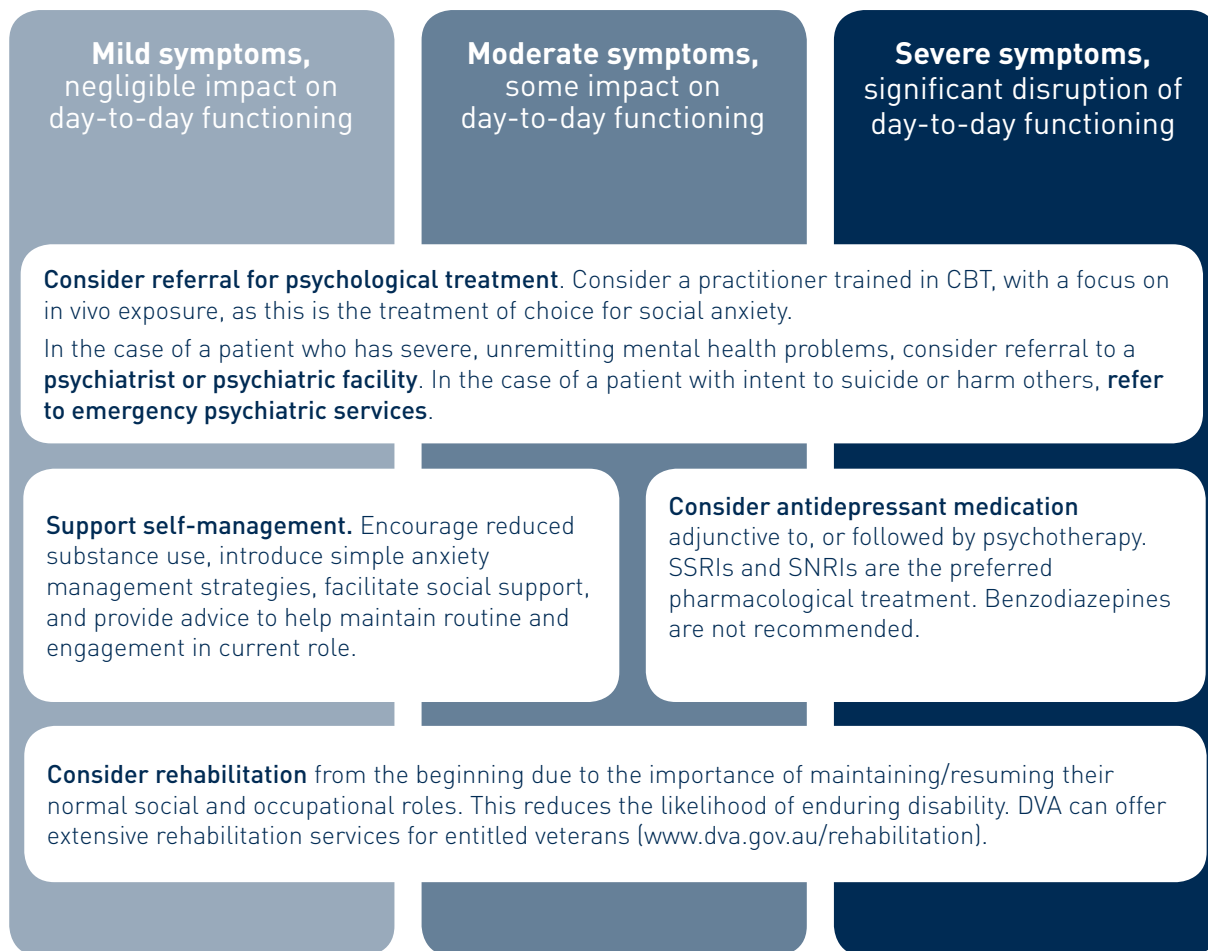
The following question can be used to screen veterans for social anxiety:

- In the past month were you fearful or embarrassed about being watched, being the focus of attention, or fearful of being humiliated? These include things like speaking in public, eating in public or with others, writing while someone watches, or being in social situations.

If the veteran responds 'yes', assess further for symptoms of social anxiety.

Assessment

- Assess the patient's mental state, presence of comorbid mental and physical conditions, cognitive impairments, strengths and resilience.
- A freely available standardised assessment tool that can assist in developing a mental health plan, or assessing severity and outcomes, is the Depression, Anxiety and Stress Scale (DASS-21). This is not a specific diagnostic measure for social anxiety. The Fear Questionnaire (FQ) helps identify situations that trigger anxiety. Both questionnaires are available in Appendix C or at www.at-ease.dva.gov.au.



Elements that you may consider during a consultation

Self-management Strategies

Practitioners may discuss basic self-management strategies with the veteran that can reduce their symptoms while more targeted psychological and/or pharmacological interventions take effect. Encourage the patient to:

- Use anxiety **management strategies** e.g., breathing retraining, problem solving etc. A useful patient resource is the Wellbeing Toolbox (www.wellbeingtoolbox.net.au).
- **Reduce substance use.** While alcohol and drugs may alleviate anxiety in the short term, they inhibit recovery by not allowing the patient to learn that they could have managed the social situation without the substance. Approximately 17% of Australians with anxiety disorders also have an alcohol use disorder, and early advice on reducing substance use is effective.
- Maintain (or re-establish) their daily **routine and current roles (e.g., work, family)**.
- **Improve assertiveness and/or conversation skills.** This may be useful as part of a broader psychological intervention (i.e., not as a standalone intervention).
- Prioritise spending time and reconnecting with **social supports** e.g., sympathetic family members and friends, local community.

Self-management Resources

- At Ease website (www.at-ease.dva.gov.au) for access to veteran-specific information on mental health wellbeing including the Wellbeing Toolbox, anxiety management and alcohol resources. The DVA *Mental Health and Wellbeing after Military Service* booklet is available to order or download.
- Useful materials are available from *beyondblue* (www.beyondblue.com.au), the Clinical Research Unit for Anxiety and Depression (www.crufad.org) and SANE (www.sane.org).
- Anxiety Online (www.anxietyonline.org.au) is an internet based treatment clinic affiliated with Swinburne University.

Psychological Treatment

- Cognitive behavioural therapy (CBT) has a strong evidence base for the treatment of social anxiety. The key components of CBT for patients with social anxiety are:
 - Exposure therapy – involves graded exposure to social or performance situations currently avoided or endured with significant distress (e.g., gradually exposing the patient to public speaking situations).
 - Cognitive therapy – to challenge the patient's beliefs about perceived scrutiny and negative evaluation from others.
 - Anxiety management strategies – e.g., breathing retraining.
 - When necessary, include social skills training (e.g., assertiveness training).
- Social anxiety is typically treated in an outpatient setting, and treatment duration varies between 8–12 sessions depending on severity. Group CBT treatment can also be beneficial.
- Patient information on effective treatments for anxiety is available online (www.at-ease.dva.gov.au) or in Appendix L, and an example script is provided below:

“One of the most effective treatments for anxiety is cognitive behavioural therapy, or CBT. CBT will teach you skills to help you overcome your anxiety and avoidance of the social situations that you find challenging such as meeting new people, making work presentations. For example, you will learn ways to challenge your negative thoughts about how others see you, and will be provided with strategies to face your feared situations in a gradual and manageable way. The therapy may involve 8 to 12 weekly sessions but may require longer depending on your needs.”

Pharmacological Treatment

- Evidence suggests that SSRIs and SNRIs are the most effective treatment for social anxiety in the short term.
- Benzodiazepines are not recommended for the treatment of anxiety disorders in the long-term as they do not treat the underlying condition and involve risk of dependency.
- It is recommended that psychological treatment continue during, and after pharmacotherapy to lower the risk of relapse. If pharmacotherapy is commenced, the veteran's mental state should be monitored and adjunctive psychological therapy commenced when appropriate.

Referral Options

- VCS – Veterans and Veterans Families Counselling Service. Phone 1800 011 046 (24 hours).
- Mental health professionals can be accessed through Medicare. A list of psychologists can be found at www.psychology.org.au/findapsychologist. A list of mental health trained social workers can be found at www.aasw.asn.au/membersdirectory.
- Private psychiatrists: A list can be accessed by GPs at www.ranzcp.org/Resources/find-a-psychiatrist.aspx.

Posttraumatic stress disorder (PTSD)

Although most people recover from experiencing a traumatic event, some will go on to develop a mental health problem such as depression or PTSD. Between 5 and 20 per cent of veterans will experience PTSD at some point in their lives.

PTSD involves four main types of difficulties:

- intrusive or re-experiencing symptoms e.g., unwanted, recurring memories, vivid nightmares, intense emotional or physical reactions when reminded of trauma
- hyperarousal e.g., sleeping difficulties, irritability and a strong startle response
- persistent avoidance of reminders of the trauma, such as activities, feelings and places associated with the event
- negative alterations in mood or cognitions e.g., feeling detached from friends and family, losing interest in activities or distorted blame of self.

Trauma-focussed cognitive behavioural therapy and eye movement desensitisation and reprocessing are the most effective treatments for people with PTSD.

Where medication is required, newer antidepressants should be considered as the first choice.

Information, patient resources and assessment tools are available at www.at-ease.dva.gov.au or in the Appendices.

Screening for PTSD

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:

- Have had nightmares about it or thought about it when you did not want to?
- Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?
- Were constantly on guard, watchful, or easily startled?
- Felt numb or detached from others, activities, or your surroundings?

If two or more are answered with “yes”, a diagnosis of PTSD is probable.

Assessment

- Assess the patient’s mental state, presence of comorbid mental and physical conditions, cognitive impairments, strengths and resilience.
- Assess and monitor risk of harm to self and others. For younger veterans in particular, risky, impulsive, self-destructive or aggressive behaviours such as dangerous driving are common.
- A standardised assessment tool that can help you develop a mental health plan, or assess severity and outcomes, is the Posttraumatic Checklist available in Appendix C or www.at-ease.dva.gov.au.



Elements that you may consider during a consultation

Self-management Strategies

Practitioners may talk through basic self-management strategies that reduce the veteran's symptoms while more targeted psychological and/or pharmacological interventions take effect. Encourage the patient to:

- Prioritise **social supports** e.g., sympathetic family members and friends, local interpersonal community activities. There is strong evidence that social support is a key factor in preventing deterioration of symptoms and in promoting recovery.
- **Reduce substance use.** While alcohol and drugs may alleviate distress in the short term, they inhibit recovery. This is a significant issue amongst veterans, with up to 80% of veteran's with PTSD developing substance use issues. Early advice on reducing substance use is effective.
- Maintain (or re-establish) daily **routine and current roles (e.g., work, family)**.
- Use **anxiety management strategies** e.g., breathing retraining, problem solving etc. A useful patient resource is the Wellbeing Toolbox (www.wellbeingtoolbox.net.au).

Self-management Resources

- At Ease website (www.at-ease.dva.gov.au) for access to veteran-specific information on mental health wellbeing including the Wellbeing Toolbox, anxiety management and alcohol resources. The DVA *Mental Health and Wellbeing after Military Service* booklet is available to order or download.
- ACPMH website (www.acpmh.unimelb.edu.au) for fact sheets and treatment guidelines.
- PTSD Coach smartphone application has been developed by the National Center for PTSD (www.ptsd.va.gov) for use in conjunction with other PTSD interventions.

Psychological Treatment

- Trauma-focussed cognitive behavioural therapy (TF-CBT) has a strong evidence base for the treatment for PTSD. The key components of TF-CBT include:
 - Imaginal exposure – to address traumatic memories.
 - In vivo exposure – to assist the patient to engage in feared or avoided activities.
 - Cognitive therapy – to address unhelpful beliefs and assumptions associated with the trauma.
 - Arousal/anxiety management – to help reduce physical arousal.
- PTSD is typically treated in an outpatient setting and should be regular, at least once a week for 8-12 weeks. Treatment may be prolonged where PTSD is severe or multiple traumas are involved. More sessions may be required to help prepare veterans for trauma-focussed therapy and address associated problems.
- Patient information on effective treatments for PTSD is available online (www.at-ease.dva.gov.au) or in Appendix L, and an example script is provided below:

“The most effective treatment for PTSD involves facing your memories of (traumatic event). A therapist will help you find a safe way to do that, and to confront situations, people, or places that you have avoided since the event. You’ll also learn skills to help you deal with the problems you’ve been experiencing with (sleep/anger/concentration/hypervigilance etc.). The therapy may involve 8-12 weekly sessions but may require longer depending on your needs.”

Pharmacological Treatment

- Antidepressants may be beneficial for veterans who are unwilling or unable to engage in trauma-focussed therapy or when psychological treatment is unavailable. Newer antidepressants such as SSRIs and SNRIs are the first line pharmacological treatment for PTSD due to their favourable side-effect profile. When a veteran responds to antidepressants, they should be continued for at least 12 months before considering gradual withdrawal.
- Benzodiazepines are sometimes used to stabilise patients, however long term use is not indicated as they do not treat the underlying condition and involve risk of dependency.
- Atypical antipsychotics can be useful for veterans who show an incomplete response to antidepressants.
- If pharmacotherapy is commenced, the veteran’s mental state should be monitored and adjunctive psychological therapy commenced when appropriate.

Referral Options

- WVCS – Veterans and Veterans Families Counselling Service. Phone 1800 011 046 (24 hours).
- Mental health professionals can be accessed through Medicare. A list of psychologists can be found at www.psychology.org.au/findapsychologist. A list of mental health trained social workers can be found at www.aasw.asn.au/membersdirectory.
- Private psychiatrists: A list can be accessed by GPs at www.ranzcp.org/Resources/find-a-psychiatrist.aspx.
- DVA-funded PTSD programs. Phone 133 254 or 1800 555 254.

Somatic symptom disorders

Somatic symptom disorders include a range of presentations. In the veteran population, chronic pain problems, health anxiety (i.e., hypochondriasis) and psychological factors affecting existing medical conditions are the most likely presentations. Somatic symptoms are associated with high rates of comorbid anxiety and depression.

Presentation usually includes disproportionate concerns about the seriousness of symptoms, a tendency to devote excessive time and energy to behaviours associated with somatic symptoms and significant distress and impairment.

Cognitive behavioural therapy can be helpful although there is insufficient evidence at this stage to make firm recommendations.

There is a lack of firm evidence for the efficacy of pharmacological interventions. If necessary, consider newer antidepressants.

Information, patient resources and assessment tools are available at www.at-ease.dva.gov.au or in the Appendices.

Screening for somatic symptoms

The following questions may help identify veterans with problems in this area:

- Have you had many physical complaints not clearly related to a specific disease?
- In the past six months, have you worried a lot about having a serious physical illness?
- Currently, is pain your main problem?

If the veteran responds 'yes' to a question, there is no complete physical explanation, and/or there is significant distress in relation to the symptoms then assess further.

Assessment

- Conduct routine medical assessment that includes thorough physical examination, judicious use of investigations and specialist referral. Avoid referral for further investigation unless clear evidence of a physical problem.
- Consider transcultural variations in presentation. In some cultures, physical symptoms are an accepted way of expressing emotional distress so may not be problematic. This does not mean that the patient does not need treatment for other psychological issues e.g., anxiety, depression.
- Assess the patient's mental state, presence of comorbid mental and physical conditions, strengths, and cognitive impairments.
- A freely available screening tool for assessing the presence and severity of somatic symptoms is the Patient Health Questionnaire-15 (PHQ-15). This is not a diagnostic measure.

Occasional or intermittent somatic presentation	Chronic somatic presentation
<p>Support self-management. While the cause of symptoms may be unknown, factors that perpetuate them should be identified and targeted. Encourage the veteran to monitor symptoms to help identify factors (e.g., times, situations and emotional states) which exacerbate the symptoms. Manage these factors through strategies such as anxiety management and problem solving.</p>	
<p>See the patient regularly for review, not in response to his or her psychosomatic crises.</p>	
<p>Consider referral for psychological treatment. CBT has the strongest evidence base for the treatment of somatic symptoms although there is insufficient evidence to make firm recommendations.</p>	
	<p>Consider referral to pain management clinic, review medication, and ensure that the patient is properly medicated if pain is severe or causes impairment.</p>
	<p>Shift treatment emphasis from symptom eradication to maintenance care, harm limitation and rehabilitation if disorder is entrenched.</p>
	<p>Consider psychotropic medication if psychological treatment is not acceptable or available to the patient or if it fails to produce a sufficient response. Avoid prescribing new medication for each new symptom.</p>
<p>Consider rehabilitation from the beginning due to the importance of maintaining/resuming normal social and occupational roles. This reduces the likelihood of enduring disability. DVA can offer extensive rehabilitation services for entitled veterans (www.dva.gov.au/rehabilitation).</p>	

Elements that you may consider during a consultation

Self-management Strategies

Practitioners may discuss basic self-management strategies that the veteran can use to manage their symptoms while more targeted psychological and/or pharmacological interventions take effects. Encourage the patient to:

- Monitor symptoms to help **identify psychosocial factors** (e.g., times, situations and emotional states) which exacerbate their symptoms. Then assist the patient to **manage these perpetuating factors** through strategies that may include anxiety management, problem solving, facilitating engagement with social support, etc.
- Maintain (or re-establish) their daily **routine and current roles (e.g., work, family)**. This is particularly important for veterans who have a lot of unstructured time.
- **Reduce substance use.** It is common for veterans to self-medicate with alcohol and other drugs when struggling with pain. If analgesic medication is used, it should be taken on a regular schedule as far as possible, rather than on an 'as needed' basis.

Self-management Resources

- At Ease website (www.at-ease.dva.gov.au) for access to general information on mental health wellbeing including the Wellbeing Toolbox, anxiety management and alcohol resources.
- HealthInsite (www.healthinsite.gov.au) is a useful website for information on chronic pain and other somatic complaints.

Psychological Treatment

- There is no current consensus on the best psychological treatments for somatic symptoms, however cognitive behavioural therapy (CBT) appears to be the most promising approach. Key components include:
 - Cognitive therapy – to help identify and modify unhelpful beliefs about symptoms and disease.
 - Behavioural techniques – to alter illness and sick role behaviours and promote more effective coping.
- Somatic symptoms are typically treated in an outpatient setting, in either an individual or a group format. It is likely that 16–20 weekly sessions would be required.
- Patient information on effective treatment for managing pain is available online (www.at-ease.dva.gov.au) or in Appendix L, and an example script explaining CBT treatment is below:

“One of the most effective treatments for managing the factors and triggers that exacerbate your pain/symptoms is cognitive behavioural therapy, or CBT. By examining and adjusting your thinking style and behaviours you’ll learn skills to help you manage these factors which will in turn help minimise the impact of your pain/symptoms. The therapy may involve 16-20 weekly sessions but may require longer depending on your needs.”

Pain Management Programs

- Pain management programs (PMPs) are the treatment of choice for veterans suffering from chronic pain syndromes. Effective PMPs adopt an explicit biopsychosocial model that uses CBT techniques. This can be explained to the patient with:

“This program takes holistic view of you and your concerns. You will be provided with education on pain coping strategies, and learn to better manage your pain. It will also look at other ways of supporting you to improve your daily functioning and lifestyle, and to improve your general physical health and fitness.”

- PMPs typically occur in a group setting and vary from two to six weeks duration.

Pharmacological Treatment

- There is a lack of firm evidence for the efficacy of pharmacological interventions, although medication may be beneficial for veterans who are unwilling or unable to engage in psychological treatment or when it is unavailable.
- In cases where medication is considered necessary, new generation antidepressants such as SSRIs and SNRIs are the first line treatment.
- Veterans with predominant pain symptoms may also respond to anticonvulsants, such as gabapentin or pregabalin.
- If pharmacotherapy is commenced, the veteran’s mental state should be monitored and adjunctive psychological therapy commenced when appropriate.

Referral Options

- WVCS – Veterans and Veterans Families Counselling Service. Phone 1800 011 046 (24 hours).
- Mental health professionals can be accessed under Medicare. A list of psychologists can be found at www.psychology.org.au/findapsychologist. A list of mental health trained social workers can be found at www.aasw.asn.au/membersdirectory.
- Private psychiatrists: A list can be accessed by GPs at www.ranzcp.org/Resources/find-a-psychiatrist.aspx.

Smoking

Approximately 15 per cent of Australians over the age of 14 are daily smokers, although the rate has been declining. There is some indication that rates of smoking are higher for veterans (particularly for younger veterans) than for the general population.

Smoking has multiple long-term health impacts, and is a major contributor to preventable disease burden for veterans and their families.

Information, patient resources and assessment tools are available at www.at-ease.dva.gov.au or in the Appendices.

Screening for smoking readiness to quit

Useful questions to ask a veteran who is a current smoker include:

- How do you feel about your smoking at the moment?
- Are you ready to stop smoking now?

If the patient has expressed an interest in quitting:

"Quitting smoking can be difficult, however by using some basic strategies you can increase your chances of quitting successfully. Do you mind if we spend a few minutes going over these strategies?"

If the patient has expressed they are not interested in quitting:

"There are a number of ways to approach quitting that make it easier to stop, and we can discuss these when you feel ready to. If it's OK with you, we can revisit your smoking at another time."

Assessment

- Assess smoking history, readiness for change, past attempts to quit, other health problems and special needs. If the patient is considering quitting then nicotine dependence can be assessed using the Fagerstrom Test for Nicotine Dependence (available from www.health.wa.gov.au/smokefree/docs/Fagerstrom_Test.pdf).
- The Smoking Cessation Framework (or the 5A's Structure for Smoking Cessation) helps structure the type of advice, support and treatment you provide the patient by taking into account their readiness to quit. More detailed information can be found in the Smoking Cessation Guidelines for General Practice, available at www.health.gov.au.



Elements that you may consider during a consultation

Self-management Strategies

Practitioners can discuss basic self-management strategies that veterans can use to manage their smoking. Depending on readiness to change, you may encourage the patient to:

- Select a quit date, ideally within the next two weeks. Arrange a follow up appointment with the patient about one week and one month after the quit date.
- Read material on how to quit smoking, and the health consequences of smoking [available from www.quitnow.gov.au and your state-based 'Quit' website].
- Use the Quitline (13 7848).
- Utilise social supports e.g., family, friends and/or other veterans.
- Weigh up the pros and cons of smoking with motivational interviewing techniques. Refer to Psychological Treatment section following for more detailed information.

Self-management Resources

- The Quit website is a government initiative that provides self-help resources (www.quitnow.gov.au) and an online counselling service (www.quitcoach.org.au).
- Telephone support, advice or counselling via the Quitline (13 7848). Services available vary from state to state.
- At Ease website (www.at-ease.dva.gov.au) for access to veteran-specific information on mental health and wellbeing including the Wellbeing Toolbox, anxiety management and alcohol resources.

Psychological Treatment

Brief psychological interventions, including motivational interviewing are indicated for veterans who are thinking about quitting, or are ready to quit.

Thinking about quitting/unsure

GP administered brief motivational interviewing assists with resolving ambivalence about smoking, and prepares the veteran for change. Ambivalence should be acknowledged and discrepancies between smoking behaviour and person's personal beliefs and goals should be discussed. Questions to ask include:

- "What do you like about smoking? What are the things you don't like about smoking?"
- After summarising the patient's pros and cons ask "Where does this leave us now?" to help shift motivation for behaviour change.

A useful resource is the Smoking Cessation Guidelines for Australian General Practice: Desktop Guidelines and Patient Education Materials, available to download from www.health.gov.au.

Ready to quit

Referral to group or individual counselling that uses cognitive behavioural therapy (CBT)-based strategies is recommended. Key components of treatment include:

- Assistance to identify high-risk smoking situations, and problem solving strategies to deal with such situations.
- Strategies and skills to cope with cravings e.g., Delay, Deep breathe, Drink water and Do something (The 4Ds).
- Encouraging the use of social support.

Patient information on effective treatments is available online (www.at-ease.dva.gov.au) or in Appendix L.

Pharmacological Treatment

Pharmacotherapy is recommended for all dependent smokers who express an interest in quitting, except where contraindicated. It should be combined with support and counselling.

- Nicotine replacement therapy (NRT; including patch, gum and inhaler methods) has strong evidence in long-term cessation success. Slow-release NRT (i.e., patch) is preferred as quick-release preparations such as gum or lozenges can contribute to nicotine dependence.
- Veterans with severe nicotine dependence or a history of cessation failure may benefit from the prescription of bupropion or varenicline as a short-term adjunctive therapy to slow-release NRT.

Referral Options

- A Quitline GP smoking cessation referral form is available from www.quitnow.gov.au.
- Mental health professionals can be accessed through Medicare. A list of psychologists can be found at www.psychology.org.au/findapsychologist. A list of mental health trained social workers can be found at www.aasw.asn.au/membersdirectory.

Alcohol misuse

Alcohol is a significant issue amongst veterans with about 3 in 10 drinking at risky levels.

- Alcohol misuse is associated with short-term harms such as accidental injury. It also has significant long-term health risks such as elevated blood pressure, liver problems, sleep difficulties, mood and anxiety problems and cognitive impairment.
- Brief interventions can be delivered by a GP and include simple feedback about use, advise and goal setting.

Cognitive behavioural therapy and motivational interviewing are also effective psychological interventions.

Pharmacotherapy should be considered for all alcohol-dependent patients following detoxification.

Information, patient resources and assessment tools are available at www.at-ease.dva.gov.au or in the Appendices.

Screening for alcohol misuse

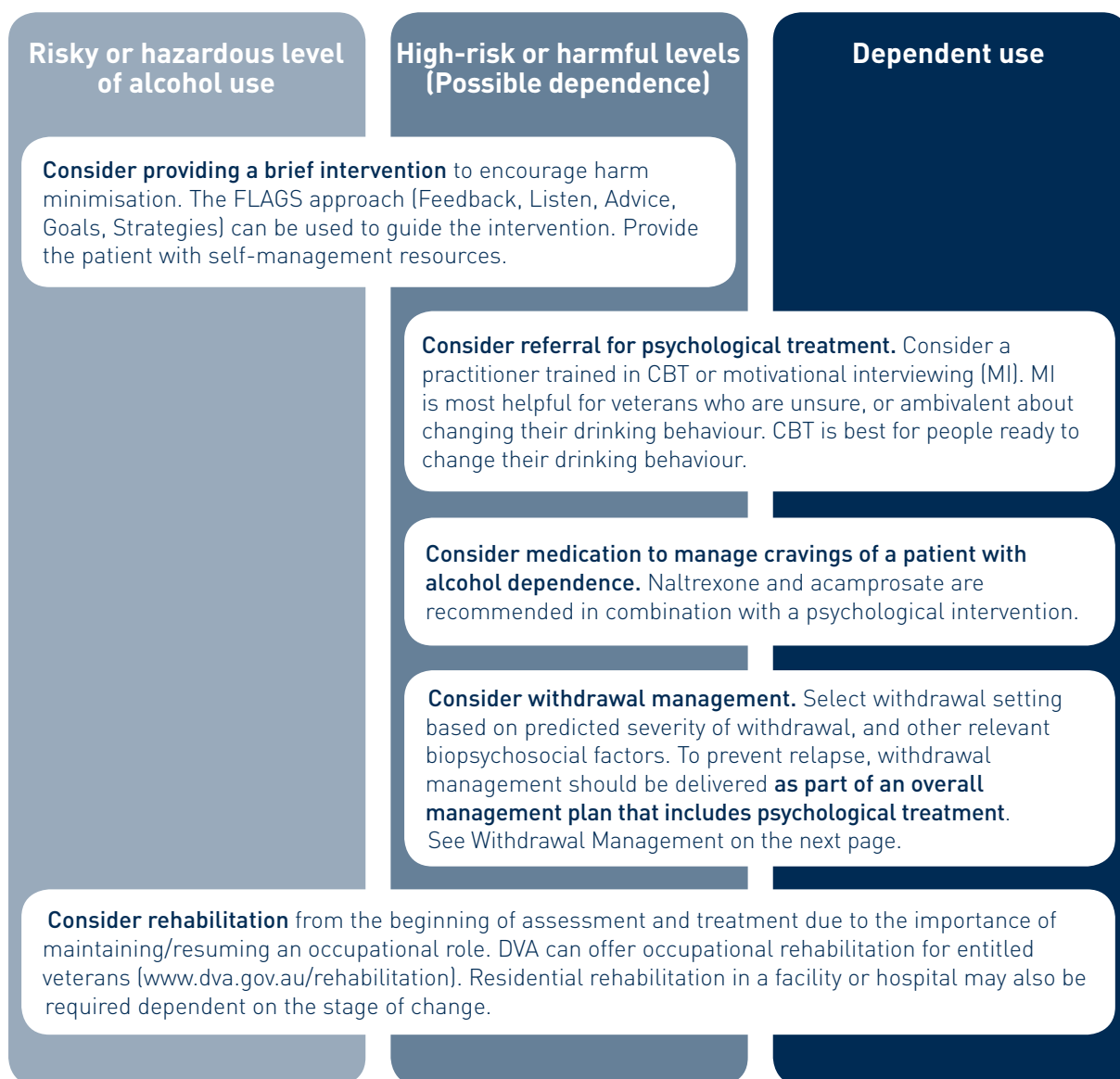
The CAGE is a screening instrument designed to identify potential alcohol misuse:

- Have you ever felt you ought to **cut down** on your drinking?
- Have people **annoyed** you by criticising your drinking?
- Have you ever felt bad or **guilty** about your drinking?
- Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?

If the patient answers “yes” to two or more of these questions, further assessment of alcohol problems is warranted.

Assessment

- Assess the patient’s mental state, presence of comorbid mental and physical conditions, cognitive impairment and strengths. Assess for risk of harm to self and others.
- A freely available standardised assessment tool that can assist in developing a mental health plan, or assessing severity and outcomes, is the Alcohol Unit Disorders Identification Test (AUDIT; see Appendix C or www.at-ease.dva.gov.au).
- Withdrawal severity can be assessed using the Clinical Institute Withdrawal Assessment for Alcohol revised scale (CIWA-Ar; available from www.tg.org.au/etg_demo/etg-ciwa-ar.pdf).



Elements that you may consider during a consultation

Brief Intervention

General practitioners are well placed to conduct a brief intervention with veterans who are drinking beyond recommended levels. It is important to tailor the intervention to the veteran's readiness for change, however the following components should generally be included:

- **Feedback** the results of the alcohol assessment in non-judgemental and non-threatening manner.
- **Listen** carefully to the patient's reactions and concerns.
- **Advise** the patient about degree of risk and consequences associated with their alcohol intake. Ask them to outline the benefits and costs of continuing to drink at current level.
- **Goals** should be set that are realistic and involve a reduction toward low-risk levels of drinking.
- **Strategies** to reduce consumption to safe limits should be discussed and implemented. The veteran may have already used some strategies with success. Begin with their suggestions, then add others (e.g., avoid drinking when in negative mood or tired, count standard drinks, avoid 'shouts').

A DVA resource outlining brief interventions can be downloaded from: www.dva.gov.au/service_providers/Documents/manual_AS+BI.pdf.

Self-management Resources

- A useful veteran specific resource is The Right Mix website (www.therightmix.gov.au). This website has interactive information, local support contacts, and tips for changing drinking behaviour. It also has Changing the Mix, an internet-based alcohol correspondence program (1800 1808 68).
- Information on drinking guidelines and self-management strategies can be found at www.alcohol.gov.au.
- At Ease website (www.at-ease.dva.gov.au) for access to veteran-specific information on mental health wellbeing including the Wellbeing Toolbox, anxiety management and alcohol resources. The DVA *Mental Health and Wellbeing after Military Service* booklet is available to order or download.

Psychological Treatment

Interventions should be tailored both to the level of alcohol use/dependence and to suit the veteran's preparedness to change.

Motivational interviewing (MI) targets ambivalence about making changes to drinking behaviour. It focuses on helping the veteran resolve ambivalence and move towards action.

Cognitive behavioural therapy (CBT) is the treatment of choice for veterans ready to change their drinking behaviour. Key components of CBT include:

- Behavioural self-management – teaches strategies to reduce alcohol consumption e.g., self-monitoring and identifying high risk situations.
- Coping skills training – targets stressful situations linked to alcohol use. Skills include assertiveness, coping with cravings, drink refusal.
- Cue exposure – places veteran in the presence of cues to drinking (e.g., pub, cigarette) whilst not drinking and observing the craving fade.
- Relapse prevention – teaches skills to maintain changes to alcohol use over time.

Patient information on effective treatments is available online (www.at-ease.dva.gov.au and in Appendix L), and an example script is provided below:

"One of the most effective ways to help reduce your drinking is using cognitive behavioural therapy, or CBT. CBT helps you develop skills to deal with situations or feelings that can trigger drinking, strategies to manage cravings, and practical ways to control the amount you drink."

Behavioural couples therapy focuses on drinking behaviour as the problem in the context of the veteran's relationship.

Self-help group programs such as SMART Recovery may be an effective self-help addition to more formal interventions for some patients.

Withdrawal Management

- Withdrawal management may be conducted in home-based, community residential and inpatient hospital settings. Choose setting appropriate to predicted withdrawal severity.
- Thiamine (preferably IM) should be provided to all veterans undergoing alcohol withdrawal.
- Long-acting benzodiazepines are the preferred pharmacotherapy for managing alcohol withdrawal but should not be continued beyond the first one to two weeks.

Pharmacological Treatment

- Pharmacotherapy should be considered for all alcohol-dependent patients following detoxification.
- Acamprosate and naltrexone have been shown to improve outcomes when used in combination with psychosocial intervention.

Referral Options

- VVCS – Veterans and Veterans Families Counselling Service. Phone 1800 011 046 (24 hours).
- Mental health professionals can be accessed through Medicare. A list of psychologists can be found at www.psychology.org.au/findapsychologist. A list of mental health trained social workers can be found at www.aasw.asn.au/membersdirectory.
- Private psychiatrists: A list can be accessed by GPs at www.ranzcp.org/Resources/Find-a-psychiatrist.aspx.

Illicit drugs and prescription medications abuse

Around one third of Australians use illicit drugs at some point in their lives. Cannabis is the most commonly used, followed by ecstasy, amphetamines and cocaine. Misuse of prescription medication, especially pain medication, appears to be a growing problem with veterans.

- Co-morbid mental health problems are common, particularly depression, alcohol abuse, anxiety and PTSD.
- Substance use and suicidal thoughts or behaviour are often related.

Recommended psychological treatments include motivational interviewing (MI), cognitive behavioural therapy (CBT) and behavioural couples therapy and family therapy.

When withdrawal management is delivered, it should be considered as part of an overall management plan to prevent relapse.

Information, patient resources and assessment tools are available at www.at-ease.dva.gov.au or in the Appendices.

Screening for substance abuse and dependence

The CAGE-AID is a screening instrument designed to identify potential substance abuse and dependence.

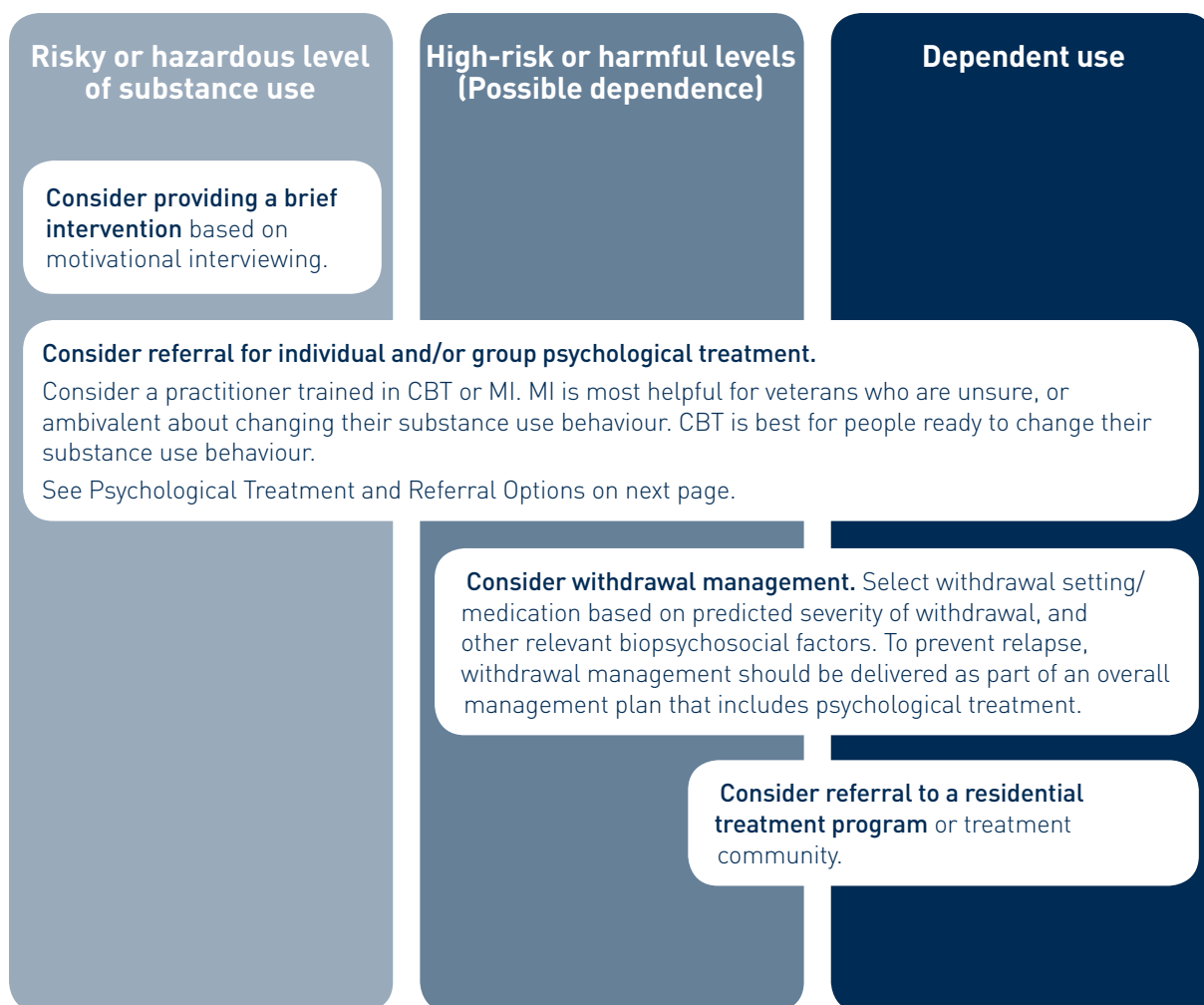
When thinking about drug use, including illegal drug use and the use of prescription drugs other than as prescribed:

- Have you ever felt you ought to **cut down** on your drug use?
- Have people **annoyed** you by criticising your drug use?
- Have you ever felt bad or **guilty** about your drug use?
- Have you ever used drugs first thing in the morning to steady your nerves or get rid of a hangover?

If the patient answers “yes” to two or more of these questions, consider further assessment.

Assessment

- Assess the patient’s mental state, presence of comorbid mental and physical conditions, strengths, and cognitive impairments.
- Due to high comorbid rates of suicidal behaviour, assessing for risk of harm to self and others is recommended. Injecting behaviour and associated risks may also warrant assessment.
- An instrument that can help you develop a mental health plan, or assess severity is the Drug Abuse Screening Test (DAST-20). The Depression Anxiety and Stress Scale is a standardised assessment tool that can assist in exploring associated mood disorders (DASS-21). This is not a diagnostic measure. Both questionnaires can be found at www.at-ease.dva.gov.au or in Appendix C.



Elements that you may consider during a consultation

Brief Intervention

The following approach, based on motivational interviewing principles, has been shown to reduce harm associated with substance use:

- Ask the patient if they are interested in feedback about their substance use.
- Ask the patient how concerned they are about their substance use.
- Provide advice on how to reduce risks associated with substance use, and provide written information where appropriate (see self-management resources).
- Whilst remaining empathic, remind the patient that he or she is responsible for changing behaviours, and that help is available:
 "...now that you have some feedback regarding your substance use and an idea of the risks involved with your use, what you do with this information is entirely up to you."
- Encourage the patient to identify the pros and cons of substance use and provide some written information on substance use and support that is available.

Self-management Resources

- Australian Drug Foundation (www.adf.org.au) provides advice on community services and information around substance use.
- *DrugInfo* (www.druginfo.adf.org.au) is a service of the Australian Drug Foundation that provides handouts on illicit substance use and prescription medication misuse.
- A self-help booklet from the World Health Organisation can be found here: whqlibdoc.who.int/publications/2010/9789241599405_eng.pdf.
- The National Cannabis Prevention and Information Centre (www.ncpic.org.au/).

Psychological Treatment

- Treatment will vary depending on the substance being used and the level of harm or dependence. Recommended treatments for a range of substances include:
 - Cognitive behavioural therapy (CBT) and motivational interviewing (MI) or motivational enhancement therapy (MET). Whilst CBT has been shown to be effective for substance use problems in general, the evidence is particularly strong for treating cannabis use.
 - Behavioural couples therapy and family therapy can help to ensure that families and/or partner are supporting change.
- Residential programs or therapeutic communities can be effective for severe cases, however keep in mind that evidence for their success is limited.
- Patient information on effective treatments is available online (www.at-ease.dva.gov.au) or in Appendix L, and an example script for a patient that abuses cannabis is provided below:

“One of the most commonly used treatments for substance use problems is cognitive behavioural therapy, or CBT. By looking at your reasons for using, and behaviours surrounding your use, you’ll learn some strategies to cope with cravings, manage responses to triggers, and learn strategies to help you with minimising your use. The duration of therapy will vary depending on your needs.”

Withdrawal Management

- Withdrawal management may be conducted in home-based, community residential and inpatient hospital settings. Choose a setting appropriate to predicted withdrawal severity.
- Not all substances will require a withdrawal management plan due their lower levels of physical dependence. For example, this may be the case with cannabis or psychostimulant users.
- Pharmacotherapy may assist with minimising the impact of detoxification or withdrawal.
- Withdrawal management should be delivered as part of an overall management plan.

Pharmacological Treatment

- Pharmacological treatment should be specific to the substance being used, and what aspect of treatment it is targeting (withdrawal, reducing cravings, or maintenance therapy). Pharmacotherapy is more likely to be suitable for people using opioids or minor tranquilisers such as benzodiazepines.
- If pharmacotherapy is deemed necessary, it is recommended you consider providing it as an adjunct to psychotherapy.

Referral Options

- VVCS – Veterans and Veterans Families Counselling Service. Phone 1800 011 046 (24 hours).
- Mental health professionals can be accessed under Medicare. A list of psychologists can be found at www.psychology.org.au/findapsychologist. A list of mental health trained social workers can be found at www.aasw.asn.au/membersdirectory.
- Private psychiatrists: A list can be accessed by GPs at www.ranzcp.org/Resources/find-a-psychiatrist.aspx.

Complicated grief

Bereavement is a universal experience. However, sometimes sustained and intense grief can become a chronic debilitating condition.

Approximately one in ten bereaved people experience complicated grief, with higher rates amongst those bereaved by disaster or violent death, or with parents who lose a child.

Complicated grief involves:

- prolonged experiences of grief, usually for more than one year
- intense yearning for the deceased; rumination about the death
- ongoing reactive distress related to the death e.g., anger, bitterness and self-blame
- sense that life is futile or meaningless; detachment from others.

Cognitive behavioural therapy (CBT) is an effective treatment for complicated grief.

Where medication is required, newer antidepressants should be considered as the first choice and should be delivered as an adjunct to psychological intervention.

Information, patient resources and assessment tools are available at www.at-ease.dva.gov.au or in the Appendices.

Screening for complicated grief

For veterans who have experienced the death of a close friend or relative at least 12 months earlier, ask if they have experienced any of the following symptoms more days than not at levels that impair functioning and cause significant distress:

- persistent yearning for and/or preoccupation with the deceased
- reactive distress to the death e.g., difficulty accepting the death, emotionally numb, bitterness related to death and difficulty having positive feeling related to the deceased
- disruption of social roles and identity, e.g., difficulty trusting and feeling detached from others, feeling that life is meaningless without the deceased.

If the patient endorses more than one of the above experiences, further assessment of complicated grief is warranted.

Complicated grief can be a risk factor for suicide; ask about suicidal ideation using direct and unambiguous questions

Assessment

- Assess the patient's mental state, presence of comorbid mental and physical conditions, strengths, and cognitive impairments. Also, assess for risk of harm to self or others.
- Currently there is no standardised assessment tool that assesses specifically for complicated grief and bereavement-related conditions. However, the Inventory of Complicated Grief - Revised is a measure recommended by the Australian Department of Health and Ageing.

Bereaved for at least 12 months and experiences persistent intense grief, with some impact on day-to-day functioning

Consider referral for psychological treatment. Consider a practitioner trained in CBT, with a particular emphasis on cognitive therapy, exposure, and behavioural techniques.
In the case of a patient who has severe, unremitting symptoms, consider referral to a **psychiatrist**. In the case of a patient with intent to suicide or harm others, **refer to emergency psychiatric services**.

Support self-management and prioritise social support. Facilitate social support, provide advice to help maintain routine, engagement in significant roles and pleasant activities, and encourage reduced substance use.

Consider rehabilitation from the beginning due to the importance of maintaining/resuming their normal social and occupational roles. This reduces the likelihood of enduring disability. DVA can offer extensive rehabilitation services for entitled veterans (www.dva.gov.au/rehabilitation).

Bereaved for at least 12 months and experiences persistent intense grief, with significant disruption of day-to-day functioning

Consider antidepressant medication adjunctive to psychotherapy. This may assist patients tolerate and respond to grief-focused CBT.

Elements that you may consider during a consultation

Self-management Strategies

Practitioners may discuss basic self-management strategies that the veteran can use to manage their symptoms while more targeted psychological and/or pharmacological interventions take effect. Encourage the patient to:

- Prioritise spending time and reconnecting with their **social supports** e.g., sympathetic family members and friends. There is strong evidence that social support is a key factor in preventing deterioration of symptoms and in promoting recovery.
- **Reduce substance use.** This is a significant issue amongst veterans, with comorbid substance abuse occurring often.
- Maintain (or re-establish) their daily **routine and current roles (e.g., work, family)**, including the use of a pleasant activities schedule.
- At Ease website (www.at-ease.dva.gov.au) for access to generic information on mental health wellbeing including the Wellbeing Toolbox, anxiety management and alcohol resources. The *DVA Mental Health and Wellbeing after Military Service* booklet is available to order or download.
- There are currently no resources specific to complicated grief although the following website has useful information on grief more generally: Australian Centre for Grief and Bereavement (www.grief.org.au).

Self-management Resources

Psychological Treatment

- Cognitive behavioural therapy (CBT) has an increasing evidence base for the treatment of complicated grief. The key components of CBT include:
 - Cognitive therapy – to identify unhelpful thinking patterns relating to the loss and find helpful ways of thinking about it.
 - Behavioural techniques – to assist the veteran to re-engage with the world, undertake positive activities, and set goals for the future.
 - Exposure therapy – can be particularly useful for those whose loss occurred in traumatic circumstances. This involves repeatedly telling the story of the loss or confronting places, activities or people associated with the loss that have been avoided.
 - Having imagined conversations with the deceased, evoking happy memories, and exploring regrets and resentment.
- Complicated grief is typically treated in an outpatient setting.
- Patient information on effective treatments is available online (www.at-ease.dva.gov.au) or in Appendix L, and an example script is provided below:

“One of the most effective treatments for your difficulties is cognitive behavioural therapy, or CBT. CBT can help you identify ways of thinking about your loss that prevent you from dealing with your grief. You’ll also learn ways to re-engage with the activities and social supports you used to enjoy, and set goals for the future.”

Pharmacological Treatment

- Newer antidepressants such as SSRIs and SNRIs are the first line for pharmacological treatment due to their favourable side-effect profile. They should be used as an adjunct to psychological intervention and be considered for the treatment of more severe symptoms.
- If pharmacotherapy is commenced, the veteran’s mental state should be monitored and adjunctive psychological therapy commenced when appropriate.

Referral Options

- WVCS – Veterans and Veterans Families Counselling Service. Phone 1800 011 046 (24 hours).
- Mental health professionals can be accessed through Medicare. A list of psychologists can be found at www.psychology.org.au/findapsychologist. A list of social workers can be found at www.aasw.asn.au/membersdirectory.
- Private psychiatrists: A list can be accessed by GPs at www.ranzcp.org/Resources/find-a-psychiatrist.aspx.

Problematic anger

Problematic anger and aggression are common problems for veterans and present a potential risk to others.

The anger may well be treated as part of interventions for other disorders, such as PTSD or depression, but there may also be some benefit in using anger-specific interventions.

Cognitive behavioural therapy (CBT) interventions can be effective. If family violence is involved, referral to a practitioner with expertise in the area or a family violence program is recommended.

Information, patient resources and assessment tools are available at www.at-ease.dva.gov.au or in the Appendices.

Screening for anger problems

It may be helpful to ask the patient these questions if you suspect a problem with anger:

- Do you find that you are often bothered by feelings of anger?
- Does it interfere with your mood, relationships, work or physical health?
- Are there times when you feel so angry that you have thoughts of harming someone?

If yes...

- What is it you have thoughts of doing and to whom?
- Do you have access to... (check means and opportunity)?
- Have there been times in the past when you have become so angry that you have harmed someone?

If yes... What happened?

Assessment

- **Assess the patient's partner** and where appropriate, other family members. It is important to address the family's safety needs and risk of harm. At least one assessment session should be undertaken with the family members without the patient being present.
- **Screening for other mental health problems.** Identification of any untreated mental health disorder (e.g., depression, PTSD, panic disorder or alcohol misuse) may not preclude participation in anger-specific treatment, although treatment of these primary mental health disorders may address the anger problem.
- A useful tool for assessing the presence and severity of anger in veterans is the Dimensions of Anger Reactions 5 (DAR5) scale, available at www.psychiatry.unimelb.edu.au/centres-units/cpro/DAR5/index.html.



Elements that you may consider during a consultation

Self-management Strategies

Practitioners can discuss basic self-management strategies that veterans can use to reduce their symptoms while more targeted psychological and/or pharmacological interventions take effect.

- Veterans are often slow to recognise the problem and may not be receptive to treatment. The following strategies **can help veterans recognise the problem and increase their motivation to engage in treatment**.
 - Provide education about anger (and/or violence) and its consequences.
 - Encourage the patient to monitor his or her anger (frequency, intensity and duration), preferably through use of a diary.

	<ul style="list-style-type: none"> • Discuss what happens to the patient when he or she is angry – focus on specific situations: “What were you thinking when you were angry yesterday? What did you do?” • Encourage the patient to do a cost/benefit analysis of the consequences of anger.
Self-management Resources	<ul style="list-style-type: none"> • Introduce simple arousal management techniques such as breathing retraining and distraction to stop escalation of anger. • Discuss behavioural interventions such as time-out. • Reduce substance use. Substance use can lead to increased risk of harming others. Early advice on reducing substance use has been shown to be effective. • MensLine Australia is a professional telephone and online support, information and referral service, helping men to deal with relationship problems in a practical and effective way (1300 78 99 78 or www.mensline.org.au). • Useful materials are also available from the Australian Psychological Society (www.psychology.org.au) and Reach Out (www.reachout.com.au). • At Ease website (www.at-ease.dva.gov.au) for access to veteran-specific information on mental health wellbeing including the Wellbeing Toolbox, anxiety management and The Right Mix alcohol resources.
Psychological Treatment	<ul style="list-style-type: none"> • Cognitive behavioural therapy (CBT) can be effective and includes the following elements: <ul style="list-style-type: none"> • Arousal management – e.g., breathing techniques and distraction techniques. • Cognitive therapy – to identify unhelpful beliefs and develop ways of challenging those beliefs, including, when appropriate, addressing beliefs about gender and exploring how these beliefs are related to the presence of abuse and violence. • Self-instruction training – provides skills to manage situations where anger is a problem. • Exposure for anger – imagining anger-triggering events and practicing skills of anger management in response. • Behavioural techniques – e.g., problem solving, assertion techniques, and negotiation and conflict resolution skills. • Patient information on effective treatments is available online (www.at-ease.dva.gov.au) or in Appendix L, and an example script is provided below: <p><i>“One of the most effective ways to help manage your anger is using cognitive behavioural therapy or CBT. CBT helps you develop skills to deal with situations and thinking habits that trigger anger, and provides you with strategies to manage your physical reactions.”</i></p>
Pharmacological Treatment	<ul style="list-style-type: none"> • If anger presents as a secondary problem related to a mood disorders, PTSD, anxiety disorders etc., effective medical treatment of these conditions will reduce the severity of abnormal anger and associated aggression. • Impulsive aggression has been shown to improve with treatments including lithium and various anticonvulsant medicines. SSRI antidepressants may have a role in improving anger symptoms even when anger occurs in the absence of other common mental health problems.
Referral Options	<ul style="list-style-type: none"> • VVCS – Veterans and Veterans Families Counselling Service. Phone 1800 011 046 (24 hours). • Mental health professionals can be accessed through Medicare. A list of psychologists can be found at www.psychology.org.au/findapsychologist. A list of mental health trained social workers can be found at www.aasw.asn.au/membersdirectory. • Private psychiatrists: A list can be accessed by GPs at www.ranzcp.org/Resources/find-a-psychiatrist.aspx. • Family violence prevention programs. A list can be found at www.relationships.org.au/what-we-do/services/family-violence-prevention.

Insomnia

Disturbed sleep is a common complaint among veterans. It can be caused by illness, stress or by poor sleep habits.

- Sleep problems can also be related to mental health problems. Given that depression, generalised anxiety, PTSD and alcohol misuse are relatively common in the veteran population, it is important to screen for these disorders if chronic sleep problems are detected.
- Self-management strategies encouraged by a GP are the first line intervention. If insomnia persists, it may be necessary to consider more formal interventions. Cognitive behavioural therapy (CBT) is the recommended psychological intervention.

Non-benzodiazepine hypnotic agents are the preferred pharmacotherapy. When possible, prescribe medications in conjunction with self-management advice or CBT.

Information, patient resources and assessment tools are available at www.at-ease.dva.gov.au or in the Appendices.

Screening for sleep problems

The following questions can be used to screen the veteran for sleep problems:

- Do you have any problems with your sleep?
- How many hours of sleep do you usually get at night?

It is important to assess for early-, middle- and late-onset insomnia:

For early-onset insomnia:

- Do you have difficulty getting off to sleep at night?
- How long does it take to fall asleep?

For middle-onset insomnia:

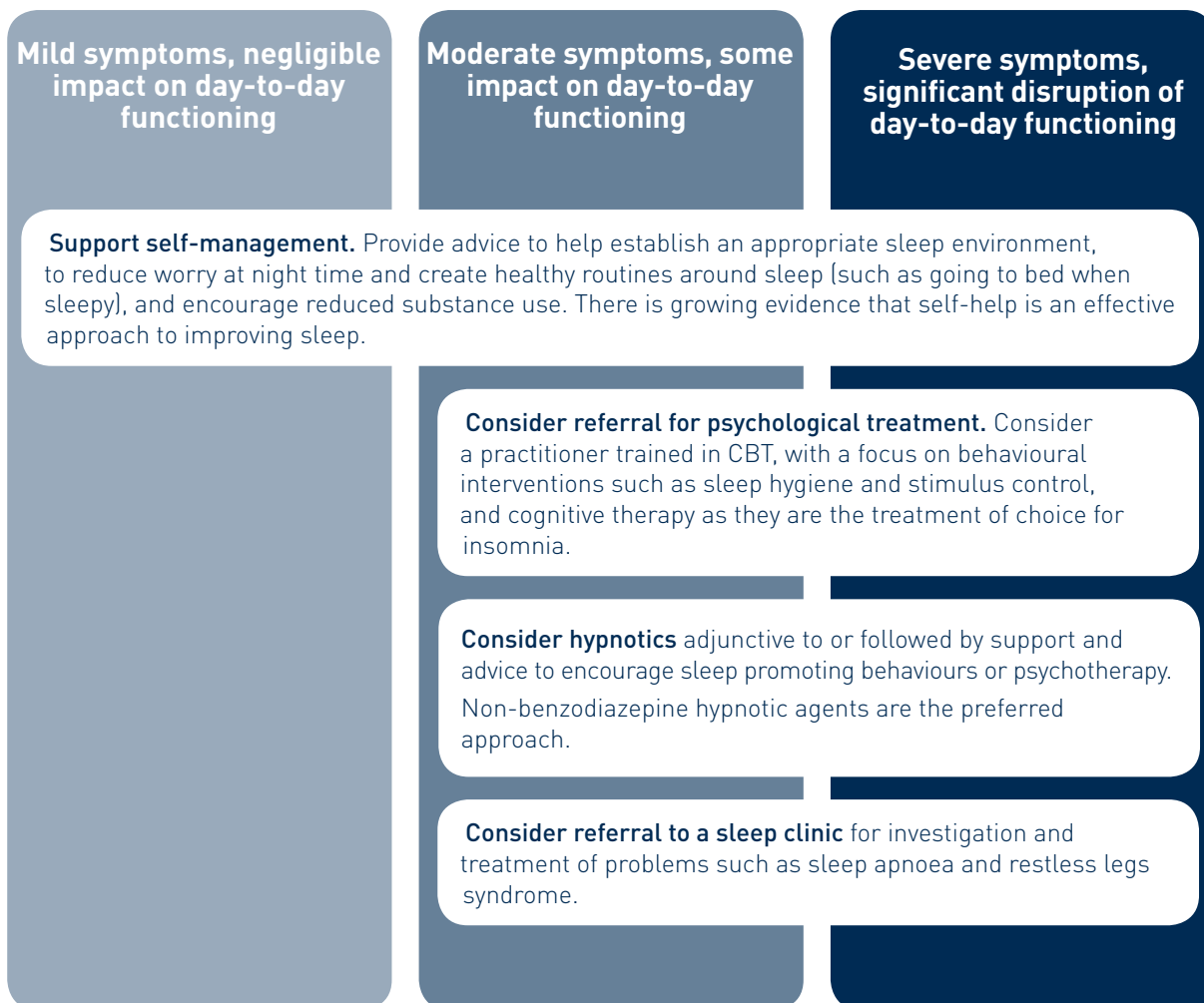
- Do you wake in the middle of the night?
- How many times do you wake?
- How long does it take to fall back asleep?

For late-onset insomnia:

- Do you wake early in the morning and have trouble going back to sleep?

Assessment

- Investigate likely causes including medications, medical conditions such as sleep apnoea and restless legs syndrome, and mental health conditions, particularly depression, anxiety, PTSD and alcohol misuse. Nightmares can also contribute to sleep disturbance.
- It can be useful to ask client to keep a sleep diary for about a week (includes time of retiring to bed and wake-up, time taken to fall asleep, number of awakenings, total time awake in bed, and level of fatigue during the day).
- Further physical investigations of sleep problems such as suspected sleep apnoea can be conducted by sleep centres or clinics.



Elements that you may consider during a consultation

Self-management Strategies

Practitioners can discuss basic self-management strategies that patients can use to reduce their sleep difficulties.

- Check if the veteran is already using sleep medication and how long they have been using it- if used over two weeks, **encourage reduced sleep medication use.**
- Develop good sleep hygiene techniques, for example:
 - **Establish an appropriate sleep environment**, e.g. insulate the bedroom against outside noises and to block out light.
 - **Remove stimuli not associated with sleep** from the bedroom.
 - **Reduce the time spent worrying in bed** about sleep or other matters, e.g. write worries down and leave them until morning.
 - **Avoid alcohol, caffeine and nicotine** in the late afternoon and evening.
 - **Exercise regularly** late in the afternoon or early in the evening, but not close to going to bed.

- **Establish a healthy sleep routine:**
 - Go to bed only when sleepy, and use the bed only for sleep and sex.
 - Wait for sleep for 15-20 minutes, get up if he/she does not fall asleep and only go back to bed when sleepy.
 - Get up at the same time each morning, no matter how long he/she has slept.
 - Do not have naps during the day.
- Self-management Resources**
- At Ease website (www.at-ease.dva.gov.au) for access to veteran-specific information on mental health wellbeing including the Wellbeing Toolbox, anxiety management and alcohol resources.
 - Information on managing sleep difficulties is available from www.sleephealthfoundation.org.au.
- Psychological Treatment**
- Cognitive behavioural therapy has been shown to be effective and includes the following elements:
 - Sleep hygiene and stimulus control strategies – e.g., removing from the bedroom stimuli not related to sleep and only going to bed when sleepy.
 - Cognitive therapy – teaches strategies to manage anxiety and avoid worrying when lying in bed, and challenges negative beliefs about sleep requirements.
 - Patient information on effective treatments is available online (www.at-ease.dva.gov.au) or in Appendix L, and an example script is provided below:

“One of the most effective ways to start addressing your sleep difficulties is by trialling some self-management strategies such as avoiding caffeine in the late afternoon, setting up a good sleep environment and writing down any worries that keep you from sleeping. If your difficulties remain, cognitive behavioural therapy can be effective, and includes ways to develop better sleep habits and to manage worries.”
- Pharmacological Treatment**
- Pharmacotherapy for insomnia should not be used in isolation, but should be part of a range of interventions, including standard sleep hygiene measures and if needed, psychological treatment.
 - Non-benzodiazepine hypnotic agents such as zolpidem and zopiclone are the preferred first-line approach. They are less likely to cause rebound insomnia or withdrawal syndromes than benzodiazepines.
 - Benzodiazepine hypnotics are problematic in their potential for tolerance and dependency, residual daytime cognitive impairment, interference with motor function and confusion and falls in the elderly.
 - When other agents such as antihistamines and sedating antidepressants are used for their hypnotic effects, the broader array of potential side effects must be considered and balanced against the desired benefits.
 - As a general principle, short-term use (less than 4 weeks) is preferable when using hypnotic medication as this helps to prevent many potential complications.
- Referral Options**
- WCS – Veterans and Veterans Families Counselling Service. Phone 1800 011 046 (24 hours).
 - Mental health professionals can be accessed through Medicare. A list of psychologists can be found at www.psychology.org.au/findapsychologist. A list of mental health trained social workers can be found at www.aasw.asn.au/membersdirectory.
 - Private psychiatrist. A list can be accessed by GPs at www.ranzcp.org/Resources/Find-a-psychiatrist.aspx
 - Many sleep clinics and specialists can be found at www.sleep.org.au/servicesdirectory.

Problem gambling

Problem gambling is characterised by difficulties to control gambling impulses. This includes difficulties limiting the money and/or time spent gambling which then leads to negative consequences for the veteran and his or her friends, family or community.

- Problem gambling is slightly more common in veterans than the general population, with around four per cent of Vietnam veterans experiencing problem gambling, compared to one to two per cent of the general population.
- Comorbid mental health problems are common in people with problem gambling.

The recommended psychological treatment is cognitive behavioural therapy (CBT).

There is limited evidence supporting the effectiveness of pharmacological treatments for problem gambling.

Information, patient resources and assessment tools are available at www.at-ease.dva.gov.au or in the Appendices.

Screening for problem gambling

Practitioners are advised to screen and assess for problem gambling in veterans with mental health problems.

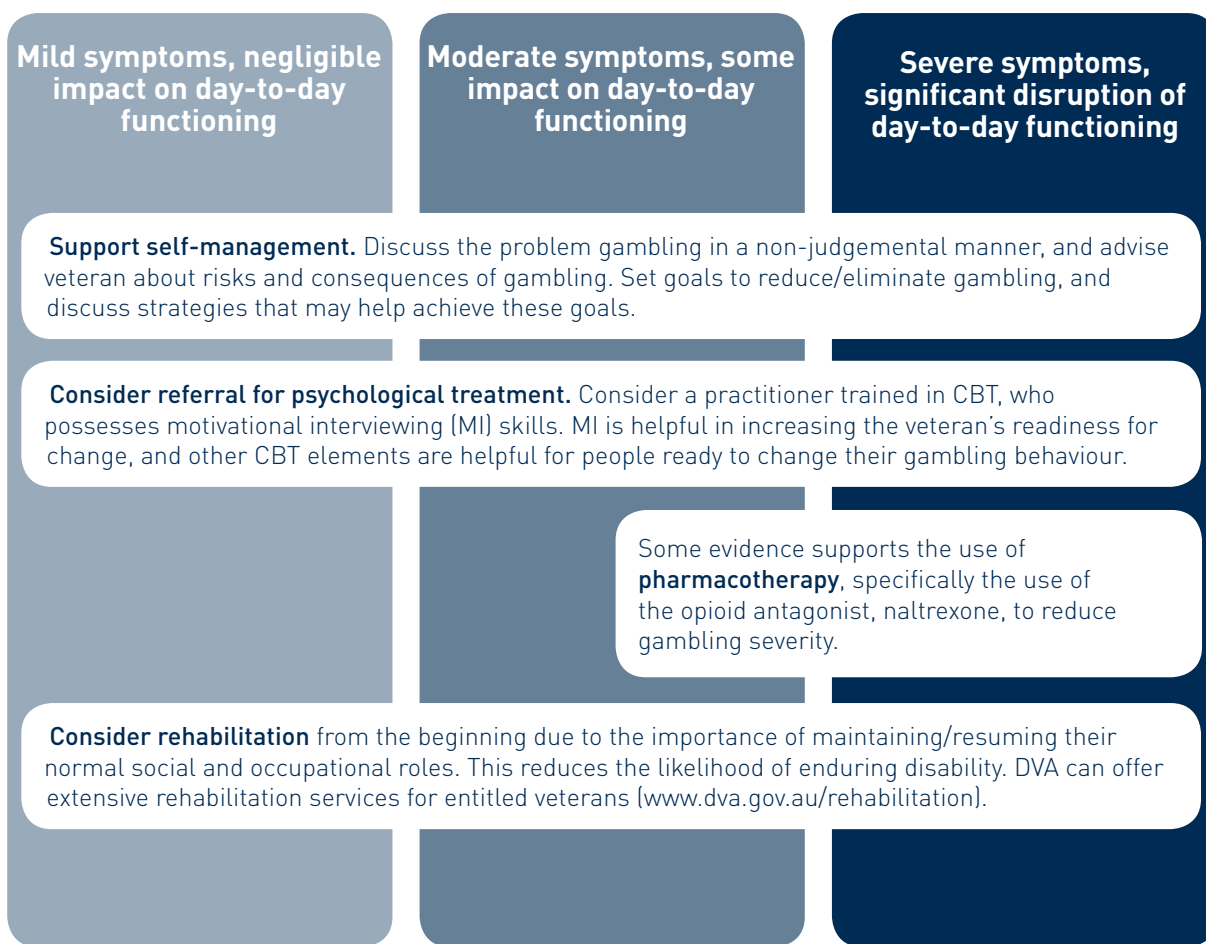
A simple question to ask is:

- Have you ever had an issue with your gambling?

If the veteran answers 'yes' to this question, further assessment of his or her gambling habits is recommended.

Assessment

- Assess the patient's mental state, presence of comorbid mental and physical conditions, cognitive impairments, strengths and resilience.
- A standardised assessment tool that can help you develop a mental health plan, or assess severity and outcomes, is the Canadian Problem Gambling Index (CPGI) (available from www.gamblinghelponline.org.au/gambling-issues/risk-assessment.aspx).
- The Depression Anxiety and Stress Scale is a standardised assessment tool that can assist in exploring associated mood disorders (DASS-21). This is not a diagnostic measure. This measure is available at www.at-ease.dva.gov.au or in Appendix C.



Elements that you may consider during a consultation

Self-management Strategies

Practitioners may talk through basic self-management strategies that reduce the veteran's symptoms while more targeted psychological and/or pharmacological interventions take effect.

- **Discuss** the problem gambling in a non-judgemental and non-threatening manner, and listen carefully to the patient's reactions and concerns.
- Advise the patient about degree of **risk and consequences** associated with their gambling. Refer them to information that dispels the myths related to gambling e.g., odds of winning, how pokies work (www.gamblinghelponline.org.au). Ask them to outline the benefits and costs of continuing to gamble at current level.
- **Goals** should be set that are realistic and involve a reduction or elimination of gambling.
- **Strategies** to reduce gambling should be discussed and implemented. The veteran may have already used some strategies with success. Begin with his or her suggestions then add others.

Self-management Resources

- At Ease website (www.at-ease.dva.gov.au) for access to veteran-specific information on mental health wellbeing including the Wellbeing Toolbox, anxiety management and alcohol resources. The DVA *Mental Health and Wellbeing after Military Service* booklet is available to order or download.
- Gambling Help provides online counselling as well as information on problem gambling, self-assessment and where to seek other support. They can be contacted on 1800 858 858 or at www.gamblinghelponline.org.au.

Psychological Treatment

- Cognitive behavioural therapy (CBT) is the recommended psychological treatment for problem gambling. Key elements include:
 - Motivational interviewing techniques – to enhance the veteran's readiness to change.
 - Cognitive therapy – to reframe unhelpful thoughts about gambling (e.g., overestimating odds of winning).
 - Identifying triggers and high risk situations and developing coping strategies.
 - Exposure therapy – including imaginal desensitisation, in vivo exposure and response prevention.
 - Activity scheduling – to help the veteran find alternative enjoyable activities.
- Problem gambling is typically treated with regular appointments in an outpatient setting.
- Patient information on effective treatments for problem gambling is available online (www.at-ease.dva.gov.au) or in Appendix L.

Pharmacological Treatment

- There is limited evidence supporting the use of pharmacological intervention with problem gambling, however there is some evidence supporting the use of the opioid antagonist, naltrexone.
- If pharmacotherapy is commenced, the veteran's mental state should be monitored and adjunctive psychological therapy commenced when appropriate.

Referral Options

- WACS – Veterans and Veterans Families Counselling Service. Phone 1800 011 046 (24 hours).
- Mental health professionals can be accessed through Medicare. A list of psychologists can be found at www.psychology.org.au/findapsychologist. A list of mental health trained social workers can be found at www.aasw.asn.au/membersdirectory.
- Private psychiatrists: A list can be accessed by GPs at www.ranzcp.org/Resources/find-a-psychiatrist.aspx.

Depressive disorders

About depressive disorders

Major depression is characterised by a persistently low mood and/or a loss of interest or pleasure in activities. In addition, the depressed veteran may experience a number of additional symptoms including:

- changes in appetite and/or weight
- insomnia or hypersomnia
- psychomotor agitation or retardation
- low energy or fatigue
- trouble concentrating or making decisions
- feelings of worthlessness or excessive guilt
- recurrent thoughts of death or suicidal thoughts or behaviour.

It is important to remember that depressed individuals will not necessarily present with a primary complaint of depression. Many will seek help for insomnia, or pain, or appear excessively worried about physical aches and pains. Veterans may complain of feeling irritable, sad, or having no feelings at all. In assessing the presence of depression, clinicians should take note of facial expressions and general demeanour in addition to the person's self-reported symptoms. For a diagnosis of depression, symptoms must be present for most of the day, nearly every day, for at least two weeks, and represent a significant departure from normal functioning. Depression can range from mild to severe, and may become chronic, relapse, or less commonly, occur as part of a bipolar mood disorder.

Some people will experience consistent feelings of low mood for two years or more, but not have symptoms severe enough to be diagnosed with major depression. This condition has traditionally been known as dysthymia and is relatively common in veterans. Note that in DSM-5, dysthymia and chronic major depression are combined in a new diagnosis called 'chronic depressive disorder'.

Approximately 15 percent of Australians will experience a depressive disorder (i.e., major depression or dysthymia) at least once in their lifetime (Australian Bureau of Statistics, 2007). These disorders (particularly chronic forms of depression) are also common in veteran populations, although prevalence rates differ across deployments. For example, depressive disorders affect around 26 percent of Vietnam veterans (O'Toole et al., 1996) and 32 per cent of Gulf war veterans (Black et al., 2004).

A number of factors place veterans at increased risk of depression, including military-specific factors such as war-related traumatic events, discharge and the transition to civilian life, and more generic stressors such as marital breakdown. As in the general population, female veterans are at greater risk of developing depressive symptoms than males. It is worth keeping this in mind given the increasing proportion of women in the younger cohort of veterans.

Screening and assessment

Screening questions for depression should include the use of at least two questions concerning mood and interest. The following questions are from the Mini International Neuropsychiatric Interview (MINI; Sheehan et al., 1998) and are recommended in the United Kingdom's National Institute for Health and Clinical Excellence (NICE) guidelines (2009):

- During the last month, have you often been bothered by feeling down, depressed, or hopeless?
- During the last month, have you often been bothered by having little interest or pleasure in doing things?

If the veteran answers 'yes' to either of these questions, further assessment of their mental state and associated social, occupational, and interpersonal difficulties should be conducted.

A number of self-report measures are available to assess the severity of depressive symptoms.

These include the:

- Depression Anxiety and Stress Scale (DASS-21; Lovibond & Lovibond, 1995). This can be used to help track depressive symptoms as well as counselling outcomes. See Appendix C or www.at-ease.dva.gov.au for the measure, administration, scoring and interpretation instructions]
- Hamilton Depression Scale (HAM-D; Hamilton, 1960)
- Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961)
- Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith, 1983)

Risk assessment – self-harm/suicide and harm to others

Depression is a significant risk factor for suicide. Veterans who are assessed as having depression should be screened using direct and unambiguous questions such as:

- Are there times when things seem so hopeless that you think about killing yourself?
- (If yes), do you have a plan of how you might do this?
- (If yes), do you have access to ... (*check means and opportunity*)?
- Have you ever harmed yourself or tried to kill yourself in the past?
- Do you live alone (or unsupervised)?
- Do you use amphetamines, alcohol, or other substances?

The above questions can be reframed to assess risk of harm to others, e.g., “Are there times when things seem so hopeless that you think about ending the lives of others around you?”

Be aware that many symptoms of depression, such as lack of motivation, psychomotor retardation, and apathy initially reduce the risk of suicide and harm to others. However, practitioners should be alert to the risk of harm to self or others as clients start to recover; they may still feel hopeless, but have regained enough energy to act on suicidal or homicidal thoughts.

Where there are issues of potential harm to self or others, practitioners should be aware of their duty of care to both the veteran and others, as set down by the ethical standards established by their professional group.

Veterans with depressive disorders may have fluctuating or continued severe distress and significant potential for self-harm. For a portion of veterans, particularly younger veterans, impulsive self-destructive and aggressive behaviours such as dangerous driving are common.

Treatment

Self-help

Cognitive behavioural therapy (CBT) is the self-help treatment of choice for depression. A guided self-help program based on CBT is appropriate for veterans with mild depression. Examples of such programs include publications such as *Mind over mood: A cognitive therapy treatment manual for clients* (Padesky and Greenberger 1995) and *Feeling good: The new mood therapy* (Burns 1999). There are also several excellent internet based self-help programs (e.g., MoodGYM www.moodgym.anu.edu.au), which have been found to reduce symptoms of depression and dysfunctional thinking in members of the general population (Christensen, Griffiths, & Jorm, 2004). There are also written materials for veterans and their families available from websites such as those included under ‘Self-management resources’ (later in this chapter).

Psychological intervention

Cognitive behavioural therapy

Mental health practitioner-delivered CBT should be considered for veterans with moderate or severe depression. Talking to a veteran, together with the veteran's family, about his or her depression is the start of treatment. A summary of useful information to be conveyed to the veteran and his or her family is included in the following text box.

Psychoeducation and self-management strategies

When providing psychoeducation it is important to explain and demystify the veteran's symptoms, and to help the veteran regain a sense of control and a sense of hope. It is also important to encourage the veteran to do the following:

- Prioritise spending time and reconnecting with their **social supports**, e.g., sympathetic family members and friends, local interpersonal community activities. There is strong evidence that social support is a key factor in preventing deterioration of symptoms and in promoting recovery.
- Maintain (or re-establish) their daily **routine and current roles** (e.g., work, family). This is particularly important for veterans who have a lot of unstructured time or have prominent or long-standing avoidance symptoms. This may include starting an exercise routine (as simple as a daily 20 minute walk) and engaging in planned pleasant events.
- **Reduce substance use.** While alcohol and drugs may alleviate distress in the short term, they inhibit recovery. This is a significant issue amongst veterans, with high comorbidity between depression and substance use issues. Early advice on reducing substance use is effective.

Whilst CBT has some general techniques applicable across a range of disorders, specific CBT techniques for targeting depression are:

- Structured problem solving – This can help the veteran address feared problems that they otherwise might find overwhelming.
- Activity scheduling – This involves scheduling a balance of pleasant, achievement-related and physical activities. It assists with circumventing rumination, and increases positive and rewarding experiences thereby targeting symptoms such as low motivation and mood, lack of energy and withdrawal from activities and people.
- Cognitive therapy – This assists in identifying and challenging excessively negative thoughts about oneself, one's future, or the loss of a loved one or something highly valued. The veteran learns to challenge the accuracy of those thoughts and identify more balanced and helpful interpretations of events, and perceptions of themselves, others and the world.

Interpersonal therapy

People with depression can be easily upset by other people's comments, and experience significant interpersonal difficulties that contribute to or exacerbate depression. Interpersonal therapy (IPT) aims to help the veteran understand and resolve these difficulties. IPT has been less thoroughly researched than CBT, but evidence so far suggests that the two therapies are broadly similar in terms of effectiveness (Cuijpers et al., 2011). Therefore, the decision to progress with one over the other will come down to the preferences of both the veteran and practitioner.

Mindfulness-based interventions

Mindfulness-based interventions aim to increase self-awareness and teach veterans to have distance from their thoughts and emotions so that unpleasant events cause less distress. It is thought that with less emotional investment, the potential for extreme negative reactions such as depression is limited. While mindfulness-based therapies are widely practised, they have been less thoroughly researched. These therapies appear to be more effective than placebo interventions (Hofmann, Sawyer, Witt, & Oh, 2010), but it is not clear how they compare

with established treatments for depression such as CBT or IPT. Therefore, at this stage it is recommended that mindfulness approaches be considered only for individuals whose depression has not responded to CBT or IPT.

Psychological treatment setting and duration

Mild to moderate depression can be treated in an outpatient setting and does not usually require admission to a psychiatric hospital unit. Requirements for admission depend on the severity of depression and the risk of self-harm and suicide. Psychological treatment for mild to moderate depression should focus specifically on the depression for a period of 6-8 sessions over 10-12 weeks. In more difficult and complex cases, a longer course of psychological treatment may be required.

Pharmacological interventions

Medication is usually not recommended for mild depression, in preference to psychological interventions. Antidepressants may be considered for veterans with moderate or severe depression, adjunctive to or followed by psychotherapy. Selective serotonin reuptake inhibitors (SSRIs) are recommended as the first line of pharmacotherapy. Older-generation antidepressants such as the tricyclics (e.g. Deptram) may be more effective in treating severe or treatment-resistant depression but pose a greater risk of overdose and should be prescribed with caution.

Electroconvulsive therapy

Electroconvulsive therapy (ECT) remains an important antidepressant treatment. It is used mainly in the context of severe depression (characterised by melancholia, psychotic features and/or high suicide risk) and it is only to be administered in a psychiatric setting with accredited facilities and practitioners. There are some medical contraindications to ECT and the general anaesthetic that it requires.

When effective, ECT provides short-term improvement. Subsequent maintenance antidepressant medication is usually required. Cognitive impairment for a time around the treatment is a side effect of ECT, but there is no objective evidence of it persisting after a course of treatment. Maintenance ECT has not been well researched, but is used on occasions where medications and psychotherapy have failed as maintenance treatments. The decision to use ECT should be taken only after careful clinical review, and documented, informed consent is given.

Referral and coordinated care

- **VVCS - Veterans and Veterans Families Counselling Service (VVCS):** This service provides veterans and their families with counselling and group programs Australia-wide. VVCS can be contacted 24 hours a day on 1800 011 046.
- **Psychiatrist:** for specialist management of more severe, chronic or complex problems. Some psychiatrists specialise in psychological treatments; they can review or prescribe medication, provide diagnoses, and manage co-occurring physical health problems. Allied health providers should liaise with GPs to arrange a referral. GPs can access a list of private psychiatrists at www.ranzcp.org/Resources/find-a-psychiatrist.aspx.
- If hospitalisation is required, there are veteran specific mental health wards and treatment programs. To find out their location, phone DVA on 133 254 or 1800 555 254.
- A treatment plan should be developed collaboratively with the veteran and their family, and coordinated across service providers.
- Consider psychosocial and/or vocational rehabilitation services from the beginning of treatment. DVA can offer extensive rehabilitation services for entitled veterans (www.dva.gov.au/rehabilitation).

Self-management resources

- Veterans Line (1800 011 046) can be reached 24 hours a day across Australia for crisis support and counselling. This service is provided by VVCS.
- At Ease website (www.at-ease.dva.gov.au) for access to veteran-targeted information on mental health including the Wellbeing Toolbox, anxiety management and The Right Mix alcohol resources. The DVA *Mental Health and Wellbeing after Military Service* booklet is available to order or download from this website.
- The Royal Australian & New Zealand College of Psychiatrists (2009). *Coping with depression: Australian treatment guide for consumers and carers*. Download from www.ranzcp.org/Publications/Clinical-Practice-Guidelines-2.aspx.
- Written materials for clients and their families are available from websites such as *beyondblue* (www.beyondblue.org.au), Black Dog Institute (www.blackdoginstitute.org.au), and the Australian Psychological Society (www.psychology.org.au).
- Internet based self-help programs, e.g., MoodGYM (www.moodgym.anu.edu.au).
- Self-help books include Greenberger & Padesky (1995), *Mind over mood: A cognitive therapy treatment manual for clients*, and Burns (1995), *Feeling good: The new mood therapy*.

Practitioner resources

- Padesky, C. & Greenberger, D. (1995). *Clinician's guide to mind over mood*. Guildford Press: New York.
- Beck, A.T., Rush, A.J., Shaw, B.F. & Emery, G. (1987). *Cognitive therapy of depression*. Guilford Press: New York.

This Advice Book has the following resources in the appendices that may be useful for veterans who are experiencing symptoms of depression or dysthymia:

- further explanation of CBT elements (Appendix B)
- veteran psychoeducation handout and general psychoeducation script outline (Appendix D and L)
- self-monitoring sheets including thoughts and feelings records and a daily activity schedule (Appendix E)
- pleasant events list (Appendix F)
- information on where veterans can get more help, e.g., Veterans Line, DVA funded psychological and rehabilitation services (Appendix J).

Anxiety disorders

About anxiety disorders

Around one in five Australians experiences an anxiety disorder at some point in their lives (McEvoy, Grove, & Slade, 2011). It is worth noting that anxiety and agitation can arise as secondary to other disorders, including depression, or substance intoxication and withdrawal, and so these potential primary diagnoses should be considered when assessing veterans.

There are a number of different anxiety disorders, with the most common among veterans being:

- panic disorder with or without agoraphobia
- generalised anxiety disorder
- social anxiety.

The causes, symptoms, duration and impact of these disorders on everyday life vary greatly, and each disorder is discussed in more detail below. Information on referral options and resources for anxiety disorder can be found at the end of this chapter.

Panic disorder and agoraphobia

About panic and agoraphobia

A panic attack is characterised by a sudden surge of intense fear or discomfort that is accompanied by a number of somatic and cognitive symptoms such as a racing heart, hyperventilation and fear of dying. Panic disorder involves repeated panic attacks, combined with persistent concern about having another attack or the consequences of the attack. The fear of panic attacks can lead to significant avoidant behaviour. For example, a veteran may avoid physical exercise in order not to experience panic-like symptoms such as sweating or accelerated heart rate.

Agoraphobia involves marked fear or anxiety about situations where escape might be difficult or help might not be available in the event of a panic attack. These situations include travelling on public transport, visiting shops or cinemas, standing in a crowd, or being outside of the home alone. A veteran with agoraphobia is likely to avoid such situations or endure them with intense fear or anxiety, or only be able to face them with a trusted friend or relative.

While panic disorder and agoraphobia tend to co-occur, either disorder can be diagnosed in the absence of the other. Approximately one in thirty Australians will suffer from panic disorder at some point in their lives, while one in forty will experience agoraphobia.

Screening and assessment

There is limited evidence for the effectiveness of screening instruments for most anxiety disorders. No specific screening test is recommended in the recent National Institute for Health and Clinical Excellence (NICE) guidelines for panic disorder and agoraphobia (2011), however, useful questions to screen for panic disorder from the Mini International Neuropsychiatric Interview (MINI; Sheehan et al., 1998) include:

- In the past month, have you on more than one occasion had spells or attacks when you suddenly felt anxious, frightened, uncomfortable or uneasy, even in situations where most people would not feel that way?
- Did the spells peak within 10 minutes?

Veterans may be screened for agoraphobia with a question from the MINI:

- In the past month, have you felt anxious or uneasy in places or situations where you might have a panic attack or panic-like symptoms, or where help might not be available or escape might be difficult (e.g., being in a crowd, standing in a queue, when you are away from home or alone at home, or when crossing a bridge or travelling in a bus, train, or car)?

If the veteran answers 'yes' to any of these questions, the practitioner should then:

- assess the frequency and nature of the panic attacks
- rule out other psychiatric disorders, physical conditions, medications or recreational drugs that could account for the panic attacks
- develop a profile of the veteran's agoraphobia and avoidance by asking them to describe the activities or places they avoid due to fear of a panic attack.

The Fear Questionnaire (FQ; Marks & Matthews, 1979) is a useful tool for identifying situations that trigger anxiety, and the Depression, Anxiety and Stress Scale (DASS-21; Lovibond & Lovibond, 1995) is a general measure that can help track stress and anxiety as well as counselling outcomes. Neither is a diagnostic measure for panic or agoraphobia. See Appendix C or www.at-ease.dva.gov.au for both these measures, as well as instructions on their administration, scoring and interpretation.

Important assessment considerations

In diagnosing panic disorder, it is important to establish that the panic attacks are occurring unexpectedly and not in the context of another anxiety disorder. For example, a veteran with PTSD might experience panic attacks when watching a documentary on the war in Afghanistan, however this should not be considered indicative of panic disorder, as the panic is occurring in response to a specific and predictable context, rather than occurring unexpectedly.

Practitioners should be mindful of the risk of unnecessary medical investigations to provide reassurance to the veteran, as this can create an unhelpful cycle of anxiety and investigation of medically unexplained or somatic symptoms. Once an appropriate set of investigations has been done, repeating these at the veteran's request reinforces his or her belief that 'something was missed'.

Treatment

Psychological interventions

Cognitive behavioural therapy (CBT) is the most effective psychological treatment for panic disorder and agoraphobia. Clear explanations of panic disorder, how it is conceptualised, and the rationale for treatment are critical to forming a solid basis for this phase of treatment. Talking to a veteran, together with the veteran's family, about his or her anxiety is the start of treatment. A summary of useful information to be conveyed to the veteran and his or her family is included in the text box on the following page.

Whilst CBT has some general techniques applicable across a range of disorders, specific CBT techniques for targeting panic and/or agoraphobia are:

- Exposure to internal symptom cues or interoceptive exposure – In panic disorder, the fear is often associated with the symptoms themselves. As such, when conducting exposure it is the internal physical symptoms that the veteran needs to confront. An example of such exposure would be to gradually get the veteran to hyperventilate in session to induce some of the sensations associated with panic, and then repeat this exercise until the veteran's distress and fear associated with the symptoms subsides.
- Cognitive therapy – This approach is beneficial for addressing misinterpretations of symptoms such as fears of going mad, of having a heart attack or of losing control. In panic disorder, 'catastrophic misinterpretation' of the physical symptoms appears to be central to the maintenance of the disorder.
- Anxiety management – Breathing retraining and hyperventilation control strategies are important treatment components. A breathing retraining exercise can be found in Appendix H.
- *In vivo* exposure – This involves assisting the veteran to gradually confront and reintegrate activities and places that he or she has been avoiding due to the associations with panic. Prior to engaging in *in vivo* exposure, the veteran should have: 1) a good understanding of the nature of panic disorder; 2) learned to effectively manage the symptoms through cognitive and breathing strategies; and 3) had exposure to the internal cues for panic and learned to manage his or her response.

The strategies outlined above are targeted at managing acute panic and anxiety, and helping the veteran to resume avoided activities. It is also important to assist the veteran in reducing their baseline level of arousal through exercise, general relaxation training and the scheduling of pleasant activities.

Providing psychoeducation is the first step to effective treatment. A summary of useful information to be conveyed to the veteran and his or her family is included in the text box below, and a client handout about symptoms can be found in Appendix L.

Psychoeducation and self-management strategies

The aim of psychoeducation is to explain and demystify symptoms so that the veteran can regain a sense of control and a sense of hope. It is also important to talk about common misconceptions veterans may have about panic attacks, such as mistaking symptoms for a heart attack or stroke. Practitioners need to discuss:

- the nature of anxiety and the fight-flight response, i.e., explain that although panic attacks may feel dangerous, they are not
- the relationship between hyperventilation and panic
- breathing retraining and hyperventilation control
- common fears held by people who have panic attacks, e.g., any medical-related fears the veteran may have regarding their physiological panic symptoms
- the prevalence of panic disorder.

It is helpful to discuss treatment goals with the veteran, namely:

- control and cessation of panic attacks
- control and cessation of fear-driven avoidance
- reducing vulnerability to relapse.

If substance use is a problem, including benzodiazepine misuse, encourage the veteran to reduce his or her substance use. This is a significant issue as 20 per cent of Australians with panic disorder and 13 per cent of those with agoraphobia also have an alcohol use disorder. A brief intervention that includes education about substance use can be effective (see page 97 on substance use disorders). If benzodiazepines are used, they should be taken on a regular schedule as far as possible, rather than on an 'as needed' or 'prn' basis.

CBT-based self-help resources are also effective in treatment. A list of self-help resources is included at the end of this chapter.

Psychological treatment setting and duration

Panic or agoraphobia is typically treated in an outpatient setting. Treatment duration will vary from 7 to 14 sessions, sometimes more depending on the severity, and will most commonly be in the form of weekly sessions of 1–2 hours. Treatment would normally be completed within a maximum of four months (National Institute for Health and Clinical Excellence, 2011). Practitioners could also consider briefer versions of CBT (approximately seven hours), as an adjunct to the use of self-help material. Telephone-administered treatment may be considered for those who cannot attend face-to-face treatment. Treatment of panic rarely requires hospitalisation, unless there is concurrent severe depression, suicidal intent or substance use requiring detoxification.

Pharmacological interventions

Psychological interventions are the preferred approach for the treatment of panic and agoraphobia. However, pharmacotherapy may be considered in moderate to severe cases, where psychological treatment is not acceptable or available, or fails to produce a sufficient response. The evidence is strongest for the use of antidepressant medications but there is little evidence that pharmacotherapy has a lasting role after completion of a course of treatment.

Selective serotonin reuptake inhibitors (SSRIs) and serotonin-noradrenaline reuptake inhibitors (SNRIs) are recommended as the first line of pharmacotherapy.

Benzodiazepines are no longer recommended for the treatment of panic disorder, as they do not treat the underlying condition and pose a risk of dependency. If benzodiazepines are considered necessary for control of severe symptoms, the course of treatment should be kept as short as possible. Benzodiazepines should not be taken to manage symptoms during *in vivo* exposure as their use negates any positive effect of exposure-based treatments.

Generalised anxiety disorder

About generalised anxiety disorder

Approximately six per cent of Australians are likely to experience generalised anxiety disorder (GAD) in their lifetime (McEvoy et al., 2011). The essential feature of GAD is excessive and persistent anxiety and worry about a number of different life domains, such as family, health, finances, and work difficulties. These anxieties or worries are present more days than not, and may be accompanied by a number of additional symptoms such as:

- restlessness
- being easily fatigued
- difficulty concentrating
- irritability
- muscle tension
- disturbed sleep.

Screening and assessment

There is currently limited evidence supporting a specific screening instrument for most anxiety disorders, and no screening test has been developed specific to generalised anxiety disorder. However, the following questions adapted from the MINI can be useful in screening for GAD:

- Have you worried excessively or been anxious about several things over the past three to six months?¹
- (If yes) Are these worries present most days?

If the veteran answers 'yes' to each of these questions, assess for symptoms of GAD. It is important to consider whether the veteran's anxiety is restricted to, or better explained by, another disorder. It is also important to ask the client about any major stressor or life change in the past six months (e.g., new job, new relationship, divorce, illness, etc.).

The Penn State Worry Questionnaire (PSWQ; Meyer et al., 1990) is a specific measure of worry, and the Depression, Anxiety and Stress Scale (DASS-21; Lovibond & Lovibond, 1995) is a general measure that can help track stress and anxiety as well as counselling outcomes. Neither is a diagnostic measure for GAD. See Appendix C or www.at-ease.dva.gov.au for both these measures, as well as instructions on their administration, scoring and interpretation.

1. Note that the proposed criteria for DSM-5 require only three months of persistent worry to be present. No new screening measures had been developed at the time of writing.

Treatment

Psychological interventions

Cognitive behavioural therapy

Whilst CBT has some general techniques applicable across a range of disorders, specific CBT techniques for targeting GAD are:

- Cognitive therapy – This involves challenging the negative and catastrophic beliefs that trigger and maintain worry, as well as beliefs about the nature and usefulness of the worrying process.
- Structured problem solving – This can help the veteran address feared problems and consequences using a more helpful method than worrying.
- Anxiety management – This includes strategies such as progressive muscle relaxation and breathing retraining, to help manage the physical consequences of worry.

As GAD reflects a generalised and persisting anxiety, it is important for veterans to learn cognitive, physiological and behavioural strategies through treatment, which they can apply in a range of circumstances and situations. This differs from strategies for other anxiety disorders, where there is a greater focus on the fears and responses to specific stimuli.

Talking to a veteran together with the veteran's family about his or her GAD is the start of treatment. A summary of useful information to be conveyed to the veteran and his or her family is included in the following text box.

Psychoeducation and self-management strategies

Psychoeducation is important as it helps to demystify the veteran's symptoms, restore a sense of control and create hope for change. It is also important to encourage the veteran to do the following:

- **Reduce substance use**, including benzodiazepine misuse. This is a significant issue amongst individuals with GAD, as 17 per cent of Australians with GAD also have an alcohol use disorder. A brief and early intervention that includes education about substance use can be effective (see page 97 on substance use disorders). If benzodiazepines are used, they should be taken on a regular schedule as far as possible, rather than on an 'as needed' or 'prn' basis.
- Maintain (or re-establish) their daily **routine and current roles** (e.g., work, family). Helping veterans to think about treatment goals in the context of what relationships and roles they would like to see improve can help motivate them.

CBT-based self-help resources are also effective in treatment. A list of self-help resources is included at the end of this chapter.

Psychological treatment setting and duration

Generalised anxiety disorder can be treated in an outpatient setting and does not usually require admission to a psychiatric hospital unit. Psychological treatment for GAD will usually involve 12-15 weekly one-hour sessions of CBT. In more difficult and complex cases, a longer course of CBT may be required.

Pharmacological interventions

Medication is usually not recommended for mild GAD, in preference to psychological interventions. However, antidepressants may be considered for veterans with moderate or severe anxiety, adjunctive to, or followed by, psychological treatment. Newer generation antidepressants should be the first-line pharmacological approach. Benzodiazepines are not recommended for long-term management of GAD, but may be considered in the initial stages of treatment for veterans who require rapid relief from severe anxiety symptoms. If benzodiazepines are prescribed, they should not usually be used beyond approximately four weeks. There is some evidence to suggest that atypical antipsychotics may have a role as an adjunct treatment for veterans with GAD who show an incomplete response to antidepressants.

Social anxiety

About social anxiety

People with social anxiety fear any social or performance situations in which they may be scrutinised or negatively evaluated by other people. Fears of being embarrassed in social situations or of public speaking are widespread in the community. With social anxiety, the fear interferes significantly with the person's normal routine, social activities or occupational functioning. Approximately one in twelve Australians will experience social anxiety at some point in their lives (McEvoy et al., 2011).

Social anxiety can be specific or generalised. It is specific if the fear is related to one or a small number of social or performance situations, and generalised where there is a fear of most social and performance situations. Veterans may go out of their way to avoid the feared situation, or suffer intense fear and anxiety when exposed to it. Situations that are commonly feared by people with social anxiety include speaking in public, speaking to strangers or meeting new people. People with social anxiety may also fear eating or drinking in public, using public toilets or writing in public (e.g., filling in a form).

Screening and assessment

As noted above, social anxiety is relatively common, yet it is often undiagnosed as veterans may be reluctant to talk about their fears. In some cases, being in the clinical setting may itself stimulate anxiety symptoms and a veteran's fear of being scrutinised, humiliated or embarrassed. A missed diagnosis can also occur if the practitioner confuses the veteran's symptoms with shyness or mistakenly judges secondary comorbid conditions, such as substance abuse and depression, to be the primary disorder. To ensure that a diagnosis of social anxiety is not overlooked, practitioners should consider the disorder whenever a veteran refers to feeling anxious in social situations. On the other hand, the practitioner should be careful to exclude the possibility that avoidance of social situations is associated with PTSD or is part of panic-related agoraphobia.

The following question from the MINI can be used to screen for social phobia:

- In the past month were you fearful or embarrassed about being watched, being the focus of attention, or fearful of being humiliated? This includes things like speaking in public, eating in public or with others, writing while someone watches, or being in social situations.

Veterans who respond 'yes' should be assessed further for symptoms of social anxiety.

Practitioners may need to ask specifically about fear of a range of social and performance situations, as the person with social phobia is unlikely to spontaneously report the full range of their social fears.

The Fear Questionnaire (FQ; Marks & Matthews, 1979) is a useful tool for identifying situations that trigger anxiety, and the Depression, Anxiety and Stress Scale (DASS-21; Lovibond & Lovibond, 1995) is a general measure that can help track stress and anxiety as well as counselling outcomes. Neither is a diagnostic measure for social anxiety. See Appendix C or www.at-ease.dva.gov.au for both these measures, as well as instructions on their administration, scoring and interpretation.

Treatment

Psychological interventions

CBT is the psychological treatment of choice for social anxiety. Talking to a veteran, together with the veteran's family about his or her social anxiety is the start of treatment. A summary of useful information to be conveyed to the veteran and their family is included in the following text box.

Psychoeducation and self-management strategies

Psychoeducation is important as it helps to demystify the veteran's symptoms, restore a sense of control and create hope for change. It is also important to encourage the veteran to do the following:

- **Reduce substance use.** This is a significant issue amongst individuals with social anxiety as using a substance (e.g., alcohol) prior to or during a social event is a common, but unhelpful, way of coping with the stressful situation. Indeed, almost 20 per cent of Australians with social anxiety have an alcohol use disorder. Early advice on reducing substance use is effective, and if benzodiazepines are used, they should be taken on a regular schedule as far as possible, rather than on an 'as needed' or 'prn' basis.
- Increasing avoidance of social situations is a significant feature of social anxiety, so encourage the veteran not to withdraw further from their **routine, social supports and current roles** (e.g., work, family).

Whilst CBT has some general techniques applicable across a range of disorders, specific CBT techniques for targeting social anxiety are:

- Cognitive therapy – This involves addressing any unhelpful beliefs about the self and others which may have contributed to the development of social phobia and continue to contribute to its maintenance.
- Anxiety management – This includes relaxation activities, breathing retraining, and self-instruction training, and provides the veteran with skills to manage the anxiety arising from confronting feared social situations.
- Social skills training, if appropriate – This can include training in assertiveness and/or conversational skills.
- *In vivo* exposure – This is considered the cornerstone of social anxiety treatment. It involves graded *in vivo* exposure to feared social or performance situations. During exposure exercises, the veteran is discouraged from using safety behaviours (or unhelpful coping strategies), such as avoiding eye contact for fear of signs of disapproval or negative judgment.

Psychological treatment setting and duration

Social anxiety seen in clinical settings is often a severe and chronic disorder, requiring specialist treatment. Social anxiety can be treated in an outpatient setting. Treatment duration will vary between 8–12 sessions, although more sessions will likely be required for more severe or difficult cases. Treatment of social anxiety does not require hospitalisation, unless there is concurrent suicidal depression or substance use requiring detoxification.

Consideration should be given to the treatment of social anxiety on a group basis when this opportunity is available. Because the condition involves a fear of social and performance situations, group membership itself can be an important part of treatment, providing exposure to a feared situation. However, the intervention should be targeted to the needs of the individual, and group therapy may be too confronting for some in the first instance.

Pharmacological interventions

Mild social anxiety will generally respond well to psychological intervention, however pharmacotherapy may be considered for moderate to severe cases. Newer generation antidepressants are the recommended first line pharmacological treatment; veterans who

fail to respond may benefit from monoamine oxidase inhibitors (MAOIs). As with all anxiety disorders, benzodiazepines are not recommended for the treatment of social anxiety due to the potential for tolerance and dependency. If benzodiazepines are considered necessary to bring about control of acute anxiety symptoms, the course of treatment should be kept as short as possible.

Referral and coordinated care for anxiety disorders

- VVCS – Veterans and Veterans Families Counselling Service (VVCS): This service provides veterans and their families with counselling and group programs Australia-wide. VVCS can be contacted 24 hours a day on 1800 011 046.
- Psychiatrist: For specialist management of more severe, chronic or complex problems. Some psychiatrists specialise in psychological treatments; they can review or prescribe medication, provide diagnoses, and manage co-occurring physical health problems. Allied health providers should liaise with GPs to arrange a referral. GPs can access a list of private psychiatrists at www.ranzcp.org/Resources/find-a-psychiatrist.aspx.
- If hospitalisation is required, there are veteran specific mental health wards and treatment programs. To find out their location phone DVA on 133 254 or 1800 555 254.
- A treatment plan should be developed collaboratively with the veteran and their family, and coordinated across service providers.
- Consider psychosocial and/or vocational rehabilitation services from the beginning of treatment. DVA can offer extensive rehabilitation services for entitled veterans (www.dva.gov.au/rehabilitation).

Self-management resources for anxiety disorders

- Veterans Line (1800 011 046) can be reached 24 hours a day across Australia for crisis support and counselling. This service is provided by VVCS.
- At Ease website (www.at-ease.dva.gov.au) for access to veteran-targeted information on mental health including the Wellbeing Toolbox, anxiety management and The Right Mix alcohol resources. The DVA *Mental Health and Wellbeing after Military Service* booklet is available to order or download from this website.
- Anxiety Online (www.anxietyonline.org.au) is an internet-based treatment clinic affiliated with Swinburne University.
- Useful materials are available from *beyondblue* (www.beyondblue.org.au), the Clinical Research Unit for Anxiety and Depression (www.crufad.org) and SANE (www.sane.org).
- Franklin, J. (1997). *Overcoming panic: A complete nine-week home-based treatment program for panic disorder*. Melbourne: APS Insight Press.
- Barlow, D.H. & Craske, M.G. (1999). *Mastery of your anxiety and panic (MAP-3) client workbook for anxiety and panic* (3rd ed.). New York: Oxford University Press.

Practitioner resources for anxiety disorders

- Andrews, G., Crino, R., Hunt, C., Lampe, L. & Page, A. (1994). *The treatment of anxiety disorders: Clinician guides and patient manual*. New York: Cambridge University Press.

This Advice Book has the following resources in the appendices that may be useful to use with veterans who are experiencing symptoms of anxiety disorders:

- further explanation of CBT elements (Appendix B)
- veteran psychoeducation handout for each anxiety disorder and general psychoeducation script outline (Appendix D and L)
- self-monitoring sheets including thoughts and feelings records, distress thermometer (SUDS) and daily activity schedule (Appendix E)
- pleasant events list (Appendix F)
- progressive muscle relaxation (Appendix G)
- breathing retraining instructions (Appendix H)
- information on where veterans can get more help, e.g., Veterans Line, DVA funded psychological and rehabilitation services (Appendix J).

Trauma-and stressor-related disorders

About posttraumatic stress disorder

Posttraumatic stress disorder (PTSD) is a serious psychological reaction that develops in some people following an experience of a traumatic event, such as combat, assault, sexual assault, natural disaster, an accident or torture.

Most people have some kind of psychological reaction to trauma — feelings of fear, sadness, guilt and anger are common. However, most survivors recover over time, with only a small proportion developing serious problems including PTSD. Prevalence estimates vary widely, however it is likely that between 5 and 20 per cent of veterans will develop PTSD in their lifetime (Ikin et al., 2004; O'Toole et al., 1996). It is important to note that PTSD is only one of a number of mental health disorders that can result from exposure to a traumatic event, with depression, generalised anxiety and substance use also commonly experienced following trauma.

PTSD is a complex disorder that can present quite differently in different people. In all cases, however, there are symptoms present from each of the groups or clusters outlined below:

- Intrusions or re-experiencing symptoms, e.g., distressing memories or dreams related to the traumatic event; distress and/or physiological reactions to reminders of the trauma; and more rarely, flashbacks and other dissociative reactions.
- Persistent avoidance of internal reminders of trauma (such as thoughts, feelings and physical sensations) and/or external reminders (such as people, places and activities associated with the trauma).
- Negative alterations in cognitions and moods, e.g., unrealistic expectations about one's self, others and the world; distorted blame of self or others regarding the trauma and its consequences; diminished interest in activities and inability to experience positive emotions; detachment from others; pervasive negative emotional states.
- Alterations in arousal and reactivity or 'hyperarousal', e.g., irritable or self-destructive behaviour, hypervigilance, exaggerated startle response, or problems with sleep or concentration.

Some symptoms of PTSD, particularly arousal symptoms such as hypervigilance, exaggerated startle response and anger, might not be recognised by veterans as problematic. These responses may have been adaptive in deployment circumstances and may have even served a critical role in the veteran's survival. It may be helpful to acknowledge this and emphasise that these responses can become problematic when they arise in circumstances when they are no longer needed and when they interfere with day-to-day civilian life.

About acute stress disorder

PTSD is diagnosed if symptoms persist for at least one month after a traumatic experience. For veterans presenting with posttraumatic distress between two days and one month after a trauma, a diagnosis of acute stress disorder (ASD) may be considered. Although similar to PTSD in many ways, ASD has traditionally placed a greater emphasis on dissociative symptoms such as feeling 'in a daze' or having an altered sense of reality. It should be noted, however, that the emphasis on dissociative symptoms is no longer considered critical. Thus, the key distinguishing feature between the two disorders is the duration of symptoms required for the diagnosis to be made. There is strong evidence that early treatment of traumatic stress symptoms leads to better outcomes for veterans (O'Donnell, Bryant, Creamer, & Carty, 2008).

Screening and assessment

Untreated PTSD can become a chronic disabling disorder, so screening, early assessment and treatment are critical, even for those veterans who do not meet full criteria for diagnosis. Use of the Primary Care PTSD Screen (PC-PTSD; Prins et al., 2003) is recommended. The screen poses the following questions:

In your life, have you ever had any experience that was so frightening, horrible or upsetting that, in the past month, you:

- have had nightmares about it or thought about it when you did not want to?
- tried hard not to think about it or went out of your way to avoid situations that reminded you of it?
- were constantly on guard, watchful, or easily startled?
- felt numb or detached from others, activities, or your surroundings?

Current research suggests that a veteran *may* have PTSD or trauma-related problems if they answer “yes” to any two items.

Further assessment of the veteran’s PTSD symptoms can be conducted using the PTSD Checklist (Weathers, Litz, Herman, Huska, & Keane, 1993) – the civilian (PCL-C), military (PCL-M) or stressor specific (PCL-S) version. See Appendix C or www.at-ease.dva.gov.au for the complete PCL–M measure, administration and scoring instructions.

Important assessment considerations

As part of a thorough clinical assessment of PTSD particular attention should be paid to the following issues:

- Many veterans have experienced a range of traumatic events including childhood trauma. It is therefore important to conduct a thorough history of traumatic experience/s.
- Because PTSD has a significant impact on functioning and relationships, broader quality of life indicators such as marital and family situation and occupational, legal and financial status should be investigated.
- Physical health is also an important consideration, including issues related to injury and health behaviour change arising from the traumatic incident.
- Because of the sustained nature of some traumatic experiences, people presenting for treatment may still be facing ongoing threat and be at risk of further exposure to trauma. For example, currently serving members about to be re-deployed and people facing ongoing bullying in the workplace may have to return to unsafe environments.

PTSD and comorbidity

Comorbidity is common, with depression, substance misuse and generalised anxiety the most likely disorders to present with PTSD amongst veterans. Thus, assessment should go beyond PTSD, covering the broad range of potential mental health problems. Consideration should also be given to the diagnosis of complicated grief if the traumatic event involved bereavement and when grief-specific symptoms are reported. Individuals who have experienced prolonged or repeated traumatic events, such as prisoners of war, or survivors of childhood sexual abuse, are more likely to experience a number of problems often associated with PTSD such as substance use or impaired emotional regulation.

Treatment

Psychological intervention

Recommended treatments for PTSD focus on confronting the memories and reminders of the traumatic event, as well as addressing associated unhelpful thoughts and beliefs. They include trauma-focussed cognitive behaviour therapy (TF-CBT) and eye movement desensitisation and reprocessing (EMDR). Some PTSD veterans may initially find confronting traumatic memories

overwhelming. Practitioners will need to establish a trusting therapeutic relationship to minimise this, and work on stabilising the veteran's emotions. Stabilisation should address any current life crises, suicidal and/or homicidal ideation and substance abuse issues. This would normally be followed by psychoeducation and anxiety management prior to attempting to confront the traumatic memories and reminders.

Before starting treatment that focuses on traumatic memories, the practitioner should take care to explain the rationale at the outset and advise the veteran and their family that they may feel worse in the short term, before they begin to feel better as treatment takes effect. Importantly, consistent with general principles of good clinical care, practitioners need to perform ongoing assessments of the client's functioning and response to treatment, to ensure ongoing client consent and the provision of optimal treatment. Information on self-management strategies to be conveyed to the veteran and his or her family is included in the following text box.

Psychoeducation and self-management strategies

When providing psychoeducation it is important to help the veteran to understand their symptoms, as well as to regain a sense of control and hope. It is also important to encourage the veteran to do the following during the stabilisation phase:

- Prioritise spending time and reconnecting with their **social supports**, e.g., sympathetic family members and friends, and local interpersonal community activities. There is strong evidence that social support is a key factor in preventing deterioration of symptoms and in promoting recovery.
- Reduce **substance use**. While alcohol and drugs may alleviate distress in the short term, they inhibit recovery and substantially contribute to PTSD becoming chronic. This is a significant issue amongst veterans, with up to 80 per cent of veterans with PTSD developing substance use issues. Early advice on reducing substance use is effective. If benzodiazepines are used, they should be taken on a regular schedule as far as possible, rather than on an 'as needed' or 'prn' basis.
- Use **anxiety management strategies**, e.g., breathing retraining, problem solving, etc. veteran handouts are provided in Appendices H and L, and another useful resource for veterans is the Wellbeing Toolbox (www.wellbeingtoolbox.net.au).
- Maintain (or re-establish) daily **routines and current roles** (e.g., work, family). This is particularly important for veterans who have a lot of unstructured time or have prominent or long-standing avoidance symptoms.

Trauma-focussed cognitive behaviour therapy

Trauma-focussed cognitive behaviour therapy (TF-CBT) is the recommended treatment for PTSD and has been shown to be effective regardless of the time that has elapsed since the trauma. TF-CBT incorporates a range of cognitive behavioural interventions including:

- Imaginal exposure – This teaches veterans to confront traumatic memories in a safe environment, until the memories no longer create high levels of distress.
- *In vivo* exposure – This assists veterans to gradually confront the situations, people or places that they have been avoiding due to the associated distress.
- Cognitive therapy – This addresses unhelpful beliefs and assumptions associated with the trauma. Cognitive therapy may be an appropriate first-line treatment for veterans who have significant difficulty tolerating the high levels of arousal that occur during the exposure interventions above, and for those for whom strong feelings of guilt or anger are more prominent than anxiety or fear.
- Arousal/anxiety management – This teaches the veteran skills in the physical, cognitive and behavioural domains to reduce arousal and manage other unpleasant symptoms. Skills include aerobic exercise, relaxation and breathing retraining (physical), self-instruction and distraction techniques (cognitive), and activity scheduling (behavioural). Arousal management can be used to support other interventions, such as exposure, or as a first-line treatment in itself, where the veteran is unresponsive to, or not yet stable enough for, more intensive treatments.

Eye movement desensitisation and reprocessing

Eye movement desensitisation and reprocessing (EMDR) was originally designed as a form of imaginal exposure that involved the client moving their eyes back and forth across the field of vision while recalling traumatic memories. The technique has evolved over time to incorporate aspects of cognitive therapy, exposure, and imaginal rehearsal of future coping and mastery responses. Studies that have dismantled the various components of EMDR have found that therapeutic benefit is derived primarily from the more CBT-like elements, with eye movements contributing little to the therapy's effects (Davidson & Parker, 2001). Therefore, it is recommended that when EMDR is used, these cognitive behavioural elements are included.

Cognitive processing therapy

Veterans can sometimes become stuck on thoughts about the trauma and its ongoing effect on their life. Cognitive processing therapy (CPT) focuses on making sense of what happened and why the veteran may have found it difficult to recover. It involves less of an imaginal exposure component than TF-CBT. Instead, veterans write down their narrative of the traumatic event and its impact, and read the narrative aloud during therapy. CPT has been less thoroughly researched than TF-CBT but evidence to date is promising, particularly in veteran populations. There is some indication that it may be particularly useful for younger veterans and older veterans with relatively mild PTSD, while additional techniques may be required to effectively treat chronic, severe PTSD (Chard, Schumm, Owens, & Cottingham, 2010).

Imagery rehearsal therapy

Several studies with promising results have examined imagery rehearsal therapy (IRT) for the treatment of PTSD, in particular for nightmare and sleep disruption symptoms (Long et al., 2011; Nappi, Drummond, & Hall, 2012). This therapy targets posttraumatic nightmares and may be a useful starting point for veterans, who, given the stigma surrounding mental health problems in the military, may be more amenable to receiving treatment for nightmares than for PTSD. In addition to several CBT elements (e.g., psychoeducation, cognitive challenging), IRT involves the veteran constructing an overlapping but alternate and positive script of the nightmare, which promotes a sense of mastery or completion. This alternate script is then rehearsed through reading and imagery.

Group therapy

Although the benefit of group therapy for PTSD has not been established empirically, it may offer an advantage over individual treatment alone in providing the opportunity for veterans to share their experiences and support each other in treatment. It is likely to be most useful for delivering the education and symptom management components of treatment. Group therapy is potentially also useful in addressing trauma-related themes more generally, where veterans are able to share their thoughts about these issues with each other. However, more targeted trauma-focussed interventions, focussing on the more distressing memories, are best done on an individual basis.

Psychological treatment setting and duration

Psychological treatment should be regular and continuous. The trauma-focussed component of treatment is best delivered at least once a week. Eight to twelve weeks of trauma-focussed treatment is usually sufficient when the PTSD results from a single event. Veterans can expect treatment sessions in which the trauma is discussed to last for about 90 minutes.

It may be necessary to extend the duration of trauma-focussed treatment beyond 12 sessions for more complex cases, such as veterans with:

- chronic disability resulting from trauma
- significant comorbid disorders
- significant social problems
- a history of multiple traumatic events.

Pharmacological interventions

Medication is not recommended as a routine first-line treatment for PTSD, however newer antidepressants (i.e., selective serotonin reuptake inhibitors (SSRIs) and serotonin-

noradrenaline reuptake inhibitors (SNRIs)) may be considered when the veteran is unwilling or unable to engage in trauma-focussed psychological treatment, when appropriate psychological therapy is not available, or if it fails to produce a sufficient response.

Benzodiazepines are sometimes used to stabilise the client, however long-term use is not recommended. Atypical antipsychotics (e.g., Zyprexa) can be useful for veterans who show an incomplete response to antidepressants.

Treatment of ASD

The provision of psychoeducation is an important first step in the treatment of ASD. There is some evidence that brief CBT, including exposure and cognitive challenging, can be useful for veterans with a diagnosis of ASD. Pharmacotherapy is not generally recommended, and there is no evidence to suggest that pharmacotherapy for ASD can prevent the onset of PTSD.

Referral and coordinated care

- VVCS - Veterans and Veterans Families Counselling Service (VVCS): This service provides veterans and their families with counselling and group programs Australia-wide. VVCS can be contacted 24 hours a day on 1800 011 046.
- Psychiatrist: for specialist management of more severe, chronic or complex problems. Some psychiatrists specialise in psychological treatments; they can review or prescribe medication, provide diagnoses, and manage co-occurring physical health problems. Allied health providers should liaise with GPs to arrange a referral. GPs can access a list of private psychiatrists at www.ranzcp.org/Resources/find-a-psychiatrist.aspx.
- If hospitalisation is required, there are veteran specific mental health wards and treatment programs. To find out their location phone DVA on 133 254 or 1800 555 254.
- A treatment plan should be developed collaboratively with the veteran and his or her family, and coordinated across service providers.
- Consider psychosocial and/or vocational rehabilitation services from the beginning of treatment. DVA can offer extensive rehabilitation services for entitled veterans (www.dva.gov.au/rehabilitation).
- There is also a range of DVA-funded PTSD inpatient and outpatient programs. Phone 133 254 or 1800 555 254.

Self-management resources

- Veterans Line (1800 011 046) can be reached 24 hours a day across Australia for crisis support and counselling. This service is provided by VVCS.
- At Ease website (www.at-ease.dva.gov.au) for access to veteran-targeted information on mental health including the Wellbeing Toolbox, anxiety management and The Right Mix alcohol resources. The DVA Mental Health and Wellbeing after Military Service booklet is available to order or download from this website.
- Australian Centre for Posttraumatic Mental Health (2007). *Australian Guidelines for the Treatment of Adults with Acute Stress Disorder and Posttraumatic Stress Disorder: Information for People with ASD and PTSD, their Families and Carers*. Melbourne: ACPMH. Available for download from www.acpmh.unimelb.edu.au.
- ACPMH website (www.acpmh.unimelb.edu.au) for fact sheets and treatment guidelines.
- DVA has developed an Australian PTSD Coach smartphone app.

Practitioner resources

- Australian Centre for Posttraumatic Mental Health (2007). *Australian Guidelines for the Treatment of Adults with Acute Stress Disorder and Posttraumatic Stress Disorder: Practitioner Guide*. Melbourne: ACPMH. Available for download from www.acpmh.unimelb.edu.au.
- Australian Centre for Posttraumatic Mental Health (2007). *Treating Traumatic Stress: Conducting Imaginal Exposure in PTSD. Clinician manual and DVD*. Melbourne: ACPMH. It is available for purchase from www.acpmh.unimelb.edu.au.

This Advice Book has the following resources in the appendices that may be useful for veterans who are experiencing symptoms of PTSD:

- further explanation of CBT elements (Appendix B)
- the PCL-M to assess the veteran's PTSD symptoms (Appendix C)
- PTSD psychoeducation handout for veteran and general psychoeducation script outline (Appendix D and L)
- self-monitoring sheets including the distress thermometer (SUDS) and daily activity schedule (Appendix E)
- pleasant events list (Appendix F)
- progressive muscle relaxation (Appendix G)
- breathing retraining instructions (Appendix H)
- information on where veterans can get more help, e.g., Veterans Line, DVA funded psychological and rehabilitation services (Appendix J).

The DVD accompanying this Advice Book includes an example of a practitioner introducing imaginal exposure to their client.

Somatic symptom disorders

About somatic symptom disorders

General practitioners commonly encounter individuals who display excessive concern with a health complaint or present with physical symptoms that have no readily evident organic cause. These presentations can lead to a diagnosis of a somatic symptom disorder (previously known as somatoform disorders).

The category of somatic symptom disorder includes a range of clinical presentations such as health anxiety (i.e., hypochondriasis), medically unexplained symptoms, and persistent pain. Common to all these conditions is the central place of somatic symptoms in the presenting problem, along with cognitive distortions and/or excessive thoughts, feelings and behaviours related to these physical complaints. For example, a veteran may present with multiple physical symptoms that medical investigations fail to explain. He or she may report disproportionate concerns about the seriousness of those symptoms, along with a tendency to devote excessive time and energy to behaviours associated with them. It is important to note that these symptoms are not intentional or fabricated, and that they cause significant distress and impairment for the veteran.

The boundary between physical and mental health can be difficult to determine. As a general rule however, a veteran's physical complaints should be considered as part of a mental health diagnosis if cognitive, emotional and behavioural problems are also prominent.

A related, but slightly different, area is the construct of psychosomatic disorders. This construct is applied when physical health problems are caused or made worse by psychological factors, such as when stress or anxiety makes asthma or a gastrointestinal condition worse. It is, therefore, important to investigate the influence of psychosocial factors on the onset,

exacerbation, and maintenance of physical symptoms. Relevant psychological factors include mental health disorders, or symptoms, personality traits, maladaptive health behaviours and stress-related physiological responses.

Clinical experience and general prevalence studies suggest that, for the veteran population, chronic pain problems, health anxiety and psychological factors affecting existing medical conditions are the most likely presentations to health practitioners. The evidence also indicates high rates of comorbid anxiety and depression.

Screening and assessment

There are no well-established and widely accepted measures to screen for somatic symptoms and related disorders. However, the following questions adapted from the Mini International Neuropsychiatric Interview (MINI; Sheehan et al., 1998) may help identify veterans with a problem in this area:

- Have you had many physical complaints not clearly related to a specific disease?
- In the past six months, have you worried a lot about having a serious physical illness?
- Currently, is pain your main problem?

If the client responds 'yes' to one or more questions, and there is no adequate physical explanation, and/or there is significant distress in relation to the symptoms, then assess further.

The Patient Health Questionnaire-15 (PHQ-15; Kroenke, Spitzer, & Williams 2002) is a freely available tool for assessing the presence and severity of somatic symptoms. A shortened version of the PHQ-15, the 8-item PHQ Somatic Symptom Short Form (PHQ-SSS)¹ was recently developed as a screen associated with the DSM-5 criteria.

Important assessment considerations

In all assessments, practitioners need to be alert to the common comorbidity of mental health problems in veterans presenting with somatic complaints.

- Ensure that any medical issue related to their complaint is attended to (e.g., ensuring that organic causes are investigated or that pain is adequately medicated). Avoid referral for ongoing specialist investigations unless there is clear evidence of a physical problem.
- Consider transcultural variations in presentation. In some cultures, physical symptoms are an accepted way of expressing emotional distress and may not be problematic. This does not mean that the veteran does not need treatment for other psychological issues such as anxiety or depression. For example, it is not unusual for aboriginal clients to present with somatic symptoms as part of their depression (Dudgeon, Garvey, & Pickett, 2000).

Treatment

There has been little advance in the understanding of somatic symptom disorders or their treatment over the past 20 years. To date, there is insufficient evidence from the research literature to make firm recommendations for the treatment of somatic symptom disorders. Many veterans with somatic symptoms disorders will be primarily treated by their general practitioners. Recommended management principles are listed below:

- Acknowledge the reality of the problem. In this way, the veteran will feel 'heard' and it will be acknowledged that his/her symptoms are not 'put on' or imagined.
- Their general practitioner should schedule regular review appointments rather than make appointments in response to the individual's psychosomatic crises (Singh, 1998).
- General practitioners should ensure they conduct a routine medical assessment that includes a thorough physical examination. Avoid diagnostic testing, prescription of new medication or referral to a medical specialist for each new symptom unless clearly indicated. Needless to say, the results should be discussed with the veteran.
- When somatic symptoms have become entrenched, shift treatment emphasis from symptom eradication to maintenance care and rehabilitation.
- The veteran should be strongly encouraged and supported in maintaining, or resuming, normal routines and activities.

1. Available on www.dsm5.org

Psychological interventions

There is no current consensus on the best psychological treatments for somatic symptom disorders as there have been insufficient studies to warrant a meta-analysis. However, a review of the published studies has found that cognitive behavioural therapy (CBT) appears to be the most promising psychological approach for managing health anxiety, somatic symptoms, and pain (Kroenke, 2007; Sumathipala, 2007). Although several variations of CBT have been employed, two elements are common to all:

- Cognitive therapy – This allows for the identification and modification of unhelpful beliefs about symptoms and disease.
- Behavioural techniques – These are helpful to alter illness and sick role behaviours, resume engagement in normal activities, and promote more effective coping.

Psychoeducation and self-management strategies

While undergoing more targeted psychological intervention it is also important to encourage the veteran to do the following:

- Monitor symptoms to help **identify psychosocial factors** (e.g., times, situations and emotional states) which exacerbate their symptoms, emphasising the links between psychological factors and the experience of somatic symptoms. Then assist the veteran to **manage these perpetuating factors** through strategies that may include anxiety management, problem solving, facilitating engagement with social support, etc.
- Maintain (or re-establish) their daily **routine and current roles (e.g., work, family)**. This is particularly important for veterans who have a lot of unstructured time.
- **Reduce substance use.** It is common for veterans to self-medicate with alcohol and other drugs when struggling with pain and other somatic symptoms. While alcohol and drugs may alleviate distress and somatic symptoms in the short term, they inhibit recovery. If analgesic medication is used, it should be taken on a regular schedule as far as possible, rather than on an 'as needed' or 'prn' basis.

Pain management programs

Pain management programs (PMPs) are the treatment of choice for veterans suffering from chronic pain syndromes, including somatoform pain disorders. Effective PMPs adopt an explicit biopsychosocial model embedded within a cognitive behavioural paradigm, and include the following elements:

- multidisciplinary teams
- a holistic view of the veteran
- education on pain coping strategies
- promotion of self-efficacy beliefs and self-management
- support for improved function and lifestyle
- targeting of related depression and anxiety
- encouragement for improved general physical health and fitness.

PMPs typically occur in a group setting and vary from two to six weeks' duration.

Treatment setting and duration

In research studies, CBT treatment for somatic symptom disorders varies between 6 and 16 sessions. It is likely that 16–20 sessions would be required for veterans being seen in routine clinical practice. Treatments may occur on an individual or group basis. Hospitalisation should be avoided. Treatment setting and duration specific to pain management programs is outlined above.

Pharmacological interventions

Given the lack of firm evidence for the efficacy of pharmacological interventions, CBT should be considered the first-line treatment for somatic symptom disorders. However, medication may be beneficial for veterans who are unwilling or unable to engage in CBT, or when appropriate psychological treatment is unavailable. In cases where medication is considered necessary, new generation antidepressants such as selective serotonin reuptake inhibitors (SSRIs) and serotonin-noradrenaline reuptake inhibitors (SNRIs) are the preferred first-line treatment. Veterans with predominant pain symptoms may also respond to anticonvulsants, such as gabapentin (e.g., Neurontin) or pregabalin (e.g., Lyrica).

Referral and coordinated care

- **VVCS – Veterans and Veterans Families Counselling Service (VVCS):** This service provides veterans and their families with counselling and group programs Australia-wide. VVCS can be contacted 24 hours on 1800 011 046.
- **Psychiatrist:** for specialist management of more severe, chronic or complex problems. Some psychiatrists specialise in psychological treatments; they can review or prescribe medication, provide diagnoses, and manage co-occurring physical health problems. Allied health providers should liaise with GPs to arrange a referral. GPs can access a list of private psychiatrists at www.ranzcp.org/Resources/find-a-psychiatrist.aspx.
- A treatment plan should be developed collaboratively with the veteran and their family, and coordinated across service providers.
- Consider psychosocial and/or vocational rehabilitation services from the beginning of treatment. DVA can offer extensive rehabilitation services for entitled veterans (www.dva.gov.au/rehabilitation).

Self-management resources

- Veterans Line (1800 011 046) can be reached 24 hours a day across Australia for crisis support and counselling. This service is provided by VVCS.
- At Ease website (www.at-ease.dva.gov.au) for access to veteran-targeted information on mental health including the Wellbeing Toolbox, anxiety management and The Right Mix alcohol resources. The DVA *Mental Health and Wellbeing after Military Service* booklet is available to order or download from this website.
- Health*Insite* (www.healthinsite.gov.au) is a useful website for information on chronic pain and other somatic complaints.

This Advice Book has the following resources in the appendices that may be useful for veterans who are experiencing somatic symptom disorders:

- further explanation of CBT elements (Appendix B)
- veteran psychoeducation handout and general psychoeducation script outline (Appendix D and L)
- self-monitoring sheets including daily activity schedule (Appendix E)
- pleasant events list (Appendix F)
- information on where veterans can get more help, e.g., Veterans Line, DVA funded psychological and rehabilitation services (Appendix J).

Substance use disorders

About substance use disorders

Substance use disorders represent a significant mental health problem, affecting around one quarter of Australians over their lifetime (Australian Bureau of Statistics, 2007). Tobacco and alcohol are the most commonly used substances that cause veterans harm. However, prescription medication and illicit substance misuse also have a significant impact. Given the cohort of younger veterans returning from recent conflicts and peacekeeping operations, it is worth keeping in mind that substance use disorders are particularly common in those aged under 35 years.

Substance misuse may be a primary problem or it may be symptomatic of other mental health problems affecting the veteran. Veterans may begin to use substances to reduce anxiety and insomnia (e.g., alcohol) or improve dysphoric states (e.g., stimulants or opiates). Veterans often find the concept of 'self-medication' a useful, non-judgemental way of understanding their substance misuse. Nevertheless, both short-term and long-term harm associated with substance misuse is often profound. It is common for veterans to present with comorbid problems such as depression, anxiety, PTSD and substance misuse disorders. The presence of substance misuse is often a prominent barrier to engagement in and response to the treatment of other conditions.

Substance misuse amongst veterans

Prevalence rates of substance use disorders vary across the different veteran populations. For example:

- Alcohol abuse/dependence is the most prevalent disorder amongst Vietnam veterans, with a lifetime prevalence rate of 43 per cent. Close to three per cent experience substance use problems in their lifetime (O'Toole et al., 1996).
- Four per cent of first Gulf War veterans experienced alcohol abuse/dependence and just less than one per cent drug abuse/dependence over a 12-month period (Ikin et al., 2004).
- The 2012 Australian Defence Force (ADF) prevalence study found a 35.7 per cent lifetime prevalence of alcohol use disorder amongst currently serving ADF members (Hodson, McFarlane, Van Hooff, & Davies, 2011).

A harm minimisation (or harm reduction) framework informs the treatment of most substance use problems and is the basis of the National Drug Strategy². This approach focuses on reducing the health and lifestyle related harms of continued substance misuse. For example, a harm minimisation approach to a person injecting heroin may involve referral to a safe injecting house to reduce the health harms associated with injecting, as well as receiving education and pharmacological treatment. This framework is not recommended for smoking.

2. Available from www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/national-drug-strategic-framework-lp

Smoking

About smoking

In 2010, 15 per cent of Australians over the age of 14 were daily smokers, down from 24 per cent in 1991 (Australian Institute of Health and Welfare, 2011). There is some evidence to suggest that smoking is more prevalent among veterans than in the general community, particularly among younger veterans, although rates differ across the three branches of military service, and across different deployments (Barton et al., 2010). As in the general population, smoking rates appear to be on the decline among veterans.

Although the physical health risks associated with smoking such as risk of cancer and risks to cardiovascular health are well known, it is important to note that these health issues are likely to impact on mental health, particularly long-term health problems like emphysema that can significantly reduce a person's ability to engage in meaningful or enjoyable activities. In addition, smoking can, in the long term, exacerbate existing mental health problems by affecting mood, arousal levels and sleep.

Screening and assessment

Assessing mental health provides an opportunity to assess and address smoking, and for the person to consider changes in their smoking habits. The following questions can be used to identify the veteran's level of motivation to cease smoking:

- How do you feel about your smoking at the moment?
- Are you ready to stop smoking now?

The Smoking Cessation Framework (or the 5A's Structure for Smoking Cessation; see Appendix I) can be used as a guide to further assess the veteran's smoking history, past quit attempts, and readiness for change. Most smokers will shift across stages of readiness, from not thinking about quitting, contemplation, planning, taking action to stop smoking, and reconsideration following relapses.

If the veteran is considering quitting, it is important to assess his or her level of nicotine dependence, as this will predict withdrawal and inform treatment planning. Signs of nicotine dependence include smoking more in the morning than at other times, having the first cigarette of the day soon after waking, and smoking when unwell. A useful tool is the Fagerstrom Test for Nicotine Dependence (Heatherton, Kozlowski, Frecker, & Fagerstrom, 1991)³.

Treatment

As smoking is a major contributor to premature death and illness, veterans should be encouraged to quit by their mental health practitioner, even when they may not be principally presenting for that problem. It is also important to incorporate smoking cessation in a veteran's overall treatment, as continued smoking is likely to contribute to poor mental health through raised anxiety, sleep disturbance, irritability and labile mood. However, there is evidence to suggest that repeatedly advising smokers to quit can damage the practitioner-client relationship, so it is important to develop strong rapport and ask permission before discussing the veteran's smoking.

The interventions used for helping veterans to quit smoking will vary on the veteran's assessed readiness to quit. However, for all veterans who smoke, including those who are not ready to quit, providing advice and support is recommended. For veterans who are thinking about quitting, are unsure about quitting, or are ready to quit, a combination of pharmacotherapy, provision of self-management resources, as well as brief counselling are recommended.

3. This measure is freely available online at www.health.wa.gov.au/smokefree/docs/Fagerstrom_Test.pdf

Psychological interventions

Psychological interventions should be adjusted according to the veteran's motivation to change.

- Not ready to quit – Veterans who are not ready to quit do not require formal psychological intervention, but should be provided with education on the benefits of quitting and the effects of passive smoking, and followed up with later.
- Unsure about quitting – Motivational interviewing can help to resolve ambivalence about smoking and prepare the veteran for change. Ambivalence should be acknowledged and discrepancies between smoking behaviour and person's personal beliefs and goals should be discussed. Questions to ask include:
 - "What do you like about smoking? What are the things you don't like about smoking?"
 - After summarising the client's pros and cons ask, "Where does this leave us now?"

This 'decisional balance' technique can assist the veteran to resolve ambivalence about change, and move towards action and behaviour change. Motivational interviewing can also help resolve ambivalence about alcohol and other unhelpful behaviours such as problem gambling.

- Ready to quit – Individual or group counselling that uses cognitive behavioural therapy-based strategies is recommended for veterans who are ready to quit smoking. Key components of treatment include:
 - Assistance to identify high-risk smoking situations, and develop problem-solving strategies to deal with those situations.
 - Strategies and skills to cope with cravings, for example 'The 4Ds' (delay, deep breathe, drink water, do something).
 - Encouragement for the veteran to utilise their social supports, e.g., family, friends and/or other veterans.

Psychoeducation and self-management strategies

Veterans who are considering quitting or are ready to quit may benefit from the following advice and information before undergoing targeted treatment. Encourage the veteran to:

- Discuss impact of smoking and provide information about harms related to smoking.
- Go through reading material on how to quit smoking, and the health consequences of smoking (available from www.quitnow.gov.au and the relevant state-based 'Quit' website).
- Select a quit date, ideally within the next two weeks. Arrange follow-up appointments about one week and one month after quit date.
- Use the Quitline services (13 7848).
- Utilise their social supports, e.g., family, friends and/or other veterans.

Pharmacological interventions

Pharmacological interventions are central to effective smoking cessation treatments, especially for veterans smoking more than 20 cigarettes each day. Treatment usually lasts for at least eight weeks. Slow-release nicotine replacement therapy (NRT) by means of a transdermal patch is the preferred pharmacological intervention, as quick-release preparations such as gum or lozenges can contribute to nicotine dependence. The sustained mode of release also counters a withdrawal syndrome. Over time, NRT is reduced at a gradual rate that the person finds tolerable without resuming smoking.

Veterans experiencing episodic cravings may benefit from a 'top-up dose' of quick-release NRT, but should be monitored to ensure that use does not become habitual. Note that resumption of smoking at the same time as using NRT may lead to nicotine toxicity with harmful effects on physical and mental health.

In cases of severe nicotine dependence or a history of failure of cessation with slow-release NRT, bupropion (e.g., Zyban) or varenicline (e.g., Champix) may be added to slow-release NRT to reduce cravings and increase treatment effectiveness.

Referral options

Given the central role of pharmacological interventions in smoking cessation, veterans should be encouraged to stay in regular contact with their GP or pharmacist.

Self-management resources

Veteran resources are well developed and widely available on the internet and should represent a mandatory component of all interventions. Useful resources include:

- The Quit website for self-help information (www.quitnow.gov.au) and online counselling (www.quitcoach.org.au).
- Telephone support, advice or counselling via the Quitline (13 7848). Services available vary from state to state.
- At Ease website (www.at-ease.dva.gov.au) for access to veteran-targeted information on mental health including the Wellbeing Toolbox, anxiety management and The Right Mix alcohol resources.

Practitioner resources

- The *Smoking Cessation Guidelines for Australian General Practice* (2004) are the foundation resource for practitioners. They are available online at www.health.gov.au and www.racgp.org.au.
- The New South Wales Guide for the management of nicotine dependent inpatients. Available from www.health.nsw.gov.au/policies.
- Cochrane reviews of the tobacco addiction literature are available from www.cochrane.org.

Alcohol

About alcohol

A large proportion of both the general and veteran communities would benefit from modifying their drinking habits in line with safe use guidelines. People with hazardous, harmful or dependent alcohol consumption are at increased risk of an array of physical, neuropsychiatric and social complications.

There is some evidence to suggest that alcohol misuse is particularly common in the veteran population. Around one third of veterans are estimated to drink at risky levels (Department of Veterans' Affairs, 2009), while approximately one in ten Australians drink at levels that put them at risk of long-term harm (Australian Institute of Health and Welfare, 2010). Risky drinking spans a wide range of consumption patterns. It includes regular weekly consumption of high levels on a daily or near-daily basis, episodic or binge drinking over several days, and single events of intoxication.

In addition to the health risks and the economic costs associated with excessive drinking, alcohol use is also strongly associated with a range of psychological problems. The 2007 *National Survey of Mental Health and Wellbeing* (Australian Bureau of Statistics) found that individuals with alcohol dependence were more likely to be experiencing another mental health disorder than those without alcohol dependence. The survey also found that more than one in five Australians who reported drinking alcohol every day also had a mental health disorder.

Screening and assessment

People who consume excessive quantities of alcohol form a high percentage of attendees at general hospitals, general practice, community health care centres and other welfare services.

Routine screening for alcohol consumption and associated problems is recommended. The CAGE (Mayfield, Mcleod, & Hall, 1974) is a screening instrument designed to identify potential alcohol abuse and dependence:

- Have you ever felt you ought to **cut down** on your drinking?
- Have people **annoyed** you by criticising your drinking?
- Have you ever felt bad or **guilty** about your drinking?
- Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?

Further assessment of alcohol problems is warranted for veterans who answer 'yes' to two or more of these questions.

The Alcohol Use Disorders Identification Test (AUDIT; Babor, Higgins-Biddle, Saunders & Monteiro, 2001; see Appendix C or (www.at-ease.dva.gov.au) is a freely available standardised assessment and can be helpful in assessing severity and treatment outcomes. The AUDIT also shows alcohol consumption risk levels and provides guidance on the interventions appropriate to each drinking risk level.

Withdrawal severity can be assessed using the Clinical Institute Withdrawal Assessment for Alcohol revised scale (CIWA-Ar; Sullivan, Sykora, Schneiderman, Naranjo, & Sellers, 1989)⁴.

Treatment

As alcohol use can act as a risk factor for both mental and physical health problems, practitioners are advised to treat any existing alcohol problem.

Education about the impact of continued high-risk drinking for a veteran's health is the foundation of effective intervention. Education should address different types of risks (short and long term) associated with alcohol use. Effective education and successful interventions are based on a motivational approach, including an acknowledgement of the advantages and disadvantages to continuing drinking, moderating use, or stopping altogether.

Psychological interventions

Interventions should be tailored both to the type of alcohol risk, and to suit the veteran's preparedness to change.

Brief interventions have strong evidence for the treatment of mild to moderate alcohol problems, and are a recommended approach in Australia (Haber, Lintzeris, Proude, & Lopatko, 2009)⁵. They range in duration from 5 to 30 minutes, and are typically delivered over one to four sessions. Components of brief interventions are guided by the FLAGS process outlined below:

- **Feedback** the results of the alcohol assessment in non-judgemental and non-threatening manner.
- **Listen** carefully to client's reactions and concerns.
- **Advise** client about degree of risk and consequences associated with their alcohol intake. Ask them to outline the benefits and costs of continuing to drink at current level.
- **Goals** should be set that are realistic and involve a reduction toward low-risk levels of drinking.
- **Strategies** to reduce consumption to safe limits should be discussed and implemented. The veteran may have already used some strategies with success. Begin with their suggestions, then add others, e.g., avoid drinking when in negative mood or tired, count standard drinks, avoid 'shouts'.

Motivational interviewing (MI) is recommended for veterans who are unsure, or ambivalent about changing their drinking behaviour. Ambivalence should be acknowledged and normalised. If possible, discrepancies between current drinking behaviour and personal beliefs and goals should be discussed. Questions to ask include:

- "What do you like about drinking? What are the things you don't like about drinking?"
- After summarising the client's pros and cons ask, "Where does this leave us now?"

This 'decisional balance' technique can assist the veteran to resolve ambivalence about change, and move towards action and behaviour change.

4. Available from www.tg.org.au/etg_demo/etg-ciwa-ar.pdf.

5. A DVA resource outlining brief interventions can be downloaded from: www.dva.gov.au/service_providers/Documents/manual_AS+BI.pdf.

Cognitive behavioural therapy (CBT) is the treatment of choice for veterans ready to change their drinking behaviour. Whilst CBT has some general techniques applicable across a range of disorders, specific CBT techniques for targeting alcohol use are:

- Behavioural self-management (i.e., controlled drinking programs) – This teaches the veteran strategies to reduce alcohol consumption such as goal setting and self-monitoring.
- Coping skills training – This training teaches skills such as assertiveness, coping with cravings, and drink refusal to enable veterans to better cope with situations that are linked to alcohol use.
- Cue exposure – This type of exposure places veterans in the presence of cues to drinking (e.g., pub, watching sport) whilst not drinking and allowing the craving to fade.
- Relapse prevention – This includes identifying internal and external relapse precipitants (e.g., feelings of low mood or fights with their partner), identifying available coping skills (such as drink refusal or coping with cravings), and using the information to minimise the risk of relapse.

Behavioural couples therapy has been shown to be effective and focusses on drinking behaviour as the problem in the context of the veteran's relationship.

Alcohol and PTSD

As trauma and alcohol-related problems are functionally related, integrated treatment of veterans with posttraumatic stress disorder (PTSD) and alcohol problems is recommended. Neither abstinence nor reduction in alcohol intake should necessarily be a prerequisite for combined treatment. Veterans can receive integrated treatment for PTSD and alcohol problems provided they are not intoxicated or in withdrawal during treatment sessions. Integrated treatment of PTSD and alcohol problems is challenging and requires cross-training of practitioners across traditionally separate areas of skill and knowledge.

Core interventions in PTSD and alcohol treatment should include the following elements to help prepare veterans for trauma-focussed interventions recommended for the treatment of PTSD:

- crisis/safety interventions
- development of coping skills
- arousal /anxiety management techniques
- alcohol self-monitoring/self-management techniques.

Psychological treatment setting and duration

Treatment setting and duration will vary depending on severity and risk factors associated with the veteran's drinking behaviour. Delivery of CBT would usually consist of one-hour sessions over 12 weeks (National Institute for Health and Clinical Excellence, 2011), although treatment duration will vary according to the veteran's needs. Veterans with alcohol dependence or those who are acutely ill or disabled by their alcohol use will require more intensive treatments.

Pharmacological interventions

Alcohol withdrawal treatment

Veterans, who are alcohol dependent or otherwise at risk of alcohol withdrawal as identified by the AUDIT, should be offered alcohol withdrawal treatment, whether or not they intend to reduce or cease their use of alcohol in the longer term. Long-acting benzodiazepines such as diazepam are the preferred pharmacotherapy for alcohol withdrawal treatment, but ideally should not be continued beyond the first one to two weeks. Practitioners should tailor the sedative regimen to the veteran's individual needs using an alcohol withdrawal scale. Thiamine should also be provided to all veterans undergoing alcohol withdrawal, especially when the alcohol dependence is associated with poor nutrition.

To ensure optimal safety and the likelihood of successful treatment, practitioners should consider the appropriate setting for intervention (inpatient, community-based, home or outpatient) and the likely severity of alcohol withdrawal. When veterans are undergoing alcohol withdrawal treatment on an outpatient or home basis, they should be reviewed daily by their practitioner to assess whether transfer to a higher-dependency setting is indicated.

Relapse prevention

Pharmacotherapies for reducing alcohol cravings, such as acamprosate (e.g., Campral) or naltrexone, should be routinely recommended to a veteran being treated for alcohol dependence, to increase the probability of reduced drinking or stopping altogether. Acamprosate or naltrexone should be prescribed in combination with psychosocial relapse prevention strategies. These should be delivered over 3–12 months.

Antabuse has had a role as an aversive deterrent in alcohol misuse disorders and is still occasionally used. Given the range of drug interactions and serious medical adverse reactions associated with its use and the availability of safer therapeutic interventions, we advise that it be used cautiously, if at all, for veterans with more treatment resistant conditions.

Referral and coordinated care

- **WCS - Veterans and Veterans Families Counselling Service (WCS):** This service provides veterans and their families with counselling and group programs Australia-wide. WCS can be contacted 24 hours on 1800 011 046.
- **Psychiatrist:** for specialist management of more severe, chronic or complex problems. Some psychiatrists specialise in psychological treatments; they can review or prescribe medication, provide diagnoses, and manage co-occurring physical health problems. Allied health providers should liaise with GPs to arrange a referral. GPs can access a list of private psychiatrists at www.ranzcp.org/Resources/find-a-psychiatrist.aspx.
- A treatment plan should be developed collaboratively with the veteran and their family, and coordinated across service providers.
- Consider psychosocial and/or vocational rehabilitation services from the beginning of treatment. DVA can offer extensive rehabilitation services for entitled veterans (www.dva.gov.au/rehabilitation).

Self-management resources

- A useful veteran-specific resource is The Right Mix website (www.therightmix.gov.au), part of the At Ease package (www.at-ease.dva.gov.au). This website has materials for veterans such as local support contacts, and tips for changing drinking behaviour. Changing the Mix is an internet-based alcohol correspondence program (www.therightmix.gov.au or call 1800 1808 68).
- At Ease website (www.at-ease.dva.gov.au) for access to veteran-targeted information on mental health including the Wellbeing Toolbox, anxiety management and The Right Mix alcohol resources. The DVA *Mental Health and Wellbeing after Military Service* booklet is available to order or download from this website
- Information on drinking guidelines and self-management strategies can be found at www.alcohol.gov.au.

Practitioner resources

- Australian Government, Department of Health and Ageing (2009). *Guidelines for the treatment of alcohol problems*. Available from www.health.gov.au.
- *Alcohol Screening and Brief Intervention (AS+BI) Manual: A skills based intervention and training resource for veteran service providers*⁶.
- A useful veteran-specific resource is The Right Mix website (www.therightmix.gov.au) which has information for health professionals.

⁶ Available from www.dva.gov.au/service_providers/Documents/manual_AS+BI.pdf (accessed 22 March 2012).

Illicit and prescribed substances

About illicit and prescribed substances

Broadly speaking, other than alcohol and nicotine there are two classes of substances that need to be considered when assessing veterans' illicit drugs and prescription medications. The growing rate of misuse of prescription medication, particularly pain medication, among veterans may be reflective of a general increase in prescription medication abuse in the community. Use of illicit drugs is also relatively common, with around one third of Australians using illicit drugs at some point in their lives (Australian Institute of Health and Welfare, 2011).

As there is an increase in the use of prescribed and illicit substances amongst young Australians, it is likely that this is the case for younger veterans. The rate of cannabis use in veterans, including Vietnam veterans is also often underestimated by practitioners. Cannabis is the most commonly used illicit substance in the general population, followed by ecstasy, amphetamines and cocaine (Australian Institute of Health and Welfare, 2011).

Screening and assessment

The CAGE questions adapted to include drugs (CAGE-AID; Brown & Rounds, 1995) is a screening instrument designed to identify potential substance abuse and dependence, and asks the following questions.

When thinking about drug use, including illegal drug use and the use of prescription drugs other than as prescribed:

- Have you ever felt you ought to **cut down** on your drug use?
- Have people **annoyed** you by criticising your drug use?
- Have you ever felt bad or **guilty** about your drug use?
- Have you ever used drugs first thing in the morning to steady your nerves or get rid of a hangover?

Veterans who answer 'yes' to two or more of these questions, should be assessed further for substance use problems.

The Drug Abuse Screening Test (DAST-20; Skinner, 1982a, 1982b) can assist in assessing the severity of the veteran's substance use problem. It can be found in Appendix C, and online at www.at-ease.dva.gov.au.

Comorbid mental health problems are common with veterans who misuse illicit or prescription drugs. Depression, alcohol abuse, anxiety and PTSD commonly co-occur with substance abuse. Also, substance use and suicidal thoughts or behaviour are often related. Therefore, where substance use problems are present, screening for risk of harm to self or others is recommended. Assessment of injecting behaviour to determine health risks is also advised.

Treatment

Psychological interventions

Talking to a veteran, together with the veteran's family, about his or her substance use is the start of treatment. A number of psychological interventions have been found to be effective in the treatment of substance use disorders. The choice of treatment will depend on the substance being used, the severity of dependence, and veteran and practitioner preferences. Recommended treatments include:

- Motivational interviewing (MI) – Veterans with problematic or risky substance use, or those who are unsure or ambivalent about changing their substance use behaviour, may benefit from MI. Ambivalence should be acknowledged and normalised. This may involve providing the veteran with information about reducing the risks associated with substance use, normalising ambivalence, and discussing discrepancies between current substance use behaviour and personal beliefs and goals. Questions to ask include:

- “What do you like about your substance use? What are the things you don’t like about it?”.
- After summarising the pros and cons about substance use identified by the veteran, ask about his or her intention to change in a non-directive manner (e.g., “Where does this leave us now?”).

This ‘decisional balance’ technique can assist the veteran to resolve ambivalence about change, and move towards action and behaviour change.

- Cognitive behavioural therapy (CBT) – Some evidence suggests that CBT can be particularly effective. Whilst CBT has some general techniques applicable across a range of disorders, specific CBT techniques for targeting substance use are:
- Behavioural self-management – This teaches the veteran strategies to reduce drug use such as self-monitoring and identifying high risk situations.
- Coping skills training – This training includes skills such as assertiveness and coping with cravings, to enable veterans to cope better with situations that are linked to drug use.
- Cue exposure – This exposure approach places veterans in the presence of cues to drug use (e.g., drug paraphernalia, other people using drugs) whilst not using and observing the craving fade.

CBT treatment elements for cannabis dependence

There is emerging evidence that CBT is an effective treatment for cannabis dependence, especially when used with motivational enhancement techniques (Buckner & Carroll, 2010; McRae, Budney, & Brady, 2003). Specific CBT techniques for targeting cannabis use are:

- Identifying and learning about external (others using, cravings, relationships) and internal triggers (negative emotional states, unpleasant thoughts).
- Developing problem-solving skills to manage triggers such as drug refusal, coping with craving, avoiding ‘high risk’ environments, and managing relationships.
- Developing cognitive strategies such as recognising automatic thoughts and thought management.
- Developing assertiveness and refusal skills.
- Managing negative mood states with, for example, relaxation exercises.

- *Behavioural couples therapy (BCT) and family therapy (FT)* – This approach recognises that family members often play a crucial role in the origin and maintenance of addictive behaviour. BCT and FT have demonstrated effectiveness in treating substance use problems, however there is limited research to identify which drugs these therapies are particularly effective for. Key aims of BCT and FT include:
 - eliminating drug abuse
 - engaging the family’s support for the client’s efforts to change their behaviour
 - restructuring patterns of couple and family interactions in ways conducive to long-term, stable abstinence.

Psychological treatment setting and duration

Psychological interventions may be delivered in either an individual or a group format, with the duration of treatment tailored to the veteran’s needs. The choice of treatment setting will depend on the severity of the veteran’s substance use problem. Residential programs or therapeutic communities (TC) may be considered for severe dependency, polysubstance use and significant comorbid issues. There is, however, limited evidence for the long-term benefits of these programs and their capacity to prevent relapse following treatment completion.

Pharmacological interventions

Pharmacological treatment of a substance use disorder will depend on the substance being used and whether the overall goal of pharmacotherapy is replacement/substitution or symptom management. Appropriate pharmacotherapy for the mental health consequences of long-term substance misuse is likely to have advantages in preventing relapse behaviour. An example of

this type of intervention is treating depression and anxiety following psycho-stimulant cessation with selective serotonin reuptake inhibitors (SSRIs).

Contingency management and twelve-step programs

- Contingency management and twelve-step programs are other approaches used for substance use disorders. However, each has its limitations.
- Contingency management (CM) involves the use of incentives, such as vouchers and prizes, to encourage reduced substance use. Evidence indicates that CM is effective for promoting abstinence during and after treatment for a wide range of substance use disorders (Prendergast, Podus, Finney, Greenwell, & Roll, 2006). However, this approach is not widely used because it is resource and labour intensive, so may be best suited to settings such as forensic monitoring and treatment.
- Twelve-step programs, such as Alcoholics Anonymous and Narcotics Anonymous, are peer-based group programs aimed to help members achieve and maintain abstinence. Alcoholics Anonymous is readily available and cost effective, and there is sufficient, but not strong, evidence to suggest that long-term participation can be effective for some people (Australian Government Department of Health and Ageing, 2009).

In general, substitution pharmacotherapy is more likely to be suitable for veterans misusing opioids, (including illicit drugs such as heroin, and prescription analgesics such as OxyContin), and for those misusing minor tranquilisers such benzodiazepines. A number of options for the pharmacological management of dependence on other drugs (e.g., cannabis, cocaine) are currently being investigated. However, at present there is insufficient evidence to support recommendations on which regimens are likely to be the most effective. Therefore, we will focus here on the treatment of opioid dependence.

Physical withdrawal from opioids can be managed by methadone or buprenorphine, with some evidence suggesting that the latter is associated with briefer periods of withdrawal. Both these medications can be used as long-term maintenance (opiate substitution) pharmacotherapy. Naltrexone can assist in the treatment of opioid dependence (particularly relapse prevention) by blocking the euphoric effects of opioids, thereby removing the 'reward' of drug use. Buprenorphine (a partial opiate agonist) has a similar effect, and also acts as a disincentive to opiate use. Note however that veterans must be assessed for recency of opiate use before commencing naltrexone or buprenorphine treatment.

Where pharmacotherapy is considered necessary for the treatment of substance use, it should be adjunctive to, or followed by one or more of the psychological interventions described above in order to maximise the likelihood of full recovery. For example, while pharmacotherapy may treat the veteran's physical dependence on the drug or concomitant mood disorders, it is unlikely to address broader psychosocial issues surrounding the veteran's drug use, such as diminished problem solving skills, relationship breakdown, unemployment, or engagement in criminal activity. In the case of naltrexone, the treatment itself has no beneficial effect on the user's mood, and so there is no immediate incentive to engage. Therefore, concurrent psychological intervention is particularly important in maintaining treatment compliance.

Withdrawal management

Clinical judgement is essential in determining whether a withdrawal plan is necessary, as a diagnosis of substance abuse or dependence will not necessarily require a withdrawal management plan. For example, users of substances with lower levels of physical dependence, such as cannabis, are unlikely to require a withdrawal management plan.

Withdrawal management may be conducted in home-based, community residential, or inpatient hospital settings; the choice of setting will be determined by the predicted severity of (or potential medical complications associated with) withdrawal. Where possible, participation in community-based withdrawal programs is recommended as these provide the veteran with ongoing professional support and advice while allowing him or her to begin practicing coping skills and other withdrawal management strategies in everyday life. Inpatient withdrawal programs may be required for polysubstance users or veterans with significant medical, psychiatric, or social problems that will make it difficult to engage in community-based programs.

Pharmacotherapy may have a particular role to play in managing the physical withdrawal from the substance of dependence, but should be considered as part of an overall treatment plan for the veteran's substance dependence, including both pharmacological and psychological interventions. In developing treatment plans, all stages of treatment should be considered and the continued involvement of the primary practitioner established. This allows a smooth transition from withdrawal to the maintenance phases of treatment and increases the likelihood of recovery. Research shows that clients who participate in withdrawal programs without a post-withdrawal plan are more likely to return to pre-withdrawal levels of substance use.

Referral and coordinated care

- VVCS - Veterans and Veterans Families Counselling Service (VVCS). This service provides veterans and their families with counselling and group programs Australia-wide. VVCS can be contacted 24 hours on 1800 011 046.
- Psychiatrist: for specialist management of more severe, chronic or complex problems. Some psychiatrists specialise in psychological treatments; they can review or prescribe medication, provide diagnoses, and manage co-occurring physical health problems. Allied health providers should liaise with GPs to arrange a referral. GPs can access a list of private psychiatrists at www.ranzcp.org/Resources/find-a-psychiatrist.aspx.
- A treatment plan should be developed collaboratively with the veteran and their family, and coordinated across service providers.
- Consider psychosocial and/or vocational rehabilitation services from the beginning of treatment. DVA can offer extensive rehabilitation services for entitled veterans (www.dva.gov.au/rehabilitation).

Self-management resources

- Australian Drug Foundation (www.adf.org.au) provides advice on community services and information around substance use.
- *DrugInfo* (www.druginfo.adf.org.au) is a service of the Australian Drug Foundation (ADF) that provides handouts on general effects of illicit substance use and harm associated with prescription medication misuse.
- A substance use self-help booklet from the World Health Organization can be found here: whqlibdoc.who.int/publications/2010/9789241599405_eng.pdf.
- The National Cannabis Prevention and Information Centre (www.ncpic.org.au).
- At Ease website (www.at-ease.dva.gov.au) for access to veteran-targeted information on mental health including the Wellbeing Toolbox, anxiety management and The Right Mix alcohol resources. The DVA *Mental Health and Wellbeing after Military Service* booklet is available to order or download from this website.

Practitioner resources

- A resource titled the *Management of cannabis use disorder and related issues: A clinician's guide* (2009) can be downloaded from the National Cannabis Prevention and Information Centre (www.ncpic.org.au).

This Advice Book has the following resources in the appendices that may be useful for veterans who are experiencing substance use problems:

- further explanation of CBT elements (Appendix B)
- psychoeducation handouts for the veteran and general psychoeducation script outline (Appendix D and L)
- the smoking cessation framework (Appendix I)
- information on where veterans can get more help, e.g., Veterans Line, DVA funded psychological and rehabilitation services (Appendix J).

The DVD accompanying this Advice Book includes an example of a practitioner conducting assessment and treatment for alcohol and substance abuse.

Complicated grief

About complicated grief

Losing a loved one or friend requires a period of adjustment, during which people grieve for the loss and re-establish their lives without the loved one's presence. For most people, the intensity of their grief recedes with time as they adjust to life without their loved one.

For some people, however, this normal grieving and healing process can become derailed such that they develop a chronic and debilitating condition. In this Advice Book, the term complicated grief will be used to refer to this condition, although it is sometimes referred to as prolonged grief or bereavement related disorder (or traumatic bereavement depending on the manner of death). Some indications that the normal grieving process has been derailed, and that complicated grief may be present, include:

- excessive rumination over concerns related to the death
- difficulty making sense of the loss
- misinterpretation of aspects of the loss (e.g., excessive self-blame)
- avoidance of reminders of the loss
- prolonged experience of grief, e.g., for more than one year

Complicated grief is associated with more prolonged distress and disability, as well as greater negative health outcomes and suicidality, than normal grief. It is important to note that complicated grief is distinct from anxiety and depression, although there are some common features across these disorders.

Approximately one in ten bereaved people experience complicated grief, with higher rates amongst those bereaved by disaster or violent death, or parents who lose a child (Shear et al., 2011).

Complicated grief reactions have traditionally been diagnosed as depression, PTSD, or an anxiety disorder. However, there is now substantial evidence to suggest that, despite some similarities and frequent comorbidity, complicated grief is distinct from these other disorders. For example, veterans suffering any post-bereavement disorder are likely to report ongoing sadness. Those experiencing complicated grief, however, are less likely to report depressive symptoms such as low mood and feelings of hopelessness, or anxiety symptoms such as restlessness or nervousness. Instead, prominent features will include preoccupation (e.g., intense yearning for the deceased, rumination about the death), reactive distress (e.g., anger, self-blame, avoidance of reminders), and identity disruption (e.g., a sense that life is futile or meaningless, detachment from others).

It is important to recognise complicated grief, as interventions only targeting anxiety, depression, or PTSD are not usually effective. Careful assessment of symptoms is therefore required. Post-bereavement anxiety, depression, or PTSD (either independent of, or comorbid with, complicated grief) can be treated using standard approaches for these disorders.

Screening and assessment

Veterans presenting with persistent and severe symptoms following the death of a close friend or relative should be assessed for the possible presence of complicated grief. In most cases, a detailed diagnostic interview is the best way to proceed, although several scales are available (e.g., the Texas Revised Inventory of Grief (Faschingbauer, 1981), the Hogan Grief Reaction Checklist (Hogan, Greenfield, & Schmidt, 2001), the Grief Evaluation Measure (Jordan et al., 2005), and the Inventory of Complicated Grief – Revised (Prigerson et al., 1995)).

Complicated grief can be a significant risk factor for suicide, as veterans may feel that life is meaningless, or express a wish to die in order to be reunited with the deceased. It is therefore important to ask grieving veterans about suicidal ideation using direct and unambiguous questions such as:

- Are there times when things seem so bad that you think about killing yourself?
- Do you have a plan of how you might do this?
- Do you have access to ... (check means and opportunity)?
- Have you ever harmed yourself or tried to kill yourself in the past?
- Do you live alone (or unsupervised)?
- Do you use amphetamines, alcohol, or other substances?

It is also important to consider and address other risk factor such as social isolation and substance abuse.

Treatment

Most people who experience grief find that, with the support of their family, friends and usual coping strategies, their grief resolves over time and no professional help is needed. The box below contains information on self-management strategies that may be useful for veterans who have experienced loss.

Psychoeducation and self-management strategies

Health care providers can offer advice on basic self-management strategies that the veteran can use to assist in recovery from grief (or while undergoing any necessary psychological and/or pharmacological interventions for complicated grief). Encourage the veteran to:

- Prioritise spending time and reconnecting with their **social supports**, e.g., sympathetic family members and friends, local interpersonal community activities.
- Maintain (or re-establish) their daily **routine and current roles** (e.g., work, family). This is particularly important for veterans who have a lot of unstructured time. This may include starting an exercise routine (as simple as a daily 20 minute walk) and engaging in planned pleasant events.
- **Reduce substance use**. While alcohol and drugs may alleviate distress in the short term, they inhibit recovery.

Psychological interventions

Cognitive behavioural therapy

Mental health practitioner delivered cognitive behavioural therapy (CBT) should be considered for veterans with complicated grief. Whilst CBT has some general techniques applicable across a range of disorders, specific CBT techniques for targeting complicated grief are:

- Cognitive therapy – This assists veterans to identify unhelpful thinking patterns relating to their loss and to revise the way they think about those aspects. This can be particularly useful for veterans who are experiencing guilt-related thoughts and intrusive memories.
- Behavioural techniques – Techniques such as activity scheduling can assist the veteran to re-engage with the world, undertake positive or pleasurable activities, and set goals for the future.
- Exposure therapy – This approach can be particularly useful for those whose loss occurred in traumatic circumstances and experience fear-based intrusive memories. Imaginal exposure involves repeatedly telling the story of the loss. In vivo exposure may involve confronting places or people associated with the loss that the veteran has been avoiding. Where the veteran did not witness the death, and their intrusive image is based on their worst fear of what the death may have involved, there may be benefit in first trying to clarify the known details and then seeking to address or correct any misinformation or

assumptions that this image may be based on. Such clarifications can potentially address the intrusive images without the requirement to engage in imaginal exposure.

- The intervention can also include having imagined conversations with the deceased, evoking happy memories, and exploring regrets and resentment so that they are able to make goals for the future.

Psychological treatment setting and duration

Complicated grief can be treated in an outpatient setting and does not usually require admission to a psychiatric hospital unit. There is not sufficient evidence to determine a recommended treatment length for complicated grief; however, as whenever using CBT, it is important to establish a clear treatment plan for each time-limited episode of care.

Pharmacological interventions

Veterans with milder forms of complicated grief will usually respond well to psychological interventions alone. Psychological interventions are also the treatment of choice for veterans with more severe symptoms; however, evidence suggests an adjunctive course of newer antidepressants can help veterans tolerate grief-focused CBT.

Referral and coordinated care

- **WVCS - Veterans and Veterans Families Counselling Service (WVCS):** This service provides veterans and their families with counselling and group programs Australia-wide. WVCS can be contacted 24 hours on 1800 011 046.
- **Psychiatrist:** for specialist management of more severe, chronic or complex problems. Some psychiatrists specialise in psychological treatments; they can review or prescribe medication, provide diagnoses, and manage co-occurring physical health problems. Allied health providers should liaise with GPs to arrange a referral. GPs can access a list of private psychiatrists at www.ranzcp.org/Resources/find-a-psychiatrist.aspx.
- A treatment plan should be developed collaboratively with the veteran and their family, and coordinated across service providers.
- Consider psychosocial and/or vocational rehabilitation services from the beginning of treatment. DVA can offer extensive rehabilitation services for entitled veterans (www.dva.gov.au/rehabilitation).

Self-management resources

- Veterans Line (1800 011 046) can be reached 24 hours a day across Australia for crisis support and counselling. This service is provided by WVCS.
- At Ease website (www.at-ease.dva.gov.au) for access to veteran-targeted information on mental health including the Wellbeing Toolbox, anxiety management and The Right Mix alcohol resources. The *DVA Mental Health and Wellbeing after Military Service* booklet is available to order or download from this website.
- The Australian Centre for Grief and Bereavement (www.grief.org.au) provides some useful information on grief for clients. Note that there are currently no resources specific to complicated grief.

This Advice Book has the following resources in the appendices that may be useful for veterans who are experiencing symptoms of complicated grief:

- further explanation of CBT elements (Appendix B)
- psychoeducation handout for veteran and general psychoeducation script outline (Appendix D and L)
- self-monitoring sheets including a daily activity schedule (Appendix E)
- pleasant events schedule (Appendix F)
- information on where veterans can get more help, e.g., Veterans Line, DVA funded psychological and rehabilitation services (Appendix J).

Associated complaints

About associated complaints

There is a range of complaints that are often associated with common mental health problems in veterans or in their own right. Practitioners should be aware of such problems when assessing veterans' mental health.

Problematic anger

About problematic anger

Problematic anger and aggression are common problems for veterans and present a potential risk to others, yet there is limited evidence-based information available for practitioners. While problematic anger is not in itself an accepted diagnosable condition, it is a commonly reported presenting problem of veterans from Australia and the United States. For example, just over one in ten US veterans of Iraq and Afghanistan report having problems controlling violent behaviour (Elbogen et al., 2010). The anger may well be treated as part of interventions for other disorders, such as PTSD or depression, but there may also be some benefit in using interventions specifically designed to address anger. The following recommendations are based on the available literature on evidence-based interventions for problematic anger among veterans and other populations.

Screening and assessment

There are a range of key questions that GPs and mental health care practitioners can ask to identify the severity of problematic anger in veterans, and to screen for risk of aggression and harm to others. Practitioners should be mindful to consider the possibility of violence to loved ones and others. Some useful screening questions for problematic anger include:

- Do you find that you are often bothered by feelings of anger?
- Does your anger interfere with your mood, relationships, work or physical health?
- Are there times when you feel so angry that you have thoughts of harming someone?

If the veteran answers 'yes' to the final question, screen for risk of harm to others with questions such as:

- What is it you have thoughts of doing and to whom?
- Do you have access to ... (check means and opportunity to use guns or other potentially lethal implements)?
- Have there been times in the past when you have become so angry that you have harmed someone? If so, what happened?

A useful tool for assessing the presence and severity of anger in veterans is the Dimensions of Anger Reactions 5 scale (DAR5; Hawthorne, Mouthaan, Forbes, & Novaco, 2006)⁷.

In a more complete assessment of anger, practitioners should:

- identify key triggers and cues to anger and the extent of the veteran's anger responses
- investigate the chronicity and pattern of poorly controlled anger
- identify vulnerabilities to anger, including:
 - intoxication and withdrawal from alcohol and/or drugs
 - acquired head injury from physical trauma
 - alcohol dependence or overdose
- identify key people related to anger (i.e., who is the anger directed towards, or who is present when anger occurs)

⁷ www.psychiatry.unimelb.edu.au/centres-units/cpro/DAR5/index.html

- assess a veteran's social network to help identify people who are likely to play an important role in treatment
- take a history of all forms of violence, including injuries to others and road rage, and make an appraisal of the veteran's potential to engage in violence
- explore the veteran's legal position, including existing orders and charges pending
- assess the veteran's ability to keep his or her partner and family safe from physical violence
- seek the veteran's agreement to ongoing monitoring of progress and practitioner contact with family members.

The assessment of anger needs to be part of a broader assessment of mental health problems. Identification of any untreated mental health disorder (such as depression, PTSD, panic disorder or alcohol misuse) may not preclude participation in anger-specific treatment, although treatment of these primary mental health disorders may address the anger problem.

Include partners and family in assessment

Ideally, where problematic anger and aggression are likely to be present, the assessment process should include a session including the veteran's partner and, where appropriate, other family members. Wherever possible, the veteran's consent to family members being interviewed should be obtained. Whether the veteran provides consent or not, it is recommended that at least one assessment session should be undertaken with family members without the veteran present, to ensure that safety concerns of family members are identified. It may be necessary to negotiate that family members are seen by another practitioner or service if the veteran does not wish his or her own practitioner to see them. The important principle here is that the practitioner maintains responsibility to also address the family's safety needs and risk of harm. The family assessment may act as another source of information about the veteran's current and past levels of violence, readiness to change and violence potential. Joint sessions with the family and the veteran should only be conducted where the partner and children feel safe in the counselling session and at home following the session.

Practitioners may consider combined sessions, after separate assessments, provided the following criteria are met:

- the couple is choosing to remain together
- the veteran's partner expresses a wish to participate
- there is no history of severe violence
- violence is not severe enough to elicit substantial fear in the partner
- both members of the couple acknowledge aggression or violence is a problem (where aggression or violence is present)
- the partner's mental or emotional state is sufficiently stable
- the partner possesses adequate support resources
- a safety plan for partners and family has been established (Campbell, 2001; O'Leary, 2001).

The interventions outlined in this chapter are not suitable for veterans engaging in violence where anger is not a significant feature of the presentation, but should be managed according to the current principles for the prevention of family violence. For example, anger management does not adequately address issues of power and control that are the main feature of most family violence presentations. Referral options for practitioners not experienced in family violence are provided at the end of this section.

Treatment

Therapeutic alliance

Therapeutic alliance is a significant factor contributing to beneficial treatment outcomes. This is particularly pertinent here as veterans with anger problems often have difficulty forming a working alliance with therapists. For example, therapists and veterans may fail to agree on the goals of therapy. Therapists may want to address a veteran's anger, but the veteran may want to focus on changing the behaviour of the targets of their anger or getting revenge.

In addition, in the context of posttraumatic presentations, the information processing bias towards threat detection may result in the therapist being perceived as a threat, and the veteran's attendance at treatment prematurely terminated.

Problems in establishing or maintaining the therapeutic alliance have the potential to reduce the benefits of treatment and may result in the treatment being terminated prematurely. For posttraumatic populations, presentation of the 'survivor mode' model of bias toward threat detection may be helpful in pre-empting threats to the alliance.

Problematic anger differs somewhat from other mental health problems in that a veteran may be slower to recognise the problem and less receptive to treatment. Veterans with problematic anger are more likely to present to treatment at the behest of others, rather than through self-recognition of their own distress and difficulties. Therefore, there is a greater emphasis on education for problematic anger as it helps to build the case to the veteran on the need for treatment. In this way, the veteran is more likely to recognise the problem and its impact, and be motivated to address it.

Psychoeducation and self-management strategies

The education phase of the treatment is critical for establishing a therapeutic alliance through personal validation, empathy and addressing motivation for change. Adopting a collaborative approach based on mutual respect when working with veterans with problematic anger is important. Essential components of education include:

- monitoring of anger frequency, intensity or duration, preferably recorded in a diary
- identification of anger cues and triggers
- identification of contextual factors that influence anger
- discussion of the individual's anger response in terms of physiological arousal, cognitive and behavioural components.

Education may also address the following:

- Costs of anger – help the veteran to see the problems caused by dysfunctional anger and the likely benefits of anger management, both in the short and long term.
- The potential impact of military training on the development of the anger response. Part 1 provides useful background information for this discussion. Other useful material on this topic can be sourced from VVCS - Veterans and Veterans Families Counselling Service.
- Other causes of anger. For example, the introduction of concepts such as the 'survivor mode' of functioning can be helpful. This view proposes that anger in posttraumatic presentations is intrinsically linked to the perception of threat and to survival needs, and that threat perception and anger are reciprocally influenced (Novaco & Chemtob, 2002).
- The potential impact of community attitudes towards a given conflict, particularly for veterans of Vietnam, Iraq, and Afghanistan. See Part 1 for more information on community attitudes and the homecoming experience.

Psychological interventions

Interventions addressing anger should be based on a CBT model and typically include the following elements:

- Arousal management – Breathing techniques, progressive muscle relaxation, and distraction techniques help the veteran to recognise and manage the physiological arousal associated with anger.
- Cognitive therapy – People with anger problems do not often process information accurately and are likely to appraise relatively benign situations as threatening. Treatment needs to address faulty attribution and evaluation styles, and assist the veteran to develop ways of challenging those thinking styles. Cognitive interventions for anger and anger-related aggression should also identify and address core beliefs about gender, and explore where and how these beliefs are related to the presence of abuse and violence.
- Self-instruction training – This helps the veteran to identify the stages of their anger reaction, such as preparation prior to entering the anger-provoking situation, coping with encountering the situation and evaluating the aftermath of the situation. The veteran learns a series of statements that act to control the negative affect in the situation and that can be rehearsed to prepare for the event and used in managing reactions after the event.
- Imaginal exposure – In anxiety disorders, exposure is maintained with the expectation that habituation will occur and the level of anxiety be reduced over time as the person learns that the situation or image is not dangerous. In anger, maintaining exposure can sometimes exacerbate the problem. Exposure in anger should include assisting the veteran to imagine anger-triggering events and practicing skills of anger management in response. As the anger reaction emerges, techniques of relaxation and breathing retraining are used along with self-instructions that act to defuse the anger. Situations are re-evoked until the veteran is able to imaginally manage each situation effectively. People or aspects of each situation that influence the level of anger experienced are also identified, to assist the veteran to manage the imaginal exposure.
- Behavioural techniques – People with anger problems often have difficulties identifying alternative strategies for solving problems, especially interpersonal problems, without resorting to aggressive behaviour. Therefore, specific skills training in problem solving, social skills, communication skills, assertion techniques, and negotiation and conflict resolution, need to be incorporated. 'Short circuit' techniques, such as time-out and time management, should also be discussed. These interventions can be introduced later in the treatment program after the veteran has developed more effective anger management skills.

Psychological treatment setting and duration

Problematic anger can usually be treated in an outpatient setting. There is currently insufficient evidence to recommend an optimal duration of psychological treatment.

Pharmacological interventions

Anger and resulting aggression can present as primary problems or they can be seen as symptomatic of other conditions. It is important to assess the situation carefully in order to guide effective use of psychotropic medications that may be beneficial. Anger and aggression can occur in the context of:

- mood disorders
- anxiety disorders, such as PTSD
- chronic pain
- psychosis
- brain injury and/or cognitive impairment.

It follows that effective medical treatment of these conditions will reduce the severity of abnormal anger and associated aggression. Impulsive aggression has been shown to improve with treatments including lithium and various anticonvulsant medicines (e.g., Sabril or Primaxin). Dysregulation of the serotonin system has been demonstrated in some studies, possibly explaining the role of selective serotonin reuptake inhibitor (SSRI) antidepressants in improving anger symptoms even when anger occurs in the absence of other common mental health problems (Kamarck et al., 2009).

Referral and coordinated care

- VVCS - Veterans and Veterans Families Counselling Service (VVCS): This service provides veterans and their families with counselling and group programs Australia-wide. VVCS can be contacted 24 hours on 1800 011 046.
- Psychiatrist: For specialist management of more severe, chronic or complex problems. Some psychiatrists specialise in psychological treatments; they can review or prescribe medication, provide diagnoses, and manage co-occurring physical health problems. Allied health providers should liaise with GPs to arrange a referral. GPs can access a list of private psychiatrists at www.ranzcp.org/Resources/find-a-psychiatrist.aspx.
- Family violence prevention programs: A list can be found at www.relationships.org.au/what-we-do/services/family-violence-prevention.
- A treatment plan should be developed collaboratively with the veteran and where appropriate, their family, and coordinated across service providers.
- Consider psychosocial and/or vocational rehabilitation services from the beginning of treatment. DVA can offer extensive rehabilitation services for entitled veterans (www.dva.gov.au/rehabilitation).

Self-management resources

- Veterans Line (1800 011 046) can be reached 24 hours a day across Australia for crisis support and counselling. This service is provided by VVCS.
- MensLine Australia is a professional telephone and online support, information and referral service, helping men to deal with relationship problems in a practical and effective way. They can be contacted 24 hours a day on 1300 78 99 78, and have useful information on their website: www.mensline.org.au.
- Other useful websites include the Australian Psychological Society (www.psychology.org.au) and Reach Out (www.reachout.com.au).
- At Ease website (www.at-ease.dva.gov.au) for access to veteran-targeted information on mental health including the Wellbeing Toolbox, anxiety management and The Right Mix alcohol resources. The DVA *Mental Health and Wellbeing after Military Service* booklet is available to order or download from this website.

Practitioner resources

- Kassirnov, H. & Tafrate, R.C. (2002). *Anger management: The complete treatment guide for practitioners*. Atascadero, California: Impact Publishers.
- O'Leary, K.D. (2001). Conjoint therapy for partners who engage in physically aggressive behavior: Rationale and research. *Journal of Aggression, Maltreatment and Trauma*, 5, 145–164.

Insomnia

About insomnia

Most people will experience periods of sleep disturbance at some stage of their lives, and disturbed sleep is common among veterans. Usually, sleep disturbance will last for less than three weeks. These short-term sleep difficulties could be caused by illness, stress, increased caffeine intake or other changes in diet. Some people, however, will have more long-lasting difficulty in initiating or maintaining sleep, or will have chronic non-restorative sleep, indicating they may have insomnia. People with insomnia may also show a decline in social, occupational or other areas of functioning, and may report cognitive impairments such as attention or memory problems, mood disturbance such as irritability, or behavioural problems including hyperactivity or aggression. Note that the presence of hyperactivity may mean that insomnia clients do not appear tired, despite subjective reports of sleepiness. Scant evidence exists

about the prevalence of insomnia, although one Australian study reported a prevalence of approximately five per cent in the general practice client population (Knox, Harrison, Britt, & Henderson, 2008). Given the increasing proportion of women in younger veteran cohorts, it is worth keeping in mind that females are more likely to suffer from insomnia than males (Zhang & Wing, 2006).

It should be noted that sleep problems are often related to other mental health conditions (such as depression, anxiety or PTSD), substance misuse and general medical conditions (such as sleep apnoea or pain). Therefore, it is important to screen for these disorders if chronic sleep problems are detected.

For veterans, sleep problems may also stem from military experiences. There may be a lingering impact of disturbed sleep routines resulting from prolonged periods of sentry or 'picket' duty shifts during the night. Veterans may have frequent nightmares related to military experiences, or hypervigilance may have a negative impact on the sleep process.

Screening and assessment

Insomnia is both a common and complex condition. Medical treatment, therefore, should always be based on a thorough assessment that includes detailed history, physical examination and in some instances, medical investigations. The assessment should also clarify the consequences of insomnia for a veteran's functioning and quality of life. Useful questions to ask the veteran include:

- Do you have any problems with your sleep?
- How many hours of sleep do you usually get at night?

Screening questions should include investigations of early, middle and late-onset insomnia. For early-onset insomnia:

- Do you have difficulty getting off to sleep at night?
- How long does it take to fall asleep?

For middle-onset insomnia:

- Do you wake in the middle of the night?
- How many times do you wake?
- How long does it take to fall back asleep?

For late-onset insomnia:

- Do you wake early in the morning and have trouble going back to sleep?

Asking the veteran to keep a sleep diary for about a week can assist with the assessment process. Useful things to include in the sleep diary include time of retiring to bed and wake-up, time taken to fall asleep, number of awakenings during the night, total time spent awake in bed, and level of fatigue during the day. Further physical investigations of sleep problems such as suspected sleep apnoea can be conducted by sleep centres or clinics.

Treatment

Self-management strategies encouraged by a GP are the recommended first-line intervention for insomnia. However, if the insomnia persists after the veteran has implemented self-management strategies, it may be necessary to consider more formal interventions.

Psychological interventions

In the event that insomnia does not respond to self-management strategies and more formal intervention is required, CBT is the recommended approach. It 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.

CBT may include the following components:

- Sleep hygiene and stimulus control strategies – These strategies include removing stimuli from the bedroom that are not related to sleep, avoiding caffeine, and ensuring that the bed is only associated with sleep. Refer to the 'Psychoeducation and self-management strategies' box below for further strategies.
- Cognitive therapy – This is important as negative thoughts or cognitions can play a role in maintaining and perpetuating sleep disturbance. For example, the veteran may have worrying thoughts around the feared consequences about the loss of sleep and unrealistic expectations about how much sleep is actually required.

Psychoeducation and self-management strategies

Practitioners can advise veterans on a number of sleep hygiene strategies that may allow them to manage their sleep difficulties that are common to many disorders. Practitioners should:

- reassure the veteran that most people have difficulty sleeping at some time in their lives, and that for the majority it is only temporary
- assist the veteran to resolve, if possible, a specific problem that is contributing to the insomnia, and where necessary, refer for psychological treatment
- discourage the use of sleeping tablets if other methods have not yet been tried
- provide education about the principles of good sleep habits.

These strategies are based on the premise that sleep problems can be developed and/or maintained by a series of problems or habits inherently disruptive to sleep. Sleep hygiene techniques seek to re-establish sleep promoting behaviours. Key features of sleep hygiene include:

- establishing an appropriate sleep environment — insulate the bedroom against outside noises and to block out light, and keep the room at an even temperature
- removing from the bedroom stimuli not associated with sleep
- reducing the time spent in bed worrying about sleep or other matters — keep a notebook next to the bed for jotting down any thoughts that come to mind for the next day, then let them go
- avoiding alcohol, caffeine and nicotine in the late afternoon and evening
- exercising regularly – but not just before going to bed.

An important component of sleep hygiene is stimulus control; encourage the veteran to:

- go to bed only when sleepy
- limit bedtime activities to sleep and sex
- wait for sleep for 15-20 minutes
- get up if they do not fall asleep
- go to another room
- stay up until they begin to feel sleepy
- only then go back to bed
- repeat this process as often as they need to fall asleep
- get up at the same time each morning, no matter how long they have slept
- do not have naps during the day.

Psychological treatment setting and duration

Insomnia can usually be treated in an outpatient setting. There is currently insufficient evidence to recommend an optimal duration of psychological treatment.

Pharmacological interventions

Pharmacotherapy for insomnia should not be used in isolation, but should be part of a range of interventions, including standard sleep hygiene measures and 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. 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. Longer-acting more potent agents such as nitrazepam (e.g., Alodorm) and flunitrazepam (e.g., Hypnodorm) should be avoided for these reasons.

When other agents such as antihistamines and sedating antidepressants are used for their hypnotic effects, the broader array of potential side effects must be considered and balanced against the desired benefits.

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 for insomnia 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.

Referral and coordinated care

- **VVCS - Veterans and Veterans Families Counselling Service (VVCS):** This service provides veterans and their families with counselling and group programs Australia-wide. VVCS can be contacted 24 hours on 1800 011 046.
- **Psychiatrist:** For specialist management of more severe, chronic or complex problems. Some psychiatrists specialise in psychological treatments; they can review or prescribe medication, provide diagnoses, and manage co-occurring physical health problems. Allied health providers should liaise with GPs to arrange a referral. GPs can access a list of private psychiatrists at www.ranzcp.org/Resources/find-a-psychiatrist.aspx.
- **Sleep clinics or centres** are another referral option for detailed investigation and treatment of some sleep disorders. Many sleep clinics and specialists can be found at www.sleep.org.au/servicesdirectory.
- A treatment plan should be developed collaboratively with the veteran and their family, and coordinated across service providers.
- Consider psychosocial and/or vocational rehabilitation services from the beginning of treatment. DVA can offer extensive rehabilitation services for entitled veterans (www.dva.gov.au/rehabilitation).

Self-management resources

- Veterans Line (1800 011 046) can be reached 24 hours a day across Australia for crisis support and counselling. This service is provided by VVCS.
- At Ease website (www.at-ease.dva.gov.au) for access to veteran-targeted information on mental health including the Wellbeing Toolbox, anxiety management and The Right Mix alcohol resources. The *DVA Mental Health and Wellbeing after Military Service* booklet is available to order or download from this website.
- Information on managing sleep difficulties is available from the Sleep Health Foundation (www.sleephealthfoundation.org.au) and through the Sleep Better without Drugs program (www.sleepbetter.com.au).

Practitioner resources

- Australasian Sleep Association (www.sleep.org.au) has information for health professionals on a range of sleep disorders, links to other useful websites, and a service directory of sleep clinics and specialists.

Problem gambling

About problem gambling

In Australia, the term problem gambling is used to refer to a condition when an individual has difficulties limiting the money and/or time spent gambling, which then leads to negative consequences for them, their family/friends and community (Neal, Delfabbro, & O'Neill, 2005). Problem gambling is also characterised by the individual's struggle to control gambling impulses despite adverse consequences in other areas of life.

According to research conducted with Vietnam veterans, problem gambling appears to be slightly more common in veterans than in the general community, with an estimated prevalence of around four per cent compared to one to two per cent. A small but increasing body of evidence has identified a higher prevalence of problem gambling in people with mental health problems (Lorains, Cowlshaw, & Thomas, 2011), and this is also the case for veterans (Biddle, Hawthorne, Forbes, & Coman, 2005; Edens & Rosenheck, 2012). Again, the comorbidity rates of gambling and mental health problems in veterans appear comparable with those of community samples more generally.

Screening and assessment

Practitioners are advised to screen and assess for problem gambling in veterans with mental health problems. A one-item screen recommended in the current Australian guidelines (Problem Gambling Research and Treatment Centre (PGTRC), 2011) is:

- Have you ever had an issue with your gambling?

If the veteran answers 'yes' to this question, further assessment of his or her gambling habits is recommended. A number of screening tools are available to assess the presence and severity of problem gambling. Scales that have been tested and validated in the Australian context include:

- Canadian Problem Gambling Index⁸ (CPGI), and its abbreviated form, the Problem Gambling Severity Index (PGSI) (Ferris & Wayne, 2001).
- Victorian Gambling Screen (VGS; Ben-Tovim, Esterman, Tolchard, and Battersby, 2001).

Treatment

Psychological interventions

Cognitive behavioural therapy (CBT) is the recommended psychological treatment to reduce gambling behaviour, gambling severity and psychological distress in people with gambling problems (PGTRC, 2011). Practitioner delivered CBT may include some or all of the following elements:

- Motivational interviewing – These techniques are used to increase the veteran's readiness for making changes to their gambling behaviours.
- Cognitive therapy – This is designed to challenge and modify any cognitive errors related to gambling (e.g., misunderstanding of randomness and the odds of winning).
- Identification of triggers and high-risk situations for gambling, and coping strategies to use in these situations.
- Exposure therapy – This includes techniques such as imaginal desensitisation, *in vivo* exposure and response prevention.
- Activity scheduling – This encourages the veteran to schedule enjoyable activities as an alternative to gambling.

8 www.gamblinghelponline.org.au/gambling-issues/risk-assessment.aspx

Psychoeducation and self-management strategies

It is useful for the practitioner to provide information on problem gambling and encourage the client to use self-management strategies while undergoing more targeted treatment. For example, the practitioner can:

- **Discuss** the problem gambling in a non-judgemental and non-threatening manner, and listen carefully to the veteran's reactions and concerns.
- Advise the veteran about the degree of risk and consequences associated with his or her gambling. Refer him or her to information that dispels the myths related to gambling, e.g., odds of winning, how pokies work (www.gamblinghelponline.org.au). Ask the veteran to outline the benefits and costs of continuing to gamble at the current level.
- Help set **goals** that are realistic and involve a reduction or elimination of gambling.
- Discuss and help implement **strategies** to reduce gambling. The veteran may have already used some strategies with success. Begin with his or her suggestions then add others.

Psychological treatment setting and duration

Problem gambling can usually be treated in an outpatient setting. There is currently insufficient evidence to recommend an optimal duration of psychological treatment, or to suggest whether therapy is best delivered in a group or individual format.

Pharmacological interventions

There has been little research investigating the effectiveness of pharmacological interventions in the treatment of gambling problems. However, some evidence supports the use of the opioid antagonist naltrexone to reduce gambling severity. At this time, naltrexone use for problem gambling is not subsidised by the Pharmaceutical Benefits Scheme (PBS).

Referral and coordinated care

- Gambling Help provides free face-to-face gambling counselling throughout Australia. They also provide financial counselling. Refer to their website for information on service locations: www.gamblinghelponline.org.au, and/or call 1800 858 858 for referral information.
- VVCS - Veterans and Veterans Families Counselling Service (VVCS): This service provides veterans and their families with counselling and group programs Australia-wide. VVCS can be contacted 24 hours a day on 1800 011 046.
- Psychiatrist: For specialist management of more severe, chronic or complex problems. Some psychiatrists specialise in psychological treatments; they can review or prescribe medication, provide diagnoses, and manage co-occurring physical health problems. Allied health providers should liaise with GPs to arrange a referral. GPs can access a list of private psychiatrists at www.ranzcp.org/Resources/find-a-psychiatrist.aspx.
- A treatment plan should be developed collaboratively with the veteran and their family, and coordinated across service providers.
- Consider psychosocial and/or vocational rehabilitation services from the beginning of treatment. DVA can offer extensive rehabilitation services for entitled veterans (www.dva.gov.au/rehabilitation).

Self-management resources

- Veterans Line (1800 011 046) can be reached 24 hours a day across Australia for crisis support and counselling. This service is provided by VVCS.
- Gambling Help provides confidential online, telephone and face-to-face counselling. The website also contains useful information for people with gambling issues and their families. They can be contacted 24 hours a day on 1800 858 858 or on their website: www.gamblinghelponline.org.au.
- At Ease website (www.at-ease.dva.gov.au) for access to veteran-targeted information on mental health including the Wellbeing Toolbox, anxiety management and The Right Mix

alcohol resources. The DVA *Mental Health and Wellbeing after Military Service* booklet is available to order or download from this website.

Practitioner resources

- Problem Gambling Research and Treatment Centre (PGTRC). (2011). *Guideline for screening, assessment and treatment in problem gambling*. Clayton: Monash University.
- Biddle, D., Hawthorne, G., Forbes, D. and Coman, G. (2005). Problem gambling in Australian PTSD treatment-seeking veterans. *Journal of Traumatic Stress, 18*, 759–869.
- Raylu, N. & Oei, T.P. (2010). *A cognitive behavioural therapy programme for problem gambling: Therapist manual*. Sussex: Routledge.

This Advice Book has the following resources in the appendices that may be useful for veterans who are experiencing these associated complaints:

- further explanation of CBT elements (Appendix B)
- psychoeducation handouts on each topic for the veteran and general psychoeducation script outline (Appendix D and L)
- self-monitoring sheets including a distress thermometer (SUDS) and daily activity schedule (Appendix E)
- pleasant events list (Appendix F)
- progressive muscle relaxation (Appendix G)
- breathing retraining instructions (Appendix H)
- information on where veterans can get more help, e.g., Veterans Line, DVA funded psychological and rehabilitation services (Appendix J).

The DVD that accompanies this Advice Book includes material relevant to problematic anger. Specifically, it includes an assessment of violence and a functional analysis that is conducted just prior to a behavioural intervention.

Cognitive impairment

About cognitive impairment

Cognitive impairment is an issue that is important to keep in mind when assessing and treating veterans. It is common for veterans to present with complex issues that involve more than one mental health disorder, and with alcohol abuse a common feature. In addition, the veteran population is ageing. This often means that practitioners have to disentangle the impact of mental health, substance and ageing related conditions on cognitive function in order to develop a meaningful treatment plan.

Other factors that can influence cognitive functioning include early life experiences (including trauma); learning and other developmental disabilities; and a range of injuries and medical conditions. Whilst the cognitive impacts associated with any of these factors can be subtle, they are nevertheless an important consideration when attempting to understand, diagnose and treat the veteran who presents with mental health problems.

Mental health and cognitive impairment

It is well established that mental health disorders can significantly affect an individual's cognitive functioning. For many people who experience a mental health disorder, changes in cognitive functions such as memory and reasoning can often be some of the most distressing

symptoms. Cognitive impairment can limit all aspects of a person's life, and exacerbate feelings of loss of control and mastery associated with many mental health problems. The table below outlines some of the cognitive changes that people with mental health issues can experience.

Attention	<ul style="list-style-type: none"> • Can't keep track when reading a book or following a conversation • Can't concentrate on anything, and get easily distracted • Can only do one thing at a time
Memory	<ul style="list-style-type: none"> • Forget what they are doing in the middle of doing it • Forget appointments, phone numbers and conversations • Dependent on others to help remember things • Can't learn new skills (e.g., computer)
Problem-solving	<ul style="list-style-type: none"> • Can't see anything through to the end, for example, start to build something but get muddled half way through • Can't cook a meal - difficulty sequencing and coordinating tasks • Difficulty filling in forms
Activation	<ul style="list-style-type: none"> • Difficulties with planning and initiating activities of daily living • Difficulties with maintaining motivation and drive

Ageing and cognitive impairment

The ageing process can influence cognitive functioning. People who develop a range of medical conditions as they age are more vulnerable to age-related cognitive changes. Interestingly, recent studies suggest that the 'healthy aged', (i.e., those who do not develop medical conditions that may affect the brain such as cardiovascular disease, dementia or brain injuries) are unlikely to demonstrate evidence of cognitive decline, at least until they reach their eighties (Wardill & Anderson, 2010). At that point, some deficits in executive functions, particularly in areas such as cognitive flexibility, concept formation, goal setting, planning and organisation, become apparent.

Dementia most commonly affects people who are aged 65 years and older, and is generally caused by Alzheimer's disease. As Australia's veterans age, it can be expected more will be affected by dementia, although no specific link has been found between war service and dementia⁹. It is estimated that around 250,000 people in Australia currently have dementia (Access Economics, 2009).

Traumatic brain injury and cognitive impairment

A traumatic brain injury (TBI) can occur when something outside the body hits the head with significant force, e.g., a penetrating injury when a piece of shrapnel enters the brain, a blast injury, or blunt force as a head hits the windscreen during a car accident. The Australian Institute of Health and Welfare report a rate of 107 TBI-related hospital stays per 100,000 people in the population (Australian Institute of Health and Welfare, 2007). However, it is important to note that a disproportionate number (around two-thirds) of these are young males, often having developed an injury through a car accident. For this reason, it is likely that Defence personnel are overrepresented in this group. The vast majority of veteran-specific research has been conducted in the United States, where mild TBI (mTBI) is often referred to as the 'signature' injury of the recent conflicts in Iraq and Afghanistan. Prevalence estimates of mTBI in US veterans range from 12-20 per cent (McFarlane, Saccone, Clark, & Rosenfeld, 2011), while mTBI is estimated to affect around four percent of UK veterans (Rona et al., 2012). Generally speaking, severity of impact, loss of consciousness, posttraumatic amnesia duration, and number of TBIs influences the severity of cognitive impairment. Research suggests that TBIs amongst the veterans from recent conflicts rarely occur in isolation, but rather TBIs have high comorbidity with pain and PTSD (Otis, McGlinchey, Vasterling, & Kerns, 2011). In this case, the veteran's treatment should target all three coexisting problems.

⁹ *Living with Dementia - A Guide for Veterans, their Families and Carers*, available from www.dva.gov.au.

Substance use and cognitive impairment

It has been well established that excessive substance use, and in particular sustained alcohol use, can lead to permanent impairments in brain function. Although the prevalence of substance-related cognitive impairment is difficult to establish, a meta-analysis of almost 40,000 post-mortems found a prevalence of alcohol-related brain changes in 1.5 per cent of the general population, and in 30 per cent of heavy drinkers (Cook, Hallwood, & Thomson, 1998). In its early stages, alcohol-related brain damage may contribute to executive function impairments and memory loss. For many people who have experienced some problems with memory and thinking because of substance use, there may be an improvement in their brain function if they are able to achieve abstinence. For others, cognitive difficulties may continue even with abstinence. In all cases however, continued heavy substance use increases the risk of more severe and permanent brain damage. Age, gender and patterns of use, can all affect the cognitive impairment potential of substance use.

Medical conditions and cognitive impairment

There is a vast range of medical conditions that can have an impact on cognitive functioning. It is beyond the scope of this chapter to outline these conditions. However, it is important that clinicians be aware that chronic conditions involving the cardiovascular and endocrine systems, kidney and liver function, neurological disorders, some autoimmune disorders, neurotoxin exposure and some infectious diseases all carry with them risks of neuropsychological impairments. Chronic sleep disorders such as sleep apnoea and insomnia can also affect cognitive function. Having an awareness of a client's medical history is fundamental to understanding their cognitive difficulties.

Comorbidity and cognitive impairment

An additional layer of complexity is added to a veteran's presentation when, as is often the case, more than one underlying condition may be influencing cognitive functioning. For example, among people hospitalised with a TBI, approximately half met criteria for depression within the year after the injury (Bombardier et al., 2010). Depressive disorders are more common in people aged 75 years and older than in the general population, with lifetime prevalence ranging between 4.5 and 37.4 per cent (Luppa et al., 2012). It is important, therefore, to consider that multiple factors may be affecting a veteran's cognitive functioning at any one time, and be mindful of this when conducting an assessment, developing a case formulation and treatment plan.

Screening and assessment

In some cases, cognitive impairment may be transitory, and its progression can be slowed, or reversed, if the underlying cause is addressed. Therefore, early identification of cognitive impairment and its underlying cause is important, as it allows the veteran to get early access to the most appropriate treatment.

A screen of cognitive functioning (past and present) is an important aspect of any thorough clinical assessment. This should include a comprehensive history, including developmental (e.g., pregnancy, birth and milestones), medical, psychiatric, substance use, and educational/occupational history and, if possible, the use of a cognitive screening tool. Some useful questions to ask a client include:

- At any stage throughout your life, have you suffered a knock to the head, a fit, a concussion or a period of loss of consciousness? (If veteran responds 'yes', obtain details).
- Have you, or any members of your family, had difficulties with learning or poor school performance? (If 'yes', obtain details).
- Has anyone in your family suffered from a form of dementia? (If 'yes' - who, what, when?).
- Have you (or anyone close to you) noticed any changes in your ability to do the following things:
 - Carry out your usual daily activities, e.g., planning, getting started, sequencing, completing?
 - Concentrate on tasks, e.g., reading a book, watching television, following conversations?
 - Remember things, e.g., recall a shopping list, remember to do things?

- Solve problems, e.g., do you sometimes choose the wrong way to do something, or make the same mistake repeatedly?

Cognitive screening tools are not, and do not, replace the need for a comprehensive diagnostic assessment. They will however, give a broad indication as to whether a person's cognition is intact or whether it requires closer examination. One widely used screening tool is the Mini Mental State Examination (MMSE; Folstein, Folstein, & McHugh, 1975). This includes measures of orientation, working and short-term memory, and language functioning. In administering the MMSE it is important to be aware that people from different cultural backgrounds or those with lower levels of education may perform poorly even in the absence of cognitive impairment. Alternatives screening tools include:

- Mini-Cog Test (Borson, Scanlan, Brush, Vitaliano, & Dokmak, 2000) – This is used to screen and monitor executive functioning. It is available at www.hospitalmedicine.org/geriresource/toolbox/mini_cog.htm.
- Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE; Jorm, 1994) – This is useful for gathering information on onset, duration and impact on daily functioning. It is available at ageing.anu.edu.au/Iqcode/index.php.

If you suspect that a veteran is experiencing difficulties or a decline in cognitive functioning, inform their general practitioner. The veteran can then be referred for further assessment to a specialist such as a clinical neuropsychologist, geriatrician, neurologist or psychiatrist to provide a diagnosis and identify underlying causes of the cognitive impairment.

Treatment and management

It is important that the appropriate treatment is sought for the underlying cause of the cognitive impairment. This treatment may involve psychological or pharmacological treatment in the case of mental health disorders, or medical treatment in the case of other underlying medical conditions.

Strategies for managing attention and memory difficulties

Regardless of the cause of the cognitive impairment, it is useful to provide the veteran with strategies to help compensate for their attention and memory difficulties. The veteran is more likely to get benefit from a strategy by getting their family's assistance with implementing it, and by practicing it often enough that it becomes habitual.

Helpful strategies for **managing attention difficulties** include:

- Keep noise to a minimum and remove unnecessary distractions
- Allow longer time than usual to process information and reach decisions
- Break large amounts of information down into manageable chunks
- Plan important activities when most alert

Helpful strategies for **managing memory difficulties** include:

- Rehearsal and repetition - Repeat information in head over and over, or say information out loud
- Add meaning - Make up a story that gives meaning to the information
- Visualise - Make a visual story out of what needs to be remembered
- Form links - Find a common theme for the things that the person wants to remember
- Chunking - Divide large amounts of information into smaller ones (e.g., phone numbers)
- Word systems - Use rhyming words or acronyms

Everyday **memory aids** include:

- Write things down in a diary or on a memo pad/calendar hanging on a cupboard/door
- Have a designated place for frequently lost items, e.g., bowl for wallet, keys, mobile phone
- Link forgotten tasks (e.g., taking pills) with a regular activity during the day, e.g., a meal
- Ask a friend to remind veteran about things, or have them accompany veteran to appointments
- Make use of electronic devices for reminders, e.g., computer, mobile phone, iPad
- Establish a routine (e.g., request the same time for appointments) to reduce memory load

Adapting psychological treatment for veterans with cognitive impairment

It is not uncommon for mental health disorders and cognitive impairment to co-occur (whatever the underlying cause of the impairment). Psychological therapy can still be effective with veterans with cognitive impairment, although it is important to accommodate for the veteran's cognitive difficulties. Below is a list of principles for adapting cognitive behavioural therapy (CBT).¹⁰

Use behavioural techniques early in treatment

- Behavioural techniques such as relaxation exercises or activity scheduling are often easier to understand than the cognitive elements of CBT, so introducing these early in treatment can help build the veteran's confidence and engagement with the CBT approach.

Simplify cognitive therapy techniques

- Match the language to the client's cognitive abilities (i.e., carefully manage use of analogies, vocabulary and amount of material presented at one time or in one session).
- It may be necessary to suggest alternative ways of thinking to clients who have difficulty challenging their own unhelpful thoughts.
- Use behavioural experiments to help make cognitive challenging more concrete.
- Explore the veteran's beliefs about their cognitive impairment. Note this may involve issues of shame and/or guilt as well as grief and loss if cognitive changes are permanent.

Adapt therapy delivery to the client's strengths

- Use the results of any neuropsychological assessment that identify strengths and weaknesses, to adapt therapy delivery. For example, use diagrammatic representations to explain concepts with clients who have good visual memory.
- Slow down the therapy process by focussing on only a couple of concepts each session, and make the most of review and repetition.
- Utilise memory aids where possible. For example, provide the client with recordings of relaxation exercises, provide diagrammatic representations or written summaries, use calendars/diaries, or cue cards that can be carried in the veteran's wallet, and make the most of technology, e.g., phone reminder alerts.

Enlist the support of a 'therapy partner'

- The therapy partner could be a family member or close friend who can help reinforce the therapy techniques in between appointments. It is important to encourage repeated practise of skills in naturalistic settings, and a therapy partner can be helpful in implementing strategies.

Referral and coordinated care

- It is important to notify the veteran's general practitioner of possible cognitive impairments, as GPs can refer to specialists such as geriatricians, neuropsychologists or psychiatrists.
- Clinical neuropsychologist: There may be assessment and clinical issues that require the input of a neuropsychologist. A list of private clinical neuropsychologists can be found at www.psychology.org.au/FindaPsychologist when using the advanced search function.
- Commonwealth Respite and Carelink Centres provide information on carer support and respite services for health practitioners and the community (www.commcarelink.health.gov.au).
- The Aged Care Assessment Service (ACAS) and Psychogeriatric Assessment and Treatment Services (PGAT) can provide assessment, care plans and referrals as required.

Self-management resources

- Alzheimer's Australia provides information, counselling and support for people with all forms of dementia and their families and carers. See www.fightdementia.org.au, www.mindyourmind.org.au or call the National Dementia Hotline on 1800 100 500.

10. This list has been adapted from the principles designed for use of CBT with people with TBI:

Wong, D., McKay, A. & Hsieh, M.-Y. [2012]. Can psychological interventions be adapted for people with moderate to severe traumatic brain injury? *InPsych*, 34, 14-15. Retrieved from www.psychology.org.au/publications/inpsych

- Aged Care Australia has information on dementia-related topics: www.agedcareaustralia.gov.au.
- *Living with Dementia - A Guide for Veterans, their Families and Carers* is available from www.dva.gov.au.
- Traumatic Brain Injury: The Journey Home website provides veteran-specific information about mild and moderate-severe TBI for clients, family and caregivers: www.traumaticbraininjuryatoz.org.
- Alcohol related brain impairment information is available from www.betterhealth.vic.gov.au.

Practitioner resources

- Vasterling, J.J. & Brewin, C.R. (Eds.). (2005). *Neuropsychology of PTSD: Biological, cognitive, and clinical perspectives*. New York: Guilford Press.
- David, A., Fleminger, S., Kopelman, M., Lovestone, S. & Mellers, J. (2009). *Lishman's organic psychiatry: A textbook of neuropsychiatry* (4th ed). Oxford: Wiley-Blackwell.
- *Clinical practice guidelines and care pathways for people with dementia living in the community*. Available from eprints.qut.edu.au.
- *Guidelines for mild traumatic brain injury following closed head injury*. Available from www.maa.nsw.gov.au. Summary guidelines for GPs are also available.
- Norton, F. & Halay, L. (2011). Cognitive brain deficits associated with alcohol abuse: Treatment implications. *The American Association of Behavioural and Social Sciences Journal*. Available from www.aabss.org.

Comorbidity and case formulation

Veterans commonly present with comorbid disorders and complex needs that require careful treatment planning. For example, up to 90 per cent of veterans with posttraumatic stress disorder (PTSD) will meet criteria for another mental health problem. More complex presentations also require ongoing negotiation with presenting veterans around treatment goals to ensure that underlying problems likely to hinder recovery are addressed. This chapter provides general guidance on case formulation and treatment sequencing for complex clients. While there is some evidence about treatment sequencing, many of the principles presented here are based on clinical opinion, rather than empirical evidence, and need to be applied judiciously by practitioners using their own independent judgment.

Using case formulation to understand complex veteran presentations

Case formulation assists in focussing on presenting problems that are likely to have the most impact on veterans' recovery and helps set priorities for treatment. There are a number of reasons for systematically and collaboratively developing a case formulation for veterans with complex needs. First and foremost, if a veteran presents with two or more diagnoses, using a diagnostic approach to guide treatment does not help sequence treatment.

In addition, it may be difficult for veterans with long standing comorbid conditions to understand how their mental health problems are maintained and to identify counselling goals that will have a meaningful impact on their recovery. For example, it is not unusual for veterans with chronic PTSD, alcohol dependence and depression to present to counselling with a goal to manage relationship problems. In this instance, avoidance symptoms associated with PTSD, low energy associated with depression, and reluctance to address alcohol problems may mean that the veteran has little awareness or motivation to address underlying problems contributing to relationship difficulties.

Finally, because complex problems often lead to ongoing crises and elevated risks, therapists sometimes focus on crises that emerge during the course of counselling and can be distracted from addressing underlying problems that maintain the client's presentation.

There are a number of definitions and approaches to case formulation. A commonly accepted definition of case formulation is, "a hypothesis that relates all of the presenting complaints to one another, explains why these difficulties have developed and provides predictions about the patient's condition" (Wolpe & Turkat, 1985). In other words, case formulation brings together all the information gathered during assessment to develop a working hypothesis that explains how a veteran's presenting problems have developed and are being maintained (Persons, 2005). It also includes a description of factors that influence and help predict recovery, including protective factors such as social connections and the veteran's strengths.

In conclusion, case formulation goes beyond summarising information gathered during assessment and provides an explanatory story that is used to focus treatment. The case formulation is used to develop a treatment plan that tackles factors that maintain presenting problems and takes into account factors that may hinder or promote change for the veteran. Because case formulation is a working hypothesis, it involves an ongoing review process throughout counselling where the formulation is tested on a regular basis and adjusted if necessary.

Elements of case formulation

A widely used case formulation model is presented below. This model can be easily adapted to fit in with most treatment approaches or orientations, taking into account factors that lead to and perpetuate presenting issues as well as the client's vulnerabilities and strengths.

A case formulation includes the following elements (see Appendix K for a suggested one page template):

- presenting problems
- factors that cause the individual to be vulnerable to the development of these problems (**vulnerabilities**)

- factors that trigger the onset of the presenting problems (**triggers**)
- factors that might be barriers or supports for change (**positive and negative prognostic indicators**).

The case formulation culminates in the following element:

- a hypothesis about the relationship between presenting problems and what maintains them (**maintaining factors**).

In order to be a useful tool, a case formulation needs to move beyond describing or listing the above factors. It should describe the relationships between these factors and provide a coherent story about the way the veteran is presenting in counselling.

Taking a collaborative approach to case formulation: helping shape client goals

A good case formulation includes and informs a client's expectations about treatment and can help collaboratively develop goals for therapy. Although the evidence about the impact of a collaborative approach to case formulation on the treatment alliance is inconclusive at present (Kuyken, Fothergill, Musa, & Chadwick, 2005), it is considered good practice to involve the client in the process as it helps shape their goals for therapy. As discussed earlier, this may be particularly important for clients presenting with complex issues as it may help them understand the importance of addressing underlying problems in order to recover.

A collaborative approach to case formulation also allows the clinician and veteran to discuss factors that maintain current problems, discuss progress and revise treatment goals throughout treatment.

What makes a good case formulation?

For a case formulation to be useful, it needs to quickly and easily lead both therapist and veteran to what needs to be prioritised in a treatment plan. A case formulation is principally a tool to ensure that treatment is targeted to what is most likely going to lead to change for the veteran. It also needs to have the right balance of information and be brief so it can guide the planning and review of treatment effectively. Too much information can lead to a lack of clarity. In addition, it is important that the hypotheses about what leads to, and maintains, presenting problems are informed as much as possible by current evidence.

Lastly, a case formulation is most effective if it explains relationships between presenting problems, vulnerabilities, protective and maintaining factors and triggers. There is evidence that many clinicians use case formulation to summarise assessment information rather than to integrate it into a coherent story that leads to a hypothesis about what maintains clients' presenting problems (Kuyken, Fothergill, Musa, & Chadwick, 2005). Examples of brief case formulations that explain rather than just describe a client's presenting problems are provided below.

Case Studies - Example of case formulation with veterans with complex needs

A DVD with three case studies is included with this book. An example of a case formulation for all three cases is outlined below.

Ron: 62 year old Vietnam veteran

Ron has PTSD and a long established pattern of dependent drinking, consuming between 10-20 standard drinks per day. He also uses high amounts of codeine to manage the chronic pain he experiences in relation to a hip injury sustained in combat. He has very high levels of social anxiety, has experienced panic attacks and spends much of his time at home. Ron and his wife have little interaction but no intention to separate and he has difficulty getting along with his adult children. He has mentioned that he has difficulty remembering things that he feels he should remember. He now gets easily frustrated when trying to complete tasks in his workshop and around the home.

Case formulation in brief - Hypothesis about how main presenting problems are maintained

There are a number of working hypotheses about Ron's presenting problems. Most importantly, avoidance seems to be the way Ron tends to deal with his problems and this avoidance seems to be perpetuating Ron's re-experiencing of traumatic events, social anxiety, substance use and social withdrawal. As part of this avoidant pattern, long standing alcohol dependence seems to be a significant contributor to psychological distress and disengagement from others. It may also have led to cognitive decline, which in turn may impact on levels of distress and capacity to change.

Chronic pain may also be contributing to Ron's distress, PTSD symptoms, avoidance and substance use. Finally, it could be that the lack of treatment goals and the long-term failure to address and treat Ron's PTSD could be leading to low motivation, increased avoidance and substance use.

Predisposing factors - vulnerabilities

In Vietnam, Ron's involvement in both platoon and civilian deaths led to the development of PTSD.

Precipitating factors - triggers to presenting problems

Ron has experienced PTSD symptoms for a number of years and it is likely that his alcohol dependence and social anxiety stem from a desire to reduce some of these symptoms. His need to avoid distress – whether caused by reminders of traumatic events, pain, or social anxiety – triggers drinking, potential codeine misuse and social withdrawal. Pain may also indirectly trigger substance use as it may act as a reminder of Ron's time in Vietnam, a time he wishes not to think about. Given the amount of alcohol and codeine consumed by Ron, cravings and/or withdrawal symptoms may also be present and lead to increased substance use. Ron's excessive drinking may have led to his recent difficulty remembering things and his increased frustration and irritability. Pain and anxiety might also be contributing factors to his memory problems.

Prognostic indicators - barriers or supports for change

A number of factors would indicate that Ron can engage in changing his behaviour and outlook. He has reduced his alcohol consumption and has some insight into the negative effects of alcohol on his life. However, Ron's motivation to change is limited and he has consistently avoided talking about his trauma. In addition, he appears to have poor expectations of the outcomes of treatment. While the fact that Ron is in a relationship may assist with his recovery, it is evident that this relationship is distant.

Perpetuating factors - what maintains the presenting problems

Ron's PTSD and social anxiety are perpetuated by the prolonged and pervasive avoidance of emotional distress. He avoids distress by using alcohol, withdrawing from social situations and potentially, by misusing codeine. He has also avoided having surgery on his hip although it causes him increasing pain.

Tim: 28 year old, veteran from Afghanistan

Tim has been diagnosed with PTSD. He binge drinks and uses cannabis on a daily basis. He also occasionally takes methamphetamine whilst at parties. Tim has intermittent bouts of extremely low mood associated with suicidal ideation. Angry outbursts are common; on several occasions he has hit his girlfriend, he has punched walls and he has been involved in a few fights outside nightclubs when intoxicated.

Case formulation in brief - Hypothesis about how main presenting problems are maintained

Two main issues seem to be contributing to Tim's current presentation: his need to avoid thoughts and feelings related to traumatic events in Afghanistan and difficulties with regulating emotions. Tim's inability to manage emotions and need to shut out memories of traumatic events lead to substance abuse and impulsive destructive behaviours which in turn lead to feelings of self-hate and hopelessness. These feelings contribute to depression and suicidal ideation which in turn increase the likelihood of substance abuse. Tim's inability to self-regulate and his need to be in control also contribute to domestic violence.

Predisposing factors - vulnerabilities

A number of factors caused Tim to be vulnerable to the development of PTSD, substance abuse, depression and anger. He has witnessed multiple deaths whilst serving in Afghanistan and witnessed the traumatic and violent death of a friend whilst deployed. In addition, Tim has described being "belted" by his father when he was a child.

Precipitating factors - triggers to presenting problems

Tim states that he wakes in the morning with low mood, stating that he "hates himself". He drinks alcohol and uses cannabis to assist with his mood but states that this makes him feel bad about himself and worsens his mood in the longer term. Tim also feels overwhelmingly angry, helpless and scared when he is reminded of events in Afghanistan and tries to shut these emotions out by using cannabis or alcohol. Tim's suicidal ideation and risk taking (such as fights) seem to be triggered by feelings of self-hatred and a sense of hopelessness that follow a bout of drinking. Tim's verbal abuse and physical violence towards his partner seems to be the result of a need to be in control and is triggered by events such as her being out of contact.

Prognostic indicators - barriers or supports for change

Tim was given an ultimatum by his partner, Kim, to attend therapy to ensure the longevity of their relationship. While Tim seems to be willingly engaging in the process, he faces a number of barriers to change, most importantly his high levels of alcohol and substance abuse. In addition, Tim presents with low motivation to change, is unsure about what he can get out of therapy and is fearful of talking about his experiences in Afghanistan.

Perpetuating factors - what maintains the presenting problems

Tim's PTSD is perpetuated by the pervasive avoidance of any reminders of the event. Tim's attempts to avoid and shut out any thoughts of Afghanistan lead to increased intrusive PTSD symptoms such as nightmares, as well as alcohol and cannabis abuse. Increased alcohol and substance use contributes to Tim's depressive symptoms. Given Tim's exposure to childhood abuse and his impulsive behaviour, it is likely that his aggression, risk taking and substance use are maintained by an inability to regulate his emotions. This, together with a need to be in control of his partner, would perpetuate his verbal and physical abuse.

Lisa: 32 years, ex-peacekeeper in East Timor

Lisa served in East Timor when she was 23 years old. She has presented for help in relation to poor sleep patterns. When she lies awake at night she ruminates on her experiences in East Timor and sometimes has nightmares. She is misusing sleeping tablets prescribed by her GP. She is experiencing low mood, a loss of interest in activities and has poor energy levels. She also may be at risk of self-harm, stating that "sometimes it is all too much". She is being

“performance managed” by her supervisor because of difficulties in concentrating at work, and frequent absenteeism.

Case formulation in brief - Hypothesis about how main presenting problems are maintained

Lisa’s rumination about events that she witnessed in East Timor, coupled with her overuse of sleep medication both appear to be contributing to Lisa’s poor sleep patterns, anxiety and low mood. These in turn have contributed to Lisa withdrawing from social relationships and activities that she used to enjoy. The lack of pleasurable activities and social withdrawal act to maintain her low mood and substance use problems. Lisa’s low mood and fatigue are likely to be impeding her ability to work effectively. Given Lisa’s high standards, her difficulties at work are likely to cause her anxiety which has led to her increased absenteeism and, in turn, contribute to Lisa’s low mood.

Predisposing factors - vulnerabilities

Lisa sets very high standards for herself. She believes that she should be in control and that it is her responsibility to perform well. These beliefs may have made Lisa vulnerable to self-recrimination and depression when faced with a situation in East Timor where she was not in control and unable to deliver help as she would have liked.

Precipitating factors - triggers to presenting problems

Lisa’s misuse of sleeping tablets is triggered by her anxiety and low mood. Given that Lisa is building a tolerance to sleep medications, it is possible that worry about not being able to contain her anxiety or cravings are contributing to her anxiety and increased medication use. Negative ruminations about East Timor have led to sleepless nights and low mood. Her reduced role at work and difficulties managing tasks exacerbate self-recrimination and criticism which contribute to her low mood and anxiety. These in turn have led to social isolation and could increase her risk of suicidal ideation and self-harm.

Prognostic indicators - barriers or supports for change

A number of factors may help Lisa in her recovery. Although she is currently socially isolated, Lisa used to have a close relationship with her mother and her sister, relationships which are still important to her. Lisa did not want to attend therapy but had enough insight and motivation to attend, and whilst in session, spoke willingly of her experiences. Lisa appears to have insight into the detrimental effects of her misuse of sleeping tablets and social isolation. However, Lisa’s precarious position at her work is of concern. Should she lose her job, Lisa may be at risk of increased depression, substance use and self-harm.

Perpetuating factors - what maintains the presenting problems

Lisa’s poor sleep patterns and low mood are perpetuated by rumination, her misuse of medication and her withdrawal from social situations. Lisa’s premorbid functioning was characterised by an active and social lifestyle and her current lack of activity is likely to be impacting on her mood and outlook. Lisa’s current difficulties at work also contribute to ongoing problems with mood and substance use.

Principles of treatment sequencing

In addition to developing a case formulation, there are a number of general principles about treatment sequencing that can help inform treatment planning. Consistent with the general principles of good mental health care, practitioners should focus on treating the disorder presenting most severely. Severity refers to the disorder that is most disabling and most likely to lead to risk of harm to the person or others. Practitioners should also focus on problems that are likely to impact on the veteran’s ability to engage in treatment. For example, problems that impair alertness, motivation, attention and emotional stability must be resolved before treatments that are dependent on these characteristics can begin. Suggestions for treatment sequencing for commonly co-existing mental health problems in veterans are outlined below.

Depression and high-risk alcohol use

When depression and high-risk alcohol use conditions are severe, treat the alcohol problems first, maintaining active monitoring of the risk of self-harm or suicide. This is because depression may have an organic basis associated with alcohol dependence, including delirium, impaired liver function or systemic illness. Treatment for depression without a reduction in alcohol use, will only have limited effectiveness. Depression may lift once the veteran is successfully treated for high-risk alcohol use. If both conditions are mild to moderate in severity, treatment can progress simultaneously.

Posttraumatic stress disorder and high-risk alcohol use

Treatment for PTSD and high-risk alcohol use can commence simultaneously, excluding the trauma-focussed component. The trauma-focussed component should not commence until the veteran has demonstrated a capacity to manage distress without resorting to alcohol. Once the veteran has reached this stage, practitioners can begin the trauma-focussed component of PTSD treatment.

Posttraumatic stress disorder, depression and high-risk alcohol use

Where conditions are severe, treat the alcohol use first, with active monitoring of the risk of self-harm or suicide. Initial phases of PTSD treatment, excluding trauma-focussed treatment, can commence simultaneously with the treatment of alcohol-use problems. Where all conditions are mild to moderate, simultaneous treatment can commence, excluding the trauma-focussed component of PTSD, until the veteran is able to tolerate two to three days per week without using alcohol.

Posttraumatic stress disorder, depression and panic disorder and/or generalised anxiety disorder

Where PTSD, depression and panic disorder and/or generalised anxiety disorder (GAD) are severe, treat the depression first. This is because depression has been demonstrated to impair the effective treatment of anxiety disorders. If the conditions are mild to moderate, treat the PTSD first. This is because improvements in PTSD are likely to result in reductions in demoralisation and depression.

Moderate to severe depression and panic disorder and/or generalised anxiety disorder

Where moderate to severe depression and panic disorder and/or GAD are present, focus on treating the depression first, ensuring you include breathing control to reduce panic. This is because depression is potentially life threatening, but also because there is evidence that poor morale and impaired attention will impair learning of arousal management, attention to exposure cues and compliance with self-care treatment.

Appendix A

Overview of the main interventions for clusters of mental health problems

How interventions are applied to clusters of common mental health problems experienced by veterans

	Depression	Anxiety	PTSD	Substance Use	Somatic Symptoms	Complicated Grief
Cognitive Behavioural Therapy Elements						
Psychoeducation advice and motivation	Provide feedback on your assessment and in collaboration with your client develop a case formulation and treatment plan					
Self-monitoring	Mood and activity diary	Subjective Units of Discomfort (SUDS) in feared and/or avoided situations	Subjective Units of Discomfort (SUDS) in feared and/or avoided situations and in confronting trauma memory	Substance use diary	Physical wellbeing and events diary	
Set realistic/ collaborative goals	Increased frequency and duration of pleasant productive activities	Overcome avoidance and fear of selected situations	Overcome avoidance and fear of selected situations and intrusive memories	Reduce substance consumed - when, where, how much	Reduce illness related behaviours including unnecessary medical investigations	Process memories associated with the loss, and re-engage with the world
Anxiety/arousal management	Progressive muscle relaxation, breathing retraining, distraction techniques, self-instruction training					
Activity scheduling	A programmed routine of activities designed to increase contact with pleasant events and with social and occupational support					
Graded exposure	For depression, activity scheduling is designed to promote exposure to pleasant and productive events	Imaginal or <i>in vivo</i> contact with feared and/or avoided situations until the anxiety subsides (social situations, reminders and memories of the trauma, being away from home)	<i>In vivo</i> , specifically cue exposure, with high risk situations until craving subsides (e.g., drinking venues, watching sport)	With anxiety-related somatic concerns, sustained imaginal or <i>in vivo</i> contact with feared situations	For loss that occurred in traumatic circumstances, imaginal exposure to story of loss, and <i>in vivo</i> for avoided situations	

	Depression	Anxiety	PTSD	Substance Use	Somatic Symptoms	Complicated Grief
Cognitive therapy	Challenging hopelessness, self-loathing and other-loathing	Challenging of the negative and catastrophic beliefs that trigger anxiety	Challenging of unhelpful trauma-related beliefs, especially for those that evoke guilt/anger	Challenging thoughts related to situations that trigger substance use	Challenge unhelpful thoughts about symptoms and disease	Challenging unhelpful thoughts related to the loss, e.g., guilt-related
Skills training	Use skills training as necessary. Individual, family and group training using modelling, behavioural rehearsal and feedback to acquire or modify skills including social skills, structured problem solving, environmental, interpersonal relationship and child rearing skills.					
Relapse prevention	Summarise therapy content and gains, then identify internal and external relapse triggers (e.g., family conflict), early warning signs (e.g., feelings of low mood) and available coping skills (e.g., anxiety management strategies). Use this information to develop a relapse plan.					
Other intervention elements						
Other interventions	Interpersonal therapy			Motivational interviewing, behavioural couples therapy, withdrawal management		Imagined conversations with the deceased, evoking happy memories, and exploring regrets and resentment
Social/occupational/rehabilitation	Promoting return as soon as possible to valued social and occupational roles by supporting negotiations with employers and families to set challenging but realistic expectations. Consider rehabilitation from beginning of treatment.					
Medical care	Identify and treat underlying physical pathology or contributing factors (e.g., cardiovascular, respiratory, gastrointestinal, neurological)			Limit unnecessary medical investigations and interventions		
Pharmacotherapies	Newer antidepressants (e.g., SSRI, SNRI). Avoid benzodiazepines.			Dependant on substance being used	Newer antidepressants (e.g., SSRI, SNRI)	Newer antidepressants (e.g., SSRI, SNRI)

Source: Adapted from Peard and Marshall (2006)

Appendix B

Key components of cognitive behavioural therapy for the treatment of veterans' mental health problems

While there are unique aspects to interventions for each cluster of mental health problems and for each problem type within the clusters, a number of the core features of recommended interventions are the same. Cognitive behavioural intervention components are the focus of this chapter as they are well established and widely used.

Developing a therapeutic alliance

A strong therapeutic alliance between practitioner and veteran, based on trust and collaboration, is needed for effective mental health care. Such a relationship will generally develop over a short period of time if the practitioner demonstrates their respect and empathy for their patient. In cases where the veteran has particular difficulties with trust, the development of a therapeutic alliance may take a little longer. In some cases, the process of jointly establishing goals and tasks of treatment can help to build the therapeutic alliance.

Providing psychoeducation and information

Psychoeducation is an important feature of all interventions. The purpose of education is not only to convey information to the veteran and their family, but to instil hope for the veteran by helping them understand their difficulties and the treatments that will be offered. Education also includes offering advice on key self-help strategies that will assist the veteran to manage their condition.

Education can demystify symptoms and help facilitate a sense of control. Practitioners should:

- be selective in the information given — not too much to be overwhelming
- be specific, clear, detailed and concrete
- be careful about timing of information provision
- include a rationale for each stage of treatment
- determine if the information corresponds with the veteran's theories and beliefs about their problems
- repeat important information where feasible
- use both oral and written information — the combination is better than either alone
- check the veteran's comprehension regularly
- involve the veteran, family members and significant others at appropriate stages in assessment and treatment.

Practitioners may wish to adapt the general psychoeducation script (Appendix D) and provide the veteran with the relevant psychoeducation handout (Appendix L).

Self-monitoring

Self-monitoring is an important component of most cognitive behavioural interventions. It involves asking veterans to record as contemporaneously as possible, their thoughts, emotions and behaviours related to the problems targeted for intervention. Initial self-monitoring contributes to the development of a functional assessment of the mental health problem, which in turn guides the treatment plan. Continual self-monitoring throughout treatment allows ongoing assessment of specific difficulties and evaluation of the veteran's progress in treatment. The self-awareness promoted by self-monitoring is also an intervention in its own right. For example, awareness of the early signs of arousal or anger allows the veteran to walk away before a situation escalates.

Self-monitoring tools include free-form recording in a diary or journal, as well as structured monitoring sheets to be completed in a prescribed way. The latter are likely to elicit more specific information that translates directly into targets for intervention, and are generally preferred. Sample self-monitoring sheets that can be adapted to different purposes are provided (Appendix E).

Activity scheduling

The systematic scheduling of activities has a range of positive mental health implications. The benefits of activity include:

- feeling a greater sense of control over life
- distraction from problems and negative thoughts
- feeling less tired
- improved motivation — the more you do, the more you feel like doing
- improved capacity to think clearly
- getting positive reinforcement through enjoyment, a sense of satisfaction and positive feedback from others.

Constructing a pleasant or positive activity schedule is often a component of behavioural interventions: events are planned, recorded and subsequently reviewed in treatment. An activity monitoring sheet is provided along with a pleasant events schedule with many ideas for activities practitioners may wish to suggest to the veteran (Appendix E and F).

Anxiety/arousal management

Anxiety/arousal management strategies help the veteran to manage his or her own anxiety, anger and other problematic emotions. Typical strategies include:

- Progressive muscle relaxation – This is a relaxation technique that teaches the veteran to recognise muscle tension, and involves tensing and relaxing major muscle groups. A script for conducting progressive muscle relaxation is included (Appendix G).
- Breathing retraining — This teaches techniques for slow, abdominal breathing to help avoid hyperventilation and the unpleasant physical sensations that accompany it. Instructions are provided (Appendix H).
- Distraction techniques — These can be used to overcome distressing thoughts, examples are, thinking about the good things in their life, counting backwards from 100 by 7s, reciting a poem, or grounding techniques, such as the following:
 - “Focus on an object in your surroundings such as a piece of furniture, a picture or a view from the window. Describe it in precise detail, how it looks, sounds and feels.”
 - “Name three things you can see, three things you can hear and three things you can touch or feel. Now name two more things you can see, two more things you can hear and two more things you can touch or feel. Now name one more thing you can see, one more thing you can hear and one more thing you can touch or feel.”
- Self-instruction training — This helps the veteran modify any unhelpful self-talk that occurs in stressful situations, and replace it with coping statements that enhance feelings of control and self-efficacy and guide adaptive behaviour (e.g., ‘just relax’, ‘follow the plan’, ‘I can do this’). These coping statements can be written on cards and rehearsed.

Structured problem-solving skills

Problem-solving in the treatment of mental health problems provides the individual with a systematic and effective means of coping with, and solving, life’s problems. The problem-solving process includes:

- defining the problem or goals in an everyday manner
- encouraging the veteran to seek a wide range of ideas and solutions
- defining solutions in terms of current needs and resources
- considering carefully the practical constraints that are involved in successfully applying the solutions.

Social skills training

Social skills training generally includes both communication and assertiveness skills. Effective communication involves a range of verbal and non-verbal skills that contribute to appropriate and rewarding social interaction with others. Non-verbal communication involves appropriate eye contact, facial expressions, tone of voice and interpersonal space. Verbal communication includes skills of listening, conveying a clear message and contributing to conversation. Assertiveness skills specifically target being able to appropriately express one's needs, wishes or opinions, without either submitting passively to the will of others or violating others' rights through an aggressive communication style. This can include negotiation and conflict resolution skills, especially in the treatment of problematic anger.

Cognitive therapy

Cognitive therapy (CT) has now been widely and successfully applied in the treatment of a range of emotional disorders, such as depression, anxiety disorders, and to some extent the psychoses and personality disorder.

Central to CT is the assumption that emotional disorders are maintained by maladaptive beliefs and interpretations about self, others and the world and are based on unhelpful thinking patterns. At its core, cognitive therapy aims to help the veteran identify and modify their excessively negative cognitions (thoughts and beliefs) that lead to disturbing emotions and impaired functioning. CT focusses on the identification and modification of misinterpretations that lead the veteran to overestimate threat, loss and negative self-judgment.

Exposure therapy

The term 'exposure' covers a range of techniques designed to help the person confront the object of their fears. Exposure may be either *in vivo* or imaginal.

- *In vivo* (live) exposure is generally recommended where the feared stimulus is an object or situation (i.e., an external stimulus). A variant of *in vivo* exposure, commonly called interoceptive exposure, is used in disorders such as panic disorder: the person is exposed to internal cues such as increased heart rate or the symptoms associated with hyperventilation. Another variant of *in vivo* exposure is cue exposure, and is used in the treatment of substance use problems. This approach places the veteran in the presence of cues to drinking or drug use (e.g., pub, watching sport, drug paraphernalia) whilst not using, and allowing the craving to fade.
- Imaginal exposure is the treatment of choice when it is not possible or desirable to expose the person to the real life object of their fears (e.g., catastrophes or distressing memories of trauma). In the case of posttraumatic stress disorder (PTSD), exposure involves confronting the memory of a traumatic experience in a controlled and safe environment (as well as confronting trauma-related avoided situations in the context of *in vivo* exposure). This approach can also be modified for the treatment of anger whereby the veteran imagines anger-triggering events, and then practices anger management skills.

A fundamental principle underlying the process of exposure is that of habituation. If the veteran can be kept in contact with the feared stimulus for long enough, the anxiety will reduce. In most cases, this occurs within an exposure session — it is virtually impossible to remain in a state of high anxiety when confronting a feared stimulus for a sufficiently extended period. Inevitably, the anxiety will diminish and this process is referred to as habituation.

Example *in vivo* exposure hierarchy for social anxiety

Below is an example of an *in vivo* hierarchy developed for a veteran with a fear of public speaking, in the context of social anxiety. His goal is to deliver a short speech at his daughter's wedding. The practitioner may work with the veteran to generate a hierarchy of tasks that involve increasingly demanding public speaking, working towards the veteran's goal. Depending upon the particular difficulties experienced by the veteran, practitioners could propose the hierarchy below:

1. Say "good morning" to a neighbour that you don't know, but see in passing on a regular basis.
2. Initiate a brief conversation with one of your daughter's friends (e.g., "Where are you girls off to tonight?").
3. Make an announcement at a family dinner (e.g., "Your mother and I have decided to go away for the long weekend").
4. Invite a group of family friends to a barbecue and initiate conversation during a quiet moment (e.g., "Did anyone see the game on Friday night? What did you think of [a player]'s performance?").
5. Contribute to discussion at a community, school or Returned Services League meeting.
6. Make a brief announcement at a work or club function (e.g., "See Joe if you need any more raffle tickets").
7. Write a short speech for the wedding and practice it in front of your wife and other children.
8. Practice the speech in front of 3–4 friends.
9. Practice the speech in front of 8–10 family and friends.
10. Deliver the speech at the wedding.

Relapse prevention

Relapse prevention is an essential component of any psychological intervention. The following steps are involved:

- summarising the components discussed during treatment and reviewing the therapy goals
- highlight any achievements and gains the veteran has made
- identify internal and external high risk situations that may trigger a relapse, e.g., family conflict or lack of sleep
- identify early warning signs of a relapse, e.g., feelings of low mood or increased flashbacks
- prepare a relapse plan with available coping skills, e.g., anxiety management and cognitive therapy strategies.

Other considerations for the treatment of veterans' mental health problems

Treatment planning and coordination

Veterans often present with complex and comorbid problems, which makes a structured approach to treatment planning and coordination important. Thorough case formulation is an approach that can assist in developing a treatment plan that will be effective and engage the veteran. The treatment plan should be developed collaboratively with the veteran and their family, and coordinated across all involved service providers. Clearly, multiple and unrelated interventions undermine the effectiveness of all treatments. Practitioners should ensure that there is clear agreement between them regarding responsibility for monitoring and treatment.

It is also important not to overlook the potential contribution of physical health problems to veterans' mental health. Medical practitioners need to apply routine medical management including the identification and treatment of underlying physical pathology or contributing factors, for example, cardiovascular, respiratory, gastrointestinal or neurological conditions.

Rehabilitation

The Australian National Mental Health Plan 2009–2014¹ recognises that recovery for people with mental health problems depends on the provision of services other than health care.

A range of rehabilitation services, such as those offered through the Department of Veterans' Affairs² (DVA) and Centrelink (Department of Human Services)³ may be considered to help improve the vocational and psychosocial aspects of a veteran's life. It is important to consider these rehabilitation services from the beginning of the veteran's treatment.

DVA offers programs to help improve daily living skills, participation in local communities, engagement with families and general quality of life. These programs are often the first steps towards achieving improved wellbeing, family and community reengagement, and a return to work. Research suggests that these interventions should be coordinated, well managed and integrated with medical treatment.

Referrals

Where symptoms are severe or long-lasting, the veteran should be seen by an experienced mental health practitioner (e.g., psychologist, psychiatrist, counsellor). DVA funds psychology services for veterans through WVCS - Veterans and Veterans Families Counselling Service (WVCS) and private practitioners.

Specialised, free and confidential counselling is also available for all Australian veterans and their families through WVCS. WVCS contracts counsellors to provide services in some regional and rural areas. WVCS can be contacted 24 hours on 1800 011 046.

GPs may refer non-entitled veterans for psychological treatment through the following government programs⁴:

- Better Access initiative – Through this program the client can access psychiatrists and psychologists, as well as mental health trained social workers and occupational therapists. GPs can also refer to GPs who are registered providers of Focussed Psychological Services (FPS).
- Better Outcomes in Mental Health Care initiative – This initiative enables clients to access allied health services through the Access to Allied Psychological Services (ATAPS) program, and provides GPs with access to client management advice from psychiatrists through the GP Psych support program.

When veterans are assessed as requiring specialist psychiatric management (usually for more severe, chronic or complex problems), DVA-funded consultations with psychiatrists are available for DVA-entitled veterans in each state and territory. As stated above, Medicare-supported psychiatric treatment is also available to non-entitled veterans through the Better Access initiative. With either source of funding, a medical referral is required, usually by the veteran's general practitioner. The duration of psychiatric management can vary from short to long term, or may be episodic according to the needs of the veteran.

¹ Fourth national mental health plan: An agenda for collaborative government action in mental health, 2009–2012. [www.health.gov.au/internet/main/publishing.nsf/content/360EB322114EC906CA2576700014A817/\\$File/plan09v2.pdf](http://www.health.gov.au/internet/main/publishing.nsf/content/360EB322114EC906CA2576700014A817/$File/plan09v2.pdf) [Accessed 24 May 2012].

² DVA rehabilitation services: www.dva.gov.au/rehabilitation.

³ Centrelink: www.humanservices.gov.au.

⁴ Detailed information can be found at www.racgp.org.au/mentalhealth/betteraccess and www.health.gov.au/internet/main/publishing.nsf/Content/mental-progs. [Accessed 24 May 2012]

Appendix C

Assessment measures

The questionnaire, scoring and interpretation instructions are included for the following assessment measures:

- Depression, Anxiety and Stress Scale (DASS-21; Lovibond & Lovibond, 1995)
- Fear Questionnaire (FQ; Marks & Matthews, 1979)
- Penn State Worry Questionnaire (PSWQ; Meyer et al., 1990)
- Posttraumatic Checklist (PCL; Weathers et al., 1993)
- Alcohol Use Disorders Identification Test (AUDIT; Babor et al., 2001)
- Drug Abuse Screening Test (DAST-20; Skinner, 1982)

DASS21

Name:

Date:

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

- 0 Did not apply to me at all
- 1 Applied to me to some degree, or some of the time
- 2 Applied to me to a considerable degree, or a good part of time
- 3 Applied to me very much, or most of the time

1	I found it hard to wind down	0	1	2	3
2	I was aware of dryness of my mouth	0	1	2	3
3	I couldn't seem to experience any positive feeling at all	0	1	2	3
4	I experienced breathing difficulty (e.g., excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5	I found it difficult to work up the initiative to do things	0	1	2	3
6	I tended to over-react to situations	0	1	2	3
7	I experienced trembling (e.g., in the hands)	0	1	2	3
8	I felt that I was using a lot of nervous energy	0	1	2	3
9	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting agitated	0	1	2	3
12	I found it difficult to relax	0	1	2	3
13	I felt down-hearted and blue	0	1	2	3
14	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15	I felt I was close to panic	0	1	2	3
16	I was unable to become enthusiastic about anything	0	1	2	3
17	I felt I wasn't worth much as a person	0	1	2	3
18	I felt that I was rather touchy	0	1	2	3
19	I was aware of the action of my heart in the absence of physical exertion (e.g., sense of heart rate increase, heart missing a beat)	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life was meaningless	0	1	2	3

DASS

Scoring template. Best printed on an overhead transparency sheet

S

A

D

A

D

S

A

S

A

D

S

S

D

S

A

D

D

S

A

A

D

Apply template to sheet and sum scores for each scale. For 21-item version, multiply sum by 2.

DASS Severity Ratings

The DASS is a **quantitative** measure of distress along the axes of depression, anxiety (symptoms of psychological arousal) and stress (the more cognitive, subjective symptoms of anxiety). It is **not** a categorical measure of clinical diagnoses.

Emotional syndromes like depression and anxiety are intrinsically dimensional – they vary along a continuum of severity (independent of the specific diagnosis). Hence the selection of a single cut-off for a specific diagnosis can be correctly recognised as experiencing considerable symptoms and as being at high risk of further problems.

However for clinical purposes it can be helpful to have 'labels' to characterise degree of severity relative to the population. Thus the following cut-off scores have been developed for defining mild/moderate/severe/extremely severe scores for each DASS scale.

Note: the severity labels are used to describe the full range of scores in the population, so 'mild' for example means that the person is above the population mean but probably still way below the typical severity of someone seeking help (i.e., it does not mean a mild level of disorder).

The individual DASS scores do not define appropriate interventions. They should be used in conjunction with all clinical information available to you in determining appropriate treatment for any individual.

With the above information in mind, we offer the following guidelines based on full (42 item) scores (if using the DASS 21 item version, multiply the score obtained by 2).

DASS Severity Ratings

(if using the DASS 21 item version, multiply the score obtained by 2)

	Depression	Anxiety	Stress
Normal	0-9	0-7	0-14
Mild	10-13	8-9	15-18
Moderate	14-20	10-14	19-25
Severe	21-27	15-19	26-33
Extremely Severe	28+	20+	34

Source: Psychology Department, UNSW – www.psy.unsw.edu.au/dass

Patient Name: _____

Date: _____

Fear Questionnaire (FQ)

Choose a number from the scale below to show how much you would avoid each of the situations listed below because of fear or other unpleasant feelings. Then write the number you choose in the space opposite each situation.

0	1	2	3	4	5	6	7	8
would not avoid it	slightly avoid it		definitely avoid it		markedly avoid it		always avoid it	
1.	Main phobia you want treated (describe)							
2.	Injections or minor surgery							
3.	Eating or drinking with other people							
4.	Hospitals							
5.	Traveling alone or by bus							
6.	Walking alone in busy streets							
7.	Being watched or stared at							
8.	Going into crowded shops							
9.	Talking to people in authority							
10.	Sight of blood							
11.	Being criticised							
12.	Going alone far from home							
13.	Thought of injury or illness							
14.	Speaking or acting to an audience							
15.	Large open spaces							
16.	Going to the dentist							
17.	Other situations (describe)							

Now choose a number from the scale below to show how much you are troubled by each problem listed, and write the number in the space opposite.

0	1	2	3	4	5	6	7	8
hardly at all	slightly troublesome		definitely troublesome		markedly troublesome		very severely troublesome	
18.	Feeling miserable or depressed							
19.	Feeling irritable or angry							
20.	Feeling tense or panicky							
21.	Upsetting thoughts coming into your head							
22.	Feeling you or your surroundings are strange or unreal							
23.	Other feelings (describe)							

24. How would you rate the present state of your phobic symptoms on the scale below?

Please circle one number between 0 and 8.

0	1	2	3	4	5	6	7	8
no phobias present	slightly disturbing/ not really disturbing		definitely disturbing/ disabling		markedly disturbing/ disabling		very severely disturbing/disabling	

Scoring the Fear Questionnaire (FQ)

Four scores are obtained from the Fear Questionnaire:

Main Phobia Level of Avoidance: Item 1 (score range 0 to 8)

Total Phobia Score: Sum of items 2 to 16 (score range 0 to 120)

- *Agoraphobia subscale* (items 5, 6, 8, 12, & 15) (score range 0 to 40)
- *Blood injury phobia subscale* (items 2, 4, 10, 13, & 16) (score range 0 to 40)
- *Social phobia subscale* (items 3, 7, 9, 11, & 14) (score range 0 to 40)

Global Phobia Rating: Item 18 (score range 0 to 8)

Associated Anxiety and Depression: Sum of items 19 to 24 (score range 0 to 40)

Patient Name: _____ Date: _____

The Penn State Worry Questionnaire (PSWQ)

Instructions: Rate each of the following statements on a scale of 1 ("not at all typical of me") to 5 ("very typical of me"). Please do not leave any items blank.

		Not at all typical of me					Very typical of me				
		1	2	3	4	5					
1.	If I do not have enough time to do everything, I do not worry about it.	1	2	3	4	5					
2.	My worries overwhelm me.	1	2	3	4	5					
3.	I do not tend to worry about things.	1	2	3	4	5					
4.	Many situations make me worry.	1	2	3	4	5					
5.	I know I should not worry about things, but I just cannot help it.	1	2	3	4	5					
6.	When I am under pressure I worry a lot.	1	2	3	4	5					
7.	I am always worrying about something.	1	2	3	4	5					
8.	I find it easy to dismiss worrisome thoughts.	1	2	3	4	5					
9.	As soon as I finish one task, I start to worry about everything else I have to do.	1	2	3	4	5					
10.	I never worry about anything.	1	2	3	4	5					
11.	When there is nothing more I can do about a concern, I do not worry about it any more.	1	2	3	4	5					
12.	I have been a worrier all my life.	1	2	3	4	5					
13.	I notice that I have been worrying about things.	1	2	3	4	5					
14.	Once I start worrying, I cannot stop.	1	2	3	4	5					
15.	I worry all the time.	1	2	3	4	5					
16.	I worry about projects until they are all done.	1	2	3	4	5					

Scoring the Penn State Worry Questionnaire (PSWQ)

In scoring the PSWQ, a value of 1, 2, 3, 4, and 5 is assigned to a response depending upon whether the item is worded positively or negatively. The total score of the scale ranges from 16 to 80.

Items 1, 3, 8, 10, 11 are reverse scored as follows:

- Very typical of me = 1 (circled 5 on the sheet)
- Circled 4 on the sheet = 2
- Circled 3 on the sheet = 3
- Circled 2 on the sheet = 4
- Not at all typical of me = 5 (circled 1 on the sheet)

For items 2, 4, 5, 6, 7, 9, 12, 13, 14, 15, 16 the scoring is:

- Not at all typical of me = 1
- Ratings of 2, 3, and 4 are not transformed
- Very typical of me = 5

Citation: Meyer, T.J., Miller, M.L., Metzger, R.L., & Borkovec, T.D. (1990). Development and validation of the Penn State Worry Questionnaire. *Behaviour Research and Therapy*, 28, 487-495. doi: 10.1016/0005-7967(90)90135-6

The Posttraumatic Stress Disorder Checklist (PCL)

The PCL (Weathers et al, 1993) is an easily administered self-report rating scale for assessing the 17 DSM-IV symptoms of PTSD. It has excellent test-retest reliability over a 2-3 day period. Internal consistency is very high for each of the three groups of items corresponding to the DSM-IV symptom clusters as well as for the full 17-item scale. The PCL correlates strongly with other measures of PTSD, such as the Mississippi Scale, the PK scale of the MMPI-2, and the Impact of Events Scale, and also correlates moderately with level of combat exposure.

Three versions of the PCL are available, although the differences are very small. The PCL-M is a military version and questions refer to “*a stressful military experience*”. The PCL-S is a non-military version that can be referenced to any specific traumatic event; the questions refer to “the stressful experience”. The PCL-C is a general civilian version that is not linked to a specific event; the questions refer to “a stressful experience from the past”. The scoring is the same for all three versions.

A total score is computed by adding the 17 items, so that possible scores range from 17 to 85. Used as a continuous measure, the PCL has good diagnostic utility. In Vietnam combat veterans a cut-off of 50 on the PCL is a good predictor of a PTSD diagnosis based on the SCID PTSD module. Principal components analysis revealed one large factor, consisting primarily of re-experiencing and hyperarousal items, and one much small factor, consisting primarily of emotional numbing items.

Citation: Weathers, F.W., Litz, B.T., Herman, D.S., Huska, J.A. & Keane, T.M. (1993). *The PTSD Checklist (PCL): Reliability, validity, and diagnostic utility*. Paper presented at the 9th Annual Conference of the ISTSS, San Antonio.

PTSD Checklist – Military Version (PCL-M)

Patient's Name: _____

Instructions: Below is a list of problems and complaints that people sometimes have in response to stressful military experiences. Please read each one carefully, put an "X" in the box to indicate how much you have been bothered by that problem *in the past month*.

No.	Response:	Not at all (1)	A little bit (2)	Moderately (3)	Quite a bit (4)	Extremely (5)
1.	Repeated, disturbing <i>memories, thoughts, or images</i> of a stressful military experience from the past?					
2.	Repeated, disturbing <i>dreams</i> of a stressful military experience from the past?					
3.	Suddenly <i>acting or feeling</i> as if a stressful military experience <i>were happening again</i> (as if you were reliving it)?					
4.	Feeling <i>very upset</i> when <i>something reminded</i> you of a stressful military experience from the past?					
5.	Having <i>physical reactions</i> (e.g., heart pounding, trouble breathing, or sweating) when <i>something reminded</i> you of a stressful military experience from the past?					
6.	Avoid <i>thinking about</i> or <i>talking about</i> a stressful military experience from the past or avoid <i>having feelings</i> related to it?					
7.	Avoid <i>activities</i> or situations because <i>they remind you</i> of a stressful military experience from the past?					
8.	Trouble <i>remembering important parts</i> of a stressful military experience from the past?					
9.	Loss of <i>interest in things that you used to enjoy</i> ?					
10.	Feeling <i>distant</i> or <i>cutoff</i> from other people?					
11.	Feeling <i>emotionally numb</i> or being unable to have loving feelings for those close to you?					
12.	Feeling as if your <i>future</i> will somehow be <i>cut short</i> ?					
13.	Trouble <i>falling</i> or <i>staying</i> asleep?					
14.	Feeling <i>irritable</i> or having <i>angry</i> outbursts?					
15.	Having <i>difficulty concentrating</i> ?					
16.	Being " <i>super alert</i> " or watchful on guard?					
17.	Feeling <i>jumpy</i> or easily startled?					

Alcohol Screen (AUDIT)

How risky is your drinking?

Alcohol use can affect your health and interfere with certain medications and treatments. Answer the 10 questions below and then turn over to find out how risky your drinking is. First check out the standard drink chart below.

Full Strength Beer 285ml 4.8% Alcohol	Low Strength Beer 425ml 2.7% Alcohol	Pre-mix Spirits 275ml 5% Alcohol	Wine 100ml 13.5% Alcohol	Spirits 30ml 40% Alcohol	Full Strength Beer Can or Stubby 375ml 4.8% Alcohol
					
One standard drink					1.5 standard drinks

Select from the answers below and place the number that corresponds with your answer in the box on the right side of the question. Try to answer the questions in terms of “standard drinks”.

	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never (go to Qs. 9 & 10)	Monthly or less	Two to four times a month	Two to three times a week	Four or more times a week	
2. How many standard drinks do you have on a typical day when you are drinking?	One or two	Three to four	Five or six	Seven, eight or nine	Ten or more	
3. How often do you have six or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected from you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total	

Low-risk drinking is part of a healthy lifestyle that includes good diet and regular exercise.

Steps to assess your drinking

- Add up all the numbers in the boxes and record your TOTAL here
- Check your total against the **1. Risk Levels** chart below.
- Compare your drinking with the **2. Low Risk Guidelines** below.
- Check if you fit into any of the **3. Additional Risks** categories below.
- Have a look at the **4. Tips for Changing Your Drinking**.
- Check the **5. Take Action** category.

1. Risk levels

If your TOTAL alcohol screen is:	Then your risk level is:	And you are advised to:
0 to 7	Low Risk – but...	Check out the low risk guidelines and additional risks to get the right mix.
8 to 15	Risky – your drinking has potential to cause harm...	Consider low risk drinking, your diet and exercise. Try the tips for change.
16 and above	High Risk – likely that you are damaging your health or having problems...	Seriously consider changing your drinking. Talk to your doctor or health professional.

2. Low risk guidelines

Low-risk drinking to reduce the lifetime risk of harm from disease or injury for healthy men and women is:

- on any day no more than 2 standard drinks.

Low risk drinking to reduce the harm of injury or death on any one occasion of drinking is:

- no more than 4 standard drinks on any one day (on a special occasion, not regular drinking) – these drinks should be spread out over several hours;
- having regular alcohol-free days.

For women who are planning to become pregnant, or who are pregnant or breastfeeding, no alcohol is the safest option.

3. Additional risks

Caution:

- Do you have a health condition made worse by alcohol i.e. diabetes, hepatitis, pancreatitis etc.?
- Do you have heart disease, high blood pressure or are gaining weight?
- Are you on medication?
- Do you suffer from depression, anxiety, or PTSD?
- Do you experience mood swings or irritability?
- Do you have trouble sleeping?
- Are you over 65?

Even if you are in the low risk category you may need to drink less if you are in one of the above groups that are more susceptible to the effects of alcohol. Talk to your doctor or other health professional.

Avoid intoxication:

If you are going to drive, operate machinery or engage in sport or other activities requiring skill you should avoid getting drunk and stay under the 0.05 Blood Alcohol Concentration (BAC) by:

Men: drinking no more than two standard drinks in the first hour and no more than one every hour thereafter.

Women: drinking only one standard drink per hour.

4. Tips for changing your drinking

- Don't drink on an empty stomach – eat before and during drinking.
- Choose light beer or other low alcohol drinks.
- Set a limit to your drinking time.
- Start with a juice or soft drink to quench your thirst.
- Drink slowly and don't top up drinks.
- Do other things while drinking – play pool, cards etc.
- Refill your own glass.
- Count your standard drinks.
- Drink at your own pace, avoid shouts.
- Have one to two alcohol free days each week.

5. Take action

If your drinking is risky or high risk and you need more help:

- Get a copy of the self help guide, "Changing The Mix - A Guide to Low-Risk Drinking for the Veteran Community".
- Talk to your doctor or other health professional.
- Talk to a VVCS - Veterans and Veterans Families Counselling Service counsellor - available to all veterans and their families.
- Get more information at www.therightmix.gov.au.

**LOW RISK DRINKING IS PART OF A HEALTHY LIFESTYLE THAT
INCLUDES GOOD DIET AND REGULAR EXERCISE.**

Patient Name: _____

Date: _____

Drug Use Questionnaire (DAST-20)

The following questions concern information about your potential involvement with drugs not including alcoholic beverages during the past 12 months.

Carefully read each statement and decide if your answer is "Yes" or "No". Then, select the appropriate response beside the question. In the statements "drug abuse" refers to (1) the use of prescribed or over the counter drugs in excess of the directions and (2) any non-medical use of drugs. The various classes of drugs may include: cannabis (e.g., marijuana, hash), solvents, tranquilizers (e.g., Valium), barbituates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions do not include alcoholic beverages.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

- | | | | |
|-----|--|-----|----|
| 1. | Have you used drugs other than those required for medical reasons? | Yes | No |
| 2. | Have you abused prescription drugs? | Yes | No |
| 3. | Do you abuse more than one drug at a time? | Yes | No |
| 4. | Can you get through the week without using drugs? | Yes | No |
| 5. | Are you always able to stop using drugs when you want to? | Yes | No |
| 6. | Have you had "blackouts" or "flashbacks" as a result of drug use? | Yes | No |
| 7. | Do you ever feel bad or guilty about your drug use? | Yes | No |
| 8. | Does your spouse (or parents) ever complain about your involvement with drugs? | Yes | No |
| 9. | Has drug abuse created problems between you and your spouse or your parents? | Yes | No |
| 10. | Have you lost friends because of your use of drugs? | Yes | No |
| 11. | Have you neglected your family because of your use of drugs? | Yes | No |
| 12. | Have you been in trouble at work (or school) because of drug abuse? | Yes | No |
| 13. | Have you lost your job because of drug abuse? | Yes | No |
| 14. | Have you gotten into fights when under the influence of drugs? | Yes | No |
| 15. | Have you engaged in illegal activities in order to obtain drugs? | Yes | No |
| 16. | Have you been arrested for possession of illegal drugs? | Yes | No |
| 17. | Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs? | Yes | No |
| 18. | Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)? | Yes | No |
| 19. | Have you gone to anyone for help for a drug problem? | Yes | No |
| 20. | Have you been involved in a treatment program specifically related to drug use? | Yes | No |

DAST-20 scoring and interpretation

The DAST total score is computed by summing all items that are endorsed in the direction of increased drug problems. Two items: #4 (Can you get through the week without using drugs) and #5 (Are you always able to stop using drugs when you want to), are keyed for a “No” response. The other 18 items are keyed for a “Yes” response. For example, if a client circled “Yes” for item #1 he/she would receive a score of 1, whereas if the client circled “No” for item #1 he/she would receive a score of 0. With items #4 and 5, a score of 1 would be given for a “No” response and a score of 0 for a “Yes” response. When each item has been scored in this fashion, the DAST **total score** is simply the sum of the 20 item scores. This total score can range from 0 to 20.

The DAST total score orders individuals along a continuum with respect to their *degree* of problems or consequences related to drug abuse. A score of zero indicates that no evidence of drug related problems were reported. As the DAST score increases there is a corresponding rise in the level of drug problems reported. The maximum score of 20 would indicate substantial problems. Thus, as the DAST total score increase one may interpret that a given individual has accrued an increasingly diverse range of drug-related consequences. Then, one may examine the DAST item responses to identify specific problem areas, such as the family or work. The following tentative guidelines are suggested for interpreting the DAST total score.

	DAST-20	Action	ASAM
None	0	Monitor	
Low	1-5	Brief counselling	Level I
Intermediate (likely meets DSM criteria)	6-10	Outpatient (intensive)	Level I or II
Substantial	11-15	Intensive	Level II or III
Severe	16-20	Intensive	Level III or IV

ASAM: American Society of Addiction Medicine Placement Criteria

Citations:

Skinner, H. A. (1982a). The Drug Abuse Screening Test. *Addictive Behaviors*, 7, 363-371.

Skinner, H. A. (1982b). The Drug Abuse Screening Test (DAST): Guidelines for administration and scoring. Toronto: Addiction Research Foundation.

Appendix D

Psychoeducation script outline

General practitioners and mental health practitioners may wish to adapt the suggested script below when providing education:

- "... you have (*mental health problem*)".

Tell them how common it is

- "Your (*problem*) explains why you feel (*list their symptoms*)".
- "The (*problem*) is treatable, but, you'll have to do some of the work to help yourself get better, such as exercise, keeping a diary and planning activities".
- "Just as there are different types of mental health problems and disorders, so there are different types of treatment. Many people have benefited from the range of treatments available".

In discussing the treatment options, practitioners may wish to adapt the following script:

- "I would like to treat your (*mental health problem*) in this way..."

Give them the treatment option(s)

- "Depending on how we go at the beginning, your treatment is likely to involve other health professionals, such as a psychologist or psychiatrist".
- "We should certainly consider the support of your family and friends, and the effect your (*problem*) may have on them".

Discuss the treatment plan and the pros and cons of:

- exercise
- activity scheduling
- self-monitoring
- medication
- factors that might impede recovery
- seeing a mental health professional
- the likelihood of the veteran following the recommended treatment.

Appendix E

Self-monitoring sheets

The following self-monitoring sheets are included:

- Thoughts and feelings record
- The distress thermometer - Subjective units of distress scale (SUDS)
- Home-based exposure monitoring sheet (for use with imaginal and in vivo exposure exercises)
- Daily activity schedule

Thoughts and feelings record

[illegible]

The distress thermometer – Subjective Units of Distress Scale (SUDS)

Try to get used to rating your distress, fear, anxiety or discomfort on a scale of 0-100. Imagine you have a 'distress thermometer' to measure your feelings according to the following scale. Notice how your level of distress and fear changes over time and in different situations.



Home-based exposure monitoring sheet (for use with imaginal and *in vivo* exposure exercises)

[illegible]

Daily activity schedule

This schedule is designed to help you plan and track your activities. Please rate mastery and pleasure activities from 0 to 5 - the higher the number, the greater the sense of satisfaction.

Date:	Prospective Plan your activities on an hour-by-hour basis at the start of the day	Retrospective At the end of the day, record what you actually did and rate each activity with an M for mastery or a P for pleasure
7:00am–8:00am		
8:00am–9:00am		
9:00am–10:00am		
10:00am–11:00am		
11:00am–12 noon		
12 noon–1:00pm		
1:00pm–2:00pm		
2:00pm–3:00pm		
3:00pm–4:00pm		
4:00pm–5:00pm		
5:00pm–6:00pm		
6:00pm–7:00pm		
7:00pm–8:00pm		
8:00pm–9:00pm		
9:00pm–10:00pm		
10:00pm–11:00pm		
11:00pm–12 midnight		

Appendix F

Pleasant events schedule

The following are suggested pleasant activities from which a veteran could select a small number to schedule into their weekly routine (adapted from MacPhillamy and Lewinsohn 1971).

Being in the country	Playing golf
Wearing expensive or formal clothes	Fishing
Listening to the sounds of nature	Seeing grandchildren
Making contributions to religious, charitable or political groups	Rearranging or redecorating your room or house
Dating or courting	Going to a health club or gym
Talking about sports	Fishing
Having friends come to visit	Singing
Meeting someone new	Having coffee or tea with friends
Going out to visit friends	Gardening or landscaping
Going to a music concert	Horseback riding
Giving gifts	Going to a sports event
Playing football or cricket	Going to the beach
Getting massages or backrubs	Having a sauna
Planning trips or holidays	Going to a barber or beautician
Photography	Acting
Buying things for yourself	Bicycling
Protesting social, political or environmental conditions	Reading stories, novels, poems, plays, magazines and newspapers
Using cologne or perfume	Dancing
Going to a bar, tavern or club	Water skiing, surfing or diving
Washing your hair	Sitting or lying in the sun
Going to lectures or talks	Travelling
Going to a restaurant	Cooking meals
Creating or arranging songs	Going to the races
Listening to music	Going to the movies
Attending the opera, ballet or a play	Doing puzzles or maths games
Having lunch with friends	Going to a party
Running or jogging	Being with someone you love
Playing tennis	Going to church functions
Going to auctions, garage sales, etc.	Going to the library
Bushwalking	Playing a musical instrument
Driving long distances	Shopping
Playing cards or board games	Snow skiing or ice skating
Swimming	Preparing a new or special meal
Playing video games	Wearing new clothes
Playing frisbee or catch	Beachcombing
Woodworking or carpentry	Riding a motorcycle
Talking about philosophy or religion	Doing housework or laundry or cleaning things
Writing stories, novels, poems, plays or articles	Just sitting and thinking
Taking a long, hot bath	Looking at the stars or the moon
Writing letters, cards or notes	Going to a fair, showground, circus or zoo
Being in the city	Surfing the internet or using social media

Appendix G

Progressive muscle relaxation

Practitioners may wish to use the suggested script below when teaching the veteran the progressive muscle relaxation exercise. It is useful for the practitioner or family member to make an audio recording of the script so that the veteran can practice this relaxation strategy whenever desired or needed.

“Get into a comfortable position, close your eyes, and sit quietly for a few seconds...

1. Build up the tension in your lower arms by making fists with your hands and pulling up on the wrists. If your nails are long, press your fingers against your palms to make fists. Feel the tension through your lower arms, wrists, fingers, knuckles and hands. Focus on the tension — notice the sensations of pulling, of discomfort, of tightness. Hold the tension for 10 seconds. Now, release the tension and let your hands and lower arms relax onto the chair or bed, with palms facing down. Focus your attention on the sensations of warmth in your hands and arms. Feel the release from tension. Relax the muscles for 20 seconds.
2. Now, build up the tension in your upper arms by pulling the arms back and in toward your sides. Feel the tension in the back of the arms, radiating up into your shoulders and back. Focus on the sensations of tension. Hold the tension for 10 seconds. Now, release the arms and let them relax heavily down. Focus on your upper arms and feel the difference compared to the tension. Your arms feel heavy, warm and relaxed. Relax for 20 seconds.
3. Now, build up the tension in your lower legs by flexing your feet and pointing your toes toward your upper body. Feel the tension in your lower legs. Feel the tension as it spreads through your feet, your ankles, your shins and your calf muscles. Feel the tension spreading down the back of the leg and into the foot, under the foot and around the toes. Focus on that part of your body for 10 seconds. Now, release the leg tension. Let your legs relax heavily onto the chair or the bed. Feel the difference in the muscles as they relax. Feel the release from tension, the sense of comfort, the warmth and heaviness of relaxation (for 20 seconds).
4. Now, build up the tension in your upper legs by pulling your knees together and lifting your legs off the bed or chair. Focus on the tightness through your upper legs. Feel the pulling sensations from your hip down and notice the tension in your legs. Focus on that part of your body for 10 seconds. Now, release the tension, and let your legs drop heavily down onto the chair or bed. Let the tension disappear. Focus on the feeling of relaxation. Feel the difference in your legs. Focus on the feeling of comfort for 20 seconds.
5. Now, build up the tension in your stomach by pulling your stomach in toward the spine, very tight. Feel the tension. Feel the tightness and focus on that part of your body for 10 seconds. Now let the stomach go — let it go further and further. Feel the sense of warmth circulating across your stomach. Feel the comfort of relaxation (20 seconds).
6. Now, build up the tension around your chest by taking in a deep breath and holding it. Your chest is expanded and the muscles are stretched around your chest — feel the tension around your front and your back. Hold your breath (10 seconds). Now, slowly, let the air escape and breathe normally, letting the air flow in and out smoothly and easily. Feel the difference as the muscles relax in comparison to the tension.
7. Moving up to your shoulders, imagine your shoulders are on strings being pulled up toward your ears. Feel the tension around your shoulders, radiating down into your back and up into your neck and the back of your head. Focus on that part of your body. Describe the sensations to yourself. Focus (10 seconds) and then let the shoulders droop down. Let them droop further and further, feeling very relaxed. Feel the sense of relaxation around your neck and shoulders. Focus on the comfort of relaxation (20 seconds).
8. Build up the tension around your neck by pressing the back of your neck toward the chair or bed and pulling your chin down toward your chest. Feel the tightness around the back of the neck spreading up into your head. Focus on the tension (10 seconds). Now release, letting your head rest heavily against the bed or chair. Nothing is holding it up except for the support behind. Focus on the relaxation (20 seconds) and feel the difference from the tension.

9. Build up the tension around your mouth, jaw and throat by clenching your teeth and forcing the corners of your mouth back into a forced smile. Hold the tension (10 seconds). Feel the tightness and describe the sensations to yourself. Now release the tension, letting your mouth drop open and the muscles around the throat and jaw relax. Focus on the difference in the sensations in that part of your body (20 seconds).
10. Now build up the tension around your eyes by squeezing your eyes tightly together for a few seconds and releasing. Let the tension disappear from around your eyes. Feel the difference as the muscles relax.
11. Now build up the tension across the lower forehead by frowning, pulling your eyebrows down and toward the centre. Feel the tension across your forehead and the top of your head. Focus on the tension for 10 seconds and then release, smoothing out the wrinkles and letting your forehead relax. Feel the difference.
12. Finally, build up the tension across the upper forehead by raising your eyebrows up as high as you can. Feel the wrinkling and the pulling sensations across your forehead and the top of your head. Hold the tension (10 seconds) and then relax, letting your eyebrows rest down and the tension leave. Focus on the sensations of relaxation and feel the difference compared to the tension.

Now, your whole body is feeling relaxed and comfortable. As I count from 1 to 5, feel yourself becoming even more relaxed. One, letting all the tension leave your body. Two, sinking further and further into relaxation. Three, feeling more and more relaxed. Four, feeling very relaxed. Five, deeply relaxed. Now, as you spend a few minutes in this relaxed state, think about your breathing. Feel the cool air as you breathe in and the warm air as you breathe out. Your breathing is slow and regular. Every time you breathe out, think to yourself the word, relax.... relax....relax..., feeling comfortable and relaxed (2 minutes). Now, as you count backwards from 5 to 1, gradually feel yourself becoming more alert and awake. Five, feeling more awake. Four, coming out of the relaxation. Three, feeling more alert. Two, open your eyes. One, sitting up."

Appendix H

Breathing retraining instructions

The way we feel is affected by the way we breathe. For example, when we are upset, we are often told to 'take a few deep breaths'. This is not quite right, however. When we are feeling anxious or frightened, we don't need to take a deep breath; we need to take a normal breath and exhale slowly. Breathing out is associated with relaxation, not breathing in.

While concentrating on a long, slow exhalation, it is a good idea to say the words 'calm' or 'relax' to yourself. These are good words to use because they are already associated with feeling peaceful and at ease. They can also be dragged out to match the long, slow exhalation, as in 'r-e-e-e-l-a-a-a-x' or 'c-a-a-a-a-l-m'.

It is also important to remember to slow your breathing down. Often when people are frightened or upset, they start to breathe faster. This is a natural reaction and prepares the body to fight the threat or to run away. If you are not going to fight or run away, however, you may be taking in too much air and starting to over-breathe or 'hyperventilate'. This causes unpleasant physical symptoms. So, what we need to do is to slow our breathing down and take in less air. We do this by taking smaller breaths and by pausing between breaths to space them out. It is also important to try and breathe in through your nose, not through your mouth. Once you have taken a normal breath in through your nose, hold your breath for a count of four before exhaling slowly.

Now, try putting it all together:

- take in a normal breath through your nose with your mouth closed
- pause briefly while you count to four
- exhale very slowly (mouth open or closed, whichever feels most comfortable) while saying 'calm' or 'relax' to yourself
- repeat the process.

It is a good idea to repeat the whole sequence 6 to 10 times. Try to practice this type of breathing at least twice a day. That way, when you become frightened or anxious, you will be ready to use the technique to help you calm down.

Appendix I

5As smoking cessation framework¹

5As	Strategy	Suggested approach
Ask	Identify and document smoking status at least every 12 months	Hand out a brief patient survey in the waiting room to identify smoking status: “Do you still smoke tobacco / cigarettes?”
Assess	Interest in quitting	“How do you feel about your smoking at the moment?” “Are you ready to stop smoking now?” “How would you rate your interest in quitting right now on a scale of 1–10, where 10 equals very interested in quitting?”
	Level of nicotine dependence	Hand out Fagerstrom Test for Nicotine Dependence, used for assessing nicotine dependence Time to first cigarette from waking (less than 30 min) Smokes 15 or more cigarettes a day Evidence of withdrawal symptoms with previous quit attempts
	Identify stage of change	Use above questioning to determine if the veteran is ready, unsure, or not ready to change
	Quitting history	“What has worked before?” “What hasn’t worked?”
Advise	Provide clear, brief and non-judgmental advice to quit	Quitting is the most important thing you can do to stay healthy for you and your family
Assist	Not ready to quit	Discuss the benefits of quitting, and risks of continued smoking Provide information on the risks and effects of passive smoking Advise help is available when the veteran is ready
	Unsure about quitting	Conduct Motivational Interviewing: “What are the things you like about smoking?” “What are the things you don’t like about smoking?” Explore barriers to quitting: “What would be the hardest thing about quitting?” Explore doubts Provide Quit information such as a Quit Pack and a referral to Quitline 13 7848

¹ Adapted from *Supporting smoking cessation: a guide for health professionals* (2011) available online from www.health.gov.au [accessed 16 May 2012] and www.racgp.org.au [accessed 16 May 2012]

5As	Strategy	Suggested approach
	Ready to quit	<p>Affirm and encourage</p> <p>Identify high risk smoking situations:</p> <p>“What would be the hardest cigarette to give up?”</p> <p>Discuss strategies and skills to cope with cravings</p> <p>Provide Quit information such as a Quit Pack and a referral to Quitline 13 7848</p> <p>Discuss pharmacotherapy (e.g., nicotine replacement therapies and bupropion)</p> <p>Discuss relapse prevention</p>
Arrange	Follow up	<p>Congratulate and affirm decision</p> <p>Review progress and problems</p> <p>Discuss relapse prevention</p> <p>Review pharmacotherapy</p>
	Support	<p>Encourage use of support services such as Quitline or Quit Pack.</p> <p>Enlist support of significant others</p>

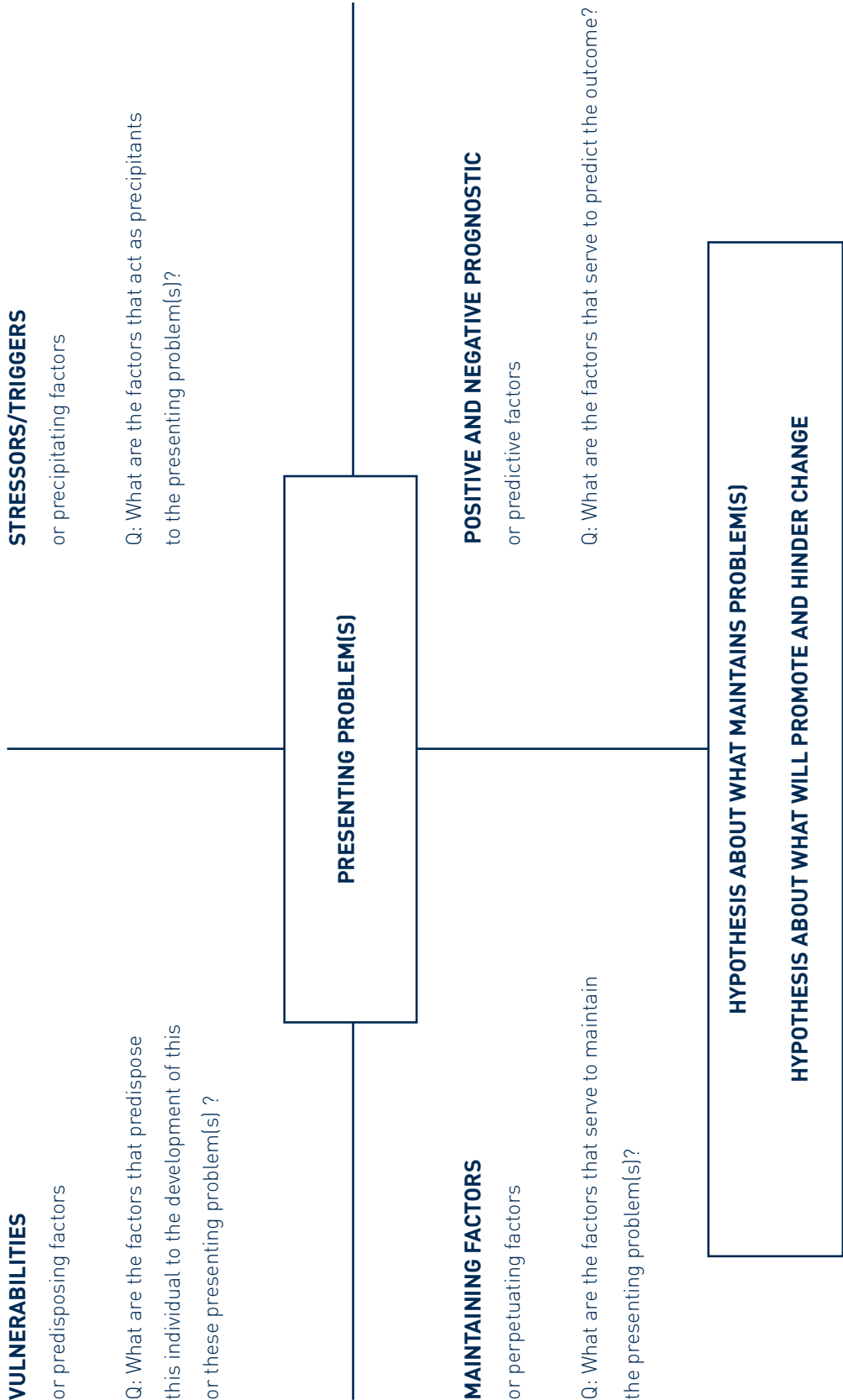
Appendix J

Where veterans can get more help

Veterans can get further assistance for their health and wellbeing from the following organisations and websites.

<p>WVCS - Veterans and Veterans Counselling Service (WVCS) Free call 1800 011 046</p>	<p>A specialised, free and confidential Australia-wide service for Australian veterans and their families. WVCS also offers a variety of educative and therapeutic group programs to enhance the quality of life for veterans and their families.</p> <p>WVCS contracts counsellors to provide services in some regional and rural areas.</p> <p>The WVCS offices are located in all capital cities, as well as Albury/Wodonga, Lismore and Newcastle (NSW); Maroochydore, Southport and Townsville (QLD) and Launceston (TAS).</p>
<p>Veterans Line Free call 1800 011 046</p>	<p>A 24 hours telephone crisis support and counselling service to assist veterans and their families in coping with crisis situations.</p>
<p>Department of Veterans' Affairs (DVA) Free call Local: 133 254 Regional: 1800 555 254 GeneralEnquiries@dva.gov.au www.dva.gov.au</p>	<p>DVA provides a range of programs and services for eligible veterans and their families, including treatment costs for mental health problems and other conditions. The health programs include community nursing, HomeFront, Men's Health Peer Education and Coordinated Veterans' Care (CVC).</p> <p>DVA also offers a range of rehabilitation services, which can address 'whole of person' needs, including counselling, group and lifestyle programs, rehabilitations aids and appliances, household services and specific vocational and psychosocial programs.</p> <p>For information about eligibility, pension, compensation or any other matters contact DVA.</p>
<p>At Ease www.at-ease.dva.gov.au</p>	<p>Through this website, veterans and health professionals can access information and resources related to mental health. It also links to other e-health initiatives including the:</p> <ul style="list-style-type: none"> • Wellbeing Toolbox – An interactive and confidential mental health support resource • TouchBase – Provides separating and separated ADF members with information on useful topics and links to a range of resources.
<p>The Right Mix www.therightmix.gov.au</p>	<p>This DVA-funded website provides information on health and alcohol use for veterans.</p>
<p>Changing the Mix Free call 1800 180 886</p>	<p>A self-help correspondence alcohol reduction program for veterans or peacekeepers provided by DVA.</p>

Appendix K: Case formulation template



Appendix L

Patient education handouts

Psychoeducation handouts are provided for the following conditions:

- depression
- panic and agoraphobia
- generalised anxiety disorder
- social anxiety
- posttraumatic stress disorder
- pain
- smoking
- alcohol and other drug use
- complicated grief
- anger
- sleep difficulties
- gambling



UNDERSTANDING DEPRESSION

At times, people may experience symptoms such as sadness, loss of interest or low motivation. Sometimes these symptoms become intense and are present most days for a long period of time. When symptoms such as these start interfering with everyday life and last more than two weeks, we refer to them as 'clinical depression' or 'major depression'. Major depression is very different from simply feeling 'blue' from time to time and includes the following changes:

Changes in mood

- Moods common to depression include sadness, anxiety, guilt, worthlessness, hopelessness and anger.
- If depression is mild, individuals may not feel bad all day but still describe a dismal outlook and a sense of gloom. Their mood may lift with a positive experience such as seeing a good friend, but fall again with even a minor disappointment.
- In severe depression, a low mood will persist throughout the day, failing to lift even when pleasant things happen.

Physical changes

- Trouble falling or staying asleep and waking up too early is common. Some people, on the other hand, find themselves sleeping more.
- Weight can change with appetite decreasing or increasing significantly.
- Sexual interest may decline.
- Energy levels fall, as does motivation to carry out everyday activities, including things that were enjoyable in the past.

Changes in thinking

Depressed people tend to see themselves as being useless, inadequate and failures. They dwell on how bad they feel and on how hopeless everything is. Sometimes, these thoughts are so negative that they can contemplate taking their own life.

Changes in relationships

People who experience depression may become unhappy and dissatisfied with their family relationships, close friends etc. They may feel shy and anxious around others and have trouble socialising. They may feel lonely and unloved, but at the same time, feel unable to reach out to others.

What causes depression?

Depression is not usually caused by one thing. We know that an individual may be vulnerable to depression if there is a history of depression in the family, and we also know that particular thinking patterns (e.g., oversteering the negative) are also associated with depression. It is important to note that having a vulnerability to depression does not mean that someone will experience depression. There are many situations that can trigger depression, including loss of a loved one, loss of working ability, relationship difficulties, or a traumatic event.

Getting help

There are effective treatments available to help people overcome their depression. One of the most effective treatments is cognitive behavioural therapy (CBT). This approach recognises that the way we think and act affects the way we feel. During this therapy you will learn:

- a structured approach to problem solving to help you manage the day to day stressors
- how to challenge your negative thinking, which will have a positive impact on the way you feel
- strategies to help you get back to your routine and enjoying your usual activities.

The therapy may involve 8-12 weekly sessions with a mental health professional but may require longer depending on your needs. Your doctor may also have suggested medication that can be of assistance in overcoming depression, especially in the case of severe depression.

Self-management resources

Below is a list of internet and other written resources that may help you, together with the treatment recommended by your doctor.

- Written materials for you and your family are available from websites such as beyondblue (www.beyondblue.org.au), and Black Dog Institute (www.blackdoginstitute.org.au).
- There are also internet based self-help programs available e.g., MoodGYM (www.moodgym.anu.edu.au).
- Useful books include *Mind over Mood: A Cognitive Therapy Treatment Manual* (Padesky and Greenberger 1995) and *Feeling Good: The New Mood Therapy* (Burns 1999).
- At Ease (www.at-ease.dva.gov.au) is a Department of Veterans' Affairs (DVA) website with information on mental health wellbeing including the 'Wellbeing Toolbox', an online interactive program. A *Mental Health and Wellbeing after Military Service* booklet is available to order or download from this website.

VETERANS LINE (1800 011 046) CAN BE REACHED

24 HOURS A DAY ACROSS AUSTRALIA

FOR CRISIS SUPPORT AND COUNSELLING.

PUT YOUR MIND





UNDERSTANDING PANIC AND AGORAPHOBIA

When we are exposed to a physical threat our bodies automatically respond with what is known as the fight-or-flight response. We become more alert, our heart beat speeds up, the muscles get tense ready for action, sweating increases to cool the body, and our breathing rate speeds up so that we can get oxygen into our bodies more quickly. With these changes we are able to run very quickly or fight the threat or our 'enemies'. These are designed to protect us from danger but sometimes our fight-or-flight response is activated when the response is not actually helpful (i.e., when there is no real danger).

What is a panic attack?

A panic attack is a sudden spell or attack when you feel frightened, anxious, or very uneasy in a situation when most people would not feel afraid. It occurs when the fight-or-flight response seemingly comes out of nowhere and culminates into symptoms of extreme anxiety including:

- rapid heart rate
- sweating, trembling or shaking
- sensations of shortness of breath or being smothered
- feelings of choking or chest pain
- nausea
- feeling dizzy
- fear of losing control, going crazy or fear of dying
- chills or hot flushes.

It is important to realise that these symptoms are part of the response to threat and are not a sign that you have a physical disease. These symptoms do not mean that you will die, go crazy, or lose control, although it may feel that way.

The panic cycle and agoraphobia

Anxiety problems originate when the fight-or-flight response is too sensitive, like an overly sensitive car alarm that goes off at the wrong time. Once the fight-or-flight response gets started, we may begin to hyperventilate causing a wide range of unpleasant body sensations. We can see there is no outside danger so we start to assume that the body sensations are a sign that our body is not working correctly and must be dangerous. That is, we may think to ourselves, "I am going crazy", "I am having a heart attack", or "I'm about to lose control". This type of thinking leads to further fear and anxiety.

As people who experience panic attacks are often anxious about the physical sensations of panic, there is a natural tendency to avoid situations where these physical sensations occur. This avoidance serves to maintain 'anxiety about the anxiety symptoms' by preventing opportunities to learn that the sensations are manageable and not dangerous. Despite the fact that anxiety symptoms can feel unpleasant, it is important to tolerate them without becoming more anxious. The more people avoid the sensations and situations that seem to trigger them, the greater the anxiety associated with them becomes.

When people start avoiding places or situations from which escape might be difficult or in which help might not be available in the event of a panic attack, they may have what is called agoraphobia. People with agoraphobia can have their life severely restricted by their fear of a panic attacks and be unable to participate in a range of activities including being in crowds, standing in line or even being outside their home without support.

Getting help

There are effective treatments available to help people overcome their panic and agoraphobia. One of the most effective treatments is cognitive behavioural therapy (CBT) – this approach recognises that the way we think and act affects the way we feel. During CBT you will learn:

- to understand your panic reactions and the fight-or-flight response better
- to challenge your fears and worries related to the physical symptoms you experience during a panic attack e.g., fears of having a heart attack or going crazy
- to face your feared situations and physical reactions in a gradual and manageable way
- relaxation strategies such as breathing retraining.

The therapy may involve 7-14 weekly sessions with a mental health professional but may require longer depending on your needs. Your doctor may also have suggested medication that can assist some people to overcome panic and agoraphobia.

Self-management resources

Below is a list of internet and other written resources that may complement the treatment plan that you have discussed with your doctor.

- At Ease (www.at-ease.dva.gov.au) is a Department of Veterans' Affairs (DVA) website with information on mental health wellbeing including the 'Wellbeing Toolbox' online interactive program, anxiety management and alcohol resources. *A Mental Health and Wellbeing after Military Service* booklet is available to order or download from this website.
- Useful materials are available from *beyondblue* (www.beyondblue.com.au), the Clinical Research Unit for Anxiety and Depression (www.crufad.org) and SANE (www.sane.org).
- Anxiety Online (www.anxietyonline.org.au) is an internet based treatment clinic affiliated with Swinburne University.

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PUT YOUR MIND





UNDERSTANDING GENERALISED ANXIETY DISORDER

Feeling stressed, worried and tense at times is very much a part of the experience of being human. However, for some people, these feelings persist to the point that they cause significant distress and interfere with normal routine, social activities or ability to work. When worry spreads across different areas of life and is persistent, excessive and hard to control, it can be part of Generalised Anxiety Disorder (GAD). GAD is one of the most common anxiety disorders, with approximately six out of 100 Australians experiencing it at some point in their lives.

Worry that is present most days for a period of at least six months is one symptom that people with GAD experience. Other symptoms of GAD include:

- feeling constantly 'on edge' and unable to relax
- muscle tension
- difficulty falling and staying asleep
- feeling tired or easily exhausted
- increased irritability
- difficulty concentrating and focussing on a task.

What causes GAD?

It is important to understand that GAD is not usually caused by one thing. A person may have a biological vulnerability to GAD if there is a history of anxiety in the family. Particular beliefs (e.g., that worry is useful or that things must be done perfectly or not at all) and avoidance of potentially stressful events are also associated with GAD. It is important to note that having a vulnerability to anxiety does not mean that the individual will experience GAD. GAD can be triggered by a stressful life event such as losing a job, relationship breakdowns, and other periods of prolonged stress.

Getting help

There are effective treatments available to help people overcome GAD. One of the most effective treatments for GAD is cognitive behavioural therapy – this approach recognises that the way we think and act affects the way we feel. During this therapy you will learn:

- a structured approach to problem-solving to help you manage the day to day stressors
- strategies to challenge your negative thinking that triggers and maintains your worry
- anxiety management strategies to help you manage the physical symptoms (e.g., muscle tension) that are associated with worry.

The therapy may involve 12-15 weekly sessions with a mental health professional but may require longer depending on your needs. Your doctor may also have suggested medication that can be of assistance in managing feelings associated with anxiety.

Self-management resources

Below is a list of internet and other written resources that may help you, together with the treatment recommended by your doctor.

- Useful materials are available from *beyondblue* (www.beyondblue.com.au), the Clinical Research Unit for Anxiety and Depression (www.crufad.org) and SANE (www.sane.org).
- Anxiety Online (www.anxietyonline.org.au) is an internet based treatment clinic affiliated with Swinburne University.
- At Ease website (www.at-ease.dva.gov.au) for access to generic information on mental health and wellbeing including the 'Wellbeing Toolbox' and anxiety management and alcohol resources. The DVA *Mental Health and Wellbeing after Military Service* booklet is available to order or download from the At Ease website.

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PUT YOUR MIND





UNDERSTANDING SOCIAL ANXIETY

Fear of being embarrassed in social situations is widespread in the community. However, for some people, it causes significant distress and interferes with their normal routine, social activities or ability to work. Social anxiety is one of the most common anxiety disorders, with approximately one in twelve Australians experiencing it at some point in their lives.

Social anxiety can occur in any situation where a person might become the focus of attention and is anxious or worried about what others are thinking of him or her - this worry usually involves being judged negatively by other people, and may include concerns about behaving in a way that is embarrassing or humiliating. Situations that are commonly feared by people with social anxiety include speaking in public, speaking to strangers, dating, going to parties, maintaining conversations, interacting with authority figures, being assertive or being watched while writing, eating, or drinking. For some people the fear can be limited to very specific situations (e.g., public speaking) and for others it may be fear of a whole range of different social situations.

What triggers and maintains anxiety?

A range of physical sensations, actions and beliefs help trigger and maintain anxiety:

Physical sensations

When we are exposed to a physical threat our bodies automatically respond with what is known as the fight-or-flight response. We become more alert, our heart beat speeds up, the muscles get tense ready for action, sweating increases to cool the body, and our breathing rate speeds up so that we can get oxygen into our bodies more quickly. With these changes we are able to run very quickly or fight the threat or our 'enemies'. These are designed to protect us from danger but sometimes our fight-or-flight response is activated when the response is not actually helpful (i.e., when there is no real danger). When people find themselves in a situation where they are worried they will be judged the fight-or-flight response is triggered.

Actions

Because the feelings associated with the fight-or-flight response are so unpleasant, people's usual response is to get away from the situation that is making them anxious (e.g., a public speech). An individual with social anxiety may start making up excuses/reasons to avoid people, places, conversations, or other social situations that cause anxiety. This avoidance serves to maintain social anxiety by preventing opportunities to learn that anxious feelings and the social situations that trigger them are manageable. Despite the fact that anxiety symptoms can feel unpleasant, it is important to tolerate them without becoming more anxious. The more people avoid the sensations and situations that seem to trigger them, the greater the anxiety associated with them becomes.

Beliefs

Individuals with social anxiety often have negative thoughts about their own behaviour or how they are being judged by others. Some examples of these types of thoughts include:

- "They must think I look silly and sound pathetic."
- "I am going to stuff this up."
- "They will realise how incompetent I am."
- "I won't know what to say."
- "Everyone can see how anxious I am."

Getting help

There are effective treatments available to help people overcome their social anxiety. One of the most effective treatments is cognitive behavioural therapy (CBT) – this approach recognises that the way we think and act affects the way we feel. During CBT you may learn:

- to challenge your fears and worries related to the social situations, e.g. worries about your performance in social situations and how others may judge you
- to face your feared and usually avoided social situations in a gradual and manageable way
- assertiveness and conversational skills if helpful.

The therapy may involve 8-12 weekly sessions with a mental health professional but may require longer depending on your needs. Your doctor may also have suggested medication that can assist some people to overcome social anxiety.

Self-management resources

Below is a list of internet and other written resources that may complement the treatment plan that you have discussed with your doctor.

- At Ease (www.at-ease.dva.gov.au) is a Department of Veterans' Affairs (DVA) website with information on mental health wellbeing including the 'Wellbeing Toolbox' online interactive program, anxiety management and alcohol resources. A *Mental Health and Wellbeing after Military Service* booklet is available to order or download from this website.
- Useful materials are available from *beyondblue* (www.beyondblue.com.au), the Clinical Research Unit for Anxiety and Depression (www.crufad.org) and SANE (www.sane.org).
- Anxiety Online (www.anxietyonline.org.au) is an internet based treatment clinic affiliated with Swinburne University.

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PUT YOUR MIND





UNDERSTANDING POSTTRAUMATIC STRESS DISORDER (PTSD)

People who have been through a traumatic event can experience a number of emotional difficulties. In the days following a trauma, people may feel shock and disbelief at what has happened or they can feel numb, as if things are unreal. After this time, intense and ongoing emotional reactions may appear. It is important to know that it is not uncommon to experience these reactions and that for most people, they decrease over time. If intense reactions last for more than a month and interfere with your ability to function in your life and relationships, you may have PTSD. A person with PTSD has three main types of difficulties:

- **Reliving the traumatic event-** through unwanted and recurring memories or vivid nightmares. There may be intense emotional or physical reactions, such as sweating, heart palpitations or panic when reminded of the event.
- **Being overly alert or wound-up-** including sleeping difficulties, irritability, lack of concentration, becoming easily startled and constantly being on the lookout for signs of danger.
- **Avoiding reminders of the event-** avoiding activities, places, people, thoughts or feelings associated with the event.

People with PTSD can also experience a loss of interest in day to day activities. They can feel cut off from family and friends and feel flat or numb.

Understanding why PTSD occurs

A traumatic event is beyond the normal experience of most people and one that can produce a great deal of shock and stress. After you experience trauma, your mind automatically tries to process and digest what happened, and tries to somehow make sense of the event. It does this by allowing memories of the traumatic event to come into the mind frequently. By thinking about the event, and coming to terms with what happened, the memory will gradually fade.

However, you may have found your mind's attempts to process the trauma far too stressful. As a result, you try to stop the 'processing' by avoiding thinking about the trauma, and avoiding things that may remind you of it. The problem with avoidance though, is that if you do not allow your mind to process and digest what happened, memories of what happened keep intruding. As you may have already discovered, no matter how hard you try to push away thoughts about the trauma, they always come back to haunt you through nightmares, or intrusive thoughts or images.

Getting help

There is evidence that there are effective treatments available to help people overcome PTSD. One of the most effective treatments for PTSD is trauma-focussed cognitive behavioural therapy. This approach recognises that the way we think and act affects the way we feel. During this therapy you will learn:

- Ways to help digest and confront the painful memories, thoughts and images so they don't continue to distress you.
- Strategies to help you resume activities or visit places that you have avoided since the trauma because it has been too distressing.

The therapy may involve 8-12 weekly sessions with a mental health professional but may require longer depending on your needs. Your doctor may also have suggested medication that can be of assistance in managing feelings associated with PTSD.

Self-management resources

Below is a list of internet and other written resources that may help you, together with the treatment recommended by your doctor.

- The website for the Australian Centre for Posttraumatic Mental Health (ACPMH) (www.acpmh.unimelb.edu.au) has useful fact sheets and treatment guidelines. You can also download the *Australian Guidelines for the Treatment of Adults with Acute Stress Disorder and Posttraumatic Stress Disorder: Information for People with ASD and PTSD, their Families and Carers*.
- At Ease (www.at-ease.dva.gov.au) is a Department of Veterans' Affairs (DVA) website with information on mental health wellbeing including anxiety management and alcohol resources and the 'Wellbeing Toolbox', which is an online interactive program. A *Mental Health and Wellbeing after Military Service* booklet is also available to order or download from this website.
- DVA has developed an Australian PTSD Coach smartphone app for use in conjunction with other PTSD interventions.

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UNDERSTANDING PAIN

Persistent or chronic pain is a common experience among veterans due to the physical nature of military service and the injuries that can result from it. Pain is an individual experience. For people who experience persistent pain-related symptoms, the effects on their lives can be serious. In addition to the physical side of chronic pain, emotional distress, depression, frustration and feelings of helplessness are common. People who suffer from chronic pain may also experience difficulties in their personal relationships. Effective pain management includes strategies that will help you deal with the physical aspects of pain as well as its impact on your emotional wellbeing and your relationships. Chronic pain can also stop you from fully engaging with life and it is important to be supported in remaining engaged in activities and roles that are important to you.

Pain and emotional wellbeing

It is important to understand that pain is not just a physical problem. Pain can be influenced by the way people think, behave and feel. Some people notice that their pain is worse when they are stressed or worried, and more manageable when their mood is better. For example, consider how stress leads to unnoticed muscular tension, which can lead to pain.

Persistent pain can combine with mental health conditions such as depression, anxiety and posttraumatic stress disorder. When this is the case, pain can be felt more intensely and be more distressing. Not surprisingly this can lead to feelings of hopelessness and worthlessness and lead to increased mental health symptoms. If this is the case for you, it is important to see a mental health specialist who will treat both pain and your mental health condition together.

Managing pain

Although it may not be possible to fully eliminate persistent pain, much can be done to minimise the pain and help you engage more fully in activities that are important to you. Here are some important tips for this process:

Talk to your doctor. It is ok to ask questions and expect to get answers you can understand. Your doctor can help you draw up a plan for managing your pain. Such a plan typically includes goals you would like to reach with your pain management, a timetable and a list of strategies that will be used (e.g., exercise, relaxation, medication). If medication is to be used, notes on when to take medication and what to do if the pain flares up (particularly after hours) should be made.

You may be given medication. Your GP may prescribe medication to treat your pain. A variety of medications can be used for this. They are collectively known as analgesics or painkillers. Medications work differently for different people. Therefore, it is important to tell your doctor if you are not getting the relief you think you should from the medication so your doctor can work out the right medication.

Set up a support network. This may include family, friends and fellow sufferers who can support you in your pain management and encourage you to do the things that make a difference to your pain. Also find out what sort of support and resources are available in your community.

Keep a pain diary. Keeping a diary can help you gain control of your pain. It is particularly useful when discussing your pain management plan with your doctor or a pain specialist. To keep a pain diary record information about your pain such as:

- when it starts (date and time)
- where you feel it
- how long it lasts
- how strong it is and what type of pain it is (e.g., burning, pressing, stabbing, throbbing)
- what may have triggered it
- what makes it better
- what makes it worse.

Sharing this information with your family members can also help them understand what you are feeling and alert them to situations that may trigger your pain.

Getting help from a specialist

Specialists usually treat people whose pain has not responded to standard medical treatments. A pain specialist will not only treat the pain but also help you manage its impact in your emotions and your social and work life. Cognitive behavioural therapy (CBT) is a treatment approach that can help you better manage your pain. During this therapy you will learn:

- practical coping strategies to help you manage your pain so that it interferes less with your daily activities e.g., how to pace yourself when doing physical activities
- to identify the situations, thoughts and emotions that can increase your pain so that you can learn strategies and ways of thinking that can lessen the impact of these factors.

Pain management programs (PMPs) which use a CBT approach are the treatment of choice for veterans suffering from persistent pain. These programs take a holistic view of your concerns, and in addition to the above components of CBT, they will also look at other ways of supporting you to improve your daily functioning and lifestyle, and to improve your general physical health and fitness. PMPs typically occur in a group setting and vary in length from two to six weeks.

Self-management resources

Below is a list of internet and other written resources that may help you, together with the treatment recommended by your doctor.

- At Ease website (www.at-ease.dva.gov.au) for access to general information on mental health wellbeing including the 'Wellbeing Toolbox', anxiety management and alcohol resources.
- Another useful website is Health*insite* (www.healthinsite.gov.au).
- A helpful document about chronic pain and its management can also be found here: www.dva.gov.au/health_and_wellbeing/physical_health/mhpe/mag/Documents/MHPE_Vol11_1.pdf.

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PUT YOUR MIND





UNDERSTANDING SMOKING

Smoking tobacco has short term and long term impacts on your health and that of your family. In addition, smoking can have negative impacts on your social life and finances. Cigarettes and cigars contain chemicals that are known to cause cancer (e.g., arsenic and cadmium), and chemicals that are toxic (e.g., ammonia and tar)¹.

Impact of smoking on your health

Smoking is the leading cause of preventable death in Australia. Smoking can lead to long term health problems that can have an impact on your quality of life and on your family. Smokers are at risk of experiencing the following:

- heart disease, heart attack and stroke
- cancer, including lung, mouth, throat, liver, bowel, bone marrow and stomach cancers
- lung diseases including chronic bronchitis and emphysema
- poor blood circulation in feet and hands, which can lead to pain and, in severe cases, gangrene and amputation
- eye problems such as macular degeneration and blindness
- reproductive problems. In males, impotence and decreased sperm count. In females, difficulties conceiving.

Half of all long-term smokers will die because of their smoking. In fact, tobacco is responsible for the most drug-related deaths, more than alcohol and illicit drugs. People who are exposed to second-hand smoke are also at risk of premature death.

Benefits of quitting

Deciding to stop smoking and getting help can be one of the most important things you do. Quitting leads to improvements no matter how long you have been smoking, and regardless of your age or health problems:

- *Within 2 - 12 weeks* your risk of heart attack is reduced and lung functioning improves.
- *Within a month* your immune system begins to show signs of recovery.
- *After 2 months* you will experience less coughing and shortness of breath. Blood flow to your hands and feet improve.
- *After 1 year* your blood pressure returns to normal, risk of heart disease is half that of continuing smokers.
- *After 5 years* your risk of mouth and throat cancer are reduced, and risk of stroke is reduced.
- *After 10 years* your risk of developing lung cancer is reduced, and your risk of bladder, kidney and pancreas cancer is reduced.
- *After 15 years* your risk of heart attack and stroke is close to people who have never smoked.

Mental health and smoking

It is common for people with mental health conditions to be heavy smokers. Nicotine is a very seductive drug as it has the unique properties of being calming and improving alertness at the same time – a powerful addiction combination.

If you have a mental health condition and plan to quit smoking, it is important to have a talk to your GP and consider getting support as the initial stages of quitting can have an impact on your mood and stress levels.

Getting help

Nicotine is one of the most addictive substances we know of. It can be difficult to quit, and it may take a number of attempts before quitting. Getting support and advice from a health professional, combined with some medication will provide with the best chance to quit:

- Your general practitioner can provide advice and prescribe medications to help you quit.
- A health professional such as a psychologist can provide counselling and support.

Self-management resources

There are a number of phone and internet resources you can access that provide guidance and information on smoking and quitting smoking.

- Quitline (131 848 or 137 848) - a phone service providing information, advice and counselling. You can order a Quit Pack from this service - a guide to help plan and prepare for quitting.
- QuitCoach (www.quitcoach.org.au) - an interactive website that assesses your smoking provides advice tailored to your needs.
- Quitnow (www.quitnow.gov.au) is a government website that provides information and tips on quitting.
- In addition, if you are attempting to quit and are experiencing stress in your life or have a mental health condition, you may find these resources useful:
- At Ease website (www.at-ease.dva.gov.au) for access to generic information on mental health and wellbeing including the 'Wellbeing Toolbox', anxiety management and alcohol resources. The DVA Mental Health and Wellbeing after Military Service booklet is available to order or download.

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1 Some information in this handout was adapted from resources provided in the QUIT website and QUIT pack (www.quitnow.gov.au)





UNDERSTANDING ALCOHOL AND OTHER DRUG USE

Substance use disorders are a significant problem, affecting around one quarter of Australians over their lifetime. Tobacco and alcohol are the most commonly used substances that cause veterans harm, but there are also an increasing number of veterans that abuse or are dependent on prescription medication as well as illicit substances.

Stress and other emotional problems are strongly related to substance use. At times of stress, people commonly increase their substance use in order to cope with distressing thoughts, emotions, and sleep difficulties. Unfortunately, increased substance use can end up leading to higher levels of stress.

Alcohol use

Alcohol use is a significant issue amongst the veteran population with about 3 in 10 veterans drinking at risky levels. Alcohol misuse has short term risks such as unclear judgement, slower reactions and aggression. It also has long-term mental and physical health risks such as sexual dysfunction, liver problems, sleep difficulties, and mood and anxiety problems. Also, people often use alcohol to help with sleep. While it may seem a good short term solution, heavy alcohol use interferes with the sleep cycle and quality of sleep.

The Australian Guidelines to Reduce Health Risks from Drinking Alcohol has recommended alcohol use limits:

- For healthy men and women, drinking no more than two standard drinks on any day reduces the risk of harm from alcohol-related disease or injury.
- On a single occasion of drinking, the risk of alcohol-related injury increases with the amount consumed. For healthy men and women, drinking no more than four standard drinks on a single occasion reduces the risk of alcohol-related injury.

Other drug use

Use of illicit drugs is relatively common, with around one third of Australians doing so at some point in their lives. Cannabis is the most commonly used, followed by ecstasy and amphetamines and cocaine. Also common is misuse of prescription medication, especially pain medication.

Steps for managing alcohol and other drug use

Increasing motivation

It can be useful to think of the PROS and CONS of substance use. As with most things, there will be pluses and minuses associated with your substance use, and it can be important to consider these before attempting to reduce your substance use. Writing things down on paper is a really good way to help you make a decision about your substance use.

Goal setting

If you have decided to change, you need to consider whether your goal is to cut down or to stop completely. Your goals should be specific, achievable, and be broken into steps. For example: "My goal is to reduce my alcohol intake to three standard drinks a day, reducing the amount I drink each week by one standard drink per night until I reach my goal". Once you have identified what you want to do about your substance use, you can write yourself a contract - this is an important part of beginning and maintaining change.

Monitoring your substance use

It is really important to monitor your substance use. By doing so you will learn more about when, where, and why you use substances. Further, it will help you to keep track of your substance use, including the financial cost, and will be a good reminder that you need to limit your intake. It is also a good way to monitor your progress towards your goals.

Rewards

It is really important to reward yourself for maintaining change and exploring alternatives to using substances. Perhaps with all the money you have saved by cutting back you can treat yourself to something you have been wanting to buy (e.g., a book) or do (e.g., go to dinner). Also, it is important to consider alternative POSITIVE activities you could be doing instead of using substances (e.g., visiting a friend, exercise).

To find out ways to manage your substance use and meet your goals (e.g., identifying strategies to help manage high risk situations that lead to substance use), see the relevant resources below:

Self-management resources

Alcohol resources

- A useful veteran specific resource is The Right Mix website (www.therightmix.gov.au) (1800 1808 68) – includes materials such as local support contacts, and tips for changing drinking behaviour.
- Information on drinking guidelines and self-management strategies can be found at www.alcohol.gov.au.

Other drug resources

- Australian Drug Foundation (www.adf.org.au) provides advice on treatment services and information around substance use.
- DrugInfo (www.druginfo.adf.org.au) is a service of the Australian Drug Foundation that provides handouts on the effects of illicit substance use and prescription medication misuse.
- A self-help booklet from the World Health Organisation can be downloaded from whqlibdoc.who.int/publications/2010/9789241599405_eng.pdf.
- Information and resources are available from The National Cannabis Prevention and Information Centre (www.ncpic.org.au).

Getting help

There are a number of evidence-based therapies available to help people better manage their substance use. Begin getting help by taking the steps outlined above and having a talk to your GP. Your GP can help determine whether you need a withdrawal management plan, or medication to assist with detox or maintaining abstinence. Your GP can also make a referral to a psychologist or psychiatrist for additional help.

Effective therapies for substance use problems include:

- Motivational interviewing which can help you make decisions about your substance use
- Cognitive behavioural therapy which provides skills to help reduce substance use, manage cravings and situations that lead to substance use
- Behavioural couples therapy or family therapy to ensure that those close to you are supportive while you are trying to tackle your substance use, especially if they use substances
- Contingency management that helps you to stay abstinent by using a reward system.

Residential programs or therapeutic communities can be beneficial for some people, particularly if they are dependent on their substance of choice.

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UNDERSTANDING COMPLICATED GRIEF

When people lose someone close to them, there is a very difficult adjustment period as they learn to accept the loss of a loved one. Nevertheless, with time they are usually able to make this adjustment while finding ways to stay connected to the memory of the person they lost. However, for different reasons it can be difficult for some to adjust to losing a loved one and some losses can continue to affect some people for many years down the track. This is what we call complicated grief – where the normal grieving and sadness continues to significantly interfere with a person's life months and years after the loss. Whilst there are similarities in the way people grieve, no one person grieves in the same way as another. Below is a list of some common grief reactions that people experience.

Feelings

- Shock, disbelief and denial
- Sadness, depression and guilt
- Anger and bitterness
- Longing and loneliness
- Emptiness or emotional numbing
- Envy (e.g., of people who have not lost a loved one)

Thoughts

- "I'll never get over this"
- "It's my fault"/ "It should have been me"
- "I can't believe this happened"/ "This is not real"
- "I'll never be loved again"/ "I'll be alone forever"
- "Why did this happen?"
- Being preoccupied with memories of the deceased
- Trying not to think about the deceased
- Seeing or hearing the deceased

Behaviours

- Withdrawal from friends and family
- Avoid being alone
- Avoid reminders of the deceased (e.g., putting away photos, avoiding conversations about the deceased) or the opposite, preoccupation with the deceased (e.g., setting a place at the table)
- Increased alcohol and/or other drug use
- Reckless behaviour

Physical reactions

- Sleep problems and fatigue
- Loss of appetite
- Concentration problems
- Loss of motivation
- Anxiety symptoms (e.g., heart pounding, breathing difficulties, being tense)
- Pain in the same area of the body, or same symptoms as the person who died.

People often have some questions about their grief. Take a moment to read through the questions below and talk to your GP or therapist about these or other questions you may have.

Is there one right way to grieve?

Whilst there are many similarities in the way people grieve, no one person grieves in the same way as another. In fact, having rigid expectations about how you should grieve can often make it harder.

Are there stages of grieving that you must go through?

Many people discuss grief as a series of stages that people must pass through (e.g., denial, shock, anger, despair). There is no evidence that you need to pass through these stages. Again, everyone grieves differently.

Do you have to 'move on' or 'let go' of the person?

People often advise you that you have to break your relationship with the deceased. Obviously, for a loved one this is impossible. Instead, some goals of grieving include accepting their death and finding a way to remember the deceased that is meaningful but not all encompassing or overwhelming.

Do people 'get over it'?

People do not 'get over' the death of their loved ones. Whilst most people adapt over time and get used to the loss, some aspects of grief never end. People change after a serious loss and these differences can be both positive (e.g., an increase in self-understanding and maturity) and negative. Recovering from the loss of a loved one is often about finding a way to remember the deceased while finding ways to re-engage in life and managing distressing emotions when they come up.

Getting help

When grief begins to interfere with your life over an extended period of time, psychological therapy can be useful to try to help you come to terms with your reactions and how to manage them. Often there are blocks that get in the way of us recovering from the death of a loved one. Therapy can help you uncover and address these 'blocks' to reconnecting with and enjoying your life while remembering and honouring the person you have lost. Therapy may be able to help you deal with what has happened in the past, to accept the death of your loved one and to start thinking about your future. One of the most effective treatments is cognitive behavioural therapy (CBT). This approach recognises that the way we think and act affects the way we feel. During this therapy you will learn:

- to identify ways of thinking about your loss that prevent you from dealing with your grief
- strategies to help you re-engage with activities and social supports you used to enjoy and set goals for the future
- to safely confront memories, places or people associated with your loss that you have been avoiding because it causes significant distress.

Self-management resources

Below is a list of internet and other written resources that may complement the treatment plan that you have discussed with your doctor.

- There are currently no resources specific to complicated grief. However, the following website has useful information on grief more generally: Australian Centre for Grief and Bereavement (www.grief.org.au).
- At Ease (www.at-ease.dva.gov.au) is a Department of Veterans' Affairs (DVA) website with information on mental health wellbeing including the 'Wellbeing Toolbox', which is an online interactive program, anxiety management and alcohol resources. A *Mental Health and Wellbeing after Military Service* booklet is also available to order or download from this website.

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UNDERSTANDING ANGER

Everyone gets angry, and anger can sometimes be useful to motivate people and help them to deal with situations in which they need to be assertive. However, if anger is expressed in ways that are harmful to the person or others, or persists over a long period of time, then it can become a problem. Anger tends to be experienced in the following ways:

- It can be acute or 'explosive' in nature when a person flies into a rage. With this type of anger there tends to be strong physical reactions such as muscle tension, heart palpitations and sweating.
- Longer term anger or resentment. This type of anger tends to be the result of thinking negative thoughts over and over again – for example, replaying frustrating events over and over again or constantly having revenge fantasies.

While anger is often a response to perceived injustice or frustration, it can be driven by a range of feelings like sadness, hurt or feeling unsafe or threatened. For example, a parent may become angry with their child for crossing the road without looking when, in fact, the driving emotion is fear for their safety.

When is anger a problem?

Anger can have its benefits when it is not accompanied by violence or intimidation. It can give people the courage to confront someone they do not usually have the courage to confront. Anger can also motivate people to be assertive, spurring them into action to help solve a problem or have their needs met. However, if anger gets out of hand and leads to actions such as hitting or threatening someone, or ending up with an assault charge, it becomes self-defeating. Intense or long-lasting anger is draining, and can affect relationships at home and at work. In the end, people's needs are more likely to be met and their relationships kept healthy if they can manage their anger and communicate their needs assertively rather than aggressively.

Anger may be a problem if:

- you feel angry a lot of the time
- your anger involves verbal, emotional or physical abuse of those around you
- you think the only way to get what you want is to be angry
- your anger is out of proportion to the trigger that set it off
- it takes a long time for your anger to subside after the situation triggering your anger has passed
- you feel anxious, remorseful or depressed about your anger
- you use alcohol or substances to manage your anger
- your anger is causing problems with your personal or work relationships, your health or the law.

Getting help

There are effective treatments available to help people better manage their anger. One of the most effective treatments is cognitive behavioural therapy (CBT). This approach recognises that the way we think and act affects the way we feel. During CBT you will learn:

- to identify triggers and warning signs of anger
- to manage your reactions so you feel less angry (e.g., using distraction or breathing techniques to calm yourself down)
- to address thinking habits that lead to anger (e.g., learning to stop thinking constantly about situations that cause anger)
- to manage situations before they get out of control. This involves preparation prior to entering anger-provoking situations, coping with encountering the situation and evaluating what happened

- to imagine anger-triggering events and practice anger management skills in response. As the anger reaction emerges you will be encouraged to rehearse the techniques you have learned to manage how you feel
- to use specific skills such as solving problems, communicating more assertively, and negotiating effectively for what you need.

Self-management resources

Below is a list of internet resources that may help you, together with the treatment plan recommended by your doctor:

- Useful materials are available from the Australian Psychological Society (www.psychology.org.au), Reach Out (www.reachout.com.au) and MensLine Australia (www.menslineaus.org.au).
- At Ease (www.at-ease.dva.gov.au) is a Department of Veterans' Affairs (DVA) website with information on mental health wellbeing including anxiety management and alcohol resources and the 'Wellbeing Toolbox', which is an online interactive mental health program. A Mental Health and Well Being after Military Service booklet is available to order or download from this website.

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UNDERSTANDING SLEEP DIFFICULTIES

Disturbed sleep is a common complaint among veterans. The majority of individuals will experience periods of sleep disturbance at some stage of their lives. Sleep disturbance can be caused by many different factors. For example, it can be caused by an illness and stress, or by poor sleep habits (e.g., too much alcohol or caffeine before sleep, too much physical or mental stimulation before going to bed). Sleep problems can also develop as a consequence of disrupted sleep patterns (e.g., from shifts during the night when in the military).

It should be noted that sleep disturbance could also be related to mental health problems. For example, depression can result in too much or too little sleep and replaying anxious thoughts can keep people awake. Also, frequent nightmares, sometimes associated with posttraumatic stress disorder, will disrupt sleep patterns.

Prolonged periods of sleep disturbance can have negative impacts on your physical and mental wellbeing, and interfere with your daily work and social functioning. For example, people can experience attention and memory problems and increased irritability.

Self-management strategies

Sometimes sleep problems can be improved by improving sleep habits. The first step is to recognise these habits (keeping a sleep diary can help), and then you can choose the specific strategies that will help you change them.

Bad sleep habits	Good sleep habits
Too active or too much stimulation before bed	Spend 30 minutes doing something non-stressful before going to bed and avoid exercise for 3 hours before going to sleep
Irregular sleep routines	Try to go to bed at the same time most nights (it will become a signal for your body that it is time for sleep) and get up at the same time most mornings
Napping during the day	Avoid naps
Other activities in bed (e.g., watching TV)	Use your bed only for sleep and sexual activity, and reading material that is not too stimulating
Lying awake for hours and worrying	If you do not fall asleep in about 20 minutes, get up and go to another room until sleepy, then try again
Consuming caffeine late in the evening	Avoid coffee, tea, cocoa, cola drinks after about 4pm
Drinking in the evening	Don't have any alcohol for several hours before going to bed (alcohol might help you get off to sleep but causes early waking 2-3 hours later and a disrupted sleep pattern)
Smoking a lot	Smoking (nicotine) will make you more alert. You may also have breathing-related sleep disturbances caused by long-term smoking (such as sleep apnoea). Avoid smoking as much as possible and consider giving up.
Frequent use of sleeping pills	Avoid frequent use as they are dependency forming and end up disturbing your sleep further

Other things to consider when identifying what drives your sleep difficulties include:***Do you get anxious about lack of sleep?***

Are you telling yourself things like “If I don’t get enough hours of sleep I won’t be able to function well the next day”, or “Poor sleep is having a serious effect on my physical health”? This kind of thinking will make it harder to get off, or back to sleep. Instead, tell yourself realistic things like: “One night’s poor sleep will not make much difference” or “If I am busy I will hardly notice the difference.”

Are you worrying about other things at night?

Your bed is not a good place to think and worry because it interferes with sleep. Do a deal with yourself. Tell yourself that you will give yourself some “worry time” the following day or write down your worries to deal with them the next day.

Getting help

If sleep difficulties persist after you have tried the above strategies, it may be useful to see a mental health professional for assistance. During this therapy you will learn:

- Strategies to develop good sleep habits
- Strategies to avoid thinking or worrying about the day’s events when lying in bed
- Information on the realistic consequences of minimal sleep and the amount of sleep required.

Self-management resources

- Written materials for you and your family are available from websites such as Reach Out (www.reachout.com), HealthInsite (www.healthinsite.gov.au) and Better Health Channel (www.betterhealth.vic.gov.au).
- At Ease (www.at-ease.dva.gov.au) is a Department of Veterans’ Affairs (DVA) website with information on mental health wellbeing including anxiety management and alcohol resources, and the ‘Wellbeing Toolbox’ online interactive program. A *Mental Health and Wellbeing after Military Service* booklet is available to order or download from this website.

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UNDERSTANDING GAMBLING

Almost everyone gambles from time to time for fun or as part of a social activity; on the races, the pokies, entering lotto, a raffle ticket or even the office footy tipping. However, gambling can become a problem for some people when they have difficulties setting limits on the time and money involved. This often leads to financial stress and relationship difficulties.

There is emerging evidence that people are more likely to have problems with gambling if they have other mental health problems, such as substance use or depression.

When is gambling a problem?

Gambling may be becoming a problem if you are:

- struggling to control your impulse to gamble
- spending more time and / or money on gambling than planned
- prioritising gambling activities over other enjoyable or important activities such as spending time with friends or family, watching your favourite TV show, or working
- thinking gambling will fix your financial problems
- struggling to pay your bills
- lying to people about the time/money spent on gambling.

Getting help

There are effective treatments available to help people overcome their problems with gambling. One of the most effective treatments is cognitive behavioural therapy (CBT). This approach recognises that the way we think and act affects the way we feel. CBT can help you to:

- identify gambling triggers and manage high-risk situations for gambling
- address thinking habits that contribute to gambling problems
- learn strategies to face gambling triggers and urges without acting on them
- plan other enjoyable activities to do instead of gambling.

Self-management resources

Below is a list of internet and other written resources that may help, together with the treatment plan recommended by your doctor.

- Gambling Help provides free face-to-face gambling counselling throughout Australia. They also provide financial counselling. Refer to their website for information on service locations: www.gamblinghelponline.org.au, and/or call 1800 858 858 for referral information.
- At Ease (www.at-ease.dva.gov.au) is a Department of Veterans' Affairs (DVA) website with information on mental health wellbeing including anxiety management and alcohol resources and the *Wellbeing Toolbox*, which is an online interactive mental health program. A *Mental Health and Wellbeing after Military Service* booklet is available to order or download from this website.

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Acronyms

AASW	Australian Association of Social Workers
ACAS	Aged Care Assessment Service
ACPMH	Australian Centre for Posttraumatic Mental Health
ADF	Australian Defence Force
AIHW	Australian Institute of Health and Welfare
APS	Australian Psychological Society
AS+BI	Alcohol Screening and Brief Intervention
ASD	Acute Stress Disorder
ATAPS	Access to Allied Psychological Services
AUDIT	Alcohol Use Disorders Identification Test
BCT	Behavioural Couples Therapy
BDI	Beck Depression Inventory
CAGE	Cut down, Annoyed, Guilty, and Eye-opener (acronym derived from the four questions of this screen for alcohol misuse)
CAGE AID	CAGE questions Adapted to Include Drug Use
CBT	Cognitive Behavioural Therapy
CIWA-AR	Clinical Institute Withdrawal Assessment for Alcohol revised scale
CM	Contingency Management
CPGI	Canadian Problem Gambling Index
CPT	Cognitive Processing Therapy
CRUFAD	Clinical Research Unit for Anxiety and Depression
CT	Cognitive Therapy
CVC	Coordinated Veterans' Care
DAR	Dimensions of Anger Reactions scale
DASS	Depression, Anxiety and Stress Scale
DAST	Drug Abuse Screening Test
DSM	Diagnostic and Statistical Manual of Mental Disorders
DVA	Department of Veterans' Affairs
ECT	Electroconvulsive Therapy
EMDR	Eye Movement Desensitisation and Reprocessing
FLAGS	Feedback, Listen, Advice, Goals, Strategies
FQ	Fear Questionnaire
FT	Family Therapy
GAD	Generalised Anxiety Disorder
GP	General Practitioner
HADS	Hospital Anxiety and Depression Scale
HAM-D	Hamilton Depression Scale
ICD	International Classification of Diseases
IPT	Interpersonal Therapy

IQCODE	Informant Questionnaire on Cognitive Decline in the Elderly
IRT	Imagery Rehearsal Therapy
K-10	Kessler Psychological Distress Scale
MAOI	Monoamine Oxidase Inhibitor
MI	Motivational Interviewing
MINI	Mini International Neuropsychiatric Interview
MMSE	Mini Mental State Examination
MSE	Mental Status Examination
mTBI	Mild Traumatic Brain Injury
NHMRC	National Health and Medical Research Council
NICE	National Institute for Health and Clinical Excellence
NRT	Nicotine Replacement Therapy
PBS	Pharmaceutical Benefits Scheme
PCAT	Psychogeriatric Assessment and Treatment Services
PCL	PTSD Checklist
PCL-C	PTSD Checklist – Civilian version
PCL-M	PTSD Checklist – Military version
PCL-S	PTSD Checklist – Stressor specific version
PC-PTSD	Primary Care PTSD Screen
PGSI	Problem Gambling Severity Index
PGRTC	Problem Gambling Research and Treatment Centre
PHQ-15	Patient Health Questionnaire
PHQ-SSS	Patient Health Questionnaire Somatic Symptom Short Form
PMP	Pain Management Program
PRN	Per Required Need (i.e., as required)
PSWQ	Penn State Worry Questionnaire
PTSD	Posttraumatic Stress Disorder
RACGP	Royal Australian College of General Practitioners
RANZCP	Royal Australian and New Zealand College of Psychiatry
RPBS	Repatriation Pharmaceutical Benefits Scheme
RSL	Returned and Services League
SNRI	Serotonin-Noradrenaline Reuptake Inhibitor
SSRI	Selective Serotonin Reuptake Inhibitor
SUDS	Subjective Units of Distress Scale
TBI	Traumatic Brain Injury
TC	Therapeutic Communities
TCA	Tricyclic Antidepressants
TF-CBT	Trauma-Focussed Cognitive Behavioural Therapy
VGS	Victorian Gambling Screen
VPAC	Veterans' Affairs Pharmaceutical Advisory Centre
WCS	WVCS - Veterans and Veterans Families Counselling Service
WHO	World Health Organization