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 Appendix 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 introceptive 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.
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 2009–2014\(^1\) 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’ Affairs\(^2\) (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 VVCS - Veterans and Veterans Families Counselling Service (VVCS) and private practitioners.

Specialised, free and confidential counselling is also available for all Australian veterans and their families through VVCS. VVCS contracts counsellors to provide services in some regional and rural areas. VVCS can be contacted 24 hours on 1800 011 046.

GPs may refer non-entitled veterans for psychological treatment through the following government programs\(^4\):

- **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.

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\(^3\) Centrelink: www.humanservices.gov.au.