Veterans in Pain: Where the body and mind meet

This document answers the most common questions that remained outstanding at the webinar's conclusion.

Frequently Asked Questions

1. **How can a practitioner normalise and influence a veteran to access services to assist their mental health and chronic pain?**

   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 who they feel understand, or seek to understand their mental health problems within the context of their military service. 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. The military culture honours 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).

   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 Department of Veterans' Affairs (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.

https://at-ease.dva.gov.au/professionals/client-resources/mental-health-advice-book/understanding-veteran-experience

The DVA provides a range of training and resources for professionals working with veterans. DVA online provider training programs include; Understanding the Military Experience, Case Formulation and Treatment Planning, vetAWARE, PTSD - Psychological Interventions and Working with Veterans with Mental Health Problems for GPs. See https://at-ease.dva.gov.au/professionals for more information.

2. How does the brain process psychological pain and physical pain?

Pain itself often modifies the way the central nervous system (the brain and the spinal cord) works, so that a person actually becomes more sensitive and gets *more pain* with less provocation. This is called "central sensitisation" because it involves changes in the central nervous system in particular that make it more reactive. People with central sensitisation are not only more sensitive to things that should hurt, but sometimes to ordinary touch and pressure as well. Their pain also fades more slowly than in other people.

Central sensitisation has two main characteristics and both involve a heightened sensitivity to pain and the sensation of touch, which is called *allodynia* and *hyperalgesia*. Allodynia occurs when a person experiences pain with things that are normally not painful. For example, chronic pain patients often experience pain even with things as simple as touch or massage. In such cases, nerves in the area that was touched sends signals through the nervous system to the brain. Because the nervous system is in a persistent state of heightened reactivity, the brain does not produce a mild sensation of touch as it should, given that the stimulus that initiated it was a simple touch or massage. Rather, the brain produces a sensation of pain and discomfort. Hyperalgesia occurs when a stimulus that is typically painful is perceived as more painful than it should. An example might be when a simple bump, which ordinarily might be mildly painful, sends the chronic pain patient through the roof with pain. Again, when the nervous system is in a persistent state of high reactivity, it produces pain that is amplified.

Ongoing pain causes stress and can heighten emotional responses and it is common for people to experience increases in levels of: anxiety, irritability, frustration, depression, anger and guilt. Pain can also interfere with sleep, activity levels, work, relationships, socialising, recreation and finances. Vicious cycles are created, whereby stress and elevations in emotional states impact on the nervous system, making it more reactive, and therefore exacerbating the pain.

For more information about how pain can impact the central nervous system and brain, please see http://chronicpainaustralia.org.au/index.php and http://www.instituteforchronicpain.org/

3. What does DVA currently do to assist with addressing chronic pain?

Where chronic pain is creating a barrier to a person being able to reach their rehabilitation goals, brief intervention counselling for pain management can be considered under the psychosocial component of a DVA rehabilitation program. This can assist the individual to adjust to the disability, injury, or to ongoing pain, by providing the skills and strategies to equip a person to more effectively manage issues as they arise.

More information on DVA's rehabilitation program can be found in DVA Factsheet MRC05 – Rehabilitation.

DVA also provides support for veterans and ex-serving Australian Defence Force (ADF) members to access mental health treatment which can be helpful with comorbid mental health problems, such as anxiety, for people experiencing chronic pain. Under non-liability health care, DVA provides

treatment for mental health conditions for current and former ADF personnel with any period of permanent or continuous full-time service. In addition, all veterans with at least one day continuous full time service and their immediate family members are also entitled to free confidential mental health support services for life through the Veterans and Veterans Families Counselling Service (VVCS).

4. How is chronic pain and moral injury linked with the military experience?

Military personnel are often confronted with situations whereby under extreme conditions, they make decisions, take action or are exposed to events that challenge their ethical and moral beliefs. Transgressions of ethical and moral beliefs and inner conflict can arise from such circumstances and lead to potential mental health problems. Research indicates that in addition to symptoms already associated with posttraumatic stress disorder (PTSD), additional features of moral injury can manifest itself as shame, guilt, loss of trust, anger, demoralisation, self-handicapping behaviours, and desire for self-harm. Hence, moral injury is a useful concept that addresses a wider range of combat-related experiences beyond threat and loss and clinical presentations not fully encompassed by current diagnostic criteria for psychopathology such as PTSD or its related features. More information on moral injury is available on the DVA Evidence Compass.

Military personnel may experience moral injury and chronic pain. This can result in a veteran experiencing a complex range of physical and mental health difficulties which can result in a vicious cycle, whereby psychological distress and pain related stressors such as poor sleep impacting on the nervous system, making it more reactive, and therefore exacerbating the pain. It is important to assess and develop a treatment plan for veterans that is inclusive of all their presenting issues.

5. What are the best psychological strategies to assist a veteran with chronic pain and mental illness?

Psychology and psychological approaches to pain are an important and accepted part of the holistic pain management model. Research has shown that psychological approaches such as cognitive behavioural therapy (CBT), graded exercise, mindfulness and hypnotherapy can be important components in improving pain management and indeed for warding off or being of benefit if anxiety or depression develop. There are a variety of psychological approaches needed to deal with chronic pain because not all treatments work the same way for everyone, hence the therapist will work with the patient to try alternative approaches to lessening the stress that pain causes on brain function and emotional responses.

For additional information please see the DVA evidence review on the efficacy of psychological interventions and multi-modal interventions that include a psychological component, for the treatment of chronic pain. https://www.dva.gov.au/health-and-wellbeing/evidence-compass/psychological

Additional Resources

The *High Res* website and mobile app can help serving and ex-serving military personnel and their families manage stress and build resilience.

The *Operation Life* website and mobile app can help those at risk with suicidal thoughts and is recommended to be used with the support of a clinician. The app provides on-the-go access to relevant emergency and professional support and self-help tools for users to regain control, keep calm and take action to stay safe.

The *PTSD Coach Australia* mobile app can be used in combination with evidence-based therapies for PTSD to tailor self-management and recovery options, including scheduling the use of particular CBT tools, activities and clinical appointments.

The *ON TRACK with The Right Mix website and* mobile app records alcohol consumption and summarises the impact on wellbeing, fitness and budget – key motivators for young serving and ex-serving ADF personnel. Clinicians can use *On Track* as a 'real-time' drinks diary, with data emailed to monitor compliance and track progress over time.

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

Clinicians can refer their veteran clients to the VVCS. This service provides free and confidential, nation-wide counselling and support for war and service-related mental health conditions, such as PTSD, anxiety, depression, sleep disturbance and anger. Support is also available for relationship and family matters that can arise due to the unique nature of the military lifestyle. The VVCS group programs calendar provides program dates in locations across Australia. If you have a client you consider may benefit from VVCS support, please call 1800 011 046 to discuss (www.vvcs.gov.au).

Health professionals have a key role delivering care to the veteran community. DVA is committed to providing you with the support you need to treat our clients with best practice, evidenced-based care, and to ensure that doing business with us is as easy as possible. Subscribe to **DVA Provider News** to receive the latest DVA information and updates, delivered to your inbox. See https://www.dva.gov.au/providers/dva-provider-news for more information.

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Janelle's story

Janelle is a 34 year old woman, recently separated from her long-term partner Donald. Donald and Janelle had been in a relationship since he moved next door to her Brisbane family home when she was 14 years old.

At the age of 15, Janelle developed a plan. She'd always made plans and this was her first long-term one. After finishing school she'd enrol in a nursing course and apply as an undergraduate to join the RAAF. She would put in ten years, leave with great memories and a fully paid up nursing qualification, ready to start a family with Donald.

The plan started well and within four years, she had joined the RAAF and was based in Darwin. Her initial orientation covered general military skills, weapons handling, leadership, and specific military nursing skills such as intubation and ventilation, as well as meeting physical standards.

This was all that Janelle expected, wanted and needed. She had grown up in a military family, relished learning, and loved her sports. Being sporty, Janelle joined the RAAF basketball team, both for the camaraderie and to keep fit.

Her first eight years in the RAAF went fast. Janelle loved the excitement and variety of the role.

She spent six months as part of the primary care team in Afghanistan, where she had vivid memories of the range and challenge of the tasks entrusted to her. "*We saw the outcome of horrifying combat, we treated NATO soldiers, not just ours. We treated Afghan forces who had been involved in fighting. At times we delivered this high quality health care to people who were seriously injured in the back of an aircraft*". Back at the base, amongst other tasks, she ran first aid medical training for new recruits, and provided nursing assistance to the medical officers.

After eight years with the RAAF basketball team they made it to the ADF combined services National Championship finals. An on court stoush during the game ended with Janelle straining the ligaments of her left knee badly. The medical officer on the base initially treated her injury with ice and anti-inflammatory medication. She also attended weekly physio sessions.

Her rehabilitation team indicated that the typical recovery time for this sort of knee injury is 6-8 weeks. After 10 weeks Janelle assured her rehabilitation team that she was fully recovered, despite experiencing niggling twinges in her knee when she was on her feet for extended hours. Janelle felt more comfortable acknowledging that she had a short-term sports injury rather than that she was struggling to keep up with the demands of her chosen career. She retired from the basketball team and didn't complain about her knee to anyone.

She struggled through her final two RAAF years. She missed basketball, the camaraderie and the opportunity to keep fit. The niggle in her knee made for long days. Most nights she'd comfort eat and collapse in bed exhausted.

One day shortly before leaving the RAAF, struggling with a large backpack, she clumsily stumbled trying to get out of a helicopter. She landed on her knees, both of which sustained bruising and subsequent swelling. She was embarrassed and didn't want to draw attention to

either the incident or to her knees. She kept her knees covered, applied ice regularly and took anti-inflammatory meds that she had left over. This time the pain in her knees felt different, it was more of a dull ache than the sharp pain of the original injury. It interrupted her sleep and affected her gait.

After 10 years she left the RAAF, a couple of kilos heavier than when she joined, but with a sense of accomplishment. She was excited to be embarking on the next stage of her plan, which was to secure casual agency nursing work and over the next 12 months, for her to try to get pregnant. At 34 she was worried that '*time was running out'.*

Securing agency nursing shifts was easy, sustaining them was hard. Her left knee was good on some days and not so good other days. On bad days, without much warning, it would lock into place and she was unable to bend it. She hadn't had a good night's sleep for as long as she could remember. She also started to develop back pain. She didn't know a nurse who didn't complain of back pain, but she did plan to ask her GP, '*what's to blame for this back pain, the sports injury or work?'*

Her GP was reluctant to apportion blame but encouraged her to return to physiotherapy, which she did, but it didn't seem to help. It was also expensive, and she and Donald were saving to purchase a home. She regularly took over-the-counter analgesics to cope with the discomfort.

Janelle thought that she and Donald had managed their long distance relationship well, but coming home permanently was different. Donald wasn't his upbeat self and was easily irritated. They nit-picked and had words often. Janelle had been home about six months when Donald announced he was leaving her. He'd re-thought having children, saying he wasn't ready for them yet, and that she'd achieved her dreams, but he hadn't even started on his.

Janelle had sensed something was wrong, but was surprised at how quickly Donald moved out and on. She was resentful and angry at what she perceived to be his impulsiveness which had thwarted her plans.

While in the RAAF she had lost many of her old social connections and now she isn't keen to connect with her RAAF colleagues because she thinks she is '*only half the woman she was when they knew her'.*

Now instead of '*plans of what she will do'* she has '*plans of what she will not do'*. She won't go shopping because the bags are too heavy (instead she shops online), she won't go to physiotherapy because it didn't work and she can't afford it; and she won't sleep without pills and a pillow under her knee.

The daily struggle with the pain is wearing her down. She starts to turn down shifts at work. She knows her gait has changed, she's not sure if it is the pain or habit, but she can't seem to stand upright bearing equal weight on both legs anymore. She has gained a couple more kilos since returning home. The over-the-counter analgesics don't seem to be working so she requests stronger pain meds from the GP and uses them to help her sleep as well. He provides a prescription and a referral to an orthopaedic surgeon.

Her GP rings to tell her that the x-ray results from the orthopaedic surgeon are not indicative for surgery, and asks Janelle to come in to discuss alternatives.

Between that phone call and the appointment, Janelle spends most of her time trying to understand how she ended up on the sofa, overweight, single, unmotivated, eating pain meds like lollies, and without a plan. She wonders if maybe she isn't as resilient as she thought she was, maybe she had peaked already? She can't believe her knee, a mere sprain, could have such an impact. And her back? What's that? It didn't even hurt that much, and yet it seems to have taken over her life. Janelle wonders if her time at the RAAF '*burnt her out'* or whether it was life itself?

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Webinar panellists

Professor Kathryn Nicholson Perry
Psychologist

Kathryn Nicholson Perry is a registered psychologist with area of practice endorsement in clinical psychology, whose primary clinical and research interests lie in health, disability, and rehabilitation. She is particularly interested in psychological management of chronic pain, and finding new ways to deliver such interventions.

She completed her PhD in the Faculty of Medicine, University of Sydney, on the utility of the biopsychosocial model in spinal cord injury pain and its management. She is currently Professor and Chair of Psychological Science at the Australian College of Applied Psychology in Sydney, where she is mainly involved in the training of professional psychologists.

Dr Meredith Craigie
Pain Specialist

Meredith is a specialist pain medicine physician in the CALHN Pain Management Unit now based at the Queen Elizabeth Hospital.

She is the Dean of the Faculty of Pain Medicine of the Australian and New Zealand College of Anaesthetists. Meredith trained in anaesthesia and intensive care in Adelaide followed by subspecialty training in paediatric anaesthesia in the UK.

Her transition into pain medicine was triggered by working with children with burns and chronic pain in the 1990s. Her interests include pain medicine education, the transition of acute to chronic pain, pain in childhood and persistent pelvic pain.

Professor Mal Hopwood
Psychiatrist

Professor Malcolm Hopwood is the Ramsay Health Care Professor of Psychiatry, University of Melbourne; based at the Albert Road Clinic in Melbourne Australia.

He specialises in clinical aspects of mood and anxiety disorders, psychopharmacology and psychiatric aspects of acquired brain injury. In the past, he led the Psychological Trauma Recovery Service, incorporating the Veterans Psychiatry Unit and the Victorian Brain Disorders Program, Austin Health.

He has held senior positions within the Royal Australian and New Zealand College of Psychiatrists including past Chairmanships of the Victorian Branch and the Board of Research, and was President of the College from 2015-2017.

In 2017 Professor Hopwood was installed as President-Elect of the Asian Federation of Psychiatric Associations (AFPA).

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In 2017 Professor Hopwood commenced as Interim Head of Department for Psychiatry, University of Melbourne.

Facilitator

Professor Mark Creamer
Clinical Psychologist

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

Mark is internationally recognised for his work in the field; providing policy advice, training and research consultancy to government and non-government organisations, with the aim of improving the recognition, prevention and treatment of psychological problems following stressful life events.

Mark is a Professorial Fellow in the Department of Psychiatry at The University of Melbourne, and has an impressive research record with over 180 publications.

Mark is an accomplished speaker and has given numerous invited addresses at national and international conferences.