Veterans’ experience of chronic pain management: it takes experience to manage this difficult relationship

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For my MSc thesis I took a qualitative approach to studying pain coping experience in veterans. I found that veteran chronic pain is managed through understanding and drawing
upon personal experience, and personal experience changes over time. The most effective pain management strategy for veterans comes from using a blend of military-civilian techniques, but whether the majority of coping techniques are military or civilian (or an equal blend of the two) is tailored to the individual, who is in a long term relationship with pain.

I have been interested in veteran physical and mental health for many years; I come from a military family, with my brother being third generation Army. As much as possible I have attempted to tailor academic work towards veteran health, so for my Health Psychology MSc dissertation I asked my veteran friends and family “what is the most common post-military physical health issue you manage?” The resounding response was chronic pain. Even those who said they did not suffer pain often referred to some sort of pain in a later conversation; they just did not think it was worth complaining about. The consensus seemed to be it is very much taken for granted that chronic pain is an integral part of civilian life. This is also a finding in previous research[1].

However, what I also found when embarking upon my own preliminary investigations is that chronic pain in veterans is all too often associated with mental health issues and PTSD. Previous research suggests that PTSD exacerbates pain[2], and that veteran PTSD sufferers are more likely to use avoidance coping strategies or perhaps focus on managing emotions rather than being more problem focused[3,4]. Whilst PTSD does seem to exacerbate pain[2], it would be fair to say that chronic pain still has an impact on veterans’ lives, even in the absence of mental health issues.

Furthermore, the vast majority of previous research is conducted using questionnaires to measure pain coping, which are generic in nature. At the date of writing, a veteran coping questionnaire and/or a veteran chronic pain questionnaire do not exist, so one cannot assume you can really capture the veteran experience of living with chronic pain by using a general coping questionnaire. Often these questionnaires are only administered once, or at the most a few times, whereas chronic pain sufferers manage pain for years. So how can you adequately understand veteran chronic pain management, by measuring it a few times, with inadequate scales?
Often previous methods used have just followed the pattern that much existing research has taken, and Munglani (2018)[5] points out that this may be due to perceptual bias and/or having a narrow view within that field of research. Health issues need to be researched in such a manner that factors for specific cultures and the time in which specific cultures are situated, and this is especially true of the veteran community.

Veterans have been conditioned by the Forces to have specific health and illness beliefs (e.g. reject help and ignore health warnings)[6,7], as well as being situated socially within specific contexts when transitioning to civvy-street. Some veterans, for example, may leave the military and find themselves in an area of high unemployment, so low income (or no income)
may impact on their ability to access resources needed to manage chronic pain. Some may even struggle to afford necessary medication. Some veterans may find themselves in areas of isolation, with low social and/or physical support, and this could impact on their ability to manage chronic pain. The UK presently has many veteran and military charities, and this reflects the current attitude that UK society (generally speaking) is supportive of its veterans, and yet some veterans may not utilise charitable support for several reasons. It could be due to logistics; the veterans cannot access support due to poor transport networks or a lack of personal transport, or it could be a case of pride; the veteran attitude of pride has possibly remained unchanged for several hundred years[8]. Therefore how veterans cope with chronic pain is multifaceted, and many factors should be considered to obtain a full understanding of the chronic pain coping relationship.

For this reason I decided to conduct semi-structured interviews with veterans, who had not been diagnosed with mental health issues, and who had managed their pain for a minimum of 3-6 months. For pain to be considered chronic it has been present (sometimes intermittently) for at least 3-6 months, so the word ‘chronic’ refers to time and not pain intensity. I also did not make any assumptions about how the veterans managed their pain; I did not assume they all self-managed and had no assistance. How they managed the pain (what steps they took, resources accessed, resources accepted, assistance or support sought) would be explored through the research process. I took a grounded theory approach to attempt to find a theory or explanation for veteran coping with chronic pain, and to get a real insight into the relationship the veterans had with coping and chronic pain.

Similar themes repeatedly emerged throughout the interviews, and after I had transcribed and analysed 7 veteran interviews no new themes emerged. This is referred to as the saturation point. The majority of veterans actually had managed their chronic pain for many years so they had profound pain management experiences. When encapsulating the essence of their experience it struck me that for them it was literally like being in a relationship with their pain. For some the relationship was like being with someone who was a bit irritating, and for others it was like managing a persistently intense and difficult relationship. Each veteran’s relationship with their pain took managing, and each veteran’s coping strategies were unique examples of how they managed their own relationship.

The way the veterans described their pain relationships and coping revealed that the pattern of coping relationships were unique to each individual. Some elements of coping were shared, but not all coping was the same. There is no universal or standard way that veterans manage chronic pain.

Key points that emerged from the findings were that veterans do draw on their military training and identity, and very much want to manage their pain their way. Research does
indicate that veterans show lower levels of agreeableness[9], are trained to be problem solvers[10] and prefer self-care[11]. This may include making adaptations and/or taking a trial and error approach. They do not seem to be afraid of exacerbating pain whilst discovering what they can and cannot do, but they have learned what makes the pain unnecessarily worse so at times use active avoidance to minimise unnecessary pain. All veterans actively avoid associations with being disabled, whether that be disabled related assistance or just being labelled disabled. This appears to clash with the military/veteran identity[11].

The veterans used very emotional language when describing their pain experience. Both negative and positive emotions are frequently found in chronic pain research[12–14], and can act as motivators to managing chronic pain[15,16]. For example it is beneficial to engage in activities that produce feelings of passion, as this distracts the sufferer from the pain and boosts feelings of general wellbeing[15]. Pride was also a commonly reoccurring emotion, which can act as a significant barrier to help-seeking, and this can be seen in previous research[8]. However, contrary to some existing evidence[17], no veterans were particularly focused on managing their emotions, but rather acknowledged that emotional responses occurred throughout pain experience/management.

The veterans also discussed the use of support; whether this was social support or professional support. What was interesting in terms of these particular veterans’ experiences was that many did seek help, despite a vast body of research suggesting that veterans are poor help-seekers[8]. Many veterans commented that they were dissatisfied or disillusioned with healthcare professionals or support services. Yet, despite that, many would seek out new treatment and/or different professional assistance to help manage the pain relationship. Many veterans sought assistance rather than waiting to be offered help, so they were active rather than passive with their pain relationship management. Also many veterans acknowledged that social support was important to general wellbeing, and just being in company could make a difference to a veteran’s pain levels. Support even seemed to extend to good relationships with work colleagues and employers, so the working environment was easier to navigate when pain levels were higher. Again, many veterans seem to be actively managing these relationships to assist with the pain management relationship.

Finally, another type of language used when discussing the pain relationship was temporal language, and it was clear that the pain relationship had changed over time for these veterans; often for the better. Most veterans shifted between the past and the present, and compared what they could do now with what they could previously do. This seemed to act as a gauge so the veterans could assess where they were with their pain management, and how much it impacted on quality of life. When pain was particularly bad it seemed like time stood still, and the pain relationship needed special attention. However, in most cases this seemed
temporary, and before long life was moving along again at an acceptable speed. The veterans were often able to reflect that their current situation is not as bad as it was, and they could see progress had been made with the pain management. This helped them to reflect that their pain relationship had improved and this was a positive thing.

The use of a qualitative methodology in this study enabled understanding of what the pain relationship was, and how it had changed over time. The qualitative nature of the study was also able to produce findings which suggested that whilst all veterans’ reactions to pain was very much shaped by military inspired experiences, beliefs and culture, it was also unique to each individual. Explanations were also offered to account for the uniqueness. Upon listening to these explanations it made me wonder whether a coping questionnaire would find that veteran A is positive towards medication and analgesics because they were a military medic, that veteran B prefers to self-care because their father was in the military and they were conditioned to believe that ‘you just crack on with it’ way before they joined the military, or that veterans C and D have positive relationships with healthcare professionals because they spent extended periods of time in hospital so had no choice but to trust doctors. These sorts of insights provided explanations for why some sought and accepted help and some did not, and that acceptance of help often came after altered veterans’ perceptions.

This demonstrates that over time, through experience, many veterans had altered their attitudes and incorporated many so called ‘civilian’ coping methods to have a better quality of life. Civilian style coping could be classed as seeking out and more easily accepting assistance, and having trusting relationships with support services. Whilst the military style of coping may be better described in terms of self-reliance that is ‘cracking on with it’. Whilst military styling coping may have been the default coping style many veterans used, some recognised this was not suitable in all instances of managing chronic pain. So it seems that all managed their pain relationship by drawing on a blend of military-civilian techniques, and how much of that was military or civilian was down to the individual. The veterans’ overall life experiences shaped how much military or civilian techniques they drew upon.

Interestingly, regarding context, factors such as living in a more or less affluent area and access to resources (physical and psychological) did not seem to make a great deal of difference to these veterans’ pain coping experiences, because any pain related issues that arose seemed to be dealt with by using a problem solving approach. Many veterans with more difficult pain relationships seem to attribute the relationship difficulty to the pain itself (e.g. location of pain site, impact of pain – lack of sleep, concerns of medication), therefore it could appear that context or environment is not a factor within the pain management relationship. However, through the interviews it became clear that context played a key role in managing the pain relationship. It was in rehabilitation contexts that some learned to trust healthcare professionals. Contrastingly, where veterans grew up in a military orientated
environment they were conditioned to reject help, on the basis that veterans should not and do not need assistance. So the many contexts veterans have found themselves in have very much shaped coping strategies adopted, whether this was pre, during or post military service.

These findings are useful for several reasons. (1) It supports existing veteran research which suggests military style techniques are often inadequate for dealing with some veteran experiences of pain; civilian style techniques need to be created and developed further which are more appropriate for certain scenarios[18]. This is especially true when veterans are transitioning from one situation to another.

(2) Findings demonstrate that quantitative measures used during pain management intervention sessions (e.g. at a pain clinic) are insufficient to fully capture the experiences a veteran has had. As mentioned above, questionnaires do not fully capture the reasons that people cope in specific ways. For example a questionnaire would not necessarily capture that a veteran does trust healthcare professionals now because they spent a lot of time in hospital and rehabilitation, and during that time they had no choice but to trust professionals. Eventually, after forming a trusting relationship with different people in a specific setting, their attitude changed. This development of trust and change in attitude will take some time.

(3) Interviews together with questionnaires would be far more useful in obtaining a better understanding of experience, which is rich in detail. Those personal experiences can be highlighted and built upon to assist with individualised chronic pain management. So an interview could produce an account of general life experience which contained positive examples of problem solving and proactivity (e.g. researching, sourcing equipment/aids, enlisting help), and these positive examples (which come from any area of life) could be used to counterbalance and challenge unhelpful pain management strategies and attitudes (if questionnaire results suggested someone was emotion focused (partially helpful) or avoidant (even less helpful)). Using positive examples elicited from interviews is also beneficial for veterans psychologically, because the emphasis is placed on utilising the positive techniques that are already in place. A veteran could use them as starting blocks rather than suggesting (as per possible questionnaire results) that they are starting off from scratch with no (or few) examples of positive coping to work from.

(4) Any intervention could be personally tailored to the pain suffering veteran, and this could prove more effective than having the sufferer enrolled in a generic pain management intervention course. This would be particularly beneficial for veterans, as it is useful to those creating interventions to understand that veterans are probably already aware that military signature injuries cause pain (e.g. long period of marching causes injuries, carrying heavy loads causes injuries, holding the ‘firing’ position for extended periods of time causes
injuries, being caught in a blast causes injuries, falling off vehicles/buildings causes injuries) [19], and that factors such as age and co-morbid conditions (e.g. arthritis) exacerbate pain [1]. Veterans also share wellness and illness management beliefs, which are accompanied by their own unique wellness and illness views. The intervention should be a blend of the two, suited to the recipient.

(5) The assessment process needs to be repeated regularly over a period of time, because if experiences change over time then these experiences need to be re-examined. More recently occurring positive experiences could be injected into long term pain management interventions, and ineffective strategies can be addressed.

(6) The knowledge that pain is effectively managed over time via experience is beneficial for managing expectations. It can be explained that chronic pain management is not a quick fix and, like any difficult relationship, it can take a protracted length of time to feel that the relationship is manageable at worst and positive at best.

Of course, it is also worth noting that many of these principles can be applied to the general population, so people can be taught that the pain management relationship can be improved over time. Those who create general pain management interventions could look to the positive strategies adopted by veterans and the military and weave them into intervention programmes, to make them more effective. Being proactive, engaging in activity, finding something you are passionate about, making adaptations so that life does not feel like it has stopped, enjoying socialising, and being as efficacious as possible can improve pain levels and general quality of life.
A full article of the study is currently being reviewed for publication.

References


