

Chronic Pain in Veterans: A Comprehensive Overview for Australian Veteran Advocates

1. Diagnostic Criteria and Australian Statistics

Diagnostic Criteria for Chronic Pain

According to the International Classification of Diseases (ICD-11), chronic pain is defined as pain that persists or recurs for longer than three months. Chronic pain may arise from underlying diseases (e.g., osteoarthritis, rheumatoid arthritis, cancer) or exist without clear pathological cause (e.g., fibromyalgia). In veterans, it is frequently linked to service-related injuries, repetitive strain, and psychological trauma.

Common subtypes relevant to veterans include:

- Chronic primary pain
- Chronic post-surgical/post-traumatic pain
- Chronic neuropathic pain
- Chronic musculoskeletal pain

Australian Statistics on Veterans and Chronic Pain

Recent findings from the Department of Veterans' Affairs (DVA) and the Australian Institute of Health and Welfare (AIHW) highlight the high burden of chronic pain in veterans:

- **Prevalence:** Estimates suggest that up to **60-70% of Australian veterans experience chronic pain**, significantly higher than the general population rate (~20%).
- **Suicide Risk:** Veterans with chronic pain have an **increased suicide risk**, with studies indicating a **two-to-fourfold increase** compared to veterans without chronic pain. Chronic pain often exacerbates underlying depression and PTSD, key drivers of suicide.
- **Mental Health Impacts:** Chronic pain is strongly associated with **higher rates of depression, anxiety, PTSD, substance abuse, and social withdrawal** in veterans. It is a major contributor to disability, unemployment, and family breakdown.

2. Historical Context and Psychosocial Sequelae

Historical Context of Chronic Pain in Veterans

Chronic pain in veterans is not new. Historical accounts from WWI and WWII often referred to "shell shock" cases where unrelenting somatic pain accompanied psychological trauma. Vietnam veterans reported high levels of chronic musculoskeletal disorders related to jungle warfare, heavy loads, and combat injuries. Modern conflicts (Afghanistan, Iraq, Timor, Solomon Islands) have led to increased awareness of chronic pain resulting from both combat injuries and repetitive strain from training.

Psychosocial Sequelae

Chronic pain exerts a multifaceted psychosocial toll on veterans:

- **Social Isolation:** Veterans often withdraw due to functional limitations and stigma.
 - **Employment Challenges:** Persistent pain limits work opportunities and financial security.
 - **Relationship Strain:** Chronic pain can erode intimate, familial, and social bonds.
 - **Loss of Identity:** Physical incapacity often clashes with the ‘warrior identity,’ exacerbating feelings of failure and worthlessness.
 - **Substance Abuse:** Veterans often turn to alcohol, opioids, and illicit drugs in attempts to self-manage pain.
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3. Clinical Case Examples

Case 1: Phantom Limb Pain in a Combat Veteran

John, a 35-year-old infantry soldier, lost his leg in an IED blast in Afghanistan. Despite amputation, he experiences **severe phantom limb pain**, described as burning and electric shocks in the absent limb. Psychological factors (PTSD, grief over injury) amplify the pain perception. Rehabilitation is complicated by sleep disturbance, depression, and frustration at his prosthesis limitations.

Case 2: Opiate Addiction from War-Related Injury

Peter, a 42-year-old veteran, sustained multiple back and knee injuries during service. Initially prescribed opioids post-discharge, he developed **opioid use disorder**. Now dependent on high-dose oxycodone, he experiences withdrawal symptoms, deteriorating mental health, and escalating pain due to opioid-induced hyperalgesia.

Case 3: Chronic Regional Pain Syndrome (CRPS) from a Minor Injury

Sarah, a 29-year-old logistics officer, developed CRPS after a minor ankle sprain during training. Despite trivial initial injury, she suffers **intense, burning pain, swelling, colour changes, and hypersensitivity** in the foot. She faces disbelief from peers and struggles with anxiety, depression, and loss of career aspirations.

4. Symptoms and Comorbidities of Chronic Pain

Common Symptoms

- Persistent, often disabling pain (burning, stabbing, throbbing)
- Fatigue and poor sleep
- Cognitive impairments (“brain fog”)
- Mood disturbances (irritability, low mood)
- Reduced mobility and physical capacity

Comorbidities

- **Depression:** Present in 50-70% of chronic pain cases

- **Anxiety Disorders:** Generalised Anxiety Disorder, Panic Disorder frequently co-occur
 - **Post-Traumatic Stress Disorder (PTSD):** Strongly intertwined with pain, both exacerbating each other
 - **Substance Use Disorders:** Alcohol, opioids, benzodiazepines misuse is common
 - **Moral Injury:** Internal conflict and guilt from military experiences can exacerbate pain perceptions
 - **Insomnia and Sleep Disorders:** A vicious cycle with pain
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5. Psychiatric Comorbidity: Alcohol, Drugs, Depression, PTSD, Anxiety, Moral Injury

Alcohol and Drug Abuse

Veterans with chronic pain often use substances to manage distress, leading to dependency. Prescription medication misuse (opioids, benzodiazepines, stimulants) is particularly concerning.

Depression

Pain and depression form a cyclical relationship: pain worsens mood; depression heightens pain sensitivity.

PTSD and Anxiety

Hyperarousal and re-experiencing symptoms in PTSD amplify chronic pain perception through nervous system sensitisation.

Moral Injury

Feelings of shame, betrayal, or ethical conflict (e.g., actions in combat) can manifest in somatic pain as part of complex grief responses.

6. Clinical Interventions

Psychological Therapies

- **Cognitive Behavioural Therapy (CBT):** Gold-standard for chronic pain; targets maladaptive thoughts, pain catastrophising, and fear-avoidance.
- **Acceptance and Commitment Therapy (ACT):** Helps veterans focus on values-driven action despite pain.
- **Dynamic Psychotherapy:** Useful for veterans with unresolved trauma or moral injury.
- **Family Therapy:** Addresses relational strains and improves support networks.
- **Mindfulness-Based Stress Reduction (MBSR):** Improves pain tolerance, reduces distress.

Lifestyle Medicine

- **Diet:** Anti-inflammatory diets (Mediterranean, whole foods-based) show modest benefits.
- **Exercise:** Tailored programs (graded activity, strength, flexibility) enhance function and mood.
- **Yoga and Tai Chi:** Improve mobility, pain, and emotional wellbeing.
- **Nature Therapies (Forest Bathing):** Shown to reduce pain-related stress.
- **Meditation and Mindfulness:** Reduces pain catastrophising and improves coping.

Medications (Non-Opiate-Focused)

- **Antidepressants:** SNRIs (duloxetine), TCAs (amitriptyline) for neuropathic and widespread pain.
- **Anticonvulsants:** Gabapentin, pregabalin for neuropathic pain.
- **Topicals:** Capsaicin, lidocaine patches for localised pain.
- **Anti-inflammatories:** NSAIDs cautiously used.
- **Medical Cannabis:** Emerging evidence in treatment-resistant cases.

Physical Therapies

- **TENS (Transcutaneous Electrical Nerve Stimulation):** For neuropathic pain relief.
- **Red Light Therapy:** May promote healing in soft tissue injuries.
- **Physiotherapy:** Movement re-education, strength building.
- **Massage:** Reduces muscle tension and pain perception.
- **Hydrotherapy:** Reduces pain through buoyancy and warmth.
- **Contrast Therapy:** Hot-cold exposure assists circulation and pain relief.

Supplements and Alternative Therapies

- **Omega-3s:** Anti-inflammatory benefits.
- **Magnesium:** Potential for muscle relaxation.
- **Turmeric/Curcumin:** Modest anti-inflammatory evidence.
- **Acupuncture:** Shown to reduce pain in certain chronic conditions.

7. DVA Definitions, SoPs, and Compensation

DVA and Chronic Pain Recognition

DVA acknowledges chronic pain through **Statements of Principles (SoPs)** which outline conditions linked to military service. Chronic pain itself may not be compensable unless tied to a diagnosable condition (e.g., osteoarthritis, PTSD). However, DVA recognizes the secondary mental health impacts of chronic pain as compensable.

Relevant SoPs for Common Pain Conditions:

- Lumbar spondylosis
- Osteoarthritis
- Neuropathic pain syndromes
- PTSD (with somatic symptoms)

Compensation Process

- Requires evidence linking the pain condition to service (direct injury or cumulative strain).
- Comorbid mental health claims (depression, PTSD) often strengthen cases.
- Advocacy requires careful documentation of the impact on function, work, and life.

DVA Treatment Entitlements

- White/Gold Cards cover a range of treatments for accepted conditions, including physiotherapy, psychology, exercise physiology, and approved medications.
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8. Future Directions in Prevention and Treatment

Emerging Therapies

- **Neuromodulation:** Spinal cord stimulators show promise for intractable pain.
- **Virtual Reality (VR) Therapies:** Used for both physical rehabilitation and distraction therapy.
- **Ketamine Infusions:** Potential in refractory chronic pain with depression.
- **Psychedelic-Assisted Therapy:** Under investigation for chronic pain tied to PTSD and trauma.
- **Stem Cell Therapies:** Research ongoing into regenerative possibilities for musculoskeletal injuries.
- **Biopsychosocial Integrative Programs:** Combining physical rehab, psychotherapy, and peer support in holistic models.

Prevention Strategies

- Better injury prevention in training environments.
 - Early intervention for acute pain to prevent chronification.
 - Psychological resilience programs addressing stress and trauma management.
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Conclusion

Chronic pain is a major and often invisible wound among Australian veterans, intricately linked to physical injuries, psychological trauma, and moral suffering. For advocates, understanding its complexity—from diagnostic frameworks to treatment landscapes and DVA processes—is essential in supporting veterans towards improved quality of life. Continued research, advocacy, and holistic care models are needed to break the cycle of pain, isolation, and despair that too many veterans endure.