Airing Pain Programme 82: Pain, PTSD and perfume

The emotional and physical impacts of injury and how to cope with them.

In the third instalment of our Airing Pain miniseries on military veterans living with pain we focus on the relationship between pain and psychological wellbeing. Anxiety, fear and anger are common responses to pain, but guilt and post-traumatic stress disorder (PTSD) can also be heavy burdens for ex-service personnel, explains clinical psychologist Dr Alan Barrett.

Gabriel Gadikor was caught in a rocket attack while serving in Iraq and has since suffered chronic pain and psychological trauma. He describes the coping strategies he has learnt while a patient at Dr Barrett's clinic, including using a favourite perfume to 'ground' himself when troubled by pain and difficult thoughts or emotions.

Although attitudes in the military have begun to change, it can still be difficult for servicemen and women to admit to psychological distress and many may not be coming forward to get the support they need. Gabriel urges his former colleagues facing the same issues to seek help: 'the longer you keep your problem, the more difficult it is to treat'.

This is ***Airing Pain***, a programme brought to you by Pain Concern, the UK Charity providing information and support for those of us living with pain and for Healthcare professionals.

Paul Evans: I'm Paul Evans and this is the third in a series of programmes to support Military Veterans living with chronic pain. It's funded by the MacRobert Trust and Forces in Mind Trust.

Now, by definition, the biopsychosocial model of pain implies that the biological, psychological and social environment all feed into a person's perception of pain. This means that the physical injury or trauma, that's the biological element which can led to chronic pain cannot be treated in isolation from a psychological trauma, such as many soldiers on active service might experience.

So, what help is available for those service personnel who've been damaged by both physical and psychological trauma when they leave the armed forces? There are of course services throughout the UK that provide psychological support to ex service personnel. In the North West of England The Pennine Military Veteran Service for Greater Manchester and Lancashire is in Bury. Psychologists Dr Alan Barratt is its clinical lead.

Dr Alan Barrett: We see people for psychological problems, such as depression, anxiety and trauma. However, at any one time about a third of our clients have experience of a long term health condition the most common of which is pain management. Things like early onset muscular skeletal conditions from just the exercise and activity from being in the military entails and obviously injuries, people with combat related injuries. So pain, although is not a specialty of a service like ours, is something we can't ignore and is something we have to incorporate into the management of. And as a psychologist, I'm particularly interested in the psychological aspect of what makes pain an individual experience, you know there's so many elements of pain that we can't really measure physically, so we very much rely on the subjective feedback.

Evans: That's Dr Alan Barrett Clinical Lead of the Pennine Military Veteran Service. We were joined by former service user army veteran Gabriel Gadikor. In 2007 Gabriel was serving in Iraq when he injured his back in a fitness exercise, two days later his tent was hit by a rocket.

Gabriel Gadikor: I just came out off night shift, went through the cookhouse which is where we eat, the dining hall, picked up an egg, straight to my tent for a few hours of sleep and then the rocket hit. Normally when the rocket is about to hit and it's definitely coming inside the hospital complex, there is this defence mechanism that shoots down the rockets and the mortars as a defence. It makes some sound, out of experience because we've been there for some time, when you hear that squeaky sound, you know that definitely it is in, there's nothing you can do about it, yes, so when I heard that thing, that was it.

I remember when I first got into Iraq and the rockets were coming in, I was kind of like scared from the beginning, but as time went on it became normal. If there was no rocket attack it is abnormal, yeah, so it was like 'Okay we're here now, when we die we die'. But then it had the opposite effect had happened now after we have had combat. The way I felt when I first went into Iraq for being scared, now I am scared, this is how I am feeling and by kind courtesy of this service – the Military Veterans Service – I've got the tools and the coping strategies that help me go along with life, which is very important to me.

Evans: Just explain to me just what those coping strategies are.

Gadikor: The coping strategies are the tools that I use to stop me thinking about my pain, to direct my mind off the pain because what I have been taught is if you have chronic pain, outside factors feed into it, the pain becomes worse. And one way of managing that pain is coping strategies, then for example, like this ball I'm holding I use it as a coping strategy to momentarily take my mind off the pain. As I am talking to you, I have got pain from the back

of my right leg, it's sciatic pain that I'm having, because I want to concentrate so much on what we are doing and not to be distracted I'm using this to help me stay focused rather than the pain actually taking over whatever I'm talking about.

Evans: You're holding a squeeze ball, a golf ball-sized squeeze ball.

Gadikor: Yes, that's right.

Evans: That helps focus the pain away from you.

Gadikor: That's right yes. Another mechanism I use is a grounding mechanism. Dr Barrett was my doctor who treated me for my psychological issues and help for the chronic pain, he described this as a grounding technique. Also that one is basically it helps you take your mind off the pain. It's a perfume.

He said I should choose a perfume that I like best. He described it as when you smell a perfume, how do you feel? And my answer was some form of happiness, okay, momentarily. So it's like if I'm having happiness, that happiness is taking away the pain for some moments. He described it as grounding, now it was up to me to decide which perfume I will use.

There is this perfume that I like which I wear most of the time Jean Paul Gautier but when you wear perfume for a long time you become nose blind with that perfume, so I have to choose another perfume that I like that I don't use often. So I remember going to a shop and I saw this perfume called Hollister Jake I liked it so much. A small bottle is quite expensive but anytime I smell it, that sense of joy occurs to me, you see right now, straight away I'm smelling it and my expression is all changed, so he used that to ground me so that I could pay attention or concentrate on the treatment he was giving me, which indeed helped so much.

Evans: So that's like – I don't know what the term for it is – so that's visualisation but olfactory visualisation or something like that. It's smell rather than…

Gadikor: Smell, That's right, yes. Another way I manage my pain is when I'm going on the computer, I like information rather than fiction and those things, so they keep my mind actively involved so I can capture whatever information I want to listen to or learn from. Even though the pain is in the background, my mind is *more* on those programmes rather than the pain itself.

Another useful tool that he taught me was anytime I am stressed it feeds into the pain cycle and it will make the pain worse. I remember telling him that I've got a lot of bank accounts

and I've got passwords but because of my psychological issues, I am unable to remember those passwords. I become so frustrated, it feeds into the pain cycle and then messes me up, so he came up with a very simple tool.

Actually, it's a coincidence, I've not seen him for some time, he told me to buy a small key ring that holds money – a coin holder utility – instead of money going in that, I have copied my passwords and then put them in there. I go to the bank or cash machine and I forget all I've got to do is open it up [jangle of keys] and then get a password that I want. Nobody knows what's in there, it hasn't got any identity, all it's got is numbers and that's it. I know what I have written is just to aid me to remember. It is helping so much that I don't have to worry about thinking about me forgetting my passwords and pins thereby making me not worry and become frustrated that will feed into my pain cycle.

And it helps me so much, every time I've been thinking about it I said 'I'm going to buy one and since it has been a good help to me, when I see Dr Barrett, I'll give it to him to pass on to another patient that would need it, so *'There you are doctor, please pass it on to someone* who *needs it'*.

Barrett: That's a really kind thought there Gabriel.

Evans: Alan, Dr Barrett, you're sitting next to us very, very quietly. It seems to me that a lot of the success that Gabriel has had has been nothing to do with medicine, it's been to do with sorting out little, little things in his life.

Barrett: In Gabriel's treatment the primary difficulty was psychological trauma around an incident which also involved physical trauma and what tends to happen is individuals whose pain flares up, it can trigger a psychological memory and sometimes when a psychological memory is triggered, such as watching a news item whatever, it can reconnect them with the pain experience.

So, what was happening was that I was losing Gabriel's attention sometimes in clinic because the pain was causing a cognitive distraction and causing him to ruminate or have a kind of have an intrusive thought or an intrusive image. So the perfume was a particular grounding technique, because it doesn't rely on your cognitive ability, the nose doesn't stop smelling so, if you can put something underneath it, it's very good at bringing you back to the room, the here and now to focus on what we are trying to achieve.

Gabriel mentioned about stress levels impacting on one's experience of pain and we know that psychological issues go hand in hand with pain and it's a bit chicken and egg. So, for example, having chronic pain can induce lots of emotional states. It can induce anxiety

where people are fearful that ‘what happens if I have an attack while out with my child or a collapse’, so there's a lot of fear and anxiety.

Sometimes there's a lot of anger and irritability, some of that is in relation to sort of 'why me' and to being quite begrudging as to the circumstances of how the injury may have occurred, but some of it may be just be in the pain itself. Pain impacts on sleep and we know we become a little less tolerant and we become a bit more irritable. And then, feelings such as guilt, guilt that we might be on a burden onto those that care about us.

And something I've noticed a lot in the Veteran Community in particular is almost like punishment, so there are some people who we see in the Service who may regret things they have taken part in or witnessed or maybe have failed to do in their role as a protective force. They almost maybe don't look after themselves as well as they could or should because they feel they are a bit deserving of the punishment. So we can never kind of ignore the fact that at any one time that one in three of our clients has probably got a pain related condition.

There's one further point I'd like to comment on and that's the non-psychological approaches to pain. Obviously we rely quite heavily on medications and analgesic medication and we do see a lot of people who are on very high doses and that does manage the pain for many of them quite successfully, however, it can impact on their cognitive processing. So we find it might slow down their thinking a little bit, their concentration might not be as good as we need it to be for therapy to be effective.

Though in fact, some work we did with Gabriel before we did the trauma focused element of the therapy was, we spent quite a lot of time mapping the pain and we had a bit of a pain diary, an electronic SMS text message type situation where Gabriel would get prompted at certain times of the day to kind of codify his pain and also document what kind of PRN medication etc. he had taken. And from that we got a real pattern as to what would be the optimal time for therapy to occur. So, he wasn't affected so badly cognitively from having had a large dose of pain killers so he could think clearly but the pain wasn't so bad it was interfering with the therapy. So we actually ended up picking a time of day which is quite close to the time of day we are now, which is why we also scheduled the interview for now, as being almost like an optimal time for Gabriel to be able to concentrate and focus.

Gadikor: Something I learnt as well, if you stay at home for a long time with inactivity your disability becomes worse. So, I tried to get myself involved in activities as much as I can, even if it is just coming out of the house and come and talk, like I'm talking there, it is a form

of therapy I am receiving. It is keeping me mobile and it is making me meet people, which in turn takes my mind off the pain momentarily, which is helping me, yes.

I'm travelling abroad on Tuesday, when I purchased the tickets I was alright but as the time was getting closer, I started getting anxious because I kind of like relate my trauma in Iraq to flights because when rockets are coming, they sound like aircrafts. Now, that the time is coming for me to fly, I'm having bad dreams, because I'm having bad dreams I have increased my activities about going out so that it will help me so, I go to Manchester Airport to look at the planes land and take off, just try to convince myself that that plane is not going to crash.

Anything that is out of my control, then I become anxious, so I try to do things to try to gain some control of it. Because I am thinking about all these issues, the plane and things like that, I have also noticed that my pain is also going up a bit. This confirms my psychological issues fits into the pain cycle to make it worse so, I have made everything possible to try to minimise all these effects on me. Basically, Dr Barrett has laid down the foundation and I'm building up on it.

Evans: Alan, Dr Barrett, it seems to me that Gabriel's pain is no longer ruling him, he's ruling the pain, how far has he come?

Barrett: I think he's come incredibly far. When we first met it was touch as to whether or not a trauma-focused psychological therapy was going to help with his psychological difficulties, because it was very difficult to maintain concentration during the session. Sessions might have only been 20 minutes instead of the usual 50 minutes, so we played around with a kind of pacing of sessions. So the fact that we invested the time to create an optimal opportunity for therapy to be beneficial was a good investment.

And I think what we found we did with some of the psychological difficulties which were quite pronounced and then once they lessened in severity and chronicity, we switched over and did some sessions looking at the pain and kind of try to titrate down the pain and then when the trauma became the bigger thing again we went back to the psychological and then we went back to the physical and gradually in a kind of stepped way we got to a stage where the pain was manageable and the psychological therapy had gone as far as we could have expected it could at that stage.

And what I've just heard Gabriel talking quite a lot about is about attention and I guess we think a lot about pain, we think it's very good at drawing our attention. And, obviously, if we

attend to it too much, we get drawn into it and we start ruminating about it and we start remembering we can't do certain things, etc.

So it sounds like from a behavioural point of view and also from a cognitive distraction point of view, Gabriel has become quite expert in noticing that the pain has got his attention and become aware that's what's happening and made an active decision to then switch his mind to, rather than focusing on the pain for half an hour, he's going to go online and look at some news stories and topics that interest him and at the end of that half an hour, he's got some added benefit. He's not really thought about the pain and he also maybe learned so new information which helps him greatly anyway.

Evans: What I'm thinking is that for Gabriel and other military veterans who are recommended to go for psychological support – I may be doing them a great injustice – but I wouldn't have thought they're touchy-feely people and to be offered support from a psychologist might make them... it takes a bit of time to get that into your head, that you're not mad.

Barrett: It does. I think we know the reason a service such as ours exists is because we don't really see the number of ex-military personnel in mainstream mental health or psychology services in numbers we might expect.

So, there is a problem in accessing services and we've done a lot of engagement work with the armed forces community and it's a combination. It's a combination of, there are service factors so, if you've been self-medicating to manage your difficulties by maybe drinking too much alcohol, for example, then some mainstream services may exclude you from accessing their therapy.

But there's also a lot of barriers located within the individual veteran themselves and that is sometimes not really understanding what psychological therapies is all about and kind of maybe making ill-informed associations with maybe some bad TV programmes about mental illness. But also there is also the pride and stigma issue in terms of if you've enlisted to one of the armed forces and you very much identify yourself with being a very physically powerful, fit, potent individual who helps others, it's a real shift in identity to even accept that you are no longer that person and the fact that maybe (a) you might need help and (b) you might now be vulnerable.

So we do see a number of veterans struggling with the new identity of what it is to be somebody living with long term pain, because they can feel physically vulnerable. We heard Gabriel mention that, when you go out of the house, you don't feel as confident as you used

to feel. You feel vulnerable, you feel like 'what would I do if maybe somebody attacked me? What would I do if some incident happened now and I wouldn't be able to perform to keep my children safe?' and things like that.

So, I understand that's it's difficult for ex-military personnel to come forward and consider a psychological approach. But as I said earlier the side effects of pain does cause a lot of psychological difficulties, such as low mood, anxiety, irritability and they in turn can magnify the perception of pain. So, therefore, to treat pain successfully I think really individuals should always seek a psychological component because even things such as social support available in the house or modifications that your employer is willing to make, they're not medical interventions, they are social interventions and psychological interventions and we do know from people's subjective feedback, they do actually help people to manage their pain.

Evans: Gabriel, what would you say to your former colleagues who don't know about this service, what advice would you give?

Gadikor: The first thing I'd like to say is, indeed, it's very difficult to own up and say you've got psychological difficulties because, one, the military and psychological issues go at loggerheads. The moment the military knows you have a mental health problem it is automatic discharge, no compromise with that. So soldiers who are fighting psychological issues within the army, they tend to hide it because they want to stay on within the army.

The other issue is, you are trained as a soldier: even if you are broken, you have to keep going. I've experienced this myself, I was having this issue in Iraq and doctors were seeing this, I was in serious denial: 'there's nothing wrong with me'. They wanted to send me back and I didn't want to come back I was forced to. Even when I was forced back I wasn't admitting psychological issues because it was my physical problems that was overshadowing the whole thing.

My advice to the military veterans or people who are still serving, who have got psychological issues or pain issues that are psychologically affected, all I can tell them is, the longer you keep your problem, the more difficult it becomes to treat.

Barrett: Gabriel mentioned about when the military find out that you've got a mental health problem, their reaction isn't always ideal. I have to say now in their defence that certainly recently there's a lot more attention given to the mental wellbeing of forces personnel. If you go on the MOD (Ministry of Defence) website there's lots of links now saying things like 'It's okay to talk' and stress management courses, so the culture, I'd like to think, is shifting.

We see people from all kinds of conflicts, from historic conflicts where maybe that wasn't their experience at the time but there are mental health services within the MOD. You know, some people don't have good experience of them, some people get a great service. It's a bit like any other service where there is good and bad. There's some barriers in the individual or the infrastructure locally which might not be represented somewhere else in the country.

Gadikor: I tried to hide my disability. I had insurance but this is why I don't blame the insurance company anymore because I was hiding my condition. I was presenting it a bit like I was alright, so the insurance company was thinking that I was faking my issue, eventually, the case was in my favour because this is me suffering but I tried to present myself outside as if I was not.

Even now at home, I don't like to present myself as if I am disabled because I don't want anybody to capitalise on my vulnerability. I've got blue badge, I never display my blue badge at home, I will never do it. The car I drive they put mobility stickers and everything there, I removed all of them because I do not want to present myself as a vulnerable person. I only use it when I have to use it, when there is no way of hiding it, I will not, that's how it is, it's a stigma but I want people to see me as normal, yes.

Barrett: I think it is a good idea if you're certainly a military veteran with a physical injury that can be attributed to your service. As Gabriel has pointed out, it's a really good idea to keep very good records and copies of documents, letters, reports because you will be required to provide them if you are seeking any kind of compensation or insurance claim, which obviously you have to have before you get deployed because the people who are supposed to keep these reports, don't always produce them at these hearings. So it's a very good tip to keep a hold of copies of your own medical records.

Gadikor: Because I did not complete my tour, I have still not got any closure, proper closure of the situation. Even though I'm hearing the news that the conflict is over, my head is not accepting that and the only way I think I will be able to have proper closure of this is to go to Iraq myself and then see it for myself that there is peace, the rockets are not coming any more. But at the same time I am scared of going, but I'm not having these nightmares of rockets coming in and things like that now.

Evans: That's Gabriel Gadikor speaking to me at the Pennine Military Veterans Service. I'll just remind you that whilst we in Pain Concern believe the information and opinions on ***Airing Pain*** are accurate and sound based on the best judgements available, you should always consult your health professional on any matter relating to your health and wellbeing, he or she is the only person who knows you, your circumstances and therefore the

appropriate action to take on your behalf. Don't forget that you can download all editions and transcripts of ***Airing Pain*** from Pain Concern's website, which is painconcern.org.uk

Now there are services like the Pennine Military Veterans Service throughout the UK and there are links to help you find them and other non NHS Services on Pain Concern's website. Once again it's painconcern.org.uk.

So who's eligible for these services? Dr Alan Barrett:

Barrett: The primary aim of a service like ours is to support the psychological needs of anybody who is a military veteran. Now the Department of Health definition of a veteran is anybody who has served in the services for a minimum of one day. So, that's actually a very large proportion of people, including those older adults who've taken part in National Service, they would also be included. Those that are in the reserves, formally the Territorial Army, they are all eligible to come forward and seek specialist services like ours.

As I said in the beginning, we don't specialise in pain but we specialise in psychological difficulties that are attributable to your service. So, for example, if you've got a psychological injury because of things you may have witnessed or experienced in a war zone, then you're very much eligible for a service like ours. But equally, if you've got a physical pain injury as a consequence of your military service, which in turn is now manifest in a constellation of psychological difficulties, we will offer help for that and people can literally self-refer, have any professional make a referral on their behalf and they can do that either on the website or via telephone, just put into a search engine, Pennine Care Military Veterans and we cover the North West of England and we're happy to point people to their local service nationally.

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