PTSD

SD and Chronic Pain

Jennifer Wolkin, PhD
min read

t-traumatic
ss disorder
SD) mostly
nown for its
ct on overall
ntal health.
re is
earch,
ever, to
port the fact
PTSD is
easingly
being recognized for its effect on physical wellness as well. Many who suffer with PTSD (veterans in particular) have higher lifetime prevalence of circulatory, digestive, musculoskeletal, nervous system, respiratory and infectious disease. There is also an increased co-occurrence of chronic pain in those who suffer with PTSD.

Chronic pain may be defined as pain that persists longer than three months that was initially accompanied with tissue damage or a disease which has already healed.

In 1979, the International Association for the Study of Pain (IASP) officially redefined pain as “an unpleasant sensory and emotional experience associated with actual or potential damage or described in terms of such damage.” This definition

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es into account the fact that pain olves thoughts and feelings. Pain is real ardless of whether the biological ses are known, and it is ultimately a jective experience.

n experienced by veterans is reported significantly worse than the public at e because of exposure to injury and chological stress. Rates of chronic pain omen veterans are even higher.

men are known to suffer chronic, malignant pain disproportionally more n men, so it seems intuitive that the n prevalence of chronic pain in enlisted nen is merely a consequence of being a woman.

Women veterans specifically diagnosed with PTSD had significantly higher rates of pain and overall poor health than women in the general population. There is not a lot known about the context of military culture that might have implications for women's health and health behaviors. Veteran women's increased prevalence of chronic pain probably is because their pain is compounded by extreme conditions that are not experienced by civilian women. The ability to manage chronic pain probably is severely limited within military context, such that pain is probably maintained or progressively worsens with little relief.

When chronic pain cannot be readily

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lained as the direct consequence of
ue damage, some people treating
nen veterans are apt to think it is all in
head. Although at greater risk for
eriencing PTSD and comorbid pain,
nen veterans are usually
erdiagnosed and underutilize mental
lth services. A reason cited is that
n in our progressed society, women in
position continue to be stigmatized.

n PTSD and chronic pain sufferers
n are stigmatized. They are relegated
ne outskirts of the community, and
ome liminal creatures.

lieve this is mostly a result of the esoteric and existential nature of both. They both defy what we know to be natural phenomena, and if you really think about it they are both really difficult to describe. I see time and again that those who experience either trauma or pain are perceived as victims of their own devices rather than just as sufferers.

Fibromyalgia is a common diagnosis given to women post-deployment. As such, woman are stereotyped as somatisizers (almost like latter-day hysterics) and told that their pain is elicited from the mental construct called the psyche, and not the brain.

Although the concept of somatization does not intrinsically disparage chronic pain, it has acquired a distinct secondary

aning — that pain symptoms are ggerated or feigned and, ultimately, in the control of the sufferer. A variety ocial and medical critics view chronic n in women as a post-modern illness ring a lineage with nineteenth-century udo-maladies such as hysteria. These sses, they contend, originate in nerable human psyches.

ıtral to these suspicions is the mingly unshakable belief that chronic n is a psychosomatic disorder, with the lication that the sufferer's pain is not dically real. Within this conceptual nework is the archetype of the traumatized women who experiences her trauma symptoms in her body. I urge women to take a stand against stereotyping and to pursue quality treatment despite critics who might make it seem unwarranted.

Veterans with chronic pain often report that pain interferes with their ability to engage in occupational, social, and recreational activities. This leads to increased isolation, negative mood, and physical deconditioning, which actually exacerbates the experience of pain.

PTSD, as aforementioned, is itself isolating, as the sufferer disconnects from both the self and others. Those suffering from PTSD as well as chronic pain suffer unfathomably, as they are betrayed by both their minds and bodies.

s premise (that PTSD sufferers suffer
e chronic pain) begs the question:
y are veterans and others who suffer
PTSD more likely to experience
norbid chronic pain?

l, for veterans in particular, the pain
lf is a reminder of a combat-related
ry, and therefore can act to actually
t PTSD symptoms (ie, flashbacks).
litionally, psychological vulnerability
h as lack of control is common to both
orders.

en a person is exposed to a traumatic
nt, one of the primary risk factors
ted to developing actual PTSD is the extent to which the events and one's reactions to them are unfolding in a very unpredictable and therefore uncontrollable way. Similarly, patients with chronic pain often feel helpless in coping with the perceived unpredictability of the physical sensations.

Some say that patients with PTSD and chronic pain share the common thread of anxiety sensitivity. Anxiety sensitivity refers to the fear of arousal-related sensations because of beliefs that these sensations have harmful consequences.

A person with high anxiety sensitivity would most likely become fearful in response to physical sensations such as pain, thinking that these symptoms are signaling that something is terribly wrong.

ne same vain, a person with high
iety sensitivity will be at risk for
eloping PTSD because the fear of the
ma itself is amplified by a fearful
ponse to a normal anxiety response to
trauma. It is normal to have a strong
ction to trauma, but most sufferers
ually tend to be fearful of their own
ponse.

fering, whether readily categorizable or
cribable, knows no bounds. But there
ope for recovery.

en the biopsychosocial mechanisms
licated in the co-occurrence of pain
PTSD, there have been models for integrated treatment of both pain and PTSD. These have been more effective than treating them as two distinct entities.

Soldier photo available from Shutterstock

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Hi, my name is Dr. Jen, and I'm a NYC-based licensed clinical health and uropsychologist, writer, speaker, and ofessor. I recently founded BrainCurves, initiative to inspire accurate + cessible mind-body-brain wellness eas for all women and all of our pporters. Let's journey together towards more holistic, healthy and happy life! u can read my blog and learn more out BrainCurves on my site niferwolkinphd.com and join us on cial media via Twitter [https://twitter.com /BrainCurves], Facebook [https://www.facebook.com/BrainCurves], and Instagram [https://instagram.com /braincurves/].

APA Reference
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