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Pain, avoidance, and suffering

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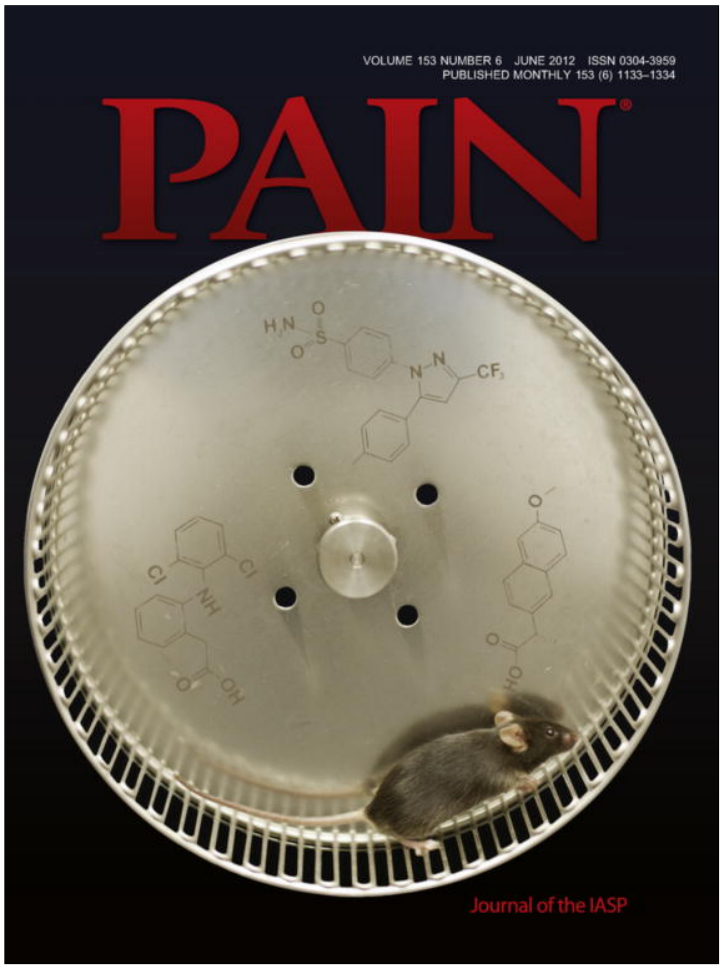

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Commentary

Pain, avoidance, and suffering

In this issue of PAIN, Drs. Vlaeyen and Linton [2] present a cogent review of research regarding the fear-avoidance model of chronic musculoskeletal pain, a model that Dr. Vlaeyen has pioneered. The model was developed in order to explain how persistent fear-based avoidance behavior could produce much of the suffering and disability associated with pain states. They highlight the key role of fear in developing pain avoidance behaviors. Pain can be considered an unconditioned stimulus (US) that activates immediate reactive measures in the acute setting. In the longer term, conditioned stimuli (interoceptive, exteroceptive, or proprioceptive) become associated with the US and then conditioned responses, such as fear/avoidance result from exposure to the conditioned stimuli. Direct experience or indirect experience, such as verbal information or observations, may influence fear, avoidance, and pain perceptions. The authors review a number of studies demonstrating the powerful effects of such indirect experience in research settings. They describe how in vivo exposure procedures have emerged as an important means of reducing fear-induced avoidance behaviors associated with pain.

The model joins the latest generation of psychotherapies that focus on acceptance, mindfulness, and decreased experiential avoidance. For example, in current cognitive behavioral approaches to anxiety disorders, individuals learn techniques to decrease experiential avoidance of feared situations. For instance, individuals may fear a phobic object, a social situation, or a panic attack. The fear may increase with time, leading the individual to have marked avoidance, such as agoraphobia in panic disorder. In the cognitive behavioral therapies with the most success, the individual gradually increases his or her exposure to the feared situation, and as a consequence learns that no catastrophe ensues. Individuals with panic disorder may still have panic episodes, but they do not have to experience them as catastrophic events to be avoided at all costs. Vlaeyen and Linton note that similar exposure therapies have shown significant success in diminishing the disability associated with physical pain.

In Acceptance and Commitment Therapy (ACT), [1] individuals learn to identify important values in their life, and to allow these values to be naturally positive reinforcers. For example, identifying an occupation that one cherishes or a family that one loves is a very different value-orientation for the individual's life than is getting pain relief. Many, if not most, patients coming to pain clinics have narrowed their life focus to the latter. In the ACT approach, individuals learn that they can continue to focus on their values, despite pain. They are taught techniques for shifting perspective (''defusing'') on painful sensations, affective states, and thoughts. The emphasis is not on pain management but rather on being able to advance one's values despite pain. Individuals begin to view ''pain scripts'' as just thoughts, not as absolute facts. The thought that one must be free of pain before one can have a meaningful life is, therefore, just an idea. Similarly, ''avoid any stress until you are free of pain'' is another common thought in individuals with pain. Viewing such thoughts as facts often brings disability and depression, whereas viewing these ideas as just thoughts, frees the individual to move on with their life values.

In Mindfulness-Based Cognitive Therapy (MBCT), [3] individuals suffering from major depressive disorder learn that much of their suffering is similarly due to avoidance behaviors. For example, a depressive state has emotional pain associated with it, but the reaction to that pain frequently amplifies the suffering considerably. ''Why do I have this'', ''I must be a weak person'', ''I'll never get better'', are all common self-statements in depression. MBCT teaches the individual to focus on the present moment–not the past or future, so that ruminations about such are diminished. MBCT also teaches individuals to decrease avoidance and accept their emotional distress as painful, but not catastrophic or forever. Paradoxically, by not trying to avoid the depressive state, it is actually easier to begin moving on from it. It is important to recognize that acceptance is not the same as resignation. For example, an alcoholic has to accept the reality of his condition before he will be able to begin to respond to it skillfully. Avoiding acceptance dooms him to continue in his pathological state.

MBCT, similar to ACT, teaches individuals techniques to view their thoughts as just mental events, not facts. Individuals learn, through mindfulness meditation, to watch their thoughts emerge into consciousness and then drift out of consciousness, like clouds drifting through one's field of vision. This ability allows the individual to shift their relationship to their thoughts and not automatically accept the thought content as fact, particularly the negative cognitions so common in depressive states. Mindfulness meditation has also been shown to reduce pain unpleasantness ratings more than pain intensity ratings, suggesting the ability to modulate different aspects of the pain experience, perhaps by engaging different areas of the brain [5].

Buddhist scholar Shinzen Young [4] has taught that Suffering = Resistance $\times$ Pain, where the pain may be physical or emotional. What we have learned is that much of the suffering that takes place is not due to the noxous/injury stimulus itself, but rather to attempts to avoid it. Reducing the resistance to and tolerating the painful stimulus may, in fact, be the most effective means of reducing the suffering.

In summary, Vlaeyen and Linton's fear-avoidance model for pain highlights therapeutic interventions aimed at decreasing avoidance through enhanced exposure to fear-induced behaviors. The model joins a growing movement aimed at enhancing function through decreased fear and experiential avoidance. In this

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approach, suffering can be decreased, not only by efforts aimed at decreasing the initiating stimulus, but also by altering the reactions to it.

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