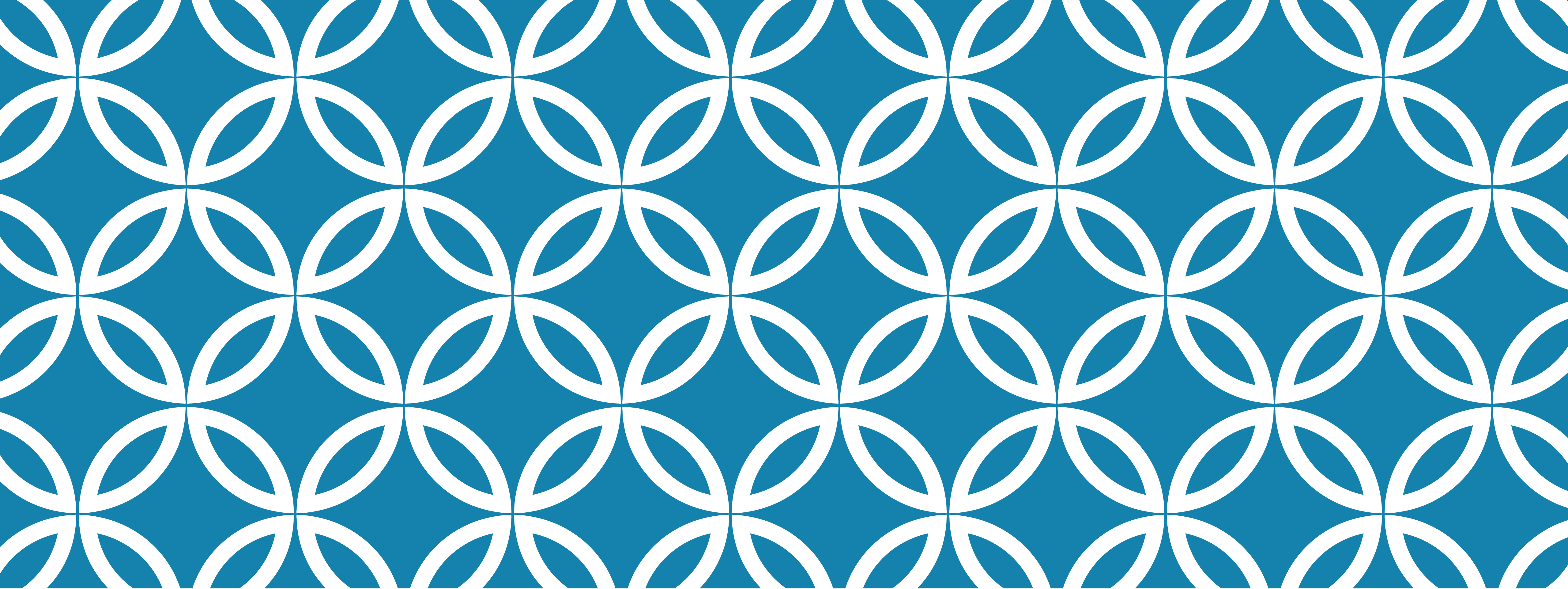
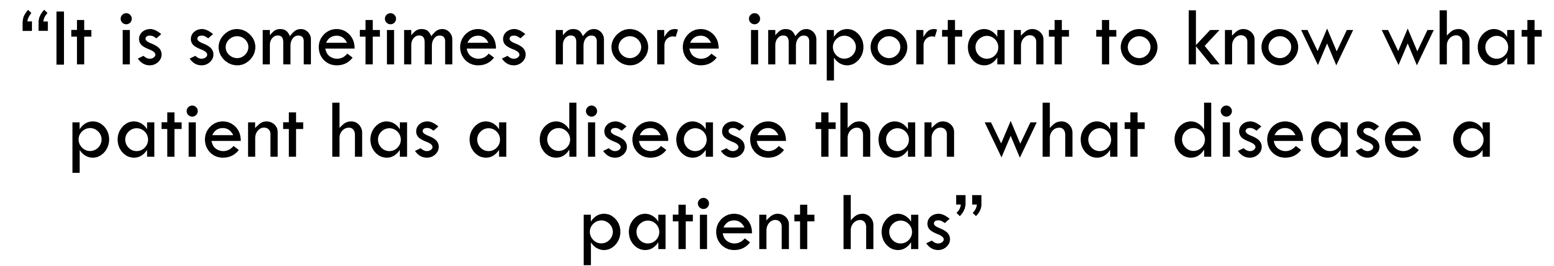


MINDFULNESS AND PAIN: USING ACCEPTANCE AND COMMITMENT THERAPY AS A TOOL TO COPE WITH PHYSIOLOGICAL AND PSYCHOLOGICAL PAIN

David RM Trotter, PhD



- William Osler

OBJECTIVES

- Describe the differences between the biomedical and the ACT definitions of pain
- Discuss the differences between psychological inflexibility and flexibility
- Practice basic ACT skills based on an understanding of the "Hexaflex"

1. Background and definitions
2. Psychological flexibility
3. ACT based skills

WHAT IS CHRONIC PAIN

Acute Pain

- Pain lasting less than 3-6 months

Chronic Pain:

- Pain lasting more than 3-6 months
- Chronic pain may be caused by an initial injury (e.g. back injury, sprain, illness); however, there may be no clear cause

(NIH, 2011)

PAIN AND PUBLIC HEALTH

Pain

- 50 million Americans struggle with pain
- Pain is involved in about 80% of all doctors visits
- $150 billion in direct health care costs

Chronic pain is a serious public health concern

- Point prevalence: 10-20% of the US population
- Accounts for about 15% of all lost work days
- Accounts for about 18% of early retirements

(Gatchel, 2007; Pfingsten & Hidebrandt, 2004; van Hecke, Torrance, & Smith, 2013)

PAIN PSYCHIATRIC COMORBIDITY

Depression: 30-54% of those with chronic pain also meet criteria for a depressive disorder.

Anxiety Disorders: Higher rates of PTSD, Panic Disorder, and Agoraphobia among those with chronic pain

Suicide: 4-5x increase in SI with abdominal pain, but decreased SI with neuropathic pain (likely associated with an identifiable disease process).

Substance use Disorders among those receiving opiate treatments (CLBP): Current- 23%, Lifetime- 54%

Aberrant Drug Behaviors: 5 -24%

(Martell et al., 2007; Sharp J. & Keefe B., 2006)

TYPICAL RESPONSES TO PAIN

Acute Pain

Acts as a biological warning that signals biological harm, increases awareness, and calls for action

Typical Response: Avoidance of pain, rest, care seeking, limit movement

Chronic Pain

Acts as a signal of harm in the same way that acute pain does.

Typical Response: Same as acute pain

The Problem: We are programed to respond adaptively to acute pain, but not chronic pain

TYPICAL RESPONSES TO PAIN

Problems with responding to acute and chronic pain in the same ways…

There is often no "fix" for chronic pain… so care seeking behaviors can become maladaptive (e.g. doctor shopping, sick role becomes part of identity)

Patients are looking for a medical remedy, and can reject other effective modalities

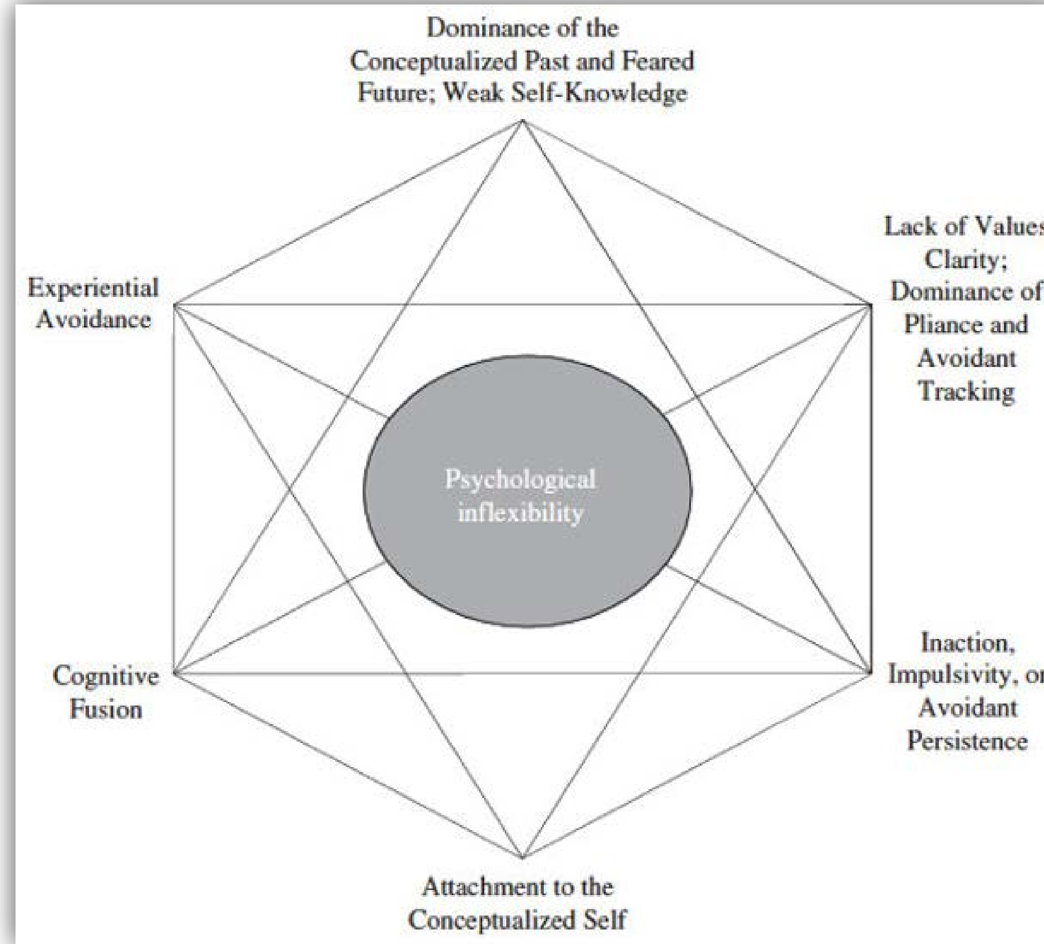
Avoidance and rest leads to deconditioning, which can exacerbate pain and dysfunction

While opiates are extremely effective for acute pain, they can cause tolerance, dependence, and even hyperalgesia when used for chronic pain

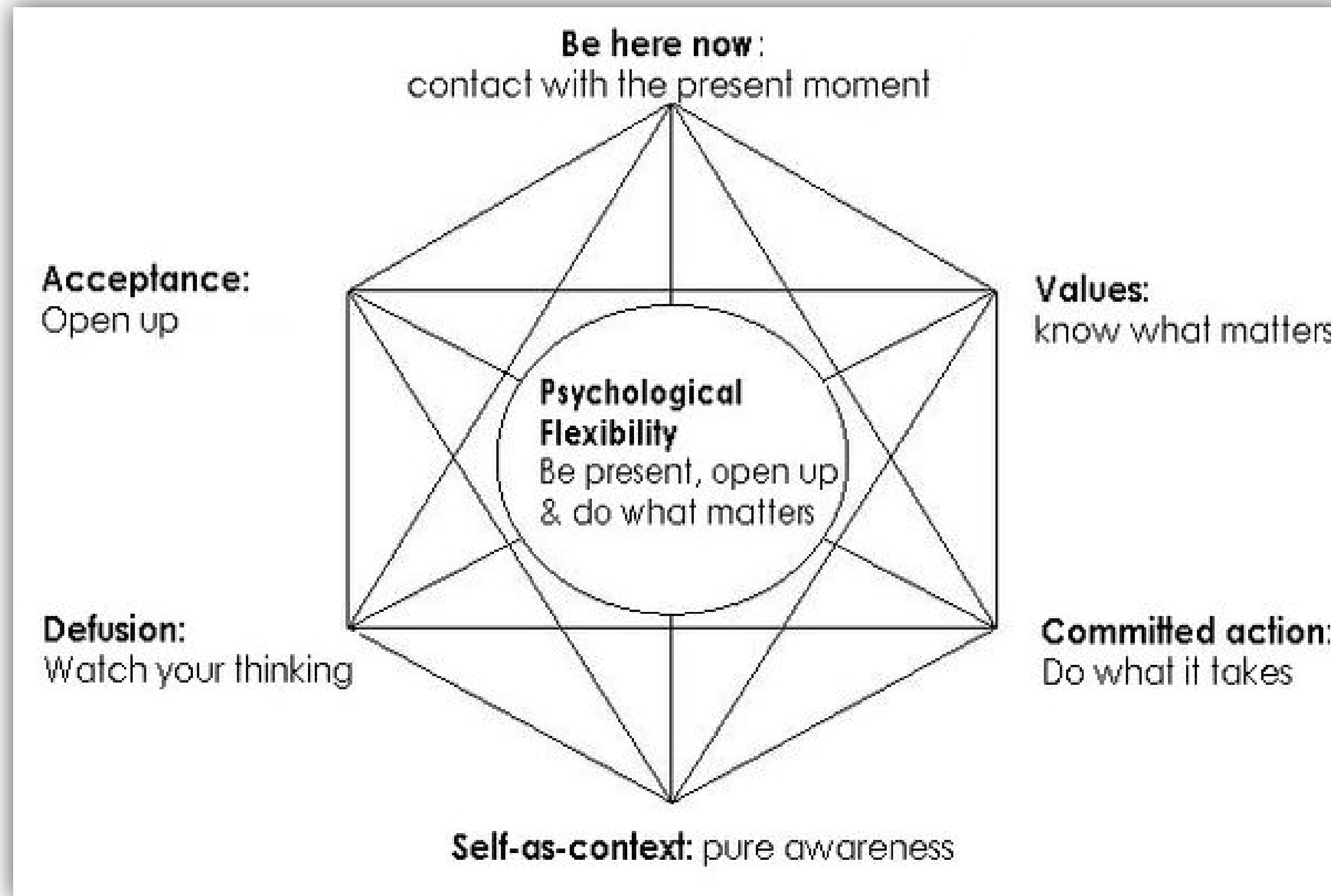
ACT: PAIN VS. SUFFERING

Pain ≠ Suffering

ACT Model of Human Suffering



ACT Hexaflex



PAST/FUTURE FOCUS VS PRESENT MOMENT AWARENESS

"Reliving" the past, how we have conceptualized it

Trying to "figure out" why things have happened the way they did

Wishing that we could "change" what we or another did

Fantasizing about the future

Worrying about what might happen

Planning

PAST/FUTURE FOCUS VS PRESENT MOMENT AWARENESS

To be psychologically present: consciously connected with and engaged in what ever is happing in the moment, in both physical and psychological worlds. (Harris, 2009)

Key elements:

- Commitment to focus
- Moment-to-moment orientation
- Nonjudgmental stance

“Mindful Breathing”

AVOIDANCE VS ACCEPTANCE

Experiential Avoidance is trying to get rid of all of the “unwanted” stuff we carry inside our skin. This can include psychological (e.g. memories, feelings, thoughts) or physical (e.g. pain, discomfort) experiences.

Experiential Acceptance is when we “open up” or “make space” for all the unwanted internal experiences. This allows us to “drop the struggle” with these experiences, freeing us to do something else.

ACCEPTANCE ROLE PLAYS

Tug-of-war

COGNITIVE DEFUSION ROLE PLAYS

Deliteralization Exercises

- Lemon Exercise

FUSION VS DEFUSION

Cognitive Fusion: Entanglement with our thoughts, memories, and images so that they dominate our awareness and drive our awareness.

Cognitive Defusion: Take a step back, and get some space between you and your thoughts, images, memories, and sensations. Get some “breathing space,” so that you can choose to behave in different ways.

CONCEPTUALIZED SELF VS SELF-AS-CONTEXT

Conceptualized Self, or Self-as-Content: When we hold onto the stories or our lives so tightly that we fail to notice that we are not in fact the story. When we view the content of our thoughts, memories, images as being who and what we are.

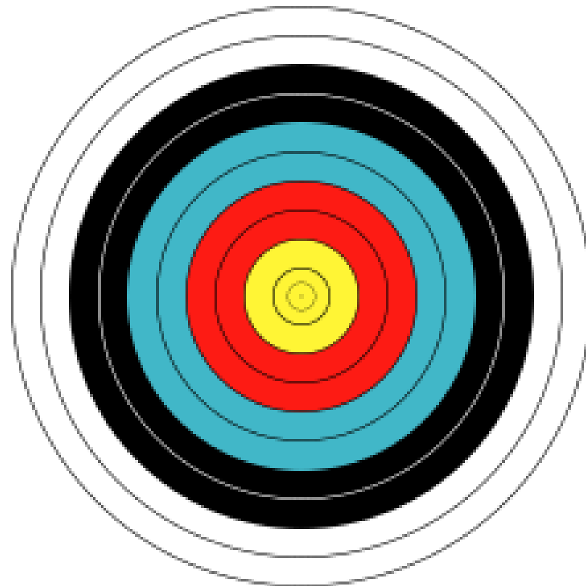
Self-as-Context, or Pure Awareness: The unchanging part of everyone that can observe what is happening. The difference between the "thinking self" and the "observing self." This is the part of you than can engage in tasks like "metacognition."

"Chess Game"

UNDEFINED VALUES VS DEFINED VALUES

Undefined Values: Loosing touch with what is important to you, and basing your behavior more on avoidance and fusion than on anything else.

Defined Values: Knowing what matters most to you. Knowing your desired *qualities* of behavior. *Not to be confused with "goals."*



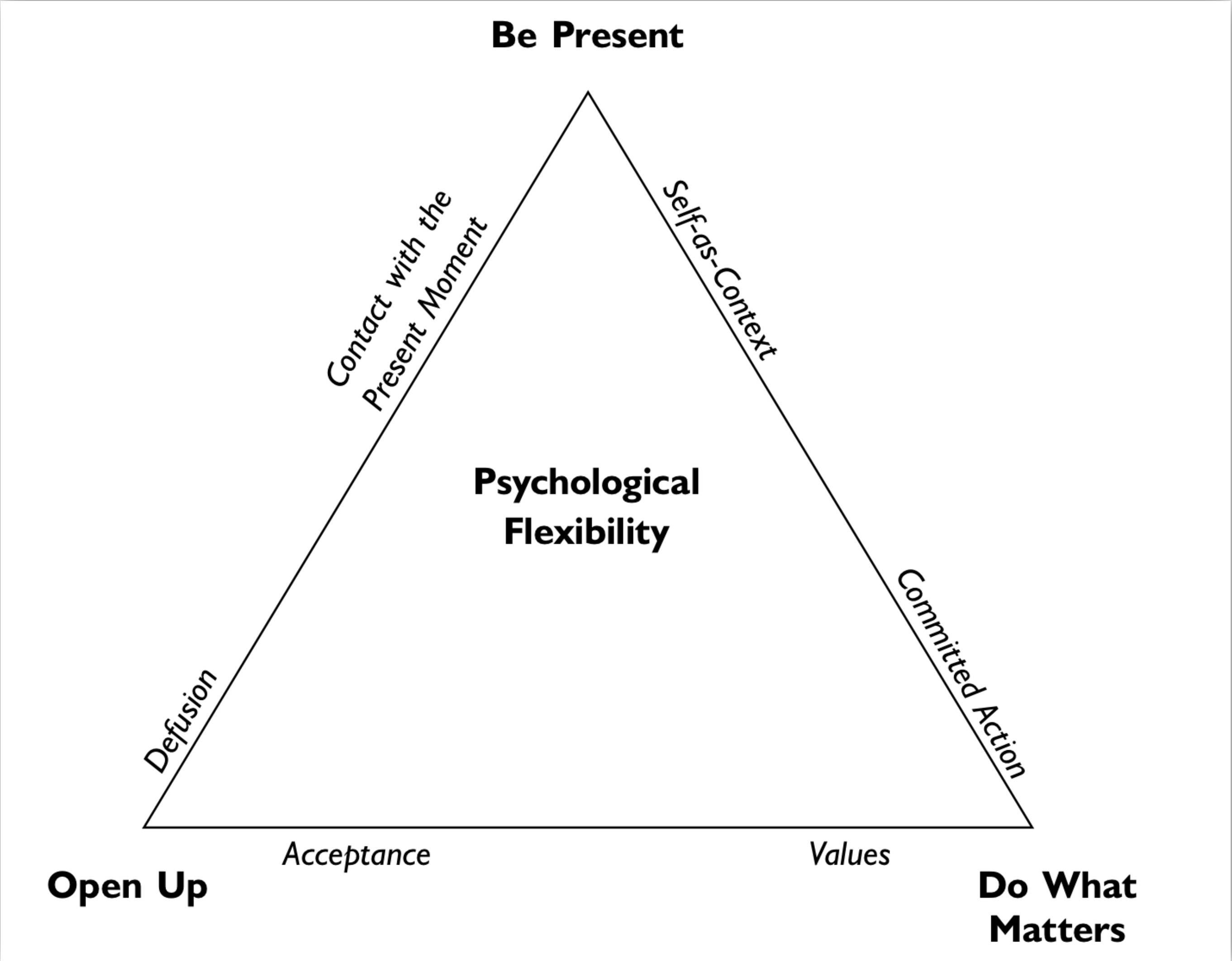
UNWORKABLE ACTION VS COMMITTED ACTION

Unworkable Action, or Unworkable Agenda: When our patterns of behavior are driven by avoidance of what we have in the moment. This can take the form of many pathological behaviors including drugs/EtOH, isolation, impulsive or risky actions, suicide attempts, seeking counseling, and so on.

Committed Action: When our patterns of behavior are consistently and effectively moving us toward our declared values. In other words, doing what is important to us, even if our minds tell us that we don't "feel" like it.

"Quicksand Metaphor"

"Perfect Anxiety Machine"



Be Present
Contact with the
Present Moment
Self-as-Context
Psychological
Flexibility
Defusion
Committed Action
Acceptance
Values
Open Up
Do What
Matters

"Physicalizing"

"Body Scan"

"Grounding"

QUESTIONS?

BIOPSYCHOSOCIAL MODEL: THE VIEW FROM 30,000 FEET

How you care for patients depends on how you understand health and human problems

Biomedical Model Assumptions

1. Biological Reductionism: health problems are only explainable by analysis and reduction to smaller cellular and molecular parts.
2. Dualism: The mind and body are separate and distinct entities.

BIOPSYCHOSOCIAL MODEL: THE VIEW FROM 30,000 FEET

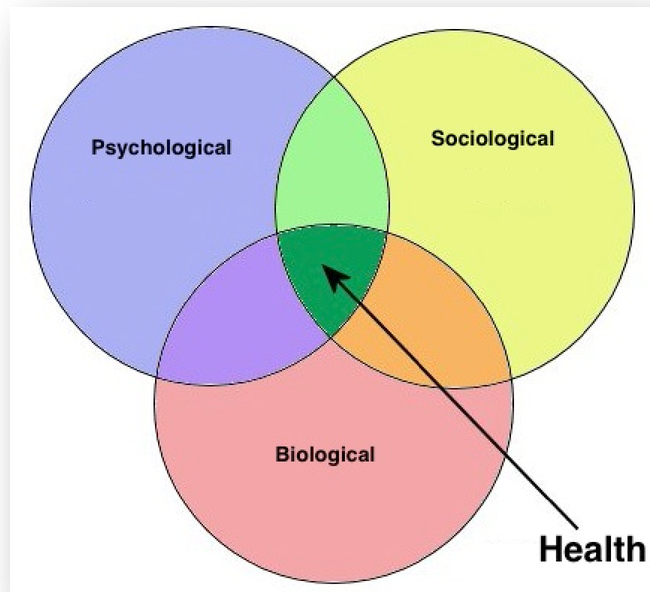
Natural Consequences of the biomedical model:

- “Magic bullet solutions”
- “Cures”
- A drive to be “right”
- Discomfort with uncertainty
- A tendency to ignore the “noise”
- Increased healthcare costs

BIOPSYCHOSOCIAL MODEL: THE VIEW FROM 30,000 FEET

Biopsychosocial Model Assumptions

- General Systems Theory: Assumes a complex, reciprocal relationship between the mind and body; a holistic perspective; health problems are at once a biological, psychological, and social experience



(Engel, 1977)

BIOPSYCHOSOCIAL MODEL: THE VIEW FROM 30,000 FEET

Natural Consequences of the biopsychosocial model:

- Complex problems need complex solutions
- “Noise” becomes data
- Increased comfort with uncertainty
- Knowledge that you do not have the “right” answer