Adaptation to Chronic Pain

Why Positive Emotions Facilitate
Adaptation to Chronic Pain

Part of the problem underlying the relative neglect of positive emotions in the papers that comprise the special issue is the narrow conceptualization of what constitutes a positive emotional state, and how such states help define psychological well-being. If one adopts a simple framework for understanding human emotion in which positive is the opposite of negative, then attention to the distress signaled by negative states is all one needs to attend to when designing and evaluating clinical interventions. Watson and Tellegen (1985), among others, have made it plain what clinicians have long known: There is tremendous variability in people’s emotional lives. Though emotion researchers will disagree on what are the best ways to dimensionalize emotion categories, most would agree that emotions have more than one dimension.

Of interest to pain researchers, as well as those who study emotion, is why positive emotions are beneficial during difficult times. Davis, Zautra, and Smith (2004) have proposed the dynamic model of affect (DMA) to account for how positive states influence adaptation to stressors like chronic pain. In contrast to other models of stress and coping, which view emotional adaptation entirely in terms of regulating psychological distress, the DMA takes into account both negative and positive states in the stress process. The model predicts that under ordinary circumstances, positive and negative emotions are relatively independent, whereas under conditions characterized by uncertainty, including pain and stress, an inverse correlation between positive and negative emotions increases sharply. Applications of the DMA in chronic pain populations have demonstrated that the inability to sustain positive states during times of high pain increases vulnerability to negative affective states and future pain episodes (for a review, see Davis, Zautra, et al., 2004). By contrast, the experience of positive emotions appears to foster adaptive recovery from pain (Zautra, Smith, Affleck, & Tennen, 2001; Zautra, Johnson, & Davis, 2005).

How Positive Emotions Arise in the Context of Chronic Pain

What factors are implicated in the maintenance and recovery of positive emotions in the face of pain? Growing evidence suggests that certain psychological attributes that allow for differentiation of positive and negative affect may prove beneficial for those with chronic pain. In an early investigation, Zautra et al. (2001) followed a sample of 175 women with rheumatoid arthritis (n = 81) or osteoarthritis (n = 94) over a 20-week period. Women reporting greater mood clarity, an aspect of emotional intelligence that reflects the ability to identify and understand specific emotions, exhibited greater differentiation of positive and negative affect. Ong, Bergeman, Bisconti, and Wallace (2006) reported similar effects for psychological resilience, a stable trait characterized by the ability to overcome and bounce back from adversity. Specifically, higher levels of trait resilience predicted a weaker association between positive and negative emotions and were linked to faster negative emotional recovery from stress. Taken together, these data suggest that those with greater mood clarity and trait resilience have a tendency to (a) experience positive emotions even in the midst of significant challenge, such as daily episodes of severe pain, and (b) draw on such experiences to resourcefully rebound from stressful circumstances.

Intervention Implications for Chronic Pain

A focus on positive emotions has implications for existing psychological pain interventions, as described in the special issue on chronic pain and psychology. For example, Davis and colleagues (2004) suggested that stress reduction techniques, such as mindfulness training, may offer a means of broadening emotional awareness and, thus, help to preserve positive emotional engagement, especially during times of high pain, a prediction borne out in recent randomized controlled trials with pain patients (e.g., Davis & Zautra, 2013). Moreover, to the extent that positive emotions serve to counteract catastrophizing cognitions that are frequently triggered by pain episodes (Ong, Zautra, & Reid, 2010), there may be benefit from expanding standard cognitive–behavioral therapy interventions to include a focus on positive emotions. Indeed, such interventions may prove to be particularly important for patients with specific chronic pain conditions, such as fibromyalgia, who show a core affective disturbance that is characterized by an overall deficit in positive emotion (Finan, Zautra, & Davis, 2009). More generally, what the literature we review advocates are pain studies and interventions that hew to a two-dimensional view of pain patients’ emotional well-being, one not defined solely by how much pain and distress they experience, but also by how well they attend to the personal goals and social relations that give meaning and value to their lives.

Concluding Remarks

More than 3 decades ago, Lazarus, Kanner, and Folkman (1980) suggested that under intensely stressful conditions, positive


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Chronic Pain and the Adaptive Significance of Positive Emotions

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The February–March 2014 special issue of the American Psychologist featured articles summarizing select contributions from the field of psychology to the assessment and treatment of chronic pain. The articles examined a range of psychosocial and family factors that influence individual adjustment and contribute to disparities in pain care. The reviews also considered the psychological correlates and neurophysiological mechanisms of specific pain treatments, including cognitive–behavioral therapy, hypnosis, acceptance and commitment therapy, mindfulness, and meditation. Although a number of articles emphasized the role that negative states of mind play in pain outcomes, positive emotions were given only brief mention. Here, we provide a rationale for the inclusion of positive emotions in chronic pain research.

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emotions may provide an important psychological timeout, help to sustain continued coping efforts, and replenish vital resources that have been depleted by stress. Until recently, there has been little empirical support for these ideas. Foundational evidence for the adaptive significance of positive emotions is beginning to accrue, however. We believe that targeted pain intervention strategies that assist clients in finding ways to enhance and sustain positive emotions are likely to play an important role in minimizing the burden of pain, fostering emotional recovery from stress, and improving the overall functioning of those with chronic pain.

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**Tarasoff’s Catch-22**

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Bersoff (2014) poses a much-needed challenge to the rationale of laws based on *Tarasoff v. Regents of the University of California* (1976), which exist in most states and require therapists to warn the intended victim, police, and/or others when a patient voices serious threats of violence. He argues that these laws may interfere with therapy by deterring patients from revealing violent intent, given the ethical duty of therapists to inform new patients of exceptions to confidentiality. As an alternative to the mandate that therapists disclose such threats, Bersoff proposes “discretion to disclose” (p. 461). He discusses sensible options short of violating confidentiality, such as seeking consultation, recommending hospitalization, and extending therapy sessions to manage imminent threats. If these fail, the therapist could then exercise the option to disclose (p. 466).

Regarding assurances of privacy, however, discretionary disclosure may not offer patients much over mandated disclosure. Properly warned of confidentiality exceptions via informed consent, patients would clearly perceive the dangers of revealing violent intent whether the therapist may or must disclose it, making its discussion and treatment remote at best. In examining this problem in relation to mandated disclosure, Bersoff (2014) quotes from the dissent in the *Tarasoff* decision itself (p. 464):

> It becomes clear the duty to warn imposed by the majority will cripple the use and effectiveness of psychiatry. Many people, potentially violent—yet susceptible to treatment—will be deterred from seeking it; those seeking it will be inhibited from making revelations necessary to effective treatment (*Tarasoff v. Regents of the University of California, 1976*, p. 360).

Bersoff also quotes the dissent’s prediction: “The majority’s duty to warn . . . will result in a net increase in violence (*Tarasoff v. Regents of the University of California, 1976*, p. 361).” And he quotes past American Psychological Association president Max Siegel’s condemnation of the *Tarasoff* decision (p. 466): “If the psychologist had accepted the view of absolute, inviolate confidentiality, he might have been able to have kept Poddar [Tarasoff’s killer] in treatment, saved the life of Tatiana Tarasoff, and avoided what was to become the *Tarasoff* decision (Siegel, 1979, p. 253).”

With all that said, it should be noted that the demise of inviolate confidentiality was not rooted in the *Tarasoff* decision. The horse was long out of the barn, and we psychologists had helped open the door. The first iteration of the *Ethical Standards of Psychologists* (American Psychological Association, 1953) states, “The psychologist should guard professional confidences as a trust and reveal such confidences only . . . when there is clear and imminent danger to an individual or society” (p. 55). In fact, when Poddar’s psychologist threatened to hospitalize him, and when the psychologist’s supervisor subsequently informed police of Poddar’s threats (Bersoff, 2014), they were acting in accordance with this standard. What the *Tarasoff* decision added was the therapist’s duty to warn the intended victim (Herbert, 2002).

Be that as it may, Bersoff (2014) stops short of arguing for inviolate confidentiality, stating, “It is a bit too late to think the law will support [it]” (p. 466). Yet laws and codes of conduct can change when lives are at stake, and current rules may imperil lives by deterring patients who are experiencing violent urges from seeking help from the very cultural institution designated to provide it.

A better rule would require disclosure of serious violent threats only with a patient’s consent. With patients willing to have their violent threats disclosed, if any exist, the result would be the same as with the present mandate, under which patients given proper informed consent will undoubtedly divulge reportable intentions only if they are willing to have them disclosed. But with patients unwilling to have their violent threats disclosed, the result would be beneficially different. Under mandated or discretionary disclosure, they are unlikely to reveal serious violent intent or even seek therapy. But if disclosure could occur only with consent, therapy would be a safe place for them to obtain help.

This better rule might usefully apply in other instances in which confidentiality is currently violated. Properly informed patients will not today reveal that suicidal intent is imminent if they are unwilling to be hospitalized—a situation I have encountered in practice. People who sexually abuse children but would consider seeking help presently have the fraught choice of...