

UNC School of Social Work Clinical Lecture Institute

**Dialectic Approach to Distress:**  
**How to Translate & Apply What We Know About**  
**Emotional Suffering to Chronic Physical Pain**  
with Deborah Barrett, PhD, LCSW

Friday, March 17, 2017  
UNC School of Social Work

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Schedule

- 9:00- 10:15 – Dialectic approach to pain management: evidence and theory  
*break: 10:15 – 10:30 am*
- 10:30 – 12:00 – Distress (or dysregulation) as its own concept; brain science applied to clinical practice; pain gate as science and metaphor  
*LUNCH 12:00 – 1:00 pm*
- 1:00 – 2:30 – Adapting tools from 3rd wave behavioral approaches: validation; behavior chains  
*Break: 2:30 – 2:45 pm*
- 2:45 – 4:00 – Adapting tools from 3rd wave behavioral approaches: skills, skills, and more skills
- 4:00-4:30 – Further application and conclusion

*1. Why Dialectical  
approach to  
Chronic Pain?*

Evidence Basis

Treatment for chronic pain, anxiety, depression



Evidence-Based intervention: DBT

- Dialectical behavioral therapy (DBT)
  - Emotional dysregulation: lots of evidence
  - Trans-diagnostic approach
  - Chronic pain – nascent attention
    - E.g., Linton, S. J., & Fruzzetti, A. E. (2014); Linton, S.J. (2010)
- missing?
  - explicit focus on physical sensation
  - translation to physical pain

Evidence-Based interventions, cont.

- Cognitive behavioral therapy for Chronic Pain (CBT-CP)
  - Behaviors: sleep, exercise, pacing, relaxation, pleasant activity, goal setting, etc.
  - Cognitions: restructure “maladaptive” beliefs and pain cognitions
  - Coping: reduce guarding and avoidance
  - Evidence: reduces pain and increases function, 1980s +

Relevance to DBT?  
Missing?


Evidence-Based interventions, cont.

• Mindfulness-based stress reduction (MBSR)

• Jon Kabat-Zinn

• Practice: mindfulness meditation. Graduated awareness practice. Start with breath, then expand to all experiences.

• Evidence: spontaneous coping responses, and symptom reduction (pain, fatigue, depression, anxiety).



relationship to DBT?

MBSR v. CBT v. usual care group (Cherkin, et al., 2016)

Comparison:

• 342 randomized (20-70 yr old) with chronic low-back pain

• 8 week groups. Significant improvement at 26 weeks and 52 weeks

• No significant differences in outcomes for MBSR and CBT

Cherkin D.C., Sherman K.J., Balderson B.H., Cook A.J., Anderson M.L., Hawkes R.J., Hansen K.E., Turner J.A. (2016). Effect of Mindfulness-Based Stress Reduction vs Cognitive Behavioral Therapy or Usual Care on Back Pain and Functional Limitations in Adults With Chronic Low Back Pain A Randomized Clinical Trial. *Journal of the American Medical Association*, 315(12):1240-1249.

Evidence-Based interventions, cont.

• Acceptance and Commitment Therapy (ACT)

• Steven Hayes; applied to pain: Lance McCracken

• Value-based life, even with pain, fear, etc. (it's not about controlling or avoiding pain)

• Acceptance → greater function, and reduction in symptoms

• evidence: 11+ RCTs and numerous uncontrolled trials



relationship to DBT?

Hughes, L. S., Hughes, L. S., Clark, J., Colclough, J. A., & Dale, E. (2016). The clinical journal of pain: Acceptance and commitment therapy (ACT) for chronic pain: A systematic review and meta-analyses. *Raven Press*.


Evidence-Based interventions, cont.

• Mindful self-compassion (MSC)

• Kristin Neff and Christopher Germer

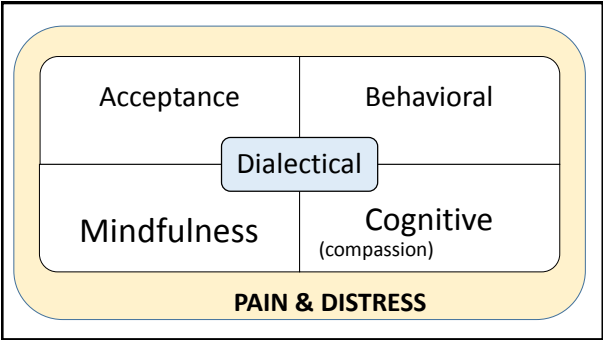
• Hold painful feeling in mindful awareness with kindness, understanding, sense of shared humanity

• Preliminary data: self-compassion may buffer distress



Costa, J., & Pinto-Gouveia, J. (2013). Experiential avoidance and self-compassion in chronic pain. *Journal of Applied Social Psychology*, 43(8), 1578-1591.

A moment of self-compassion can change your entire day. A string of such moments can change the course of your life. -Christopher K. Germer



Acceptance Behavioral

Mindfulness Cognitive (compassion)

Dialectical

PAIN & DISTRESS

Dialectical approach

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2

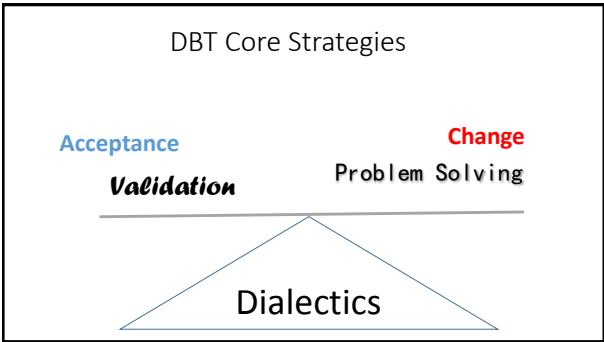
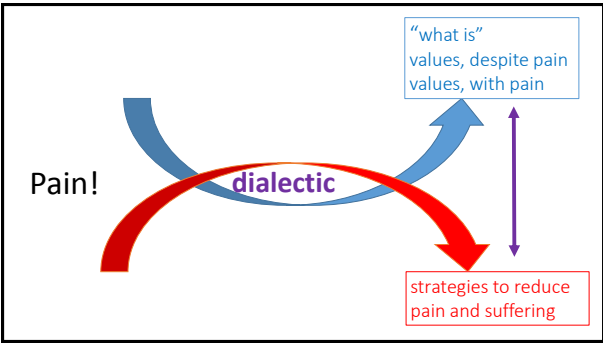
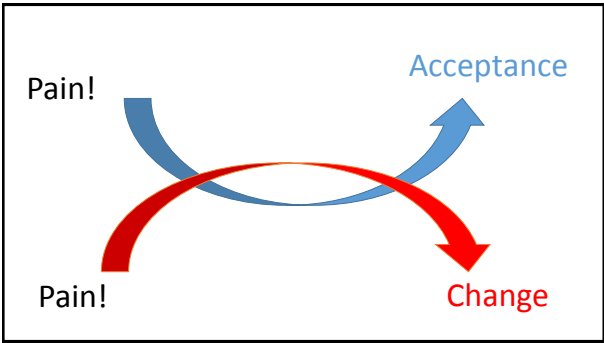


Why is “dialectic” relevant to chronic pain?

Q: All-or-Nothing Thinking

examples?

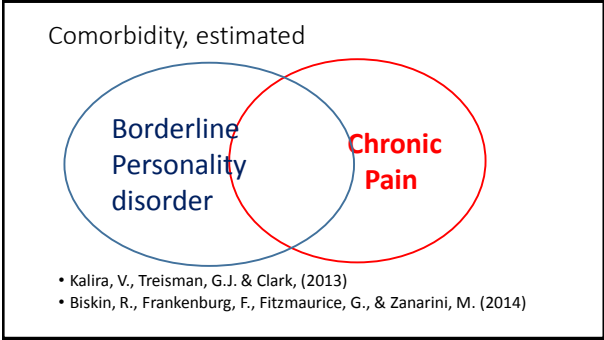
effects?



Dialectical Behavioral Therapy

What is DBT?

- Marsha Linehan, 1993
- Cognitive behavioral approach + Buddhist acceptance
- Originally with chronically suicidal women



- Components of DBT
- *DBT individual therapy*
    - Diary Card – to track “target behaviors” and daily skills use
    - Hierarchy in session:
      - I. Life-threatening behaviors and self-harming behavior.
      - II. Therapy-interfering behaviors
      - III. Quality of life
    - Behavioral Chain Analysis
  - *DBT phone coaching* - in-the-moment coaching for clients
  - *DBT skills training group* - weekly class teaches skills and assigns HW practice
  - *DBT therapist consultation team* - to keep therapists motivated, competent, and supported in work with people with complex, difficult-to-treat disorders

- Assumptions in DBT about emotionally sensitive people
- They are doing the best they can
  - They want to improve
  - They must learn new behaviors in all relevant contexts
  - They may not have caused all of their own problems, but they have to solve them anyway
  - They cannot fail in DBT
  - They need to do better, try harder, and/or be more motivated to change
  - Their lives are unbearable as they are currently being lived

DBT for emotional dysregulation

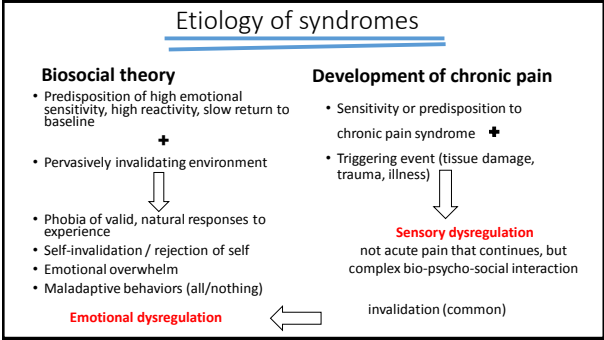
Translation to sensory dysregulation . . .

Parallels in experience of chronic suffering

Emotional Dysregulation, Borderline personality disorder	Chronic pain, fibromyalgia and other pain disorders
<ul style="list-style-type: none"><li>• Emotions can feel overwhelming and out of control</li><li>• Hopelessness</li><li>• Invalidation</li></ul>	<ul style="list-style-type: none"><li>• Pain can feel overwhelming and out of control</li><li>• Hopelessness</li><li>• Invalidation</li></ul>

Attitudes about chronic suffering

Emotional dysregulation / BPD	Chronic pain disorders
<ul style="list-style-type: none"><li>• “Difficult”</li><li>• Undesirable</li><li>• Turnover with therapists</li><li>• Focus on maladaptive behaviors</li><li>• “Axis II”</li><li>• Professionals may not have training → “too much”</li><li>• Fear</li><li>• Lack of empathy</li></ul>	<ul style="list-style-type: none"><li>• “Difficult”</li><li>• Not responsive to tx</li><li>• Poorly understood</li><li>• Invisible ailment</li><li>• Medical professionals may feel ineffective</li><li>• Blame patient</li><li>• “Medication seeking”</li><li>• Maladaptive</li></ul>



Vulnerabilities

	Emotional suffering (Borderline Personality Disorder)	Physical suffering (Chronic pain syndromes)
baseline	• heightened emotions “emotional burn victim”	• heightened sensation “unbearable pain”
triggers	• greater emotional arousal, slow to return to baseline, coded as emotional	• “neutral” stimuli → arousal (in sensory system)
invalidation	• formative history, and triggering	• aggravating factor, triggering

*“My guess is that if we withheld pain medication from them [people in intense pain], they would vacillate in exactly the same manner as borderline individuals”*

Linehan, L. (1993). *Cognitive-Behavioral Therapy of Borderline Personality Disorder*. New York, NY: Guilford Press, p. 18.

- What skills are needed to cope well with exquisitely sensitive system?
- To cope skillfully with invalidation
  - Capacity to self-validate
  - Radical acceptance
    - Understand that people are wired differently
    - Know who and what can handle
    - Ability to act differently to adapt
    - Some days need to push, uncertain how will react
  - Skills to decrease vulnerability
    - Coping ahead
    - Balancing “PLEASE skills”
  - Understand and live the acceptance/change dialectic
- Wise mind
    - Be able to plan retreat
    - Learn balance point
    - Structure one’s environment
    - Nonjudgmental, one-mindful
  - Effective
    - Life worth living
    - know what this is
    - values and risk taking
- (Notes from Kelly Koerner, UNC, May 2015)

2. Distress  
as its own concept

- When Pain Becomes Chronic
- Not a simple reflection of tissue damage
  - Pain = psycho-bio-social construct
  - Complex distress response

Concept of “Distress”

- **Language**
  - *broken heart, hurt feelings, emotional pain*
- **Experience**
  - Bereavement
  - Cross-cultural diagnosis
- **Brain**
  - amygdala (involved with emotions and emotional vigilance)
  - right anterior insula (helps regulate motor control and cognitive functioning)
  - superior frontal gyrus (involved in self-awareness and sensory processing)
  - hypothalamus (links the nervous system to the endocrine system)
  - dorsal anterior cingulate cortex (autonomic functions- heart rate, blood pressure; cognitive functions - reward anticipation, decision making, empathy, impulse control; and emotions)



Emotional and Physical Pain (“Distress”)

- **So much research!**
  - shared brain circuitry in emotional & physical distress
  - brain changes with chronic physical pain
  - brain changes with emotional dysregulation
  - distress in one area predisposes to other
  - treatment of one generalizes to the other

examples . . .



Research findings show overlap:

- Shared brain systems:
  - Example: genetic mutation feels pain with bereavement
  - Social and physical pain share circuitry
    - social rejection; empathy for other's pain
- Chronic distress:
  - Chronic pain:
    - persistence of inflammation, even in absence of injury
    - When pain persists, brain activity changes from “sensory” to “affective”
  - BPD/emotion dysregulation:
    - heightened arousal, altered emotion processing circuits, and greater sensitivity to physical pain too

Other examples of chronic distress?

Research findings show promise:

- Shared outcomes:
  - Close contact and social kindness reduce distress sensitivity
    - “cage mate,” holding hands, beliefs **11**
  - Medication reduces distress behaviors
    - Opiates across species (distress calls mother-infant)
    - Experiments on social rejection (Tylenol as “emotion relief”?)
- Chronic pain:
  - Emotional regulation has analgesic effect
  - Vagal nerve and inflammation
  - Psychologically modulated analgesia holds promise for treatments

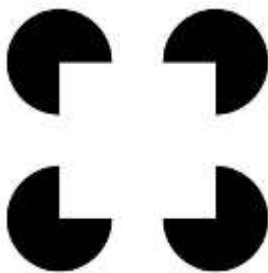
Brains are very complex  
based on **predictions**, not immediate sensory input

What is an Emotion?

*physiological experience* + attribution

All emotions come from training,  
and can also be retrained.

Lisa Feldman Barrett (2017) How emotions are made: The secret life of the brain.



- Neurons that fire together wire together



Neuroplasticity

- Why so hard - *Validation*
- Also, hope for change
- Finding and extending the **exceptions**
- Teaching skills and approach

Creating new neuropathways

Recap: Why DBT helps with chronic pain

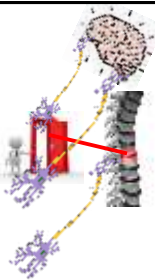
- Evidence basis: acceptance, change, mindfulness
- +
- Dialectic involved with chronic pain
- +
- Parallels between emotional and physical distress



Bridging to chronic pain

### 3. Pain Gate

*How Chronic Pain works and  
what you can do*



**PAIN GATE THEORY OF PAIN**  
Ronald Melzack & Patrick Wall (1965)

**Pain-modulating system:**

- **Neural gate** in spinal cord
- “Pain Gate” opens and closes
- affects how brain perceives sensation
- Pain NOT simply message from injury → brain

Model of Distress      Emotional ↔ Physical  
Shared neural circuitry

**Components of physical pain**

Sensory	Affective
1. Location	1. Evaluative component
2. Quality	2. “good”/ “bad”
3. Intensity	3. Drive to terminate

When pain is chronic, brain activity shifts from “sensory” to “affective”

What Opens and Closes Your Pain Gate?



**What affects experience of Pain**

- Complex processes → great variability in experience.

Pain Gate <b>Openers</b>	Pain Gate <b>Closers</b>
<ul style="list-style-type: none"><li>• stress, anxiety</li><li>• depression</li><li>• catastrophizing</li><li>• attention</li><li>• mind-wandering</li><li>• expectations</li><li>• uncertainty</li><li>• anticipation</li><li>• invalidation</li></ul>	<ul style="list-style-type: none"><li>• emotional regulation</li><li>• relaxation response</li><li>• social kindness</li><li>• closeness / connection / love</li><li>• distraction/positive engagement</li><li>• mindfulness practice</li><li>• meaning / commitment</li><li>• hypnosis / guided imagery</li><li>• acceptance</li></ul>



Utility of **Pain Gate** Concept

Why does it matter??

1. Mindfulness practice – it keeps changing

2. Science and metaphor to frame experience

- find helpful responses
- find choice (where to “spend pain”)

3. Data-driven thinking

- experimental mindset
- active, engaged expert
- develop new intuition
- “evidence-based” action

Some take aways:

1. Concept of “distress”  
NOT: emotional OR physical

2. Brain has responses to **distress**, and **chronic distress**.

3. Validate what makes this so hard, and also opens more strategies.

Distress Tolerance Skills:  
Self soothe (with five senses)

Vision  
Hearing  
Smell  
Taste  
Touch

Evidence based strategies

Aroma  
Beauty  
Biofeedback  
Body scan  
Breath work  
Caress  
Compassion  
Connection  
Guided imagery  
Heat and cold  
Hypnosis  
Intimacy

Laughter  
Love  
Massage therapy  
Medication  
Meditation  
Mindfulness /MBSR  
Music  
Progressive muscle relaxation  
Taste  
TENS  
Touch  
Yoga

LUNCH

4. How to work with distress?

DBT

1. Solve

2. Change how you feel

3. Radical Acceptance

4. Stay miserable

5. Make worse

Practice: to radically accept “what is” and make changes

startwith

Validation


Validation → change

• Carl Roger’s (person-centered therapy)

- trust in competency to be self-determining, and provide a relationship infused with congruence, empathy, and acceptance

• Strong, accurately worded validation

- Regulates emotions
- Increases adaptive responses
- Reduces arousal



How to Validate

1. Express empathy (other’s perspective)

2. Communicate that their experience and responses “make sense ...”

levels of validation

1. awake, alert, aware

2. reflection

3. nonverbalized

4. past learning or biology

5. current circumstances

6. radical genuineness

→

self validation

Validate without reinforcing dysfunction

What can you always validate?

1. Experience of sensation, emotion, behavior, thought (“kernel of truth”)

2. Problem importance

3. Task difficulty

4. Wisdom in ultimate goals

5. Ultimate ability to meet goals

Do NOT validate the invalid.

Avoid “but...”

Use “and...”

Practice example

New client.

Terrible pain. Calls to say that she’ll miss session. She just feels too awful to come in.

Has been in bed for days due to pain.

What to validate? (without reinforcing dysfunction)

How and when do you invite change??

Validate the Valid

- 1. Validate the experience
- 2. Problem importance
- 3. Task difficulty
- 4. Wisdom in ultimate goals
- 5. Ultimate ability to meet goals

Validate the Valid

- |  |             |
|--|-------------|
| 1. Validate the experience                             | what level? |
| • How frustrating . . .                                | 2,3         |
| 2. Problem importance                                  |             |
| • You want to be able to come in . . .                 | 2,3         |
| 3. Task difficulty                                     |             |
| • Anyone who hurt like that would be struggling . . .  | 5           |
| 4. Wisdom in ultimate goals                            |             |
| • I know you want to be doing better . . .             | 3,5         |
| 5. Ultimate ability to meet goals                      |             |
| • You've been through harder and I am in this with you | 4,5         |

And then, gently invite change:

- *Are you willing to imagine something?*
- *Imagine yourself here. Ok? What feels different between here and there?*
- *I wonder ... what would it take to ... ?*
- *What's the hardest part?*

dialectical strategies

- Bring awareness of dialectical tensions into all interactions
- Hold dialectic of both/and (not: either/or)
- Use metaphors and stories
- Devil's advocate
- Take client more seriously than she takes herself
- "What do you know in your wise mind to be true?"
- Lemons to lemonade: "Gift" or opportunity to practice
- Stylistic: irreverence, vulnerability, radical genuineness

Case example



Case example

- Man presents with primary complaint of pain, with suicidal ideation. He wants to contribute to his family, but feels overwhelmed by pain. Sometimes he pushes through the pain until he collapses in pain and exhaustion. What used to be easy for him now causes his pain to spiral out of control. He vacillates between "trying" and feeling overwhelmed with exquisite pain. At times he turns to alcohol to numb everything. He feels frustrated, despairing, and desperate to stop the pain and get back his life.
- 1. Validate his experience (and not what's invalid)
  - 2. Introduce concept of Pain Gate (link with his experience)
  - 3. Identify "life worth living goal"
  - 4. Introduce dialectic approach (acceptance and change, both)

DBT Behavioral Chain Analysis

- Collaborative strategy
- About getting a complete picture of a behavior: what it is? how did it start? what keeps the behavior repeating?
- Helps keep crisis from undermining motivation to engage, understand, move forward
- Goal: to decipher factors that led to behavior, identify patterns, and put new behaviors into effect.

You cannot solve what you cannot understand.

Process of chain analysis

1. Start with **specific problem behavior** (most severe and best remembered) – use specific language about events, thoughts, feelings, intensity.
2. Describe **prompting event**
3. Identify **vulnerabilities** (more than usual)
4. **Chain of events** that led up to behavior (in excruciating detail) include thoughts, feelings, behavior, reactions
5. Identify **consequences** (to self, to others)
6. **Solutions?**
  1. Where could you do something different?
  2. Anything you could have done to prevent from starting?
  3. Repairs that you can make?

Behavior Chain Analysis

Behavior? \_\_\_\_\_  
Prompting Event?  
Cascade of thoughts, feelings, actions.  
Places for skillful intervention.

**Possible Types of Link:**  
A = Antecedent  
B = Body Skill/Action  
C = Consequence  
D = Delay  
E = Effect  
F = Follow-up

Learning from BCA

- Learn what led to outcome.
- Identify skills to regulate emotion and/or physical distress
- Change **problematic contingencies, CONDITIONED RESPONSES** and **ineffective cognitive processes**
- Find patterns over time, too

Emphasize choice: What's effective? How impacts pain gate?

- **Emotions:** Identify, validate, experience as wave
- **Thoughts:** as “thoughts” not whole truth.
- **Behaviors:** nonjudgmental labeling of behaviors, after effects, and reinforcers
- **Sensations:** nonjudgmental description and experiencing

Man presents with primary complaint of pain, w/ SI



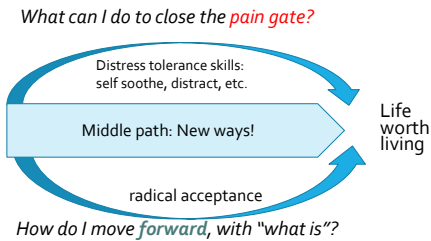
He wants to contribute to his family, but feels overwhelmed by pain. Sometimes he pushes through the pain until he collapses in pain and exhaustion. What used to be easy for him now causes his pain to spiral out of control. He vacillates between “trying” and feeling overwhelmed with exquisite pain. At times he turns to alcohol to numb everything. He feels frustrated, despairing, and desperate to stop the pain and get back his life.

Practice: Select target and conduct BCA to increase understanding

Dialectical Pain Management Skills Class

1. Dialectical approach and Pain Gate
2. Core mindfulness
3. Radical acceptance and values work
4. Emotions and Pain
5. Mindful self compassion (as cognitive restructuring)
6. Self-care to reduce vulnerabilities
7. Validation, recovering from invalidation, and being effective
8. Coping ahead

Week 1: Dialectical approach and Pain Gate



Week 2: Core Mindfulness

What it is? (and what it isn't)

- A way of paying attention
- Only this moment
- Focus of attention (like spotlight)
- Slows things down
- Opens possibilities
- Can respond (not react)
- Can focus, choose, savor



All we every have is  
this very moment.

Mindfulness:

curious, experimental mindset

Awareness: **PAIN GATE** and how it works  
All data = Useful information

Core Mindfulness

Problems:

- Avoidance of discomfort produces maladaptive behaviors
- Feeling overwhelmed
- Despair that life isn't fair

Core Mindfulness

Goals of module:

- Observe thoughts, feelings, and **body sensations** (without reactivity)
- Cultivate non-judgmental stance
- To experience reality as "it is"
- Participate in life with awareness (not impulsive or mood-dependent behaviors)

Core Mindfulness – states of mind

• Awareness of each "mind state"

Cultivate "Wise Mind"

- Balanced point of view
- Intersection of reason and emotion states
- Embraces dialectic

Core Mindfulness – states of mind

Practice noticing with intention and without judgment

- emotion = emotion
- thought = thought
- sensation = sensation

Core Mindfulness – practicing mindfulness

What to do:

- Observe
- Describe
- Participate

How:

- Nonjudgmentally
- One-mindfully
- Effectively

*middle path  
how to engage in life as it is  
right now, as you are right now*

*closes pain gate*

Mindfulness

- Non-judgmentally observe and describe experience (including sensations, emotions, thoughts)
- Pain is a judgment
- One-mindfully participate with present moment
  - Engage senses (self-soothe), engage mind and body (distract/accepts skills)
- Effectiveness: adaptation (middle path)

Week 3: Radical acceptance and ACT values work

What it is?

- Acknowledging "what is" in the present moment


Radically accept that life can be worthwhile, even when there's pain.

Non-acceptance is trying to assert will on reality (in that moment) to be different than it is.

What it isn't


- Liking situation
- Approval
- Giving up or giving in
- About "forever"
- "Live with it" mentality
- "It'll always be this hard!"

Radical ACCEPTANCE




- Alternative to acceptance?
- Fighting against or denying reality
  - Myths ("if others understood....")
  - "Should"s & " I wish. . ."
  - Denial → overdoing (cycle)
- Opens PAIN GATE and turns PAIN into SUFFERING


Pain + non-acceptance = suffering



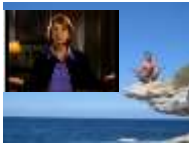
Distress Tolerance Skills: Willingness

Small smile





Willing hands, posture



Willingness is saying yes to the mystery of being alive in each moment.  
Willfulness is saying no, or perhaps more commonly, "yes, but . . ."

Source: Gerald May, 1982, in *Care of Mind-Care of Spirit: Psychiatric Dimensions of Spiritual Direction*, San Francisco: Harper and Row, p.6.

Acceptance and Commitment Therapy (ACT)

Values and values-based committed action

- Exercise to get at values
  - If stuck on "desire for less pain," ask: then what?
  - Identify value.
  - Operationalize → goals
  - Small steps.



Pain → Values

Acceptance	to be accepting of myself, others, life, etc.
Adventure	to actively explore novel or stimulating experiences
Authenticity	to be authentic, genuine, and real, true to myself
Caring	to be caring toward myself, others, the environment, etc.
Compassion	to act kindly toward myself and others in pain
Connection	to be fully present with others
Contribution	to contribute, give, help, assist, or share
Cooperation	to be cooperative and collaborative with others
Courage	to be brave in the face of fear, threat, or difficulty
Creativity	to be innovative, express through art
Curiosity	to be curious, open-minded, and interested; to explore and discover
Encouragement	to encourage and reward behavior that I value in myself or others
Excitement	to seek, create, and engage in activities that are exciting or stimulating
Justice	to be fair and just to myself or others
Fitness	to look after or improve my physical and mental health
Flexibility	to adjust and adapt readily to changing circumstances
Independence	to choose how I live and help others do likewise

Friendliness	to be companionable, or agreeable toward others
Forgiveness	to be forgiving toward myself or others
Fun and humor	to be fun loving; to seek, create, and engage in fun-filled activities
Gratitude	to be grateful for and appreciative of myself, others, and life
Honesty	to be honest, truthful, and sincere with myself and others
Industry	to be industrious, hardworking, and dedicated
Intimacy	to open up, reveal, and share myself, emotionally or physically
Kindness	to be kind, considerate, nurturing, or caring toward myself or others
Love	to act lovingly or affectionately toward myself or others
Mindfulness	to be open to, engaged in and curious about the present moment
Order	to be orderly and organized
Persistence	to continue resolutely, despite problems or difficulties
Respect	to treat myself and others with care and consideration
Responsibility	to be responsible and accountable for my actions
Safety	to secure, protect, or ensure my own safety or that of others
Pleasure	to create or enjoy pleasurable and sensual experiences
Sexuality	to explore or express my sexuality

examples of **ACCEPTANCE**

- ✓ Getting yourself here, just as you are
- ✓ Using a scooter in grocery store
- ✓ Exercising for 30 seconds
- ✓ Showing up for people I care about
- ✓ Taking recuperative breaks
- ✓ Cooking for family while seated
- ✓ Allowing yourself to grieve, and move forward
- ✓ Getting out of bed even when every fiber hurts

What **not** accepting reality looks like:

Thought Examples:

- Black/White thinking
- All or Nothing thinking
- Sick or Well thinking
- Pain or No pain
- Giving up
- This will never change
- I can't stand this
- Why me?
- It's not fair that ...
- Catastrophizing

Emotion Examples

- Dread
- Hopelessness
- Apathy / lack of caring

Behavior Examples:

- Avoiding doing things
- Avoiding engaging in life
- Unwillingness to try to help yourself
- Doing things that make it worse
- Powering through (no matter what)

What does **acceptance** look like?

Thought Examples:

- I am living right now, even with this pain
- I cannot stand this **and** I am standing this
- The pain is what it is
- I am many things. Pain is one part of my experience
- I don't know why I am experiencing this pain right now, and I can still live a meaningful life.
- I can have this pain right now, and still do things that matter to me.

Emotion Examples:

- Curious
- approach:
  - Open, willing
  - Hopeful
  - Caring / life matters

Behavior Examples:

- Engaging with the moment
- Willing to try things
- Willing to do what works in the moment

Week 4: Emotions and Pain

What's the relationship between emotions and pain?

Emotion Regulation Skills

1. Understand emotion – “like a wave”
2. Accumulate positives, and build mastery
3. Acting opposite to emotion (and body)

Emotion Regulation Skills: Understand emotions




### Accumulate Positives

Engage in positives emotional experiences

- Short-term (daily)
- Long-term (invest in positive life, step by step)
- Be unmindful of worries

Mindful engagement on positives.  
Savor, share, reflect on these.


Notice effect on **pain gate**?



- ❖serenity
- ❖love
- ❖gratitude
- ❖peace
- ❖pleasure
- ❖connection
- ❖forgiveness
- ❖compassion
- ❖joy
- ❖tenderness
- ❖openness
- ❖gratitude
- ❖connection

### Build Mastery

- Do something each day to feel competent, confident, and capable
- Combats hopelessness and helplessness
- Pain, plus . . . ?



### Opposite to Emotion Action

Opposite to **body** also

1. Notice “urge” that arises
2. Validate
3. Engage in behavior that’s effective, even when you don’t feel like it
4. Observe effects

→ practice developing new intuition based on data

What effect on emotions and pain gate?

### Week 5: Mindful self-compassion (MSC)

MSC	DBT	ACT
1. Kindness to self	1. Nonjudgmental	1. Mindfulness of
2. Common humanity	2. Check the facts	thought
3. Mindfulness – drop into experience with compassion	3. Self validate	2. Values-based
	4. Cheerlead	action

### Week 6: Self-care

Balance to reduce vulnerabilities

PLEASE skills → CARES skills

### Reducing vulnerabilities

**PLEASE:**


- Physical health
- Eating
- Avoid mood-altering drugs
- Sleep and rest
- Exercise



Reducing vulnerabilities

(CARES):

- Consume sensibly
- Activities
- Relaxation response
- Exercise
- Sleep




Balance energy budget

Reducing vulnerabilities

(CARES):

- Consume sensibly
- Activities
- Relaxation response
- Exercise
- Sleep



Exercise increases stamina, endorphins and enkephalins  
**Key** is to approach with mindful awareness.

Opposite Action to Emotion / Body

“Vitals” – gentle approach to things “you don’t feel like”

Validate experience  
Image  
Take a small step  
Applaud  
Lighten the load (anticipate benefit)  
Sweeten the pot (positively reinforce)

Week 7: Interpersonal effective (IPE) skills

*How relevant to pain?*

IPE with chronic pain

- People often need a higher level of skill
- Relationship imbalances
- Ability to ask for what need, effectively
- Ability to say “no” skillfully
- “Understanding” myths
- Intrapersonal effectiveness
- **Self-validation and recovering from invalidation**

Interpersonal Effectiveness

**Validation skills**

Recovering from Invalidation

- Reasons for invalidation:
  - you are ignored,
  - repeatedly misunderstood, misread, misinterpreted,
  - important facts in your life are ignored or denied,
  - you are disbelieved when truthful, or
  - your private experience is trivialized or denied.

1<sup>st</sup> step: Recognize experience of invalidation

Recovering from Invalidation

Practices:

- Recognize invalidation hurts.
- Be compassionate toward yourself. Practice self-soothing.
- Be non-defensive. Check facts. Consider others' views. Be curious!
- Remember: All behavior is caused. Blaming rarely helps.
- Practice radical acceptance of the invalidating person.
- Enlist someone you trust to validate the valid.
- Remember: being invalidated is rarely a complete catastrophe.
- Grieve traumatic invalidation and the harm it created.



Clarify Interpersonal Effectiveness Goal – 3 types:

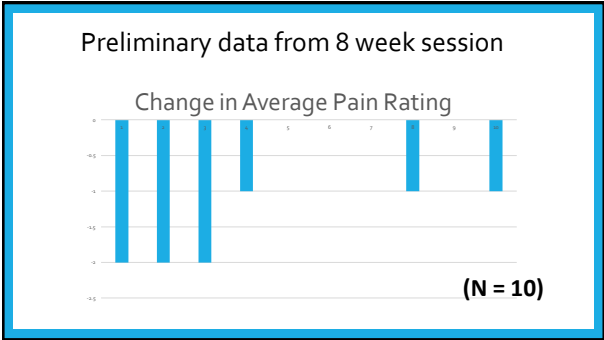
- Objective
- Relationship
- Self-respect

Self-advocacy, even if others don't "get it"

Week 8: Coping ahead

- Develop and rehearse a plan to deal skillfully with challenging situations
- Mental rehearsal (research on effects)
- Plan on how you will cope calming and effectively with pain and stress
- Brainstorm skills that will help. Practice mental rehearsal to ready yourself for skill use.





Pros and Cons of using skills

	Pros	Cons
Using skills		
Not using skills		

	Pros	Cons
Acceptance and adaptation (e.g., pacing)	<ul style="list-style-type: none"><li>• More sustainable</li><li>• More realistic, middle path</li><li>• Engage, and not make things worse</li><li>• Can reward myself</li><li>• More potential for connection</li><li>• Will feel pride, accomplishment</li><li>• Act according to my values</li><li>• Feel like my life is not PAIN</li></ul>	<ul style="list-style-type: none"><li>• Facing problem is hard, depressing</li><li>• Have to admit the problem</li><li>• May look weak to others</li><li>• Would have to give up on "old ways"</li><li>• Others may invalidate my struggle</li></ul>
NOT accepting or adapting (e.g., bed)	<ul style="list-style-type: none"><li>• Can have my denial</li><li>• Can stay in bed</li><li>• Don't have to face anyone</li><li>• Less scary</li><li>• Can watch Netflix</li><li>• Can hide out</li><li>• May sleep</li><li>• May not have pain</li><li>• I appear as I feel (no judging)</li></ul>	<ul style="list-style-type: none"><li>• Doesn't solve anything</li><li>• Self esteem plummets</li><li>• Not sustainable</li><li>• Lonely</li><li>• Depressing</li><li>• Risk losing valuable parts of my life</li><li>• Feel stuck</li><li>• Shame</li><li>• Self-pity</li></ul>

Mini treatment assessment

- Client is "HERE"
- Client needs to be "HERE" ("life worth living" goal)
  - State positive and inspiring to client. Something they want for itself (not means to end). Use imagery, slogan, metaphor that client embraces.
- ID factors & behaviors interfering w/ ultimate goals?
  - What needs to learned, eliminated, increased, or decreased for goals to be attained? Identify reinforcers that keep current pattern. Consider pros & cons of current thinking/behavior and making changes.
- Approach dialectically: Do you/they know what to do? How to do it? How is your/their motivation?

Change strategies

- Mindfulness strategies to relax body and mind
- Mindfulness as deliberate attention to engage
- Mindfulness as self-soothing
- Positive emotional experiences
- Graduated exercise

Acceptance practices

- Radical acceptance
- Live according to values, despite pain
- Pain as sensation (practice nonjudgmental stance)
- Mindful self-compassion
- Cheerlead through difficult parts
- Cope ahead

Conclusion: outcomes

- Dialectical stance (acceptance and change)
- Strategies to reduce pain (greater efficacy)
- Less concern about pain, more on life quality
- See choice in the moment
- Ability to engage in life despite pain
- Acceptance of "what is" in the moment
- Middle path adaptation behaviors
- Process of grief (expressing emotion) → acceptance

Agenda and take-way points

- ✓ "Dialectical" approach (both/and)
- ✓ Pain Gate (science and metaphor)
- ✓ Distress concept, focus on downregulation and neuroplasticity
- ✓ Validation, how and why
- ✓ Acceptance and change strategies to move towards "life worth living"



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