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Beyond Traumatic Events and Chronic Low Back Pain: Assessment and Treatment Implications of Avoided Emotional Experiences

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A burgeoning literature demonstrates that emotionally difficult experiences, including trauma, interpersonal conflicts, work stress, and social rejection contribute to chronic pain [2,5], particularly in patients with central sensitization or augmentation disorders [12]. In their study, Tesarz and colleagues [10] demonstrated the contribution of traumatic events to pain amplification in people with chronic low back pain (CLBP). Using comprehensive and sophisticated quantitative sensory testing, the authors showed that self-reported trauma exposure was associated with hyperalgesia at both the lower back and a distal site, compared to patients with CLBP not reporting trauma exposure and controls without pain. Although trauma-related hyperalgesia was limited to pressure pain threshold, and the difference in threshold between CLBP trauma groups was modest in size, the study's use of sensory testing is persuasive because it attenuates the bias that often accompanies clinical pain reports in trauma-exposed patients.

However, the study's conceptualization, assessment, and treatment implications of trauma exposure deserve comment, because a greater understanding of trauma and emotional processes can lead to a more nuanced appreciation of their impact on pain. It is likely that both groups of patients with CLBP—those classified as either with or without trauma—were heterogeneous, leading to smaller study differences in pain augmentation than might otherwise have been found. Although the group with trauma excluded patients with full PTSD, presumably some patients in this group had trauma that remained unresolved or problematic to them, continuing to augment their pain. In contrast, other individuals in this group probably experienced traumatic events that no longer affected them—that had resolved with time, with or without professional help. We would expect such people to have little or no trauma-induced pain augmentation [8], so their inclusion in the trauma group probably reduced observed study differences in hyperalgesia. Ideally, one should assess when in life the trauma occurred and, more importantly, whether or not the person remains emotionally conflicted or troubled by it.

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We also think that the group of patients with CLBP but no trauma merit much closer inspection and critical thought. Although this group likely included some individuals who were free from psychological problems, it probably also included two types of people with emotional difficulties that contributed to their hyperalgesia.

First, some patients in this group likely had experienced trauma, but they simply did not report it. The disclosure of stigmatizing or emotionally painful experiences requires not only self-awareness but also the willingness to acknowledge it openly to both oneself and an interviewer. In possible support of this view, we note that only 37.6% of the 149 pain patients in this study reported lifetime trauma. This prevalence, and that of several specific traumas, seem well below population base rates, especially for patients who lack structural pathology for their pain, most of whom have chronic widespread pain (68%) and are female (69%)—three factors associated with increased trauma exposure [2,3]. For example, sexual assault was reported by only one person (0.7%), and sexual contact as a child was reported by only nine (6%). Although these low rates might stem from the exclusion of people with PTSD and the requirement that the event generated “intense fear, helplessness, or horror,” some patients likely just avoided disclosure of such experiences and, hence, were misclassified.

Second, some patients without trauma likely experienced important psychological conflicts that contributed to hyperalgesia. Tesarz et al. followed standard diagnostic practice, which views trauma exposure as an external experience—something exceptional that happens to a person. However, many people report no traumatic events but are, nonetheless, quite emotionally and relationally conflicted [1]. For example, unresolved struggles with parents or siblings, conflicts over perfectionism, shame or guilt related to stigmatized desires or actions, ambivalence toward one's children, and a host of other issues can drive stress reactions and pain. We view the key pathological process in both unresolved trauma and internal conflict to be the avoidance or suppression of one's primary or adaptive emotions, which then activates neural pathways that trigger, augment, or maintain pain and other symptoms. Classifying emotionally conflicted patients as “without trauma” likely weakened the study's effects.

Regarding clinical implications, Tesarz et al. rightly suggest that practitioners approach patients with CLBP and trauma from a “central point of view.” They recommend assessing further signs of pain augmentation but make no treatment suggestions. It is unfortunate that many pain practitioners seem not to be influenced by the evidence that trauma and emotional conflict drive pain, and they offer such patients only cognitive-behavioral pain management. The effect of this approach on pain reduction, however, is rather small [11], perhaps because it fails to deal directly with patients' trauma or emotional conflicts.

Our team has been developing and testing approaches that target unresolved trauma, conflict, and relational disturbances in patients with musculoskeletal pain, fibromyalgia, headaches, irritable bowel syndrome, and pelvic pain [4,6,7,9]. We first conduct a life-course interview, which commonly identifies associations between patients' stressful experiences and emotions and the onset and exacerbation of their pain. Interviews also test the expression of avoided emotions, and immediate changes in pain demonstrate to patients

the connection between their emotions and symptoms. In therapy, we present patients with a mind-body model that explains chronic pain as due to neural pathways that were formed by prior learning and maintained by emotional avoidance, but which can be “unlearned” with powerful corrective emotional experiences. We help patients identify, experience, and express three types of primary emotions or needs: power or anger toward sources of hurt; vulnerability and intimacy (grief, love) toward sources of attachment; and compassion and forgiveness toward the self. We then help patients learn to adaptively express genuine feelings directly to others. Our clinical and research experiences thus far indicate that many patients are open to this model, willing to engage in the difficult therapeutic work, and often show remarkable pain reduction as well as improvement in various life domains. We encourage researchers and clinicians to follow the growing evidence, bolstered by the findings of Tesarz et al., and assess and treat trauma and emotional conflict in their patients.

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