(a)
Self-empowerment, self-efficacy and mindfulness.
Does multidisciplinary pain therapy inhibit or support?

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Abstract

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Objectives:
Today`s pain management ought to be executed in a multidisciplinary and - even better - an interdisciplinary setting. Unfortunately, due to a very different discourse and different beliefs this may lead to non-acceptance of the other party‘s competence and might even be judged as an offence to one`s own practice. To achieve an increase of the mutual appreciation of the somatic and the psychological perspective we address:

- the imperative need of pain-treatment for the patient who is in despair;
- the reduced interference of interventional pain management with the patient’s self-empowerment compared to medical therapy with long-lasting pharmaceuticals;
- the increase of self-efficacy once the patient’s “active” mode is (re-)installed; and
- methods of accepting some chronic pain using tools to remove the focus on pain from the patient`s attention.

Methods:
In order to also consider pain as an expression of suffering an integral part of life, we have consulted philosophical sources. In order to evaluate long-term, and in particular drug therapy, pain-specific self-efficacy and mindfulness techniques, we conducted a database search (pubmed).

Results:
Chronic pain and suffering have to be discussed not in an utilitarian framework but in a phenomenological context inspired by Schopenhauer, Wittgenstein, Jaspers, van Buitendijk, Scheler and Merleau-Ponty. There is an imperative need of pain-treatment for the patient who is in despair. No literature could be identified on whether or not interventional pain management implies reduced interference on patient´s self-empowerment compared to medical therapy with long-lasting pharmaceuticals. Studies on self-efficacy and those on methods of accepting some chronic pain will be discussed.

Discussion:
Chronic Pain – as all suffering – develops from being essential to being existential. To a certain extent, it is a contingent part of life, and it might even be meaningful. A multidisciplinary team therapy should generally be targeted at lowering the pain level to create valences for the patients, to subsequently enable them to take control again.

Key words:
Interdisciplinary pain management; interventional pain management; self-empowerment; self-efficacy; mindfulness.

Self-empowerment, self-efficacy and mindfulness.
Does multidisciplinary pain therapy inhibit or support?

Introduction:
Today`s pain management ought to be executed in a multidisciplinary and - even better - an interdisciplinary setting. Unfortunately, even in established pain clinics, therapists representing the somatic perspective and those representing the psychological perspective often live and practice in "different" worlds, due to a very different discourse, different types of education and different beliefs. This may lead to non-acceptance of the other party's competence and might even be judged as an offence to one`s own practice. We see a need in publications that highlight the synergistic effects of combining somatic and psychological therapies in pain management and thus may increase the mutual appreciation of both disciplines.
To achieve this we address:

- the imperative need of pain-treatment for the patient who is in despair;
- the reduced interference of interventional pain management with the patient's self-empowerment compared to medical therapy with long-lasting pharmaceuticals;
- the increase of self-efficacy once the patient's "active" mode is (re-)installed; and
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Materials and Methods:
In order to also consider pain as an expression of suffering an integral part of life, we have consulted philosophical sources. In order to evaluate long-term, and in particular drug therapy, pain-specific self-efficacy and mindfulness techniques, we conducted a database search (pubmed).

Results:
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Discussion:
Should we treat pain? Is it permissible? Should the individual do everything possible to lead a life free of pain and suffering?
Where am I as a therapist regarding Epicurus: "This is what it is all about: a life without pain and without fear." Similarly, Escrivá states: "Let us bless pain. Love pain. Sanctify pain [...] – Glorify pain!".

No one can be held responsible for their pain. However, the attempt of taking responsibility for one's pain is one of the most effective strategies in dealing with it[1].

Pain, or chronic pain, is an illness sui generis[2], with the unknown end and the cause, which often cannot be clearly determined, often comprise severe factors[3]. It is an existential threat that leaves nothing unaffected[4], resists any habituation and affirmation, narrows down time and space to endanger social relationships and language and will over time become normal[5]. However, accepting the restructuring of the habitual body ("what I can generally do"[6]) as a new normal is rather challenging.

Reactions and strategies:
The experience of pain is always subjective and uncatchable[7], even though its evaluative assessment is culturally characterized[8] and communication about it is a social fact[9]. Uninvolved persons may wonder where pain goes when it appears in undulating intensity or when it is reported with a smile ("…always has a severity of 8 to 10 of 10"). May alexithymia – the inability of patients with chronic pain to express their feelings – be a reaction to their inability to share the actual pain experience with the environment without others despairing and refusing to understand or cooperate?[10] Why can everything that is important and potentially lost be the cause of pain?[11]
Other persons and therapists are hardly able to imagine the diverse dimensions that the vulnerability of the individual in pain may take on[12].

However, access to another person – and to oneself – can be found through a newly connoted shared suffering – empathy and sympathy[13]. Then, treatment of the mind and body will be targeted at supporting patients in managing their “new normal” and creating conditions in which pain can be reduced. Since chronic pain significantly inhibits the individual's motivation, self-empowerment and activity through the often-experienced despair, pain therapy should generally be targeted at lowering the pain level to create valences for the patients, to subsequently enable them to take control again via self-empowerment. This is also true when merely pain in the body - and not necessarily suffering in the perceiving body -, can be treated[14].
For this, the entire armamentarium that is available to us today must be offered and used – regardless of specialist discipline.

Risk of undermining patients autonomy:
Medical interventions, i.e., therapies, that address identified somatic causes and neurophysiological/neuropathological targets, generally run the risk of undermining patients' autonomy and their participation in the process. This is all the more sustained the longer such therapies last. Interventional, minimally-invasive and invasive therapies are, due to the limited area of their application, less interfering than, for example, long-term medication, which also often comes with prolonged adverse effects that limit quality of life. We hypothesize minimal invasive pain treatment procedures, by interfering for a shorter period of time, have less impact on patient`s self-empowerment.
Cognitive and physical impairement after application of minimal-invasive pain-treatments, like infiltrations and neuroablative procedures, are rare. In contrast, oral and transdermal opioid treatment for non-malignant pain must be questioned due to the consecutive danger of falling and potentially lethal risks such as sleep apnea and the risk of abuse[151617]. However, many prescribing physicians and opinion-formers consider this therapy adequate. Guidelines, for example, do not generally exclude opioid prescription in excess of six months for non-malignant pain[18].
Interventional pain-therapy procedures have a bad reputation, for example, in the German-speaking literature, and are thought to cause potentially chronic states compared with medication[19]. However, the exclusively temporary influence on the patient that is inherent in many diagnostic and therapeutic interventions is not sufficiently considered in addition to these shortcomings.

Following therapy: self-efficacy and mindfulness:

There is no doubt that the reduction of pain is ethically justified. In the best case of partial pain reduction, treatment of the mind and body can support patients in recognizing and accepting pain as such and the resulting suffering to a certain extent – as an expression of their being alive – enabling them to push pain from the focus of their attention. Methods that support the conviction of perceived self-efficacy are important aids in this process.

Perceived self-efficacy is trust in being able to master difficult situations with your own competence[20]. Meta analyses have shown that an increase of this trust can reduce pain, for example, in arthritis and can reduce the fear caused by tumor pain[21]. Coping strategies and physical activity can also be improved[22].
However, weak confidence in self-efficacy, as well as low social support, may lead to depression[23] – and thus, similar to increased fear avoidance – increased invalidity[24].

An active attempt can now be made to push the remaining pain – which should likely be accepted as "being part of oneself" – from the focus of attention. This can be done with techniques aligned with mindfulness.

Mindfulness-based techniques that are relevant in pain medicine are derived from meditative approaches, such as MBSR (Mindfulness-Based Stress Reduction), MBCT (Mindfulness-Based Cognitive Therapy) and Zen meditation.
The first study on the secular, non-esoteric mindfulness technique MBSR for chronic pain was published by Kabat-Zinn in 1982[25]. Its efficacy in treating chronic pelvic pain[26], the adverse effects of HIV therapy[27], fibromyalgia[28] and anxiety[29] have since been proven.

Mindfulness-based techniques can reduce pain[30] and can be effective against depression[31]. Empathy-relevant areas in the brain show increased activity both for experienced pain and when perceiving the pain of others in functional imaging in persons experienced in meditation[32 33]. Pain is perceived as less unpleasant as a consequence[34] and resources can be activated more successfully.

Meta-analyses show "limited evidence" for their effect on acceptance, "inconclusive evidence" for their pain-reducing effect[35] and "moderate evidence" for their efficacy in treating anxiety, depression and pain[36]. The treatment effect can be increased by (self-)hypnosis[37].
Meditation and self-hypnosis can be considered non-invasive neuromodulation methods[38].

Mindfulness-based methods are intended to support meeting pain with understanding[39], rather than avoiding or rejecting it. Such access may also increase psychological flexibility[40], as analyses of pain-diary entries suggest[41].
Mindfulness-based techniques lead to better results in groups than in individual therapy[42]. It must be noted that, to date, studies on mindfulness-based techniques have rarely been performed with an active control group[43].

Perspective:
Treatment expectations and hope for healing are important mechanisms in pain treatment. After treatment by an empathetic therapeutic team achieves some initial success, the further process relies on an active patient. A change of perspective may support patients in recovering their active role. In such a context pain is not only an expression and cause of suffering, but usually also a problem for the sufferer. While managing suffering is targeted at mitigation, addressing problems requires a solution. Such a change of perspective challenges the entire emotional and intellectual creativity of the suffering person – not only for “better handling of pain” or “good pain management”, but also for a conscious life design that allots pain the space in life that it is due.

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