



## The role of experiential avoidance in acute pain tolerance: A laboratory test

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### Abstract

The present investigation examined the role of experiential avoidance in terms of acute pain tolerance and subsequent recovery. Seventy nonclinical participants completed the Acceptance and Action Questionnaire [Hayes et al., *The psychological record*, 54 553–578] and underwent a well-established cold pressor task. Results indicated that individuals reporting higher levels of experiential avoidance had lower pain endurance and tolerance and recovered more slowly from this particular type of aversive event. Consistent with theoretical prediction, these findings suggest that experiential avoidance may play a role in tolerance of acute pain.

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## 1. Introduction

Experiential avoidance (EA) denotes an affect-related regulatory process whereby persons are unwilling to remain in contact with certain private experiences (e.g., thoughts, emotions) and attempt to regulate the form, frequency, or contexts that occasion these experiences (Hayes, Wilson, Gifford, Follette, & Strosahl, 1996). Experiential avoidance is theorized to be a broad-based affective diathesis that is implicated in a variety of psychiatric problems (Blackledge & Hayes, 2001; Hayes et al., 1996). Available evidence suggests that while EA is believed to be a general diathesis, it is distinct from other vulnerability factors implicated in pain-related responding. Theoretically, EA is a process that subsumes other specific processes implicated in the pathogenesis of pain-related responding. Empirical evidence also has differentiated EA from cognitive processes implicated in prototypical types of emotion dysregulation. For instance, the global index of the anxiety sensitivity construct, as measured by the 16-item Anxiety Sensitivity Index (Reiss, Peterson, Gursky, & McNally, 1986) total score, shared only 9% of variance with EA, as indexed using the Acceptance and Action Questionnaire (AAQ; Hayes et al., 2004), in an inpatient residential substance abuse population (Forsyth, Parker, & Finlay, 2003). Together, there is reason to believe the AAQ measures a psychological construct that is related to, but distinct from, other emotion vulnerability constructs and therefore may add unique explanatory power to models of pain-related responding.

Emerging empirical evidence supports EA as a broad-based vulnerability for emotional distress. First, deliberate attempts to suppress unwanted thoughts and negative emotions lead to greater amounts of such thoughts rather than less (Gold & Wegner, 1995; Gross & Levenson, 1997; Wegner, Schneider, Knutson, & McMahon, 1991; see Purdon, 1999, for a review). Second, EA, as indexed by the AAQ (Hayes et al., 2004), is elevated among women with, versus without, a history of childhood sexual abuse (Batten, Follette, & Aban, 2001) and mediates the relation between history of childhood sexual abuse and subsequent distress (Marx & Sloan, 2002). Third, higher AAQ scores are associated with problem drinking (Stewart, Zvolensky, & Eifert, 2002). Fourth, EA is significantly associated with various types of fear and anxiety (Feldner, Zvolensky, Eifert, & Spira, 2003; Forsyth, Parker, & Finlay, 2003; Karekla, Forsyth, & Kelly, 2004; Roemer, Salters, Raffa, & Orsillo, in press; Sloan, 2004; Zvolensky & Forsyth, 2002) and decreases with remission of such fears (Zettle, 2003). Collectively, the extant literature suggests that EA does, in fact, increase the probability of various types of emotional distress.

Despite the potential importance of EA, there unfortunately has been little attention applied to this construct in terms of better understanding pain-related experiences and problems. Consistent with the general prediction derived from EA theory, deliberate suppression of acute pain increases pain in future circumstances (Cioffi & Holloway, 1993). Additionally, acceptance of pain (i.e., openness to positive and negative aspects of human experience without deliberate defense), which is the antithesis of EA (Orsillo, Roemer, & Barlow, 2003), is associated with less pain-related disability and chronic pain (McCracken, 1998; McCracken, Spertus,

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