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THE ‘‘SAFETY SEEKING BEHAVIOURS’’ CONSTRUCT AND ITS APPLICATION TO CHRONIC PAIN

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Abstract. Paralleling developments in other areas of clinical psychology, psychological theories of chronic pain have evolved from the purely behavioural models of several decades ago, to those that have increasingly recognized the importance of cognitive constructs (without necessarily neglecting the influence of behavioural factors that remains significant). As is well established in the domains of anxiety and depression, pain related cognitions and coping strategies are now considered to be just as, if not more, important as behavioural constructs such as reinforcement contingencies. At the same time, however, some of the exciting developments in other clinical areas have only just begun to receive due attention from those interested in pain. In particular, the ‘‘safety seeking behaviours’’ construct, which has received a considerable amount of attention in recent years from anxiety researchers, appears to have been virtually ignored by those researching pain. Although related constructs such as ‘‘fear avoidance’’ have increasingly been recognized and investigated, specific reference to safety behaviours (in relation to pain) does not seem to have occurred. This paper presents a brief overview of how the concept of safety seeking behaviours could be applied to chronic pain patients. Although not advancing a radically new approach, it is argued that there are theoretical and clinical advantages to integrating safety seeking behaviours in to psychological models of pain.

Keywords: Chronic pain, safety seeking behaviours, avoidance.

Introduction

Psychological models of chronic pain have undergone a gradual evolution from the purely behavioural to the more contemporary, multidimensional cognitive-behavioural models that are implicitly embedded within a larger biophychosocial context. Fordyce (1976) is most famous for initially proposing the operant behavioural approach in which he argued that (observable and measurable) ‘‘pain behaviours’’ be considered as distinct from other unobservable and subjective aspects of the pain experience. Fordyce argued that pain behaviours (such as limping, grimacing or groaning) were subject to the same forces and influences of reinforcement and learning as were other behaviours. As such, the operant model proposed that pain behaviours could be maintained beyond the normal, expected healing time of an injury if they occurred within certain reinforcing contexts.

The operant model has been well supported by research and further, behavioural treat-

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ments based on this theory proved to be very effective in modifying ''inappropriate'' pain behaviours. At the same time, however, with significant theoretical advances in the conceptualizations and treatment of other disorders (such as depression), it became increasingly clear that cognitions could also have an important role to play in models of chronic pain. Accordingly, cognitive behavioural models were developed. Although not ignoring the importance of behaviour, these models placed greater emphasis on the patient's understanding of their pain, their methods of coping with the pain, and on their reactions to the pain (Turk, Meichenbaum, & Genest, 1983).

The safety seeking behaviours construct

This evolution essentially followed a similar pattern of theoretical development that took place in the fields of anxiety and depression. Early formulations of the anxiety disorders, for example, were similarly focused on behaviour with little recognition of the role of thoughts or beliefs. These formulations have significantly evolved, however, such that contemporary models of anxiety place cognitions at the heart of the problem (e.g., Clark, 1986). In recent years, this evolution has continued and one of the more significant advances has been the proposal of a construct that effectively solves the long-term conundrum of the ''neurotic paradox''.

One of the more perplexing problems facing clinicians and researchers in the anxiety disorders was why patients with panic disorder, to take one of the more common disorders, continued to catastrophize and to fear terrible outcomes, despite what appeared to be a substantial amount of disconfirming evidence. Despite having had many episodes of panic, for example, most patients presenting to clinics for treatment have never died, nor have they had heart attacks, fainted or experienced any other of their primary fears. Why then had their belief not been modified accordingly?

The answer appears to lie in what have come to be known as safety seeking behaviours (Salkovskis, 1991). In brief, safety behaviors are those behaviours utilized by patients in an attempt to avoid a feared outcome. Avoidance and escape have long been recognized in anxiety patients, and can be considered to be gross forms of safety seeking behaviour. At the same time, safety seeking behaviours can be far more subtle and may involve an anxious patient tensing his/her muscles on entering a supermarket. The patient believes that by doing so, they are overcoming the ''wobbly legs'' they experience when becoming anxious and thereby avoid ''collapsing''. Empirical support for this construct has grown in recent years and it has gradually been applied to other anxiety disorders such as social phobia (Wells et al., 1995).

Application of the safety seeking behaviours construct to chronic pain

Somewhat surprisingly, clinicians and researchers do not appear to have attended to the potential application of the safety behaviours construct to chronic pain. Although recent years have seen significant advances in conceptualizations of chronic pain, and although cognitive research in pain has become increasingly sophisticated, the construct of safety seeking behaviours has yet to be incorporated into psychological models.

There is a group of psychological models, however, that has come close to touching on the construct of safety seeking behaviours. One of the more recent versions of this group of

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models is the cognitive model of fear or movement/(re)injury (Vlaeyen, de Jong, Geilen, Heuts, & Breukelen, in press). In this model, Vlaeyen and colleagues have emphasized fear of pain, and they have proposed that if fearful patients avoid (as opposed to confront) daily activities, then the fear of pain will be exacerbated and/or maintained.

What this model does not do is specifically explain how the fear is maintained. This paper argues that fear is maintained via the effect that avoidance and other safety behaviours have on the cognitions and beliefs underlying (or associated with) the fear. That is, if a patient with chronic low back pain is afraid that lifting will result in re-injury, then avoiding lifting will maintain the belief that lifting may lead to further damage. If patients continue to avoid this and similar activities, there will be no opportunity to disconfirm the belief. More subtle safety seeking behaviours, such as wearing a back brace, may also influence the disconfirmation (or lack thereof) of specific pain-related beliefs. Although it could be argued that these actions (i.e., avoidance and/or wearing a back brace) are influenced by iatrogenic factors such as doctor's advice, their effect on maintaining the beliefs is significant nonetheless.

Implications for treatment

The advantages of applying the safety seeking behaviours construct to the problem of chronic pain have been demonstrated by Vlaeyen et al. (in press). Specifically designed exposure programmes, targeting specific fears and related cognitions and beliefs, should increase the efficacy of cognitive-behavioural treatments for patients with chronic pain (particularly the group of patients with high fear-avoidance). Vlaeyen et al. have shown that a tailored exposure intervention can be more effective than more general graded activity programmes. This is not surprising, as more general treatment programmes are less likely specifically to challenge patients' fears and are less likely to provide evidence that might directly disconfirm fear related cognitions.

Incorporating the construct of safety seeking behaviours may further improve the impressive (albeit preliminary) outcomes achieved by Vlaeyen and colleagues. Whereas they developed a ''graded hierarchy of fear-eliciting situations'', an individually tailored conceptualization of patients' fears, incorporating specific pain related beliefs and the associated (maintaining) safety seeking behaviours, should lead to the development of even more specific behavioural experiments that may not need to be graded into a hierarchy. This approach has been used in the treatment of panic patients and has led to the development of impressively brief (and effective) treatments (Salkovskis, Clark, Hackmann, Wells, & Gelder, 1999).

Conclusion

This report reflects on the impressive advances made in psychological formulations of chronic pain, but also suggests that these models could benefit from attending to the construct of safety seeking behaviours and from placing greater emphasis on the specific cognitions and maintaining behaviours that are associated with pain-related fears. As well as adding to the integrity of these psychological formulations, it is suggested that these modifications would also lead to more effective treatment.

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