COMMENTARY

Toward a Fully Functional, Flexible, and Defused Approach to Pain in Young People

Lance M. McCracken, Royal National Hospital for Rheumatic Diseases and University of Bath

What is one to do with pain? If one were to trace the developments of pain management methods over the past 40 years, one would see that psychologists have answered this question in a range of increasingly sophisticated ways. This history of clinical psychology’s approach to pain resembles a line drawn through operant-based treatments, through cognitive behavioral therapy, and following on through a small number of contemporary approaches, approaches that are particularly functional and contextual, as exemplified by Acceptance and Commitment Therapy (ACT) and the case presented by Wicksell, Dahl, Magnusson, and Olsson (2005). Particularly in the application of ACT with young people, pain management is still in its early stages of development. Nonetheless, the question of what to do with pain, or how to manage discouraging thoughts and feelings more generally, is meeting new and exciting models of human suffering and yielding new methods for responding to chronic pain.

A Functional Contextual Approach

To approach chronic pain from a functional and contextual model is to see that human suffering comes, in part, from cognitive processes that add painful and restricting influences to situations, from patterns of struggling with and attempting to avoid unwanted psychological experiences, from confining social influences and rigidly held beliefs about our identities, from a lack of awareness of the world around us, and from failures to clarify and follow our values on some occasions (Hayes, Strosahl, & Wilson, 1999). Treatments available for these processes include methods to loosen unhelpful cognitive influences on action, to enhance acceptance or willingness to have painful experiences, to promote some connection with a contextual sense of self and a more full and present-focused perspective on events, and to produce action in accord with what is most important to the individual.

The case presented by Wicksell and colleagues (2005) is clearly a success, with rated goal achievement that meets 100% in each of nine domains, steady school attendance with no absences, and pain that appears at a level of zero on a 10-point scale, each maintained at 6-month follow-up. Measured improvements in general daily functioning and emotional avoidance further fortify this case for success. These results are impressive. However, as the authors well know, their methods do not allow general statements about the efficacy of their treatment beyond the observation of improvements in one case—a modest but valuable and much-needed start.

Several questions or comments are raised from Wicksell et al.’s (2005) case presentation. It is mentioned that the etiology of pain is unclear or “idiopathic.” Is this relevant to the choice of psychological treatments or the results of treatment? Is this merely a way to say that behavioral and cognitive methods can help where other approaches fail, even in the presence of diagnostic ambiguity? Might these methods help whether other approaches have helped or not, or in cases where definitive diagnoses exist? The authors state that for some chronic pain “pharmacological therapy is often insufficient” (p. 415). It could be added that most non-CBT-based therapies have a record of limited success for improving chronic pain sufferers’ participation in life. Reassurance from a physician was used to “reduce pain-related anxiety and facilitate an increase in activity” (p.419). How important is this, or are there other ways to achieve the same final goals? There appears to be a need to understand the limits of reassurance in wider health contexts and perhaps to address the problem of pain and anxiety at a deeper level.

Social Influences on Pain

The role of parents in treatment, as presented in the case report, is worth further examination, particularly from a functional and contextual perspective. When young people suffer, this creates an occasion for parents...
to suffer and to feel a need to help. These parental responses likely play a critical role in the daily functioning of that young person. No doubt parents face all the same challenges as the young person, when their behavior is unhelpfully influenced by their thoughts and feelings, when they avoid or struggle with unwanted experiences, when they fail to act in ways that serve what they care most deeply about. These premises, however, will require further study to see if they are so.

This type of analysis of parental behavior calls for ways to address the behavior and suffering of the parent as much as the young person. A limited study of social influences in adult chronic pain showed relations between responses from a significant other and the patient’s level of acceptance of pain (McCracken, 2005b). All treatment is a process of behavior change in a social situation. The mutual social influences within parent-child relationships deserve further study and elaboration both for how this will help families and young people in pain and for how it provides a general view on social contexts of suffering and healthy functioning.

**Functional Contextual Methods**

The descriptions of treatment methods in Wicksell et al.’s (2005) case report may look familiar and therefore some key distinctions between CBT and ACT are worth highlighting. Particularly, the “behavior analysis” of factors that increase pain or anxiety, the use of exposure, and the note that the patient was “instructed to acknowledge and accept...these private events” could lead the reader to see this demonstration of ACT as largely indistinct from the wider array of methods in standard CBT.

ACT is based on the notion that psychological struggles to get rid of painful experiences simply do not work in the way they are intended. ACT is ultimately a pragmatic approach, and any response can be a healthy one, regardless of what it looks like, if it leads to a freer and fuller life. It turns out, however, that trying to get rid of painful sensations, unwanted emotions, distressing memories, or discouraging thoughts often leads one away from activities that are personally important and deeply desired. While a “behavior analysis” may be done to find circumstances that can be usefully changed or controlled, it need not be for purposes of reducing pain. Such analyses can be effective ways to raise awareness of the thoughts, feelings, sensations, and urges that are present in a situation, to show that these need not dictate actions taken, and to allow continuing guidance from the individual’s values.

Much of the time in CBT exposure is applied as a strategy to reduce fear and perhaps to correct mistaken assumptions about presumed threats in a situation. The suggestion is that when fear and irrational thoughts are reduced, the patient need no longer avoid a situation and can behave more effectively. The principles behind ACT show that fearful emotional responses and discouraging thoughts come from a person’s history and cannot be completely eliminated—there will remain the possibility that some situation will occasion these feelings and thoughts in the future, and their influences over action may, very likely, remain, at least to some extent. If the relationship between fearful experiences and avoidance remains intact, maintenance of treatment gains will depend on fearful thoughts and feelings remaining absent. The focus of exposure in ACT is not on the reduction or elimination of fearful thoughts and feelings but on a willingness to have these experiences and act according to what is most important to achieve. In essence, exposure is for learning that healthy and free action can be taken both when it feels easy and certain and when fear is present or even when thoughts say it cannot.

An additional assumption of ACT is that it is likely to be difficult to talk or think oneself out of a situation created by talking and thinking. Accordingly, logic and instructions are expected to have limits in creating behavior change. While treatment for chronic pain may usefully aim for acceptance, it is unlikely to help simply to tell, or otherwise logically persuade, the pain sufferer to accept his or her pain (an approach likely to be seen as a failure to understand how the patient feels and to be met with resistance). The focus within ACT, and again one that can be difficult to convey within the space of a brief report, is on experiential learning and metaphorical use of language, methods designed to undermine entanglement with thoughts and private experiences rather than merely to reformulate or elaborate them. Hence, therapy is presumed to work most effectively when situations are created for a patient to experience the utility of acceptance, of “doing nothing” in relation to unwanted experiences when that is the most workable choice, rather than presenting them with verbal reasons or the logical argument to accept. Acceptance is not, after all, a process of changing belief but a process of loosening the influence of misleading private experiences over actions taken. It appears that the best way to do this is with experience and not with a direct verbal assault.

It may or may not be noticed that there is a lack of assessment technology for the key processes within a functional and contextual approach to pain in young people. There is a fairly well developed measure of acceptance of pain for adults, the Chronic Pain Acceptance Questionnaire (McCracken, Vowles, & Eccleston, 2004); at least two measures of values, the
Valued Living Questionnaire (Wilson & Murrell, 2004) and the Chronic Pain Values Inventory (McCracken & Yang, in press); a general measure of experiential avoidance and psychological flexibility, the Acceptance and Action Questionnaire (Hayes et al., 2004); and there are measures of related processes, such as mindfulness (Baer, Smith, & Allen, 2004). While there is work under way, measures for young people of acceptance of pain, cognitive defusion, values-related processes, or mindfulness are not yet widely available. Our ability to study these processes of treatment, to refine treatments, and to make a strong case for the framework on which they are based will require further development of assessment instruments.

Wicksell et al. demonstrate that there are more data from studies of adults with chronic pain than from young people. In fact, there are at least nine clinical studies of acceptance and related processes and four relevant treatment trials (McCracken, Carson, Eccleston, & Keefe, 2004; McCracken, 2005a). For young people, it has been concluded that interdisciplinary, family-inclusive, broadly behavioral and cognitive therapy for chronic pain is a promising approach to the management of chronic pain (Eccleston, Malleson, Clinch, Connell, & Sourbut, 2003), however, efforts for developing treatments specifically for young people do lag behind efforts for adults. In this regard, Wicksell and colleagues are to be congratulated for moving into precisely the territory where all indications would suggest the work needs to go.

**Conclusion**

No one wants to feel pain or to watch others feel it. When a young person is in pain, the urge to take it away can be overwhelming. To be truly caring may be to watch that urge and to be aware that there are more important purposes to be served by helping the young person not to struggle with experiences that do not yield results from that effort, and to stay on a steadier track with actions in accord with what he or she values (i.e., family, time at school, relationships with friends, preparing for a future, developing as a person). Having said all that, and as promising as this appears, convincing support for this approach awaits further study.

**References**


Address correspondence to Lance M. McCracken, Ph.D., Pain Management Unit, Royal National Hospital for Rheumatic Diseases, Bath, UK; e-mail: Lance.McCracken@RNHRD-tr.swest.nhs.uk.