COMMENTARY

The Elaboration and Evolution of CBT: A Familiar Foundation and Creative Application With Chronic Pain

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The case presented by Wicksell and colleagues (2005) raises a number of intriguing issues, particularly about the utility and application of cognitive and behavioral approaches in pain management. Rather than focus on the specific application of Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, and Wilson, 1999) in this case, we have chosen to comment on how their work reminds us of the similarities across CBT approaches and to suggest some minor but important modifications. We also emphasize the importance of understanding both the common foundation in CBT and the need for continued evolution, elaboration, and creative application of these therapies in new and challenging environments.

As McCracken (2006; this issue) has so eloquently reminded us, the application of clinical psychology in pain management is clearly tied to cognitive behavioral therapy, with an increased focus on the functional and contextual aspects of the problem, such as with the case presented. Just as the application of ACT emphasizes the functional and contextual elements of a targeted problem, recent advances in cognitive theory have offered an approach that is much more flexible and easily applied in challenging clinical environments such as with chronic pain. Beck’s (1999) recent modification of traditional cognitive theory, the theory of modes, is relevant to the discussion, particularly since it has received surprisingly little attention in the clinical and research literature. A mode is defined as being comprised of “specific suborganizations within the personality organization that incorporate the relevant components of the basic systems of personality: cognitive (information processing), affective, behavioral, and motivational” (Beck, 1999; p. 4). What is important about this modified approach is that the theory of modes is a sharp and significant departure from the notion of simple linear processing and the primacy of cognition. The theory is one that both recognizes and emphasizes the importance of a synchronous, interdependent, and interactive system. From this perspective, all pain is idiopathic because pain is a function of interdependent systems that are very much embedded in the patient’s developmental history and personal experience. Pain is inevitable and unavoidable, both physically and emotionally. We cannot control it in the sense that it can somehow magically be eliminated from life. We can only experience, process, interpret, and respond to it. ACT tends to emphasize the latter whereas the theory of modes integrates all elements. The value (and goal) tied to this perspective is that pain cannot be avoided, only managed and integrated into a broader philosophy of life and related belief system manifested by behaviors (compensatory strategies).

In short, the theory is, at its very foundation, contextual and functional. Individual vulnerability to pain develops over the course of a life and is expressed via cognition (thoughts and beliefs), affective/physiological symptoms, and related behaviors. The foundation for the patient’s pain beliefs are embedded in previous operant and classical conditioning, social modeling, traumatic experiences, and the like. In many ways, it is theoretically irrelevant to tease apart the various elements given their synchronous and interdependent nature. From this multicomponent perspective, diagnostic ambiguity and uncertainty is to be expected in chronic pain cases. Similarly, we would expect limited (but perhaps clinically meaningful) response to medication in cases of chronic pain. The rationale is simple—the medication addresses limited aspects of the pain mode, that is, the physiological subsystem. Medication neglects the elements of cognitive processing and social, contextual influences on the experience and maintenance of chronic pain.

The theory would argue that each one of us has an identifiable pain mode comprised of cognitive (the pain belief system), affective/physiological (pain symptoms), and behavioral/motivational (pain behaviors) elements that are interactive and interdependent, all working together to drive both our pain experience and response.
From a cognitive perspective, the pain belief system is particularly relevant and a central means to both understand and monitor a patient’s response to treatment. For example, in the case provided by Wicksell and colleagues (2005), beliefs such as I can’t function with this pain or I can’t manage this pain are particularly relevant, working synergistically to drive the symptomatic (subjective) experience of pain and related behavioral compensatory strategy (in this case, avoidant coping via inactivity). The net result or cognitive consequence of avoidant coping is the emergence, strengthening, and eventual crystallization of beliefs of incapacity and incompetence (impaired functional status) that are all too often reinforced by well-intentioned and well-meaning family members. The case presented is particularly delicate and challenging since engaged and loving parents simply want to minimize the pain experienced by their child, not impair functional capacity. As evidenced, the notion of a pain mode is an idiopathic one by nature, recognizing and emphasizing the importance of personal history and experience in forming and maintaining the various elements of the mode. McCracken (2005) has provided some initial compelling evidence of the relationship between responses from significant others and adult acceptance of chronic pain. Extension of these findings downward to adolescents is important for clinicians.

Similarly, one critical element (and there certainly are many others) in the application of ACT is the construct of acceptance. From a definitional perspective, it is arguable that acceptance is an elusive and slippery construct, certainly one that must exist and be expressed on a continuum—or as levels or stages of some sort. How do we know the identified level of acceptance in this case? How do we differentiate between initial efforts at acceptance and manifest acceptance? As evidenced in the case provided here, the obvious response is in observable changes or shifts in behavior. A valued life is expressed in the behavioral goals articulated and accomplished. However, according to the theory of modes, these changes do not occur in isolation, without associated cognitive processing and interpretation. It would be interesting to ask the patient a simple question. What do the changes in behavior say about her ability to manage or tolerate her pain, to live a valued and meaningful life with pain? A more traditional cognitive behavioral therapist would likely ask this question, perhaps not as early as some might suspect, but certainly at least midway into the exposure task. A concerted effort would also be made to track changes in this belief (and other pain beliefs dealing with tolerance and functional capacity) over time, paralleling more challenging exposure tasks. The theory of modes would also predict that as behavior changes (a valued life being expressed), not only would the pain belief system be modified, but the subjective experience of pain would diminish. This is certainly the case here, as the patient’s mean pain ratings fully resolved within a matter of 6 months.

As mentioned by Hayes and Duckworth (2006; this issue), the emphasis is not on changing targeted thoughts or feelings but on a willingness to experience pain in order to achieve in accordance with individually identified and stated values. I think we all agree that exposure is central to effective treatment regardless of what aspect is emphasized as a primary mechanism of action. From a theory of modes perspective, the goal is to modify the pain mode, with the evolution and emergence of more active and healthy compensatory strategies and associated changes in pain beliefs. As noted above, such change is believed to occur in synchrony. It is important to note that evolution in the pain mode can be achieved through exposure work, entirely consistent with that evidenced in the case example, with secondary review of cognitive consequences for pain beliefs. For example, gradual increases in activity despite continued pain can lead to conclusions such as, I can go to school even when I hurt or I can still accomplish things that are important to me when I’m in pain. In short, increased activity is evidence of modifications and productive evolution of the pain mode. In contrast to ACT, a pain mode approach would argue that recognition and integration of these cognitive consequences is important to lasting change and resilience to relapse.

It is important to mention the similarity of both approaches to Linehan’s (1993) construct of distress tolerance and emotion regulation and the application of similar techniques with other chronic problems such as suicidal behavior (Rudd, Joiner, and Rajab, 2004). At the heart of this approach is skill development and behavioral change, with no particular emphasis on the associated (and we would argue) inescapable cognitive processing and contextual nature of the experience. Enduring change in the pain mode (or any identified mode) would require explicit cognitive processing. Certainly, implicit processing occurs but making it explicit provides the opportunity for lasting resilience.

Although the contributions of Wicksell et al.’s (2005) case example are limited from a scientific perspective, it gives rise to exciting and invigorating conceptual debates that ultimately help both science and clinical practice move forward. The clear and overwhelming evidence of success in this case begs both exploration and explanation of the mechanism(s) of action in order to scientifically test, validate, and disseminate a proven effective treatment. Unquestionably, this is a considerable task, one that likely would take several years, randomly controlled trials, and complex designs. What is not lost in the case presented, however, is the importance of clinical
practice in informing science. Such profound success under unique and challenging circumstances reminds us of the importance of science in confirming both that a given approach works and why. But these findings also remind us that not only is it important to identify potentially unique elements in a therapy but also to consider common elements that can be identified and considered through the careful and cautious application of theory. The application and evolution of cognitive therapy is exciting. What is particularly important is for theory to keep pace, remaining flexible and amenable to practice. This case tells a compelling story that that indeed is happening.

References


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