

Using What We Know about Couples in the Context of Chronic Pain to Push for Continued Progress: Commentary on Vivekanantham and Colleagues

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The existent literature on the experience of chronic pain suggests that it is a complex phenomenon. Studies highlight the importance of social factors, notably relationships with close others, as an important factor in the experience of pain and pain outcomes [1]. The paper by Vivekanantham and colleagues in this issue presents a unique way to examine how both members of a couple can impact relationship satisfaction in the context of chronic pain. The findings from this work suggest that spouses of patients with chronic pain who have symptoms of depression experience significantly lower satisfaction with some aspects of marital relationship. Additionally, the findings suggest that for spouses who are not depressed, increases in patient pain severity may serve as a “bonding agent” as measured by consensus in the relationship. This paper provides an interesting addition to the literature and offers a chance to reflect on what has been learned in terms of couples relationships and pain. It may also help provide insight for both clinicians and researchers as to how to continue to progress forward in this important area of study.

One of the biggest advances in research on pain and interpersonal relations is how couples’ dynamics have been conceptualized in the context of pain. Early behavioral and cognitive-behavioral models of pain focused on the role that the spouse played in terms of reinforcement, exacerbation, or reduction in pain symptoms or behavior [2,3]. Although these models have received empirical support, continued work in this area has led to the development of more dynamic models of couples’ relationships and pain. One such model, put forth by Cano and Leong [4], and mentioned by Vivekanantham and colleagues, suggests that there is an interactional process between and within individuals with regard to pain-related couples exchanges. Additionally, approaches based on “social cybernetics,” which highlight the cyclical nature that couples dynamics can have over time in the context of health problems [5], could be applied to pain to help understand how pain specific behaviors/limitations could serve a maintenance function of the couple, at least in the short term.

Likely driven in part by the advancement of conceptual models, assessing factors in the social environment of the person with pain, and not just the experience of pain within the person, provides new and important information to the existing literature. The work by Vivekanantham and colleagues exemplifies this. First, their focus on psychological distress in the spouse is noteworthy. Current research clearly demonstrates an increased level of depression of spouses of patients with pain [6], and an effort to enhance understanding of this phenomenon and how it impacts the relationship is important. Second, their focus on the marital relationship as an outcome should be commended and recognized. Given the importance of marital relationships on pain, research that examines more than pain-based outcomes is needed in the literature, especially given the possibility that pain could serve a purpose in a couple’s relationship. Furthermore, having a stable and satisfying relationship may help partners to navigate new challenges that pain may introduce and/or act as a protective factor if the pain condition worsens or other health issues arise in either partner [7,8].

Advancements in dyadic theoretical models for pain and shifts in focus off of the patient with pain, coupled with the findings from Vivekanantham and colleagues lend to several suggestions to aid in future research pursuits and clinical utility. In terms of clinical recommendations that incorporate the current work, pain reassessment of persons with pain should include a comprehensive evaluation of his/her social system. This evaluation should include not only physical assessment, but also psychological assessment as well. Early identification of problem areas may ultimately provide benefit at the individual, and as the current article suggests, at the couple level as well. For instance, if symptoms of depression in spouses are addressed, the spouse may be more likely to engage in differential attributions regarding support provision. Collecting data from both partners, or other members of the patient’s social system, could enhance not only clinical practice with patients with pain, but also with couples research on pain. Collecting dyad level data, however, necessitates that the inherent issue of nonindependence in data be addressed [9]. Current use of hierarchical linear modeling or other multilevel modeling would allow for examination of both actor/partner effects as well as phenomena that occur at either the individual or the couple

level. Second, pain assessment and intervention needs to be flexible enough to include marital processes. A recent article by Baucom and colleagues provides thoughtful guidelines for the implementation of couple-based treatments for medical problems [10], and it may be that an approach specifically targeted at the marriage would lead to numerous patient gains. This suggestion could also be an avenue for future research endeavours. Specifically, future research could attempt to elucidate whether or not relationship targeted interventions or treatments matched to specific couple needs treatment matching might be helpful. For instance, the current study might suggest that cognitive restructuring of support provision, particularly in spouses who experience symptoms of depression might work to increase sense of cohesion. Regardless, as a field we can look back over the last several decades with a sense of satisfaction that our knowledge of the complexity of pain has been advanced and we can look forward to the future with a sense of hope as there are still many opportunities to progress forward.

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