Psychological Flexibility at the Heart of CBT for Chronic Pain: Ought We?

Lance M. McCracken, PhD

Psychology Department, Institute of Psychiatry
King's College London &
INPUT Pain Management Unit, Guy's and St Thomas'
NHSFT, London

KING'S College LONDON

Guy's and St Thomas' NHS
NHS Foundation Trust

Outline

- Briefly discuss current cognitive behavioral approaches to chronic pain.
- Present theory and principles from an approach called Acceptance and Commitment Therapy (ACT).
- Discuss its relevance for the future of chronic pain management.

The Journal of Pain, Vol 7, No 11 (November), 2006: pp 779-793
Available online at www.sciencedirect.com

ELSEVIER

FOCUS ARTICLE

Evidence-Based Scientific Data Documenting the Treatment and Cost-Effectiveness of Comprehensive Pain Programs for Chronic Nonmalignant Pain

Robert J. Gatchel* and Akiko Okifuji†

**Department of Psychology, College of Science, The University of Texas at Arlington, Arlington, Texas.*
†Pain Research Center, Department of Anesthesiology, University of Utah, Salt Lake City, Utah.
Written for the American Pain Society Task Force on Comprehensive Pain Rehabilitation, Glenview, Illinois.

Perspective: *A comprehensive review was conducted of all studies in the scientific literature reporting treatment outcomes for patients with chronic pain. This review clearly revealed that CPPs offer the most efficacious and cost-effective treatment for persons with chronic pain, relative to a host of widely used conventional medical treatment.*

Psychological therapies for the management of chronic pain (excluding headache) in adults (Review)

Eccleston C, Williams ACDC, Morley S

THE COCHRANE COLLABORATION®

This is a reprint of a Cochrane review, prepared and maintained by The Cochrane Collaboration and published in *The Cochrane Library* 2009, Issue 3

http://www.thecochranelibrary.com

Results for Disability: Effect Sizes

	Post Treatment		Follow-up	
	TAU	Active	TAU	Active
Cognitive Behavior Therapy		**0.16**		**0.21**
Behavior Therapy				

Available online at www.sciencedirect.com
ScienceDirect
Clinical Psychology Review 27 (2007) 173–187
CLINICAL PSYCHOLOGY REVIEW

Do we need to challenge thoughts in cognitive behavior therapy?

Richard J. Longmore [a,*], Michael Worrell [a,b]

[a] *Central and North West London Mental Health NHS Trust, United Kingdom*
[b] *Royal Holloway, University of London, United Kingdom*

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Research Article

Positive Self-Statements

Power for Some, Peril for Others

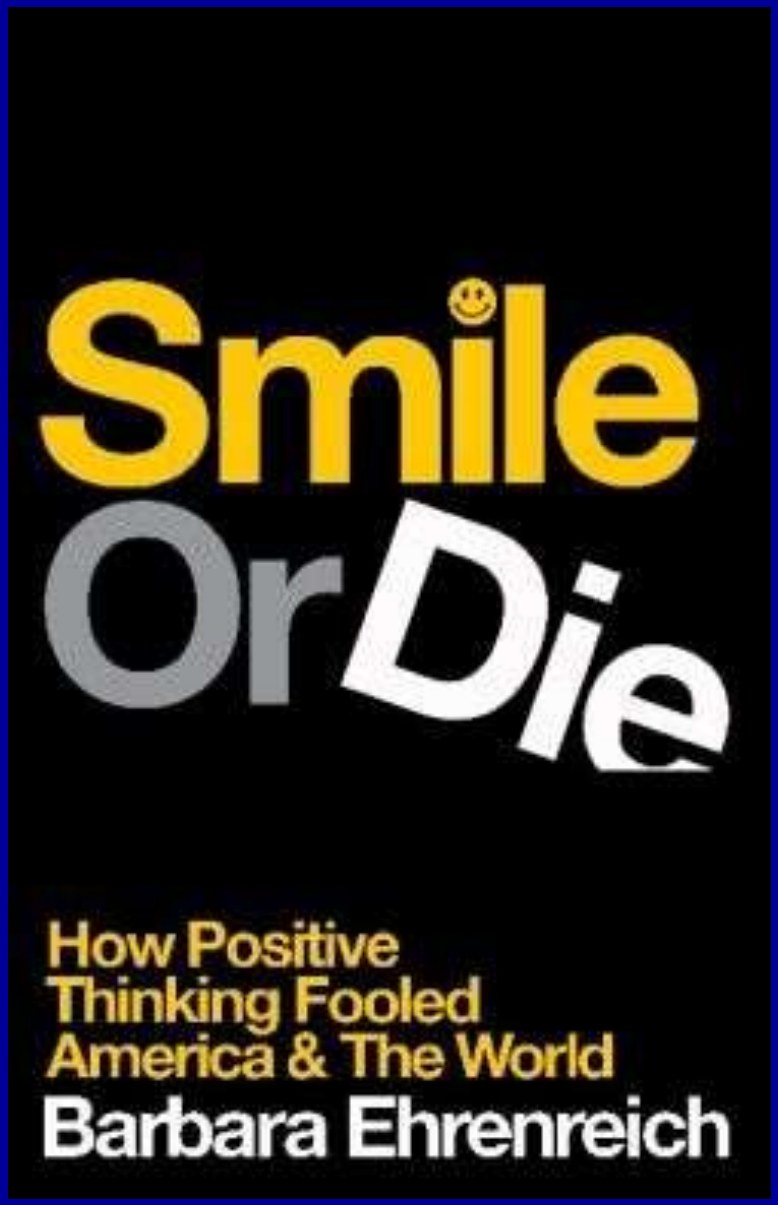
Joanne V. Wood,[1] W.Q. Elaine Perunovic,[2] and John W. Lee[1]

[1]University of Waterloo and [2]University of New Brunswick

ABSTRACT—*Positive self-statements are widely believed to boost mood and self-esteem, yet their effectiveness has not been demonstrated. We examined the contrary prediction that positive self-statements can be ineffective or even harmful. A survey study confirmed that people often use positive self-statements and believe them to be effective. Two experiments showed that among participants with low self-esteem, those who repeated a positive self-statement ("I'm a lovable person") or who focused on how that statement was true felt worse than those who did not repeat the statement or who focused on how it was both true and not true. Among participants with high self-esteem, those who repeated the statement or focused on how it was true felt better than those who did not, but to a limited degree. Repeating positive self-statements may benefit certain people, but backfire for the very people who "need" them the most.*

(b) in studies in which confounds, such as therapist attention or demand characteristics, seem highly plausible but were not controlled. The true impact of positive self-statements, then, is unknown.

We propose that, contrary to popular belief, positive self-statements can be useless for some people, even though they may benefit others. They may even backfire, making some people feel worse rather than better. We base our predictions on research involving attitude change, self-comparison, and self-verification. According to the "latitudes of acceptance" idea (Sherif & Hovland, 1961), messages that espouse a position close to one's own attitude are more persuasive than messages that espouse a position far from one's own (Eagly & Chaiken, 1993). Messages that fall outside one's latitude of acceptance are thought to meet resistance, and even to have the potential to backfire, leading one to hold one's original position even more strongly (Zanna, 1993). Positive self-statements can be construed as messages that attempt to change attitudes—in this


Smile
Or Die
How Positive
Thinking Fooled
America & The World
Barbara Ehrenreich

European Journal of Pain 13 (2009) 178–188

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European Journal of Pain

journal homepage: www.EuropeanJournalPain.com

Cognitive-behavioral therapy for persistent pain: Does adherence after treatment affect outcome?

Charlotte Curran [a], Amanda C. de C. Williams [a,*], Henry W.W. Potts [b]

[a] Research Department of Clinical, Education and Health Psychology, University College London, Gower Street, London WC1E 6BT, United Kingdom
[b] Centre for Health Informatics and Multiprofessional Education (CHIME), University College London, Archway Campus Highgate Hill, London N19 5LW, UK

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ABSTRACT

It is a tenet of cognitive behavioral treatment of persistent pain problems that ex-patients should adhere to treatment methods over the longer term, in order to maintain and to extend treatment gains. However, no research has quantified the causal influence of adherence on short-term outcome in this field. The aims of this study are to assess determinants of adherence to treatment recommendations in several domains, and to examine the extent to which cognitive and behavioral adherence predicts better outcome of cognitive behavioral treatment for persistent pain. Longitudinal data from a sample of 2345 persistent pain patients who attended a multicomponent treatment programme were subjected to structural equation modeling. Adherence emerged as a mediating factor linking post-treatment and follow-up treatment outcome, but contributed only 3% unique variance to follow-up outcomes. Combined end-of-treatment outcomes and adherence factors accounted for 72% of the variance in outcome at one-month follow-up. Notwithstanding shortcomings in the measurement of adherence, these findings question the emphasis normally given to adherence in the maintenance of behavioral and cognitive change, and clinical implications are discussed.

“If taken at face value, the findings suggest that both theory and practice of recommending adherence to treatment methods require re-examination if not overhaul.” (p 187)

Key Variables in CBT

Depression

Distraction

Coping

Catastrophizing

Self-efficacy

Beliefs

Anxiety

Self-management

Key Variables in CBT

Interruption
Health beliefs
Distraction
Depression
Pacing
Catastrophizing
Endurance
Coping
Self-efficacy
Anger
Anxiety
Neuroticism
Beliefs
Hopelessness
Self-management

Key Variables in CBT

Key Variables in CBT!

Pain prone personality

Abuse history

Fear-avoidance

Spouse responses

Injury sensitivity

Health beliefs

Interruption

Trauma

Distraction

Health anxiety

Depression

Anxiety sensitivity

Pacing

Disease conviction

Lack of control

Catastrophizing

Coping

Endurance

Attachment

Self-efficacy

Anger

Hypervigilance

Neuroticism

Anxiety

Beliefs

Locus of control

Flexible goal adjustment

Avoidance

Rumination

Hopelessness

Self-management

Activity cycling

Mental defeat

Misdirected problem solving

Attention

Worry

Helplessness

Stop rules

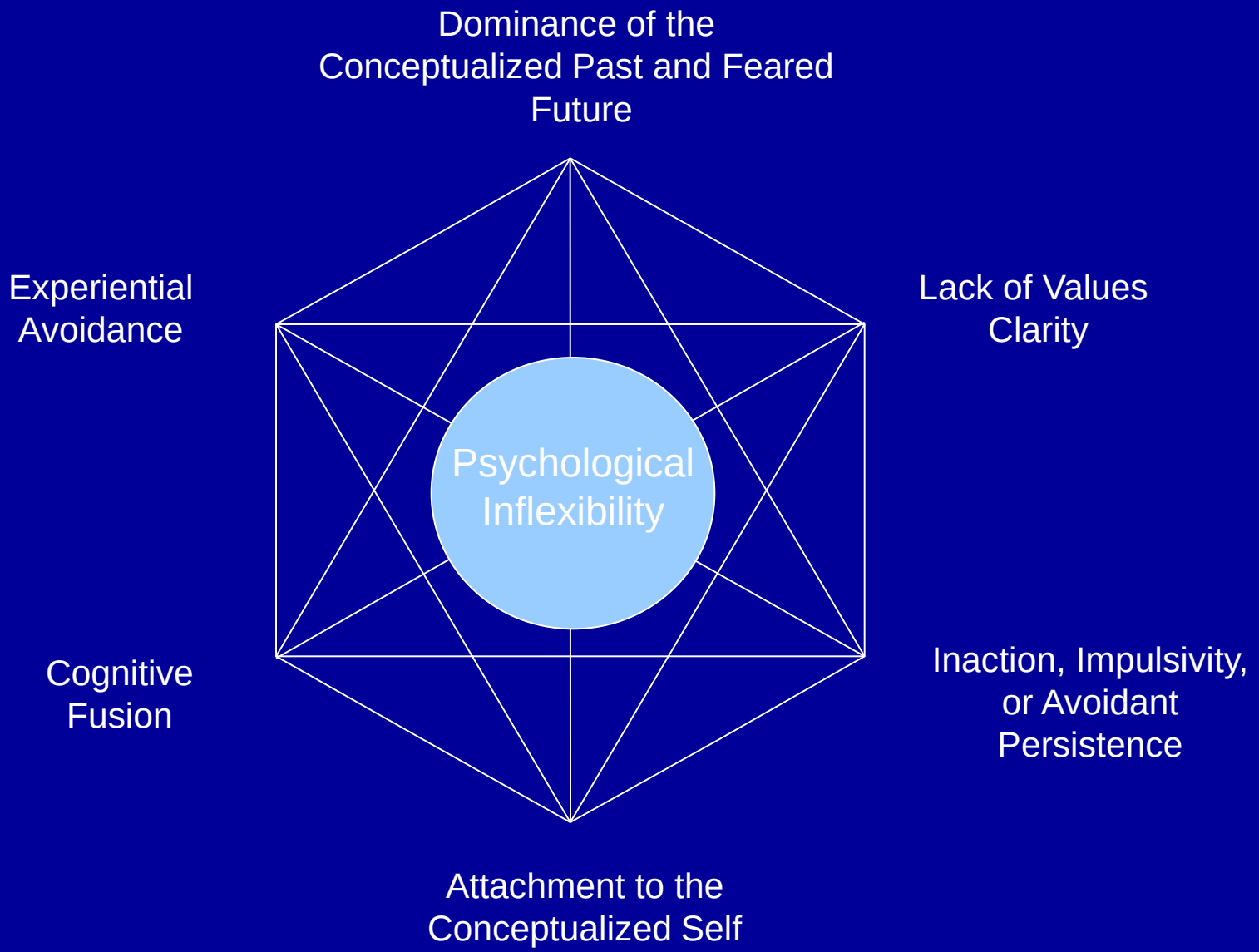
Assimilation & Accommodation

Deconditioning

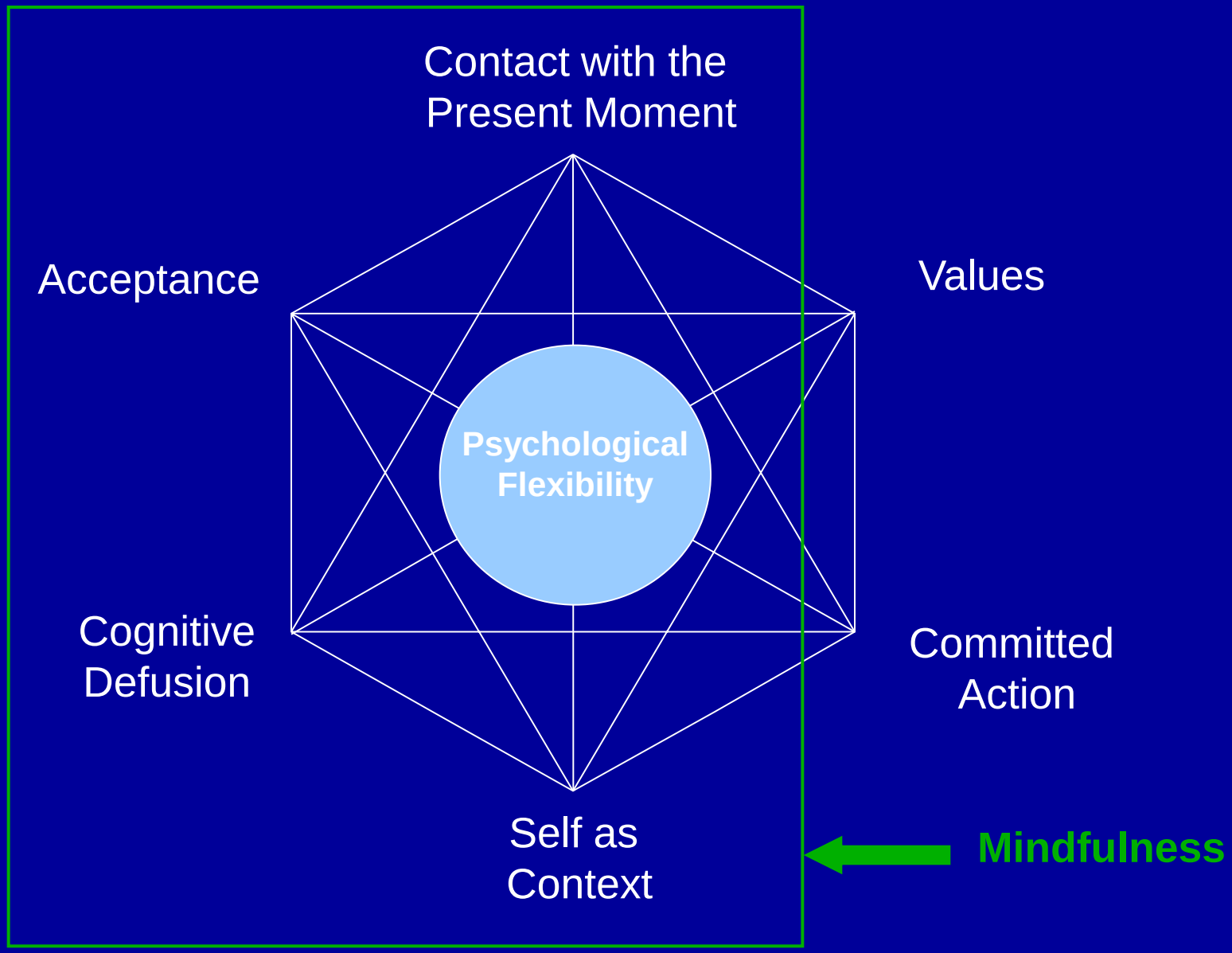
Key Methods

- Education and information.
- Cognitive therapy.
- Activity Management.
- Relaxation.
- (Graded Exposure).

The ACT model of Psychopathology



ACT Treatment Processes



ACT Therapeutic Processes

Contact with the
Present Moment

Acceptance

Values

Cognitive
Defusion

Committed
Action

Self as
Context

ACT Therapeutic Processes

Acceptance

Values

Cognitive
Defusion

Committed
Action

ACT Therapeutic Processes

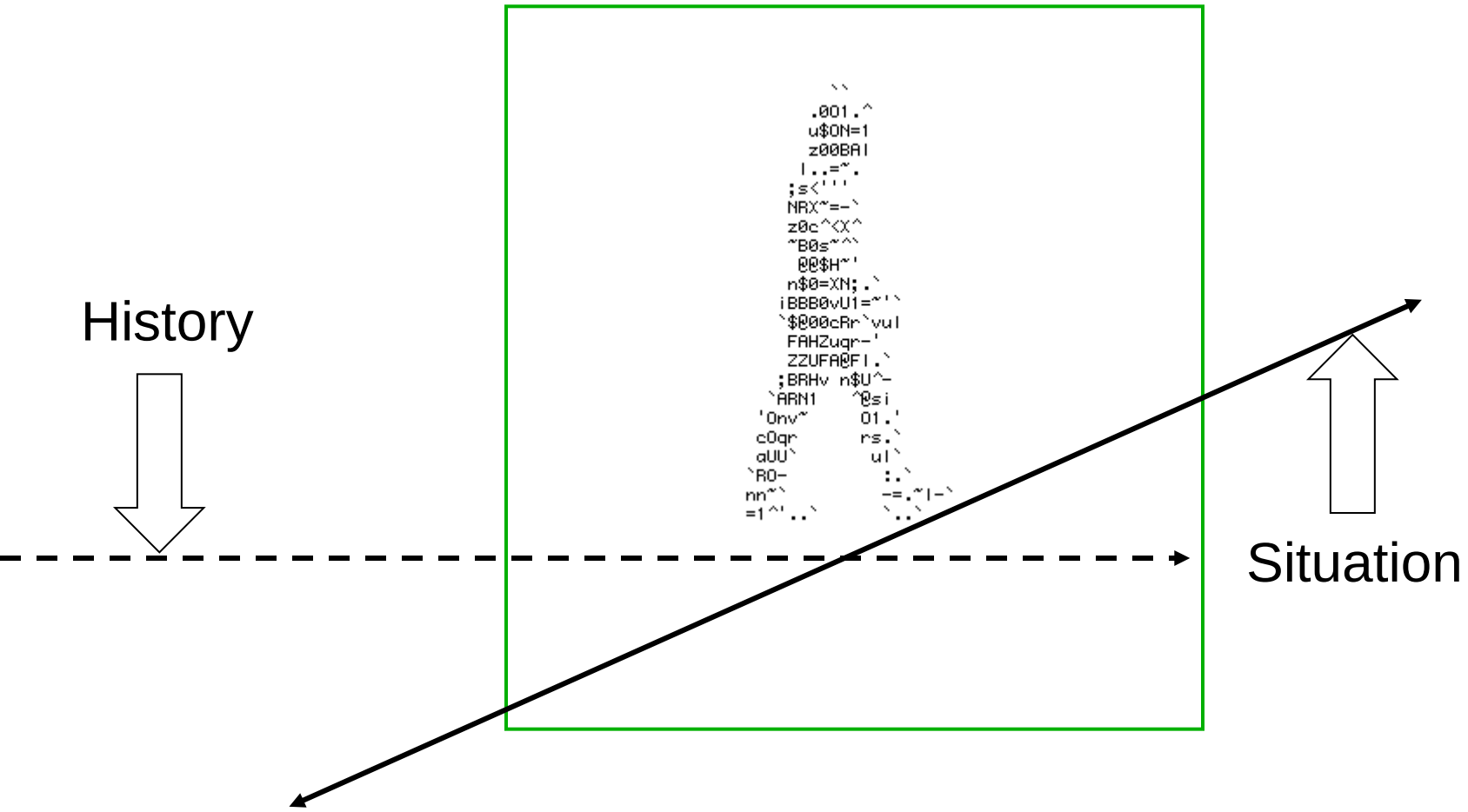
Psychological Flexibility

“Psychological Inflexibility”

A process based in interactions of language and cognition with direct experiences that produces an inability to persist in, or change, a behavior pattern in the service of long term goals or values.

From: Hayes et al. *Behav Res Ther* 2006; 44: 1-25.

Context



Behavior Modification
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http://bmo.sagepub.com
SAGE

Investigating the Similarities and Differences Between Practitioners of Second- and Third-Wave Cognitive-Behavioral Therapies

Lily A. Brown[1], Brandon A. Gaudiano[1], and Ivan W. Miller[1]

Internet-based Survey of “Second” (n = 55) and “Third” (n = 33) Wave CBT Practitioners

- Second wavers reported greater use of cognitive restructuring and relaxation.
- Third wavers reported greater use of mindfulness/acceptance and exposure-based methods and used a wider total number methods.
- No differences in attitudes toward evidence-based practice, alternative treatments, or in rational versus intuitive thinking style.

ACT-Based Treatment for Chronic Pain (N = 8 Studies)

- Dahl et al., 2004
- McCracken et al., 2005
- McCracken et al., 2007
- Vowles & McCracken, 2008
- Wicksell et al., 2008
- Vowles et al. 2009
- Johnston et al. 2010
- Wetherell et al. 2011

Society of Clinical Psychology
American Psychological Association, Division 12

Chronic or Persistent Pain in General (including numerous conditions)

Description

There are numerous sources of chronic or persistent pain such as fibromyalgia, headache, back problems, and rheumatological conditions among many others. Some treatments are being examined as interventions for chronic or persistent pain regardless of the source of the pain. Research on such treatments will be presented on this page.

Psychological Treatments

Acceptance and Commitment Therapy for Chronic Pain

(Modest Research Support)

http://www.div12.org/PsychologicalTreatments/disorders/pain_general.php

Cognitive Behaviour Therapy Vol 37, No 3, pp. 169–182, 2008

Routledge
Taylor & Francis Group

Can Exposure and Acceptance Strategies Improve Functioning and Life Satisfaction in People with Chronic Pain and Whiplash-Associated Disorders (WAD)? A Randomized Controlled Trial

Rikard K. Wicksell[1,2], Josefin Ahlqvist[1], Annika Bring[3], Lennart Melin[4] and Gunnar L. Olsson[1,5]

[1]*Pain Treatment Service, Astrid Lindgren Children's Hospital, Karolinska University Hospital and* [2]*Department of Clinical Neuroscience, Karolinska Institute, Stockholm, Sweden;* [3]*Department of Neuroscience and* [4]*Department of Psychology, Uppsala University Uppsala, Sweden;* [5]*Departments of Physiology and Pharmacology, Karolinska Institute, Stockholm, Sweden*

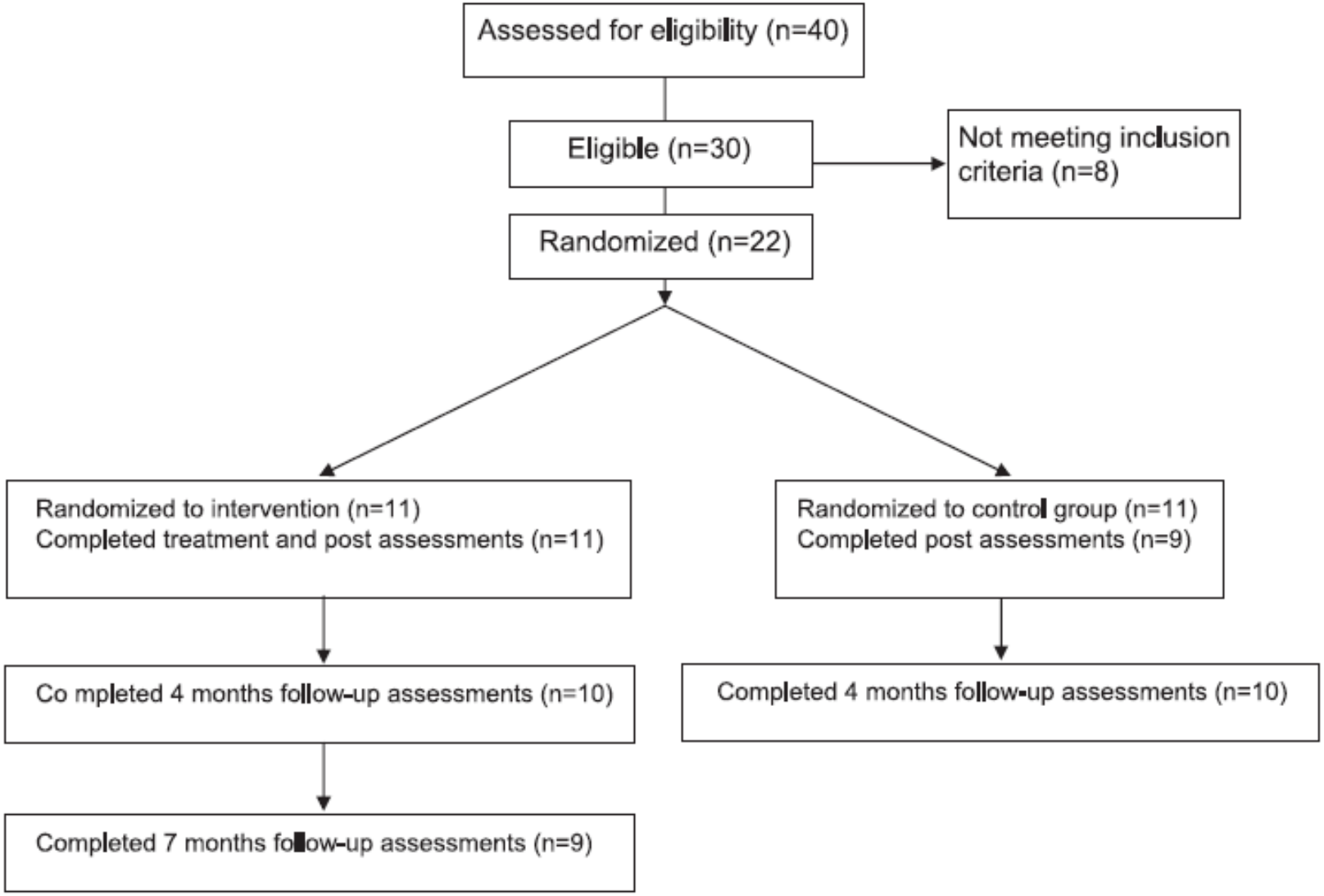

Figure. 1. A flow diagram of the trial. One participant in the control group withdrew before collection of baseline data and one withdrew during the treatment period. Only the treatment group completed 7-month follow-up assessments.

Table 3. *Results on all measures expressed as group means (SD): groups compared using analysis of covariance (pretreatment scores as covariate)*

Dependent variable[a]	Pretherapy	Posttherapy[b]	4-mo FU[b]	$F(1, 16)$	η_p^{2c}
Primary outcome variables					
PDI (0–70)				12.6, $p=.003$	.44
Treatment	37.1±12.3	24.3±14.0	31.6±14.3		
Control	33.9±13.0	38.3±15.2	40.9±13.2		
SWLS (5–35)				10.1, $p=.006$	.40
Treatment	17.0±6.1	23.7±6.2	23.4±5.9		
Control	19.1±5.7	17.9±4.5	17.8±6.8		
Secondary outcome variables					
TSK (17–68)				10.8, $p=.005$	.40
Treatment	33.4±9.4	29.0±6.1	28.7±6.4		
Control	34.1±9.7	40.1±9.2	35.2±10.4		
IES (0–60)				7.2, $p=.017$	.31
Treatment	25.6±19.6	19.1±19.0	11.8±14.7		
Control	22.1±14.9	27.6±22.5	24.9±24.2		
HADS-Anxiety (0–21)				2.9, $p=.111$	.16
Treatment	8.3±4.0	5.4±3.7	5.0±2.5		
Control	9.7±5.7	8.4±5.6	8.9±6.2		
HADS-Depression (0–21)				22.8, $p<.001$	.60
Treatment	8.1±4.9	4.4±3.6	4.1±2.6		
Control	8.9±5.5	8.7±4.0	9.8±5.6		
Pain intensity (0–100)				0.2, $p=.675$	.01
Treatment	5.3±1.0	4.8±2.1	5.2±1.9		
Control	6.3±1.5	5.7±1.6	5.8±1.4		
Pain interference (0–100)				7.3, $p=.016$	.31
Treatment	4.6±1.3	2.9±1.5	3.5±1.6		
Control	5.6±1.8	4.8±2.1	5.7±1.4		
Process variables					
PIPS-Avoidance (10–70)				24.6, $p<.001$	.61
Treatment	41.9±9.1	25.6±7.4	27.6±10.7		
Control	40.6±12.9	39.1±12.6	42.3±14.3		
PIPS-Fusion (6–42)				8.2, $p=.011$	.34
Treatment	32.1±4.9	22.3±8.5	23.0±8.9		
Control	31.0±5.8	31.7±5.7	33.2±5.6		

Note. *FU=follow-up; PDI=Pain Disability Index; SWLS=Satisfaction with Life Scale; TSK=Tampa Scale of Kinesiophobia; IES=Impact of Event Scale; HADS=Hospital Anxiety and Depression Scale; PIPS=Psychological Inflexibility in Pain Scale.*

[a] *Values in parentheses represent score range.*

[b] *Values represent original means and standard deviations (i.e. without adjustment for covariates).*

[c] *Partial eta square (η_p^2): .01=small effect, .09=medium effect, .25=large effect (Cohen, 1988).*

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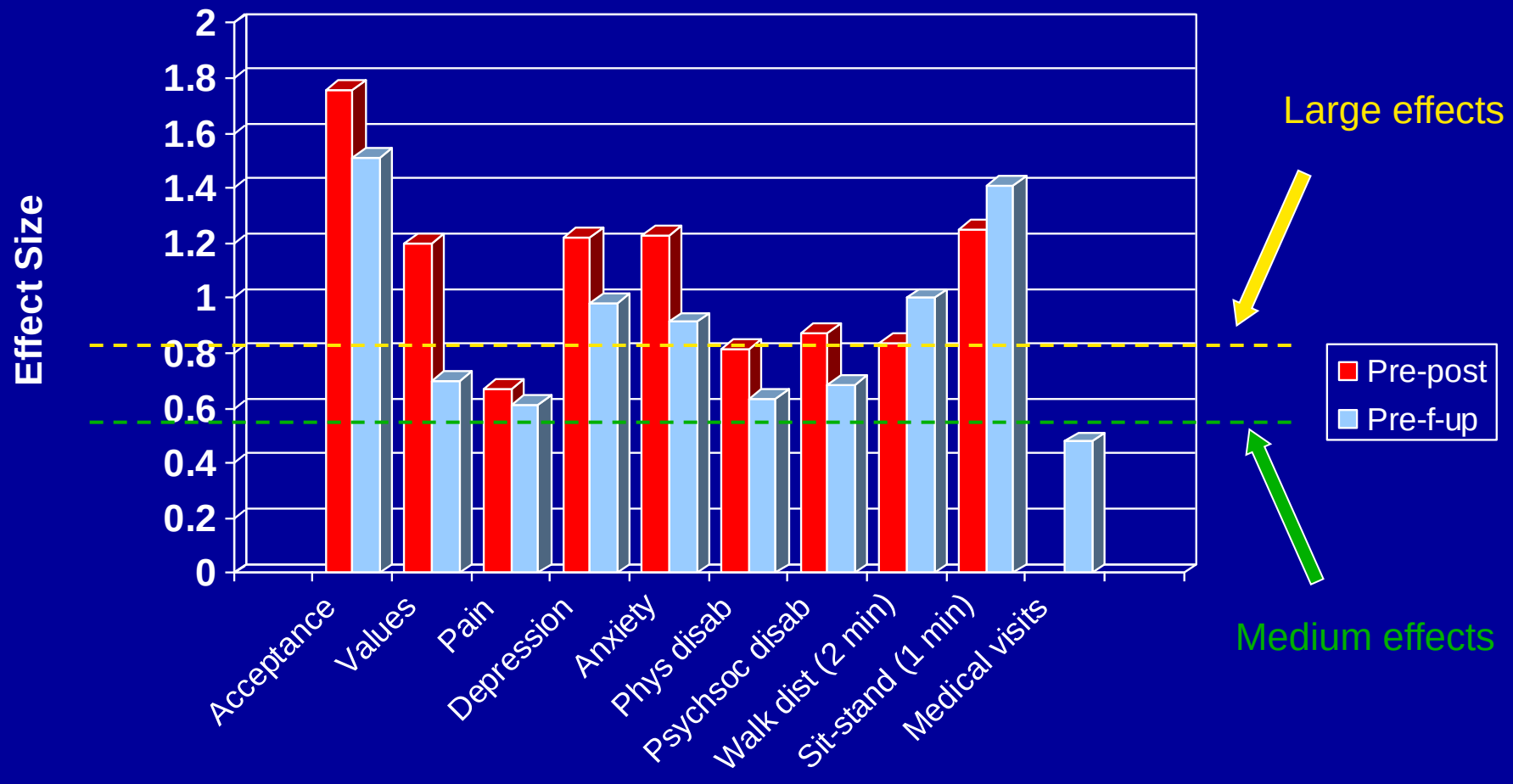
Acceptance and Values-Based Action in Chronic Pain: A Study of Treatment Effectiveness and Process

Kevin E. Vowles and Lance M. McCracken
University of Bath and Royal National Hospital for Rheumatic Diseases

Developing approaches within cognitive behavioral therapy are increasingly process-oriented and based on a functional and contextual framework that differs from the focus of earlier work. The present study investigated the effectiveness of acceptance and commitment therapy (S. C. Hayes, K. Strosahl, & K. G. Wilson, 1999) in the treatment of chronic pain and also examined 2 processes from this model, acceptance and values-based action. Participants included 171 completers of an interdisciplinary treatment program, 66.7% of whom completed a 3-month follow-up assessment as well. Results indicated significant improvements for pain, depression, pain-related anxiety, disability, medical visits, work status, and physical performance. Effect size statistics were uniformly medium or larger. According to reliable change analyses, 75.4% of patients demonstrated improvement in at least one key domain. Both acceptance of pain and values-based action improved, and increases in these processes were associated with improvements in the primary outcome domains.

Keywords: acceptance, values, chronic pain, contextual cognitive-behavioral treatment, acceptance and commitment therapy

Results at Post Treatment (N=171) and 3-Month Follow-up (n = 114)



Effect Size Summary

Effect	Range	Mean
Post Treatment	0.67-1.76	1.07
Three-Month Follow-up	0.48-1.51	.89

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Processes of change in psychological flexibility in an interdisciplinary group-based treatment for chronic pain based on Acceptance and Commitment Therapy

Lance M. McCracken [a, b, *], Olga Gutiérrez-Martínez [c]

[a] Centre for Pain Services, Royal National Hospital for Rheumatic Diseases, Upper Borough Walls, Bath BA1 1RL, UK
[b] Centre for Pain Research, University of Bath, Bath, UK
[c] Department of Personality, Assessment and Psychological Treatments, University of Barcelona, Spain

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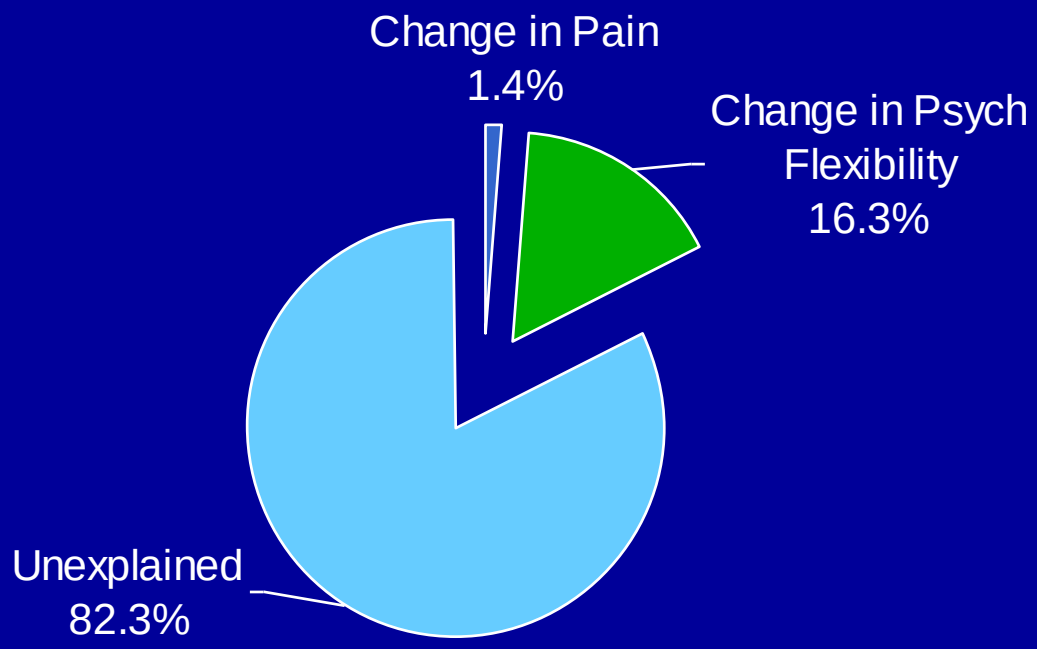
ABSTRACT

There are now numerous studies of Acceptance and Commitment Therapy (ACT) for chronic pain. These studies provide growing support for the efficacy and effectiveness of ACT in this context as well as for the role of ACT-specific therapeutic processes, particularly those underlying *psychological flexibility*. The purpose of the present study was to continue to build on this work with a broader focus on these processes, including acceptance of pain, general psychological acceptance, mindfulness, and values-based action. Participants included 168 patients who completed an ACT-based treatment for chronic pain and a three-month follow-up. Following treatment and at follow-up, participants reported significantly reduced levels of depression, pain-related anxiety, physical and psychosocial disability, medical visits, and pain intensity in comparison to the start of treatment. They also showed significant increases in each of the processes of psychological flexibility. Most uncontrolled effect sizes were medium or large at the follow-up. In correlation analyses changes in the four processes measures generally were significantly related to changes in the measures of depression, anxiety, and disability. In regression analyses the combined processes were related to changes in outcomes above and beyond change in pain intensity. Although in some ways preliminary, these results specifically support the unique role of general psychological acceptance in relation to improvements achieved by treatment participants. The current study clarifies potential processes of change in treatment for chronic pain, particularly those aiming to enhance psychological flexibility.

Method

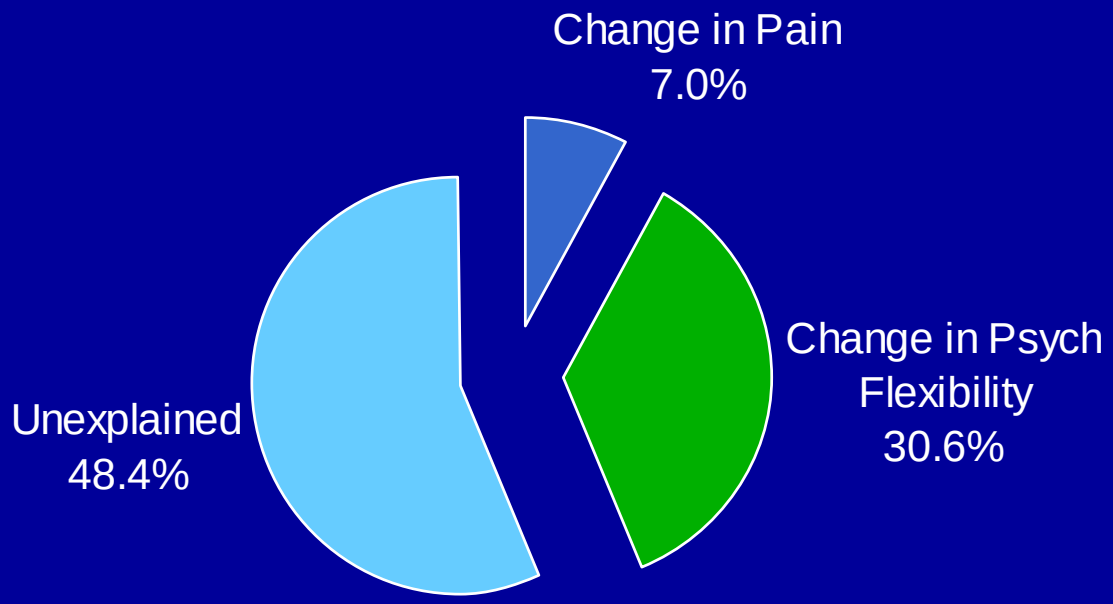
- N = 184.
- 63.6% women.
- Age M = 46.3 (SD = 10.1)
- 96.7% white European.
- 63.7% married.
- 87.8% not working.
- Pain duration Mdn = 118.9 months
- Primary pain 57.5% low back, 12% lower limbs, 9.2% upper limbs, 9.2% full body.

Process Change at Post Treatment in Relation to Outcome Improvement at Follow-up: Physical Disability



Note: No significant individual predictors, AAQ (β = -.24; p = .07).

Process Change at Post Treatment in Relation to Outcome Improvement at Follow-up: Psychosocial Disability



Note: Significant predictors included pain (β = .22), AAQ (β = -.44), and CPVI (β = -.23).

Regression Results

Dependent variable and step	Predictor	ΔR^2	Beta	sr^2
Depression				
Step 1		.10**		
	Pain intensity		.30**	.078
Step 2		.20***		
	Acceptance of pain		.01	.0001
	Values-based action		−.12	.010
	Psych acceptance		−.44***	.116
	Mindfulness		.14	.012
Total R^2		.30***		
Pain-related anxiety				
Step 1		.05*		
	Pain intensity		.11	.012
Step 2		.25***		
	Acceptance of pain		−.24*	.032
	Values-based action		−.05	.0025
	Psych acceptance		−.15	.014
	Mindfulness		−.19	.026
Total R^2		.30***		
Physical disability				
Step 1		.02		
	Pain intensity		.06	.0036
Step 2		.18***		
	Acceptance of pain		−.16	.014
	Values-based action		−.05	.0025
	Psych acceptance		−.26*	.040
	Mindfulness		−.06	.0025
Total R^2		.20***		
Psychosocial disability				
Step 1		.09**		
	Pain intensity		.28**	.073
Step 2		.25***		
	Acceptance of pain		.12	.0081
	Values-based action		−.17	.023
	Psych acceptance		−.42***	.102
	Mindfulness		−.09	.0049
Total R^2		.34***		

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Acceptance and values-based action in chronic pain: A three-year follow-up analysis of treatment effectiveness and process

Kevin E. Vowles [a,b,c,d,*], Lance M. McCracken [c,d], Jane Zhao O'Brien [c,d,e]

[a] Interdisciplinary Musculoskeletal Pain Assessment and Community Treatment Service, Haywood Hospital, Stoke-on-Trent PCT, Burslem, Stoke-on-Trent ST2 8BY, UK
[b] Primary Care Sciences Research Centre, Keele University, UK
[c] Bath Centre for Pain Services, Royal National Hospital for Rheumatic Diseases NHS Foundation Trust, Bath, UK
[d] Centre for Pain Research, University of Bath, Bath, UK
[e] School of Psychology, University of Newcastle Upon Tyne, Newcastle Upon Tyne, UK

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ABSTRACT

Recent developments in CBT emphasize the promotion of psychological flexibility to improve daily functioning for people with a wide range of health conditions. In particular, one of these approaches, Acceptance and Commitment Therapy (ACT), has been studied for treatment of chronic pain. While trials have provided good support for treatment effectiveness through follow-ups of as long as seven months, the longer-term impact is not known. The present study of 108 participants with chronic pain examined outcomes three years after treatment completion and included analyses of two key treatment processes, acceptance of pain and values-based action. Overall, results indicated significant improvements in emotional and physical functioning relative to the start of treatment, as well as good maintenance of treatment gains relative to an earlier follow-up assessment. Effect size statistics were generally medium or large. At the three-year follow-up, 64.8% of patients had reliably improved in at least one key domain. Improvements in acceptance of pain and values-based action were associated with improvements in outcome measures. A "treatment responder" analysis, using variables collected at pre-treatment and shorter term follow-up, failed to identify any salient predictors of response. This study adds to the growing literature supporting the effectiveness of ACT for chronic pain and yields evidence for both statistical and clinical significance of improvements over a three-year period.

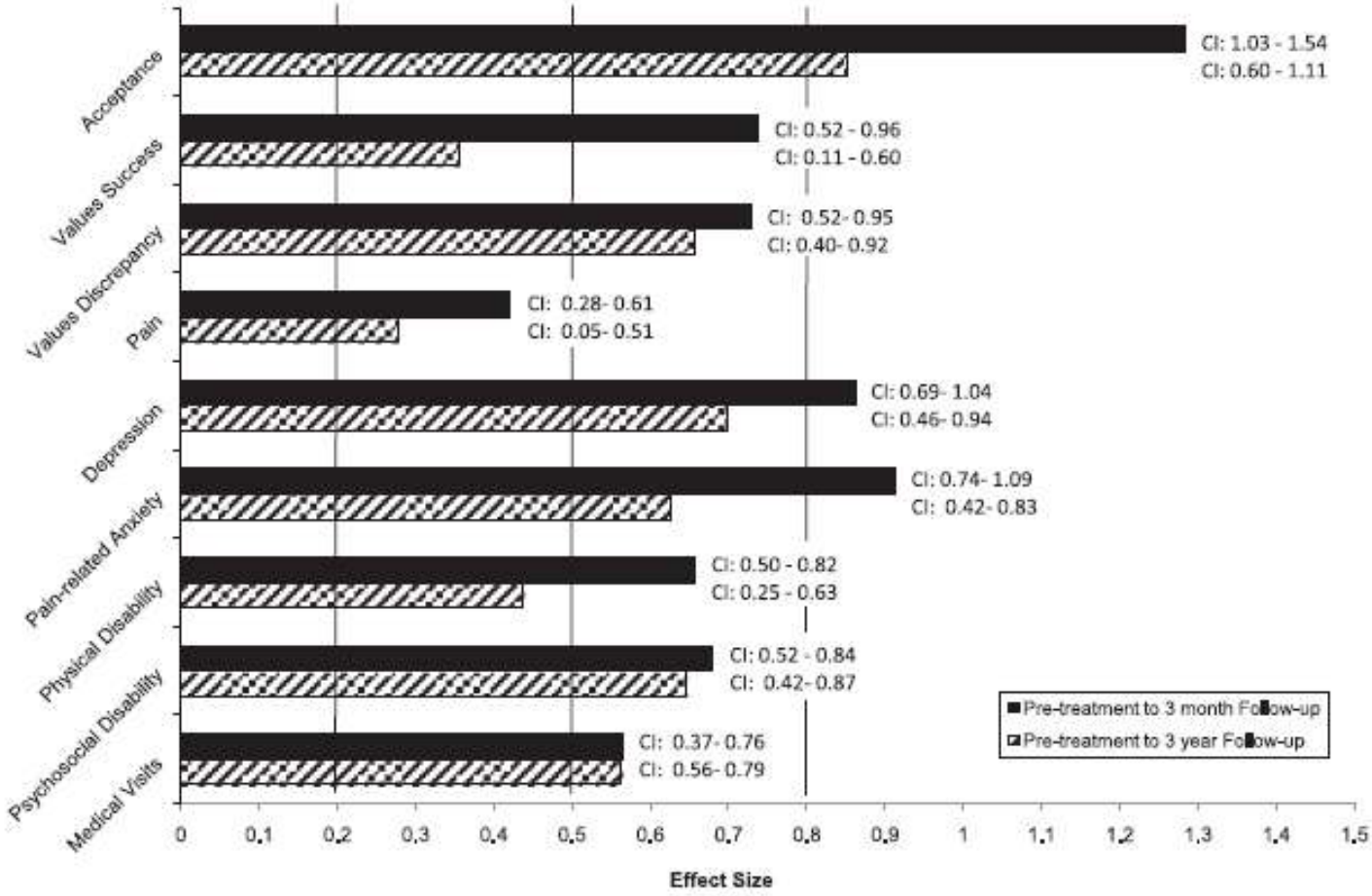

Fig. 1. Within-subjects effect size statistics (Cohen's *d*), controlled for within participant correlations, with 95% confidence intervals. Vertical reference lines in the figure represent small (.2), medium (.5), and large (.8) effect sizes.

Outcome at **3 Years** (N = 107)

	Pre-Tx	3 Yr F-up	Sig	Effect Size (d)
Pain	6.97 *(1.84)*	6.37 *(1.84)*	<.05	**.33**
Physical Disability	.19 *(.12)*	.12 *(.10)*	<.001	**.60**
Psychosocial Disability	.28 *(.16)*	.18 *(.14)*	<.001	**.63**
Depression	27.51 *(12.74)*	15.74 *(12.6)*	<.001	**.92**
Anxiety	46.52 *(18.69)*	32.88 *(22.14)*	<.001	**.73**
Acceptance	50.61 *(15.12)*	69.55 *(25.36)*	<.001	**1.25**

d > .2 small, > .5 medium, > .8 large

Randomized Trials of ACT

Problem Area	Authors
Depression	Zettle & Rains, 1989
Work stress	Bond & Bunce, 2000 Flaxman & Bond, 2010 Brinkborg et al., 2011
Psychotic symptoms	Bach & Hayes, 2002 Gaudiano & Herbert, 2006
Pain and stress	Dahl et al., 2004
Polysubstance abuse	Hayes et al., 2004
Drug refractory epilepsy	Lundgren et al., 2006
Trichotillomania	Woods et al., 2006

Randomized Trials of ACT- Continued

Diabetes	Gregg et al., 2007
Anxiety and depression	Forman et al., 2007
Performance of Psychology trainee therapists	Lappalainen et al., 2007
Stigma toward people with psychological disorders	Masuda et al., 2007
Chronic pain	Wicksell et al., 2008 Johnston et al. 2010 Wetherell et al. 2011
Pediatric chronic pain	Wicksell et al., 2009
Social anxiety disorder	Kocovski et al., 2009

Randomized Trials of ACT- Continued

Subclinical eating pathology	Juarascio et al., 2010
Obsessive Compulsive d/o	Twohig et al., 2010

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Evidence-based treatment and therapist drift

Glenn Waller*

Central and North West London NHS Foundation Trust and Institute of Psychiatry, King's College London, London, United Kingdom

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Therapist drift

ABSTRACT

Cognitive-behavioural therapy (CBT) has a wide-ranging empirical base, supporting its place as the evidence-based treatment of choice for the majority of psychological disorders. However, many clinicians feel that it is not appropriate for their patients, and that it is not effective in real life-settings (despite evidence to the contrary). This paper addresses the contribution that we as clinicians make to CBT going wrong. It considers the evidence that we are poor at implementing the full range of tasks that are necessary for CBT to be effective – particularly behavioural change. Therapist drift is a common phenomenon, and usually involves a shift from 'doing therapies' to 'talking therapies'. It is argued that the reason for this drift away from key tasks centres on our cognitive distortions, emotional reactions, and use of safety behaviours. A series of cases is outlined in order to identify common errors in clinical practice that impede CBT (and that can make the patient worse, rather than better). The principles behind each case are considered, along with potential solutions that can get us re-focused on the key tasks of CBT.

Therapist Drift

- Therapists often to not fully implement CBT.
- This usually includes shifting focus from doing to talking.
- This arises from therapist cognitive distortions, emotional reactions, and avoidance.

Waller G. Evidence-based treatment and therapist drift. BRAT 2009; 47: 119-127.

Letting Go


Is it Sunset or a New Dawn for Psychological Approaches to Chronic Pain?

Progress, Growth, and Development in Psychological Approaches

- Adopt a progressive model.
- Focus on PROCESS.
- Avoid “variable abuse.”
- Focus on treatment integrity.

Summary

- Traditional CBT is considered effective for chronic pain.
- At the same time there are weakness in the data and worrying trends.

- ACT is CBT and focuses on psychological flexibility.
- It may have advantages and seems promising.