Review: cognitive and behaviour therapies are effective for chronic pain


QUESTIONS: In patients with chronic pain, excluding headache, how effective is psychological treatment (including cognitive behavioural therapy [CBT], behavioural therapy, and biofeedback), and is it more effective than alternative active treatments?

Data sources
Studies were identified by searching 4 databases and scanning reference lists.

Study selection
Selected studies were randomised controlled trials of psychological treatments (including cognitive behaviour therapy, CBT), and biofeedback), and is it more effective than waiting list control conditions. Compared with alternative active treatments, psychological treatments are superior for chronic pain (table). When treatment subtypes were analysed, the results were similar to those of the waiting list control comparison: CBT showed the greatest efficacy.

CONCLUSIONS
In patients with chronic pain, psychological treatment (including cognitive behaviour therapy, behaviour therapy, and biofeedback), is more effective than waiting list control conditions. Compared with alternative active treatments, psychological treatments are superior for such outcomes as pain experience, positive coping, and behavioural expression of pain.

COMMENTARY
The limited success of conventional medical approaches to the treatment of chronic pain has in part facilitated the development of psychological treatment methods—predominantly cognitive behavioural in nature; patients entering such programmes will usually have obtained only limited relief from medication alone and often have depression, along with cognitive, behavioural, and social dysfunction. Thus elimination of pain, or even the reduction of pain intensity per se, are seldom core aims of pain management programmes (CBT or otherwise), and this accounts for the wider than usual domain of outcomes identified in the review by Morley et al.

This systematic review provides a thorough and valuable research synthesis in a field which is underdeveloped compared with mainstream psychotherapy outcome research. In this respect the meta-analysis might be considered less a review of formal efficacy research (ie, testing an exact model of treatment) and closer to a review of effectiveness studies (ie, concerned more with real world clinical effects of a broad CBT based approach).

With this in mind, this review shows that CBT based approaches (including behaviour therapy) are more clinically effective than simple waiting for further treatment for improving outcomes in patients with predominantly chronic low back pain and arthritis. They also show superiority—in some outcome domains—to the mixed bag of alternative treatments (eg, symptom monitoring, bibliotherapy, physiotherapy) in the studies reviewed.

The multicomponent nature of CBT approaches means that most studies evaluate the effect of a treatment package. The specificity of the effects of different treatment programme components in relation to different patient characteristics, problem domains, and outcomes, is an area of research in chronic pain management where limited progress has yet been made. Clinicians need to be mindful of this when considering delivering cut down versions of the multicomponent CBT approach where fewer components could simply mean lower effectiveness.

The fact that 76% of treatments were delivered in groups contrasts with most CBT research in psychiatric services where individual treatments have more commonly been evaluated. This may not only have economic significance, group therapy being cheaper to deliver, but must also be appreciated by clinicians wishing to work individually with pain patients. The role of group processes such as peer support remains as yet unknown as a determinant of chronic pain treatment outcome within the CBT framework.

Phil Richardson, PhD
Tavistock and Portman NHS Trust
London, UK