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Editorial comment

Partner validation in chronic pain couples

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In this issue of the *Scandinavian Journal of Pain*, Edlund and co-workers introduce a novel perspective to the management of chronic pain, namely the role of validation from the partners of people struggling with chronic pain [1]. Through an experimental within-groups design, the authors aim to investigate how a brief validation training of the partner without pain would influence pain and emotions in the partner with pain. The study, which included 20 couples where the partners without pain received a brief validation training, did indeed show that the training was successful in increasing validating responses, which again were followed by a decrease in negative affect in the partner with pain.

It has long been known that chronic pain takes a toll on the spouse of the chronic pain sufferer as well as the person suffering from chronic pain [2]. Deterioration of the marital relationship is unfortunately a common consequence of long-lasting pain, with role changes and decreased sexual activity as contributing factors [3]. Few intervention studies on chronic pain have focused their efforts on the couple interaction itself, and even fewer, if any, have targeted partner validation specifically. The study by Edlund et al. thus contributes with much needed knowledge about a novel angle to include in pain treatments.

The main effect of the validation training appeared to involve a reduction in negative affect, as reported by the chronic pain sufferer. As mentioned by the authors, this is concordant with the theoretical rationale behind partner validation, which is the intimacy models of interaction [4]. In contrast to operant models of pain, where solicitous responses from the spouse are considered likely reinforcers of dysfunction, intimacy models postulate that one particular response style, namely validation of emotional disclosure, has great potential to facilitate pain adjustment and healthy emotional regulation [4]. Validating responses differentiates from other pain communication and pain behaviour by communicating understanding, legitimacy and acceptance. Since chronic pain patients often live in intimate relationship with a partner, involving the partner with a targeted intervention may represent an untapped potential in treatment. Biopsychosocial treatment approaches often seem to forget the "social" part of the triad. Offering a brief validation training to the partner, as an add-on to ordinary pain treatment, could thus be one way of strengthening this important but often neglected factor.

In the last couple of decades, the focus on contextual themes such as validation and acceptance has markedly increased within the cognitive behavioural approaches to chronic pain – the so-called third wave of CBT. Within these new approaches, less focus is placed on pain control strategies and changing of negative thought content. Instead, patients learn to let go of pain control strategies that often limit their lives and hinder them from achieving their goals, and learn to accept pain as part of their everyday lives and live more in accordance with their values [5]. More broadly, methods within the third wave of CBT, also referred to as contextual CBT, target the *context and function* of psychological events more than the actual *content* of such events [6]. Two such approaches that mix together and integrate acceptance, validation, and motivation to change, are Acceptance and Commitment Therapy (ACT) and Dialectical Behavioural Therapy (DBT). While ACT uses mindfulness, acceptance and behavioural activation techniques to produce psychological flexibility, DBT combines mindfulness, acceptance and validation strategies to achieve emotional regulation and behaviour change [6]. In DBT, validation is provided by the therapist and entails understanding the patients and their situation, and communicating this to the patient. The application of these techniques has shown promising results and is, perhaps, particularly suitable for patients suffering persistent pain with comorbid problems, such as depression [7]. The study by Edlund et al. supports this by demonstrating a reduction in negative affect in the chronic pain sufferer following more validating responses from the partner. If validation is, in fact, a significant therapeutic mechanism responsible for improvements in chronic pain sufferers, it is reasonable to assume that validation training of the people close to the sufferer will contribute to the therapeutic result. Furthermore, as depression is a highly prevalent complaint in chronic pain patients [8], therapeutic approaches that include validation strategies may be applicable for a significant proportion of the patients.

The study suffers from a number of methodological shortcomings, including lack of control group, small sample, a mix of dyads, lack of long-term follow-up, and a possible selection bias and "order effect". These are all mentioned by the authors and taken into account, but above all emphasize the need for replication studies. Another interesting point that could be pursued further is how the increased validation from the partner results in decreased negative affect, but no change in positive affect. It appears as if

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they operate in different dimensions, and that validation, or lack thereof, only affects one of them. Yet another topic that remains to be explored is the apparent gender difference in response to partner validation. Although the study by Edlund et al. was too small to stratify on gender, there are some indications from the literature that male partners may have worse adjustment as a result of increased spouse validation, while both genders appear to respond well to less invalidation [9].

The authors suggest the validation training could be used as an add-on to ordinary pain treatment. This could be an exciting avenue for future research, exploring the potential of third wave CBT in the management of chronic pain. The validation training could be tested in a feasible and ethically sound randomized controlled trial, by adding it to ordinary pain treatment and comparing it with ordinary pain treatment only. As a further advancement, partner validation training could be added to a course of DBT or ACT to investigate whether adding this component would yield synergistic effects on the outcome.

In conclusion, the paper addresses an important and understudied topic, and could, as the authors say, set the stage for future studies of validation from the partner as an intervention for pain patients. The study shows two important things, first, that validation is a communication skill you can learn, and second, that more of this skill has the potential to mitigate distress in the partner with pain.

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