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Editorial

The communal coping model and interpersonal context: problems or process?

Lackner and Gurtman (2004) provide a new approach to examine the Communal Coping Model of Pain Catastrophizing (CCM, Sullivan et al., 2000), using an interpersonal circumplex model to explore the interpersonal correlates of CCM. Methodological strengths of this paper include a relatively large sample, patients with moderate to severe pain symptoms and durations, and use of standard diagnostic criteria for IBS. Their approach highlights additional conceptual/theoretical concerns, and raises methodological considerations that may guide future research in this area.

1. Conceptual/theoretical concerns

The basic premise suggested by the authors is that if catastrophizing serves a communal coping function, those who tend to catastrophize will be more likely to self-report interpersonal relationship problems. Although this may be a consequence of catastrophizing, relationship problems are not a central component of CCM. Rather, interpersonal process is at the core of CCM. The CCM as originally proposed suggested that catastrophizing in patients with pain, rather than being aimed at pain reduction per se, might be aimed at reducing pain-associated distress by garnering social proximity and support. Although based on an interpersonal understanding more complex than a simple stimulus-response conceptualization, CCM has been explored by several researchers using an operant conceptualization. Keefe et al. (2003) reported that in participants with gastric cancer, patients who tended to catastrophize judged their spouses as more instrumentally supportive, but not more emotionally supportive. Furthermore, the spouses of high catastrophizing patients viewed the patient in a more negative light, and reported more caregiver stress. Boothby et al. (2004) reported that chronic pain patients who catastrophize perceive their spouses as more punitive than solicitous.

Recent advances in behavioral theory emphasize the reciprocal nature of complex interactions, rather than a simple stimulus-response (Keefe and Lefebvre, 1999). Systems theories such as those offered by Schefft and Lehr (1985) emphasize that since components of interpersonal systems are interconnected, changes in any one component will affect others through feedback and feedforward loops. Interpersonal theory also has developed beyond some of its stimulus-response roots. For example, Horowitz et al. (1997) have shown that problematic interpersonal complementarity, such as when a depressive person's submissive behaviors are continually met with controlling responses by a spouse, is a process that develops over time. Interpersonal styles also may depend on the focus and /or models of self and other (Bartholomew and Horowitz, 1991; Benjamin, 1993).

These important theoretical developments in behavioral and interpersonal theories are similar in that they have allowed for research advances in explaining more complex phenomena. The CCM is based on these developments and we are disappointed that Lackner and Gurtman only used more straightforward trait measures but then assumed the results spoke about the CCM model. For example, it is probable that as a painful condition becomes more chronic, the nature of the interpersonal interaction changes. Indeed, Cano (2004) has shown that chronic pain patients with shorter duration pain perceived their spouses as more supportive and solicitous of their pain, whereas patients with longer-term pain perceived their spouses as less supportive and more punitive. Thus, it is necessary to consider the developmental nature of chronic pain, and the likely impact on changes in the interpersonal system.

Lackner and Gurtman also suggest that their findings indicate that those who catastrophize are more likely to self-report difficulties in the area of interpersonal relationships that involve exaggerated needs for affiliation coupled with the tendency to put aside their own needs in a self-sacrificing and unassertive manner. It is unclear why the authors do not hypothesize a different octant—that is, a demanding—needy style rather than an unassertive, passive, self-sacrificing interpersonal style. In an elaboration of the CCM, Keefe et al. (2003) suggested that those who catastrophize may have

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a tendency to be demanding of social support and caretaking. It is possible that catastrophizers have a tendency to have a style that is friendly and submissive early on but becomes hostile and demanding at a later point. Interpersonal models might allow for a better test of Keefe et al.'s elaboration of the CCM than the circumplex model used by Lackner and Gurtman. Benjamin's (1993, 1974) structural analysis of social behavior (SASB) offers additional methodological tools for specifying the developmental course for these interpersonal processes. SASB could also specify whether there are manifestations of both friendly-submissive and hostile-demanding communications in catastrophizing. These two opposing messages within a single statement are referred to as complex communications in SASB (e.g. 'Thanks—I appreciate your helping me not become totally bed-ridden for the rest of my life.').

CCM is a variant of a broader model as originally conceived. The notion of a communal coping process was first advanced regarding how people cope with stress, rather than being a pain-specific model (Lyons et al., 1998). This original model emphasized three facets: (1) a communal appraisal of the stressor, that is, a conceptualization of the stressor as 'our problem' rather than 'my' problem or 'your' problem; (2) communication regarding the nature and meaning of the stressor; and (3) collaborative effort to manage the stressor. The process of communal coping, by definition, puts a premium on interpersonal relationships.

2. Methodological consideration to guide future research

The current study, as well as previous studies, has not adequately assessed the three key components of coping as a communal process. A limitation of the present study is the focus on self-report of tendencies to have interpersonal problems, rather than looking at processes of interactions, which is at the core of communal coping. Such processes could be studied by examining patient–partner interaction patterns (see Romano et al., 1991). Second, our current research regarding catastrophizing has not yet moved from the assessment of catastrophic thoughts to behavioral correlates of catastrophizing (with the exception of Sullivan et al., 2004, who measured pain communicative behaviors in cold pressor participants). When Sullivan and colleagues first advanced a communal coping model of pain catastrophizing, they suggested that catastrophizers might engage in exaggerated displays of their pain-related distress as a means of coping with pain. Communication regarding a stressor must take place at the behavioral, rather than cognitive level, and more research exploring these cognitive–behavioral connections is needed (Thorn et al., 2003). Third, we have no idea from prior research whether patients who catastrophize, and partners or significant others, feel that the coping process is a shared, transactional effort. Research involving the perceptions of both patients and their partners, and including behavioral process measures, is sorely needed. Additionally, given the important differences in gender role behavior between the sexes, examination of potential sex differences among all of the variables mentioned above needs to be included in all studies.

As a final note of caution, although the authors assert that IBS is a good model to look at because it is 'unrelated to underlying pathology.' We believe this is overly simplistic and may foster the continuation of a mind–body dichotomy between 'organic' and 'functional' pain syndromes. Certainly there could be dysfunctions in pain processing and pain regulation phenomenon (e.g. central sensitization).

This study is part of a growing literature examining the social context of pain catastrophizing and pain coping. Recent evidence suggests that a broader social perspective can enhance our understanding of pain. The present findings have important implications for pain assessment and treatment, including broadening the scope to include the interpersonal as well as intrapersonal, assessment of the person–environment interaction, and further exploration of the cognitive–behavioral connections of catastrophizing.

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