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Interpersonal dynamics in chronic pain: The role of partner behaviors and interactions in chronic pain adjustment

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Keywords

Chronic pain; Partner behaviors; Interpersonal dynamics; Social support; (In)validation; Stigma; Couple interventions

Abstract

Chronic pain affects one-third of adults globally, leading to significant disability and healthcare costs. This review highlights the role of interpersonal processes in chronic pain adjustment, focusing on how partner behaviors and interactions influence patient well-being and functioning. It synthesizes recent theoretical perspectives and empirical findings, discussing both potentially maladaptive responses, such as solicitousness and invalidation, and adaptive behaviors, including validation of emotional disclosures and encouragement of valued activities. The review identifies gaps in current research, emphasizing the need for clearer conceptualizations of partner behaviors, advanced methodological approaches to capture dynamic interactions, and robust measurement tools. Prioritizing couple interventions that enhance communication, relational dynamics, and partner support for functional autonomy may lead to more holistic and effective chronic pain management.

1. Introduction

Pain is a universal human experience. Acute pain serves as a vital warning signal, often indicating tissue damage and aiding survival. When pain persists or recurs beyond the typical healing period of three months, it is classified as chronic pain (CP). According to the IASP classification of CP for the International Classification of Diseases (ICD-11)[1], CP can be secondary to an underlying condition (e.g., cancer-related pain) or recognized as a disease in its own right (e.g., fibromyalgia). Around 1 in 3 adults suffer from CP, making it a leading cause of disability worldwide, often referred to as a silent public health epidemic [2]. CP has wide-ranging impact [3] on individuals (e.g., well-being and functioning), interpersonal relationships (e.g., caregiving burden on partners [4,5]), and society (e.g., increased healthcare costs).

Understanding the complex etiology of CP is essential for developing effective interventions to prevent pain persistence and promote self-management across the lifespan. CP is a multifaceted bio-psycho-social phenomenon, encompassing sensory, emotional, cognitive, and social dimensions [6]. While CP experiences are influenced by multilevel social determinants [3], the present review focuses on interpersonal processes, particularly how significant others - primarily spouses or partners - impact CP outcomes. It synthesizes recent theoretical perspectives and empirical findings on pain-specific partner behaviors and their role in CP adjustment (e.g., well-being and functioning). Furthermore, it identifies gaps in the literature and proposes directions for future research and intervention development.

2. Chronic pain within an interpersonal context

The Social Communications Model of Pain [7] highlights that, alongside biological and psychological processes, interpersonal interactions play a crucial role in experiencing and expressing pain. Partners or spouses can significantly influence this by decoding and responding to individuals' pain behaviors (i.e., overt actions that convey pain, such as grimacing, moaning, or verbal complaints) and well behaviors (i.e., overt actions that reflect a healthy and functional lifestyle despite experiencing pain, such as maintaining physical activity and social engagement). The Empathy Model of Pain by Goubert and colleagues [8] further elaborates on pain decoding, referring to observer processes as three components of empathy: cognitive (interpreting other's pain), emotional (e.g., distress) and behavioral responses (e.g., helping behavior). This review focuses on partner/spousal behavioral responses and interactions. Drawing from a risk-resilience framework [9], it examines how these interactions can either undermine or promote the well-being and functioning of individuals with CP. Understanding what constitutes helpful versus unhelpful partner responses to pain and well behaviors may help develop more effective interventions to prevent pain persistence and promote quality of life for people living with CP.

3. Interpersonal context as a risk factor: how partners can (unwillingly) undermine the functioning and well-being of individuals with CP

Adults with CP often cite partner support as a crucial resource [10], but certain partner behaviors can, often unintentionally, undermine individuals' well-being and functioning, such as through solicitous, invalidating, or stigmatizing responses to their pain experience.

3.1. Solicitous partner responses to pain behaviors

In their 2017 scoping review, Bernardes et al. [10] found that over 90% of articles on pain-specific informal social support focused on solicitousness, where partners are highly attentive to pain behaviors and take over chores. Most of the findings focused on received solicitousness (i.e., self-reported by the person with CP) and mainly drew upon two theoretical models [10]: 1) The Operant Model of pain [11], predicting that solicitousness, by being positively reinforcing of pain behaviors, would worsen pain outcomes; and 2) The

Communal Coping Model of Pain Catastrophizing [12], predicting a cyclical relationship between excessive pain-related worrying (formerly known as pain catastrophizing [13]), increased pain behaviors and higher partner solicitousness.

An analysis of the extracted data in the 2017 review showed a predominance of cross-sectional/correlational findings suggesting that solicitousness is an interpersonal response to pain behaviors that should be used with caution. Although some studies showed solicitousness was positively associated with increased relationship quality, many findings showed that it was associated with increased pain severity, pain interference, pain behaviors, and poorer physical and psychological functioning [10]. A few studies also showed that partner solicitousness was associated with increased pain worry, accounting for worse pain outcomes [10].

Although interest in partner solicitousness has waned, recent studies - using experimental or prospective designs - show mixed results. Some indicate that partner solicitousness predicted poorer CP outcomes [14]. For example, it has been linked with increases in fibromyalgia tender points [15], functional limitations and decreases in activity levels among older adults with osteoarthritis [16], as well as slight decreases in pain acceptance after a multimodal rehabilitation program [17]. In contrast, some studies showed that partner solicitousness did not predict subsequent pain worry [18] or activity engagement [17] and even predicted better outcomes after psychological or medical treatments [19].

Overall, results suggest that the temporal relationship between partner solicitousness and CP adjustment (and their mediating mechanisms) still needs further investigation. This is particularly important considering that, as predicted by the Social Communications Model of Pain [7] and the Empathy Model of Pain [8], worse CP outcomes can also drive partner solicitous responses. A recently published cross-lagged mediation panel study with older adults with chronic musculoskeletal pain [20] showed that, although reciprocal effects were found over time, worse pain outcomes at baseline (higher pain severity/interference and lower physical functioning) more consistently predicted formal caregivers' support for functional dependence (alike solicitousness) than vice-versa. The extent to which a similar pattern of findings would be found in romantic relationships is, to the best of our knowledge, yet to be ascertained.

3.2. Partner invalidation and stigmatization of pain experiences

Individuals with CP often encounter invalidating or stigmatizing responses from others, including their partners [21], especially when their pain lacks a "visible" biomedical cause [22]. Although invalidation is widely reported by individuals with CP, it remains poorly conceptualized and can be confused with stigma – a specific form of invalidation. Below, we first elaborate on invalidation and then address stigmatization.

Nicola et al. [23] provide a valuable framework for understanding invalidation through a thematic analysis of 431 articles containing narratives from adults with chronic non-cancer pain. They identified four dimensions of pain invalidation by partners but also providers, friends and others: a) *Not being believed* (e.g., denying the pain or dismissing it as psychological); b) *Lack of compassion* (e.g., indifference or absence of empathy); c) *Lack of pain awareness/understanding* (e.g., minimizing the severity or blaming the individual); and d) *Feeling stigmatized* (e.g., being labeled as a "maligner," "lazy," or "drug abuser"). Invalidation is intensified by the absence of observable medical evidence for pain (common in primary CP conditions), the unpredictable nature of pain and treatment failures [23]. The mechanisms linking (partner) invalidation to CP outcomes remain unclear, but theoretical frameworks offer valuable insights. Nicola et al. [24] propose that invalidation contributes to psychological distress through feelings of guilt, shame, and anxiety, as well as the anticipated or actual loss of support, which may, in turn, exacerbate CP. Additionally, negative emotions like guilt and shame may stem from the combined impact of CP itself and the identity and self-esteem erosion caused by pain invalidation from others.

Interestingly, Nicola et al. [23] identified “feeling stigmatized” as a dimension of invalidation. Stigma, according to De Ruddere and Craig [25], involves the devaluation of individuals who deviate from societal norms, especially the biomedical model of pain, which posits that pain must have a clear, identifiable cause. Whereas Nicola et al.'s model [24] focuses on interpersonal dynamics only, the concept of stigma is often situated within broader societal and cultural contexts, with interpersonal (partner) interactions representing just one level [26]. Invalidating and/or stigmatizing partner behaviors are linked to poorer CP outcomes. Individuals who perceive their pain as disbelieved or dismissed by partners report greater pain severity [27], higher disability [21,23,24], reduced well-being [22–24], and elevated distress, anxiety, and depressive symptoms [24,27]. A recent systematic review [28] found small to moderate positive correlations between stigma and outcomes such as pain intensity, disability, and depression, with some evidence suggesting that pain conditions with less clear pathophysiology are associated with higher stigma levels.

4. Interpersonal context as a resilience mechanism: how partners/spouses can promote the well-being and functioning of individuals with CP

The interpersonal context of adults with CP, particularly the support from partners or spouses, may play a critical role in the resilience and adaptive functioning of these individuals. This section provides an overview of partner responses that can effectively promote individuals' functioning, emphasizing the balance between reinforcing individual's well behaviors and validating their emotional experiences.

4.1. Partner facilitative responses to well behaviors

Research on partner responses to well-behaviors in CP is limited, with Bernardes et al.'s review [10] showing only around 13% of the included papers focusing on this topic. Most of these studies drew upon the Operant Model of pain [29], predicting that facilitative responses to well-behaviors positively reinforce individuals' active engagement in daily activities and improve CP outcomes. Despite some mixed findings, research generally showed that partners' facilitative responses to well-behaviors were associated with lower depression, fewer pain behaviors, lower pain severity and improved sexual and relationship outcomes [10].

In the last decade, few studies have focused on partner facilitative responses to well-behaviors, despite its potential as a valuable protective factor. Some prospective studies found no significant effects on healthcare use among women with fibromyalgia [30] or on pain adjustment and sexual function after treatment among women with vulvodynia [19]. However, some research has begun to uncover mechanisms linking partner facilitative responses to better CP adjustment. The Interpersonal Regulation Model of Women's Sexual Dysfunction [31] posits that partner responses to pain and well behaviors of women before, during and immediately following sexual intercourse influence couple adjustment outcomes through emotion regulation processes. Some evidence shows that, although women with different coping patterns did not differ in their reports of partner facilitative responses to well behaviors [32], women's sexual assertiveness (i.e., their ability to express their thoughts, needs, feelings about sex) fully/partially mediated the effect of partner facilitative responses to well behaviors on women's sexual function/satisfaction [33].

4.2. Partner validating behaviors

Validation refers to a supportive response that acknowledges the legitimacy of an individual's pain experience and emotional disclosures, fostering acceptance and understanding. Nicola et al. [24] define pain validation as comprising three components: (a) believing that the individual's pain is real and authentic, (b) accepting the individual's expressions of pain as legitimate, and (c) communicating this belief and acceptance effectively. Recent research highlights the benefits of (partners') validating [24,34] and empathic responses [16][35] in improving CP outcomes, including improved quality of life and marital satisfaction as well as reduced pain intensity and negative emotions.

The impact of validation on CP adjustment and its underlying mechanisms has been conceptualized in three key theoretical models [34]. First, the *Operant Model* suggests that validation can act as social reinforcement, increasing the likelihood of the validated behavior [34]. When validation follows maladaptive behaviors, such as avoidance or excessive focus on pain, it may inadvertently reinforce these patterns. A second theoretical model regarding validation - the *Biosocial Model* - highlights validation as a means of reducing negative affect and emotional arousal, providing soothing effects that improve emotional well-being and reduce pain [34]. Finally, the *Interpersonal Process Model of Intimacy* posits that validation enhances perceived partner responsiveness, promoting intimacy and relationship satisfaction, which can indirectly alleviate pain [34]. These models offer complementary perspectives on how partner validation might influence CP outcomes. Nicola et al. [24] recently emphasized the broader psychosocial implications of validation, noting its role in mitigating stigma, buffering negative emotions, and safeguarding individuals' identity. However, often it is not clear which behavior should be validated. Caño and Goubert [36] argue that (partner) validation should target emotional disclosures of pain-related distress rather than (non/verbal) pain expressions or dysfunctional beliefs (e.g., belief that activity will lead to more pain) or behaviors (e.g., avoidance behaviors). These disclosures, when validated, enhance emotional regulation and intimacy, reducing the psychological burden of CP. The most beneficial partner responses may be those that include emotional validation of disclosures of pain-related distress and encouragement and reinforcement of valued activities, including physical activity, to promote health and reduce pain [36].

5. Gaps of existing research and future research directions

The existing literature underscores the crucial role of partners' behaviors in CP management. Despite substantial progress in understanding this role, several key gaps remain, pointing to directions for future research.

5.1. Concept expansion, definition and measurement issues

Broader and clearer conceptualizations and operational definitions are needed to advance the field (see also [37]). Previous research has mostly focused on what partners should not do when facing pain behaviors, except for studies on pain validation. More research is needed on what partners should do. For example, older adults in formal care settings who received social support for functional autonomy (i.e., support promoting activity engagement despite pain) reported better pain outcomes [38,39]. The effectiveness of these responses in informal contexts has only recently been explored but shows promising results [40][41].

Furthermore, as in many domains of psychology, insufficient attention has been paid to clearly defining and validating constructs [42,43], leading to confusion between concepts like invalidation and stigma, and between validating versus generally empathic responses. Researchers may consider using the Decentralized Construct Taxonomy (DCT) approach, which involves formulating comprehensive definitions of constructs, instructions for use in research, and unique identifiers for psychological constructs to improve clarity, consistency and cumulative knowledge [44].

Additionally, more robust, precise and psychometrically validated measurement tools are necessary to enhance our understanding of how partners can impact patient outcomes. Currently, most self-report measures focus upon partners' solicitousness or invalidation, neglecting other relevant behaviors such as validation, stigmatization and partner support for functional autonomy. To better understand the different roles of partner behaviors and its differentiating effects on patient outcomes, more nuanced measurement instruments are needed. Instruments should measure the intended construct without conceptual overlap with outcomes [43]. New self-report instruments should be developed using standardized methodologies for assessing content validity, such as the COSMIN framework [45]. Promising recent instruments measuring other's responses to pain behaviors are outlined in Table 1. Although these instruments assess responses from sources other than the romantic partner specifically, they can be easily adapted to a couple context. As shown in Table 1, the Perceived Validation and Criticism in Pain Questionnaire (PVCPCQ; [46]) and the Pain-

Invalidation Scale (Pain-IS; [47]) generally assess pain (in)validation, whereas the revised Informal Social Support for Autonomy and Dependence in Pain Inventory (ISSADI-PAIN [41,48]) taps into received social support for functional autonomy or dependence. Regarding pain stigmatization, no high-quality questionnaires are currently available. The recently developed Persistent Somatic Symptom Stigma Scale for Healthcare Professionals (PSSS-HCP; [49,50]), which applied the COSMIN framework, may serve as a starting point for developing a version for significant others in future studies

Table 1: New self-report measures of other's responses to pain/well behaviors

Instrument name	Key reference	Measured constructs	Source of response	Number of items	Subscales	Item examples
Perceived Validation and Criticism in Pain Questionnaire (PVCPCQ)	[46]	Pain validation and criticism	Others in life (i.e. partner, children, friends, other family members)	23	1. Validation in pain 2. Criticism in pain	1. "When I am in pain, I feel I can express my emotions" 2. "People get angry at me when I can't do certain activities due to my pain"
Pain Invalidation Scale (Pain-IS)	[47]	Pain invalidation	Self, immediate others and health professionals	24	1. Invalidation by the self 2. Invalidation by immediate others 3. Invalidation by healthcare professionals 4. Invalidation by over-attentive others	1. "My pain condition makes me feel abnormal" 2. "Immediate others who hear about my pain condition seem to think that I am being weak" 3. "My healthcare professional seems to think I am faking or exaggerating my symptoms" 4. "Immediate others assume I cannot do tasks that I am capable of".
Revised Informal Social Support for Autonomy and Dependence in Pain Inventory (ISSADI-PAIN)	[41,48]	Received social support for functional autonomy/dependence	Family members	11	1. Perceived Promotion of Dependence 2. Perceived Promotion of Autonomy-emotional support 3. Perceived Promotion of Autonomy-Instrumental support	When I am in pain my family members... 1.... "advise me to stop everything I am doing" 2.... "encourage me to participate in fun and leisure activities" 3.... "help me to take care of practical aspects so that I can participate in activities/social outings"

5.2. Dyadic, dynamic and cyclical nature of partner-patient interactions

Future research should adopt a dynamic perspective to examine partner interactions as evolving and reciprocal processes. Studies often provide a one-sided view of pain-related social support interactions [10]. Instead, research should explore the *cyclical nature of interpersonal exchanges* using advanced designs such as prospective (diary) studies (e.g., [51][52][18]), observational paradigms (e.g., [35]), actor-partner interdependence models (e.g., [53,54][35]), and sequential analyses (e.g., [55]). Recent diary studies supporting the Communal Coping Model [51] have for instance found that higher levels of pain-related worrying in individuals with CP are associated with greater perceived spouse support [51], but also – prospectively - with increased pain intensity (particularly when spouse support was perceived as low [56]) and an increase in pain behaviors observed by the spouse [51]. This pattern can create a cycle of increased

pain behaviors and fluctuating responses from partners, including criticism and hostility [51]. Burns et al. [51] suggested that while spouses may initially respond with empathy, they might also provide feedback and advice that patients perceive as critical. Using a prospective diary design, Martire and colleagues [18] showed that excessive pain-related worrying in the individual with CP leads to higher perceptions of punishing responses from the spouse, which in turn contribute to more patient pain-related worrying. This cyclical process involving spouse criticism and hostility may negatively impact patient functioning.

In addition, current research tends to focus on one particular response, such as solicitousness, but partner responses do not occur in isolation. To advance the field, future research should examine the *co-occurrence of different partner responses* and their impact upon individual's outcomes. Analytical approaches like profile analysis can identify patterns of partner responses associated with either adaptive or maladaptive adjustment to CP. A longitudinal cohort study in individuals with chronic low back pain - utilizing latent class analysis - identified distinct clusters among individual with CP-partner dyads, with the cluster with the lowest levels of solicitous responses reporting lower disability levels compared to the cluster characterized by highest levels of solicitous (and also distracting) responses [57]. A lifespan perspective may provide insights into how partner reactions and their impact on CP outcomes vary across developmental stages.

Support behavior by partners should also be considered within its context: *when and why is helping behavior effective* [58][10]? One type of caregiver response to pain cannot be considered adaptive or maladaptive in itself. Variables such as relationship characteristics (e.g., low versus high relationship satisfaction), partner variables, and variables pertaining to the individuals with pain may moderate the effectiveness of partners' responses to pain and well-behaviors. For example, the effectiveness of partner supportive responses may, for instance, depend upon the extent to which these meet the needs of the sufferer and why partners engage in support behaviors [58]. For instance, research has shown that when partners provide help volitionally (i.e., because they enjoy or value this behavior) rather than out of obligation, the quality of support improves, leading to better CP outcomes and greater relational satisfaction [59][60]. Regarding validation, research is necessary to determine which behaviors should be best validated to optimize CP outcomes. Caño and Goubert [36] suggested that emotional disclosures of pain-related distress are the most relevant targets, but the evidence is not yet there.

5.3. Interventions targeting partner responses and couple interactions

Couple interventions may be more effective in treating CP than individual interventions [61]. Nonetheless, most psychological interventions still primarily target the individual with CP alone, neglecting relational dynamics that can exacerbate pain-related distress [61,62]. Current couple interventions mostly focus on psychoeducation and primarily position the partner as a coach to guide and support the person with CP in implementing pain coping strategies (e.g., relaxation, distraction [61]). Only a few interventions focus on communication skills underlying effective pain-related supportive interactions, relational skills (e.g., conflict resolution, problem solving) and/or partners' experiences and needs [61], leaving critical aspects of couple functioning underexplored.

Programs for couples with low relational distress, besides positioning the partner as a pain coping coach, could prioritize fostering adaptive partner responses to pain and well-behaviors, such as validating pain-related emotional expressions and encouraging engagement in meaningful activities. For example, brief validation training enhances partner responsiveness, reducing negative affect of individuals with CP [63]. Programs for couples with high relational distress should also address partners' needs and experiences [5], and the relational dynamics of the couple as a unit [62,64,65]. The novel Mindful Living and Relating Program, which fosters couples' psychological and relational flexibility [62,64,65], has shown promising results [64,65]. These approaches underscore the potential of integrating partners and relational dynamics into pain management, paving the way for more holistic, impactful interventions.

6. Conclusions

Partners can play a pivotal role in the adjustment of individuals with chronic pain (CP), acting as both risk and resilience factors. Whereas partner solicitousness and invalidation can exacerbate pain-related distress and hinder functioning, partner facilitation of well behaviors and validation of pain-related emotional experiences seem to be more adaptive. Encouraging engagement in valued activities while preventing reinforcement of avoidance behaviors, coupled with validation of emotional disclosures, represents a particularly beneficial approach [36]. Despite the progress made, future research should refine conceptualizations of partner behaviors, use advanced methods to capture interaction dynamics, and develop better and more nuanced measurement tools. Interventions targeting couple interactions should be prioritized, with a focus on enhancing communication skills, relational dynamics, and partner support for functional autonomy.

Conflict of interest statement

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Data availability

No data was used for the research described in the article.

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During the preparation of this work the author(s) used Co-Pilot to improve readability and language. After using this tool/service, the author(s) reviewed and edited the content as needed and take(s) full responsibility for the content of the publication.

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References of particular interest have been highlighted as

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Further Reading

20. This prospective study explores, via cross-lagged mediation models, the recursive relationship between social support for functional dependence and chronic pain outcomes in older adults in formal settings. It finds that poorer pain outcomes often lead to increased support for functional dependence. The study also notes that activity patterns like avoidance and overdoing are influenced by both pain and support. These insights suggest that enhancing functional autonomy could improve chronic pain management.
10. This scoping review draws upon social support theoretical models, to understand how pain-related social support has been conceptualized and measured and how its relationship with pain experiences has been investigated in research published between 2000–2015. It identifies several conceptual and methodological gaps in the literature on informal pain-related social support and proposes several ways to move research forward.
41. This study validates the Informal Social Support for Autonomy and Dependence in Pain Inventory (ISSADI-PAIN), a measure assessing family support for functional autonomy and dependence in pain contexts. The findings highlight the measure's reliability and validity and its potential to enhance understanding of family dynamics in pain management, particularly in differentiating between supportive behaviors that promote autonomy versus dependence.
43. In this paper, the authors recommend precise definitions, appropriate timescales, and consideration of confounding factors to improve future research on the causal effects of psychological factors on pain outcomes.
34. This paper highlights the concept of validation of pain communication and several theories that explain the impact of validation on patient outcomes. Furthermore, it reviews several studies examining validation and invalidation in the context of pain, highlighting important future directions for research.
9. This paper explores how a resilience approach to chronic pain can enhance our understanding of adaptation and maladaptation to pain. It emphasizes the importance of shifting focus in pain research and interventions to include positive outcomes, highlighting key resilience psychological mechanisms and providing a framework for empowering patients to sustain fulfilling lives despite pain.
28. This systematic review and meta-analysis examines the association between stigma and chronic pain outcomes. The findings indicate significant positive correlations between stigma and pain intensity, disability, and depression, with small to moderate effects. The review also suggests that individuals with pain conditions having less clear pathophysiology may report greater stigma, highlighting the need for further research in this area.
3. This review explores the social determinants and consequences of pain, emphasizing the need for a socioecological, intersectional, and life course approach. It highlights how social factors at various levels—interpersonal,

group/community, and societal—affect pain experiences and outcomes. Various examples of consequences of chronic pain at multiple socioecological levels are provided. The authors propose a novel framework to integrate these perspectives, aiming to enhance pain research, prevention, and management by addressing social inequities and improving health outcomes across populations.

14. * This experimental study found that individuals with chronic back pain experienced higher pain and increased brain activity when their solicitous spouse was present during painful stimulation. This effect was specific to painful stimulation at the site of clinical pain and was not observed in patients with non-solicitous spouses or healthy controls. The findings suggest that solicitous spouse behavior may reinforce pain behaviors and enhance pain perception.
24. ** This paper defines pain-validation as the acknowledgment, belief, and acceptability of an individual's pain experience, communicated to them effectively. Pain-validation can reduce the stresses of chronic pain by providing social support, buffering negative emotions, and improving treatment adherence. In contrast, pain-invalidation can exacerbate stress and pain. The authors suggest incorporating pain-validation practices in therapeutic interventions to enhance chronic pain outcomes and adherence to treatment plans.
47. ** This study introduces the Pain-Invalidation Scale (Pain-IS), designed to measure different aspects of invalidation perceived by individuals with chronic pain. The scale includes four subscales: Invalidation by the Self, Invalidation by Immediate Others, Invalidation by Healthcare Professionals, and Invalidation by Over-attentive Others. The Pain-IS has sound psychometric properties and may be useful to identify domains where pain invalidation should be addressed in clinical practice.
44. * This paper introduces the Decentralized Construct Taxonomy specifications (DCTs) to address the theory and measurement crises in psychology by providing comprehensive, standardized construct definitions and instructions to enhance transparency, reduce hidden heterogeneity, and facilitate cumulative scientific progress.
57. * This prospective cohort study uses Latent Class Analysis to identify three subgroups of people with chronic low back pain based on their profiles of interactions with significant others, revealing associations with disability, psychological factors, and pain sensitivity, highlighting the importance of considering these interactions in clinical practice.
31. * This article uses the case of genito-pelvic pain/penetration disorder to propose a novel interpersonal emotion regulation model of women's sexual dysfunction, where distal and proximal interpersonal factors (such as partner responses to pain and well-behaviors) are considered as predictors of illness/pain adjustment. It shows how the novel model builds on existing theories from the fields of chronic pain and sex and relationships research.
61. ** This systematic review identified randomized controlled trials of couple interventions, highlighting strategies to include in treatments with individuals with chronic pain and their partners. Several strategies derived from cognitive-behavioral therapy, acceptance and commitment therapy, and operant behavioral traditions, but delivered relationally, are identified and suggestions as to how to integrate them in future interventions are provided.
64. ** This pilot study assesses the feasibility, acceptability, and preliminary outcomes of a promising novel intervention – Mindful Living and Relating - aiming at improving well-being in couples in which one or both partners experiences chronic pain and relationship distress.