



Editorial

Relapse prevention: Still neglected after all these years

Almost 2 decades ago this journal published two reviews by Dennis Turk and his colleagues that discussed neglected topics in the treatment of chronic pain patients [6,7]. In the first of these reviews [6] they identified the issue of relapse after treatment and concluded that between 30% and 60% of patients showed evidence of relapse after successful treatment. Even at the lower estimate this presented a significant clinical problem that demanded an urgent solution. So what has been achieved in the last 17 years? To this author's knowledge there are remarkably few papers that report randomised controlled trials of strategies designed to maintain or enhance treatment outcomes. A quick check of the 104 citations recorded by Scopus of the Turk and Rudy [6] original paper indicates that few such trials have been conducted.

What have we been doing in the intervening years and why are there not more randomised controlled trials (RCTs) on this important topic? In answer to the first part of this question it is clear that clinical researchers have continued to generate evidence for the effectiveness of psychological treatments, mainly cognitive behaviour therapy (CBT). There are now more than 50 RCTs that directly test the efficacy of CBT over a number of diagnostic groups and for a variety of implementations of CBT. Although these trials include follow-up assessments they often do not extend beyond a year or so. Perhaps this feature holds the clue as to why research on relapse is so sparse; research funders are reluctant to extend grants for the additional 2, 3 or years necessary to test relapse prevention strategies. On the other hand we should consider that the absence of publication is just that, i.e., evidence of publication bias and the file drawer problem and an editorial unwillingness to publish null results.

In this issue Naylor et al. [5] report a small RCT in which they combined an old (telephone) and relatively new (IT) technology as Therapeutic Interactive Voice Response (TIVR) to deliver a 4-month programme designed to maintain and enhance what patients had learned in a preceding 11-week programme of a CBT group based treatment. At post-treatment the participants were randomly allocated to either the TIVR arm or the control group that received treatment as

usual, which in this case was continued access to their regular sources of care. Data on the effectiveness of TIVR was collected at the end of TIVR i.e. at 4 months post-treatment and 4 months later i.e. 8 months post treatment. Although the sample is relatively small and the follow-up period short, this initial evaluation of TIVR is favourable for the majority of the outcomes. Detailed reading of the report gives a more nuanced view of this précis of the conclusions. The purpose of this editorial is to highlight one or two aspects of design that suggest that it should be possible to develop this line of research without engaging in expensive RCTs to test the efficacy of the original treatment and to enable clinical researchers to concentrate on testing post-treatment relapse strategies as per Naylor et al.

Naylor et al. used a well-known technology with which the majority of patients will be comfortable and confident. Little or additional training is required to use a push button telephone system, there is no direct cost to the participants, and the content of the telephone interview also mapped directly onto the content of the initial treatment: It is an intervention with high ecological validity. In addition, the computerized nature of the system checks and maintains data integrity. This trial also included a monthly call from the group therapist who prepared a personalized message for each participant so that the TIVR is consistently individually focussed. This has the advantage of maintaining therapist factors which are known to be powerful in psychological treatment cf. [8]. Incidentally, the presence of the therapist is another possible explanation for the observed effect and future trials might consider comparing the full TIVR protocol with simple therapist contact only. This may be a rather more appropriate control than the current no-contact control. A therapist contact control group might also go some way to mitigate any possible unwanted treatment diffusion effects [1].

A significant feature of the Naylor et al. study is that allocation to the arms of the trial was made at *post-treatment*. With the relatively small sample size in this trial there is a risk of bias, e.g., non-equivalent gains in the treatment period for the two groups, but this can be partly corrected in the statistical analysis. However, the main

point to consider is that Naylor et al. used a treatment protocol and outcome measures that have been the subject of extensive previous research and shown to be effective [2]. This feature is extremely attractive because in principle it allows one to sacrifice the RCT design for the initial treatment phase that includes a control arm in which patients are allocated to a presumably less effective treatment. The common treatment and outcome measures allow the effectiveness of the initial treatment to be assessed against benchmarks derived from the extant randomised controlled trials [3,4]. The randomised groups established at post-treatment/pre-TIVR can therefore be assessed against a common standard rather than merely relatively. This strategy has ethical, quality assurance, efficiency and cost advantages, and in principle it means that any pain management facility that offers psychological treatment could contribute to this research if they chose to adopt a treatment protocol of known effectiveness and the outcome measures used in the definitive trials. The only additional cost is the introduction of a TIVR-like follow-up procedure. Although Naylor et al. do not provide cost-effectiveness data for the present study it is unlikely that a relatively highly automated system would incur the direct costs of a comparable live therapist system. What is required is additional evidence on the health care savings, both direct and indirect, produced by reduced relapse rates.

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