

Discounting pain in the absence of medical evidence is explained by negative evaluation of the patient

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ABSTRACT

This study investigated the effect on observer responses of the presence/absence of information about medical evidence for pain and psychosocial influences on the patient's pain experience. Additionally, the moderating role of the patient's pain expressions and the mediating role of the observer's belief in deception and evaluation of the patient was examined. Sixty-two participants were presented with videos of 4 patients, each accompanied by a vignette describing the presence or absence of both medical evidence for the pain and psychosocial influences on the patient's pain. Participants estimated patients' pain and rated their own sympathy and inclination to help; they re-estimated patients' pain when the patient's self-report of pain was provided. Finally, participants evaluated each patient as positive or negative and the likelihood that the patient was feigning pain. Participants gave lower ratings on pain, sympathy, and help when medical evidence was absent. Further, in the presence of psychosocial influences, participants took patients' self-reported pain less into account. Next, only for patients expressing high-intensity pain, information about both medical evidence and psychosocial influences was taken into account. Finally, the observer's evaluation of the patient and his/her belief in deception fully, respectively partially, explained the effect of medical evidence. The results indicate that discounting pain in the absence of medical evidence may involve negative evaluation of the patient. Further, the patient's pain expression is a moderating variable, and psychosocial influences negatively impact the degree to which patients' self-reports are taken into account. The results indicate that contextual information impacts observer responses to pain.

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1. Introduction

Pain experiences are inherent to human life. Nevertheless, pain management often remains unsatisfactory [3,36], especially when pain is chronic and/or when diagnosable pathology is absent [3,37]. When a clear medical explanation for pain is lacking, people in pain may feel frustrated and may feel that they are disbelieved by others [1,21,30,42,45]. Furthermore, those who observe people in pain may feel unable to provide adequate care when clear medical evidence for the pain is lacking [29].

Further insight into the social context in which an individual experiences pain for which there is no clear medical explanation is fundamental. Research demonstrated that observers attribute less pain to a patient [5,6,12,38,39,41], feel less sympathy for the

patient, and are less inclined to help the patient [12] when clear medical evidence for the pain is lacking. Others' reactions toward the person with pain, such as pain estimation, feelings of sympathy, and the inclination to help, are important because these responses may underlie pain management decisions and affect the wellbeing of the individual in pain [19].

At present, it is not known which mechanisms account for the effects of lacking medical evidence on observer responses. The absence of diagnosable pathology determining the patient's pain is considered a risk factor for observers to impute to the person with pain the intention of feigning pain [7,8,14]. Additionally, there is preliminary evidence for the role of negative evaluation of the patient in the process of estimating a patient's pain when there is no clear medical evidence [41]. De Ruddere et al. [10,11] found that observers' negative evaluations of patients seem to generate lower observer pain estimates.

Using a vignette paradigm with videos of low back pain patients performing 4 back straining activities, the present study had 3

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objectives. First, we investigated the effects of absence vs presence of medical evidence and of psychosocial influences on observer responses (pain estimates, sympathy, and inclination to help). Although psychosocial factors and influences are common in pain suffering [4,16,28,31], it remains unclear whether their presence also affects observer responses. We also investigated whether information about both factors influences the degree to which observers take the verbal pain report of the patient into account when estimating the patient's pain. Second, we examined the patient's pain expressions as a moderating factor in the relationship between absence vs presence of medical evidence and psychosocial influences on observer responses. We hypothesized that the effects of absence or presence of medical evidence and of psychosocial influences would be most pronounced when patients expressed high-intensity pain. According to Tait et al. [40], observers might be more likely to take into account contextual information when judging high-intensity pain. Third, we examined potential mechanisms underlying the effect of medical evidence on the observer responses. In particular, we investigated the mediating role of the observer's belief in deception by the patient, as well as the mediating role of the observer's judgment of how positively or negatively the patient is evaluated.

2. Methods

2.1. Participants

Participants were recruited by an advertisement in local newspapers. Sixty-two (30 men, 32 women) individuals volunteered. To be eligible, participants had to be 18 years or older and speak Dutch fluently. Further, participants who indicated that they knew one of the patients shown on the videos were excluded. The mean age of the sample was 33.74 years (SD 13.08, range 19 to 64 years). About half of the participants were married, in a relationship, or cohabiting (58.1%); and about half of the participants had education beyond the age of 18 (53.2%). Most were employed (67.8%), and a quarter of the participants (25.8%) were university or college students. The unemployment rate was 6.4%. About one third of the participants (N = 18) reported having had no pain in the prior 6 months. The reported mean pain intensity during the past 6 months of the remaining 44 participants ("In the past 6 months, on the average, how intense was your pain rated on a 0 to 10 scale where 0 is 'no pain' and 10 is 'pain as bad as could be'") was 4.00 (SD 2.01, range 1 to 8). All participants were Caucasian. The study was approved by the ethical committee of the Faculty of Psychology and Educational Sciences of Ghent University.

2.2. Design

The experiment consisted of 4 phases (Fig. 1). In the first, the pain estimation phase, participants were shown pictures of 4 different patients each accompanied by a vignette. The information in the vignettes was manipulated in a 2 × 2 within-subjects design. Vignettes described the presence or absence of (1) medical evidence for the pain, and (2) psychosocial influences on the pain experience. After each picture, a video of the patient performing a pain-inducing activity was shown. Subsequently, participants estimated the patient's pain and rated their own sympathy and inclination to help the patient with daily activities. Second, during the pain estimation after feedback phase, videos of the patients were presented again with the pain ratings of the patients themselves. Participants again estimated the patient's pain. Third, during the patient evaluation rating phase, pictures of the patients were shown and participants rated to what extent they judged the patients to be positive or negative. Fourth, during the deception

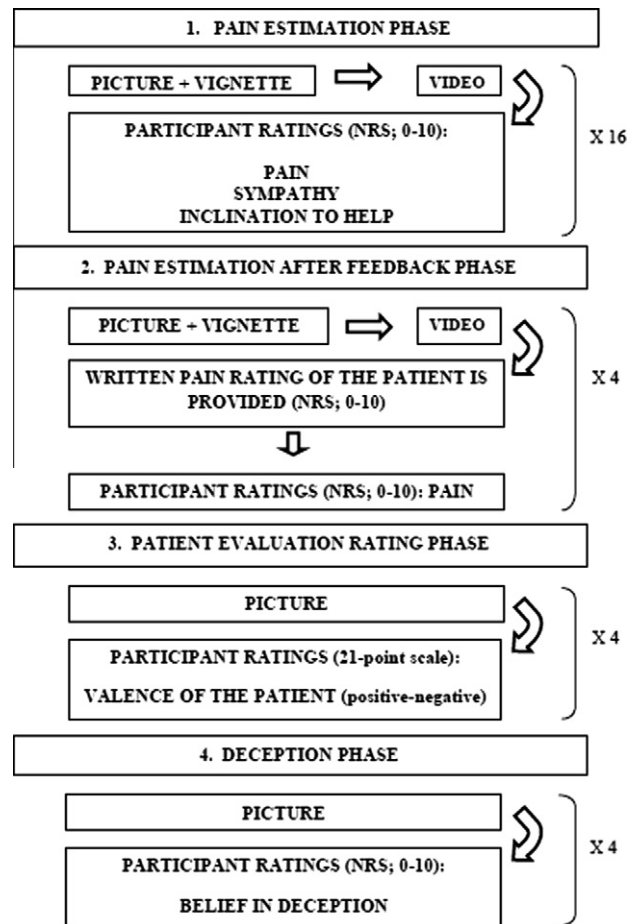


Fig. 1. Flow diagram of the study design.

rating phase, pictures of the patients were shown again and participants rated to what extent they thought the patient was feigning his or her pain.

2.3. Stimuli

2.3.1. Videos and pictures

The videos and pictures were selected from the Ghent Pain Videos of Daily Activities, consisting of videos displaying 34 chronic back pain patients (19 women, 15 men; $M_{age} = 52$ years (range 23 to 74, $SD_{age} = 12$ years) who performed 4 back straining movements. All patients reported chronic low back pain and were in (outpatient) treatment for pain at the University Hospital in Ghent. The patients were asked to execute 4 movements: (1) lying down on a bed and standing up; (2) sitting down on a chair and standing up; (3) taking a box from the ground, putting it on a table, and then lifting it and replacing it on the ground; and (4) picking up marbles from the ground. Each movement was videotaped, and every patient started the movement in upright position with the face directed to the camera. The videos display patients' full-body pain behaviors, i.e., facial pain expression and active pain behavior (e.g., guarding, holding, or rubbing). Further, patients provided verbal pain ratings on a numerical scale (0: no pain at all to 10: pain as bad as could be) after the performance of each movement.

For the present study, video sequences of 4 patients were selected. These patients were selected based on specific criteria. In particular, to ensure generalizability across gender, we selected 2 female patients and 2 male patients. To investigate effects of pain expression, 2 patients displaying a low level of pain and 2 patients

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