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Letters to the Editor

Defining Activity Pacing: Is It Time to Jump Off the Merry-Go-Round?

To the Editor:

Many researchers have acknowledged that activity pacing is a poorly defined construct and the various sources of conceptual confusion relating to the term activity pacing have been documented.[1,11-13,15] This has cast doubt about the validity of current activity pacing self-report measures.[2,5] In response to this, a number of research groups have recently attempted to define activity pacing through varying methodologies and have worked toward developing tools to assess activity pacing.[5,6,12,15] Although this may seem like a positive step toward advancement in the field, each research group has arrived at different conclusions adding to the level of uncertainty about the meaning of the term activity pacing.

In a recent publication, Esteve and colleagues[7] developed a new measure for assessing activity patterns in chronic pain, the Activity Patterns Scale. Three of the 8 subscales of the Activity Patterns Scale purport to measure activity pacing. Each of these activity pacing subscales consist of 3 items relating to a specific activity pacing strategy (ie, breaking activities into smaller tasks, slowing down, and taking frequent short breaks) with the subscales being differentiated by the goal or intended outcome of the behavior (eg, pain reduction vs increasing activity levels).

Esteve and colleagues[7] developed their activity pacing subscales on the basis of the conclusions made in Nielson and colleagues'[15] narrative review. In their publication the authors state that instruments for assessing activity pacing should include 3 activity pacing behaviors, one of which is slowing down.[7] This, however, is in disagreement with the results of 2 recent Delphi surveys.[5,6] Antcliff and colleagues[5] conducted their Delphi survey to determine items to include in a new activity pacing measure: the Activity Pacing Questionnaire.[4] Items that referred to slowing down were not endorsed by most experts, primarily clinicians, who participated in their study (78%) and as such were not included in the final questionnaire. Similarly, a Delphi study by Cuperus and colleagues[6] revealed that most of a panel of experts did not consider slowing down to be an activity pacing behavior in relation to rheumatology care.

As outlined by Nielson and colleagues,[15] slowing down is endorsed as a pacing strategy in some theoretical works (ie, energy conservation, Keefe's approach to graded activity[10]) but not others (ie, Fodyce's seminal work,[8] Sternbach's operant approach[16]). It is possible that the experts recruited for the aforementioned Delphi studies might have favored a particular theoretical stance that introduced bias. Another factor that may have contributed to clinicians being unwilling to endorse slowing down as a pacing strategy is that it may not be clear what slowing down actually means. Slowing down could encompass a number of behaviors; it could signify decreasing the rate at which an activity is performed or decreasing the total time spent on an activity. Alternatively, it could denote ceasing an activity altogether.

From our perspective, as clinicians, we avoid use of the phrase, slowing down when educating habitually overactive individuals about activity pacing because: 1) the belief that activity pacing will reduce an individual's overall productivity level is a treatment barrier, and 2) patients report being more productive and even doubling their activity levels after successful activity pacing implementation.[3] There are instances, however, where we would recommend individuals implement some of the behaviors that may relate to slowing down. An example of this is a mother who values family and is struggling to juggle all household chores. As part of a course of treatment, one could establish the activities/behaviors that are important to the role of being a mother and, for example, encourage delegation of the activities deemed less important (eg, vacuuming) to free up time and energy for more important activities (eg, going shopping with one's daughter). Similarly, you could assist an individual who is struggling to work in a labor-based job to transition a more sustainable career path, which would involve encouraging this individual to cease their current job. The treatment processes related to these scenarios are, however, obviously at lot more involved than simply telling the patient to slow down.

On the basis of recommendations by Nielson and colleagues,[15] Esteve and colleagues[7] linked each activity

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pacing strategy in their questionnaire to 1 of 3 specific goals: increasing activity levels, conserving energy levels for valued activity, and reducing pain. As part of their Delphi survey, Cuperus and colleagues[6] asked their expert panel the most important goals of pacing interventions. To facilitate participation in meaningful activities was selected by the vast majority of panelists as being the most important goal. A concept analysis by Jamieson-Lega and colleagues[12] also concluded that the overall goal of activity pacing is to increase function and facilitate participation in meaningful activity. This was not directly considered as a specific goal of activity pacing by Esteve and colleagues.[7] In addition, a recent qualitative study by Andrews and colleagues[3] highlighted the multitude of ways pacing may positively affect daily function, which included less apparent benefits such as improving sleep quality and reducing opioid use. The 3 pacing subscales that were developed by Esteve and colleagues[7] were highly correlated (.75). This does make you question if individuals with chronic pain have a specific goal for using activity pacing strategies or if there are often multiple reasons why individuals pace activity. It is possible that having more than 1 activity pacing-related goal may actually encourage and facilitate behavioral change.

The points discussed in no way invalidate Esteve and colleagues'[7] questionnaire but highlight that there continues to be a lack of international consensus surrounding the definition of activity pacing despite multifaceted attempts by multiple research groups to address this. We have developed a provisional framework in an attempt to deconstruct activity pacing and incorporate the various ways the term activity pacing is being used (Fig 1). Nielson and colleagues developed a broad definition of activity pacing after their narrative review: "the regulation of activity level and/or rate in the service of an adaptive goal or goals" (pp 465).[15] This overarching label could be thought to have 3 components: 1) breaking up and rescheduling activity, 2) increasing activity, and 3) decreasing activity in the service of 1 or more adaptive goals. The term activity pacing has been most commonly used to describe the first component: breaking up and rescheduling activity.[1,9,12] However, some research groups consider increasing activity[4] or decreasing activity (ie, slowing down)[14] to be a component of activity pacing. As illustrated, the components can be further broken down into specific strategies, which we have labeled subcomponents. There are then multiple treatment processes a clinician could apply to facilitate the implementation of these strategies. In our framework, goals are presented in a way that they are not linked to a particular strategy and it is possible for an individual to have more than 1 goal.

In addition to being used as an overarching label and to describe component(s), the term activity pacing is also used by clinicians and researchers to describe their own conceptualization of the construct where they have selected the components, subcomponents, treatment processes, and goals that they believe underpin the activity pacing construct. For example, Jamieson-Lega and colleagues describe pacing as "an active

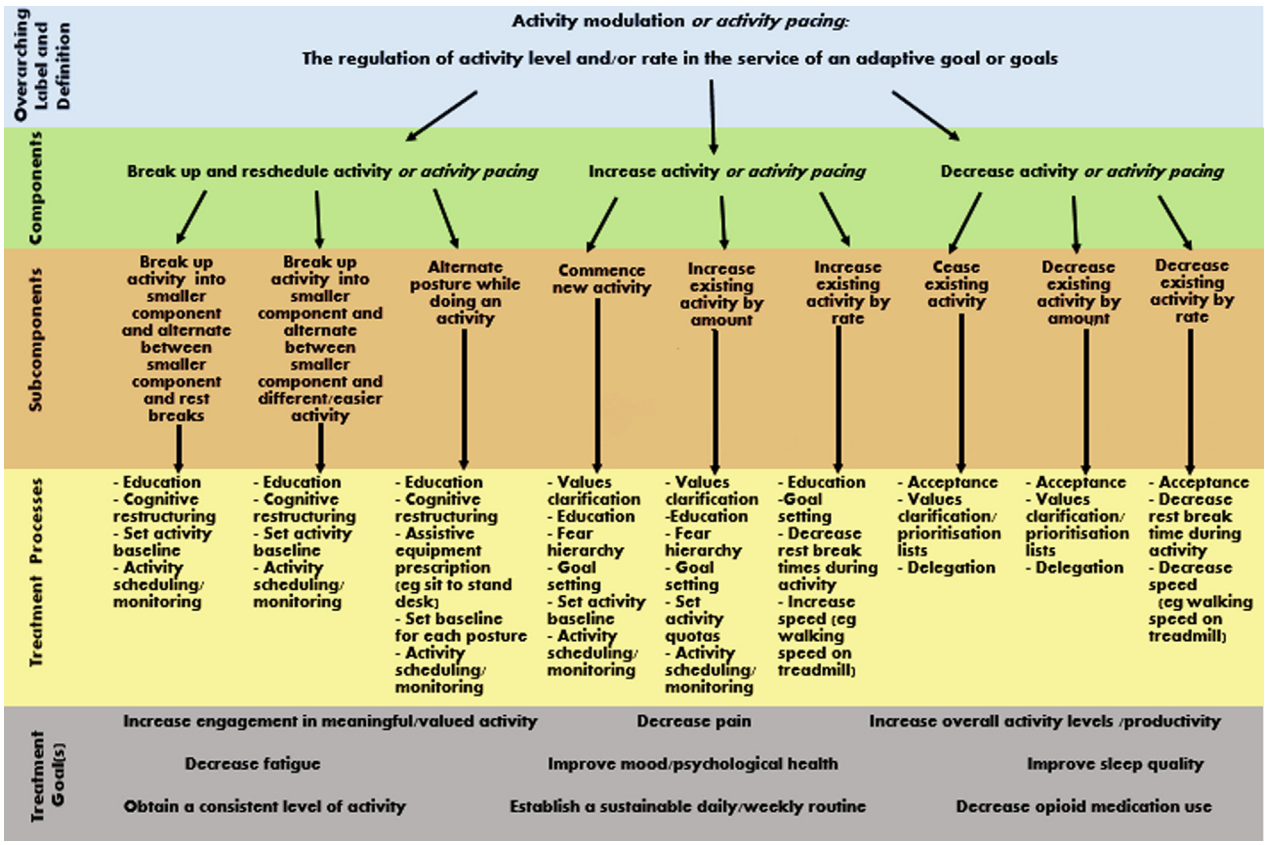

Figure 1. Provisional activity pacing framework.

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