

## Committed Action: An Application of the Psychological Flexibility Model to Activity Patterns in Chronic Pain

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**Abstract:** Whether a person with chronic pain avoids activity, persists with activity, or overexerts himself or herself is considered important to the quality of his or her daily functioning. However, results from studies of these activity patterns have not always yielded clear and consistent findings. It is suggested that applying the psychological flexibility model to activity patterns may clarify and integrate research in this area. Psychological flexibility is defined as the ability to persist or to change behavior in a setting of competing psychological influences, guided by goals and dependent on what the situation at hand affords. One aspect of psychological flexibility that appears pertinent to chronic pain is called committed action. Committed action is essentially goal-directed, flexible persistence. The purpose of the current study was to develop a measure of committed action, the committed action questionnaire (CAQ), in people seeking treatment for chronic pain (N = 216), to examine preliminary reliability and validity, and to test how well a summary score from the measure is able to predict patient health and functioning. Results generally support the internal consistency of the CAQ and show that it is correlated with another established component of psychological flexibility. In regression analyses the CAQ was able to account for significant variance in depression, social functioning, mental health, vitality, and general health, beyond the contributions of pain and acceptance of pain.

**Perspective:** The psychological flexibility model may be useful for understanding patterns of behavior in relation to chronic pain. It appears possible to assess a process in this model called committed action, and this process appears related to important aspects of functioning.

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**Key words:** Psychological flexibility, chronic pain, acceptance, cognitive-behavioral therapy, committed action.

Patterns of daily activity have long served a central role in models of chronic pain and disability. This includes such patterns as avoidance, a key focus within the operant model<sup>3</sup> and in the current fear-avoidance model of chronic pain.<sup>18</sup> This also includes patterns of excessive activity persistence.<sup>5</sup> It is assumed that both excessive inactivity and excessive activity represent risks for greater pain-related disability and suffering for those with chronic pain. The allied assumption is that those with chronic pain need to find the happy medium,

that they need to pace themselves. Yet, this happy medium appears elusive.

The evidence for the relative advantage of different activity patterns in chronic pain is both consistent and inconsistent. Avoidance is quite consistently related to greater disability and distress.<sup>8,10,12</sup> On the other hand, activity persistence is sometimes related to greater disability and distress<sup>8</sup> and sometimes related to less.<sup>2,9</sup> Apparently there are both beneficial and detrimental forms of persistence, depending how the pattern is defined.<sup>10</sup> Pacing, the standard approach to improving activity patterns for people with chronic pain, likewise shows inconsistent evidence, sometimes appearing helpful<sup>14</sup> and more often unhelpful.<sup>10,12</sup> Once again, variations in how pacing is defined may lie behind the inconsistent results.<sup>4,10,12</sup> This area of research may progress better with a deeper, unifying theoretical framework that can integrate these results.

A potential unifying framework for understanding activity patterns in chronic pain is the psychological flexibility model, the model behind acceptance and

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commitment therapy.<sup>6,7</sup> Psychological flexibility is the capacity to persist with or change behavior in a context of personal goals, psychological influence, and situational prospects. Within this model a relative emphasis is placed on problems of avoidance, and behavior is viewed functionally, not formally, in how it interacts with other events, not its structure or appearance (behavior under the influence of pain is a functional distinction—a behavior pattern broken into active segments and rest breaks is a formal distinction). The focus of the psychological flexibility model is on patterns of behavior or action. One specific element within this model is its focus on what is called committed action. Committed action includes behavior patterns that are linked to values and goals; persistent, in that they can incorporate failure and discomfort; and flexible, in that they are guided by values and goals, and are abandoned when unsuccessful. There are currently no measures of this behavior pattern.

The purpose of this study was to develop a measure of committed action in a sample of people with chronic pain. The study includes preliminary analyses of the reliability and validity of this measure, and its unique ability to correlate with measures of patient functioning, independent of another potential significant correlate, acceptance of pain. Results, including statistically significant and clinically meaningful correlations, are expected to support the potential utility of the measure for further research into activity patterns and chronic pain.

## Methods

### Participants

Participants in this study were 216 consecutive adults with chronic pain seeking services from an interdisciplinary pain treatment unit in central London. Most of these,  $n = 154$ , were attending a 4-week, residential pain management course and the remainder,  $n = 62$ , were attending a 2-week residential pain management course as part of a process of being considered for neuromodulation-based treatment (ie, spinal cord stimulators). Participants were mostly women, 62.5%, and white, 76.6%; followed by black, 13.9%; Asian, 6.3%; and other, 3.2%. Most were married or living with a partner, 51.8%, followed by living alone, 32.1%, or living with other family, 16.3%. Their mean age was 47.5 years,  $SD = 13.4$ . The average education achievement was 12.6 years,  $SD = 3.0$ . Areas of the body where pain was present (nonexclusive) included back, 88.3%; lower limbs, 88.3%; upper extremities, 62%; neck, 53.4%; pelvis, 37%; head, 29.4%; chest, 27.6%; and anal or genital, 11.8%. The median duration of pain was 104 months, and the range, 9 to 600. Most of the participants were out of work due to their pain, 42.2%, followed by not working for other reasons, 29.9%, working full time, 16.5%, and working part time, 11.4%. Nearly all participants reported current medication use related to pain, 94.6%. The mean number of different pain medications was 2.9,  $SD = 1.6$ . The most frequent current medications reported included tricyclic antidepressants, 45.2%; anticonvulsants, 44.6%;

and strong opioids, 43.3%. Finally, the participants reported seeing a median of 5 different doctors in the past related to their pain; range, 1 to 20. Those attending the service are typically not in any other treatment at the same time other than using medications.

All data were gathered between January 2012 and August 2012 on the occasion of each person's first day of treatment. All patients were assessed and screened by a consultant physician or specialist physiotherapist and a clinical psychologist. All had chronic pain and were significantly disabled by it, were deemed appropriate for residential treatment aimed at improving daily functioning, and agreed to attend the treatment. The measures completed were designed to assess treatment outcomes and potential therapeutic processes as a standard part of service procedures. Only the baseline data are examined in this current study. All patients included in the current study provided consent for their data to be used for research purposes, and the study was approved by a UK research ethics committee (REC reference: 12/SC/0451). Two potential participants during the period of this study refused to give consent and refused to complete the measures.

### Measures

All measures were completed in the treatment setting and supervised by clinic staff to ensure complete and clear data. Patients provided information about standard background variables such as age, gender, education, home situation, work status, pain sites, pain duration, and health care history. They rated their average pain in the past week on a standard scale from 0, "no pain," to 10, "worst pain possible." They also completed the standardized measures described below and the items of the committed action measure.

### Committed Action Questionnaire (CAQ)

The CAQ is being developed in the present study. To complete this work a pool of items was generated by the author based on definitions of committed action in the psychological flexibility model. The item pool was then examined by a second expert in the psychological flexibility model, chronic pain, and assessment methods. Through discussion the items were examined and in some cases revised until a consensus was achieved that each reflected the intended process. As an additional check on content the interim item pool was distributed to an interdisciplinary team of 15 chronic pain treatment providers to solicit additional comments and suggestions regarding consistency with "committed action," as they understood it, and clarity for patient use. This led to the final pool of 24 items administered to participants for this study. In completing the measure respondents are asked to "please rate the truth of each statement as it applies to you by circling a number." Each of the items is rated on a scale from 0, "never true," to 6, "always true." The instructions and rating scale were adapted from the Chronic Pain Acceptance Questionnaire (CPAQ, see below) as this measure is validated, and consistency in format between these measures was regarded

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