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## Scandinavian Journal of Pain

journal homepage: [www.ScandinavianJournalPain.com](http://www.ScandinavianJournalPain.com)

Clinical pain research

# Pain patients' experiences of validation and invalidation from physicians before and after multimodal pain rehabilitation: Associations with pain, negative affectivity, and treatment outcome



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## HIGHLIGHTS

- Most patients feel validated by their rehabilitation physician.
- However, there is a subgroup that experiences invalidation.
- This group reports more pain interference and negative affectivity after treatment.
- Increasing validation may be particularly important for this subgroup.

## ARTICLE INFO

## Article history:

Received 21 April 2017

Received in revised form 27 June 2017

Accepted 5 July 2017

## Keywords:

Chronic pain  
Communication  
Validation  
Invalidation  
Treatment outcome

## ABSTRACT

**Background and aims:** Validating and invalidating responses play an important role in communication with pain patients, for example regarding emotion regulation and adherence to treatment. However, it is unclear how patients' perceptions of validation and invalidation relate to patient characteristics and treatment outcome. The aim of this study was to investigate the occurrence of subgroups based on pain patients' perceptions of validation and invalidation from their physicians. The stability of these perceptions and differences between subgroups regarding pain, pain interference, negative affectivity and treatment outcome were also explored.

**Methods:** A total of 108 pain patients answered questionnaires regarding perceived validation and invalidation, pain severity, pain interference, and negative affectivity before and after pain rehabilitation treatment. Two cluster analyses using perceived validation and invalidation were performed, one on pre-scores and one on post-scores. The stability of patient perceptions from pre- to post-treatment was investigated, and clusters were compared on pain severity, pain interference, and negative affectivity. Finally, the connection between perceived validation and invalidation and treatment outcome was explored.

**Results:** Three clusters emerged both before and after treatment: (1) low validation and heightened invalidation, (2) moderate validation and invalidation, and (3) high validation and low invalidation. Perceptions of validation and invalidation were generally stable over time, although there were individuals whose perceptions changed. When compared to the other two clusters, the low validation/heightened invalidation cluster displayed significantly higher levels of pain interference and negative affectivity post-treatment but not pre-treatment. The whole sample significantly improved on pain interference and depression, but treatment outcome was independent of cluster. Unexpectedly, differences between clusters on pain interference and negative affectivity were only found post-treatment. This appeared to be due to the pre- and post-heightened invalidation clusters not containing the same individuals. Therefore, additional analyses were conducted to investigate the individuals who changed clusters. Results showed that patients scoring high on negative affectivity ended up in the heightened invalidation cluster post-treatment.

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**Conclusions:** Taken together, most patients felt understood when communicating with their rehabilitation physician. However, a smaller group of patients experienced the opposite: low levels of validation and heightened levels of invalidation. This group stood out as more problematic, reporting greater pain interference and negative affectivity when compared to the other groups after treatment. Patient perceptions were typically stable over time, but some individuals changed cluster, and these movements seemed to be related to negative affectivity and pain interference. These results do not support a connection between perceived validation and invalidation from physicians (meeting the patients pre- and post-treatment) and treatment outcome. Overall, our results suggest that there is a connection between negative affectivity and pain interference in the patients, and perceived validation and invalidation from the physicians.

**Implications:** In clinical practice, it is important to pay attention to comorbid psychological problems and level of pain interference, since these factors may negatively influence effective communication. A focus on decreasing invalidating responses and/or increasing validating responses might be particularly important for patients with high levels of psychological problems and pain interference.

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## 1. Introduction

Although there are empirically supported psychological treatments for chronic pain (e.g. [1]), the effect sizes are fairly modest [2] and there is room for improvement. One potential area of improvement is communication between health care professionals and patients, as effective communication is important for adherence to treatment [3], treatment satisfaction [4], and positive effects on health outcomes [5].

One component of effective communication is validation [6–8]; that is, the communication of empathy, acceptance, and understanding [7,9–11]. Validation has a positive impact on adherence to treatment [12] and pain catastrophizing [13]. Validation is also known to help regulate negative emotions [8], which is relevant to pain patients, who commonly experience co-occurring emotional problems. Invalidation communicates that a person's perspective or experiences are strange, wrong, or unworthy of attention or respect [14]. Examples include negative judgments, or stating what the other person "should" feel. Consequences of invalidation include increased emotional arousal [8,15] and reduced mental well-being and social functioning [16].

The importance of validation when communicating with chronic pain patients has been highlighted [17], but many questions remain unanswered. For example, there is a lack of knowledge about the relation between patient perceptions of validation and invalidation from their physician (both before and after cognitive and behavioural pain treatment), and pain severity, pain interference, and negative affectivity. Comorbid emotional problems (e.g. depression and anxiety [18,19]), the tendency to view emotional symptoms as dangerous (i.e. anxiety sensitivity [20,21]) and the use of dysfunctional control strategies (e.g. pain catastrophizing [22]) are all known to be related to chronic pain. In this study, the term negative affectivity is used as an umbrella term to summarize these more specific constructs.

The occurrence of and differences between subgroups of pain patients based on psychological variables and treatment outcome is known [23,24], but subgrouping based on perceived validation and invalidation remains uninvestigated. There may be differences between patients who experience mainly validation, mainly invalidation, or a mix of both. Although objectively rated responses are important, it is also of interest to study patient perceptions, since it has been suggested that validation and invalidation are always in the eye of the beholder [25]. It is not known whether perceived validation and invalidation are stable over the course of treatment, or whether they can change, perhaps as a result of treatment being successful in modifying cognitive bias and/or reducing negative affectivity. Moreover, little is known about the connection between perceived validation/invalidation and

treatment outcome. Since effective communication in general has been shown to be important for positive health outcomes (e.g. [5]), this is worth investigating.

The overall aim of this study was therefore to examine the relationship between patient perceptions of validation and invalidation, negative affectivity, pain, and pain interference in a sample with chronic pain. More specifically, we aimed to answer the following questions. Firstly, what are pain patients' perceptions of validation and invalidation from their physicians before and after treatment? Secondly, are patient perceptions stable or do they change between pre- and post-treatment? Thirdly, do patients with different perceptions of validation and invalidation differ in terms of negative affectivity, pain, and pain interference? Finally, is there a connection between perceived validation and invalidation (before and after treatment) and treatment outcome?

## 2. Method

### 2.1. Procedure

The current study has a longitudinal design and is part of a larger prospective study investigating the comorbidity between social anxiety and chronic pain: the Social Anxiety and Pain (SAP) project. Data were collected between 2011 and 2014 in the context of routine care at a pain rehabilitation clinic in Sweden. Patients were asked to answer self-report questionnaires at three different time points: (A) immediately before or in conjunction with the assessment visit to the rehabilitation physician, (B) at the meeting with their rehabilitation physician before treatment start (which occurred if the patient was deemed eligible to receive treatment), and (C) at the meeting with their rehabilitation physician after treatment. The data used in the present study were collected at time points (B) and (C); that is, immediately before and immediately after treatment. The patients met with the same physician at both time points. In general, the purpose of the pre-treatment meeting with the physician was to provide a summary of the team's assessment. The purpose of the post-treatment meeting with the physician was generally to plan the future based on the treatment results. Participation in the study was voluntary, and all patients gave their written consent. The study was approved by the Regional Ethical Review Board in Uppsala (case no: 2011/010).

### 2.2. Participants

During the period of data collection, the pain rehabilitation clinic had 955 new patients seeking care, 535 of whom went on

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