



One day at a time: The impact of daily satisfaction with spouse responses on pain, negative affect and catastrophizing among individuals with rheumatoid arthritis

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Abstract

The majority of research on pain catastrophizing has focused on its negative consequences for adjustment to chronic pain, with few investigations of factors that influence catastrophizing or its detrimental effects. Using a daily process methodology, the current study examined, first, the extent to which a supportive social environment plays a role in reduced catastrophizing, and second, the extent to which support might protect against the detrimental effects of catastrophizing on well-being. Sixty-nine married individuals with rheumatoid arthritis took part in an initial background interview, followed by twice daily telephone interviews (regarding pain intensity, negative affect, catastrophizing and satisfaction with spouse responses) for 1 week. Multi-level modeling indicated several pathways through which satisfaction with spouse responses disrupts the vicious cycle of pain, negative affect and catastrophizing. Consistent with past research, catastrophizing was associated with increases in pain and negative affect. However, when individuals reported increases in satisfaction with spouse responses they were less likely to experience increases in negative affect due to catastrophizing. Satisfaction with spouse responses also reduced the likelihood of feeling overwhelmed and helpless in dealing with daily pain. The relationship between pain and catastrophizing was attenuated in the context of increases in satisfaction with spouse responses. Negative affect was associated with increases in catastrophizing, but only when individuals reported decreases in satisfaction with spouse responses. Overall, findings were consistent with a model in which satisfaction with spouse responses serves as a coping resource, and suggests the importance of involving close others in treatments to reduce pain and catastrophizing. © 2007 International Association for the Study of Pain. Published by Elsevier B.V. All rights reserved.

Keywords: Social support; Pain catastrophizing; Chronic pain; Rheumatoid arthritis; Daily process methodology

1. Introduction

Psychosocial factors play a significant role in the experience of chronic pain, and catastrophizing has been identified as among the most important of these (Sullivan et al., 2001). There is clear indication that catastrophizing can result in a range of negative outcomes, from psychological distress (Severeijns et al., 2001) to increased pain intensity (Tan et al., 2001). Although

there is some evidence that catastrophizing reflects a stable way of responding to pain (Sullivan et al., 1995), recent research suggests that individuals vary in the extent to which they catastrophize on a day-to-day basis and these fluctuations cannot be accounted for by pain alone (Grant et al., 2002; Turner et al., 2004). Surprisingly, few studies have investigated factors that influence catastrophizing over time.

Biopsychosocial models of chronic pain highlight the importance of the social environment in shaping the pain experience (Keefe and France, 1999). Cross-sectional and longitudinal research suggests that individuals with chronic pain who report higher satisfaction with support

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tend to report fewer depressive symptoms (Suurmeijer et al., 2005) and lower pain (Evers et al., 2003). Furthermore, the negative consequences of maladaptive coping may be reduced when individuals feel well supported (Marin et al., in press).

The impact of the social environment on catastrophizing has only recently been considered. This research has focused on the extent to which solicitous responses to pain behaviors may reinforce exaggerated expressions of pain and distress (communal coping model; Sullivan et al., 2001); we still know very little about how *satisfaction* with supportive responses may help reduce catastrophizing and its effects. Preliminary evidence comes from a cross-sectional study by Cano (2004), who found, among those with longer pain durations, higher perceived support was associated with less catastrophizing. However, Keefe and colleagues (2003) found a correlation between perceived instrumental (but not emotional) support and *higher* catastrophizing.

Unfortunately, research on the social context of catastrophizing, and catastrophizing in general, has relied heavily on retrospective, cross-sectional designs. The current study is the first to employ a daily process methodology to investigate the relations among catastrophizing, satisfaction with spouse responses, and well-being as they unfold over the day. Twice daily assessments for 1 week allowed for an examination of processes closer to their real-time occurrence and clarification of the temporal ordering of variables (Tennen et al., 2006). First, we investigated the direct effects of catastrophizing and satisfaction with spouse responses on well-being. Higher catastrophizing and lower satisfaction were expected to be related to greater pain and negative affect, concurrently and across the day. Second, we examined the direct effects of satisfaction with responses on catastrophizing, with the expectation that greater satisfaction would be related to lower catastrophizing, concurrently and across the day. Third, we tested our hypothesis that satisfaction with responses would attenuate the detrimental lagged effects of morning catastrophizing on evening pain and negative affect. Finally, based on the buffering model of support (Cohen and Wills, 1985), the lagged effects of morning satisfaction on evening catastrophizing were expected to be greatest at higher levels of pain and negative affect.

2. Methods

2.1. Sample and recruitment

Participants were recruited as part of a larger prospective study on psychosocial factors influencing adjustment among community-dwelling patients with rheumatoid arthritis (RA). RA is an incurable autoimmune disease that affects approximately 1% of the western population and is associated with a variety of debilitating symptoms, including chronic pain of

variable duration and intensity, stiffness and inflammation of the joints, fatigue, and frequent mood changes (Smith and Wallston, 1992; Evers et al., 1998). Only those procedures and measures used in the current study will be discussed here. A list of potential study participants was randomly selected from a database of patients registered with the Mary Pack Arthritis Society, a local organization that offers treatment and education to arthritis sufferers across the province of British Columbia, Canada. Individuals who were over the age of 18 and living outside the Lower Mainland in British Columbia were mailed an initial contact letter describing the study and requesting participation. Interested participants contacted our research office and were screened over the telephone to ensure that they had been diagnosed with RA, experienced pain due to RA during the past month, and were able to read, write, and speak English. Participants in the current sample were also required to be living with a spouse or common law partner. With their permission, individuals who contacted our research office regarding participation in our study were entered in a draw for \$1000.¹ In addition, upon completion of the initial telephone interview, all participants were mailed a small gift, valued at \$10.

The final sample consisted of 69 patients diagnosed with RA. Study participants were predominantly female (84%) and Caucasian (86%), ranging from 29 to 82 years of age (mean = 59, SD = 10.9).² Participants had been married (96%) or cohabitating (4%) with an opposite sex partner for a mean of 30 years (SD = 14.9), ranging from less than 1 to 59 years. The average number of years since being diagnosed with RA was 17 (SD = 12.7), ranging from 1 to 50 years. The majority of participants had completed at least a high school education (86%). Twenty-eight percent were employed at the time of the study (74% of these individuals were employed outside the home, 58% were working full-time, and 95% had paid employment). The remainder of participants were either retired (36%), on disability (16%), on sick leave (10%), homemakers (7%), or temporarily laid off (1%). The modal family income was between \$25,000 and \$50,000 (Canadian dollars).

2.2. Attrition

Initial contact letters were mailed to 800 individuals with arthritis. Of the 188 patients diagnosed with RA who contacted our research office, 28 declined to participate prior to additional eligibility screening.³ Of the 160 who agreed to participate in additional eligibility screening, 71 (44%) met the

¹ The initial draw was for \$300. However, due to a low response rate, the draw value was increased to \$1000 approximately half way through the recruitment phase.

² The higher percentage of women in the current study is consistent with the greater prevalence of RA among women (i.e., the overall ratio is 3:1; Anderson et al., 1985).

³ Over the course of the recruitment phase of the study, 85 initial contact letters were returned due to an incorrect mailing address. We were also informed that six of the individuals on our mailing list were deceased, and 14 had never been diagnosed with RA. Unfortunately, we have no way of knowing why the remainder of patients did not respond (i.e., did not receive our letter, were not diagnosed with RA, were deceased, or were not interested in participating). Twenty-eight individuals declined to participate prior to additional eligibility screening due to: having been in too many studies ($n = 1$), being too ill ($n = 3$), being too busy ($n = 9$), or for an unspecified reason ($n = 15$).

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