



Chronic pain couples: Perceived marital interactions and pain behaviours

Toby R. Newton-John ^{a,*}, Amanda C de C Williams ^b

^a *Innervate Pain Management, Hunter Specialist Medical Centre, Newcastle NSW 2292, Australia*

^b *Sub-Department of Clinical Health Psychology, University College London, Gower St, London WC1E 6BT, United Kingdom*

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Abstract

Patient adjustment to chronic pain is well known to be influenced by the spouse and his or her response to patient expressions of pain. However, these responses do not occur in a vacuum, and the aim of the present study was to investigate patient–spouse interactions in chronic pain in detail. Ninety-five patient–spouse dyads completed questionnaires relating to mood, marital satisfaction and communication, and 80 couples also took part in semi-structured interviews. Data were analysed using quantitative and qualitative methods. Results showed that spouses of chronic pain patients reported engaging in a far wider repertoire of responses to pain behaviours than has been recognised to date. New response categories of ‘hostile-sollicitous’ and ‘observe only’ were identified. Patients generally interpreted solicitous responses less favourably than spouse responses which encouraged task persistence. Male spouses identified fewer pain-related situations than female spouses but were more likely to report responding solicitously to patient pain behaviours. Marital satisfaction was significantly higher in patients who rated themselves as talking more frequently about their pain. Spouse perceived frequency of pain talk was not related to spouse marital satisfaction. There were no gender differences in marital satisfaction. The results of this study challenge some of the assumptions that have been held regarding chronic pain patient–spouse interactions.

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1. Introduction

The spouse of the chronic pain patient has an important influence on patient coping and adjustment (Turk et al., 1985; Flor et al., 1987; Schwartz and Edhe, 2000), most commonly sampled from patient or spouse using the Spouse Response Scale from the Multidimensional Pain Inventory (MPI; Kerns et al., 1985; Kerns and Rosenberg, 1995). This identifies three kinds of spouse behavioural response to patient expressions of

pain behaviour: solicitous (e.g., “Tries to get me to rest”), punishing or negative (“Gets angry with me”) and distracting (“Tries to get me involved in some activity”).

Operant behavioural theory identifies solicitous behaviours as positively reinforcing, so maintaining pain behaviours, and negative responses as aversive, thereby extinguishing them (Fordyce, 1976). While the evidence generally supports this formulation (e.g., Romano et al., 1992, 1995; Fillingim et al., 2003), there are failures to confirm them (Lousberg et al., 1992; Schwartz et al., 1996) and counter-examples, where higher pain levels and greater activity interference were associated with more frequent punishing spouse responses (Burns et al., 1996; Papas et al., 2001). In addition, patient

* Corresponding author. Tel.: +61 2 4969 5309; fax: +61 2 4940 0322.

E-mail addresses: tobynj@innervate.com.au (T.R. Newton-John), amanda.williams@ucl.ac.uk (A. CdeC Williams).

gender is not acknowledged in operant formulations although it has emerged as a moderator of patient–spouse interactions (Fillingim et al., 2003; Cano et al., 2004; Smith et al., 2004); for example, spouse solicitousness was associated with greater self-reported disability only for male patients.

The cognitive behavioural marital literature offers a somewhat different perspective on dyadic interactions. Greater variability in spouse behaviour is recognised than in the operant pain literature (Hahlweg et al., 1984; Fincham, 1994, 1997), with spouse cognitions highlighted as determinants of the variability in spouse behaviour (Cheung, 1996). Couple communication is also considered differently. From an operant pain perspective “pain talk”, or patient verbal reports of pain, is classified as pain behaviour and therefore targeted in treatment for extinction. In contrast, the marital/relationships literature conceptualises open disclosure of emotions as generally desirable in close relationships (Kennedy-Moore and Watson, 2001), so encouraging this is a treatment goal to promote intimacy (Baucom et al., 1998). Although marital communication in the context of chronic pain has been discussed to a limited extent (Rowat and Knafl, 1985; Osborn and Smith, 1998), the relationship between patient pain talk and marital satisfaction for chronic pain couples has not yet been explored.

The present study was designed to address several of these issues, including patient and spouse gender as variables. The first aim was to determine whether chronic pain patients’ spouse responses to patient pain behaviours covered a wider repertoire than currently represented in the chronic pain literature. Second, the immediate emotional impact on the patient of the spouse’s response was investigated in order to test the desirable/aversive assumptions regarding solicitous and punitive behaviours. Third, the role of patient pain talk was investigated in relation to communication within the relationship and marital satisfaction for patient and spouse.

2. Methods

2.1. Study population

Ninety-five heterogeneous chronic pain patients and their spouses were recruited for the study (see Table 1). Subjects were obtained over a 12-month period from consecutive patient referrals to an inpatient, chronic pain management programme (Williams et al., 1996). Inclusion criteria for the study were as per the Williams et al. (1996) study, and in addition patients were required to be in a primary relationship and to have been cohabiting with that partner for at least 12 months. Of the 162 eligible couples approached to participate, 95 (59%) agreed to take part. Information regarding refusal to participate was requested from each declining couple and obtained from 25 (38%) couples. Eight percentage of this group cited childcare commitments, 24% cited travelling dis-

Table 1
Patient and spouse demographic data

Demographic	Patient	Spouse
Age (years)		
Mean (SD)	48.2 (10.4)	49.1 (11.5)
Range	25–68	28–71
Sex		
Male	38	57
Female	57	38
Ethnicity (%)		
White	93	94
Black/Afrocaribbean	2	2
Asian	4	4
Other	1	–
Pain site (%)		
Low back	64	
Upper limb	17	
Head/neck	12	–
Other	7	
Pain duration (years)		
Mean (SD)	9.7 (9.2)	
Range	1–50	–

N = 95.

tance, 16% said the cost of travelling was prohibitive, 12% cited the spouse’s work commitments and 32% said they were not interested in participating in the study. The remaining 8% gave a mixture of other reasons.

Eighty-nine percent of the final sample was married, with a mean relationship duration of 20.9 years (SD = 12.8 years). There were no same-sex couples. 29/95 (30%) of the spouses also reported experiencing a chronic illness, including chronic pain. Of the 95 couples that completed the self-report measures, one refused to take part in the semi-structured interviews and 14 were not available due to time constraints, leaving a total of 80 couples interviewed.

2.2. Ethics

The study protocol was approved by St. Thomas’ Hospital Research Ethics Committee on behalf of the Guy’s and St Thomas’ NHS Trust, London.

2.3. Measures

Pain intensity. Following the recommendations of Jensen et al. (1986), pain intensity was measured on an 11-point numerical rating scale (0 = no pain at all, 10 = pain as bad as it could be). Subjects were asked to rate their average pain intensity over the last week, having first anchored their response by rating their present pain level.

Beck Depression Inventory (BDI; Beck et al., 1979). This 21-item self-report questionnaire is among the most widely used mood measures in the pain literature. Although its factor structure in chronic pain has been the subject of some debate (Williams and Richardson, 1993; Miles et al., 2001), there is substantial support for its psychometric properties in general (Beck et al., 1988). Given the overlap between somatic items of depression and common symptoms of chronic pain (sleep

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