

## Perceived entitlement to pain-related support and pain catastrophizing: Associations with perceived and observed support

Annmarie Cano\*, Laura Leong, Jaclyn B. Heller, Jillian R. Lutz

Department of Psychology, Wayne State University, 5057 Woodward Avenue-7th Floor, Detroit, MI 48202, USA

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### ABSTRACT

Studies on the determinants of pain-related support are needed to enhance couples-based treatments for pain. The purpose of this study was to determine the extent to which pain catastrophizing and perceived entitlement to pain-related support (i.e., support entitlement) were associated with perceived and observed social support. Participants were 106 chronic pain couples recruited from the community. They completed surveys as well as an observational discussion task. Greater support entitlement in persons with pain was correlated positively with pain catastrophizing, punishing spouse responses, and observed spousal invalidation but negatively correlated with perceived spousal support, solicitous spouse responses, and observed validation. Catastrophizing was correlated with perceptions of general spousal support but not the other support variables. Hierarchical regression analyses demonstrated that among persons with lower levels of support entitlement, catastrophizing was associated with greater solicitous spouse responses. Among those with a greater entitlement to support, catastrophizing was associated with greater punishing spouse responses and observed invalidation by the spouse. These results suggest that support entitlement plays an important role in couples' supportive interactions about pain. Continued research is needed to determine how a desire for pain-related attention and support and catastrophizing translate into behaviors that affect support provision and receipt.

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### 1. Introduction

Despite the recent calls for research on the determinants of social support [22], few studies have investigated the predictors of spousal support in pain (cf., [4,5,24]). Identifying the correlates and determinants of spousal support can provide valuable insights as to how social support delivery and receipt can be achieved in couples-based pain interventions. Research has shown that characteristics of the support provider may influence support provision [13]. However, characteristics of the person with pain may be just as important given that one may elicit responses from close others in a variety of ways [12,28]. In this study, we investigate two characteristics of persons with pain—pain catastrophizing and perceived entitlement to support—as correlates of perceived and observed spousal support.

According to the communal coping model, one purpose of pain catastrophizing is to elicit support from close others [28,29]. An implicit and untested assumption of the communal coping model is that some persons who catastrophize *desire or feel entitled* to more pain-related support or attention. These thoughts and desires may have implications for social support seeking and provision. Evidence from the pain field has demonstrated that pain catastro-

phizing is positively associated with refraining from talking about pain concerns with one's partner [26]. In fact, some people with pain do not directly disclose their pain experience to others because they expect negative social reactions [25]. This research also finds that some persons with pain rely on indirect methods of communicating pain such as body posture and facial expressions as opposed to verbally disclosing their distress more directly. People who catastrophize or who feel entitled to support may be especially prone to indirect support seeking attempts because of negative social expectations. Unfortunately, indirect support-seeking behaviors tend to be aversive for potential support providers [3,31], who react with unsupportive or rejecting behaviors. It is also possible that perceived entitlement indirectly conveys that the person is more interested in receiving than giving support. Spouses may perceive the inequity in support provision and receipt, which could contribute to spousal distress and unsupportive behaviors [2,21].

In this cross-sectional study of chronic pain couples, we hypothesized that perceived entitlement to support would be positively related to pain catastrophizing, and that both of these variables would be inversely related to spousal support. We also investigated the possible mediation of catastrophizing and support entitlement in relating to support. Last, based on social support provision models, we expected that perceived entitlement would moderate the associations between catastrophizing and support.

\* Corresponding author. Tel.: +1 313 577 1492; fax: +1 313 577 7636.  
E-mail address: acano@wayne.edu (A. Cano).

Specifically, stronger feelings of entitlement combined with higher levels of catastrophizing may be especially frustrating for close others, who engage in unsupportive and invalidating behaviors. To expand the investigation of pain-related support to observable behaviors, we also assessed spousal support during a discussion task about the pain problem.

## 2. Method

### 2.1. Participants

The initial sample consisted of 108 couples residing in the community. Women comprised 54.6% of the persons with chronic pain. Approximately 49% ( $n = 53$ ) of persons with pain self-reported as African American, another 49% ( $n = 53$ ) self-reported as Caucasian, and approximately 2% ( $n = 2$ ) reported as another race. This distribution was similar for spouse participants (Caucasians: 51%,  $n = 55$ ; African Americans: 47%,  $n = 51$ ; other groups: 2%,  $n = 2$ ). The mean age of persons with pain was 52.03 years ( $SD = 13.40$ ), and the mean age of spouses was 51.85 years ( $SD = 13.49$ ). On average, couples had completed some college (persons with pain:  $M = 14.31$ ,  $SD = 3.03$ ; spouses:  $M = 13.95$  years,  $SD = 2.88$ ). Mean marriage duration was 21.73 years ( $SD = 15.71$ ). Mean household income was \$46,447 ( $SD = \$24,112$ ) and was obtained from block-level group income information in the U.S. Census. The back or neck was the most frequently reported as the site of worst pain ( $n = 70$ ; 65%). The most common chronic pain problems reported were back problems (e.g., degenerative disc disease, herniated disc, pain from spinal fusion;  $n = 59$ , 54.6%) and Osteoarthritis ( $n = 38$ , 35.2%). Persons with pain reported an average pain duration of 11.71 years ( $SD = 10.50$ ) and a mean pain intensity score of 5.37 ( $SD = 2.05$ ) on a 4-item measure (current, average, worst, and least pain;  $\alpha = .89$ ) using a numerical rating scale (0–10 scale).

### 2.2. Measures

Partners with chronic pain completed the self-report measures. Their spouses' supportive behaviors were assessed in the observational task described below.

#### 2.2.1. Perceived entitlement to pain-related support

The Survey of Pain Attitudes (SOPA [17]) assesses beliefs and attitudes regarding pain. The original SOPA has 7 subscales, one of which is the 6-item Solicitude subscale, which was designed to assess attitudes concerning the responsibility of others to provide pain-related support. Because the term "solicitude" is not often used in the pain literature and is more accurately defined as anxious, special, or particular care or attention [1] (OED), we use the term *support entitlement*. Items include "When I hurt, I want my family to treat me better", "When I am hurting, I deserve to be treated with care and concern", "It is the responsibility of my family to help me when I feel pain", "My family needs to learn how to take better care of me when I am in pain", "My family does not understand how much pain I am in", and "I need more tender loving care than I am now getting when I am in pain". Higher scores indicated a greater perceived entitlement to pain-related support. Participants responded on a 5-point Likert-type scale (0 = untrue for me and 4 = very true for me). Inter-item reliability in the current study was adequate ( $\alpha = .74$ ).

#### 2.2.2. Pain Catastrophizing

Pain catastrophizing was assessed with the pain catastrophizing scale (PCS [27]). The PCS assesses three dimensions of catastrophizing about pain: magnification, rumination, and helplessness [27,30]. These subscales were significantly correlated with one

another in the current sample ( $r$ s ranged from .54 to .68,  $p < .0001$ ). The total catastrophizing score was used to ensure the full range of catastrophizing cognitions were assessed. Internal consistency was excellent in the current study ( $\alpha = .92$ ).

#### 2.2.3. Support measures

Spouse responses to pain were assessed with the multidimensional pain inventory (MPI [20]). Perceptions of spouse *punishing* (4 items), *solicitous* (6 items), and *distracting* (4 items) responses to pain were measured. Subscale sums were used in the analyses. Inter-item reliability was adequate to excellent for the subscales (punishing  $\alpha = .84$ , solicitous  $\alpha = .83$ , distracting  $\alpha = .69$ ). One participant did not complete the punishing items. The mean for the sample was entered for this participant to ensure a consistent sample size across analyses. Because of the low inter-item reliability for the distracting subscale and its high correlation with solicitous responses ( $r = .70$ ,  $p < .0001$ ), we do not include distracting responses in further analyses.

*Perceived spousal support* was measured with a romantic partner-specific support scale (12 items [8]). Higher scores indicate greater perceived support from the spouse. Note that this scale measures support more generally, rather than examining pain-specific support. In the current study, inter-item reliability was excellent (spousal support  $\alpha = .87$ ). The mean for the sample was entered for the one participant who did not complete this scale to ensure a consistent sample size across analyses.

*Observed support behaviors* were assessed during two 10-min interaction tasks about the pain problem. The validation and invalidation behavior coding system [10] was used to assess supportive and unsupportive responses during an interaction about pain. Each partner's validating and invalidating responses were coded but only spouses' responses are used in the current study since the focus of this study is on spousal support. Validation includes empathic and supportive responses to the partner's emotional expressions (e.g., questions aimed at understanding the thoughts and feelings of the partner). Invalidation consists of negative responses to a partner's emotional expressions (e.g., inattentiveness to a partner's emotion, changing the subject, telling the spouse what they should be thinking or feeling, or denigrating the spouse). Raters coded global validation and invalidation on a Likert-type scale ranging from 1 (validation: no validation above basic attention; invalidation: no invalidation) to 7 (only validation/invalidation). An advantage of such global methods of coding interaction is that these systems provide simultaneous coding across dimensions of interaction (e.g., quantity and quality, non-verbal and verbal) [23].

Each interaction was coded by 4–6 raters, all of whom were trained by the first author. Raters participated in 5 weeks of training, which consisted of education in couple interaction and observational research issues, reading the training manual, and in-session and practice coding of videotapes from a previous study. Once coders were reliable with the first author and other coders, they were able to code interactions for this study. Coders were not blind to the identity of the patient because the topic of discussion was the impact of pain but coders were blind to survey responses. Coders were allowed to watch the tapes as many times as was necessary to make confident coding decisions.

Inter-rater agreement was assessed with the  $r_{wg(j)}$  statistic, which is calculated from observed and expected variances across coders and items [16]. Like other measures of agreement for continuous variables,  $r_{wg(j)}$  accounts for random measurement-error variance. This measure also accounts for the amount of systematic variance that reflects rater response bias and is used when there are at least 2 parallel items for each measure (i.e., in this study,  $j = 2$  ratings because there were two interactions, as described in Section 2.3). Other measures of agreement or consistency on con-

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