

Response to Andrews and Deen on Defining Activity Pacing

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Response to Andrews and Deen on Defining Activity Pacing



To the Editor:

We thank Drs. Andrews and Deen for their letter¹ and for once more bringing attention to the concept of activity pacing.

We agree that there is much confusion in the use of the term, "pacing." As Andrews and Deen discuss,¹ recently several attempts toward clarification were made,^{5,6,8} but this has not led to a uniform conceptualization. One source of confusion relates to the use of the term pacing as being a set of behaviors taught during clinical intervention or as being a coping strategy used by patients with pain.¹⁰ This could for instance explain why "slowing down" is not considered by clinicians to be a pacing behavior^{4,6} whereas it might reflect spontaneous behavior that patients use to regulate their activity.¹⁰ This distinction may also be evident when defining the goal of activity pacing. Pain reduction is often not the main goal of activity pacing as taught in clinical practice, but it may be for patients when using pacing as a coping technique.

In the construction of the Activity Pattern Scale (APS)⁷ we aimed at assessing a variety of behaviors that patients use to cope with pain, including but not restricted to activity pacing. Following Nielson and colleagues^{9,10} we differentiated pacing behaviors not only according to the specific pacing technique (eg, taking breaks), but also according to the goals they serve. On the basis of the operant and energy conservation approach 3 main goals were identified: increasing activity level, conserving energy for valued activities, and pain reduction. We found preliminary evidence that differentiation of pacing according to the goal it serves is indeed important. Whereas pacing for the goal of increasing activity or conserving energy for valued activities was positively associated with daily functioning, pacing for pain reduction was not.⁷

As Andrews and Deen illustrate in their comprehensive framework, activity pacing can encompass a variety of behaviors and serve many different goals. The APS was designed as a concise instrument and included only strategies and goals most commonly considered. The framework might inform future attempts to construct a dedicated and comprehensive activity pacing instrument. Nevertheless, the main problem with any self-

report measure is to know how patients understand and interpret the items. Validation should include qualitative analyses and assessment of actual behaviors by observation or ecological momentary assessment. Andrews and colleagues have already done important work in this area.^{2,3} We are currently validating the APS by comparing self-reported behavior with observed behavior in standardized situations.

The primary purpose of Andrews and Deen's letter was to generate discussion on future use of the term activity pacing. One option they suggest is to abandon the term altogether and replace it with a different label. However, we believe that this will not in itself resolve the issue, as any label might give rise to confusion when not properly defined. As an example, the label "activity modulation" that they introduce in the aforementioned framework as an alternative overarching concept could likewise encompass a variety of behaviors, including activity avoidance and overactivity. It is the accompanying definition and specification of sub (components) that clarifies the meaning of the label. We would argue that the label activity pacing can still be used, as long as one clearly defines what is meant by and subsumed under this label, just as this will be necessary for any other label. First and foremost it should be clear whether activity pacing is used to refer to a treatment strategy or to behaviors—taught or spontaneous—that patients actually use to cope with their pain.

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