Comment on Nicholas and Asghari: Pain 2006; 124; 269-79

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We were pleased to find the recent paper by Nicholas and Asghari (2006). They conducted a study of adjustment, in patients with chronic pain, primarily focusing on the role of acceptance of pain and a number of ‘‘cognitive variables’’, including pain self-efficacy. They present interesting findings from factor, correlation, and regression analyses. Based on these analyses, they suggest revision of the instrument currently used to assess acceptance of pain, the Chronic Pain Acceptance Questionnaire (CPAQ; McCracken et al., 2004), and a reconceptualization of acceptance in general. We were keen to comment on their work as it is not clear that their paper has fully answered the question raised by the title: ‘‘Is acceptance broader than we thought?’’

Nicholas and Asghari mentioned a number of our studies, which is much appreciated. It was heartening to find others interested in researching processes that have been the focus of our work for more than eleven years. We were slightly dismayed, however, by the seemingly radical nature of their conclusions, and wish to consider these within the context of a larger body of ongoing work. Nicholas and Asghari conclude, ‘‘the CPAQ, by itself, may not be sufficient to explain the processes of acceptance of pain’’ (p.269). They also state, ‘‘the pain willingness subscale of the CPAQ is not robust and should be discarded’’ (p.269). We believe that 14 studies we can identify, including eight different samples in three different countries, support a different conclusion (see McCracken and Vowles, 2006 for a recent review).

The suggestion to discard the pain willingness scale was based primarily on two sets of analyses. The first was a factor analysis showing three ‘‘pain willingness’’ factors, rather than one. The second was a hierarchical regression analyses that failed to show significant prediction, by pain willingness, of depression, disability, or pain, after self-efficacy, fear-avoidance beliefs, and activity engagement were taken into account. Unfortunately, their factor analyses included an exploratory, not confirmatory, method, and thus cannot adequately test the fit of a proposed solution. They retained their solution seemingly based on a single criterion (eigen value greater than one), and apparently did not take into account results from a scree plot, the interpretability or parsimony of their solution, the extent of convergence from differing extraction and rotation methods, or other means for identifying a ‘‘best solution’’. The fact that they found a solution that was ostensibly different than the subscale structure of the CPAQ is in no way surprising (we say ‘‘ostensibly’’ because items from the two subscales were separated with remarkable fidelity). As regards the regression results, we have conducted 30 similar regression analyses, including both scales of the CPAQ, in 4 studies published between 2004 and 2006 (McCracken et al., 2004; McCracken and Eccleston, 2005; McCracken and Eccleston, 2006; McCracken and Yang, 2006). Pain willingness was a significant predictor of adjustment variables in 19 of these analyses and achieved a larger or equal regression coefficient to that of the activity engagement scale 13 times. We feel that exceptions in a pattern of results do not prove a variable is worthless but rather signal a need for further investigation.

It might be noticed that for Nicholas and Asghari, as in our work, in comparison with the subscales, the total acceptance score always achieves higher correlations with measures of patient adjustment. In a real sense, the whole is greater than the sum of its parts: acceptance is ‘‘activity engagement’’ AND ‘‘pain willingness’’. Indeed, we have used the separate scales when it has been more conservative to do so, and when it provides more detail, but this was not meant to put them in competition. From the perspective outlined here, the pain willingness scale does not diminish the CPAQ, but is integral to it.

The definition of acceptance that guides our work, and from which the CPAQ is derived, comes from a functional contextual framework, unlike the framework of current measures of catastrophizing, fear-avoidance, or self-efficacy. This is perhaps the most important point to appreciate. The CPAQ is intended not to assess whether the patient thinks, feels, or believes that dreadful things may happen to them or, alternatively, feels confident that they can function ‘‘despite’’ it all. It is an attempt to assess the degree to which the patient’s behavior, while pain is

present, is free from the influences of pain that lead to a narrowing of behavioral options and to unnecessary avoidance. The primary focus of the CPAQ is not on the content of thought, belief, or experience but on the influences associated with that content and the behavior patterns they determine.

We have, over recent years, focused much of our work on acceptance. Acceptance, however, is only a starting point and represents just one part of a larger model of behavior and suffering (Hayes et al., 1999), a model that we refer to as contextual cognitive-behavioral (McCracken, 2005). This model includes other interrelated processes such as values (McCracken and Yang, 2006), accurate present-focused awareness (McCracken, in press), cognitive de-fusion, committed action, and a contextual sense of self (e.g., Crombez et al., 2003). There may be confusion that acceptance is somehow meant to encompass all of these. To answer the question raised by Nicholas and Asghari, ‘‘Is acceptance broader than we thought?’’ The answer, we believe, is not straightforward and will depend on the assumptions and purposes of the person asking. On the other hand, the model of which it is a part most certainly is broader, and deeper, and, by all intention, more progressive, than a single variable alone.

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