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Editorial

Pain coping and recovery from whiplash: New data on an important problem

The contribution of pain coping strategies to outcomes such as pain severity, mood disturbance, and health functioning has been studied mainly in patients with rheumatoid arthritis, osteoarthritis, and fibromyalgia (Nicassio and Greenberg, 2001). A significant body of research in this area has found that passive coping, reflecting tendencies to avoid activity, focus on pain, and talk to others about pain predict greater psychosocial and physical dysfunction over time in such populations. In contrast, active coping, emphasizing tendencies to stay busy or active, exercise, or use distraction, has revealed an opposite, albeit weaker, pattern with these clinical outcomes. The findings from Carroll et al. (2006) in this issue extend the relevance of passive and active coping to self-reported recovery in persons who suffered whiplash injuries from motor vehicle accidents. Their data clearly showed that passive coping was a potent contributor to slower recovery, and that the presence of depressive symptomatology significantly exacerbated the deleterious role of passive coping in post-whiplash recovery.

These findings are important for several reasons. First, these results held up after the authors controlled for a range of demographic factors, medical co-morbidities, and post-collision pain severity. Second, the study was prospective, following patients at regular intervals until a year after the injury. Third, whiplash is a public health problem that can lead to a range of damaging physical, psychological, legal, and financial consequences that have a societal impact. It is important to know, therefore, if coping and other psychosocial factors contribute to these consequences. Fourth, the study raised important theoretical questions about passive and active coping and the development of behavioral interventions designed to enhance the coping process in chronic pain conditions.

Based on these findings, it is important to consider the reasons for the importance of passive coping to post-whiplash adjustment. As a start, it is helpful to analyze the contribution of passive coping in a broader theoretical context. For example, research that has examined the role of passive coping within a cognitive-behavioral model of pain coping has shown that passive coping is linked to higher helplessness and depressed mood (e.g., Brown and Nicassio, 1987; Nicassio et al., 1995). In addition, passive coping has been found to partially mediate the relationship between helplessness and depression in chronic pain populations (Nicassio et al., 1995). Thus passive coping is illustrative of a broader process of dysfunctional adaptation to pain, involving distorted beliefs, mood disturbance, and poor health functioning.

It also should be noted that some of the passive coping items reflect a form of disengagement (e.g., "Restricting or canceling social activities," "Wishing for better pain medication") that some may argue does not indicate the presence of coping at all, but rather a form of resignation to the experience of pain. When pain is acute and quickly resolves, any form of coping, including passive coping, is far less relevant to adjustment than when pain persists, and the outcomes are far less certain such as after experiencing a whiplash injury. Coping becomes more salient under these circumstances just as it is when patients have arthritic conditions. In essence, persons suffering from whiplash and arthritis face similar adjustment challenges, making the role of passive coping equally important for both groups. The data from the Carroll et al. (2006) study provide support for this claim.

Another potential explanation for the negative impact of passive coping is that this type of coping orientation may be correlated with personality traits such as dependency, pessimism, and low resourcefulness that pose risk for the development of depression in the face of stress and, which this study indicates, interacts with high passive coping to retard recovery. At this juncture, while very little is known about the personality dimensions associated with passive coping, patients who rely

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on passive coping may be less resilient than others and, therefore, less able to respond to adversity in a constructive manner. Future research could be directed toward examining whether deficits in personal resources are associated with passive coping and, in part, explain its effects.

In contrast to passive coping, active coping had no independent effect on recovery. Active coping has been less significant than passive coping in predicting health outcomes in arthritis. In this sense, the Carroll et al. (2006) study findings are consistent with the arthritis literature. In addition, their data showed that passive and active coping are largely independent ($r = -.16$), indicating that they are different forms of pain coping that do not lie on opposite poles of the coping spectrum. The independence between these two forms of coping, however, does not explain why active coping is a less robust predictor of psychosocial adjustment and health outcomes. However, a potential reason for this finding is that there may be greater conceptual overlap between passive coping and such outcomes as depression and disability than between active coping and these outcomes. Common method variance from self-report assessment of these constructs could also partly explain relationships between passive coping and negative health outcomes. Alternatively, active coping may show a stronger relationship with outcomes reflecting a state of positive psychosocial functioning such as positive affect, self-acceptance, and effective social relations (Schanowitz and Nicassio, 2006), constructs that are seldom assessed in the chronic pain literature and that were absent in the Carroll et al. (2006) study.

Finally, the results of this study raise important questions about the psychosocial management of whiplash patients. Clearly, such patients could benefit from behavioral interventions to enhance the coping process post-injury. However, the Carroll et al. (2006) data suggest that traditional cognitive-behavioral interventions focusing exclusively on mastery and problem-solving principles may be not be appropriate for these patients. Rather, because of the importance of passive coping, treatment should encompass techniques to eliminate self-defeating patterns such as focusing on pain, wish fulfillment surrounding pain medication, and activity restriction. Simple education about the importance of not going down this path may be sufficient for some patients, while others may require more assistance in managing these problem areas. In addition, the Carroll et al. (2006) data document very clearly the importance of targeting mood disturbance separately from pain in managing patients with chronic pain conditions. Behavioral treatment aimed at pain may or may not affect depression (Nicassio and Greenberg, 2001). Depression in whiplash patients may result from the increased stress and loss resulting from being injured and not the pain alone. Intervention approaches focusing on coping with the recovery process and augmenting pleasure and meaningful activity may help ameliorate depressive mood and other uncomfortable emotions that, over the long run, interfere with health functioning and recovery in those suffering whiplash injuries. The data from Carroll et al. reinforce the need for effective, rationally based interventions for this population that would incorporate these elements.

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