



Editorial comment

Invisible pain – Complications from too little or too much empathy among helpers of chronic pain patients

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In this issue of the *Scandinavian Journal of Pain* Tapio Ojala and co-workers publish a qualitative, phenomenological study focusing on health care providers' difficulties in trying to understand chronic pain patients and communicate with them, and how failed communication negatively affects quality of life of the patients [1]. They demonstrate vividly how pain patients have negative experiences in their contacts with the health care system, how they are stigmatized in several ways, and how detrimental is the lack of empathy from those who are supposed to help. Their impression after in depth interviews of 34 patients with various causes of long term non-cancer pain, and formally analyzing the responses according to Giorgi's four-phase phenomenological method, are that: Chronic pain patients without obvious anatomical explanation of their pain, experience disbelief and lack of trust from their health care providers (mostly physicians). The patients can experience that the helpers "do not understand how the patients are suffering"; they "do not know how to treat these pain conditions". The patients get the impression that the helpers often say implicit that "the pain is only in your head". The patients can feel that they are outright rejected by their doctors and other helpers in the social security system [1].

These are impressions of Tapio Ojala and coworkers after their interviews with 34 patients with more than 5 years chronic pain conditions (5 patients with low back pain, 10 with sciatica, 4 with complex regional pain syndromes, others with cervical disc herniation, cervical spinal stenosis, cervical spondylo-arthritis/-arthritis, chronic neck pain, and fibromyalgia).

Too much empathy and suffering with our patients

The ability to experience empathy with our fellow human beings clearly varies from person to person [2]. A few have been equipped with too much empathy, and they, more often women than men, suffer too much with the patients who are experiencing intractable chronic pain. Failure to help chronic pain patients can cause "burn-out" among helpers. They may be unable to stay with this

kind of work, unless their leaders, mentors, and the other members of the team are able to provide adequate support.

Even in the best of pain centers, not more than about 50% of patients with severe chronic pain will be helped to better quality of life [3]. Those who suffer too much with the intractable chronic pain patients, are prone to continue trying treatments that we know are less likely to help, sometimes ending up trying treatment approaches that we know have considerable risk of damaging the patients. Escalating doses of opioids in spite of little or no pain relief is a not uncommon result when the helper suffering with the patient is trying "everything" [4]. Invasive interventional techniques, e.g. intraforaminal epidural injections can cause paraplegia from spinal cord injury [5].

Too little empathy and failed communication with pain-patients

Too little empathy, while protecting the helper from "compassion-fatigue" [2] and burn-out, clearly can result in aggravated burden for many patients already suffering from difficult-to-treat or intractable chronic pain, as so clearly documented by Tapio Ojala and co-workers [1].

Finding the optimal attitude and professional approach when dealing with "difficult patients" is a responsibility of the leaders of our pain clinics and pain centers. This was the important message from Sir Michael Bond, former president of IASP, the International Association for the Study of Pain, when he lectured and wrote about this highly important and always present issue [6].

Conflict of interest

No conflict of interest declared.

References

- [1] Ojala T, Häkkinen A, Karppinen J, Sipilä K, Suutama K, Piirainen A. Although unseen, chronic pain is real – a phenomenological study. *Scand J Pain* 2015;6:33–40.
- [2] Gleichgerricht E, Decety J. The relationship between different facets of empathy, pain perception and compassion fatigue among physicians. *Front Behav Neurosci* 2014;8:243. <http://dx.doi.org/10.3389/fnbeh.2014.00243> [Published online 11.07.14].

DOI of refers to article: <http://dx.doi.org/10.1016/j.sjpain.2014.04.004>.

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- [3] Heiskanen T, Roine RP, Kalso E. Multidisciplinary pain treatment – which patients do benefit? *Scand J Pain* 2013;4:201–7, <http://dx.doi.org/10.1016/j.sjpain.2012.05.073>.
- [4] Breivik H, Gordh T, Butler S. Keeping an open mind: achieving balance between too liberal and too restrictive prescription of opioids for chronic non-cancer pain: using a two-edged sword. *Scand J Pain* 2012;3:1–4.
- [5] Hong JH, Kim SY, Huh B, Shin HH. Analysis of inadvertent intradiscal and intravascular injection during lumbar transforaminal epidural steroid injections. A prospective study. *Reg Anesth Pain Med* 2013;38:520–5.
- [6] Bond MR, Simpson KH. Pain – its nature and treatment. With a foreword by Ronald Melzack. London: Churchill Livingstone/Elsevier; 2006.