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Editorial

Empathy is not empathy is not empathy in the management of chronic pain

Clinician empathy can improve health outcomes, patient adherence, and patient satisfaction. When clinicians express empathy in response to patient negative emotion, patients tend to be more satisfied with the care they receive, tend to adhere to treatment recommendations, and consequently, tend to fare better. Research indicates that when clinicians respond to patient negative emotion with an empathic statement, such as, "I can't imagine how hard this is for you" or "You seem scared," patients feel heard, show less distress, and are better able to comprehend treatment information. Further, research indicates that when clinicians respond to patient emotion the first time the patient expresses it, patients often do not repeat the emotion. However, when clinicians do not respond, patients express the same emotion over and over again until the clinician addresses it or the encounter ends [1]. Based on this research, conducted primarily within the context of oncology, it is recommended that clinicians should express empathy in response to patient negative emotion more times than not to have the most efficient and meaningful encounters where patients feel heard and are able to make wise treatment decisions. In essence, this represents a "more is more" approach.

Outside of oncology settings, responding to empathic opportunities might not be as straight forward. Particularly, when interacting with patients who suffer from chronic pain, there are several challenges to communicating empathy. First, clinicians might not easily *recognize* patient negative emotion, especially when patients' suffering and distress are ubiquitous and the primary symptoms they convey. For example, every patient with chronic pain inevitably communicates that they have been experiencing moderate to severe pain – after all, they wouldn't be seeking specialist advice if their pain wasn't causing them a degree of suffering. When pain is routine in this way, pain specialists risk becoming numb to patient suffering. A similar pattern can be found when patients seek a surgical consult as most patients do not seek surgical advice unless they have tried most other paths and are still experiencing pain and/or lack of mobility.

Thus, in a non-chronic pain consult, when a patient says she could barely walk from the parking deck to the clinic because she was in "so much agony," the clinician likely would express empathy about how hard that must be. Chronic pain clinicians, however, might respond with, "Does it hurt to lie down also, or is it only painful upon movement?" as they need to obtain their clinical data to formulate an individualized approach to pain management. Yet, in the process, they inadvertently overlook the fact that the patient just talked about being in unbearable pain. For clinicians to express empathy, they must be able to put themselves in the patients' shoes. When the shoes are filled by a tremendous amount of suffering, and each pair of shoes following that pair is filled with the same suffering, it is easy to see how clinicians stop trying on those shoes. Surgeons and other clinicians who witness tremendous suffering need to remember that even though the suffering seems routine to them, it is not routine for that patient who is expressing it.

Once pain clinicians have successfully recognized patient suffering as an empathic opportunity, the next challenge is how to *calibrate* their empathic response to ensure that they are not validating or reinforcing maladaptive (catastrophizing) pain beliefs. It is well recognized that pain catastrophizing is one of the strongest predictors of chronic pain-related disability (together with pain self-efficacy, discussed below) [2]. Effective pain management often involves therapeutic interventions (pain education and cognitive behavior therapy) that aim to minimize pain-related distress and maximize daily functioning despite pain [3]. In other words, patients are encouraged to "accept the things they cannot change" (the physical sensation of pain) and "change the things they can" (their emotional and behavioral responses to pain).

One key function of clinician empathy is to validate patients' experience. In the case of chronic pain management, clinicians must be careful not to validate maladaptive pain beliefs (e.g., "My spine feels like it is crumbling") and exacerbate distress or avoidance of daily activities by responding with empathy that is calibrated to match patients' experience of pain and distress (e.g., "That must be awful"). In doing so, pain clinicians can inadvertently validate and reinforce patients' perceived pain and suffering. Clinicians might err on the side of not responding to pain related distress at all rather in an effort to avoid reinforcing maladaptive pain beliefs. However, Edmond and Keefe [4] suggest clinicians should show empathy by simply acknowledging that they see their suffering in the moment (e.g., "I can see you are distressed by the pain", "I can understand why you might feel that way") without validating catastrophizing thoughts about the pain ("That sounds terrible", "Many patients feel that way").

A related challenge for clinicians helping patients to manage chronic pain is the need to respond to patient expressions of negative emotion without encouraging patients to "dwell on" and potentially

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exacerbate their distressed state. In situations where patients' are expressing strong emotions and there is a perceived risk that to empathize would "push them over the edge", clinicians' may understandably wish to ignore the emotion entirely and perhaps change the subject. Again, we argue that some empathy is better than no empathy when clinicians deliver the empathy skillfully. Perhaps the best way to deliver empathy when patients express particularly unsettling strong emotions is to use "buried" empathic statements [5] (statements of empathy that directly preface medical talk or a closed-ended statement) rather than "unburied" empathic statements (statements that are followed by a pause to allow the patient to continue with emotion disclosure). Buried empathic statements can be used strategically to re-direct disruptive patient emotions whilst at the same time acknowledging patient suffering. For example, after a patient has demonstrated that they are not sleeping through the night and cannot imagine having to go on like this night and night (e.g., catastrophizing), clinicians might empathize and redirect the patient with "I can see this is hard for you. Let's talk about some things you can do to improve your sleep."

In sum, the expression of clinician empathy can be challenging, as demonstrated by the complexities of responding to patient emotion with empathy in the context of chronic pain management. First, these clinicians have to remember to recognize primary symptoms as empathic opportunities. Next, they need to calibrate their empathic response appropriately to avoid reinforcing catastrophic thinking and distress. Finally, they must decide whether it is helpful for the patient to explore their emotions further (using an unburied empathic statement) or to help patients to acknowledge their emotion and redirect their attention elsewhere (using a buried empathic statement). Ultimately, empathy can come in different shapes and sizes and needs to be tailored to the needs of the patients. Although some clinicians worry about expressing empathy as they fear it will only deepen patient suffering, most patients feel better when their clinicians show they are trying to understand their emotional condition.

References

[1] S.L. Kennifer, S.C. Alexander, K.I. Pollak, A.S. Jeffreys, M.K. Olsen, K.L. Rodriguez, R.M. Arnold, J.A. Tulsky, Negative emotions in cancer care: do oncologists' responses depend on severity and type of emotion? Patient Educ. Couns. 76 (1) (2009) 51–56.
[2] R. Severeijns, J.W. Vlaeyen, M.A. van den Hout, W.E. Weber, Pain catastrophizing predicts pain intensity, disability, and psychological distress independent of the level of physical impairment, Clin. J. Pain 17 (2) (2001) 165–172.
[3] M.K. Nicholas, F.M. Blyth, Are self-management strategies effective in chronic pain treatment? Pain Manage. 6 (1) (2016) 75–88.
[4] S.N. Edmond, F.J. Keefe, Validating pain communication: current state of the science, Pain 156 (2) (2015) 215.
[5] T.W. October, Z.B. Dizon, R.M. Arnold, A.R. Rosenberg, Characteristics of physician empathetic statements during pediatric intensive care conferences with family members: a qualitative study, JAMA Netw. Open 1 (3) (2018) e180351-e180351.

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