

EFFECTS OF FAILING TO BELIEVE PATIENTS' EXPERIENCES OF PAIN

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ABSTRACT Clarke, K.A., Iphofen, R. (2008) Effects of failing to believe patients' experiences of pain. *Nursing Times*; 104: 8, 30–31.

The aim was to explore the effects of healthcare professionals failing to believe patients with chronic pain. The study (n=8) adopted a multi-method approach involving a low-structured interview coupled with patients' diaries and a follow-up interview. Themes identified were: 'I am in pain'; 'I don't believe you'; 'When you feel that you are not genuine'; 'Alienation'; and 'Being believed'. This study highlights that practitioners can show they believe patients by simple means.

BACKGROUND

McCaffery (1968) stated that: 'Pain is whatever the experiencing person says it is, existing whenever the experiencing person says it does.' This definition is frequently quoted by nursing staff but it could be argued that it is not always put into practice. From my experience as a clinical nurse specialist in pain management, patients often attended the pain clinic and expressed relief at having their chronic pain experience believed. Sometimes they felt they were being believed for the first time.

AIM

Although the study's primary aim was to explore the lived experience of chronic pain, the effect of not being believed and the issues around this became a central focus. The second aim of the study, therefore, was to examine the effect of not 'being believed'

IMPLICATIONS FOR PRACTICE

- Healthcare professionals need to confirm the validity of the pain account by means that do not reinforce illness behaviour but empower patients to accept chronic pain and live with it rather than be ruled by it.
- This suggests that healthcare professionals and patients should enter into a therapeutic relationship based on shared medical decision-

making, where practitioners engage patients in choosing the most appropriate treatment plan.

- The emphasis on accurate assessment as the foundation for successful management is an intrinsic principle of acute pain management. This needs to be extended to chronic pain assessment across all disciplines and settings and not restricted to pain clinics only.

by healthcare professionals. A literature review was carried out for this study – for details see nursingtimes.net.

METHOD

This study adopted a multi-method approach – an extended, low-structured taped interview with each patient coupled with diaries, and a follow-up 'debriefing' interview. It is based on a hermeneutic analytical approach within a phenomenological framework. Ethical approval was given by the local research ethics committee.

The sample (n=8) was a purposive convenience sample, generated from patients who had been attending a nurse-led chronic pain clinic in a district general hospital in North Wales for at least three years. The sample comprised four men and four women, aged 37–74 years. Confidentiality was preserved by using a coding system and pseudonyms for family and friends.

The bodily location of the chronic pain varied. It included back pain (n=4), stump pain (n=1), bladder pain (n=1), abdominal pain (n=1) and foot pain (n=1). For details on inclusion criteria, see nursingtimes.net.

Data collection

Two methods of obtaining data were identified as the most appropriate – interviews and diaries. Selected patients

were approached during a routine clinic appointment and asked if they were willing to participate. Written information was provided and written consent obtained. Eight initial interviews lasting 50–90 minutes were taped and transcribed verbatim. The second interview lasted 15–30 minutes. Patients were presented with a blank diary during the first interview, which they maintained for approximately four weeks and was collected at the second interview.

RESULTS

Six out of eight patients reported incidents indicating their pain account was not believed. This study uses data from those interviews and diaries for analysis.

The two patients who did not have an issue with being believed both had a long-term physical disability. Perhaps it can be assumed that their accounts were always accepted as credible because they had a disability that made the cause of their pain appear more visible.

Through reading and re-reading of transcripts, a sense of the emotions associated with feeling disbelieved was revealed. In addition, the reasons why patients felt they were not believed were highlighted. The themes identified were labelled as: 'I am in pain'; 'I don't believe you'; 'When you feel that you are not genuine'; 'Alienation'; and 'Being believed'.



'I am in pain': There were several reasons given for patients feeling they were not believed. The withholding of analgesia figured strongly in two transcripts, although in one instance it was an episode of acute-on-chronic pain that had warranted admission to hospital and had prompted the request for further analgesia. Another patient recalled being prescribed pethidine for chronic bladder pain and then her GP shouted at her for taking more pethidine than had been prescribed.

'I don't believe you': The attitudes of healthcare professionals towards patients experiencing chronic pain varied from empathetic, to extremely disbelieving, to appearing rude. Practitioners who showed poor manners appeared to be unfriendly or actually told patients they did not believe their story, which further compounded feelings of being disbelieved.

'When you feel that you are not genuine': Patients expressed various emotions about feeling they were not believed. This ranged from anger, frustration and sadness to thoughts of suicide. One patient expressed frustration at being made to feel that they were not genuine, while emphasising the effort needed to maintain normality. One patient acknowledged how pain caused feelings of depression but it was the feeling of not being believed that caused her to contemplate suicide.

'Alienation': Apart from frustration and depression, feeling disbelieved alienates patients from healthcare professionals, who are there to help them manage pain. Some patients felt unable to ask for help because they were made to feel as if they were nuisances. Another patient felt that her pain caused the nursing staff additional work.

'Being believed': Not all recollections are negative, however. One patient recalled her first appointment at the pain clinic, which she described as 'such a new experience, to be believed'. Another patient spoke with gratitude about a previous hospital admission.

DISCUSSION

Successful pain management depends on accurate assessment (Plaisance and Logan, 2006). It is not possible to provide appropriate treatment or management options if an accurate appraisal has not been undertaken. Pain assessment is often seen as the cornerstone of acute pain management and nurses are still taught McCaffery's (1968) definition of pain.

This definition immediately acknowledges the subjectivity of the process and places the onus of the pain intensity in patients' domain. In other words, healthcare professionals are obliged to accept patients' reports of pain because there is no objective way of determining whether it does or does not exist.

This, however, is the point at which pain assessment frequently fails. Healthcare professionals – through attitude or actions such as withholding analgesia – show that they are not accepting patients' pain reports.

Chronic pain has further assessment difficulties, as acute pain is often accompanied with physiological signs. Chronic pain frequently has no signs or symptoms other than patients' self-report.

McCaffery and Beebe (1989) stated that practitioners have a responsibility to believe patients' reports of pain or give them the benefit of the doubt. They said that professionals are entitled to their own opinion about the credibility of patients' accounts but it is a professional responsibility to accept their reports and to help patients by adopting a positive and responsive manner.

Listening is an action that takes little physical effort by practitioners and yet appears to be one of the skills most underused. Practitioners need to develop skills that show patients they are listening.

Feeling that they are not believed contributes to the negativity of patients' pain experience by increasing negative emotions. Patients stated that these emotions were further compounded by healthcare professionals' attitudes, which forced them to use strategies to develop credibility while preserving integrity.

Being made to feel that they are not genuine questions patients' integrity. The effect of not appearing that they are speaking the truth can lead them to isolate themselves from situations. Isolation can then exacerbate depression, which is frequently associated with chronic pain.

REFERENCES

McCaffery, M., Beebe, A. (1989) *Pain – Clinical Manual for Nursing Practice* (UK edition). Aylesbury: Mosby.

McCaffery, M. (1968) *Nursing Practice Theories Related to Cognition, Bodily Pain, and Man-Environment Interactions*. Los Angeles, CA: University of California at LA Students' Store.

Plaisance, L., Logan, C. (2006) Nursing students' knowledge and attitudes regarding pain. *Pain Management Nursing*; 7: 4, 167–175.

A further negative effect of not being believed is the damage that it can cause to the patient/healthcare professional relationship. Patients begin to feel alienated from those who they expect to help them and this can cause them to seek alternative help from other sources, compounding the fruitless search for a cure.

The relationship between healthcare professional and patient is based on trust – patients trust practitioners to listen and respond to their needs. However, with practitioners continually failing to 'cure' the pain, people with chronic pain can be seen as 'heart-sink' patients from professionals' perspectives.

It could be argued that the reverse happens when a patient feels believed – that trust is mutual, the patient/practitioner relationship is therapeutic, patients feel supported and respected and the effort put into trying to gain credibility can be used to manage pain more effectively.

CONCLUSION

The effect of believing patients' accounts of chronic pain experiences cannot be underestimated. In this small study, patients expressed gratitude, relief and even surprise when they found their pain experiences were accepted at face value without having to 'prove' its existence.

Practitioners can help patients to manage pain and also retain a good quality of life by simple means such as active listening, being non-judgemental and accepting the pain experience as credible. These measures demonstrate to patients that the relationship is based on caring and empathy. ■

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