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# A Perspective on Adolescent Chronic Pain Dismissal

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## To the Editor

Optimal management of chronic pain is complex and often daunting. In the pediatric and adolescent population, care-givers face additional biases in the face of youth and perceived states of health, which compounds this challenge and frequently leads to dismissal or under-treatment of chronic pain complaints. One study reports that approximately 20%–35% of young adults experienced chronic pain during childhood or adolescence that was 'dismissed' by parents, teachers, or physicians.[1] This study also draws connections to several patient-reported, negative, long-term effects including self-directed negativity and isolation.[1] It is, therefore, important to consider the potential roots of this problem to strive future improvements in care. As young physicians, we suggest that our perceptions of a patient's chronological age and state of apparent health biases us against acknowledging pain in the absence of an associated diagnosis, and therefore education and training are needed to improve patient care.

A brief review of the literature reveals that the challenges of adequately addressing patients with idiopathic chronic pain are not new. In *The Art of Handling 'Difficult' Patients,* Chesanow confides that chronic pain patients are often perceived as "difficult."[2] They require complicated and time-consuming management and are frequently emotionally distressed.[2] He also reports that physician dynamics are another major factor.[2] Unfortunately, most physicians have at least one personal experience involving a patient seeking treatment for reasons that are not purely medical. We therefore feel compelled to consider the possibility of patient ulterior motives such as getting out of a test or missing school. Many physicians also feel pressured for time in that face of a full clinic, which may contribute to these patients' feelings of dismissal.[2] Additionally, a survey conducted

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by Bahtia et al reveals that the majority of physicians report feeling unprepared and under-trained to manage these patients.[3] Physicians are understandably uncomfortable prescribing pain medications, all of which are associated with well-known adverse effects, when our personal biases tell us that these young patients without comorbidities should be pain free.

With a large proportion of young adults reporting dismissed chronic pain and the majority of physicians reporting uncertainty in the face of managing these patients, the question becomes, "how do we fix this?" Two recent prospective studies report high levels of accuracy differentiating genuine complaints from intentional symptom exaggeration using the Minnesota Multiphasic Personality Inventory-2-Reconstructed Form (MMPI-2-RF).[4,5] Though we strive to provide each patient with the best possible care, we also want to confirm that we will 'do no harm,' when prescribing pain medication. Universally employing these screening tools in the context of idiopathic chronic pain may improve physician confidence in a way that does not make the patient feel judged, dismissed, or singled out. Additionally, in a poll of international adolescent and pediatric pain experts, these specialists stress the importance of a multidisciplinary staff, additional formal clinical training, and public education and advocacy.[6] While it may not be possible or necessary for every patient to visit a designated multispecialty pain clinic, perhaps emphasizing the existence and development of such teams would make it possible for physicians to refer patients with persistent symptoms for specialized care.



Defernderfer et al raise important concerns regarding the effect of dismissed pediatric and adolescent chronic pain on long-term emotional wellbeing.[1] Physicians are facing an almost discipline-wide challenge to combat biases in idiopathic chronic pains and find the balance between benevolence and non-maleficence for the best possible patient care. Perhaps the key to making this goal attainable lies in a combination of increasing awareness of pediatric and adolescent chronic pain, additional training in the use of tools such as the MMPI-2-RF, and referral networks to trained multidiscipline care teams. ✤



## Contribution

All authors contributed to the conception and design of the work, drafting the and revising important intellectual content, and approve of the final version to be published and agree to be accountable for all aspects of the work.

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## Conflicts of Interest

Jacquelin Peck MD and Omar Viswanath MD have no conflicts of interest to disclose.

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