

The rise of invalidation in medicine

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Drawing on clinical experience as a psychiatrist working with people living with complex chronic pain, this article explores the phenomenon of patient invalidation within healthcare encounters, and examines its emotional, relational and systemic consequences. Individuals with chronic pain frequently report dismissal, minimisation, or misattribution of their symptoms, experiences that may culminate in medical gaslighting. The article highlights how unintended invalidation erodes trust, undermines dignity and damages the therapeutic alliance. Drawing on Chochinov's dignity-conserving care framework, practical strategies for validation are outlined, emphasising presence, curiosity and empathic engagement as core clinical skills rather than optional extras. The article argues that restoring validation and human connection in healthcare is not only ethically imperative, but central to effective, compassionate medicine.

Keywords: chronic pain, patient-centred care, professional-patient relations, empathy, dignity, medical gaslighting, invalidation, psychiatry

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Being a psychiatrist working with people living with complex chronic pain conditions allows me to view medicine through a different lens. One where the experience of peoples' encounters with the medical profession has time to be heard. And what I am hearing concerns me deeply.

Recently I followed up with one of my patients whom I had last spoken to when she had just started chemotherapy for stage 3 ovarian cancer. When I enquired how she had been coping, she said it was so much easier having cancer than chronic pain. She said that when she went to casualty with cancer, she was treated with empathy and care. However, on previous occasions, when she had needed treatment for an acute pain flare-up, she was made to wait and was ignored – treated as if she was making it all up.

What are we doing, or not doing, when it is easier to have cancer than chronic pain? I wish I could say that hers was an isolated story. The problem is, I hear this theme with most, if not all, of my patients living with chronic pain. The medical profession brushes them off, minimising their symptoms.

This isn't usually intentional. And, I would like to believe, it rarely comes from cruelty or disregard. But in the pressured environments we work in – where 10-minute appointments and admin overload are the norm – something vital is getting lost: the human connection to our patients. And the result, we end up invalidating our patients.

What does invalidation look like?

Invalidation can be obvious, but it can also be subtle hiding behind quick reassurances, silence, or misplaced efficiency. It might sound like:

'Your scans are clear, so there's no reason you should still be in pain.'

'You just need to stay positive.'

'Other people manage; you'll be okay.'

'It's probably just stress.'

We may say these things hoping to comfort, or to encourage resilience, maybe because of our own discomfort, or because we have run out of treatment options. But for the person on the receiving end – who has finally worked up the courage to consult us about something difficult, painful and distressing – those words can be devastating.

What they hear is: 'I don't believe you'; 'Your pain isn't real'; 'This is your fault.'

And when this happens repeatedly, it does damage – not just emotionally, but also to the therapeutic relationship and to the patient's willingness to seek help in the future.

Where does it come from?

As healthcare professionals, we are taught to diagnose and treat. We're trained to look for the problem, identify the cause and fix it. This model works beautifully in many settings – a respiratory tract infection, a fracture. But in the case of chronic pain, it is not enough.

When there's no clear pathology to fix, we may be left feeling helpless. And because we're not taught how to sit with that helplessness, we retreat into defensiveness, rationalisations, or minimisation. We reach for something – anything – that will make the situation feel manageable again.

That's where invalidation creeps in.

There's also a deeper cultural issue. In medicine, we often value certainty over ambiguity, stoicism over emotion, and 'being strong' over being vulnerable. These values get passed down through medical school and reinforced in practice. Unfortunately, they also teach us – implicitly – that validating distress is somehow indulgent or unprofessional.

In his landmark article 'Dignity and the essence of medicine',^[1] psychiatrist Dr Harvey Chochinov urges us to examine our attitudes and assumptions, noting that these can profoundly affect how patients perceive their own worth. He reminds us that what we believe about our patients 'may affect them profoundly' – and that patients often look to us, the healthcare providers, as mirrors, seeking affirmation of their own dignity and humanity.

The impact of invalidation

For our patients, being invalidated is often more painful than the symptoms themselves.^[2]

I have worked with patients who are not just struggling with their pain, but depressed and desperate from years of being told 'It's all in your head.' Some have been to multiple different doctors, and are left feeling hopeless and unheard.

Sometimes they meet a specialist who promises that they have ‘The Cure’, that they alone have the treatment that will relieve their pain. Only to be abandoned with unanswered emails and phone calls when this never realises.

Many patients start doubting their own experience, ashamed for continuing to seek help. Some stop trying altogether, losing faith in the medical fraternity.

Invalidation erodes trust – not just in us, but in the healthcare system as a whole. And worse, it teaches patients not to trust themselves.

This erosion of personhood^[3] echoes Chochinov’s findings, particularly in patients with advanced or chronic illness. He warns that when patients no longer feel seen, valued, or respected, they begin to feel like burdens, and may even question the worth of their continued existence.

His research in palliative care shows that perceptions of being treated with respect and not being a burden are central to preserving dignity, and that these perceptions are shaped directly by how clinicians engage with their patients.^[1]

Working with people living with chronic pain has taught me a lot about the importance of validation. It is about creating the space to allow your patient’s voice to be heard. Without rushing and without judgement. Simply listening – fully, with curiosity, and without trying to immediately explain symptoms away is enough to shift the dynamic. Trust is restored, and with it comes a tremendous sense of relief from patients that they are believed.

When invalidation becomes medical gaslighting

There’s a growing recognition in medical literature of a more insidious form of invalidation: medical gaslighting.^[4] This term describes what happens when patients’ symptoms are systematically dismissed, minimised, or misattributed – often to psychological causes – despite persistent physical or functional concerns. For example, a meta-analysis of how women with endometriosis experienced health encounters^[5] found that women were told that ‘as a woman, you don’t know real pain’, or that ‘there is no diagnosis called menstrual pain’ and ‘it is only stupid women who expressed themselves like this’.

Gaslighting doesn’t always come from malice. It can arise from diagnostic uncertainty, cognitive bias, time constraints, or discomfort with complexity. But its effects are profound. Patients are left doubting their own reality, and lose their sense of identity.^[6] Many describe feeling humiliated, ashamed, or even paranoid. Some stop seeking care altogether, fearing they’ll once again be told ‘it’s all in your head.’

Studies have linked medical gaslighting to diagnostic delays in conditions such as fibromyalgia, myalgic encephalomyelitis/chronic fatigue syndrome, endometriosis, autoimmune disorders and long-COVID. It disproportionately affects women, people of colour^[7] and those with psychiatric or chronic illness. It erodes trust in the medical system and deepens emotional distress.^[5-10]

Validation, by contrast, does the opposite.^[2] It strengthens therapeutic relationships. It helps patients feel grounded in their experiences. It invites collaboration rather than defensiveness. And most importantly, it affirms that patients’ suffering is real – and that they are worthy of care.

So, what can we do differently?

Here’s the good news: validation isn’t difficult. It doesn’t require a new qualification or more tests or a new diploma. It simply requires us to be more human.

1. Slow down – even for a moment

You don’t need to add 30 minutes to every appointment. Try this: put down your pen. Make eye contact with your patient. Ask, ‘Tell me more.’ Pause. Listen. Just being present for someone is an act of validation.

2. Acknowledge the experience

You don’t need to agree with everything your patient says. You don’t even need to understand the full picture. But saying things like, ‘That sounds really hard,’ or ‘I can hear how difficult that must be,’ creates space for the person to feel seen.

3. Get curious, not defensive

Instead of jumping to fix or explain, ask open-ended questions:

‘What has this been like for you?’

‘What do you think is wrong?’

‘What’s helped you cope so far?’

These questions communicate interest and respect – two things that are sorely lacking in many healthcare experiences.

4. Validate emotions, not just symptoms

Chronic pain, mental illness and life-threatening illnesses are emotionally draining. Patients often feel grief, fear, anger, shame and isolation. These emotions are part of the clinical picture, not separate from it. When we validate those feelings, we validate the whole person.

5. Create a culture of validation

This isn’t just about patient encounters. We can model validation in how we talk about patients with colleagues. Instead of rolling our eyes at the ‘frequent flyer’, or talking about ‘the patient in B2 with the opioid problem’, what if we asked, ‘What might be going on for this person that we are missing?’ Culture change starts in tea rooms and handovers, not just policies.

These simple acts of presence and validation fall squarely within what Chochinov^[1] calls dignity-conserving care. His ‘A, B, C and D’ framework – attitude, behaviour, compassion, and dialogue – offers a practical, memorable structure for integrating dignity into every clinical encounter. It starts with attitude, challenging us to reflect on our assumptions. It continues with behaviour, encouraging small but intentional acts of respect and kindness. It includes compassion, reminding us to connect with the suffering of others. And it ends with dialogue, urging us to get to know our patients beyond their diagnosis.

Validation is not weakness

Sometimes clinicians worry that validating a patient’s experience will encourage ‘dependency’ or ‘catastrophising’. But that’s not what happens.

When people feel heard, they feel safer. When they feel safe, they’re more open to working collaboratively. In fact, research consistently shows that validation builds therapeutic alliance, improves adherence and leads to better outcomes – especially in chronic illness and psychiatric care.^[2,9,11-13]

Final thoughts

Invalidation is easy. It’s what we do when we’re rushed, uncertain, or uncomfortable. Validation takes intention. It means slowing down, listening and getting curious. But it’s also deeply rewarding.

We may not always be able to fix the problem. But we can offer presence. We can bear witness. We can say, ‘I see you. I believe you. I’m with you.’

And sometimes, that's the beginning of healing.

We need to bring humanity back into medicine. And it starts with caring.

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