

## Chapter 2

# Pain and Intercultural Communication

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### Introduction

Pain is a universal experience, suffered in isolation. At the most basic level, pain serves a useful function in alerting organisms to threats to bodily integrity. In more advanced, social animals such as chimpanzees, communication regarding pain may enhance the chance for survival as others are enlisted in defense and support of the individual. In humans, communication obviously takes on far greater levels of complexity as potential responses to communicated pain are so varied and nuanced. Still, at its core communication about pain is driven by the need for assistance from others.

In this chapter, we will examine communication about chronic pain through the lens of intercultural communication. Intercultural communication as a field offers a useful perspective that may heighten awareness of common pitfalls that frequently give rise to miscommunication. I will then suggest some strategies that should minimize the risk or severity of miscommunication in the context of pain.

Much of the literature about pain communication, including work on survey instruments and pain scales, has focused on trying to determine pain severity, the qualitative characteristics of pain, and at times the veracity of pain complaints. Driving this literature is an understandable desire to characterize the underlying physiology giving rise to a pain complaint, so that therapy can most appropriately and effectively be delivered. Cross-cultural work in this vein often seeks to determine the transferability of survey instruments among cultural groups (Gaston-Johansson et al. 1990; Zatzick and Dimsdale 1990; Thomas and Rose 1991; Cleeland and Ryan 1994; Chaudakshetrin et al. 2007). This is admirable and necessary, but efforts in this vein fall short in a most basic way. Such approaches tend to perceive language and culture as barriers or veils, which must be broached in order to locate an underlying biologic reality (Cleeland and Ryan 1994). While this may be reasonable at a certain level of physiology, such reductionism neglects the fact that pain as an experience is inexorably interwoven with culture and that for humans language is essential in giving voice to such experience (Pugh 1991; Im et al. 2009; Schiavenato and Craig 2010).

Cross-cultural misunderstandings can indeed obscure formal medical diagnoses. However, it is also true is that any episode of communication about pain represents its own truth within a cultural context and such truth is correlated with but independent of biologic reality (Fruend 1990; Trnka 2007).

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This truth usually represents in part a request for some response from others within the context of a particular relationship in a particular culture. The response may be behavioral, the administration of some aid or medication, or relational, as through a demonstration of empathy (Goubert et al. 2005). For example, if a person with a history of substance abuse purposely lies about pain with a goal of getting some drug, there certainly is a problem in the episode of communication in terms of biologic veracity. However, the communication is still “truthful” or at least real in terms of being a request from one person to another for a desired response. Such a request is made in the context of a social and regulatory system that gives access to such drugs to a select few.

The emphasis in many survey instruments on severity of pain and its biologic origin is itself a cultural construct of biomedicine, which prioritizes physiologic causality over more social aspects of experience (Hahn 1995, Kleinman 1995; Fabrega 1997; Hallenbeck 2007). In any such instrument, particular aspects of pain communication are to be elicited to the exclusion of others. Survey instruments, then, represent a culturally sanctioned form of forced communication, albeit with beneficent intent, which may or may not serve the purposes of individuals experiencing pain.

## High and Low Context Communication

Intercultural communication is a field of anthropology, first developed by Edward Hall (1976, 1983, 1990, 1997). Hall noted that human interactions and related communication can be broadly classified as being high or low in their cultural context. High context communication embeds large amounts of meaning within the situation or context within which communication occurs. Where people are when they are communicating, who is present, and how they position themselves relative to one another are all parts of the context in which a message is delivered, interpreted, and received. High context communication is thus *relational*. That is, a major goal of such communication is to affect in some way the relationship of those participating in it. Relational goals may include establishment or clarification of the relationship. They may also relate to a request for some change in behavior or assistance. In everyday life, courtship behavior such as dating is an example of an inherently high context encounter. Low context communication, in contrast, is concrete, situation specific, and task-oriented and involves minimal relational work. Such communication is usually straightforward and relatively unambiguous. Asking for street directions is an example of low context communication.

Hall noted that serious cross-cultural misunderstandings can occur when people using low context communication styles interact with others using high context communication styles (or where people using very different high context styles interact with one another). Different ethnic groups may prefer relatively higher or lower contextual communication styles. Certain groups, most notably those of Northern European descent, are believed to be relatively lower in contextual style than others, such as Southern Europeans or Asians (Samovar and Porter 1997). Clashes can occur among individuals from different ethnic groups, based in part on their differing communication styles in this regard. However, cross-cultural clashes can also occur within relatively homogenous ethnic groups. A case in point can be seen commonly in encounters between clinicians, acculturated to the low context world of biomedicine and the lay public, who tend to experience sickness as relational, high context events, regardless of ethnicity (Hallenbeck 2006; Hallenbeck and Periyakoil 2009). Both high and low context approaches to sickness make sense within their particular cultural framings. A scientific, physiology-driven understanding of *disease* allows for a very precise and often effective optimization of medical therapies. Low context communication includes math, computer, code, and scientific and medical language. It often works better across linguistic groups and cultures precisely because it avoids complex and confounding meanings associated with ordinary language. For instance, the use of pain scores as a means of communicating pain severity via mathematical symbols (1–10) is a low context means of communication, which offers a real advantage in this regard. A Likert scale between 1 and 10 means pretty much the same thing in all languages and cultural

groups. In contrast, high context communication about sickness also makes sense in that *illness* (as opposed to a disease) almost always affects more than one person. Serious illness usually involves an alteration in the relations among closely linked individuals. The sick person becomes dependent upon others, clinicians, family members, and caregivers, for a wide range of needs. High and low context approaches to sickness make sense in their own realms; and ideally these two approaches are complementary and synergistic. However, at worst, what is risked is people talking past another and serious miscommunication.

In terms of intercultural communication, pain is a particularly interesting topic. Like all symptoms pain is by definition a subjective phenomenon. The definition of pain according to International Association for the Study of Pain (IASP) suggests the nature of the problem:

Pain has been defined as an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage. Note: The inability to communicate verbally does not negate the possibility that an individual is experiencing pain and is in need of appropriate pain-relieving treatment. Pain is always subjective (2010).

As this quote states, pain is a subjective biopsychosocial experience, which may or may not be associated with tissue damage. As a symptom, pain is unusual in its variable correlation with objective reality (tissue damage). By contrast, patients with nausea or dyspnea usually have clear objective markers associated with their symptoms. The cautionary note regarding communication points to difficulties linking subjective experiences with objective reality. One could also add that when pain *has* been communicated, it does not necessarily mean that tissue damage has occurred. When no association with tissue damage is found, what does this mean? Does it mean that such an association is present, but clinicians have missed it? Is the “unpleasant experience” being described properly in terms of pain but with no tissue damage? In this instance is the usage of the word pain takes on metaphoric implications. Or, is the person claiming pain not having an unpleasant experience and is in effect lying?

Tissue damage suggests the need for a low context approach to healing. The machine is broken and repairs are in order. Where repair is not possible, a “system override” is needed, where the brain is told to ignore the blinking red panic light. The subjective and often emotional experience of pain in contrast cries out for connection with others in hopes of finding assistance and relief or, where relief is inadequate, at least some degree of empathy and understanding and is thus high context (Biro 2010). Pain, then, is both a high and low context event, requiring both technical and relational expertise for optimal treatment.

In some conditions, common experience leaves little question as to whether tissue damage has occurred. Patients with acute and obvious wounds, burns, and broken bones rarely need to convince others of the severity or veracity of their pain. Cries of anguish and grimacing erupt spontaneously in such severe pain, even in the absence of another person. The objective reality of trauma and the subjective cry for help present as one coherent message. However, in many pain states often classified as chronic pains, there may be little correlation between objective markers of tissue damage and subjective experience of pain and suffering, even where the associated suffering is every bit as real and great (Hadjistavropoulos and Craig 1994). Curiously, one would think that it is precisely in such cases that individuals would want to communicate verbally their distress to others, if for no other reason than to compensate for the lack of physical stigmata validating their complaints. And yet, clinicians often see the exact opposite. Patients with chronic pain tend to withdraw. They do not cry out.

## Acute and Chronic Pain in Evolutionary Terms

Pain is obviously a fundamental biological property of evolved species that is replete with significant information regarding the need states of an organism and its capacity for adaptive behavior. It constitutes a hallmark of sickness and can elicit caring and nurturing. Fabrega (1997, p. 62).

Let us consider more closely the puzzle presented by the nature of pain. Why is it that when pain is most obvious, people scream the loudest and when pain is least obvious, they are often silent? Such a communication strategy makes sense in evolutionary terms, as highlighted by the experience of nonhuman, social animals. In calling out with acute injury, a social animal alerts other members of the herd of an immediate and urgent need for defense and support. Other members of the group may not only provide defense (e.g., against an attacking animal), but may be able to provide immediate pain relief (as in taking a thorn out of a foot). Both the vocal and nonverbal communication of pain and the social response of “sympathetic pain” (feeling pain or discomfort in seeing another wounded and in pain) appear instinctual and transcultural in their prevalence (Prkachin 1992; Oti et al. 2010; Williams 2002; Goubert et al. 2005; Frith 2009). By way of example, Botvinick and colleagues demonstrated through magnetic resonance imaging similar patterns of cortical stimulation in volunteers viewing facial expressions of pain as occurred in them during thermally induced pain (Botvinick et al. 2005). How then to explain the withdrawal and silence so common in many chronic pains?

Many pains characterized as “chronic” are in fact better characterized by their representing in fact or metaphorically certain types of deep tissue pain. Temporal longevity of a pain episode (acute versus chronic) is variably correlated with this type of pain for which we lack a commonly accepted word in English. Headaches offer a very good case in point. Most headaches, while temporally of a short (acute) duration, do not give rise to vocal outbursts, but rather often result in withdrawal and relative quiet typical of “chronic pain.” Withdrawal in evolutionary terms would be an appropriate response to bodily damage involving certain deep tissues. In animals and in ancient times for people the best chance for survival would have been hiding out and waiting for internal healing, if possible, to occur. Others would be less likely to be of immediate assistance. Indeed, there may have been some survival benefit attached to keeping a low profile. In such situations, communication between the sick individual and other members of the herd or tribe would be less urgent. Such communication to the extent it existed would likely transmit the importance of keeping quiet and being less, rather than more visible.

While primitive people often had little to offer medically to treat conditions giving rise to such chronic [sic] pains, they were generally able to provide support, such as food, water, and shelter, to the sick individual, while they waited to heal. Following traumatic injury, after the initial, spontaneous crying out of acute pain, tissue damage is often so obvious that further evocation or communication would seem unnecessary for the purpose of enlisting ongoing support and exemption from one’s usual social duties. However, for chronic pain, the opposite is the case. Precisely because there is no obvious stigmata of tissue damage, language offers a means for communicating the internal experience of pain, eliciting needed support, and justifying exemptions from social duties. Thus, while chronic pain may not provoke as immediate and guttural a cry as acute pain tends to do, if anything the need for verbal communication is far greater.

One could make the argument, based on the above, that we are “hard-wired” in our responses to acute pain. That is, we are programmed to respond viscerally to images and vocalizations of acute pain. The more horrific the image, the louder the vocalization, the more immediate and intense our instinctual response. Put simply, we are pretty good at “seeing” and empathetically responding to acute pain. In contrast, for equally valid reasons in evolutionary terms we are “color-blind” to certain “chronic” pains. We cannot “see” them and our empathetic responses to such pains are blunted.

A small study highlights the above point. In a study of “gold standard” (thought to be truthful in their pain complaints), cancer patients’ clinicians and caregivers (mostly family members) spent time talking with patients in varying degrees of pain (Grossman 1991). They were not allowed to speak specifically about the pain. Patients, clinicians, and caregivers were then asked to rate the pain

using a 0–10 scale. Concordance between patient-reported pain and other’s assessment was then noted. The results are included in a table below.

Patients’ assessments correlated with those of	0–2 Little or no pain (%)	3–6 Moderate pain (%)	7–10 Severe pain (%)
Nurse	82	51	7
House Officer	66	26	21
Oncology Fellow	70	29	27
Caregiver	79	37	13

What can be seen is that when patients had little or no pain, concordance by clinicians (nurse, house officer, oncology fellow) and caregivers (people who knew the patient well) was fairly good. However, these observers were unable to recognize more severe states of pain. These results are rather the opposite of what we might imagine were the study to be replicated with acute, traumatic pain. In acute pain we can easily imagine great concordance between subjects and observers. The study is also interesting because it dispels two common myths; that if a person just “knew” the patient better, they would be better at recognizing severe pain. Caregivers were in fact less accurate than the physicians. Another myth is that people in more sensitive, empathetic positions (nurses, caregivers) should do better than “less sensitive” task-oriented people, like physicians. In fact, nobody was very good at “seeing” the severe, chronic pain of the patient.

The problem is actually worse than this. In many cases we are not only color-blind to chronic pain, we are blind to our blindness. Because we are so good at recognizing and responding to acute pain, we come to believe we are able to recognize pain in all forms. The common resistance by clinicians to efforts to get them to repeatedly inquire about pain using pain scores, for example, can be understood not so much as objection to the notion that pain is bad and ought to be treated but rather as a deeper resistance to the apparently absurd notion that we need to ask about what should be so obvious (Biro 2010, p. 13; Young and Davidhizar 2008).<sup>1</sup>

## High and Low Context Pain Communication

Communication regarding acute pain is relatively low in context, even when help is requested from others. The guttural cry of acute pain is straightforward, task-oriented, and works well across very divergent cultures and language groups. As noted earlier, biomedicine, as a subculture, tends to favor low context communication. Numbers, data, and images are valued over words and meaning. Fabrega, who has written extensively on the evolution of sickness and healing, notes that modern medicine has become quite skilled at alleviating most acute symptoms such as pain, but less skilled in alleviating the distress and suffering associated with chronic illness (Fabrega 1997). Chronic pain would be included among such distress. In part this undoubtedly reflects physiologically based difficulties in alleviating certain chronic conditions such as neuropathic pain. However, in part it may also be that low context, biomedical clinicians are more comfortable responding to the low context communication of those in acute pain and conversely less comfortable responding to more complex, high context communication typical of chronic pain. One could argue that greater comfort in response

<sup>1</sup>In the healthcare system within which I work pain scores have been mandated as “the fifth vital sign” for over a decade. Objections to this policy first arose based on the technical and rather trivial point that pain is a *symptom*, not a sign. In watching many case presentations by residents in training and other physicians it is extremely rare to see pain presented as a vital sign (following pulse, respiration, temperature, and blood pressure), despite this official policy. Rather, the oxygen saturation number, which is new fifth vital sign is eminently measureable, fills this role.

to acute pain communication reflects not only relatively greater efficacy of treatment and certainty of diagnosis, but also a more favorable reimbursement structures, at least in fee-for-services healthcare systems. However, such reimbursement systems are themselves a product of a society that values low context certainty and unambiguous results over high context relationships. The common aversion to patients with chronic pain goes beyond such practicalities. The inherently high context nature of interactions with individuals suffering chronic pain may be threatening for clinicians, who understandably seek clear boundaries between person and professional personae. Given current limitations in our ability to “cure” chronic pain and the common public perception that such cure is a reasonable expectation of care, clinicians may fear getting caught up in a sticky web of protracted interactions.

Let us then consider such high context communications in more detail. As has been stressed earlier, high context communication is primarily relational. However, the nature of such relationships varies from ones of the provision of basic aid or simple defense to extremely complex relationships based on empathy, mutual understanding, and even politics, enacted through mutually constructed narratives.

In discrete encounters, relational work is often interwoven with task-oriented work. Such relational work often manifests as a set of subtexts to the “text” of verbal communication, which often revolves around concrete, low context medical tasks. Common relational/high context subtexts include (among others):

- Trust
- Respect
- Obligation
- Affect (gratitude, anger, etc.) relative to the other person
- Empathy and mutual understanding
- Specialness
- Empathy and mutual understanding
- Legitimacy of pain complaint/sick role
- Power

While these subtexts are presented as discrete categories, considerable overlap exists among them. Trust, respect, and empathy, for example, overlap. Let us consider these categories in more detail and highlight them with relevant examples in pain management. For illustrative purposes we will consider here relationships between providers and patients, although these subtexts also exist in other relationships (e.g., among family members).

*Trust:* Trust exists relative to distrust. Trust relates to truthfulness or veracity of the pain complaint, but also to the ability of participants to abide by social contracts. Such contracts may be formally codified in written form as may be done with opioid agreements (Heit). However, the use of such agreements does not mean that true trust exists. It is often quite the opposite. Where such contracts are thought necessary almost by definition trust is questionable, at best. Indeed, where the use of such agreements is mandated by the clinician, this is more a display of differential power than a marker of trust. Still, as Heit notes, “Opioid agreements have the potential to improve the therapeutic relationship.” (p. 376) While much writing, especially as relates to pain management in substance abuse, addresses the issue of trust and truthfulness of patients, trust or lack thereof is by definition a two-way street. Patients need to trust that they are respected, that clinicians have adequate competency to address their problems, and that clinicians will do so with due diligence. The “therapeutic relationship” Heit writes about to a large degree reflects an evolving, iterative, process in which trust is either built or damaged through interactions among participants. While trust/mistrust as an issue may be relatively overt, as in drug screening, more often, where mistrust exists it works as an unspoken subtext, played out as participants try to demonstrate their relative trustworthiness or question the trustworthiness of the other (Parsons et al. 2007).



*Respect:* Respect overlaps with trust, empathy, and an appreciation of specialness (Branch 2006). It differs somewhat from trust in that it is less tightly linked to truthfulness. Respect requires an appreciation for the other, which may exist even if and where the other is quite foreign, even though evidence suggests respect tends to grow with familiarity (Beach et al. 2006). Disrespect, conversely, may be driven either by a negative past history with an individual or a negative experience or stereotype regarding a group or class the other person is perceived as representing. Disrespect or frank prejudice may be felt and displayed toward others based on race, religion, ethnicity, gender, sexual orientation, social or professional role – or any number of factors. While mistrust and distrust may reflect stereotyping or prejudice, they may also be rooted in the personal histories of individual clinicians and patients. Evidence suggests, for example, that African-Americans may receive substandard pain management, relative to other ethnic groups (Nampiaparampil et al. 2009). The reasons for this are likely very complex. Some clinicians may associate drug-seeking behavior with certain ethnic groups such as African-Americans, based both on stereotyping and perhaps past interactions with individuals that may have suggested a link between ethnicity and drug abuse. Conversely, some African-Americans may be all too aware of a history of substandard treatment and care for African-Americans and may have experienced discrimination in seeking medical care. Such experiences on both sides can sow the seeds of distrust, which can readily manifest in shows of disrespect, which insidiously can confirm underlying distrust. Conversely, respect can be demonstrated and expressed even in initial encounters, prior to any evolution of a trusting relationship, which takes time. Indeed, in most initial clinical encounters, the demonstration of mutual respect is the cornerstone upon which strong, trusting relationships are built.

*Obligation:* What is a “therapeutic relationship?” A therapeutic relationship is defined as a relationship that maximizes the possibility of healing of body, mind, and spirit. In the process of creating such a relationship some sense of personal closeness or bonding between clinician and patient is inevitable, even within their professional relationship. Obligation is a term rarely used in low context cultures, but is of great importance in high context encounters. It refers to an internal drive to respond to a need in another person by doing something positive or helpful. Obligation may exist as simply relative to an ascribed role. Thus, clinicians may speak of a *professional obligation* to treat patients beneficently and to do as little harm as possible. However, obligation is also very personal, based on prior interactions among people. If previously a person responds positively and does some good for another, then the other may feel a sense of indebtedness to this person. In “returning the favor” to this person, mutual obligation is built. Such mutual obligation acts rather like a social glue binding people together. In professional relationships, obligation may or may not be engendered simply by doing one’s job. Relieving a patient’s pain (and in turn being thanked and paid for this service) may foster some sense of mutual obligation – or not – if such work is viewed merely as an equal trade or barter transaction. Personal obligation is more reliably fostered if and when something outside the expected role is done. Thus, for example if a clinician “goes out of the way” (beyond formal role expectations) to do something good for a patient (get a blanket, e.g., for a cold inpatient or gives a patient their personal cell phone number), then a sense of obligation is likely to be fostered.

*Affect:* Emotions are present in many clinical encounters as a subtext. This is readily apparent in facial expression. People smile or frown. They speak with anger or fear, or perhaps the voice and body language suggest comfort, trust, and positive feelings toward the other. This is entirely natural. As with other subtexts, in clinical encounters emotions tend to arise while addressing task-oriented work, such as clinical assessment, procedures, or information giving. Studies suggest that many physicians encountering emotions during such encounters will tend to focus on the cognitive or medical tasks at hand, rather than address the emotion directly (Suchman et al. 1997; Detmar et al. 2001). This may be because clinicians feel they are in a stronger position when dealing with technical matters, but it may also be because clinicians believe it is unprofessional (outside their role) to deal with the emotions of the other or their own feelings. Most clinicians lack formal training on how

best to deal with strong emotions either in patients or themselves (Parle et al. 1997). Even simple skills such as mirroring techniques (“You seem angry [or afraid or whatever] ...”) can be of help if and when strong emotions are present and need to be openly recognized and adequately discussed.

*Specialness:* We all want to be thought to be special in some way, which we may label “specialness.” When we are in trouble or sick, as when we are in pain, the desire for recognition of our specialness grows stronger. This seems particularly so in our modern world, where healthcare is more an impersonal industry than a unique relationship between healer and patient. The need for such recognition tends to be even greater if one belongs to an underclass group, such as minority or other disenfranchised population, including chronic pain patients (Haugli et al. 2004). Such a need may also be greater where the particular illness is one that is questioned or held in low esteem in society. Patients with certain forms of chronic pain or substance abuse, and patients lacking mental capacity, as in those with retardation or dementia, are examples of such patient classes. However, most all of us feel this in our roles as patients. We want clinicians who recognize our uniqueness and importance not just as a matter of ego aggrandizement, but for very practical reasons.

*Special patients get better care:* Explicit recognition of specialness is a great way to display respect and to build strong relationships, although at times limits need to be placed if and when specialness spills over into entitlement. An example of such recognition might be, “I’ve treated many patients with your condition, but I know they are not you and that each person’s situation is unique. I want to understand your situation so I can better help you (as compared to treating the disease).” Practically speaking, patients want clinicians to recognize specialness by devoting adequate allocation of time and energy to their cases. Most people are aware, I believe, that clinician time is very limited and they reasonably worry that they might be short-changed. However, as important as time is, the relative attention or energy a clinician invests in a case or encounter is just as important. Most patients can readily tell if a clinician is really focused on them and their needs or is distracted by other thoughts.

*Empathy and mutual understanding:* Empathy and mutual understanding arise from an existential and practical paradox. In being empathetic and understanding of the other we must appreciate that individual as a unique person and yet must also ground ourselves in some commonality of being (Goubert et al. 2005; Moore and Hallenbeck 2010). The need to be understood both at cognitive and emotional levels is a very advanced human trait. Patients living with pain, especially chronic pain, experience their pain as a part of a rich and complex narrative. Such narratives, like any good play, have various actors, heroes and villains, plot twists, and often morals. Narratives progress over time. The complexities of such stories present real challenges for patients and clinicians, given the limited time available in real-world clinical encounters. Patients, driven by a need to be understood, often work very hard to figure out how best to encapsulate their complex experiences into a few short phrases – rather like trying to tell an epic poem in haiku form. They are variably successful. Some patients actually writing out the epic in long form, in hopes the clinician will take the time to read the entire document. This is rarely a successful strategy. Often, patients use metaphor, a compressed form of speech, to try to explain themselves (Biro 2010; Scarry 1985). The use of metaphor is a high context mode of communication, in that it is based on both speaker and listener sharing a common understanding of the metaphor’s meaning. For example, if a patient said, “I feel like Sisyphus. Every time I make a little progress, the rock rolls over me,” this could be a very effective means of communicating frustration and a lack of progress, despite great effort. However, metaphor depends on a common understanding of implied meanings. The Sisyphus metaphor is meaningless if the listener is unfamiliar with the story of Sisyphus.

Specific to pain, Biro and others point to yet another paradox: The need to give voice to that which is unspeakable (Biro 2010). Pain is beyond words. Elaine Scarry goes further in noting that severe pain “unmakes” peoples’ social worlds (Scarry 1985). And yet, for both practical reasons, discussed earlier in terms of survival value, and existential reasons there is an overwhelming drive



to transcend the subjective isolation of pain. Biro and Scarry both highlight the importance of metaphor as means to this end. The best we can do in trying to help others understand and relate to our pain is to try to invoke some common image. Metaphors often relate to external weapons, such as a knife, or violent actions, such as stabbing, shooting, burning, tearing, or crushing. Such imagery can be useful in a low context way of directing a differential diagnosis. Beyond such practicality, metaphor works to promote at least a semblance of common understanding, which in turn works to promote empathy (Moore and Hallenbeck 2010).

Clinicians may similarly be challenged in their efforts to communicate. Time restraints are an obvious problem, limiting their ability to attend to the patient. It is difficult to communicate often alien medical narratives, stories of how certain diseases come about and how associated disease plots may unfold. Clinicians may also resort to metaphor in trying to explain complex aspects of physiology. The other great challenge clinicians experience is that they too seek and appreciate empathy and understanding, although they may feel discouraged in their professional roles to admit or display such a need. Self-disclosure by a clinician, particularly of a weakness or vulnerability can be dangerous in an highly litigious society, and to the extent it is overly self-serving, and unprofessional (Hallenbeck 2000). However, sometimes it is precisely the trust engendered in risking self-disclosure that patients need, if a deeper relationship is to develop. How is it that we, as clinicians, communicate to patients that while we cannot really “feel” their pain, we find some resonance with their suffering, as we too have experienced pain and have suffered? (Moore and Hallenbeck 2010) Sometimes, what is most therapeutic for patients is just knowing they are working with another real-life human being, who has his or her own narrative and associated vulnerabilities and limitations.

*Legitimacy:* Legitimacy is really a subset of specialness, but given its importance in pain management, I have expanded on this point at this time. Legitimacy is rarely considered openly by clinicians in thinking about healthcare, but it is very important given the relative value and attention paid to certain illnesses over others. Legitimacy of various illnesses differs among cultures and shifts over time<sup>2</sup> (Sontag 1978; Tishelman 1991). In our current medical culture, diseases that are *visible* – either directly or via scans, are *treatable* (preferably to cure), and viewed as *independent of individual responsibility* – due to “bad luck” or genes versus bad behavior, are favored over illnesses lacking these characteristics. In terms of pain management, consider by way of contrast pain due to acute trauma, as compared to chronic pain of unclear etiology. Is there any doubt that as a society we recognize the legitimacy of the prior over the latter? Especially in many cases involving chronic pain, the subtext of patients’ communication seems often to revolve around trying to establish the legitimacy of their complaint (see also Palermo 2011). Such communication and behavior may take the form of “pseudoaddiction,” as Weissman put it, which may manifest through rather unusual behaviors which may be misunderstood by clinicians as evidence of addiction, when in fact they are efforts toward recognition of legitimacy, tolerance to pain medications (e.g., opioids), and the need for adequate pain relief (Weissman and Haddox 1989; Weissman 1994). Conversely, where the patient’s story is suspect, the subtext for many clinicians may be a questioning of legitimacy.

*Power:* Power differentials exist in most social interactions. In pain management, power differentials are particularly great. Pain is a most personal experience and yet, people suffering from pain generally are not “in charge” of their own care; clinicians are. Such power differentials also exist elsewhere in healthcare, often because special technology or skill is required to address a specific concern, as in surgery. What is unusual about pain management is that most such care is low-tech. The general public has free access to acetaminophen, aspirin, and nonsteroidals, but for most everything else, especially controlled substances such as opioids, they are completely dependent on clinicians. That is, to a very large degree we must depend upon others both to recognize the legitimacy

<sup>2</sup>See Sontag on the shifting view of cancer over time from an illness that was seen not only as a death sentence, but as something overtly shameful (Sontag 1978).

of our pain and provide relief from it.<sup>3</sup> Power differentials generally stay in the background in clinical care unless major disputes arise. In such cases, jostling for power positions may become a subtext to clinical encounters. Clinicians may stress their authority, through clinical role, competency/expertise, and law, to be the judges of who gets what therapy. Patients who disagree with clinical decisions may stress their “patient rights” and general autonomy. They may claim discrimination and stigma. Or they may argue from the position that their pain and associated suffering are ultimately unknowable by others. The subtext often seems to read, “It is *my* pain. You cannot possibly know what this is like. Why are you in charge of my suffering?” It is true. While pain may or may not be affirmed or even legitimized, it cannot be denied. As clinicians we may have the power to deny desired medications or therapies, but we can never be completely sure in our opinions as to whether or not pain is actually present.

Paradoxically, given this, patients do have a certain power. Precisely because objective markers for pain are lacking, it is impossible to prove that someone is *not* in pain. Kleinman has noted that complaints of pain may be one of a limited set of sanctioned means of protest within ascribed sick roles in certain social and political contexts. For example in China, as Kleniman explores, complaints of pain may represent a relatively acceptable form of protest against totalitarian aspects of society (Kleinman 1994). As such, complaints of pain may in part reflect an effort of disempowered individuals to be socially acknowledged and to gain some control over their lives. Again, here we must stress that in terms of communication the issue is not whether such complaints are or are not “real.” Independent of any such reality complex dynamics of power exist for both clinicians and patients.<sup>4</sup>

There is nothing inherently wrong with the fact that power is an issue in encounters regarding pain. However, issues of power may escalate to frank battles at the level of discourse and practice, wounding patients and clinicians alike, if the subtext is not acknowledged and addressed in some meaningful way either through the subtext or by raising the subtext to the text. As discussed further below, when a subtext, power, or any other is addressed through (or within) the subtext, this means that the clinician, who is aware of such a subtext, modifies what he or she says or does in a manner that addresses the concern of the subtext, but without drawing explicit attention to that subtext. For example, in addressing a power subtext through the subtext the clinician might state his or her understanding of expectations and responsibilities for both his or herself and the patient. “Raising the subtext to the text” might be done by calling attention to a power struggle underway and explicitly addressing power concerns. For example, a physician might state, “We are struggling with who gets to decide what medicine is best for you. I understand that only you can really appreciate how much pain you are in. However, the state says that when I write a prescription, it is on my license. So I have a professional obligation to meet certain standards of care in doing so. I don’t blame you for being frustrated with this, but, yes, I am in charge of determining how much and what medicine to give you. I will do my best to listen to you and weigh your concerns in making a decision.”

While the above could be expanded upon and arguably other common relational themes could also be added, hopefully the reader gets the point. While such subtexts often play a significant role in high context clinical encounters, they usually remain in the subtext, and are therefore not acknowledged.

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<sup>3</sup>As a palliative care physician, who teaches pain management to physicians-in-training, I am acutely aware that should I need opioids for some pain, I am completely at the mercy of such physicians and their colleagues for relief. While I can, if need be, prescribe my own blood pressure pills and many other medications (wisely or unwisely), I cannot prescribe for myself or my family opioids or other controlled substances. I am not suggesting that this is wrong, but given the well-documented lack of general competency in primary pain management, it is worrisome and a strong motivator for me as a teacher.

<sup>4</sup>Scarry presents a detailed discussion of legitimacy and power in relation to torture. Her thesis is that torture is not so much about information gathering as it is an attempt by a regime whose legitimacy is threatened to bolster legitimacy through the “unmaking” or de-legitimizing the world of the dissident through a display of power and the induction of pain. While such a discussion is far from the field of clinical care, it graphically highlights the importance of legitimacy and power in any discussion about pain (Scarry 1985).

Too often they are the proverbial “elephants in the room” that nobody recognizes or talks about. Clinicians often do not address them with patients, despite their important roles. At the end of the chapter I will give some suggestions for how to deal more skillfully with these subtexts, when they do arise.

## Pain Assessment Instruments

Let us now consider pain assessment instruments in light of the above. Such instruments serve very useful functions. Well-designed instruments allow us to better understand important aspects of pain experiences, such as severity, temporal variation, qualitative aspects of pain, and the impact of pain on functioning and quality of life (McDowell 2006). Instruments help us understand not only the experience of individuals, but to compare experiences and response to therapies across groups. They may serve as helpful reminders of good questions we might otherwise forget to ask in doing a pain assessment. As mentioned briefly earlier, by formal design, pain instruments are low in context as a means of communication in their focus on specific aspects of the pain experience and their task-oriented nature – working to answer specific questions, depending on the instrument. Their low context nature offers real advantages. While language and culture may serve as barriers cross-culturally, even these barriers are open to study. One can determine which words work or do not work across cultural groups, as many studies have demonstrated. The great attraction of the numerical pain score, arguably the assessment tool lowest in its contextual framing, is precisely that numbers tend to mean the same thing in all languages. But let us consider the cost of such low context approaches. By filtering communication through a prescribed form (the instrument) certain messages get through and others do not (Schiavenato and Craig 2010). While such filtering enables standardization and consistency, it is important to recognize that any such instrument is itself a product of culture. Certain questions and answers are valued to the exclusion of others. This may be problematic to the extent that pain instruments, including visual analogue or other pain scales, become imposed on patients as the approved means of communicating, even when such cultural imposition is done with beneficent intent (de Williams et al. 2000; see also Palermo 2011). Holen et al. reported on results from an expert panel on the relative importance of ten dimensions of pain assessment in palliative care – intensity, temporal pattern, treatment and exacerbating/relieving factors, location, treatment, interference with quality of life, quality, affect, duration, beliefs, and pain history in that order (Holen 2006). Reviewed instruments commonly neglected even such highly ranked dimensions temporal variation in pain (16%). No tools addressed all top five ranked dimensions (Dy 2009). We see in this rank ordering a prioritization of more disease-specific aspects of pain such as intensity and pain location. Aspects related more to patients’ life narratives (effect on quality of life, beliefs, and pain history) were ranked less important. Pointing this out is not so much a criticism of this rank order (presumably patients are rather interested in the intensity of their pain) as a comment on the inevitable filtering that occurs in the use of such instruments. Relational issues between the patient and the particular clinician working with that patient are, as far as I know, NEVER a sanctioned or queried topic with the possible exception of general patient satisfaction surveys – despite the obvious importance of therapeutic relationships in healing. Even the few quality of care measures that have been developed deal with *process* issues (changes in treatment, follow-up) or more general patient satisfaction, not the specific relationship between the patient and treating clinician beyond perhaps asking how broadly satisfied patients are (Dy 2006; Lorenz 2006).

I have posited that by definition interactions relating to pain are inherently high context and relational. Does this mean that where pain assessment tools are used that these relational aspects of communication are negated? Hardly. Patients generally try to communicate their relational needs

*through* and *around* such assessments. Consider the visual analogue pain score. The overt intent of the analogue pain score (and related instruments) is to facilitate communication of severity of pain at the moment the patient is being queried. It is rather like a “snapshot” of pain severity, useful in trending pain intensity and response to therapy. While this is precisely what the clinician desires through the use of this low context metaphor, this is not necessarily all the patient wishes to communicate. Pain can be monitored as a series of snapshots, but it is experienced as a continuum. In self-assessing their situations, patients tend to project from past experience through their current state and from there, into the future. The *trend*, whether things are getting better or worse, is not just an academic measure of severity or response to therapy (although this is important) but a critical element in assessing whether further help is needed or not and indeed it is an important factor in the greater issue of suffering. If pain is becoming difficult to bear and is worsening, then the perceived need for assistance becomes greater. Standard analogue scales in and of themselves contain no method of communicating this sense of urgency. Some pain assessment forms add on a question regarding the adequacy of pain relief and good interviewers may ask if current pain relief is “adequate” or if additional help is needed, but such queries goes beyond the narrowly defined meaning of a 0–10 pain score. So what, then, do patients do, if faced with the conundrum of trying to communicate a more urgent need? Certainly, they may do so by communicating *outside* the score – by more frequent, louder, more emphatic requests, or by nonverbal behaviors suggesting more severe pain, as they often do (Schiavenato and Craig 2010). However, they may also learn to communicate *through* the pain score (de Williams et al. 2000; Knotkova et al. 2004). Through an iterative series of interactions with clinicians they may learn that reporting certain pain scores gives rise to more predictable responses from clinicians. Knowing this, transmute the metaphor, using numbers to reflect the relative urgency of response desired, rather than pain intensity. From my observations, while there is significant variability among patients in this regard scores from 0 to 3 generally mean there is little urgency, 4–6, some urgency and 7+ great urgency. Patients may even report on a “0–10 scale” scores of 12 or 15, which, while mathematically absurd, accurately reflect desired urgency of response. Patients then become acculturated to the use of the pain and in turn co-opt the pain score metaphor and use it with their own meaning for their own purposes, which are not necessarily the same as clinicians’ meanings and purposes. Patients likely vary in their use of scores for this purpose and the internal thresholds they set for determining relative urgency.

## Intercultural Communication Skills in Pain Management

The discussion earlier would be little more than a philosophical rambling if it did not result in some changes in clinician communication and behavior. Some suggested strategies for doing so are outlined below. In the introduction, I suggested that serious miscommunication is a risk to the extent that clinicians do not understand or respond to high context messages from patients (and families). On the flip side, skillful use of high context communication skills can promote improved understanding, a deeper “therapeutic relationship,” possibly time savings, and almost certainly better patient and clinician satisfaction.

*Awareness.* It may seem strange, but the most important communication skill related to this topic is awareness of contextual issues when they arise and subsequent classification into low and high context categories. In everyday life, high and low context communication “happens” largely out of consciousness. While this is adequate, indeed appropriate for everyday life, it is not adequate for good clinical care provided in situations, as in pain management, where low and high context styles frequently clash. Clinicians are advised to start by cultivating awareness of the task-oriented (low context) and relational (high context) aspects of their interactions. All the subtexts listed earlier are

examples of high context issues that may arise. Additional, common, basic examples of task-oriented and relational events are listed in the table below.

Task-oriented communication	Relational communication
Clinical assessment and reassessment of disease process	Introductions and greetings
Communication regarding biologically directed disease treatment – medications, injections, blocks, etc.	Inquiry regarding nonbiological aspects of personhood
Patient education regarding medical aspects of disease process	Compliments, praise, statements of respect
Healthcare process issues – setting up follow-up appointments, billing, etc.	Use of metaphor

The following, brief vignette highlights how task-oriented and relational communication might intermingle in routine office practice.

Interaction	Interpretation
“Good morning Mrs. Smith. Nice to see you.” “Nice to see you, Doctor”	Greeting. Positive affect toward other. Respect
“How is your back pain today? On a scale of 0–10, how much pain do you have?”	Clinical assessment
“About a 2. Those pills you gave me really helped. Thank you”	Low context response. Praise. Gratitude
“I’m glad. I know it has been hard for you. You have really hung in there with the treatment plan”	Positive affect toward other. Empathy. Praise
“Is the pain still going down your leg?”	Clinical assessment

Of course, in real life things are more complicated, especially where negative or threatening subtexts arise. However, the basic skills of awareness and classification still serve. Having become more aware, the clinician can make conscious *choices* as to how best to respond (as compared to responding automatically or semiconsciously). Some common choices to be made are:

- Address highlight relational issues (or not)
- Expand current lines of communication or truncate them and switch to another line
- Raise subtexts to “texts” or deal with them within the subtext

*Highlight relational issues:* Probably the simplest thing a clinician can do is to look for opportunities to say and do things that promote positive relationships. One exercise is to observe and reflect on the percentage of time spent on task-oriented issues relative to relational issues. In many, arguably most situations the task issues are the priority and will quite appropriately take the bulk of time. However, the clinician is encouraged to increase somewhat the quantity and quality of relational comments made. Statements of respect and praise go a long way. Brief inquiries and statements regarding non-medical aspects of a patient serve both as statements of respect, but also are evidence of the clinician’s recognition of the patient’s personhood. Stating explicitly your intent and obligation to do good and be helpful is encouraged. When sad or difficult emotions arise, you may wish to share them with the goal of demonstrating your caring and humanness. If, for example, a procedure does not have the desired effect, consider sharing your regret, given your desire to do good.

*Expansion, truncation, and switch:* In the vignette above notice where the physician expanded on the relational thread started by the patient in thanking the doctor. The physician continues on this line and offers praise in return. However, with the sentence, “You have really hung in there,” this line of conversation is truncated, followed by a switch back to clinical assessment. A common error made by clinicians is to miss cues or opportunities to continue or expand on a particular thread – even

where such is clearly indicated (Suchman et al. 1997).<sup>5</sup> The clinician may stubbornly stay on a low context thread (often clinical assessment), even where the patient has signaled a desire for a shift, as the following vignette highlights:

Physician: “On a scale of 0–10, how bad is your pain?”

Patient: “About a 9. Doctor, I don’t know if I can stand it anymore. Nothing you seem to do makes any difference. When I finally get to sleep, I wish I just wouldn’t wake up ...”

Physician: “Uh-huh. That’s too bad. Have you been doing your exercises as ordered?”

This example is a caricature, but in real life clinicians often miss cues as presented here that some expansion on a thread is needed. The patient statement at a minimum requires clarification of the ambiguous statement about “not waking up.” Is this suicidality or the patient’s way of communicating the severity of suffering and perhaps frustration with therapy as prescribed by this physician to date? Beyond this, the patient’s statement practically begs for expansion of the relational thread. Note, the challenge to the physician; nothing *you* do makes any difference. The statement calls for at least an empathic response beyond, “Uh-huh, that’s too bad.” The physician may choose to raise this subtext (questioning the physician’s skill and interest) to the text or may choose to address it within the subtext. An example of continuing this thread and raising the subtext might be:

I’m sorry to hear you are having such a difficult time. It sounds like you are frustrated that the therapies we’ve tried to date have not worked. I’m frustrated too, as I want you to feel better. I wouldn’t blame you if you were upset with me (*raising the subtext to the text*) because the pills haven’t worked. You need to know I’ll keep trying to find something that helps. I hope you will keep trying too. Now, tell me more about not wanting to wake up. Is it that you just are tired of the pain or have you had thoughts of suicide?

One reason clinicians may fear following up on patient cues and relational issues is that they may think that by doing so, they will spend or waste precious time. However, at least one study suggests that where they ignore such cues in fact they end up spending more time (Levinson et al. 2000). This positive reframing of emotional and verbal cues may lead to increased patient satisfactory and a decrease in clinician burnout. Moreover, as the suggested response above highlights, addressing these issues need not be unduly time consuming.

*Raising subtexts to texts versus addressing within the subtext:* The statement above gives a another simple example of how a subtext might be raised, when the clinician says, “I would not blame you for being upset with me ...” As this example illustrates, usually the dilemma of how to deal with a subtext manifests when the subtext is negative or threatening in so way. Far too commonly, when negative subtexts arise the subtext is simply ignored, often by focusing on whatever low context, clinical issues are at hand. It is difficult to state exactly when one should raise the subtext versus dealing with it within the subtext. This depends on the context. The following general guidelines for raising the subtext are offered for consideration:

- When the subtext has become so dominant that it is difficult to make progress on other tasks and difficult to work within the subtext toward a positive outcome.
- When the raising of the subtext, even when negative, offers an opportunity for positive framing of the response (The example above offers an illustration of this – “upset-ness” gives rise to an opportunity to find common ground and a statement of caring.).
- When the clinician believes that both patient (or family) and the clinician can handle the issue raised emotionally without losing control.

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<sup>5</sup>I recall a dramatic example of this in observing a new medical student practice doing a history and physical. The student was pushing through a list of questions on a “check-list.” In doing the social history he asked, “Are you married?” “No, the patient replied. “My wife died six months ago.” Uh-huh. Children? How many sexual partners have you had in the last year?” The patient’s response begged for an empathic statement and at least a brief expansion. Continuing with the check-list – especially given the questions asked, seemed heartless, even cruel, even though this was completely unintentional.



- When such an explicit statement of a relational subtext would be culturally acceptable to the other. Raising the subtext is, somewhat paradoxically, a low-context approach to a high context problem. This may be more acceptable in some groups and for some individuals than for others.

The above suggests that as important as whether to raise a subtext is how the subtext is understood and how it is raised. At one extreme, subtexts may be raised by “taking off the gloves” and engaging directly in battle. For example, in a power dispute with a pain patient with a history of substance abuse, who is insulting the clinician, it might be tempting in anger to “get personal” in return or make an insensitive statement of power, by saying something like, “Listen, you, I’m the doctor here. You will take what I give you or you can go someplace else.” Obviously, this would be a highly unprofessional response. A preferred strategy might be saying something like that posed above, which dispassionately outlines the fact that physicians write prescriptions on their licenses.

## Summary

I have introduced what are likely for many new terms for particular aspects of communication. And yet we all naturally and skillfully shift from low to high context communication every day. In other words, we are already experts in many of the issues and techniques raised earlier. The difference, I hope, is that clinicians struggling in difficult encounters with patients with pain will be able to more consciously and skillfully use these concepts to improve the quality of their interactions with patients, which will in turn result in improved patient outcomes and mutual satisfaction.

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