Intercultural Communication About Pain

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Abstract As far as language and communication studies are concerned, pain is barely visible on the radar. It has received even less attention in the context of intercultural communication. And yet pain is universal. It is prominent among the causes why we visit the doctor. And its impact on the quality of life of pain sufferers, as well as on national economies, make it a topic of urgent interest: it highlights, in a particularly sharp perspective, some of the key issues currently facing intercultural communication, and specifically intercultural communication in Asia.

The purpose of this chapter is threefold: to present pain as a bona fide area of research in linguistics and communication studies, specifically in intercultural communication; to survey the current state of play of research into pain and communication; and to outline the implications of intercultural pain communication for the key themes of this volume, with special reference to Asia. Pain will be seen, as it is communicated by individuals in an internationalizing world, at the intersection of linguistic, cultural and value systems.

1 Introduction

Pain is a universal of the human condition. There is a small number of people who have Congenital Insensitivity to Pain (CIP, congenital analgesia), and who are unable to feel pain. Systematic analgesia can also result from leprosy (Hansen's Disease). People who cannot feel pain often do not live very long, because the feedback and warning functions of pain are absent: a broken bone, the heat sensation from touching a hot object, the awareness of sharp objects in the eye – all these and similar symptoms are simply not registered, and the person does not take either evasive or remedial action. Pain, in short, is one of our most valuable and necessary survival mechanisms (Biro 2010; Butler and Moseley 2013).

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Most humans are familiar with a variety of experiences of pain during their lives. They suffer it, live with it, and take action to mitigate or remove it. They communicate about their pain to doctors and healthcare professionals, to experts in traditional medicine, and to their families. And in the globalizing world of the twenty-first century, such pain communication is increasingly crossing cultural boundaries.

The academic study of pain is profoundly interdisciplinary. It includes at least:

basic science
medicine and alternative medicine
neuroscience
areas of biology and microbiology, including stem cell research
allied health, including dietetics
pharmacology
neurology, neuroanatomy
psychology
communication studies and language / linguistics
anthropology and ethnography
philosophy
physical sciences including physics and chemistry as they apply to pain.

In this chapter we concentrate on pain in languages, linguistics, communication studies, and value systems. This discussion is framed by their implications for education, not principally in the sense of formal instruction, but more specifically in terms of the kinds of knowledge about pain and communication which are necessary to the understanding and management of pain in individuals and human societies – and which might, for instance, form part of professional development for healthcare professionals, and general education for people in pain in the broader context of public health.

2 Pain: Definition and Evidence

The standard definition of pain, as approved by the International Association for the Study of Pain, is:

> […] an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage. (www.iasp-pain.org/Taxonomy)

(and see Melzack and Torgerson 1971; Merskey and Bogduk 1994). This definition concentrates on physical pain, and leaves aside the very large domain of emotional pain, which may accompany physical pain, or may exist in its own right. In this chapter we will similarly concentrate on physical pain, while bearing in mind that it has close links to non-physical pain and suffering.

Most humans are familiar with "acute" or short-term pain, often in the context of some wound, lesion or medical condition. Acute pain often begins rapidly, and has a specific cause like a wound, damage from an accident, infection or other lesion (known as "nociceptive"). Pain, then, can be an indication of actual or impending threat to the organism, and as such is highly influenced by emotion and the

"significance" of the injury to that person. It recedes when the cause is treated or removed. In contrast, "chronic" pain is defined as lasting beyond the resolution of the cause of acute pain, and typically lasts for more than three months. It is possible for pain to persist, and for the body to experience pain without nociceptive cause, and this can happen with pain pathways which have been habituated to transmitting pain signals long after the original nociceptive cause has healed or been removed. Such chronic pain can persist with agonizing intensity for years, and is now recognized as a disease in its own right.

The importance of pain in our medical lives is shown by the fact that it is among the most common reasons why people go to see their doctor or seek medical help. A study in Finland found that 40% of patients visited their doctor because of pain (Mäntyselkä et al. 2001). A large scale investigation by the Mayo Clinic in the USA showed that while skin diseases were the most common single reason why patients visited the doctor, the second and third most frequent causes were osteoarthritis and joint disorders, and back problems, two pain-based groups of medical conditions which together easily outnumbered skin diseases (Sauver et al. 2013). And that is without counting the times we visit a pharmacy, or simply buy painkillers off-the-shelf.

The economic impact of pain has also been calculated in a number of studies. Access Economics in Australia estimated that chronic pain costs the economy approximately 4.4% of GDP every year, or AUD 34 billion in 2007 dollars (Access Economics 2007). Data from the USA (American Academy of Pain; Institute of Medicine 2011) have shown that in the American economy chronic pain costs a similar percentage of GDP, amounting to between USD560 billion and USD635 billion every year, or $2000 for every person living in the United States of America.

These sobering quantitative results are paralleled by important considerations of quality of life. It is estimated that fewer than 50% of cancer patients receive appropriate relief from the pain, in spite of the fact that medical science is able to relieve 90% of that pain. And among chronic pain sufferers, less than 10% receive appropriate pain management, whereas as much as 80% could be alleviated (National Pain Strategy 2011, p. 2).

A major complicating factor is the lack of objective biological or technical proof of the existence, intensity, periodicity or location of pain. Pain is perceived in the brain, even though we may believe that it is localized in parts of the body. "Phantom pain" can occur in parts of the body which are no longer there, for instance after amputation. But a brain scan (electroencephalograph, EEG) does not give decisive results. It can indicate that pain is present when the patient feels no pain at all. Mutatis mutandis, a patient can be in agonizing pain and the EEG will show no evidence of pain. As a result, as was confirmed in correspondence in the leading journal *Pain* in 2015,

> […] pain is fundamentally subjective with self-report providing the most complete and reliable access to another's pain (Sullivan and Derbyshire 2015, pp. 2119–2120).

If pain is a universal of the human condition, then it is also a universally covert aspect of the human condition. None of us can experience the pain of another. As the

philosopher Wittgenstein has argued (1953/1989), pain can be conceived as a beetle in a box. Everybody has a box, but only they can see their beetle, and no-one may ever see anyone else's beetle. The other person's box might indeed be empty. The only way that we can know about the existence of pain is the way in which it is made manifest in body language and in language itself. This leads naturally to a problem of validation. The health care professional, faced with a patient reporting pain, will triangulate many kinds of information in evaluating whether and what kind of pain is present. But it is still possible for people to lie about pain and persuade both health practitioners and the courts, as is evident from some damages claims which have been shown to be fraudulent when the victim is later discovered to be leading a pain-free life.

In other words, the patient's account is the key source of information about their pain – and by "account" we must include all modes of communication, including various metalinguistic factors: swearing, for instance, increases one's tolerance for pain (Stephens 2009), and there is a positive correlation between the intensity of pain and the amount of pain talk (Rowbotham et al. 2014). Pain may be universal, or nearly so. But its expression certainly is not. Pain is deeply embedded in our culture and values, social and personal.

3 Pain as a Component of Culture

There is ample evidence of the ability of how culture and value systems affect the way we experience pain, drawing on the ground-breaking study *People in pain* by Zborowski (1969; and see Fabrega 1976). Some people under torture have deflected their thoughts from the pain by concentrating on Christian values and symbols (Bourke 2012, 2014). Less dramatically, in many cultures children, especially male children, are brought up to believe that acceptable standards of behaviour include not showing pain and not talking about it. This is true for instance of childbirth: in some cultures women are taught to go through labour and childbirth in silence as a matter of cultural practice, as happens among Bariba women in Benin and Nigeria (Sargent 1984), while in other cultures the expression of pain is expected and encouraged (Bourke 2014). The "show no pain" mindset can persist throughout people's lives. In other words, nurture, and the cultural values so instilled, can filter or mask the expression of pain. It can also affect not just the way we express pain, but also the nature of the pain which we feel (Al-Harthy et al. 2015; Butler and Moseley 2013; Kwok and Bhuvanakrishna 2014). To be sure, pain can be blocked by willpower, meditation and medication, and by medical interventions related to neurological systems. But the medical treatment of pain is a relatively recent development, which has arisen as a result of advances in biology, physiology, neurology, pharmacology, and wider areas of medical care. This in turn increases the need for an understanding of how patients express their pain, especially pain which cannot clearly be linked to visible causes like injury.

This can be seen very clearly from some of the key developments in the history of pain over the last 400 years (Rey 1998; Bourke 2014). In the Christian tradition, which covers a wide range of languages and cultures, pain – the word comes from Latin *poena,* meaning "punishment" – was an expected component of human life. Resurrection would relieve the suffering of humans. In the meantime pain was a natural accompaniment of life, illness, childbirth, injury, and also through deliberate infliction in education and religious zeal, where it was thought to make the individual a better person. As Rey puts it, pain was seen as:

> [… a] necessary trial, unpleasantness preceding some greater good, punishment, or fate (Rey, p. 2).

Individuals were expected to bear pain with courage and fortitude. Numerous accounts of battlefield surgery without anaesthetics, borne by wounded soldiers with minimal fuss and complaint, show how a system of values can make humans able to tolerate pain in a way which would be unthinkable nowadays. Routine surgery was often performed without analgesics well into the twentieth century. And the church once took the position that pain relief for a dying patient would render them incoherent when they met their Maker (Bourke 2014, p. 288).

The steps by which we have grown through and beyond such mindsets owe most to the impact of scientific discovery on the understanding and treatment of pain. The gradual growth of knowledge about human physiology from the seventeenth century led to a less theological, and more biological and eventually pharmacological, approach to the treatment of pain. In the nineteenth century pain was progressively medicalized, with the discovery of morphine and related opioids, anaesthetics, and painkillers like aspirin. From a fatalistic acceptance of pain as part of a divine plan, we have now moved to a position where we regard pain as removable, and expect our health care professionals to do precisely that. So even within a single cultural tradition, values about pain can change radically over the course of several centuries, driven by science, technology, and social change. An English person of Shakespeare's day would find themselves in an intercultural conversation when talking to us in the twenty-first century about pain and its treatment.

In some respects the Christian view of pain is not too different from what we find in Buddhism, Confucianism and Islam. For the Buddhist, pain and suffering are among the defining characteristics of the human condition. Someone feeling pain has bad karma, as a result of bad acts. This belief is broadly also a feature of Hinduism. The true Buddhist should practice the eight true paths of right speech, right action, right living, right effort, right mindfulness, right meditation, right thought and right understanding in order to achieve a higher state of being without pain. Buddhists therefore tend to be stoical about pain, and are slow to seek medical relief. They may also profit from the reputation and proven efficacy of Western medicine for short-term ailments, but may rely more on traditional medicine for longer term problems (Bourke 2014, 121ff.)

Confucianism is dominant throughout East Asia. Having pain is seen as affirming one's status as a human being, and pain should be endured in silence until it becomes unbearable. It should not be shared with others, a value which is the

converse of Western views, after Freud, that "bottling it up" is bad for you. Confucianists respect the harmony of those around them, and so tend to conceal their pain and avoid talking about it to others. They will also postpone seeking help for pain until much later than might be the case in Western countries. In addition, Confucianists respect social hierarchy, and so are subservient and passive to the health practitioner in a medical consultation.

For the Muslim, pain is part of the will of God, and divine predestination. It should be borne patiently. This view is very close to the Christian one. A stoic resignation is a proper attitude to the arrival and existence of pain, and is part of one's religious duty. Painkillers are less readily advocated than in contemporary Western medicine, though the rules about sedation in end-of-life pain contexts may be relaxed with the permission of an Imam.

4 Pain, Communication and Culture

When we place pain in the context of cultures, three questions arise:

> How do languages differ in giving us tools to talk about pain?
> How do cultural differences themselves relate to these tools?
> How do cultural differences within a language, especially English, and most especially English as a lingua franca, relate to the tools which we have available to talk about pain?

These questions were posed in a somewhat different format as early as 1976 by Fabrega and Tyma, who proposed three key questions about the universal nature of pain vis-à-vis its cultural specificity:

> Is there a limited set of semantic categories that people and languages draw on to describe pain?
> Do the pain behaviors of a people bear a non-trivial relation to the models of pain which the culture imposes on people or to the grammatical rules and conventions which the language system imposes?
> Which facets of a pain experience are communicated verbally, which ones non-verbally, and how do groups differ in the way they use these channels? Are there cultural invariants in any of these channels? (Fabrega and Tyma 1976, p. 336).

And yet there is no headword entry for "pain" in the most recent encyclopaedia of intercultural competence (Bennett 2015).

5 Pain Communication: Language

Scarry (1985) notes that at the elemental level pain cancels language:

> Physical pain does not simply resist language but actively destroys it, bringing about an immediate reversion to a state anterior to language, the sounds and cries a human being makes before language is learned (Scarry 1985, p. 4).

We can communicate about pain through body language or vocally. Body language, including movement and touch, is more instinctive but also less rich in information. Vocal communication about pain may involve instinctive responses to the pain stimulus, which are pre-linguistic, and involve groans and exclamations.

1. elemental: *argh*

There are then three levels of linguistic (verbal) response to pain which are language-specific:

2. involuntary exclamations: *ouch* (French *aïe,* Russian *okh)*
3. *awful burning pain*
4. *overall increases in input through cutaneous and proprioceptive channels*

#4 involves the technical medical descriptions in the language of the healthcare professional. These last three levels can be either spoken or written. But even regulation communication about pain is fraught with difficulties, as Barker et al. (2009) have shown in their analysis of the problems of communicating about back pain, where there is a genuine lack of a common agreed language of pain communication. On the other hand, there is good reason to believe that *pain* is a universal of human languages, and that it is one of perhaps eleven emotional universals (Wierzbicka 1999), which then relate to words like *happiness* (Goddard and Ye 2014) and *suffering* (see Wierzbicka 2012, 2014, for an analysis in the theory of Natural Semantic Metalanguage).

Spoken pain communication (Pauwels 1990) can exploit features of the human voice like tone, volume, pitch and pace. Both spoken and written and communication make use of vocabulary, grammar, metaphor and discourse (Sussex 2009). Of these levels of language the grammar of pain has received some attention, especially from Halliday (1998) on English, and in Lascaratou's (2007, 2008) extended study of pain communication in Modern Greek. There has been some work on pain language and metaphor (Lascaratou and Marmaridou 2005; Kövecses 2000, 2008). But the overwhelming body of research has been based on vocabulary and on English as a means of understanding pain.

The dominant pattern of this work, in one way or another, is based on or derives from the McGill Pain Questionnaire ("MPQ") (Melzack 1975; Wilkie et al. 1990). The MPQ consists of 78 adjectives, in four broad semantic categories: sensory, evaluative, affective and miscellaneous. These four categories are then further broken down to yield a total of 20 groups, each containing between three and six adjectives, ranked from weakest to strongest. A typical set from the sensory category is:

pricking
boring
drilling
stabbing
lancinating

In the pain consultation, patients are shown a picture of the human body and are asked to indicate where the pain is felt. They then fill in the written MPQ questionnaire, selecting a total of 20 adjectives to describe their pain. The results are then scored, with "1" for the weakest adjective in each group up to whatever number

corresponds to the highest-ranked item in each group. The 20 scores are then summed to give a pain index (Melzack 1975).

There are many linguistic reservations which can be made about the MPQ (Sussex 2009). All the 78 adjectives, for example, are metaphors: *hot* comes from the vocabulary of heat sensation, while *flickering* comes from the domain of light, and *beating*, which is listed in the same group of "sensory" terms, comes from either sound or tactile sources. It is a valid question whether the semantic disparity of these items, and their different metaphorical interpretations, can be independently justified. There is also the question of scoring. The five terms in the "pricking" group score between 1 and 5 on the grounds of rising intensity. But how could one prove that there is a single unit of intensity between *pricking* and *boring*, and between *boring* and *drilling*? There is also a fundamental objection to some of the 78 adjectives on the grounds of frequency and familiarity. *Lancinating,* the strongest term in the "pricking" group, suggesting the penetration of the skin by a sharp object, is ultimately related to the mediaeval war weapon *lance.* Except among healthcare professionals, however, the use of the word "lancinating" is vanishingly rare: in the 1.9 billion word GLOWbE corpus of English (corpus.buy.edu/glowbe/), it occurs only 15 times, and of those, 12 for some unexplained reason come from India.

The MPQ also makes a simplifying assumption that one diagnostic instrument can be used for all people and all purposes. The example of *lancinating* shows that this assumption is lexically unsound. But there are also strong sociolinguistic reasons why the MPQ does not offer a single undifferentiated flat playing field. Strong et al. (2009), for example, showed that gender plays a major distinguishing role in the pain language use of 232 healthy young undergraduates (Strong et al. 2009; see also Nayak 2000; Wiesenfeld-Hallin 2005). These issues are compounded with speakers whose first language is not English.

For all its imperfections, the MPQ has been undoubtedly successful in clinical practice, where it has dominated the use of word-based diagnostic instruments for pain. Realising that the 78 adjectives had significant problems, Melzack (1987)) produced the Short-Form MPQ, with only 18 terms in more transparent categories (and see Fernandez and Boyle 2001; Fernandez and Towery 1996; Towery and Fernandez 1996). Dworkin et al. (2009) have more recently proposed a further short version, the "Short Form MPQ-2".

The performance of the MPQ as a diagnostic instrument over 40 years of practice has recently been reviewed by Main (2015). He recognizes the utility of the MPQ in the assessment and treatment of pain, and in the way it has helped to at least partly legitimize pain and its qualitative assessment in the context of a growing emphasis on evidence bases and empirical, quantitative data in the practice of medicine. Main is correct in identifying the absence of the social and contextual dimension in the administration of the MPQ, building on suggestions by Craig (2009), Hadjistavropoulos et al. (2011), and Menezes Costa et al. (2009). It is significant that it has taken nearly 40 years for these issues to be raised in a systematic way, which is itself an indication of the lack of involvement of the linguistic, sociolinguistic and cultural linguistic professions in the study of pain talk (Sussex 2009) –

for instance, from the sociolinguistic viewpoint with variables like age, education, socio-economic status and ethnicity (though cf. Zborowski 1969).

6 Pain Communication in Other Languages

The MPQ has been translated into more than 25 languages, with multiple competing versions in both French and Spanish. But here too there have been problems of equivalence of vocabulary, and it has been necessary to adapt the array of adjectives from the MPQ in each language. Here some more linguistic difficulties have arisen. Since the MPQ terms are all metaphors, they come with a variety of attendant semantic information. They are not merely "denotations", referring to some specific property (e.g. "red" as the name of the colour); they also carry connotations (e.g. *red* is the colour of good luck in Chinese, the colour of the Communist party, or the colour associated with political parties, red for the left-leaning Labor Party in Australia, and for the right-leaning Republican Party in the USA).

A specific, and symptomatic, difficulty arose with the translation of the MPQ into Finnish (Ketovuori and Pontinen 1981). One of the MPQ's categories includes the five terms *punishing, gruelling, cruel, vicious* and *killing.* These words in English carry overtones of punishment or retribution. But the equivalents in Finnish were identified by test subjects as being overwhelmingly associated with the intensity of pain. The Finnish version of the MPQ ("FPQ") had to be re-designed and re-structured accordingly, and the words re-located in the "Evaluative" category. A range of other difficulties of translation and interpretation have been found in adaptations of the MPQ into languages like Japanese (Hasegawa 2001; for the MPQ in other languages see e.g. Boyle 2003 for Spanish; Kim et al. 1995 for Norwegian; and Mystakidou 2002 for Greek).

There are also major differences in the arrays of pain terms available in different languages. In English we have four principal terms for physical pain: *pain, hurt, sore* and *ache,* with *suffering* ambivalent but more oriented towards emotional pain. Some European languages make a clearer fundamental distinction between physical and non-physical pain (though metaphors blur the distinction in both directions):

	Physical	Non-physical
French:	*douleur*	*peine*
Spanish:	*dolor*	*sufrimiento*
German:	*Schmerz*	*Leid*

But this semantic specialization is overshadowed by the lexical richness of the terms for physical pain in Japanese. In Japanese, as in many Asian languages, the standard terms for pain are verbs rather than the nouns which we find in English. Japanese has a category of mimetic or reduplicated verbs where the repeating structure intensifies the action or adds information (*kirakira* "to shine sparklingly").

Japanese has a number of specific mimetic verbs to express pain (Iwasaki et al. 2007; Asano-Cavanagh 2014):

gan-gan	pounding headache
zuki-zuki	throbbing pain
shiku-shiku	dull pain
kiri-kiri	sharp continuous pain
hiri-hiri	burning pain
chiku-chiku	prickly pain
piri-piri	pain from scraped skin or electric shock

As the English translations show, it is certainly possible to render these semantic differentiations in English by adding one or more adjectival modifiers. But it is also clear that the conceptual map of pain in Japanese, organized around these specific pain terms, is structurally different from that of English. Certain categories of pain have been reified by the allocation of specific designations.

The Japanese coding of pain expressions as verbs is also found in Thai verbs of pain:

chep	general pain
saep	stinging / smarting pain, usually superficial
yok	sudden piercing / stabbing pain, focused
puet	deep seated aching pain, hot and diffuse
mueai	soreness and aching of joints, muscles, tendons
khlet	dislocation pain
chuk	pain from swelling, blocking, pressure
siat	focused abdominal pain

(Diller 1980; Fabrega and Tyma 1976; for Modern Greek see Lascaratou 2007, 2008; Halliday 1998; Lascaratou and Marmaridou 2005; Sussex 2009). Two features stand out from this array of terms. The first is that the central grammatical expression of pain in these languages is the verb. Pain is not a thing but a process. This presents a fundamental difference of epistemology and understanding (Halliday 1998). And the second is that the first categorization of pain is not like *pain – hurt – sore – ache* in English, but is cast rather in terms of surface *versus* deep-seated pain: *chep* (general and surface) versus *puet* (deep-seated). The same semantic distinction is found in Vietnamese, where pain is initially categorized into *đau* for surface pain, and *nhức* for deep-seated pain (Nguyen 2014).

7 Intercultural Communication and Pain

In one sense it is not necessary to come from a different language background in order to be involved in intercultural communication. There are many sub-cultures within each language, depending on many factors like age, gender, education, socio-economic status, and more. The closest thing to an intra-cultural communication in a medical consultation might be when one medical professional treats another: a doctor treats a doctor, and so on. But even here, socio-linguistically speaking, there are differentials, especially those relating to power and the health practitioner < > patient dyad. As we move further away from a balanced dyad, and the patient becomes less like a doctor and more like a member of the general public, the asymmetry grows. And with it, the differences of culture. These differences can clearly be seen in the way cultural accommodation plays out in the medical consultation (Kim et al. 2000; and for a more general review of Asian health care communication, see Lwin and Salmon 2015).

We can take this a step further. As Kecskes has argued (2018), it is misleading to conceive of the intracultural/intercultural distinction as belonging to two different dimensions. Instead, they can be seen as fitting along a continuum. At one end the cultural values of the participants can be close. At the other end they may diverge radically, a situation which is exacerbated if the health practitioner has never experienced the kind of pain that the patient is presenting with. Participants in conversation therefore have to begin by negotiating exactly where they are in relation to cultural identity and cultural overlap: the health practitioner, for instance, needs to work out how much the patient understands about medical terms and conditions, so that they can achieve the right level of communication. Leaving a wide gap will quite possibly result in lack of communication, as when the health practitioner mistakenly assumes that the patient knows more (or less) than they do. In contrast, assuming a wide gap on the part of the health practitioner may well appear condescending or insulting to a medically well informed patient. The "common ground" (Clark 2009; Kecskes and Zhang 2009) which they negotiate defines a cultural space for effective communication.

Negotiating common ground often takes place quickly, and sometimes under confusing and conflicting circumstances. The medical consultation, for instance, may last eight minutes or less. During that time the health practitioner, who is effectively directing the encounter, has to make rapid judgements about the patient, especially if the patient is on their first visit. Here physical appearance can provide valuable clues: dress, age and presentation. Body language is important, particularly in indicating the patient's degree of comfort. Linguistic competence is highly relevant. Does the patient express themselves fluently and with a sophisticated vocabulary? The lack of these properties may not indicate lack of education or sophistication. In particular, we do habitually rely a great deal on linguistic competence and communicative expertise as an indicator of cultural identity and competence. And yet this may be quite misleading. There are people who are able to express themselves in a language other than their mother tongue with great fluency, but who have never

mastered the cultural value systems of that language. And there are others who, while having limited linguistic competence in the foreign language, are in fact culturally well adapted and capable.

The potential complexity of these factors in interpersonal pain communication can be appreciated in an example from French, a language which has had long and continuous contact, both linguistically and culturally, with English. The word *mal* in French has a range of meanings not dissimilar to those of the English word *pain:* pain, difficulty, illness, lack, damage, calamity, ill luck, evil. The standard phraseology for "my X hurts" in French is *j'ai mal à* plus the organ concerned, so literally "I have a pain in the X": *j'ai mal à la tête*, literally "I have (a) pain in the head", means "I have a headache".

Now consider the following scenario. A patient enters the consulting room of an English-speaking health practitioner. The patient speaks English reasonably fluently but with a clearly French accent. He says in accented English: *I have a pain in the heart.*

Is the health practitioner to call a cardiologist? Perhaps. But there is a difficulty of which the health practitioner may not be aware. In French *j'ai mal au coeur* literally means "I have a pain in the heart". But it is also the conventional way of saying "I feel nauseous, I feel off-colour". If the health practitioner calls a cardiologist he may be acting literally, but at least responsibly. However, the Frenchman may not know that English does not have a parallel expression involving the heart when one is feeling off-colour, and is simply translating his idiom literally. Is the health practitioner aware of this? He may be. Then it comes down to a matter of the health practitioner knowing enough about French, and the possible dangers of literal translation into English, to ask the patient to clarify his condition, in order to determine whether in fact the cardiologist is needed, or a routine consultation. What in fact was the patient trying to express in English? As we have seen before, uttering English sentences does not necessarily mean that one is uttering English meanings. And here, before we even get to underlying cultural values, there is a problem of phraseology and idiom to be resolved. There is, incidentally, a parallel problem with the French phrase *j'ai mal aux reins,* literally "I have a pain in the kidneys", which is the conventional phraseology for saying that you have a backache.

A great deal of the talk between health practitioners and patients will not be complicated by such problems of idiom and translation. Routine medical matters, with a clearly identified cause, may be relatively straightforward, since the various factors can be seen and tested by methods that both the health practitioner and the patient can share. Ostensive definitions and regulation investigations will confirm swollen tonsils, an infected finger, a sprained knee. More deeply hidden problems, like damaged disks and tumours, will often yield to the evidence of a CT scan or MRI. But the hidden and subjective nature of pain makes pain communication altogether more complex and uncertain, and intercultural pain communication introduces additional values and interpersonal considerations. Wittgenstein's beetle is not only obscure within its box; the box may itself be obscure behind cultural barriers and distortions which may or may not be evident.

We can capture some of this complexity diagrammatically. This schema is broadly adaptable to non-pain communication, but for pain it serves to highlight the special points of difficulty ("PiP" = Person in Pain, "HCP" = Health Care Professional):

Pain (Beetle in box)	>	PiP (Person in Pain)	>	Pain Message Out	>	Pain Message In	>	HCP Health Care Professional	>	Pip's pain/ beetle?
		A		B		C		D		E

Each of the arrows points to a location where intercultural pain communication may encounter difficulties. The health practitioner is able to see the person in pain, and to perceive their pain message as it is transmitted and received. The health practitioner cannot directly see or verify the existence of the pain, a.k.a. the beetle in the box. The difficulties offered by the points A-E include these:

A. The beetle is invisible, and can only be inferred by the health practitioner from the visible appearance and speech of the person in pain, and the messages that they make. The pain is not empirically verifiable or accessible to ostensive definition.
B. Is the person in pain presenting a full and un-skewed account of their pain, real or imaginary?
C. Is the transmission of the message affected by any factors in the context of the consultation? For example, the power dynamics between the health practitioner and the patient, the formality, constraints of professional contact, stereotypes of behaviour from some culture, visible or presumed?
D. In receiving and processing the incoming pain message, is the health practitioner applying their own cultural habits, or making allowance for the patient's cultural background, or presumed cultural background?
E. In interpreting the pain message, how faithfully and confidently can the health practitioner take the evidence which is offered?

In addition, there are the beliefs of the interlocutors about each other, about each other's cultural frameworks, and about what each thinks about the other. Some healthcare professionals have had wide experience of different cultural backgrounds in communicating with patients, and may understand where the patient's values are situated. The health practitioner will still make a number of inferences about the patient's cultural identity and orientation. But that identity and orientation, as presented by the patient, may be affected by the way the patient believes the health practitioner wants to see them, and perhaps by apprehension or uncertainty at what the health practitioner may feel about the patient if the patient speaks too fully, or perhaps not fully enough, about their pain. In particular, cultural taboos and stereotypes can interfere with the full and frank transmission of information about pain, and with its reception in the way the patient either intended it to be received, or hoped that it would be received, in order to achieve the desired outcome from the health practitioner. And embedded in this complex network of communication is the issue of face (Lim and Bowers 1991), the way we present ourselves to others and want them to see us, together with what we think about them and what we think they

think about us. Managing all this in the context of what will probably not be a relaxed interchange in the medical consultation is difficult and sophisticated. And negotiating and clarifying all this common ground (Kecskes and Zhang 2009) and communication in the space of a short consultation, while proceeding with the business of investigation and diagnosis, is a daunting task by any measure, especially with a topic like pain which may carry with it many kinds of social value and even stigma.

Central to the success of the negotiation of common ground is accommodation, or the ways in which interlocutors adapt their behaviour to match and suit that of the other participant (Giles 2016). Becoming a socially competent accommodator is part of our education as competent speakers of our language, and competent representatives of our culture and its values. Communication is aided by accommodation, and people are often comfortable with adapting their behaviour, at least to some extent, to lessen the distance between them and the other person. This is another part of the two-and-fro of negotiation. As it proceeds we ask: is the other person accommodating to me? How do I know? What do they know about my language and culture? What do I know about their language and culture, assuming that I know what it is?

One can accommodate in either language or culture or both (as well as along some other parameters like pragmatics, which we will leave aside here). In practice accommodation is very often asymmetrical between the participants, which means that one will accommodate more than the other. If they accommodate to the point where they overlap, communication may be enhanced. But it is perfectly possible for the participant to be making major concessions in terms of language, but staying within their own cultural frame of reference. In this case, there may be significant difficulties of cultural communication brought about by the gap between the two, even after accommodation has been negotiated and taken place.

A further complication involves the presence of a "third person in the room" in the chain of communication in the medical consultation. Parents are very aware of their role as intermediary and interpreter when they take a young child to the health practitioner, or when we accompany an elderly relative with cognitive impairment. This situation has some parallels with the presence of an interpreter, except that the intermediary is already very well acquainted with the patient. The "third person in the room" phenomenon, however, is a standard feature of the practice of medicine in countries like Vietnam. When a woman goes to see a health practitioner she is routinely accompanied by a relative, who may be male, and may be her husband or even her father. The health practitioner, who until recent times has been most likely to be male, directs most talk to and from this third person, who speaks on behalf of the patient. And as we have seen, since pain is the most likely single reason for visiting a health practitioner, pain communication is centrally involved in this medical consultation (Fan 2011; Sakai and Carpenter 2011; Wolff and Roter 2008, 2011).

8 Contexts of Intercultural Pain Communication

We now turn to concrete contexts of intercultural pain communication, where people from different cultural backgrounds communicate about pain, especially but not only in a medical context. Intercultural pain communication is occurring with increasing frequency as people and messages become more mobile, and English is the dominant lingua franca for communication in these domains. But using English linguistic forms does not necessarily imply making culturally English messages (Sussex and Kirkpatrick 2012; Sussex 2012), especially in contexts like:

1. **Multicultural societies,** prompted both by higher levels of cultural diversity in the homeland, and the freer movement of peoples across geo-political borders, as with the Schengen Agreement in the European Union.
2. **Tourism** involves travellers away from their homeland finding themselves in need of medical attention. Statistica reports 1.186 billion international tourism arrivals in 2015, and the tourism industry is annually worth USD7.27 trillion (https://www.statista.com/topics/962/ global-tourism/).
3. **Medical tourism,** a category of tourism undertaken specifically to access medical services overseas, is growing dynamically. Medical tourism occurs when people either choose voluntarily, or are unable to afford the cost of certain medical procedures, including elective surgery, in their home country, and travel abroad to seek alternative providers. The principal providers are (in alphabetical order) Costa Rica, India, Israel, Malaysia, Mexico, Singapore, South Korea, Taiwan, Thailand, Turkey, and the USA. More than half the target countries for medical tourism are in Asia. Although no firm figures are available, it is estimated that this industry was used by 11 million cross-border patients in 2014, including 1.2 million Americans (Patients Beyond Borders n.d.). The revenue from medical tourism is estimated at between $38 billion and $55 billion American dollars a year (Patients Beyond Borders n.d.). Medical tourism is particularly relevant to intercultural pain communication because of the prominence of English in the medical consultation, in all its various manifestations. It is quite possible to have professional conversations where none of the participants has English as a native tongue. At a Thai hospital specialising in medical tourism, for example, a Thai health practitioner, a German patient and a Philippino nurse would routinely communicate in English (Lian and Sussex 2018).
4. **Education overseas.** Growing numbers of students study overseas, especially in English-speaking countries, partly because of the quality of education and its prestige, and partly because of the economic and cultural status of the English language. The top four destinations for overseas education are the United States of America, the United Kingdom, France and Australia. The numbers are substantial: in 2014–2015 nearly 975,000 overseas students studied in the United States of America alone, led by China (31.2%) and India (13.6%) (https://en.wikipedia.org/wiki/International_student), and while studying these students experience health care outside their homelands. The students who then return to their homelands are already functionally bilingual and at least partly bicultural.
5. **International business, trade and commerce,** where people, messages and products move around the world with increasing freedom. Sometimes these products and their messages are adapted to the target country, sometimes less so.
6. **Migration,** with people from one language and culture voluntarily take up residence in another, with substantial unmet needs for medical care in general, and pain management in particular (Brady et al. 2016).
7. **In-migration of overseas-trained health care professionals.** In 2011 in Australia, for instance, the Australian Bureau of Statistics (ABS) reported that 56% of GPs and

47% of medical specialists had been born overseas, together with 33% of the nurses. The countries of origin for GPs and specialists were led by the UK, India and Malaysia, with China and New Zealand in fourth and fifth position. While extensive quality controls are applied to incoming health care professionals for medical and communicative competence, there is obvious diversity in the backgrounds of health care professionals, not to mention their contact with the 240 languages spoken in Australia. Again, competence in English may not be matched by intercultural competence.

8. **Refugees.** The enormous numbers of refugees from the Middle East and Africa, and most recently especially from Syria and Iraq, need medical care outside their homeland and home context.

9. **Westernization of medical practice and medical education.** Although the dominance of the Americas and Europe is now starting to be challenged, especially from the leading technological countries of Asia, westernized models of medicine are clearly prominent internationally. In some parts of the world, for example in Asia, traditional medicine continues to flourish in parallel, sometimes with points of contact with Western medicine. But this change creates a situation where not only clinical medicine, but also the social aspect of medicine, bring together homeland and imported practices.

In terms of medical education, younger generations of health practitioners are increasingly being trained overseas, especially in English-speaking countries. They return home with knowledge and principles of practice derived from the places where they have studied, and so become bicultural practitioners in their homeland – and here "bicultural" can include medical practices from different traditions and systems (Chen et al. 2013).

10. **Retiring abroad.** Increasing numbers of retirees from wealthier countries, including those who were badly affected by the Global Financial Crisis of 2008, are deciding to retire in less costly countries. Some of these are in Europe, but others involve countries like Malaysia, which have widespread English language competence, an appropriate standard of living, and – very important for older retirees – quality medical care.

This list is not exhaustive, but is representative and wide-ranging. And the categories of intercultural contact that it defines reveal issues of intercultural medical communication of substantial volume and complexity.

From the sociolinguistic point of view intercultural pain talk can be divided into two broad categories, professional and social-informal. In professional talk between a health practitioner and a patient, typically in a medical consultation, there is an archetypical power differential, where the health practitioner is in a position of power and knowledge, and the patient is seeking help and remedies (Todd and Todd 1993). In many cases the health practitioner will be speaking their first language and activating their first culture, and it will be the patient who accommodates. And if the patient does not have that knowledge and skill, and if the health practitioner is not bilingual and bicultural in the patient's context, then an interpreter will be necessary. The numerous Arabic-speaking refugees arriving in Europe from the Middle East present precisely this kind of situation, and one often exacerbated by medical emergencies as a result of their experiences.

In many other cases, however, and especially in Asia, patients will try to choose medical practitioners who speak their language, or at least a language in which they have adequate competence. That will usually be English, and specifically Lingua Franca English (Canagarajah 2007) in many cases.

9 Implications for Education

The evidence presented in this chapter shows that there is indeed an urgent need for education in the area of the intercultural communication of pain. As we have seen, pain itself is a major burden on economies, and more importantly, on the quality of life, of millions of people world-wide. We have established that current communication about pain is insufficient to correct this situation. To cite one example among many: pain in younger women is under-appreciated and under-reported (Evans and Bush 2016; Perquin et al. 2000), to the extent that 20% of a sample of females aged 16–18 in Canberra, Australia, were shown to have missed school due to menstrual pain (Parker et al. 2010). And when we add the dimension of intercultural communication we find ourselves in an area where disturbingly little has been done, and the nature and extent of the problem are only now starting to be realized.

Rather than beginning from educational principles, let us start by considering an optimal intercultural pain communication, and then reverse-engineer the educational needs from there. Optimal intercultural pain communication would require that the barriers and disruptors to intercultural communication and pain communication should be realized, understood and neutralized. The health practitioner needs clear and complete information from the patient about the location, nature, severity and periodicity of the pain, together with its impact on the patient's quality of life. The patient needs to provide that information without cultural or personal filtering, and to volunteer relevant information if the health practitioner's line of questioning omits it; patients need to feel free to ask the health practitioner unprompted questions, and to provide unprompted information. The two need to be able to negotiate these issues through the consultation to a point where the health practitioner understands all that the patient is able to communicate about the pain, and can make the most reliable possible diagnosis about the pain, its cause, and a subsequent plan of action. For their part, the patient should not be constrained by stereotypical or cultural models of the all-powerful and omniscient health practitioner, and should feel at the end of the consultation that the interactions have led to a full and satisfying, and personally reassuring, outcome.

In educational terms, reaching this position will take a great deal in terms of effort, resources and learning. From the point of view of the training of doctors and healthcare professionals, there is already an emerging view, especially among pain specialists, that medical education about pain is limited and unsatisfactory. In a medical curriculum which is already both full and intense, finding room for training about pain, especially chronic pain, will be difficult. In contrast, training for health practitioner – patient communication is better established, and many medical curricula devote training to this question. However, when we come to intercultural communication as a part of medical training the situation is more serious. There is intercultural communication training for healthcare professionals who have to work with specific ethnic groups, for instance with numerically substantial immigrant communities. The best levels of intercultural communication competence are probably found with health practitioners in countries where English is not a national language, but is

increasingly being used as a lingua franca (House 2018) in medical consultations. As we have seen, the situation applies particularly clearly to tourism and medical tourism. But there are also broader needs for training in intercultural communication across the full range of healthcare professions. And healthcare professionals also need training in working with interpreters, in order to achieve a comprehensive understanding of what the patient has to tell them. Interpreters for their part will need special training in the specific difficulties of pain in medical consultations. And there is also the problem posed by the "third person in the room" phenomenon.

If there is already a framework for achieving these goals in the training of healthcare professionals, both before graduation and after it in professional development, the same cannot be said for the patient perspective. Being a helpful and constructive pain patient in the context of intercultural pain communication is not straightforward, even for patients who appear to be competent in the same language as a healthcare professional. As we have seen, linguistic competence is not necessarily accompanied by cultural competence. The situation is compounded if a doctor, a nurse and a patient all come from different linguistic and cultural backgrounds, and are using English as a lingua franca, with indeterminate cultural values operating in the communicating situation. Patients may also be constrained by stereotypes from their homeland culture, including the "omniscient health practitioner", respect for power, and related matters. It is necessary, in other words, to "educate" patients to be full and productive contributors to an intercultural pain consultation. How that could be done is yet to be addressed.

10 Conclusion

Pain is not merely a private part of our personal lives. As acute pain it has an important part in medical diagnosis and treatment, as well as its effect on our quality of life while we are recovering. And as chronic pain it is recognized as a disease in its own right, something requiring sophisticated and specialized attention from healthcare professionals. Pain is expensive, costly, and a burden on the quality of life of those who are unfortunate enough to suffer from it.

As our world becomes increasingly globalized, people from different languages and cultures are finding themselves more and more away from their homeland in places where they need to seek medical help. And pain, because of its covert and difficult existence, presents itself as one of the most difficult aspects of our medical condition to communicate. Pain talk, since pain is the most common reason why people go to the doctor, inevitably dominates talk between healthcare professionals and patients.

This chapter has presented a quantitative and qualitative case for promoting pain as one key aspect of intercultural communication. And within the range of medical conditions which bring us to visit a doctor, pain is among the most difficult and intractable. As we have seen, only a small number of pain sufferers receive appropriate treatment for their pain (National Pain Strategy 2011, p. 2).

Asia, with its dynamic growth of population and its population-movement, is an area where intercultural pain communication will become more frequent and therefore more important. English as a lingua franca will certainly be the dominant language and culture paradigm in this expanded area of intercultural communication (Lian and Sussex 2018). The accelerating influence of China in Asia – the movement of people out of and into China for business, education and cultural goals – means that the Chinese language and values will also become increasingly important players in the communication of pain.

From the linguistic point of view, pain is under-explored territory. The bulk of the work done so far on pain language has been carried out by non-linguists, and has concentrated on vocabulary and the creation of instruments for clinical pain assessment. As we have seen, at least in a brief analysis, these approaches have a number of assumptions which need rigorous testing. The grammar of pain, apart from work by Halliday and Lascaratou, has been hardly touched. The same is true of the conversational analysis of pain talk, especially in the crucial context of the medical consultation between health care professionals and patients. The sociolinguistics (e.g. the role of swearing in pain tolerance: Stephens 2009), sociology and anthropology, as well as the metalinguistics (e.g. tone of voice) and pragmatics, of pain are waiting for investigation.

Pain as a topic of intellectual enquiry in intercultural communication finds a number of points of engagement with the chapter in the present volume. The whole question of English as a lingua franca is central here, both as a code for communication, and as value systems which accompany it, since people using English forms may not be making English messages in the L1 semantic, pragmatic and cultural sense (Sussex 2012).

The issue of the language construction of how people in pain formulate their pain reports, and their interpretation, relate closely to the notion of culture and artefact (Curtis 2018). In a fundamental sense pain IS its constructed report: that is the only way we can get at it, in the absence of independent objective means and representations. But the artefact of the pain report depends in turn on the underlying value systems, both as intended by the speaker, and understood by the hearer. The two may not mesh, and grasping and externalizing pain descriptions may turn out to be a complex matter of negotiation, misunderstanding, repair and renegotiation. Here the Confucian values addressed by Pham (2018) are of central importance. Respect for power figures, including professional power figures, can shape and limit the patient's readiness to speak fully and frankly about their pain. So too are issues of gender, of respect, and of interpersonal roles, whether in the workplace (Pham 2018; and see Nguyen 2014) or in the medical consultation. And, in ways which have not yet been adequately addressed, contexts of pain communication involves issues of intra-and inter-cultural communication (Kecskes 2018). It is relatively straightforward to classify as "intercultural" the communication between a health practitioner and a patient where one of them is speaking a second or foreign language. But when the health practitioner and the patient are speaking the same first language, it is still possible to conceptualize the conversation in terms of inter-cultural communication, as between a professional and a non-pro-

fessional discourse and system of values. Here the gradient which Kecskes proposes between intra-and inter-cultural communication offers opportunities for new analysis.

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