Pain, Intercultural Communication, and Narrative Medicine

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James Hallenbeck

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. Pain is experienced, communicated, and shared not just in the here and now, but as part of one's life narrative, extrapolating from the past into an often uncertain future.

In this chapter, we will examine communication through the lenses of intercultural communication and narrative medicine. Intercultural communication as a field offers a useful perspective that may heighten awareness of common pitfalls that frequently give rise to miscommunication. Narrative medicine offers a complementary framing of the experience of pain. Based on these perspectives, I will suggest strategies and communication skills that may minimize the risk or severity of miscommunication and increase the potential for constructive collaboration in treatment.

Much of the older 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 work 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 both in giving voice to pain and in negotiating an experience that transcends the individual (Pugh

J. Hallenbeck, MD (✉)
Division of Primary Care and Population Health, Department of Medicine, Stanford University School of Medicine, Stanford, CA, USA

VA Palo Alto Health Care Services, Palo Alto, CA, USA
e-mail: James.Hallenbeck@va.gov

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1991; Im et al. 2009; Schiavenato and Craig 2010). 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).

More recent literature has examined pain-related encounters between patients and medical providers, often using qualitative analysis approaches (Esquibel and Borkan 2014; Hughes et al. 2015; Matthias et al. 2010, 2013, 2014; Zheng et al. 2013). Much of this literature has been driven by rising tensions regarding the use of opioids for "non-malignant" pain (Bergman et al. 2013). This literature highlights the very different perspectives and narratives from which patients and providers tend to approach pain, but also suggests possibilities for decreasing tension and working toward greater collaboration.

While patients and providers may disagree as to the biologic reality behind an expression of pain, any episode of communication about pain represents its own truth within a personal and cultural context. Such truth is correlated with but not identical to biologic reality (Trnka 2007). This truth usually represents in part a request for some response from others within the context of particular relationships in a particular situation and culture. The desired response may be behavioral, the administration of some aid or medication, or relational, as through a demonstration of empathy (Goubert et al. 2005). Narrative medicine considers the personal contexts of patients and providers, which in turn are embedded in greater cultural contexts (Charon 2001). A useful way to think about such narratives is to consider them as stories that patients and providers bring to and act out through particular encounters. Both patients and providers relate to the other based on their own personal narratives. They also ascribe narratives to others. For example, patients bring with them their own stories regarding how they came to be in pain and their relationship to the pain. They also ascribe certain roles and expectations to clinicians with whom they interact. Similarly, clinicians ascribed stories to their patients as a way of "making sense" of a particular patient presentation. These stories typically contain certain common elements such as character types (protagonists, heroes, and villains), and plot evolution over time – all of which happens within a certain staging, such as the doctor's office. While patients and providers may share the same physical stage, they often are acting out very different stories, arising from differing life experiences and cultural framings. Morris has argued that narratives may be particularly relevant to a better understanding of pain. "First, narrative, like pain, always comes with filaments attaching it to the social world" (Morris 2012).

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 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) is a complex personal experience that almost always affects more than the individual. This complexity is processed and understood by people, typically, in terms of narratives, which in turn arise within particular cultural contexts. The newly sick person has experienced a major disruption in his or her life story, a narrative shift of sorts (Becker 1997). This shift in turn unavoidably gives rise to changes in the person's life story and those of closely linked individuals – family and friends, and medical providers. The sick person typically 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, too often what happens is that people talk past another, based on very different interpretations or stories, resulting in serious miscommunication.

Pain is a particularly interesting topic in this regard. Like all symptoms, pain is a subjective phenomenon. According to the International Association for the Study of Pain (IASP), pain is 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 suggests, pain is a subjective 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 in the definition 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 just missed it? Is the "unpleasant experience" being described properly as a pain, albeit a "non-physical" pain? In such an instance is the usage of the word pain metaphoric, or is the person claiming pain not really having an "unpleasant experience" and is in effect lying?

Any demand for evidence of tissue damage suggests a low context framing and 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, support, and understanding. It is thus high in cultural context (Biro 2010). Pain, then, is both a high and low context event, requiring both technical and relational expertise for optimal management.

In some situations, 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 situations 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 group of an immediate and urgent need for defense and support. Group members 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). In humans, 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; Otti 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 to many chronic pains?

Many pains traditionally 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 result in withdrawal and relative quiet, typical of "chronic pain." In evolutionary terms, withdrawal would be an appropriate response to bodily damage involving certain deep tissues. In animals and in ancient times for people with such deep tissue pain, the best chance for survival would have been hiding out and waiting for internal healing, if possible, to occur. Others members of the herd or tribe 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 group 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 deep tissue 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 no obvious stigmata of tissue damage exist, 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 as observers 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. Put simply, we are pretty good at "seeing" and empathetically responding to acute pain. Indeed, in such cases, empathy is more than just concern for the other, to a large degree it represents a neurologic mirroring of pain (Moya-Albiol et al. 2010; Schott 2015). 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, regardless of how kind, considerate, or compassionate we might be.

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 the following table.

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 can recognize pain in all forms. The common resistance by clinicians to efforts to get them to use proxies for communicating pain, such as 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).

High and Low Context Pain Communication

The guttural cry of acute pain is straightforward 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 acute pain, but less skilled in alleviating the distress and suffering associated with chronic illness (Fabrega 1997). Chronic pain should be included among such distress. To a large degree, the current opioid epidemic reflects not just the dangers of opioid misuse, but the collective failure of modern medicine to address chronic pain and related suffering adequately (Brennan et al. 2007; Cheatle and Gallagher, Chap. 25, this volume; Volkow and McLellan 2016). 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 biomedically oriented 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 the greater comfort most clinicians have in response to acute pain reflects not only relatively greater efficacy of treatment and certainty of diagnosis, but also a more favorable medical climate for such treatment. Reimbursement systems tend to favor the management of acute care and acute pain. For the most part, the receipt of such care is viewed as a fundamental right. However, both medical society and society at large are less supportive of people with chronic illness. In terms of pain management to a large degree, this reflects uncertainty as to legitimacy of chronic pain, as discussed later, as well as concerns regarding treatment options, especially with opioids (Lillrank 2003).

As Morris states, “Pain is a magnet for complications and uncertainties” (Morris 2012, 735–6). However, aversion to treating patients with chronic pain, when present, goes beyond this. To put it bluntly, for most clinicians, treating chronic pain “isn’t fun” or personally rewarding. It is not just that we face uncertainty as to the veracity of pain, or that our current therapies are problematic. Nor is it anything as straightforward as a simple “skill deficit” (Volkow and McLellan 2011, 2016). Patients with chronic pain are often perceived as being “difficult patients.” While we tend to ascribe such “difficulty” to patients’ personae, sometimes rightly and sometimes wrongly, it may be harder for us to face the fact that in part this is because of the high context nature of our interactions with chronic pain patients. These relationships are inherently “sticky,” making it difficult for us to extract ourselves when encountering unpleasantness.

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 related to the provision of basic aid or simple defense to extremely complex interactions. Such relationships usually evolve over time. The roles stakeholders take on in these interactions emerge in turn from their life narratives – that is, their stories as to how they got to this point in their lives, where they believe they are headed, and their beliefs about their respective roles, given the situation. Stakeholders also project their understandings of expectations and appropriate roles onto other stakeholders. To the extent stakeholders’ narratives are in synch, a common, *co-constructed* story may unfold (Mattingly and Garro 2000). However, when stakeholders act from very different narratives, conflict often arises.

At the simplest level, narrative conflict between patients and provider may exist when patients seek highly relational (high context) support from providers and providers see their role as providing technical, low context medical assessment and treatment. In turn, low context providers may find such relational work distracts them from the perceived “real work” of medicine – to treat disease.

In reality high context, relational work between patients and providers is usually interwoven with low context, medically oriented work, such as diagnostic tests and medical therapies. 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. Often, such subtexts exist at a subconscious or semi-conscious level. 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
- 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 (Helft et al. 2014). 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 Helft notes, "Opioid agreements have the potential to improve the therapeutic relationship" by clarifying expectations and serving as a form of disclosure (Helft et al. 2014, p. 376, Rager and Schwartz 2017). 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 a two-way street. Patients need to trust that they are respected, that clinicians have adequate competence 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 mistrust as an issue may be relatively overt, as in drug screening, more often it exists 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; Hughes et al. 2015).

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. However, evidence suggests respect tends to grow with familiarity (Beach et al. 2006). Respect is also related to empathy and compassion. Evidence similarly demonstrates that an empathetic and compassionate response is easier to the extent some commonality of being is recognized. Disrespect, conversely, may be driven by a negative past history or a negatively-framed narrative of "the other." Disrespect, a lack of empathy, 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 frank 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 complex.

Some clinicians may associate drug-seeking behavior with certain ethnic groups, based both on stereotyping and perhaps past interactions with individuals that may have suggested a link between ethnicity and a propensity to 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 confirm and promote greater distrust, and limit empathetic potential. 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?” We might define it 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 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 a 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 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 medically oriented work, such as clinical assessment, procedures, or information giving. Studies suggest that many physicians encountering unpleasant 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 ascribed 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 a desire for “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; Bergman et al. 2013). 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 underclasses. However, most all of us feel this desire for specialness, when we are in the patient role. 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, 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 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 shortchanged. 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 (specialness) and yet we must also ground ourselves in some commonality of being (Goubert et al. 2005; Moore and Hallenbeck 2010).

Patients living with pain, especially chronic pain, experience their pain as a part of rich and complex narratives. 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 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 write 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; Morris 2012). 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 and efficient 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.

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 a 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, which alludes to a common experience. 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 a highly litigious society, and to the extent, it is overly self-serving, 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 will expand on this point. 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 (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?

Growing concern, understandably, about the current opioid epidemic has manifest in part as a sharper delineation between "legitimate," sanctioned pain syndromes for the use of opioids and those syndromes increasingly deemed "illegitimate" as far as opioid use is concerned. Crudely, the delineation is often between cancer or "malignant" chronic pain (legitimate) and "non-cancer/malignant" (illegitimate) chronic pain (Houry and Baldwin 2016). While there are "legitimate" clinical reasons why opioids are often more appropriate in advanced, metastatic cancer and less appropriate in other chronic pain syndromes, such a simplistic dichotomy of legitimacy should concern us all. While injudicious use of opioids has done significant harm, reducing the problem down to a simplistic question of legitimacy risks dehumanization, treating pain as if it is disease and not a form of suffering. Under-treatment of pain may also occur, when effective alternatives to opioids do not exist. Thus, the question of legitimacy appears to be growing in clinical encounters around pain, especially for those individuals with chronic pain, who are "unlucky" enough not to have metastatic cancer, but who require opioids for relief.

Especially in cases involving chronic pain, the subtext of patients' communication seems often to revolve around trying to establish the legitimacy of their complaint (Kenny 2004; Matthias et al. 2013). Such communication and behavior may take the form of "pseudoaddiction," as Weissman put it, which may manifest through unusual behaviors which may be misunderstood by clinicians as evidence of addiction, when in fact they are efforts toward recognition of legitimacy 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 (Kristiansson et al. 2011). Pain is a most personal experience and yet, people suffering from pain generally are not "in charge" of their own care, at least in terms of medication; 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 nonsterioidals, but for most everything else, especially controlled substances such as opioids, they are completely dependent on clinicians. That is, we must depend upon others both to recognize the legitimacy of our pain and to provide relief from it. 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." They may claim discrimination and stigma. Or they may argue 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, 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 pain actually exists.

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.

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. Such subtexts often play a significant role in high context clinical encounters. However, they usually remain in the subtext and are therefore not acknowledged. 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 this chapter, I will give some suggestions for how to deal more skillfully with these subtexts, when they do arise.

Subtexts and Narrative

Subtexts evolve from the interaction between patient and clinician narratives – both from self-ascribed narratives and narratives of the other party. A better understanding of one's own narrative and that of the other may help the clinician "make sense" of manifest subtexts, particularly where they are confusing or resulting in conflict. What does not make sense "from the outside" usually makes some sense "from the inside." For example, if a patient presents with distrust and anger, stating perhaps that the clinician is uncaring and just a bureaucrat in not doing what the patient desires, it may help to consider this in light of that patient's narrative, which may be one of struggle against discrimination and helplessness. Equally important, it may help the clinician to contemplate his or her own personal narrative, seeing his or herself as a caring clinician, who also has an obligation to do no harm. The accusation of being uncaring and a bureaucrat is an assault on this clinical narrative (Kristiansson et al. (2011)**.** Tempting as it is to staunchly defend against this "narrative assault," this is often counterproductive. A war of narratives (my story is right and yours is wrong) is rarely helpful. It is more than possible that parties may disagree as to the right course of action and yet the conflicting narratives are truthful from their respective perspectives. While respecting differences, it may be possible to seek common ground – at least in terms of the underlying narrative of the other and in highlighting aspects of one's own narrative to which the patient may relate. Finding common ground, where it exists, increases the chance that empathy may develop between parties. Empathy, when present, in turn may provide the opportunity for bringing conflicting narratives together, a process some have termed narrative co-construction (Mattingly and Garro 2000). It is important to understand that narratives are not entirely fixed, but are malleable, evolving from past experience and yet directed toward the future.

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 earlier, by design, pain instruments are low in context as a means of communication in their focus on specific aspects of the pain experience and their medically 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 is precisely that numbers tend to mean the same thing in all languages. But let us consider the cost of such a low context approach. 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 highlighted 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; Palermo 2013; Palermo, Chap. 39, this volume). 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 highly ranked dimensions as temporal variation in pain (16%). No tools addressed all top five ranked dimensions. 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 clinician are, as far as I know, NEVER a sanctioned or queried topic with the possible exception of patient satisfaction surveys – despite the obvious importance of therapeutic relationships in healing (Reynolds Losin et al. 2017). 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 (Lorenz 2006).

I have posited that 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 seem to 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, at least according to our clinician narratives, 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 by using 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 go 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, they may 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 reflects the desired urgency of response. Patients thus acculturate to the use of the pain score and in turn coopt it for their own 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 techniques 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 medically 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. In contrast, common, basic examples of medically oriented and relational events are listed in the following table.

Medically 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 or empathy
Healthcare process issues – setting up follow-up appointments, billing, etc.	Use of metaphor

The following brief vignette highlights how medically 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 initial 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.

Narrative Awareness

Heightened awareness is also critical if one is to effectively negotiate conflicting narratives. In difficult circumstances, it is all too easy to push on in accordance with one's own self-ascribed narrative, to simply act one's part. If under attack, we typically defend our narratives and fortify our roles. However, if we can step back and bring into fuller consciousness how we are acting out a particular narrative, a form of nonjudgmental awareness or mindfulness, this may open up new choices as to how better to respond (Beckman et al. 2012). Sometimes in our effort to be "professional," we do not admit to ourselves the less professional, but understandably human stories we create about our patients. The following hypothetical example illustrates how this type of awareness might occur, during a difficult encounter:

Patient: "What kind of doctor are you? Don't you care about your patients? Why won't you give me the pills I need?"

Mindful Reflection

Of Self: Feeling attacked, questioning me as a physician and my caring. Really pushing my buttons, feeling defensive, and wanting to get out of here, but must remain professional.

Of Patient: He is pushing hard. Is this desperation or manipulation? Do I think he is "drug seeking" or perhaps he's just a bully? Perhaps he thinks this is the only way to get my attention or has had previous experiences, where doctors have not responded caringly.

Reflection along these lines does not provide an obvious answer for how best to respond, but it may allow new possibilities. Is this an opportunity to open up a bit in a nondefensive manner about one's own professional narrative, such as revealing the challenge of balancing caring with the obligation to do no harm? Might one inquire with genuine curiosity about what the patient's past experiences have been with other doctors? Is this a time to raise a possible concern about substance abuse to "the text" with a statement like, "You are doing some things that suggest to me that you may have a problem with substance abuse. I hear you that you want to just give you the pills, but as a physician I have an obligation to try to understand whether this is a problem or not before making a decision." Or is this something you wish to explore within the subtext, perhaps by a more general inquiry about the patient.

Inquiring about a sensitive issue like possible substance abuse is difficult for all of us. Consider this last sentence in quotes above about possible substance abuse. It matters far more how it might be said than what exact words are spoken. The reader might consider saying the words first defensively and then with caring and curiosity to experience the difference.

As the example above demonstrates, with greater awareness, 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 as follows:

- Address relational issues, such as trust or respect (or not)
- Expand current lines of communication (tell me more about that) or truncate them and switch to another line
- Raise subtexts to "texts" or deal with them within the subtext
- Share one's narrative perspective or explore the other's narrative.

Address 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, again an exercise in awareness, is to observe and reflect on the percentage of time spent on medically oriented issues relative to relational issues. In many, arguably most situations, the medical issues are the priority and will quite appropriately take the bulk of time. However, the clinician is encouraged to try 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 nonmedical 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 to be helpful is encouraged. When sad or difficult emotions arise, you may wish to show that you share them with the goal of demonstrating your caring and humanness. If, for example, a procedure or therapy 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). Clinicians may unskillfully shift the discussion abruptly. "You have really hung in there" is both a positive, relational phrase and facilitation of a smooth transition to medical work. Too often clinicians 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? 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 when 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 satisfaction 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 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 the patient (or family) and the clinician can handle the issue raised emotionally without losing control.
- 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 or not 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" and 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 aspects of communication. And yet we all naturally and skillfully shift between low to high context communication every day. In other words, we are already experts in many of the issues and techniques raised earlier. My hope is that clinicians struggling in difficult encounters with patients with pain may use some of the concepts and techniques suggested here to more consciously and skillfully improve the quality of their interactions with patients, which will in turn result in improved patient outcomes and mutual satisfaction.

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