

the language of pain.

part two: pain as verb and as narrative

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Pain, in its most elemental form, is pre-language. Its outcry is often raw, disruptive. Yet in our statistic-driven society, as Simone Lucas' analysis shows, pain has been defined largely in terms set in the 1970s by the McGill Pain Questionnaire (MPQ), a diagnostic tool translated into more than twenty languages worldwide. The MPQ was based on the research of Melzack and Wall later published as The Challenge of Pain (1983). It presents pain as a subject for description and inquiry, a noun to be modified by a series of adjectives chosen from a list.

Simone Lucas has described two of the primary objectives that the MPQ serves: communication and measurement. The questionnaire is meant to provide physicians with descriptive information that will assist in assessing qualitative aspects of the patient's pain. Second, it is supposed to provide physicians with a quantitative account of the patient's condition: to measure the amount of a patient's pain via a yardstick with which to calibrate progress or setbacks.¹ A third aim of the MPQ is more covert: to evaluate the patient's psychological state. The questionnaire asks patients to assign different numeric values to sensory experiences linked with the pain (throbbing, stabbing, crushing, wrenching, burning, etc.) and also to emotive dimensions attributable to the pain (viciousness, wretchedness, punishment, etc.). Without the patient being informed of the fact, the questionnaire is being used to assess mental as well as physical health. In the process, pain conditions (disorders of the brain and nervous system such

The paper that Simone and Eve present here is based on a co-authored paper they gave at the Study in Action conference 2012. Longer versions are available at www.convergencejournal.ca

Their collaboration began with exchanges about women writers. Recently, their discussions grew into a shared project on pain and disability as lived experiences and as subjects of study. Their joint research focuses on the social construction of pain and on the intellectual and technical means used to describe and evaluate it.

as phantom limb pain, cluster headaches and burning mouth syndrome) are being set apart from most other medical conditions (for example, heart disease or pancreatic cancer) by making their diagnosis partly an assessment of the patient's emotional response to his or her illness.

In spite of imperfections and a lack of transparency, the MPQ nonetheless has played a critical role in changing theoretical and clinical understandings of pain. By providing a mechanism for collecting statistical data about the pain of different patient groups, the questionnaire helped foreground Pain Medicine as a valid field for research and helped make the alleviation of pain a reasonable expectation on the part of patients. By the 1990's, for the most part, pain was no longer seen as an unavoidable stage of illness to be observed rather than counteracted; instead, untreated pain was widely understood as a dynamic that could set off cascades of lasting system-wide effects and, in some cases, lifelong disability. Pain as a noun with adjectival qualifiers helped found both a field of study, Pain Medicine, and a clinical setting for carrying out research and for treating patients - the Pain Clinic.

Today, however, what progress had been accomplished from the seventies to the nineties under the rubric of "Pain as a noun" is being threatened in the twenty-first century by an emerging alternative: "Pain as a verb". The Washington State doctor proposing this new definition, part of a larger movement aimed at reducing opioid prescriptions, explains his views in a video titled, "Pain as a Verb" (Seattle Times, 2012). He argues that in order to better address the problem of pain a shift in paradigm, accompanied by a redefinition of pain as a verb, is required. In fact, "pain" is already used as a verb in English; the existing usage is that of a transitive verb meaning to cause emotional distress to someone. However, the new usage being proposed by the Washington State doctor is that of pain as an intransitive verb. According to his video, the patient must be educated to see pain as an action in his or her control. This patient would not tell a doctor, "I have pain," but would say, instead, "I pain." As the video explains, speaking for the patient with severe pain, "Pain is not in the brain . . . pain is in me." The idea that pain is not in the brain contradicts decades of research on pain and the brain, particularly in the field of neuroplasticity and changes in brain structure and chemistry associated with protracted pain. By focusing on the attitude and language of those in pain, the video changes the subject of the discussion from that of alleviating pain and addressing its neurological basis to that of controlling the patient's behavior. From this perspective, severe persistent pain is less an alarm-bell for prompt medical intervention by doctors and specialists than it is a signpost of a psychological problem to be owned and dealt with by the patient.

The redefinition of pain as a verb is not just an exercise in semantics. Although this specific shift in terminology is the proposal of a single individual, the idea behind it is part of a larger campaign to rewrite actual laws governing the prescription of opioid medications, the most potent medications available today for treating pain. In Washington State, a new law went into effect in 2011. This law was drafted by the author of the video, together with a state representative (a former drug addiction counselor) and the medical director of the state's Department of Labor and Industries (a manager of worker's compensation) (Meier, 2010). The law places new restrictions on pain medication with the aim of decreasing the number of opioid prescriptions being written; for the remainder of patients in severe pain still eligible for opioids under the new law, urine testing is now mandated, even when patients are in no way suspected of breaking the law or of abusing their doctor's trust (Berens & Armstrong, 2011). Now that the law is in effect, patients prescribed opioids to reduce their suffering, grandmothers with trigeminal neuralgia and paraplegic war veterans, must find transportation to drug testing centers and wait in long lines holding cups of urine. False positives, a regular occurrence in drug testing of the kind, risk making patients who are just trying to get better, subject to harassment or even criminal charges.

The change of focus in public policy from reducing pain to reducing opioid prescriptions is having a profound impact on doctors, patients, and society at large. Some 116 million Americans live with an intractable pain condition.² Pain impacts more Americans than diabetes, heart disease and cancer combined. In Canada, chronic pain affects up to 40% of the population, according to some studies; a recent newspaper article puts the number of chronic pain sufferers at 6 million.³ Yet current media and political campaigns are re-framing this critical public health concern as a problem of drug abuse rather than a problem of effective treatment for millions living with pain disorders.

Theoretically and practically, pain is being redefined from a complex neurophysiological dysfunction amenable to treatment to an emotional-behavioral problem that is medically insoluble. In other words, what was once treated as a scientific and clinical matter, is becoming a behavioral and law-enforcement issue. In "Pain as a Verb," the Washington State doctor explains what this re-conceptualization of pain means in practice:

I see patients that pain very well. They have things I don't even understand how they survive. But they pain in a good way and I learn from them. And then there are others who pain very disruptively, disruptive to them, destructive to their family nucleus and to society. So our goal is to help them to pain a little better (Seattle Times, 2012).

Only patients who pain without complaint, without disruption to the “family nucleus,” earn the doctor’s praise: “they pain in a good way.” One consequence of seeing “Pain as a verb” is a change in the doctor’s relation to the patient. Under the rubric of Pain as a verb, the doctor’s role shifts from that of healer to that of moral judge who rates patients as praiseworthy or blameworthy on the basis of their supposed pain endurance.

The novelty of this approach is not that the attitude of the person in pain is being assessed. The McGill Pain Questionnaire, as we have seen, has a psychological dimension; it asks patients to describe pain sensations they experience by selecting words meant to reveal their emotional responses (e.g. “cruel,” “fearful,” “miserable”). However, Melzack and Wall dedicated *The Challenge of Pain* to “the millions of people in every country who live and die in needless pain” (1983, v). They attended to the emotional dimension of pain in order to highlight kinds of suffering they believed to be treatable and therefore “needless.” By contrast, those who today promote a shift to a more disciplinary approach depict pain as a burden to be borne by the patient rather than a medical condition to be remedied or improved upon by the doctor. While the video states that the doctor-narrator wants the patient to be “the driver of this bus,” i.e., the master of his or her pain condition, in reality the extent of the actual agency to which the driving metaphor refers is limited to the stoic toleration of pain, a capacity to pain intransitively, avoiding outbursts or demands. The patient is invited to drive a bus that seems to be permanently parked on the side of the road.

Is pain a noun? Is pain a verb? Clearly, it is both. But what both these models of pain leave out are nouns, verbs, and adjectives chosen by patients themselves and formed by them into sentences and paragraphs. In other words, Pain as a narrative. In art and literature, narratives of pain are central to works as varied as Michelangelo’s *Pieta*, Picasso’s *Guernica*, Frida Kahlo’s self-portraits, Verdi’s *La Traviata*, Thomas Mann’s *The Magic Mountain*, and Toni Morrison’s *Beloved*. Yet the engagement with pain that audiences find enthralling when it concerns an imaginary character in a novel or play somehow does not carry over to the pain of actual people in the world around us, in medical settings, in the workplace, in neighborhoods and communities. In the real world of the twenty-first century, even in doctors’ offices and hospitals, there is mostly aversion to hearing what people in pain have to say in their own words. Nonetheless, the stories that each person living with protracted pain has to tell are crucial for the medical system to hear so long as alleviating pain remains a fundamental responsibility of every physician. In addition, those stories offer knowl-

edge of our shared humanity and matter for society at large. Understood in its full complexity - not abstracted, reduced, judged or disembodied - pain brings us to crucially important places: to the limits of language and of numbers, to intersections of our spiritual and physical beings, and to moral questions about deciding what others should suffer.

endnotes

1. In the words of Melzack and Wall, "If the study of pain in people is to have a scientific foundation, it is essential to measure it" (Melzack and Wall, 37).
2. Maia Szalavitz, "Report: Chronic, Undertreated Pain Affects 116 Million Americans," TIME Healthland, June 29, 2011 (<http://healthland.time.com/2011/06/29/report-chronic-undertreated-pain-affects-116-million-americans>, accessed August 10, 2012).
3. Chronic Pain Association of Canada, "What is CPAC" (<http://www.chronicpaincanada.com/cpac.html>, accessed August 10, 2012); Sharon Kirkey, "Treating the invisible affliction," Montreal Gazette, October 3, 2011, p. A4.

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