33 Communication with Pain Patients

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> "Yes, but there is something, something that accompanies my cry of pain! And it is for the sake of this something that I make it. And this something is what is important— and terrible." - Whom do we share this with? And on what occasion?
>
> Ludwig Wittgenstein (1968: § 296)

Abstract: For many clinicians, communication with pain patients is an integral part of their working practice. At the same time, these communication situations are considered to be prone to complications.

The following chapter aims to depict the characteristics of pain communication and illustrates challenges and potentials for physicians and patients.

First, we show different forms of verbal pain display and how they are interactively processed in conversation (§ 33.1). We presume that pain representations are jointly constructed and negotiated by patients and doctors. Furthermore, linguistic categorisations of pain as well as gestural and mimic means of pain display (§ 33.2) are presented. The potential of pain presentations for differential diagnosis has not yet received sufficient attention in teaching and practice; practical examples and recommendations for efficient communication are intended to address this (§33.3). Different conceptions of pain on the part of the physician and the patient (§ 33.4) often lead to unsatisfactory communication situations for the all participants, which not only affects the ongoing conversation but also the health care provided.

The same applies to gender-specific (§ 33.5) and age-specific (§ 33.6) pain communication.

In order to facilitate appropriate communication and to improve doctor-patient-communication about pain, the chapter concludes with practical tips, guidelines and methods (§ 33.7), to optimise medical communication with pain patients.

33.1 Verbal pain displays

Pain is an immediate and tangible symptom of illness - talking about it is central to the anamnesis, diagnosis and treatment. There are multiple forms of presenting pain. Verbal descriptions are one of many ways that patients communicate their experience to clinicians. We therefore use the term “pain displays” as an umbrella term to cover all forms of pain presentation. It includes descriptions, narratives, scenic descriptions, but also other, potentially non-verbal (see also § 12) forms of pain communication.

Communication about pain in a medical context often appears to be problematic: patients are confronted with the difficulty of describing their subjective perception of an exceptional condition, using the descriptive repertoire available to them in a way that is appropriate to the situation.

At the same time, physicians face the task of “translating“ these descriptions into medically and diagnostically interpretable information (Ehlich 1990, Menz et al. 2002, Mishler 1984).

This process is encapsulated by the relatively recent term 'communication work,' originally coined by Donovan in the context of cancer diseases (2019, Donovan-Kicken et al. 2012) and subsequently applied to pain communication (Hintz, Scott 2021, Hintz, Suk 2023). It refers to “*the coordinated effort of creating, exchanging, and interpreting messages that are pertinent to the experience of illness and embedded in the larger context of daily life and ongoing relationships*” (Donovan 2019: 244).

Pain communication proves to be particularly complex and prone to errors, when the participants face language barriers (Hofer-Falk 2023, Menz 2013, Hofer et al. 2017).

In routine medical practice, healthcare professionals frequently encounter three types of pain representations: 1) Crying and groaning 2) Pain interjections such as “ouch“ 3) Verbal pain descriptions (Ehlich 1985: 180). The primary focus for the interaction between healthcare professionals and patients lies in the description of pain.

In reality, the expression of pain (crying, screaming, whimpering, and expressions of pain) and the verbal description of pain often conflict with each other. While the expression of pain provides limited assistance for diagnostic purposes, the verbal accounts provided by patients introduce challenges mentioned earlier (Heath 1989).

33.1.1 Classification possibilities

In medicine, pain is topologized and systematised in many different ways. From a linguistic perspective, three types of differentiation are relevant for pain displays.

At the outset, it makes sense to differentiate between acute and chronic pain, as these different disease dynamics are associated with specific requirements and expectations in medical dialogue and patient participation (Kreissl et al. 2004, Lalouschek 2008, 2010, Overlach 2008).

Furthermore, from a linguistic and discourse analytic, it is crucial to distinguish between primary and secondary pain. In the case of the former, the pain itself constitutes a treatable ailment, while in the latter, it emerges as an accompanying or consequential symptom of anoth-

er illness. In the case of primary pain, the medical consultation is the most important diagnostic tool.

Thirdly, cultural perspectives must also be taken into account (§ 28), as the perception of pain is characterised by historical, cultural and psychosocial aspects that influence communication about pain (Ferreira-Valente et al. 2023, Krupić et al. 2019, Lalouschek 2010, Morris 1991).

33.1.2 Presenting pain as a joint interactive task in medical conversations

From a linguistic perspective, pain is considered an "interactive phenomenon" (Ehlich 1985) that must be collaboratively addressed by both patients and physicians.

Determining what constitutes pain is not ascertainable through simple perception or inherent recognition. Instead, it requires interactive consensus, such as drawing the boundary between pain and non-pain and establishing its treatment worthiness, as illustrated in the following excerpt from a conversation (Reisigl 2010: 109f.).

E 33.1		Pain vs. Non-Pain [Orig. German, English translation by Regina Geisler-Knünz]
26	D	No. Unfortunately, I can't make it [go away].
27	P	[laughing] H but no, that's too much to ask, I understand. I [I]
28	D	[Okay.]
29	P	am also prepared to live with it. You know, I [don't say],
30	D	[Yes, (no.)]
31	P	that it's a pai:n. But [it's . un:pleasant.]
32	D	[Yes. Hmhm]

The patient reports numbness in her hand, a symptom the doctor "unfortunately can't make [go away]". This prompts the initiation of a negotiation dialogue to establish a consensus on the necessary treatment. begins in order to agree on what needs to be treated.

However, as will be seen later, these negotiation processes often stem from divergent concepts of pain between doctors and patients. Varied perspectives on what constitutes pain, coupled with different systems and descriptive inventories used by laypersons and experts,

frequently lead to disruptions and challenges in dialogue (Deppermann 2003). Linguists have systematically analyzed many of these issues.

Discourse and conversation analytical investigations not only yield insights into various representations of pain and the (predominantly) verbal and nonverbal means employed for this purpose but also unveil specificities in the description of pain. In particular, aspects of information processing, pain differentiation, and the influence of certain sociological parameters such as gender and age on pain representation are considered. Finally, tasks and perspectives for medical communication are outlined to facilitate the interaction with patients experiencing pain in medical practice and contribute to optimization. The assumption that pain representations are collaboratively constructed and negotiated by both the patient and the physician is consistently assumed throughout.

33.2 Practices of pain depiction

When examining language corpora for the representation of pain in German, clear preferences can be identified regarding the grammatical constructions used in pain displays (Overlach 2008: 164).

By far the most common construction is the representation of pain as a possession (“Ich habe Schmerzen”/ ”I have pain”). Copula constructions with the nominal expression of pain in subject position are also frequent („Der Schmerz ist …“/ ”The pain is … ”). Furthermore, constructions with „wehtun” (“to hurt”) and syntactic expletives “es/das” (“it/the”) in subject positions are also common, often in conjunction with “if-then”-sentences (“It hurts here when I …”).

Exceptions are sentences with a nominal expression of pain in the subject position, describing the impact of pain on patients (“The pain won't let me sleep”), as well as sentences with verbs that involve sensory perceptions of pain with patients in the subject position (“I feel pain”).
Descriptions of pain often take the form of “referring expressions“: The same pain must, therefore, be describable from both the perspective of the person experiencing it and the perspective of an unaffected person (Borg et al. 2019: 4).

In the English language possessive forms are used to refer to pain commonly as well: pain is therefore often treated as an object (“I have pain in my wrist”), while at the same time (even within a single se-

quence of expression pain) various labels for processes are used, when expressing pain: “My wrist hurts” frames “hurting” as a process the object (the wrist) is experiencing. It is also interesting to note that pain terms occur both as count nouns and as mass nouns. “I have a pain in the finger” and "There is pain in the lower back” or “I've been having pain all night” are common forms (Halliday 1998, Borg et al. 2019: 4).

The rather arbitrary realisation of descriptions indicates that the everyday repertoire for talking about pain is not very differentiated and insufficient for medical clarifications. Therefore, in conversations about pain, healthcare professionals must find more meaningful forms that manifest in specific categorizations.

33.2.1 Linguistic categorisations of pain display

Pain questionnaires, such as those used in pain management clinics or pain management units, are well suited as a starting point for analysing more complex pain presentations. The most common categorisations of pain primarily involve four dimensions:

- The localisation of the pain and its dynamics (“Where does it hurt and where does the pain go?”)
- The intensity of the pain and its dynamics (“How strong is the pain and how does the intensity of the pain change?”)
- The temporal dimension, which includes the time, duration, frequency and temporal dynamics of the pain, as well as
- the quality of the pain. For describing the quality, metaphorical expressions such as “burning, stabbing, piercing, cutting" and similar terms are primarily employed (Reisigl 2010).

Such categorisation schemes are primarily based on information-gathering strategies used by doctors. When we analyse patients' descriptions as they talk about their pain in non-medical contexts, their categorisations differ. In addition to the specification of pain, which contains the four dimensions of localisation, intensity, time and quality described above, there are additional differentiations that are summarised in Figure 33.1 (Blasch et al. 2010: 129, English translation by Regina Geisler-Knünz).

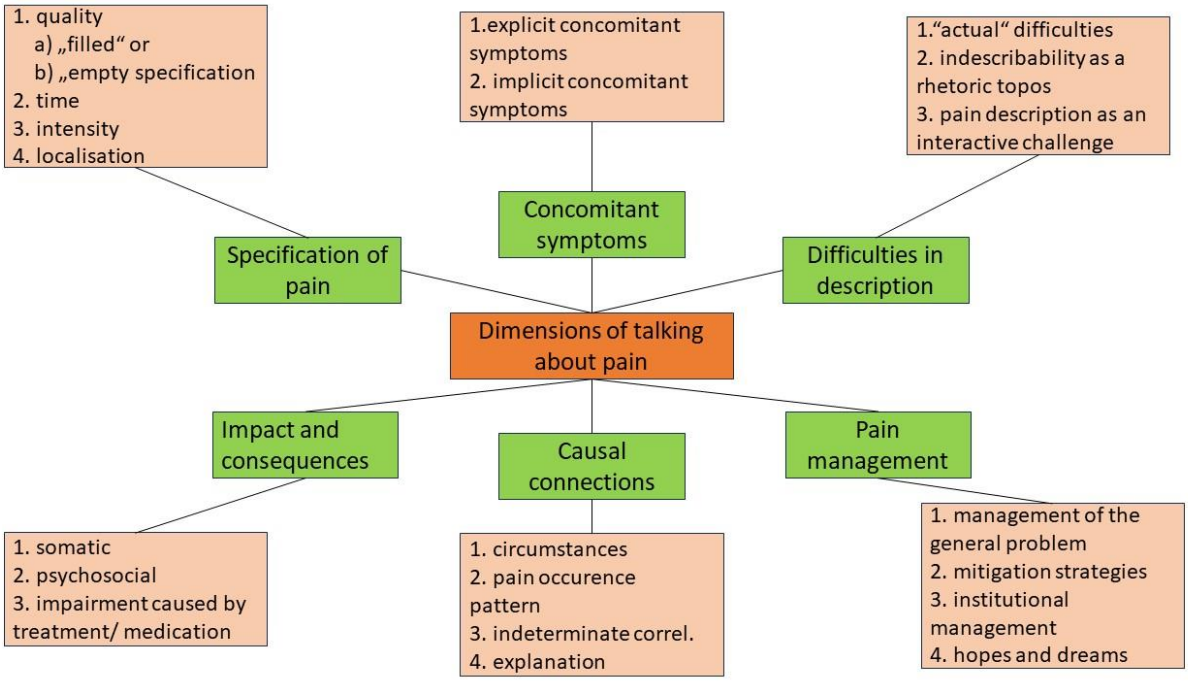

Fig. 33.1: Pain differentiations

The representations provided by the patients are indeed complex and encompass far more areas than are typically addressed in medical conversations. The dimension of “difficulties in description” in particular is still given too little consideration in medical contexts. Figurative language (metaphors, metonymies and comparisons) is often used, as these variants make it possible to communicate experiences that are difficult to convey and to describe the seemingly “indescribable” (see also § 11) (Brünner, Gülich 2002, Surmann 2002). Particularly patients with chronic pain use various forms of metaphors to describe their pain experiences (Steward, Ryan 2019, Munday et al. 2021).

Furthermore, the divergent conceptualization of pain, as evident in the presented distinct categorization frameworks, can be a cause of problematic communication (see also § 33.3).

33.2.2 Gestures and facial expression in pain display

Describing pain is not an easy task, so gestures are often used for clarification. Weatherall et al. (2021) argue, that a joint understanding for the pain is built multimodally and over time.

In particular, *pointing gestures* are often used to precisely locate pain (§7.2, 12, 21). The gesture makes the body both the subject and the object of the pointing. As an object, the pointing gesture refers to the painful area; as a subject, the person pointing must simultaneously maintain connection with the doctor. This is done by maintaining eye contact (Stukenbrock 2008). Certainly, this is a complex activity, as the direction of gaze and the pointing gesture do not align.

In addition to pointing gestures, so-called *imitation gestures* are also used in medical consultations. Patients imitate a movement that usually causes pain or is painful in itself. Ultimately, patients sometimes use *abstract descriptive gestures*. They are primarily used to differentiate pain and to depict specific aspects of individual types and qualities of pain, but without using concrete pointing or imitation gestures. Cramp-like pain in the abdomen, for example, can be emphasised by clenching the fist in addition to the verbal description (Hydén, Peolsson 2002: 331ff).

33.3 Pain differentiation as a diagnostic tool

Many pain patients, particularly those with headaches, experience different forms of pain, which they often try to differentiate during medical consultations. In doing so, they use various strategies for distinguishing between different types of pain, providing healthcare professionals with optimal points of departure for the differential diagnostic investigation of the complaints (Sator 2011).

The differentiation strategies of the patients can be classified into two main categories. Firstly, they can be distinguished by *explicit articulation* (“Well, I have two different types of headaches”). Alternatively, patients may utilize *implicit pain differentiation*, as illustrated in the following example:

E 33.2		Implicit pain differentiation [English translation by Regina Geisler-Knünz]
01	P	Because of my migraine . problems, which I have had since . youth . so . practically since . puberty hh and . which are now occurring again . more frequently . and ah . so . I'm not finding any relief . from the medication. hh Where I used to respond to them, I don't respond at all now. The classic migraine has now the/ah been joined by headaches from the cervical spine . hh and the tension . from the neck . uh shoulder, neck up so it's even more severe.

The patient begins to narrate her complaints and to frame them in terms of both temporal progression and intensity. The patient does not clearly differentiate between two forms of headache, but rather emphasizes the course of the pain and the deterioration of the condition. Nevertheless, she linguistically distinguishes between a “classic migraine“ (line 4) and “headaches from the cervical spine“ (line 5). However, an explicit differentiation between the two types is neither made by the patient nor by the physician (Sator 2010).

Secondly, the differentiations can be either *typifying* or *non-typifying*. In the example above, the formulations 'classic migraine' and 'headaches from the cervical spine' are examples of such typifications.

They are generally more interactively complex than the non-typifying representation of different forms of pain. Thirdly, in terms of sequencing, pain differentiations by patients involve either a contrastive juxtaposition and direct comparison (referred to as *parallel-contrastive representation*, e.g., 'the headaches from the cervical spine are here, while the classic migraine is more in that area,' accompanied by a pointing gesture), or a systematic treatment of various pain forms in succession (known as *systematic-consecutive pain differentiation*, e.g., 'I have two types of headaches,' followed by two clearly separated detailed descriptions) (Sator 2011: 244-7).

In the same way, doctors can deal with patients' offers of differentiation in various ways. Firstly, they can *emphasise* or *minimise* the task of pain differentiation (§ 17.4, 20.4), i.e. they can respond to differentiations made by patients or disregard them. Secondly, they can take up or reshape the strategies of typification and presentation (parallel-contrastive or systematic-consecutive), i.e. choose the opposite strategy.

Thirdly, verbal contributions from physicians can expand, reduce, modify or confirm patient-initiated pain differentiations, ensuring a shared focus on specific pain variants and a correct understanding.

Patients do not always differentiate between different types of pain. However, if they use differentiation strategies, then a “differentiation obligation” also arises for doctors (Sator 2011: 242), this means that the introduced differentiations must be addressed interactively. This has advantages and disadvantages: On the one hand, the differentiation or typology introduced by the patients can contribute to the diagnostic acuity of the pain variants. On the other hand, the differentiation framework is also limiting because all variants of the pain experience must be fitted into the predetermined order, which is not always feasible in practice. This leads to interactive complications in doctor-patient communication. In addition, it remains difficult to translate patients' everyday pain differentiations into medically-diagnostically applicable categories since patient-initiated differentiations do not always align with those considered medically relevant.

The following strategies prove to be useful for doctors in the context of a productive handling of pain differentiations:

Box 33.1 Recommendations for pain differentiation

- It is advisable to align oneself with the differentiations provided by patients and, based on these, to take any additional differentiations in a subsequent step. The differentiation of the patients should continue to be taken into account (for example by using the terms that patients have used in the description) (Sator 2010: 198).
- Prematurely focusing on specific variants of complaints is not advisable, as keeping the descriptions of complaints as open as possible at this stage allows patients to provide more detailed explanations. Open-ended questions are preferable in consultations, both when describing pain and when addressing the psychosocial consequences of pain (Laerum et al. 2006: 38).
- Physicians should select clear reference forms for each type of pain, aligning with the typology and terminology used by the patients (Sator 2010: 197).
- Physicians should present open-ended questions without preconceived categorizations, as otherwise, it may cause confusion among patients (Sator 2010: 198).

33.4 Divergent conceptualizations of pain between patients and physicians: The issue of alignment

In § 33.2.1, attention was already drawn to the potential issue of different conceptualizations of pain between patients and physicians, as they each emphasize different aspects.

One of the consequences is information deficits in the patient's medical history, significantly complicating the diagnostic process for physicians. In consultations with dentists regarding chronic facial pain, this imbalance of information was particularly noticeable in the areas of "complaint history", "impairment/distress" and "biopsychosocial history" (Kreissl et al. 2004). In conversations with non-medical personnel, up to 10 times more points relevant to the medical history, yet consistently left unmentioned, were reported compared to discussions with physicians. This was mainly due to the way in which the interviews were conducted, i.e. the use of open-ended, narrative-generating questions. The typical question-answer format in the interaction between physicians and patients necessitates a structurally more closed form, making it challenging for patients to articulate their own concepts of pain. This is because the concept of physicians unequivocally takes center stage in the interaction, severely limiting the descriptive space available to patients.

The organisation of the interaction has a more significant impact on the course of the conversation than the objectively available time. However, comprehensive medical history assessments are unusual in dental practice. Moreover, they are legally limited as a billing item in the fee schedule and are compensated to a limited extent.

Examining the question of how and what is talked about in pain displays, it becomes evident that the aspects of pain discussed vary significantly in different settings. In medical consultations, the specifications of pain quality (location, intensity, time, type of pain), medication, accompanying symptoms, and pain differentiations take center stage. These topics can be classified as *symptom-oriented*.

When patients talk to individuals other than physicians, such as in discussions with a linguist, about their pains, they predominantly address issues related to pain management, the impact of pain on daily life, subjective illness theories, and psychosocial repercussions. (Kreissl et al. 2004). Pain is described in terms of its impact on daily life and not so much in terms of symptomatology and its forms. Patients contextual-

ize their pain within the framework of their everyday lives, presenting it as a sometimes substantial aspect of their life experiences and primarily describing it through their coping mechanisms. They address avoidance strategies they use to prevent the onset pain, identify influences favorable to the (non-)development of the overall pain scenario, and, if the pain has already occurred, discuss coping strategies aimed at achieving a positive impact. These forms of pain display can be summarised as *contextualising*. In non-medical conversations, patients not only discuss pain more extensively but also emphasize different focal points.

From the clinician's point of view, focusing on pain specifications and medication may seem logical. However, for patients this focus is particularly irritating if their main concerns were not (subjectively) sufficiently addressed beforehand or if the purpose of the consultation remains unclear. Lack of alignment with the primary topic and the primary purpose of the conversation are the most significant causes of unsuccessful communication in this area (Blasch et al. 2010: 285). It is therefore important to keep the possibility of different conceptualisations in mind throughout the conversation and, if necessary, to address the alignment of the conversation.

33.5 Aspects of gender in pain displays

„The pain field has moved on from debating whether sex differences in pain exist, to recognizing the importance of these differences" (Greenspan et al. 2007: 27).
"What is especially worrying is that gendered perceptions of pain are prevalent amongst healthcare practitioners influencing assessments and treatments" (Jaworska, Ryan 2018: 109)

Gender-specific differences in treatment and care can arise from both physiological and anatomical factors and the historical presence of gender bias in medicine on different levels. Simultaneously, behavioural roles and strategies for dealing with pain are crucial influencers for treatment and diagnostic variations between men and women (Schopper et al. 2013, Keogh, Boerner 2024). Awareness of the impact of gender facilitates dealing with diverse pain representations from both female and male patients in medical practice.

Pain displays in relation to gender bias allow conclusions to be drawn about differences in treatment, focusing on the behaviour of doctors and patients: On the doctor's side, there are differences in the (communicative) behaviour of doctors that lead to differences in the way pain is treated with medication and surgery. Specifically, women with non-specific pain symptoms are more likely to be asked about psychosocial factors in their medical history and more likely to be diagnosed with non-specific conditions. In contrast, men are more likely to be referred for laboratory tests (Hamberg et al. 2002, Schäfer et al. 2016). So far, comparisons have been conducted within the binary framework of two gender identities, however non-binary approaches to gender may allow a richer exploration of factors in the context of pain and gender (Keogh 2021).

Pain displays show significant gender differences:

- Women use semantically rich concepts and fewer semantic placeholders (“it”, “that”) to refer to pain in medical consultations than men.
- Furthermore, women use significantly more variance to describe their pain compared to men: while men use expression routines more frequently (“having pain” and “hurting”) women's pain displays are more diverse and varied.
- Women use more indefinite adverbs indicating frequency such as 'mostly', 'sometimes', etc. than men, who tend to rely more on absolute modalities like 'always'. This can also be interpreted as indicative of greater differentiation among women. (Blasch et al. 2010).
- While men employ a smaller number of pain-related words in describing pain, the words they use tend to be more emotionally charged. In general, women's expressions of pain exhibit greater variance and diversity compared to those of men. (Jaworska, Ryan 2018, Koegh 2021).

Some medical studies (Penque et al. 1998, Shaw et al. 1994) suggest that due to these different strategies of presenting pain, certain conditions, such as coronary artery disease, are more likely to be overlooked in female patients than in male patients, resulting in a higher mortality rate. As the description of chest pain is a key diagnostic tool for distinguishing dangerous from harmless causes and for taking appropriate (sometimes life-saving) therapeutic measures, verbal pain display is of

crucial importance. Differences in the description of pain can be found in four areas (Menz, Lalouschek 2005, Menz et al. 2002):

Men present themselves as informed and interested in their illness, medication and therapy, elevate the significance of their illness by emphasizing the unique and serious aspects during the experience of pain. They present themselves as coping with pain, expressing interest in addressing the root causes, and providing a highly symptom-oriented and specific description of pain.

In contrast, women primarily emphasize the psychosocial context, tend to downplay their pain, present themselves as enduring pain, which is described in mitigated terms. They are more inclined to delegate the treatment to the institution and provide highly contextualized and tendentially non-symptomatic ("diffuse") descriptions of pain.

The following examples provide an impression of these different modes of presentation.

E 33.3	Typical display of a woman I (62, cause of pain: coronary): "Well it will stop again"
168 P	Yes, but I'm like that: as I said, I'm a: Per:son that which is just hh when you have a bit of pain, you think, well, it'll stop, and then when it stops: … I forget about it. don't I?
169 D	Mhm […]
171 P	Some people go straight to the doctor, but I'd rather: . not go straight away. No?

E 33.4	Typical pain display of a woman II (70, cause of pain: coronary): "I can't say why"
08 D	How is that? Uh, you said you have pain here?
09 P	Yes. that: uh, I do. I want to tell you. he:re. he:re. and it it pulls over there, . it pulls like this and it hurts.
10 D	Mhm …
11 P	You can't really describe it like that: . what it's actually like. it appears . … I also have that when I'm lying down.
12 D	Yes?
13 P	Or walk; … and when I: uh . I have a: . where I live, … I have to walk a bit … uphill . uh is not much … that, uh . and there I often come/ have to . I go to the house, . I can't breathe, . everything hurts, … I throw everything down, . and I have to eng/ ah

		lay in bed right away.
14	D	Mhm
15	P	Or I have to sit down and I have to . I lie there for about an hour, then I feel better again. That happens out of the blue! ... I can't say why:.

Contrasting, typical male pain display is shown below.

E 33.5	Typical pain display of a man (61, cause of pain: coronary): "Started? Actually, completely unexpected."

40	D	What was it like with the pain?
41	P	Started? . Actually completely unexpected.
42	D	Yes?
43	p	In the night from Sunday to Mo:nday, as I said... point of time around one twenty in the morning: . with sudden onset of cold=sweats ... headache, vomiting, diarrhea, dizziness . and a pressure in the . chest which became a real feeling of fear.

While the man's pain description is specific and symptom-oriented, responding to the very open-ended question "How was it with the pain?" (line 40) with detailed information about the onset of symptoms and the quality of pain, the woman in Transcript 33.4 refers to the difficulty of describing the pain (line 11). She uses her journey home as an example for the description (lines 13-15), but does provide details about timing or quality of the pain, emphasizing not so much coping but enduring ("I have to lie down," "I have to sit down") the pain.

The man's statement that the pain turned into a "real feeling of fear" elevates the intensity of the pain and adds urgency to his description. In complete contrast, the description by the female patient in Transcript E 33.3 downplays both the urgency and intensity of her pain ("will stop again", "when you have a bit of pain" line 168).

These examples clearly illustrate that the men´s descriptions are more "medical oriented", aligning more closely with the expectations of doctors. This has historical roots, as heart attack diagnoses were developed based on men and for men. Consequently, their representation proves to be "normal" and expected, while women's representations deviate from the expectations of physicians.

Box 33.2 Gendered pain descriptions

Due to the different forms of pain display, men's descriptions of pain are perceived as more precise, informative and cooperative. Women's presentations do not meet the doctors' expectations.
This leads, on the one hand, to frustration and, on the other hand, to communication problems that can extend to incorrect or delayed diagnoses. Since women tend to downplay their pain and delegate the illness narrative to the physicians (downgrading), it is incumbent upon the doctors to elevate these patients and their pain through appropriate cues, thus upgrading their status once again.

33.6 Older adults expressing pain

Communication in old age is characterised by peculiarities on different levels. Differences can be observed in the subjects discussed, in communicative patterns, as well as in the acts of speaking and listening/understanding (Fiehler 2003). Taking these particularities into account in the medical context, especially concerning pain communication, is an essential task for physicians to ensure appropriate pain treatment for older patients. The most obvious peculiarity is that although older patients provide a great deal of information about the location, timing and intensity of pain, they rarely discuss the side effects of medication, physical activity or weight loss. However, this information is often important for treatment. Therefore, it is of great importance to pay even closer attention to obtaining additional characteristic information through open questions and targeted follow-up questions which facilitates treatment.

The influence of the questioning technique on the information provided about pain is undisputed: Open-ended questions from physicians elicit significantly more information from patients, and in particular, an open-ended question at the beginning elicits pain information that a closed-ended question at the beginning would not elicit, even with additional follow-up questions (McDonald et al. 2009).

Clarke et al. (2012) further suggest alternative approaches to elicit verbal accounts, such as using similes and metaphors and contextualising the effects of pain on activities that are relevant to patients.

33.7 Strategies and tasks for physicians to facilitate pain communication

Patients have a diverse verbal and multimodal repertoire to describe their pain. However, as this is not always easily accessible (especially within medical institutions, cf. § 33.4), clinicians can utilise different tools to make patients' descriptions of their pain accessible and productive for diagnosis. Some of these are reviewed in § 33.7.1. § 33.7.2 concludes with general recommendations for specific communication with pain patients.

33.7.1 Assessment instruments and visual support for verbal pain communication

One of the most widely used standardised pain assessment instruments is the McGill Pain Questionnaire, which was proposed by Melzack (1975) and has since been modified several times. The questionnaire is divided into four pain criteria, including sensory, affective, evaluative and mixed quality of pain. Each category contains suggestions for describing the pain, using mainly metaphorical expressions. The following table from Reisigl (2010: 81f) can be used as a suggestion for a differentiated description or questioning of pain.

Sensory qualities				
Group 1	**Group 2**	**Group 3**	**Group 4**	**Group 5**
• *flickering*	• *jumping*	• *pricking*	• *sharp*	• *pinching*
• *quivering*	• *flashing*	• *boring*	• *cutting*	• *pressing*
• *pulsing*	• *shooting*	• *drilling*	• *lacerating*	• *gnawing*
• *throbbing*		• *stabbing*		• *cramping*
• *beating*		• *lancinating*		• *crushing*
• *pounding*				
Group 6	**Group 7**	**Group 8**	**Group 9**	**Group 10**
• *tugging*	• *hot*	• *tingling*	• *dull*	• *tender*
• *pulling*	• *burning*	• *itchy*	• *sore*	• *taut*
• *wrenching*	• *scalding*	• *smarting*	• *hurting*	• *rasping*
	• *searing*	• *stinging*	• *aching*	• *splitting*
			• *heavy*	
Affective qualities				
Group 11	**Group 12**	**Group 13**	**Group 14**	**Group 15**
• *tiring*	• *sickening*	• *fearful*	• *punishing*	• *wretched*
• *exhausting*	• *suffocating*	• *frightful*	• *grueling*	• *blinding*
		• *terrifying*	• *cruel*	
			• *vicious*	
			• *killing*	
Evaluative and miscellaneous qualities				
Gruppe 16	**Gruppe 17**	**Gruppe 18**	**Gruppe 19**	**Gruppe 20**
• *annoying*	• *spreading*	• *tight*	• *cool*	• *nagging*
• *troublesome*	• *radiating*	• *numb*	• *cold*	• *nauseating*
• *miserable*	• *penetrating*	• *squeezing*	• *freezing*	• *agonizing*
• *intense*	• *piercing*	• *drawing*		• *dreadful*
• *unbearable*		• *tearing*		• *torturing*

Tab. 33.1: McGill Pain Questionnaire (Melzack 1975) as seen in Reisigl (2010)

The Brief Pain Inventory Short Form (BPI-SF) pain measure has a similar purpose. It consists of 15 questions focusing on pain quality, location and intensity, including previous treatment and pain-related functional limitations in psyche and daily life (McDonald 2011).

Pain scales are used in many different forms, including numerical scales (where patients verbally choose a numerical value to represent their pain on a given scale), descriptive scales (which work similarly to numerical scales, but use verbal descriptions of intensity instead of numerical values), and visual analogue scales (which follow the princi-

ples of the above scales, but are physically presented to the patient and the pain is indicated by the patient on the scale (Menz 2016).

Analogue or digital *pain manikins* (pain drawings or pain body maps) serve similar purposes: patients can shade or select painful areas to locate and specify pain. Pain manikins are a valid tool for pain assessment with high potential regarding accessibility to people with lower literacy levels and/or limited language proficiency (Ali et al. 2023).

For patients with chronic conditions, a *pain diary* is a useful tool for describing pain. In this diary, patients should document their perception of pain, medication, pain-relieving measures, etc. at different times of the day. This allows the patient to be an active participant in the treatment process, provides the clinician with important information that may not be obtained in this way during a consultation, and can be referred to during the consultation.

Pain tracker apps on smartphones or wearable technologies are widely accepted by patients and health professionals. As long as they provide the ability to add qualifying comments, they can assist professionals and patients in documenting and understanding their symptoms (Kenning 2024).

In addition to analogue *questionnaires*, computer-based tools are widely used in pain management: virtual *'training doctors'* are designed to prepare older people with pain for face-to-face consultations and enable them to prepare for questions from doctors in advance. The results of this pilot study show that the use of these virtual “practice doctors” in combination with informational videos about the disease and its course has a positive effect on consultations: significantly more relevant information about pain quality and pain experience is given when patients are prepared for the consultation by a virtual “practice doctor” in advance (McDonald et al. 2011).

Artificial intelligence (AI) and machine learning (ML) are currently employed in pain research in different contexts to enhance pain assessment and management. AI-facilitated advancements in optimizing pain communication, especially for patients with limited verbal communication skills, show potential (Walter et al. 2020), provided they can encompass the (cultural, gender, and age-related) spectrum of pain displays.

Exploratory studies focusing on the interpretation of visuals, gestures, and paralanguage to assess patients' pain hold promise for the future of multimodal pain research (Zhang et al. 2023, Lötsch and Ultsch 2018).

However, current machine learning applications in pain research have predominantly centered on the utilization and evaluation of clinical notes, rather than focusing on verbal pain representation.

33.7.2 Conversation design in interaction with pain patients

Conversations between doctors and patients with pain have a significantly different structure and focus than conversations with patients without pain. Doctors spend more time taking the patient's history and discussing diagnostic and therapeutic implications, while areas such as prevention are neglected. In conversations with pain patients, doctors also make fewer attempts to actively involve patients in the interaction, for example by asking fewer questions (Bertakis et al. 2003). If patients are not asked directly to talk about their pain, they face multiple interactional dilemmas. Patients use different sequential, grammatical, and prosodic strategies to present their pain display as something the doctor asked for, and thus as accountably motivated by a virtual solicitation (McArthur 2018).

The distribution of speaking time, similar to other consultations, is unevenly balanced in conversations about pain. In these discussions, physicians predominantly occupy the majority of speaking time and interrupt patients when they provide information or ask questions. Moreover, a noticeably higher number of closed-ended questions are posed, adversely affecting comprehensive information exchange (McDonald et al. 2009).

This style of communication contradicts the needs of pain patients. They, in fact, have a strong desire for open communication and discussion about further treatment, ranking patient involvement as highly important (Farin et al. 2012).

The sense of being taken seriously holds great significance and is often the primary concern in pain communication. If patients perceive a lack of seriousness in how their pain is acknowledged and encounter disenfranchising talk, it has long-term effects on patient´s agency and influence their expectations for future interactions with their healthcare provider (Hintz 2023). The second most important factor is an adequate explanation of the pain and its consequences by health care professionals (Laerum et al. 2006). More knowledge on the part of the patient ultimately leads to a more active form of coping with the illness (Kreissl et al. 2004).

These results show that there is great potential for improvement in pain communication. It is therefore very important to integrate the findings of discourse analytic and linguistic analysis into everyday medical practice, especially in differential diagnostic procedures, because *"[w]hen pain symptoms appear elusive, imprecise, and multifaceted, it makes sense to focus not only on the described—and, indeed, persistently obscure—pain phenomena themselves but also on the manner of the description. At times, this obscure quality may reveal itself as the truly relevant information."* (Gülich et al. 2003: 234, translated by Regina Geisler-Knünz).

33.8 Further information

One of the earliest linguistic studies of the description of pain was Ehlich's (1985) work on the "Language of pain" which provided a profound, mainly theoretical, insight into the language of pain.

The concise and descriptive article "Pain Talk: The Expression of Suffering in the Medical Consultation" (Heath, 1989) is also crucial for the linguistic, sociological and psychological exploration of pain communication.

The grammatical-semantic level of pain expressions is the focus of the primarily linguistically relevant work "Sprache des Schmerzes - Sprechen über Schmerzen" (Overlach 2008). "On the grammar of pain" by Halliday (1998) investigates the grammar of pain in modern English.

The anthology "Sprechen über Schmerzen" (Menz et al. 2010) is equally relevant for both physicians and linguists: qualitative linguistic analyses of authentic conversations are combined with medical, cultural and semiotic perspectives and presented in a holistic context.

In their article "The multimodality and temporality of pain displays", Weatherall et al. (2021) provide an interdisciplinary overview of communication about pain in the medical setting and show the broad spectrum of pain displays.

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Further references on doctor-patient communication can be found in other topic-specific chapters and in the complete bibliography of the handbook.

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