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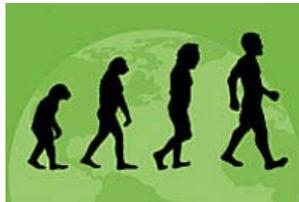
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The Ways We Talk About Pain

By Krystal D'Costa | September 27, 2011 | 1

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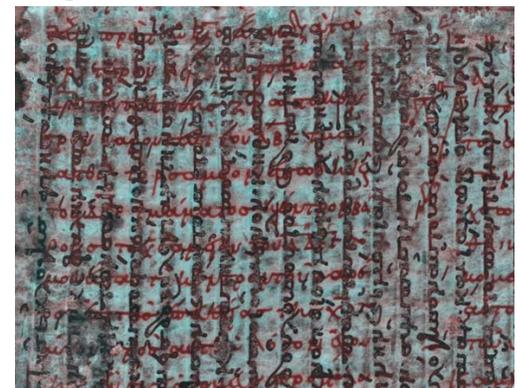
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Archimedes sent a fax to XXI century

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Excerpts from the Personal Journal of Krystal D'Costa [i]

Tuesday:

I fell. Again. This time it was while getting out of the car. I'm not sure how I managed it. I got my foot caught on the door jamb and tumbled forward. I hit my shin—hard—against the door jamb and I think I tweaked my ankle in the process. S hurried around to my side of the car to help me up. He pulled me to

my feet and asked, "Are you okay?" I'm not—but the truth is I feel like a total fool. Who falls getting out of the car? I told him I was fine and I hobbled into the house.

I'm going to bed.

Wednesday:

Morning – I woke up with some soreness, and there's a large bruise on my shin, but I think I can hide that with some concealer. The ankle feels okay, but I think I'll pass on the heels today. I still feel pretty silly about how I fell—glad I won't have to tell this story to anyone.

Afternoon – My shin hurts, and I think the ankle is swelling. Will take a closer look when I get home.

Evening – I walked home from the train this evening. Boy, was that a brilliant move: my ankle is four times its normal size. What did I do to myself?

I sent S a text message with a picture of the ankle. I made an ice pack using a Ziploc bag, crushed ice, and one of his old socks (to hold the thing in place). And now I'm sitting here with it on the coffee table. The shin hurts too.

Thursday:

Afternoon – I wrapped the ankle and went to work. I felt silly explaining to people how I hurt it. But I think there's something wrong with the shin—the bruise is growing, and it hurts like hell. Maybe I should see a doctor?

Evening – MRI reveals I have a bone bruise! Apparently, I was lucky not to break my tibia—did I really hit the bone that hard? Anyway, a bone bruise is a step below a fracture, and there's nothing to do but RICE it. Hopefully, I'll be able to walk on Saturday—though the doctor told me I have to take it easy. Right. He actually said, "You're moving faster than your body can. Slow down. Let your feet catch up to your brain."

Friday:

Thank goodness for casual Friday—saved me from having to explain why the shin is wrapped now instead of the ankle. Though I told a few people—the ones least likely to laugh, the ones who've noticed the limp.

Sunday:

Holy hell. What was I thinking yesterday? I can't move today. My shin hurts like nothing I've ever felt.

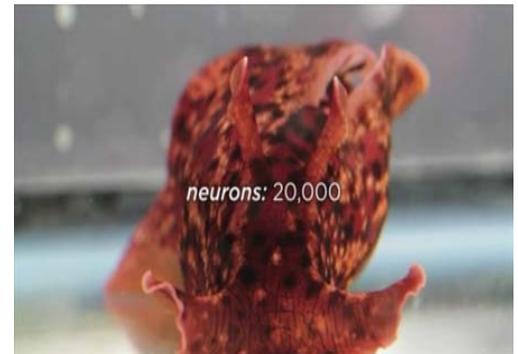
Monday:

Home from work today. Probably for the best. But at least the time isn't wasted—I have writing to do.

Tuesday:

Back to work today. Hid the bandages under tights, but this won't work tomorrow; it's just too warm. Getting ready to explain the new bandages. Gosh, I feel foolish. When are these bruises going to fade?

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Friday:

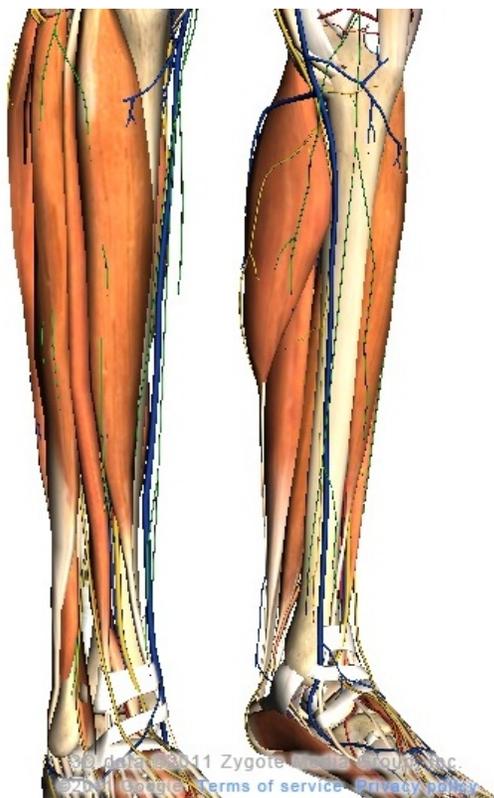
It's raining today—been raining all week, and my leg hurts like crazy. It's probably the weather so I'm trying not to complain too much. I've kept up the RICE regimen and the bone itself feels better. There's new swelling though, so I might need to have it looked at again.

Monday:

New diagnosis—hematoma near the shin. FML. Mandatory slow down – will need to be off of my feet until further notice. Well, at least it'll have time to heal.

On the Mend

Bone bruises can take a really long time to heal. The tibia is the strongest bone in the body—which is apparently fortunate for me, but it's also the least protected by surrounding muscle and tissue. I'm pleased to say I'm definitely on the mend: the pain in my shin is there, but it's not off the charts (I can get by with ibuprofen when I need it) and the bruises are fading. The ankle is still a bit swollen, but I've been resting it as much as I can, and my regimen of RICE (rest, ice, compression, elevate) is pretty well set. The complication of the hematoma means I have to be off of my feet for a bit, but it could be worse. The leg, after all, is not fractured or too worse for the wear because I felt like a fool and pretended it was okay.



Anatomy of the shin, captured from BodyBrowser.

The experience forced me to think about **our relationship to pain**—not chronic pain, but acute experiences: **how much of it we think we're allowed to feel, how much of it that we express, and how we're supposed to respond when we're hurt**. None of us are immune to physical pain. At the very least, we've all likely stubbed a toe or scraped a knee at some point. Some of us have broken bones. And we've probably had some degree of headache. However, for each of these scenarios there is a particular response. If you stub your toe, for example, and behave as though you've broken your leg, you'll likely be met with skepticism about the magnitude of pain you claim to feel. And if you persistently do this, your reputation may lead toward dramatic or hyperbole.

- **How do we learn these measured responses?**
- **How do we learn to talk about and share experiences of physical pain?**
- **Why might we be reluctant to share that we're hurt?**

Establishing a Standard

Medical professionals use a numbered scale of zero to ten to help patients express the degree of pain they are experiencing. Zero is a pain-free state, and 10 represents the most excruciating pain imaginable. One, two, and three are “bearable”; four, five, and six are “moderate”; seven, eight, or nine are “severe” levels; and ten is unbearable. Within each group, there are higher and lower ends of the spectrum. But it’s entirely possible for one person’s bearable to be another’s moderate or even severe. How are these quantitative measures defined? And do they account for the emotional elements of pain?

The [Diagnostic and Statistical Manual of Mental Disorders](#), which helps mental health professionals apply a standard diagnosis to patients, identifies the following criteria for pain disorder as follows:

- Pain in one or more anatomical sites is the predominant focus of the clinical presentation and is of sufficient severity to warrant clinical attention.
- The pain causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- Psychological factors are judged to have an important role in the onset, severity, exacerbation, or maintenance of the pain.
- The symptom or deficit is not intentionally produced or feigned.
- The pain is not better accounted for by a mood, anxiety, or psychotic disorder and does not meet criteria for dyspareunia.

Pain disorders are chronic and the pain associated with them must be severe. The criteria for diagnosis can help us understand views concerning pain, and how the patient might report incidences of pain. Note that for pain to be considered severe it must cause distress and impairment, and it is falls to the patient to demonstrate that the pain is not fictionalized—which is particularly important as pain sometimes does not have a physical counterpart. The injured must be sufficiently convincing. How do we learn how to share this information?

It's Okay to Cry—If You Aren't Tall Enough to Ride the Rollercoaster



The ways children come to understand concepts of illness can shed light on how children come to understand and measure pain. Pain exists—I’m not suggesting that children have to learn to create notions of pain, but that they learn appropriate responses via their interactions with others,



Alternative playground surfaces are meant to reduce chances of serious injury.

who help them identify sensations that are out of the ordinary and require attention. [ii] For example, when a child falls down, after assessing the situation adults may tell the child “You’re okay.” This reassures the child that the experience is minor and the bump or bruise can be tolerated—no additional extra care is necessary. Over time, children learn that some sensations of discomfort are part of our normal everyday existence. [iii]

But not all discomfort should be tolerated. Pain, after all, alerts us that something is wrong. Adults teach children when it is appropriate to express larger displays of pain by what behaviors they allow depending on the context. A child who fusses over a bump may be told repeatedly that he is okay, and his complaints may be ignored or told he is exaggerating. Adults have a sense for *how much* the bump should hurt and work to transfer this reference to their children. The amount of care an injury requires relays the significance of that injury. There comes a time when you can’t cry because you aren’t tall enough to ride the roller coaster—you have to accept it as a part of the reality at the moment and move on.

The Body as Object

The learning process also places distance between the experience and isolates the discomforting sensation. Distance and isolation help pain become a part of the “everyday”—remember, we aren’t discussing chronic pain here, but acute experiences that don’t create long-term impairments. However, when the pain is more extreme and requires more care, distance and isolation help focus attention to the location of the discomfort. Children will talk about pain in terms of the whole experience. For example, if you ask a young child “Where have you hurt yourself?”, the child is likely to place the pain in context. The response might be “On the swing” or “In the sandbox,” rather than by identifying an elbow or a knee that is injured. [iv]

The injury becomes a social event. Children view themselves as subjects integrated into the world at large—they can be acted upon by their environment. Adults tend to objectify the body by emphasizing the somatic experience rather than the context of the event. Medical anthropologist Arthur Kleinman suggests the former is more in keeping with how we experience pain:

However complicated to articulate and difficult to interpret, the patient’s experience of pain is lived as a whole. Perception, experience, and coping run into each other and are lived as a unified experience. When reconstituted as a medical problem, however, the experience is fragmented into a series of dichotomies that represent the deep cultural logic of biomedicine. Physiological, psychological; body, soul; mind, body; subjective, objective; real, unreal; natural, artificial – these dichotomies, so deeply rooted in the Western world and its profession of medicine, are at the heart of the struggle between chronic pain patients and their care givers over the definition of the problem and the search for effective treatment. [v]

Effective treatment is one of the reasons we have to learn how to categorize pain so

that others can understand it. Children may not accurately report the nature or extent of what they feel. If they view the incident as part of the everyday, they might not report it at all, which impacts treatment and care. But part of the way we categorize pain is via the physical manifestation of the injury.^[vi] With this foundation, a sprained ankle later in life that does not display extreme bruising may not be regarded as severe by the injured individual or his friends and family—though that might not be the case. The physical appearance of the injury may cause the injured to delay treatment because he has been taught that there is a particular response to this scenario.

Social Survival



Note: My leg isn't broken—though it's sort of neat that the name on the cast is Krystal.

Reporting an injury and expressing pain becomes a complex social endeavor. The injured has to be sure she is accurately representing the experience—and in my case, since I tend to fall fairly often, there's another layer that I need to consider. Pain is not limited to the individual—it affects everyone around the afflicted, from family to friends to coworkers to strangers who might feel compelled to offer a seat in the face of a visible injury. When I'm injured, greater burdens are placed on people around me, who will all work to help me manage my pain whether that means that S is doing more around the house so that I can stay off of my feet or altering his schedule to take me to the

doctor or that friends have to walk more slowly when we're together—these are all ways that my pain becomes a social, shared experience.

This creates another reason to suspect reports of pain: pain can be used to manipulate social situations. Kleinman refers to this as “pain games:” it can be leveraged to control others, justify dependency, avoid work and social obligations, gain attention, punish others, and avoid relationships others.^[vii] If I'm not really hurt and I'm faking it, then the others are making unnecessary accommodations—and even if I'm not faking, repeated instances of being injured can be tiresome to even the most amiable caregiver. There's pressure to heal and be an active, productive member of society—which might also translate into pressure to feign normalcy and minimize pain.

Survival of the Fittest?

I've gotten over feeling like a fool about falling—it happens. I didn't hurl myself out of the car intent on getting a bone bruise. What I do feel foolish about is delaying treatment for as long as I did because I probably extended the recovery period by not getting help. But I also felt that I had to minimize the injury because I've been hurt badly before, requiring extended and extensive care from my network.

Sharing my experience with some friends recently, they seemed to understand my

reluctance—in the wild, they reminded me [viii], the weaker animals get picked off by predators or abandoned by the herd in many cases. While, exaggerations of acute experiences may eventually lead to isolation, we shouldn't hesitate to get the help we need. New advances in medicine may minimize the doubt of the subjective experience. A recent [PLoS paper](#) discusses the ways neuroimaging may help physicians understand patients' experiences of pain. [ix]

As for me, I'll be off of my feet for a few days, but there are no lions in the neighborhood, so I should be safe.

Thanks due to Kyle West for reference suggestions.

Notes:

[i] These events are true—though I don't actually keep a journal. | [ii] , [iii] Christensen 1999: 41. | [iv] Christensen 1999: 49. | [v] Kleinman et. al. 1984: 8. | [vi] Kleinman et. al. 1984: 50. | [vii] Kleinman et. al. 1984: 11. | [viii] Dave Mosher, Kendra Snyder, and Hannah Waters get credit for the “life in the wild” example. | [ix] Brown et. al. 2011.

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1. Hasufin

9:34 pm 09/27/2011

I'm gonna leave this here: <http://xkcd.com/883/>

Now, let me share a few stories of pain, for perspective purposes

First, let me tell you how I injured my wrist. I like swordfighting – fencing, SCA-style, shortswords, you name it. About ten years ago, I was going to a regular weekend group which engaged in SCA-style swordfighting at a local park. I had started to feel some strain in my wrist, and so decided it was a good idea to take a break. While resting, a newbie approached me with a “genius” idea for why what he'd seen the more experience folks doing was totally wrong, and he wanted to show me. So, I figured, sure, I wouldn't break a sweat showing him why he was wrong. I picked up my weapon again and we went at it. I was right in my assessment of skill levels – but I made a very wrong decision that day. The slight strain became a burning feeling that didn't go away. The next day, I found I couldn't pick up even lightweight items using that hand without feeling pain. I didn't have medical insurance at the time, but as far as I can tell I strained the tendons in that wrist. It took years of RICE, wrapping, controlled weight training, and patience, but today I can use that hand without (significant) pain. The Marines say “pain is weakness leaving the body”, but really it's the body say “stop doing that, dumbass.”

You'd THINK that sort of warning would sink in, but no. I'm kinda dumb that way. In fencing, one of the more unlikely-seeming strains one puts on the body is on the plantar fascia, a tendon that runs the length of the bottom of the foot. You might feel it stretch if your foot slips on loose gravel. In college, I was particularly known for a move that puts EXCEPTIONAL strain on that tendon. I can't point to any one incident that caused the damage, but it has taken its toll; I still fence, but on bad days I have significant pain in my leading foot. On really bad days, it's serious enough that I simply don't want to stand up because it hurts so badly. The fix for this is extremely expensive (and not covered by my insurance, of course) orthotic inserts for my shoes. Since it's not all the time, I simply use a cane on those rare bad days when it's necessary. But, what you might find interesting is, I make a point of concealing, even from my girlfriend, the days when I need the cane. Sometimes I grit my teeth and tough it out; other days I just try to arrange to not need to stand or walk much when

other people are around. The reasoning is subtly different than in your case. I don't want to worry those around me. My girlfriend, and my other friends, know I have this problem but I don't want it to be a part of their lives. It's something I want to deal with personally and without anyone else being involved.

Thirdly, I do have medical problems that *aren't* related to fencing – go figure! I have chronic headaches. Yes, you're not talking about chronic pains, but it's semi-relevant. I'm often reluctant to talk about these headaches, for a number of reasons. You see, I mention "chronic headaches" and to most people this means "migraines". And on comes the sympathy: we all know migraines are so horrible, and how do I manage? But... they're not like that. They're mild. The kind of headache that maybe you pop a tylenol to treat. Except, well, I'm resistant to acetaminophin. And aspirin. And codeine. You get the picture. But, regardless, these aren't serious headaches unto themselves. They became an issue in September of '09, when I realized the last time I'd gone a day without a headache was in '08. Early '08. I didn't talk about them, because they were just minor headaches. But after a year, a minor symptom becomes an issue. And there was a quality of life issue – imagine trying to get a good night's sleep when you ALWAYS have a headache. And how mornings feel when everyone starts with dull, aching pain. I saw a doctor. He tried a couple of drugs, ran some tests, nothing worked. He sent me to a neurologist. That's when I learned that sometimes people "just have headaches" like this. She was sympathetic. We ran tests (on the plus side, I can prove to my detractors that I DO SO have a brain, and I have pictures to prove it!). We have yet to find a cause. There's nothing in any medical test that even suggests I have this problem. But, believe it or not, that's normal. I'm currently taking a neuralgic pain inhibitor, and so long as I keep up my doses, I'm okay. But treatment is a far cry from cure; even my friends frequently labor under the misapprehension that this problem is "fixed". If I miss a few doses of my drugs, the pain comes back. And it's not a drug that I can pop and feel better in an hour, no, it takes days to build back up. Mostly I don't talk about it, though – I don't want to worry anyone.

For contrast, I have a friend who, due to her own neurological issues, does in fact suffer from migraines quite frequently. I'm not in her head, but they seem to be of the more traditional, debilitating sort. Her response to them is sometimes to talk about them, but more often than not to try to go in to work anyway, because staying home and taking sick leave puts a strain on her co-workers – plus she always runs out of sick days before the end of the year. One cannot express how much this worries her daughter.

What I find interesting in all of these is that the more responsibilities we have, the more we're expected to help

others – and, admittedly, the more pride we have – the more likely we are to ignore or understate the pain we're feeling, often to our own detriment.

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