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Discourse

Relieving Pain: What's in a Name?

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Several years ago I had a conversation with Leora Kuttner, child clinical psychologist and author of the seminal works *The Child in Pain* (Kuttner, 1996) and *No Fears, No Tears: Children Coping with Cancer* (Kuttner, 1986). This conversation changed my thinking and the way I speak about what it is that we do as clinicians to help people in pain. During our conversation, Dr. Kuttner challenged my use of the term "non-pharmacological" when referring to cognitive and behavioural interventions to relieve pain. She said the term indicated a bias towards pharmacological interventions and implied that cognitive and behavioural interventions were inferior.

Since that conversation, I have tried to be meticulous in my choice of words when describing interventions to relieve pain in infants and children. Although the language becomes cumbersome at times, I have tried to avoid the term "non-pharmacological" when I really mean behavioural and environmental interventions. I try to avoid implying that pharmacological interventions are the gold standard for pain relief and that we must choose one kind of intervention over the other. I have argued that environmental and behavioural strategies provide the foundational substrate for neonatal pain management to which pharmacological therapy is additive or synergistic (Franck & Lawhon, 1998).

The Pain Name Game

Nevertheless, I must confess that I am still plagued by the issue of how to describe pain-alleviating interventions that do not involve administration of a drug. Recently, my colleagues and I collaborated on a research project to test the efficacy and safety of three such interventions for preterm newborn infants undergoing painful procedures:

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(a) a pacifier dipped in water (non-nutritive sucking), (b) a pacifier dipped in a 24% sucrose solution, and (c) prone positioning. My inclination was to categorize these interventions as "comfort measures" as they were intended to provide comfort during the painful event. However, during the research I received comments from nursing and medical colleagues that the term "comfort" did not sound as if it would be very effective in relieving *true pain*, nor did it suggest the need for a qualified health-care provider to administer these interventions. We could have labelled the interventions "analgesic," which would have fitted logically with our theoretical model and hypothesis — that these interventions alter pain transmission patterns and pain responses. However, I received feedback from clinical colleagues that the term implied a pharmacological effect and therefore, to avoid confusion, should not be used when describing other types of interventions. This view was corroborated by the Oxford English dictionary (Pearsall & Hanks, 1998), which defines analgesia as "medication that acts to relieve pain," although adding that the word originates from the Greek term for "painlessness."

An informal poll of clinicians further revealed that the term "pain-alleviating interventions" was too benign and the terms "anti-nociceptive" and "anti-algic" too esoteric. Further browsing through the dictionary revealed that the words "alleviating" and "relieving" can be used interchangeably, as both refer to the lessening of pain severity but, importantly, imply that pain is not completely prevented, only reduced. "Ameliorating" is defined as making a bad thing better and "control" is defined as limiting or regulating. However, when either word is coupled with the word "pain" it still leaves unanswered the question of whether or not complete absence of pain is possible or intended. Thus our use of these terms may reveal a bias that pain cannot (or should not) be eliminated. Why are terms such as "pain elimination" and "pain prevention" not more commonly used, especially as advances in pain treatment have made complete pain relief a possibility, if not a reality?

The Semantic Legacy of Pain

Our ambivalence and uncertainty over the centuries regarding the nature and meaning of pain as an entity have received much attention (for reviews, see Caton, 1994; Pernick, 1985; Scarry, 1985). Essays by scholars and clinicians in a recent issue of the journal *Pain Forum* (*8*[2], 1999) eloquently highlight some of the historical and current biases that impede a common definition of pain. The essays focus our attention on the clinical and ethical implications for populations who cannot com-

municate their pain through language, such as newborn infants. However, although they highlight how the definition of pain influences pain treatment and research, all of the references to pain treatment are specific to pharmacological methods alone (Anand, Rovnaghi, Walden, & Churchill, 1999; Kopelman, 1999; Rollin, 1999). The omission in the debate of any mention of the myriad pain treatments that do not involve the use of medication is, I believe, revealing of pharmacological idolatry in the field of pain.

The late John Liebeskind, who has contributed so much to our scientific and human understanding of pain, proposes that ethical problems and mismanagement of pain often derive from semantic problems and that convenient terms such as "pain stimulus" and "pain response" can be misleading. He states: "We may study nociception in vitro by recording from the frog's isolated sciatic nerve. However, if there is pain anywhere in the situation, it is not in the dish but in the garbage pail with the frog!" (Liebeskind, 1991). He and others (e.g., Cassell, 1982; Sullivan, 1995) caution against the tendency to categorize pain as having a psychological or physical origin, reminding us that all pain is "indivisibly a psychobiologcal unity." These authors warn that the dualistic mind/body categorization of pain leads clinicians to either ignore important psychological aspects of pain or over-emphasize them to the exclusion of important somatic aspects.

Where Is Nursing?

From a philosophical and theoretical perspective, nursing has purposefully avoided reducing the phenomenon of pain to a physical or psychological state. Instead, nurse scholars have sought to explicate the broader and more inclusive term "suffering" (Kahn & Steeves, 1986; Lisson, 1987) and to highlight the implications of the social concept of pain and suffering for particularly vulnerable patient groups such as newborn infants (e.g., Franck, 1997). Professional groups such as the American Nurses Association [ANA] (1985) specifically address the rights of patients and the responsibilities of nurses in the alleviation of suffering. Nevertheless, as much as we pride ourselves on our avoidance of the dualistic mind/body trap, with respect to pain treatment our professional literature reflects the physical/psychological dualism and the pharmacological idolatry in the field of pain. Close inspection of the nursing literature reveals the predominance of pharmacological interventions for pain management. In fact, a CINAHL search of the key words "pain" and "management," "treatment," "interventions," "relief," "reduction," "control," and "therapy" yielded no mapping to

subject headings other than analgesics or drug therapy (curiously, "pain relief" yielded a link to a subheading of electrical stimulation). It is an interesting commentary that the very pain interventions that in large part are under the autonomous control of nursing receive the least attention in the nursing literature.

Several statements by nursing regulatory bodies further illustrate that, despite the rhetoric about holistic nursing, pharmacological management of pain explains the dominance of medication-focused nursing literature, rather than cognitive, behavioural, or environmental interventions. For example, the ANA (1992) Position Statement on Promotion of Comfort and Relief of Pain in Dying Patients focuses almost exclusively on the use of medications. Furthermore, the California Board of Registered Nurses (1994) Pain Management Policy refers briefly to non-drug interventions to "assist in pain alleviation" following an extensive discussion of pharmacological management. Neither of these documents mentions the nurse's independent role in implementing interventions to treat pain. A recent issue of the *Annual Review of Nursing Research* (17, 1999) summarizes and critiques the literature on interventions such as guided imagery and music therapy for the treatment of pain. However, few conclusions about the efficacy of these treatments could be drawn because there were so few studies and many lacked adequate design and outcome measures to provide meaningful conclusions.

One may argue that the controversy regarding the nurse's role in pharmacological management is the impetus behind documents such as these. I would argue that the controversy reveals our own biases with regard to the hierarchy of pain-alleviation strategies. Furthermore, the lack of attention to interventions other than medication has implications for our management of other symptoms experienced by patients. The use of a pharmacological reference point (as in the term "complementary therapies") and the use of pejorative or minimizing terms (such as "alternative" or "adjunctive" treatment) reveal biases and consequences similar to those seen in the treatment of pain.

Invisible Interventions

Most revealing of our bias towards the pharmacological gold standard for pain relief is the lack of documentation of pain-relieving interventions other than analgesics in the patient's medical record. Across all patient populations and settings, one can find a consistent and conspicuous absence of documentation regarding nursing interventions that provide physical, psychological, emotional, social, or spiritual comfort

for patients in pain. This failure to accurately document the full range of patient-care interventions can be explained and condoned only if the prevailing view is that these strategies are unimportant and harmless. This assumption is in stark contrast to how pharmacological interventions are viewed: a nurse's failure to document medications administered to relieve pain is considered negligent and could result in disciplinary action. In many settings, there is not even a designated area in the nursing record for adequate documentation of pain-relieving interventions other than medications.

What does this practice indicate to the patient and to other professionals about the value we place on non-drug interventions? Does it indicate that we believe these measures are ineffective, incidental, and not worthy of notation? At the very least, the lack of adequate documentation by nurses and other health professionals on the full range of interventions implemented for pain inhibits the advancement of the science of pain. This omission fails to make explicit important interventions that may have main effects as well as interactions with the pain interventions under investigation. How many clinical drug trials of analgesics are erroneous in their conclusions because of failure to account for a systematic bias in the application of physical, psychological, emotional, spiritual, or social interventions by nurses or the patients themselves? These interventions may wholly or partially explain the changes observed after drug treatment but were not accounted for because they were not deemed important enough to document or control for in the study design and methods.

Speaking Plainly About Pain for Everyone's Gain

Perhaps the way forward is to simply try to adhere to the adage "say what you mean and mean what you say." For example, when we mean that we intend to eliminate an infant's pain by physical manipulation of the infant's position or activation of the suck reflex, we should label these interventions what they are, physical pain treatments. When we intervene to alter a person's cognitive interpretation of a painful event or their emotive response to a painful stimulus, we should label these interventions specifically as cognitive or emotional pain treatment. Where the physiological mechanism of action of the intervention is understood (i.e., many cognitive and distraction techniques activate attentional and arousal systems [Bushnell, Duncan, & Dubner, 1985; Miron, Duncan, & Bushnell, 1989]), perhaps a mechanistic term such as "anti-algic" should be used. As Sidani and Stevens suggest in their methodological paper on placebo and placebo effects (in this volume),

clear understanding of the underlying mechanism of an intervention minimizes the misapplication of terms such as "placebo."

We should emphatically avoid terms that imply the qualifications necessary to implement an intervention, such as "medical intervention" or "nursing intervention." Perhaps "comfort" is too generic a term, one that will always imply an intervention of limited value that can be attempted by any kindly lay person. We should also be more cognizant of the implied defeatism in such terms as "alleviating," "ameliorating," and "relieving" pain, as they suggest an incomplete redress. We should more positively suggest we are treating to achieve pain prevention or pain elimination.

However we resolve the semantic dilemma regarding pain and interventions to treat pain for the present, we can be guaranteed that the issue will surface again in the future. We must acknowledge that the language of pain, like the experience of pain, has a high degree of plasticity. The terms we use to describe pain will evolve over time to reflect the social and scientific conceptions of cultural groups at any specific point, with acknowledgement of historical ways of thinking. However, we must strive to continually make these conceptions explicit, so that the assumptions will be instructive and not simply a source of bias.

Lastly, the slogan "make pain visible" has been the hallmark of education and intervention related to pain for the past decade (Max, 1990). Nurses would do well to take on this slogan with respect to pain interventions so that pharmacological interventions do not dominate the literature and the consciousness of clinicians and patients alike. Only by making the complete range of pain interventions performed by nurses more visible will we achieve an adequate undertanding of the efficacy and mechanisms of pain relief.

I am grateful for Dr. Kuttner's probing of the meaning behind my words when I was discussing pain interventions with her. I hope that this discussion will prompt further questioning and probing regarding the power of our words to promote or obstruct effective research and patient care.

Postscript

The reader may wish to know that we settled on the term "developmentally sensitive interventions" for our study of pacifiers, pacifiers and sucrose, and positioning (Stevens et al., 1999). I am not entirely satisfied that this description captures the essence of the interventions and

I continue the search for a more useful descriptor. I welcome your comments and suggestions to stimulate further discourse on this issue.

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