Social Science & Medicine 69 (2009) 666–669

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

The inarticulacy/indescribability of pain: A rejoinder to Mowat

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Keywords:
Pain
McGill Pain Questionnaire (MPQ)
Phantom limb
Language
Embodiment
The body

Introduction

In his commentary "Indescribable pain in literature: a commentary on Crawford", Mowat (2009) raises a series of important questions about the essential nature of pain experience and he does so by bringing the humanities and the social sciences into conversation with one another, a rarity to be sure. I share Mowat's eagerness for forging these kinds of exchanges as they are invariably fruitful. I also share his enthusiasm for illuminating counter-medical and subversive discourses with emancipatory potential. After all, the nature of the public discourse on pain is profoundly meaningful to all of us.

Borrowing from a number of literatures, Mowat (2009) buttresses the claim that pain is "indescribable", that it is fundamentally pre-linguistic. He argues that pain's inherent indescribability is reflected in the work of literary critics who, for example, expose the difficulty in describing pain or the tendency for sufferers to creatively generate a personal vocabulary of pain. Likewise, it is a central feature of phenomenological accounts of pain experience which foreground the aspects of lived embodiment that precede consciousness. And, it is relevant to postcolonial critiques of the representation of oppressed bodies in pain.

In the end, Mowat argues that a constructionist account of the intersubjective nature of pain is not at odds with a pre-linguistic account of pain like the one advanced by some literary critics. This is in part because both approaches share the common goal of generating "a subversive and intersubjective discourse on pain that goes beyond traditional medical accounts" (Mowat, 2009). He proposes that literary criticism, overtly interested in political and ethical concerns, can be of value to sociology, which emphasizes everyday interaction and the analysis of non-literary texts.

The inarticulacy of pain

Let me begin with a clarification. Although the MPQ did challenge the dominant medical vocabulary of the time, as Mowat (2009) recounts – one that was arguably inadequate – the instrument has ultimately functioned to refine and elaborate the medical discourse on phantom limb pain and, thus, to accentuate the ethereal pain brought on by amputation. As a corollary of a paradigmatic shift in pain theorizing occurring circa 1965, the new language of phantom pain engendered by the MPQ did have its origins in attending to the "problems associated with objectifying and diagnosing pain" (Mowat, 2009). However, these problems were assertedly redressed by the creation of a more responsive, more sensitive tool for capturing the newly understood complexity and multi-dimensionality of pain. In other words, it was the MPQ that made the objectification of pain increasingly possible.

Further, although this new discourse did conceptualize pain as potentially intersubjective, it was the instrument itself, as Melzack has argued, that allowed for pain to be shared with practitioners (and others) reliably and straightforwardly perhaps for the first time (Melzack, 2005). Consequently, pre-MPQ pain was (re)constructed as poorly measured and pain reporting of the past as fraught with inauthenticity.

At the time when Scarry (1985) and Morris (1991) were writing, the assertion that the MPQ (and technologies like it) could objectify pain existed in tension with a broader discourse that conceptualized the patient, the pained body, as irreducibly complex. This idea began to take hold circa 1980, when (among other changes) the biopsychosocial complexities of disease surfaced as a core concern of practitioners, researchers, and patient communities. Although originally a model for psychiatry, by the mid-1980s "biopsychosocial medicine had been taken up with alacrity" and had "achieved wide currency" (Armstrong, 1987: p. 1213). From this perspective, physical pain was constructed as highly individuated and personal (Engel, 1977). Because of the complexity of the

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0277-9536/$ – see front matter
doi:10.1016/j.socscimed.2009.06.034

interactions between body and mind – between physiological and psychological processes taking place in specific socio-cultural contexts – pain was considered difficult to measure and to share. Set against this backdrop, the discourse engendered by the MPQ (and many other changes occurring in pain medicine), appeared to challenge the dominant medical account.

In the decades since, medicine has been transformed in a number of consequential ways. One of the key epistemological changes has been the blurring of the boundaries between treatment and enhancement, between "normalization and customization" (Clarke, Shim, Mamo, Fosket, & Fishman, 2003: p. 181). Consequently our bodies have become more, not less, amenable to transformation, optimization, and objectification (Rose, 2007). And because of the demand for ever more knowledgeable, proactive and engaged biomedical consumers, health, disease and pain have been pushed more and more into the realm of public discourse. The MPQ, as a part of a larger set of practices and knowledges, has given amputees, clinicians, researchers, the community of scholars writing about pain, and others a common language.

Indeed, the fact that both Scarry (1985) and Morris (1991) employ the MPQ in their arguments attests to its authority and influence. Though he does assert that pain is "inherently resistant to language", Morris (1991: pp. 3, 18) acknowledges that the MPQ aids diagnosticians in regimenting pain, in managing pain's "slipperiness", in bringing it under control. And although she argues for the inexpressibility of physical pain, Scarry (1985) herself seems almost in awe of the power of the MPQ to make pain linguistic and material. She writes:

> "through the mediating structures of this diagnostic questionnaire, *language…has begun to become capable of providing an external image of interior events*…[N]ecessary to the invention of this diagnostic tool was Melzack's assumption that *the human voice, far from being untrustworthy, is capable of accurately exposing even the most resistant aspects of material reality*. The depth of his belief in the referential powers of the human voice only becomes visible, however, when one recognizes that he has found in language not only the record of felt experience of pain, the signs of accompanying disease, and the invitation to appropriate treatment (as are all suggested by the McGill Questionnaire) but has found there even the secrets of the neurological and physiological pathways themselves" (Scarry, 1985: p. 8 emphasis added).

As for Melzack (2005: p. 201 emphasis added), he did intend for the MPQ to account for "the *perceived*, subjective qualities of a person's pain", but this was because his gate control theory highlighted the role of the social and the emotional. Far from being illusive, he assumed that a language of pain quality could, if rigorously developed, capture these aspects of the pain experience, and, in fact, affective and evaluative dimensions became central to the instrument's structure. This gave the MPQ efficacy vis-à-vis gate control theory and, not insignificantly, gave gate control theory efficacy vis-à-vis the MPQ.

Mowat (2009) further suggests that both Morris's (1991) and Scarry's (1985) conceptions of pain as "indescribable undermines the medical view of pain as a symptomatic inscription of illness…provid[ing] an innovative description of pain that transcends the traditional medical account". The tendency for transcendence, Mowat (2009) proposes, is a commonality between Scarry, Morris and my reading of what the MPQ "'says' about pain". The central question, then, is does a conception of pain as fundamentally private and pre-linguistic transcend established biomedical accounts? Or, by contrast, does the conception of pain as historically understood and fundamentally intersubjective challenge dominant biomedical discourse?

Silence and repression

In his commentary, Mowat (2009) argues that a critical examination of how the body, illness and pain are represented in literature exposes 1) the silence (the voicelessness) that characteristically surrounds pain – "vulnerable silent aspects…that in the past [have] been subsumed by competing accounts of suffering", and 2) the "difficulty in describing pain" and the tendency for pained subjects to imaginatively coin their own words when asked to give voice to their experience. In short, literary critics reveal the ways in which these descriptions of pain and illness are incongruous with medical accounts.

Historically, amputees have been silenced. There was a relative dearth of references to phantom pain at the turn of the twentieth century, attributed to amputees' reluctance to admit a pain that seemingly communicated not just physical suffering but mental instability (Hoffman, 1954). Reports of pain originating in an absent limb testified to an amputee's maladjustment to limb loss. The prevalence rate of phantom pain during this period was reportedly less than one percent (see for example Simmel, 1959). At other times, phantom pain testified to the possibility that demobilized amputees (and other war-wounded) could effectively disrupt post-war renormalization efforts if "stories" like these circulated (Gerber, 1994). In the post-WWII context, the US Office of War Information was established by executive order to coordinate the dissemination of war-related information and to eliminate what was considered confusing, disrupting or disordering (Roeder, 1996: pp. 52–61).

Silence has characterized the history of phantom pain. However, it is important to note that silence of this kind – a lacuna in the medical literature at the turn of the 20th century or censored material in the post-WWII context – is not evidence of the pre-linguistic nature of pain. Silence or voicelessness differs from the pre-linguistic in that the former is "to not be listened to", while the latter is "to be unable to express". The former is an effect of power, while the latter is not. Consequently, acknowledging that pain *is* intersubjective and linguistic allows for the interrogation of power, for a critical examination of its effects. Proposing that pain is pre-linguistic theoretically precludes this kind of interrogation.

As the literature on phantom pain reveals, amputees have also had difficulty describing their pain and have turned to the kind of linguistic creativity that Mowat highlights. For example, amputees have given the following descriptions of their painful phantom limbs: "the sensation of his great toe nail being twisted off" (Russell, 1949: p. 1025); "the sensation of blood welling between his toes" (Russell, 1949: p. 1026); "a continual fiercing feeling, as if there were a knife stuck in it and always being turned round" (In Der Beeck, 1953: p. 225); "as if a sharp scalpel were being repeatedly driven into the flesh" (Livingston, 1938: p. 356); "as if there were a wire down the center of his arm…[and] some force were pulling on the wire as if to pull the fingers up through the arm" (Livingston, 1938: p. 357); "as if it had been scratched and skinned from the elbow to the wrist" (Livingston, 1938: p. 358); and "as though her right hand were touching hundreds of sharp-pointed pins" (Stone, 1950: p. 746). Most of these richly detailed descriptions are found in the pre-MPQ medical literature. Thus, the role of the MPQ has been to standardize and reify a specific language of phantom pain quality curtailing the kind of linguistic creativity indicative of past descriptions.

Still, it would be wrong to conclude that the MPQ was repressive. While one could purpose that the words of amputees in pain were appropriated by Melzack, the MPQ did give amputees "permission to speak", which practitioners and researchers have argued is reflected in the dramatic rise in pain prevalence rates (see for example Ribbers, Mulder, & Rijken, 1989). The widespread use of