Title: Do we mean to ignore meaning in pain?

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Although Pain Medicine is a rapidly developing clinical discipline, medical explanations about pain are often unsatisfactory. The problem seems to be with meaning: some people with pain do not find meaning in clinical discussions of pain, and clinicians typically are not looking for it.[1,2] For patients with pain, biomedical information can be perceived as lacking meaning in relation to their personal experience. By contrast, patient narratives and stories about pain, clinical encounters and therapies, cautionary tales, and common-sense experience seem to offer meaningful and actionable information.[3] No biomedical explanation of pain, however useful it might be to a pain clinician, could describe the personal meaning or burden of pain to the individual. Traditionally, scientific research has had much to say about the physical nature of pain but much less about pain experience. It seems that one limitation in the ability of clinicians to effectively treat pain or pain-related suffering is an incomplete appreciation of ‘pain experience.’[1,2] This special issue in *Pain Medicine* focuses on a pivotal aspect of this problem: how to understand the meaning of pain, for both the patient and the observing clinician.

While there is no consensus on the meaning of ‘meaning’, perhaps its most basic denotation is *association*.[4] Learning the use of a word (‘chair’) in connection with an object (*this* chair) is a form of conditioned association that enables the child learner to adapt her behaviour to societal norms. This normatively-shaped behaviour is indispensable in learning subsequent higher cognitive competencies and more sophisticated associations.[4] When learning the word ‘pain,’ a child acquires a symbolic mode of telling ‘what is going on,’ which develops into exploring and negotiating complex meanings of pain through intersubjective discourse.[5,6] Meanings build slowly over time, are context-dependent and culturally determined.[4] In clinical settings involving pain, a major challenge is to establish the biologically-determined associations that contribute to health outcomes in patients. But this biomedical approach does not seek or address other associations that may have been formed by the person experiencing pain.

Natural language is arguably humankind’s premier tool for articulating meaning.[7] In the first contribution in this special issue, Samantha Bunzli and colleagues employ discourse analysis methods to identify different ways in which language about knee osteoarthritis is used, and what specific meanings these discourses convey. The final analysis included 62 articles reporting data from people in 16 countries with knee osteoarthritis, in addition to data obtained from their carers and clinicians. Two discourses were identified, labelled *impairment* and *participation*. In the 'impairment' discourse, the body was viewed as a machine that inevitably deteriorated over time and required repair. The authors argue that this meaning of impairment may discourage people from engaging in physical activity, thereby increasing their reliance on doctors and passive treatments such as medication to repair perceived joint damage. By contrast, the 'participation' discourse viewed a 'busy body' as 'healthy.' Accepting the presence of pain, patients with knee osteoarthritis led full, active lives. Compatible with clinical practice guidelines, patients associating knee osteoarthritis with 'participation' successfully engaged in physical activity because they focused on what they could do, rather than on what they could not.

Evidence suggests that pain associated with labour is experientially different from other pain experiences. In their empirical investigations, Laura Whitburn and Lester Jones established that, in an uncomplicated labour, increasing pain does not signify pathology or bodily damage to the labouring woman. Rather, it signifies 'progress towards the birthing of a baby,' which is a positive event. The authors argue that the meaning a woman assigns to her labour pain determines the quality of her experience and how she copes with it. Despite advances in understanding pain mechanisms and new definitions and classifications to describe pain conditions, pain assessment remains challenging. Whitburn and Jones acknowledge that current approaches to the assessment of labour pain are inadequate, as many tools do not assess the emotional context of labour or capture the increasing intensity of the sensory experience as labour progresses. They recommend adopting a woman-centred approach to the assessment of labour pain, which includes evaluating the meaning of pain to the woman.

In the third article, Francine Toye and colleagues considered that the evidence describing what it means for a person to live with chronic pain does not typically include what it means to *recover* from chronic pain. The authors report a meta-ethnography, involving a systematic review of qualitative research published since 2012 that reported on adults' experience of living with, and being treated for, chronic pain. From 1328 titles initially screened, 195 reports of 170 unique studies were evaluated, which included at least 3600 people with chronic pain. Their conceptual model identifies the themes of *validation* and *reconnection* that can motivate a person with chronic pain to undertake 'a journey of healing', which requires considerable commitment, energy, and support from clinicians, family and/or caregivers. Recovery in the context of chronic pain is a developing and iterating experience, not a final destination with a fixed outcome. Recovery occurs only if the patient is supported by others in his or her care network. Thus, integrating certain themes into clinical pain management practice may make a meaningful difference to people who have embarked on their own 'pain healing' journey. Such themes include: validating pain through meaningful and acceptable explanations, validating patients by listening to and valuing their experiences, encouraging patients to connect with a meaningful sense of self, being kind to themselves, exploring new possibilities for the future, and facilitating safe reconnection with the social world.

Existential and spiritual factors influence how people cope with disability and life-threatening illnesses. How pain impacts on meaning and purpose in life and in turn how this may affect ability to cope have not been studied. In the final article in this special issue, Melanie Lovell and colleagues investigated spiritual well-being in people with persistent pain (n=132) compared with people with cancer (n=74) and healthy controls (n=68). The authors found that spiritual well-being scores were significantly lower in people with persistent pain compared with controls, but were no different from scores in people with cancer, including those with both cancer and pain. Low levels of meaning and purpose significantly predicted depression, anxiety, and stress in all groups. Considering spiritual concerns or meaning in life in people with chronic pain and their families may broaden clinical understanding of how patients adjust to pain. Meaning-related concerns or changes in a person's search for meaning can be discussed at regular clinic appointments or hospital admissions with the patient or family members. Interventions and treatment programs that address loss of meaning and purpose in life may alleviate comorbid psychological dysfunction in some patients with pain.

Meaning in the context of pain may be elusive and challenging for clinicians to appreciate. Yet, as illustrated cogently and differently in each of these four articles, *meaning* — in its broadest sense of associations that can lead to understanding — is integral to the experience of pain and conveys major implications for assessment and therapy. This dimension of pain is another challenge to the teaching and learning required by and for pain clinicians.[6]

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