Beyond Pathology: (Re)conceptualising Distress in Chronic Pain Care

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A Case Study

Felicity[1], a woman in her 60's who has experienced low back pain for 40 years, was referred by her general practitioner to my workplace: a neurosurgical service in a tertiary hospital. Felicity was assessed by a specialist physiotherapist, determining she had low back facet joint pain and stiffness. Non-surgical management by a multidisciplinary team (physiotherapy - me - and psychology) was recommended.*

My immediate impression was that Felicity was uptight (quite a judgment!). She sat upright, rigidly perched at the front of her chair with knees and feet pressed together. She held her hands firmly together and maintained a serious facial expression and tone. She appeared apprehensive and unhappy. I felt uncomfortable, I sensed tension in the room and in my body, possibly due to being unable to sit with Felicity's emotions.

Felicity told me that she had constant pain. She was scared of bending her back without support. She moved rigidly, avoiding bending and lifting. She believed her pain was due to damage in her back, that her pelvis was unstable and needed protection. She attended a chiropractor every 4-5 weeks since her injury, believing if she discontinued, it would result in severe pain. Felicity had sought help from many other healthcare professionals (including physiotherapy) in the past, none of whom provided relief, with some increasing her pain.

I thought Felicity's beliefs and feelings seemed irrational and extreme; I also believed they were increasing her pain. Through using education on anatomy and pain neuroscience, I tried to reassure Felicity that her pelvis was stable, it was safe to move her back, and that her emotion—such as fear, unhappiness, apprehension, and worry—were likely exacerbating her pain. Felicity frowned and appeared unconvinced. I felt frustrated (ashamedly) because she did not believe me. I then prescribed gentle back movement, breathing, and mindfulness exercises to ease her pain and help her relax.

Within a few weeks, it was clear this approach was not working. Felicity's pain did not improve. Frustrated, I convinced Felicity that she needed to move less rigidly and allow her back to bend more throughout the day. I decided that I needed to prove to Felicity that it was good to bend, by 'safely' exposing her to the movements that she feared. I prescribed bending exercises, gradually decreasing the level of support. Felicity forced herself to do them. I did not pick up on signals at the time that this was highly stressful for her. Felicity did not attend her next appointment.

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Felicity eventually returned a few weeks later, extremely upset. The exercises caused a flare-up, prompting her to see the chiropractor more frequently, which was a financial stress. She had spent days in bed and struggled to cope with daily life, withdrawing from work and social activities. Felicity described how she often got periods of severe pain, where she was unable to work and required more help from the chiropractor. This has made maintaining a full-time job difficult. She was worried she would have to quit her job again. She became scared of engaging further with physiotherapy. I felt sad and worried. I did not believe the exercises would cause physical damage, but it highlighted the fact that there was more to Felicity's life and context contributing to her pain.

I spoke with Felicity's psychologist, who provided more insight into the emotional context of her life, including past experiences of domestic violence and childhood trauma. I realised that not only had I prescribed exercises outside of her physical 'safe' zone, but that they were provided just prior to Christmas—a stressful time requiring engagement with complex family dynamics. Not understanding this context meant that the exercises were not emotionally safe at a time when Felicity's emotional safety was already threatened.

Case Study Reflection

'Felicity' is a vignette case study, constructed from a constellation of my experiences and reflections working as a physiotherapist in the area of chronic pain. I expand on the case study throughout this article. Like many of my patients, distress was part of Felicity's story. Although I [2]* recognized elements of her distress [3]*, through her body language, words and actions, I did not understand her distress, and the many factors producing her distress within and outside of the clinical encounter. Therefore, I did not navigate it well, nor did I appreciate how my distress, evidenced through my discomfort, frustration, and uncertainty, was influencing how I (inter)acted within the encounter and how this may have impacted Felicity.

I am an experienced physiotherapist. Over time, I have become increasingly aware of my own and my patients' distress and how it is often sidelined or labeled as problematic. Frustrated with the limited resources and training available to physiotherapists in navigating distress within clinical encounters, I looked to sociology to aid my quest to understand this element of clinical care. Through reflexively engaging with sociology theories of emotions and my experiences working with patients with chronic pain, I recognized that distress is not just implicated in chronic pain experiences but also in navigating relations of care.

DISTRESS IN CHRONIC PAIN CARE

Distress is often a reasonable and common aspect of chronic pain experiences, care, and life in a complex world. However, it is poorly conceptualized and operationalized, separated from pain experiences, and seen as a problem within the patient.[1] This limits a full understanding of pain experiences and how best to navigate chronic pain care. Yet, emotions like distress are relational and shared.[2] The overarching aim of this article is to propose a (re)conceptualization of distress in chronic pain care.

Grounded in the Felicity vignette, in this study I draw from theories of emotions to attend to what any implicit conceptualizations of distress *do* to/within clinical interactions in chronic pain care. This article unfolds in three parts:

1. I begin by outlining historical and contemporary understandings of emotions and distress broadly, and then specifically within chronic pain contexts, to demonstrate why (re)conceptualization is required.

2. I then draw on approaches that dominate current understandings of emotions: classical psychology and symbolic interactionist theories. These theories are paired with the vignette to illustrate what these conceptualizations make (im)possible in chronic pain care.

3. Finally, returning in more detail to the vignette about Felicity, I draw on critical, sociocultural, affective, and relational theory understandings of emotions as assemblages, flowing and connecting across human and non-human bodies, institutions, and society, to propose a new conceptual framework for distress in chronic pain care.

This (re)conceptualization offers a heuristic to navigate distress more comfortably and relationally in chronic pain care, and lays a theoretical foundation for future empirical research.

Distress

Distress could be considered an umbrella word for all 'negative'[4]* emotions. It is an equivocal term, understood differently through various cultural, social, and historical lenses.[3] These lenses matter: attitudes toward a phenomenon such as distress impact how it is experienced and operationalized.[4] Within neoliberal Western societies, distress has been progressively medicalized and individualized, seen as a sign of weakness, a disorder, or mental illness, and a target of consumption.[5,6] Distress is often blamed on dysfunctional brains, with harmful political, social, and work environments overlooked as potential causes.[5,6] Distress is stripped of any deeper meaning, or as something potentially instructive transformative, or helpful.[5] For example, Mad studies highlight the broader social causes and consequences of distress, like poverty, relational conflict, isolation, adversity, injustice, abuse, and stigma.[6] Therefore, they conclude that people's distress should be seen as expressions of deeper social problems.[6]

Similarly, feminist and Marxist scholars argue that emotions like anger can be inevitable, and instructive in revealing the violence inflicted by oppressive systems such as the patriarchy, colonialism, and racism—systems in which women and people of color are often expected to perform disproportionate amounts of emotional labor in their daily work.[2,7,8]

Exploring the history of emotions and the origins of the concept of distress prompts recognition of the ambiguity in understanings of distress, its pathologization and individualization.

A Brief History of Emotions

Exploring conceptualizations of emotions over time reveals how the understanding of emotion and its expression varies across eras, places, languages, cultures, and traditions.[9,10] There is little agreement among scholars about the definition of emotions.[11] Ancient Greek philosophers studied emotions—

referred to as appetites, passions, affections, and sentiments—as mental and physical states transcending individuals.[9,12]

The Stoics and medieval Christian scholars brought suspicion to their treatment of emotions, considering passions as 'diseases of the soul' and 'violent forces' that could conflict with reason, and were in need of management.[9(p339)] (Pre-)enlightenment philosopher Descartes suggested humans are dualistically composed of immaterial minds and material bodies, likely reinforcing this apprehension of emotion. (Mis)interpretations of this work furthered belief in cognition as central to what it means to be human, emotion and reason as opposites, and emotion as an embodied threat to mental reasoning.[13] Emotions were subsequently understood as separate from the mind; thinking occurred in the mind, and emotions were embodied phenomena, primarily linked to bodily sensation (ie, physiological). Reason was seen as superior, with emotion considered to be a force of nature not to be trusted, and irrational.[2,13]

This dichotomy has been argued by feminist scholars to translate into a hierarchy, with reason and rationality associated with the masculine and Western, and emotion associated with the feminine, racial minority, and other minoritized groups.[2,14] This dualistic and disconnected treatment of emotion is evident in professions such as medicine and law, where emotions are cast as threats to objectivity.[15-17]

Considering the history of emotions may explain why distress is pathologized and seen as a problem contained within the individual in chronic pain care. Next, I consider distress specifically—unpacking how its meaning has changed over time.

The Etymology of Distress

In reviewing distress's development in the English language, variation is evident. The noun distress originated in the 13th century and referred to emotions associated with everyday hardship.[17] By the 14th century, conceptualization had shifted to a diagnosis of mental pathology, to compulsions linked to suffering followed by misery linked to mental and physical afflictions.[18] Contemporary definitions refer to mental or bodily suffering (eg, emotional or gastric distress), painful situations, and dire need (eg, a ship in distress).[19] Viewed through a medical or bioethical lens, distress is used to indicate emotional pathology, as in psychological distress.[17] Understanding distress's etymology helps bring to the fore what we take for granted in contemporary conceptualization and operationalization of distress in chronic pain care; its meaning has shifted from an experience embedded in socio-material conditions to an abstracted medical pathology.

Attending to the history of emotions and origins of the word distress goes some way toward explaining why distress is often backgrounded, individualized and pathologized in present-day chronic pain care interactions such as between Felicity and myself. Prevailing conceptualizations and practices support consideration of distress as a mental health diagnosis, siloed to psychological care. Yet from the start of the vignette, distress is evident in both Felicity and myself as the physiotherapist, but divorced from my approach to providing chronic pain care. Here the legacy of (Western) historical conceptualizations of emotion (distress in particular) is useful in drawing attention to other possibilities in attending to emotionally-imbued health care interactions.

Next, drawing from chronic pain literature, I discuss why emotions are important within chronic pain care, and how emotions like distress are conventionalized and operationalized in this context.

Emotions, Pain, and Distress

Emotions are fundamental to human experiences and permeate all human interactions.[10] Although disciplinary definitions vary, I draw from contemporary sociological understandings of emotions as relational and cultural affective phenomena, involving physiological and cognitive changes, and embodied sensations and expressions, and shaped by social expectations, labels, and norms.[20] Such understandings of emotions have not been well applied in chronic pain care. Chronic pain is defined as pain that persists or recurs for more than three months.[21] People with chronic pain almost always experience some level of distress and/or other emotions.[1] The International Association for the Study of Pain's (IASP) widely-recognized medical definition of pain recognizes this entanglement, defining pain as a subjective "unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage."[22(p2)]

While most pain researchers and clinicians now acknowledge pain's sensory and emotional entanglement, the urge to treat pain as objective and quantifiable, focusing on sensory elements that can be 'fixed' is pervasive, as illustrated in Felicity's example where her initial diagnosis focused on lumbar joint pain.[23] Such an approach has potentially reinforced poor attention to emotions within biomedical pain research; when attention is paid to emotions, dualistic and physiological understandings persist. Furthermore, such definitions do not capture pain's sociopersonal complexity. In Felicity's scenario, I initially foregrounded physiological considerations of her distress. It was only once she experienced a flare-up that she articulated her distress and I gave it more focused attention. Attempts to attend to the complex and multidimensional experience(s) of pain within clinical care include the 'biopsychosocial model.' This model aims to recognize that physical, psychological, and social factors all contribute to a pain experiences.[24] Yet, its application is often fragmented, or focused on the biological and narrow psychological aspects, with pain's socioemotional elements lowlighted.[24] Furthermore, the biopsychosocial model treats the patient as a discrete individual, with little or no recognition of emotional or relational dimensions of care. Clearly, broader conceptualizations of emotions incorporating social and relational dimensions are needed within chronic pain care.

EMOTIONS ARE ENTANGLED IN PAIN EXPERIENCES

Neurologically, pain and emotion are inseparable.[25] Emotions are implicated in the development and modulation of pain experiences.[25] Neuroscience research shows social pain and physical pain to have overlapping neurobiological pathways, with non-prescription analgesics shown to relieve emotional pain from personal rejection,[26] and pain shown as producing and/or amplifying ('negative') emotions.[25] Qualitative research exploring people's experiences of living with chronic pain show it to be emotionally 'negative'—with incurable, invisible, omnipresent, and unpredictable pain underpinning feelings of distress,

despair, and fear.[27] Furthermore, implicated in chronic pain are feelings of exclusion, isolation, rejection, dismissal, misunderstanding, and stigma, when others (eg, family, friends, clinicians) (un)intentionally blame or doubt the person experiencing chronic pain.[28,29]

Although sometimes reproducing binaries, research on pain and emotions helpfully demonstrates their entanglement: chronic pain involves emotional changes, and emotions can also drive or maintain chronic pain.[25] However, 'negative' emotions associated with experiences of chronic pain are often considered maladaptive and in need of down-regulation or elimination.[25]

'NEGATIVE' EMOTIONS AS HINDERING RECOVERY

So called 'negative' emotions associated with pain, such as anger, fear, despair, and hopelessness are often cast as hindrances to recovery. Concepts created to describe such emotions, such as 'catastrophizing', 'fear avoidance' and 'mood disorders' (eg, depression, anxiety), are often reduced to standardized scales and considered to predict poor outcomes.[1] For example, catastrophizing—a maladaptive or exaggerated negative emotional response or anticipation of disastrous consequences—is argued to increase psychological distress, pain intensity, and disability.[30,31] There has been debate about applying the term within physiotherapy, but it has nonetheless shaped practice.[30] In turn, 'psychological distress' has been associated with poorer treatment outcomes,[32] increased disability,[33] and increased pain intensity.[32]

Drawing on such findings, some scholars and clinicians have concluded that 'negative' emotions are irrational, pathological, and in need of suppression or management.[1] Ashamedly, this is how I viewed Felicity's distress: as irrational, associating it with fear avoidance and catastrophizing about bending and lifting her damaged back and unstable pelvis.

PROBLEMATIC MEASUREMENT SCALES

This understanding underpins the widespread use of standardized measurement scales used in clinical practice, such as the 'pain catastrophising scale'[31] and 'fear avoidance beliefs questionnaire'.[34] Such scales of 'negative' emotions are problematic.

- They over-simplify the emotional elements of pain experiences, limiting the focus to one factor.
- They position the problem as within individuals.
- In turn, they may prompt individuals with chronic pain to feel shame, stigma, and judgment by healthcare professionals.[35]

Measuring one emotion in isolation—focused on severity, intensity, and implications for functioning[36]—entrenches singular understandings of 'negative' emotions. Consequently, how people think, feel, and behave in relation to chronic pain is overlooked,[27] leaving little room for understanding emotions or distress as situated, reasonable, expected, or helpful responses to living in an unjust social world. As we can see in Felicity's scenario, such individualized and pathologized understandings of distress can have significant consequences for a person.

Clinical pain scholarship is beginning to recognize that

'negative' emotions are reasonable responses to pain's threatening and unpredictable nature.[37] But broader conceptualizations of emotion are necessary to goad this shift further to include emotions as relational and socially-situated. How clinicians conceptualize distress matters, as it influences how distress and chronic pain experiences are understood, managed, and navigated in clinical encounters. In the next section, I draw from critical, affective, and feminist depictions of emotions as: 1) relational and thus shared across bodies and objects, reflecting people's interdependence; and 2) situated within sociohistorical landscapes that privilege some bodies over others, and cultural settings with embedded social expectations underpinning emotional meaning and expression.

Distress/Emotions as Relational and Socially-Situated

Emotions are relational and socially-situated. Not only do we (humans) learn to give meaning and value to affective experiences through socialization, they are also shared. Affective states permeate and shift across beings. In chronic pain healthcare contexts, distress then is not only located in individuals experiencing pain; clinicians also experience emotions, such as distress within clinical encounters. Despite the centrality of emotions to care relations, clinician emotions, like distress, are not well attended-to in chronic pain care. Where distress appears in this scholarship, it is largely implicit. Aston-James and colleagues[38] explored burnout among clinicians working in multidisciplinary pain clinics. Several emotionally-challenging situations were described: 'exposure to others' trauma and pain, feelings of helplessness to treat patients' pain' along with 'conflict with colleagues,' and the stress, guilt, and frustration of administrative tasks, waitlists, resourcing deficits, and limited treatment effectiveness.[38(p511)] However, distress did not feature in the analysis. Other studies exploring clinicians' experiences of caring for people with low back pain[39] and chronic pain[40] suggest that clinicians feel unable to or uncertain about navigating patients' emotions, especially distress, prompting a lost sense of control, powerlessness, and distress (although distress is not defined) within clinicians. I argue that conceptualizations of distress in chronic pain care should be explicit and emphasize relationality, acknowledging that emotions are shared and socially-situated.

EMOTIONS AND PAIN

Emotions are imbued with the effects of social relationships and hierarchies. Similarly, pain is more than feelings corresponding to tissue damage.[2] Dynamic social and cultural worlds in which people are situated shape the meaning attributed to pain and distress, mediating its experience and effects.[2,23] Furthermore, developmentally and over time, our bodies and emotions are inscribed by social standing.

Formative emotional experiences, including trauma, shape how individuals experience distress in the context of chronic pain. Research into pain's complexity points to it being layered, involving interrelated internal and external forces at individual, familial, community, and structural levels.[41,42]

Social conflict offers an example. Social conflict includes relationship conflict, neglect, bullying, discrimination, abuse, oppression, an unstable home environment, homelessness, poverty, and living in areas of high crime rates, all of which can precipitate and exacerbate chronic pain.[42] Such situations may undermine a person's self-worth and trigger emotions such as loneliness, depression, anxiety and anger, which, in turn, can increase pain sensitivity and disability.[42] Social stressors have also been suggested to contribute to chronic pain experiences due to their capacity to exacerbate the body's inflammatory responses.[43]

Conversely, social support and empathy have been shown to decrease pain intensity by providing an individual with evidence of safety when pain elicits a sense of continual threat.[41] However, the effectiveness of social support in modulating pain is also influenced by an individual's attachment style, which again is influenced by social adversity throughout the lifespan.[41] Emphasizing chronic pain's sensory and socioemotional entanglements, research suggests chronic pain follows a social gradient; people from lower socioeconomic positions or migrant communities are more likely to experience chronic pain and have poorer treatment outcomes.[43]

THE BIOPSYCHOSOCIAL MODEL'S SHORTCOMINGS

Emotion's situated nature, as socio-cultural and reflecting one's social standing, is often backgrounded in chronic pain scholarship.[21] For example, the dominant framework for understanding chronic pain in clinical research and practice—the biopsychosocial model—tends to consider some aspects of social support, beliefs, attitudes, self-efficacy, cognition, coping, and individualized effects including distress, depression, and anxiety.[21] However, such understanding emphasizes individual psychological experiences, collapsing the social to an individual level.[44] Acknowledgement of structural inequalities is absent—underpinned by politics and policies at the institutional, national, and global levels—shaping who experiences pain, how pain is experienced and viewed, and the role of the medical-industrial complex.[21,23]

Such individualized understanding of chronic pain neglects the role of broader social and political forces and inequalities central to pain experiences, such as poor working conditions, financial insecurity, discrimination, or injustices and harm arising from inequitable sociopolitical systems and structures.[21,43,44] Clearly, the social, political and relational dimensions of pain deserve more scholarly attention within chronic pain care. Broader conceptualisations of distress, incorporating the sociality of emotions, may shift chronic pain care beyond individual approaches, to incorporate how these forces influence pain experience and care.

In sum, 'negative' emotions—like distress—should not necessarily be seen as a hinderance to chronic pain recovery. Neurologically and socially, chronic pain and distress are inseparable, reflecting the way culture and social structures get 'under the skin.'[45] What's more, pain and distress are shared across clinicians and people with chronic pain. Distress, pain, clinicians, patients, lives, behaviors, and meaning-making are all entangled. But how do clinicians navigate this situatedness and relationality? Despite substantial research on the interconnectedness of pain and emotions such as distress, clinicians do not feel well-equipped to navigate psychosocial elements[46]; concepts, theories, ways of interacting, and models of care remain focused on pain's biological elements.[47,48]

To move beyond individualistic and pathologizing terms such as 'catastrophization'[30] and 'difficult patients,'[49] broader conceptualization of distress in chronic pain care and skills in recognizing and responding to one's own and others' distress are needed. To work toward offering such a (re)conceptualization, in the following section I draw on multiple theorizations of emotions. Grounding this (re)conceptualization in the sociomaterial realities of healthcare practice, I pair the theoretical exploration with Felicity's vignette.

Conceptualizing Distress

I now utilize sociological theories on emotions to (re)conceptualize distress. Like Ahmed,[2] I call attention to what emotions *do*, or more precisely, following Anonymised and colleagues,[10] I explore what differing *conceptualizations* of distress *do* in clinical interactions with people who have chronic pain. Working with Felicity's vignette, I explicate three theories of distress, from:

1. Classical psychology.
2. Symbolic interactionism.
3. Critical, sociocultural, affective, and relational theories of emotions.

I do this to highlight what they each make (im)possible in relations of chronic pain care.

CLASSICAL PSYCHOLOGY

Classical psychology presents a physiological approach to emotions and distress. Here, emotions are conceptualized as 'universally experienced and part of our physical make-up'[50(p73)] or a series of biological and neurochemical responses.[15] The focus is on embodied expressions of individual emotional experiences[10] contained within a person. Physiological theories stem back to Darwin,[51] who proposed emotions to be basic, valanced, and universal, serving the purpose of communication, and prompting nervous system responses that result in facial and bodily expressions. Building on this work, William James suggested emotions arise in response to external stimuli.[52] Both argued that humans are wired to express emotion in universally measurable ways, often beyond consciousness and control,[15] furthering an understanding of emotion as opposite to reasoning, problematic, unpredictable, and in need of management.[50] Understood from a classical psychological theoretical perspective, distress can usefully draw clinicians' attention to physical changes associated with emotion, such as facial expression, vocal pitch, and skin temperature.[10] However, as illustrated below in returning to Felicity's initial consult, such an approach has limitations in overlooking distress's relationality and socio-cultural entanglements.

> *I encouraged Felicity to relax, to let go of her overly extended back posture, as I postulated this to be increasing her pain. Physiological treatments might include medications, yoga, breathing, and bending exercises for relaxation, or mindfulness meditation to help manage worrisome thoughts. It is clear in hindsight that I was viewing Felicity's emotions from a classical psychology lens. But, focusing on the physiological manifestations of Felicity's emotions, to the exclusion of*

others, was insufficient (and detrimental).

Although viewing Felicity's distress through a physiological lens enabled me to recognize her distress, I did not understand the many factors contributing to it or how this was entangled with her pain. Like many other clinicians I have observed, I treated Felicity's distress as something to be eliminated or 'fixed.' Yet such approaches may only provide short-term alleviation of pain or distress, and can amplify distress and pain, as was the case for Felicity. I also failed to recognize my own distress and how this impacted how I (re)acted within clinical encounters with Felicity, and how it could impact Felicity and the creation of a safe and comfortable therapeutic environment.

Building on this common enactment of distress in clinical settings, I next present symbolic interactionism, a theoretical lens that incorporates social and cultural influences on distress.

SYMBOLIC INTERACTIONISM

Symbolic interactionist conceptualizations acknowledge but expand on a biological/physiological basis for distress.[53] Within the symbolic interactionist tradition, meaning-making and interactions between individuals and social groups are argued to shape and construct our social reality, influencing how we see ourselves and others.[54] Thus, interactionist theories of emotions foreground the influence of social and organizational culture in shaping expectations, regarding what emotions are, and how, when, or where they should be expressed.[10] The most well-known perspective within this approach is sociologist Arlie Hochschild's[55] theory of emotion management.

Hochschild[55] coined the term 'emotion management' as an overarching term to recognize the efforts a person makes to comply with 'feeling rules' or expectations of how individuals should feel in given situations.[50] The process of altering one's feelings or those of others, to comply with workplace expectations is referred to as emotional labour; emotion work is used to describe these same efforts in the private sphere.[55] This work can be conscious or unconscious, with sociocultural forces seen to shape emotion experienced or expressed in interpersonal exchanges.[10] It can be superficial or genuine, ranging from 'surface acting' to more authentic efforts to change felt emotions, called 'deep acting.'[55]

Hochschild's concept of *emotion work* can be applied to understanding the interactions of people with chronic pain within clinical interactions. Patients may shape how they feel or express their emotions dependant on the 'feeling rules' of a given healthcare context to get the care they need or in an attempt to be believed. For example, displays of too little or too much distress may influence how a healthcare professional responds to a patient and the care they deliver. Healthcare professionals may determine a person with chronic pain to be 'exaggerating,' drug-seeking, physically or psychologically weak, if socially-unacceptable amounts of distress are expressed. This may result in patients managing their distress to be believed or heard.[21,56]

Hochschild's concept of *emotional labor* can be applied to understanding clinicians' interactions with people with chronic pain, illustrating the efforts clinicians make in complying with institutional and cultural expectations. Caring for people with chronic pain can be distressing for clinicians (and patients), requiring emotional labor. This allows us to understand the work

that clinicians do to moderate their own and patients' distress. However, with time-limited appointments, emotion management is likely limited to surface-acting emotional labor, which is associated with burnout.[38,57] Felicity's vignette offers an example.

> *Feelings were part of Felicity's story, but I was unsure of how to attend to them and whether I should. In chatting to Felicity, she disclosed that the diagnosis received from the specialist physiotherapist contradicted the information provided by her chiropractor. Felicity's chiropractor asserted that she had an unstable pelvis, requiring readjustment monthly. The specialist physiotherapist said that the pain originated from joints in her spine. Felicity looked and sounded troubled as she explained this. These diagnoses were also biomedically-focused. I disagreed with this solely biomedical understanding of her pain, but I was unsure how emotions contributed. How could I explore this and help her to move beyond a biomedical understanding without seeming dismissive? I felt anxious. This uncertainty required emotion management. Aligned with physiotherapy's cultural expectations, I tried to present myself as confident, knowledgeable, and positive, to counter Felicity's confusion and worry. Being unsure of whether I was correct and if I should attend to this element of Felicity's pain heightened my anxiety and worry and required further emotion management.*
>
> *After assessing Felicity's body, I felt more confident that her pain was multifactorial and proceeded to share this information. Felicity's tone of voice became firm, her body language stiffened, her eyebrows furrowed, she seemed angry but remained silent. I felt despair; I had failed. Again, emotion management was required to hide my disappointment, to remain outwardly calm, optimistic and empathetic. I had to remain 'professional,' in control.*
>
> *Compounding challenges in managing my emotions and conducting a 'successful' clinical interaction were systemic factors. All of this was to be completed within a 30-minute appointment. Worries scrolled in the back of my mind: I am running out of time, I am late for my next patient, the specialist physiotherapist will review Felicity and may be unhappy with my approach.*

Considering the clinical encounter with Felicity from an interactionist perspective draws attention to the work I undertook to adapt my emotional presentation to comply with cultural expectations and the political and organizational forces underpinning (and constraining) these expectations. It also alludes to the costs (eg, risk of burnout) of the emotional labor often required in chronic pain care relations. The same could be said for Felicity. Distress was evident in her body language, but remaining silent possibly indicates that she was feeling too uncomfortable to express her distress verbally due to the societal expectations that these emotions are 'bad' or 'pathological.'

Such interactionist conceptualizations are underpinned by a social constructionist paradigm, whereby researchers consider emotions such as distress as co-constructed within social contexts.[10] That is, emotional realities are thought to be made through social interactions and institutions specific to a cultural setting. This moves away from the singular view of emotions in physiological theories (ie, emotions as existing within one person) and toward a conceptualization of distress as plural (ie, existing within more than one person). However, interactionist approaches may not go far enough in recognizing power, and positioning emotions as affective and relational.

Hochschild's original concept of emotion management emphasized, from a Feminist and Marxist tradition, the

exploitation involved in emotional labor and emotion work.[8,58] However, it may have lost some of its critical edge in recent organizational psychology applications,[58] which position emotional labor as contained within the individual,[15] implying an individual responsibility for navigating workplace challenges. Furthermore, Hochschild's theories on emotion management have been critiqued for giving primacy to language and discourse—missing the embodied, non-verbal, pre-conscious, relational, and affective dimensions of emotions[10] that are foregrounded in critical, sociocultural, affective, and relational theories. I next present a broader approach to emotions. I draw from critical, sociocultural, affective and relational understandings of emotions to propose distress in chronic pain care as an affective assemblage.

Critical, Sociocultural, Affective, and Relational Theories of Emotions

Sociocultural and relational approaches to conceptualizing emotion—or affect—assert that what people feel (including distress) plays a role in producing the world, or world-making.[2] Emerging from 17th-century philosopher Spinoza is the relational concept of *affect*[59] Often involving active (not passive) states, Spinoza defined affect as 'the body's power of acting' that could be 'aided or restrained.'[59(p493)] Spinoza described body and mind as two attributes of the same substance, arguing that increasing the body's capacity to be affected and to affect others is the means by which the subject progresses.[60] Unlike symbolic interactionist theories, which continue to treat individuals as discrete, affect theorists articulate beings as porous and intersecting, *affected* by other bodies (human and non-human) and elements (pheromones, chemicals). Extending this work, French philosopher Deleuze[61] includes affect beyond humans; by 'body' Deleuze meant human, non-humans, animals and objects: anything could have the potential to act/affect. Distress is part of such affective entanglements.

Combining Deleuze's and earlier critical theorists' work positions emotion as one form of affect within a broader interplay between bodies, other entities, and the social.[2,62,63] This framing shifts the focus from individually-experienced feelings toward exploring how bodies, things, social institutions, and abstractions affect each other; emotions are part of a continuum of affectivity that links human bodies to their physical and social environment.[62]

Ahmed[2] focuses on the relationship between emotions, language, cultural and political discourses, and bodies, suggesting that emotions can be entangled in acts of speech, felt sensations, and objects. Like Deleuze and Spinoza's conceptualizations of affect as an active force, Ahmed suggests that rather than defining emotions, we should look to what emotions do: how they position, discipline, and liberate us within/from sociocultural and political forces. Drawing on such critical, relational theories of emotion as a form of affect, I ask: what does distress do in chronic pain care? Specifically, I draw on Ahmed's and Fox's Deleuze-inspired work to consider distress as made up of assemblages of affective flows: an 'affective assemblage of bodies (human and non-human), discourses, practices, performances, and their complex relationality.[63(p3)]

The concept of assemblage builds on Deleuzoguattarian conceptualizations of a diverse collection of human and non-human (things) through

which desires, energy, ideas, social institutions, and emotions can flow in, through, and among: affective flows.[64]

For example, in a clinical interaction between a health professional and patient there are many sources of affective flow: two human bodies, multiple sources of knowledge, a clinic room, a team, a hospital, a health system, furniture, social positionings, technology, political context, and so on. The relations between all of these form the distress assemblage. Deleuze suggests affect connects elements into a mutually-affecting assemblage. Rather than static, structural, or predictable, Fox[62] describes assemblage relations as dynamic, potentially fleeting, and emerging in unpredictable ways around actions and events. Deleuze[64] discusses assemblages as machines that often operate without our knowing.

Essentially, every aspect of life, including chronic pain experiences and care relations, can be understood as assemblages, with subjectivities—thoughts, feelings, bodies, roles, and social forms (re)inflecting political and economic institutions. Take for example the interactions between myself and Felicity.

> *In our first meeting, Felicity was (it seemed to me) uptight and serious. Her body language and serious tone affected me. I felt anxious and uncertain. I could feel my body's tenseness. My response, body language, and behaviors such as trying to appear certain, and exerting power, potentially affected Felicity and made her feel unsafe. Other power dynamics within the clinic also influenced distress. I felt unsafe and uncomfortable communicating with the specialist physio overseeing Felicity's care as our beliefs around what was causing felicity's pain and approach to care differed. I felt frustrated that her pain was being reduced solely to lumbar joint pain and stiffness, but fearful that I would be blamed for Felicity's pain not improving. This distress assemblage also involved the technology in the room, the sterility and busyness of the clinic and waiting rooms, the multiple and conflicting sources of knowledge from various healthcare professionals, Felicity's past experiences with health care professionals that increased her pain, her history of trauma, and my past experiences with conflict or situations where I felt unable to help patients. These human and non-human things may have reinforced Felicity's discomfort. The institution's 30-minute appointment time-limit may have also affected my behavior and Felicity in turn. In Felicity's later appointment, the dynamic assemblage involved worry about time off work, financial stress, concern about family dynamics and Christmas family gatherings, Felicity's frustration with having another debilitating flare-up, disappointment, mistrust in me her physiotherapist, fear that she will not get better, my sadness that I contributed to Felicity's flare-up and the consequences of that, and feelings of helplessness, not knowing how to help Felicity, and fear that I had lost her trust.*

Affects and emotions can enhance or diminish the capacities of relations.[62] The changes produced in bodies can be physical, psychological, social, emotional, economic, and more. Embodied beings/humans interact with changing social and material worlds. Viewing emotions and distress through a critical, sociocultural, affective, and relational lens allows greater appreciation of this dynamism, accommodating a social reality that is plural and subjectively experienced. It broadens understandings or capacities of emotions to prioritize knowledge through bodily intensities and becomings.[62]

Extending beyond symbolic interactionist views of emotions, relational approaches include the affect shared across social and material artefacts and how

they permeate our identities, work, and relationships. They emphasize emotion and distress as collaborative, dynamic, and unstable forces. Such conceptual approaches may also facilitate recognition of how power, injustices, and emotions relationally shape clinical interactions, explicating how broader macro-political inequalities imbue distress in chronic pain care.

Such an approach is generative to clinical practice in chronic pain care, broadening the focus to appreciate the importance of patients' distress to their own experiences of chronic pain. It also recognizes the importance of clinician distress and how this may produce or amplify patients' distress. Alternatively, being attuned to distress through bodily sensations can be a resource for clinicians, drawing their attention to their own and their patient's emotions, to recognize how they may be (re)acting, interacting, or communicating—and prompt reflection on the forces potentially producing distress. It invites possibilities to move away from reductive enactments of distress produced through standardized checklists and outcome measures.

Furthermore, such an approach helps us shift away from understandings of distress as an individual pathology, toward appreciating its potential as a conduit working through the social-clinical-institutional assemblage. By conceptualizing distress as part of a dynamic assemblage made up of many interconnected elements—some of which may not be immediately visible or understandable—it becomes possible to approach distress with greater nuance.[63] Distress can be a result of harms from broader social structures (eg, neoliberalism, patriarchal violence) and relational challenges, beyond the sphere of influence of individuals. This may help clinicians to be more compassionate, recognizing the need to acknowledge and validate a patient's distress. It may help clinicians to first listen to what distress may be signalling rather than simply trying to 'fix' or manage distress, which risks unintentionally increasing distress.

Conclusion

I have presented in this article a case for (re)conceptualizing distress within chronic pain care. I've demonstrated how distress is poorly conceptualized and operationalized in chronic pain care: as a pathology within the patient, a hinderance to recovery, as separate from the physical elements of pain, and as something to be avoided. However, distress is more than an individual pathology. Distress is relational and socially-situated; both clinicians and patients experience distress and can be affected by and affect each other. Furthermore, many cultural and sociomaterial factors like human and non-human bodies, past experiences/histories, trauma, social relationships and adversity, structural inequalities and injustice, discourses, practices, organizational and systemic structures and expectations, culture, societal and academic understandings, all influence the experience and expression of distress.

Therefore, I argue that distress—conceptualized as an affective assemblage—is often a normal response to a person's history and circumstance. Importantly, while distress is reasonable, it is often the result of harmful sociopolitical systems and structures. This should prompt healthcare professionals and systems to look beyond individual solutions to fight for solutions to social inequalities and injustices.

This conceptualization of distress as an affective assemblage—using a critical, sociocultural, affective,

and relational lens—lays a theoretical foundation that can be applied to research and relations of care in chronic pain. It provides a broader and more dynamic perspective compared to predominating models (eg, the biopsychosocial model), which often encourage dualistic or fragmented approaches to care and miss the relationality of clinical encounters.

Viewing distress as an affective assemblage shifts the focus beyond the individual in pain to see the person interacting with complex physical, social, spiritual, and cultural environments—including the clinic and clinician. It expands consideration of how broader political, economic, cultural, social, and organizational forces impact pain experiences. Future research should draw on this theoretical lens, and the hypothetical vignette provided herein, to further explore what it makes (im)possible in chronic pain care, and how it might help in re-imagining and redressing inequities in care.

Footnotes

[1]* *Italics* connote a change in 'voice' to the vignette.

[2]* In this paper we draw from the physiotherapy clinical experiences of the first author and therefore the paper is written in the first person. However, the whole authorship team contributed their expertise through conceptualization, and engagement with theory, physiotherapy, and chronic pain care.

[3]*I purposefully do not provide one definition of distress here; instead, our positioning and purpose is to attend to its conceptual multiplicity and the effects of different conceptualizations in chronic pain care.

[4] * ' negative' is placed in quotation marks, acknowledging debates within emotions scholarship on the extent to which emotions can be valanced without consideration of their culturally- and individually-relative meaning.[66]

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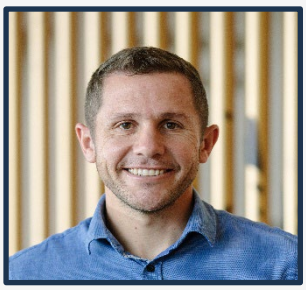

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