Commentary: Pain, Stigma, and the Politics of Self-Management

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In his 2016 "President's Message" to the American Academy of Pain Medicine, Carr suggested that "the depth and complexity of [pain patients'] experiences are not easily captured by purely quantitative data" [1]. Quintner follows the implied charge, that is, to use multiple methodological approaches to understanding pain stigma, in his article "Why Are Women with Fibromyalgia so Stigmatized?" [2]. His approach to pain stigma, rooted in a historical narrative, deepens our understanding of how this problem, especially for women suffering from pain, is deeply systemic insofar as it is embedded in the very cultural structures of language, religion, philosophy, and literature.

As a scholar of religion, my work (see, e.g., *Peace, Love, Yoga: The Politics of Global Spirituality*, forthcoming) [3] analyzes what I call *neoliberal spirituality* in order to further our understanding of religion in contemporary society. In the present editorial, I hope to bridge that work with some themes in the literature on pain stigma, building on Quintner's analysis by bringing into consideration the present cultural moment, more specifically, the context of neoliberal capitalism. I argue that many of the factors responsible for the ongoing stigmatization of those suffering from pain, especially women, and arguments for self-management interventions are as embedded in the contemporary dominant ideology and structures of neoliberal capitalism as they are in the historical sources Quintner discusses.

Following Brown [4], I use neoliberalism to refer to not just a set of late capitalist, free market economic policies, but also a governing rationality that disseminates market values and metrics to every sphere of life, formulating everything, everywhere, in terms of capital investment and appreciation, including and

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especially living beings. Neoliberal governmentality—which holds the individual fully responsible for their conditions—can be seen at play in discourses of self-sufficiency, which reify the individual, construed as an automaton, ideally self-optimizing, self-sustaining, productive, and entrepreneurial.

My work on neoliberal spirituality teases out the deep elective affinity between self-care industries, such as yoga and mindfulness, and the dynamics of neoliberal capitalism. Most significantly, I highlight the tendency to wed the goal of material "prosperity" to "self-care" in the quest for freedom (from oppression, pain, suffering), rooted in some form of ancient or exotic wisdom. Huge swathes of consumers in global cities all over the world spend their money on self-care commodities, hence the emergence of large transnational corporations, indeed entire industries, producing self-care products and practices. Increasingly, the medical system reflects the growth and mainstreaming of those industries; we see increasing attention in medical contexts to what are called self-management programs, which can include tai chi, yoga, mindfulness, or other self-care interventions, in hospitals, doctors' offices, and labs.

Self-management is a term used loosely in the pain literature to refer to a wide range of programs through which the individual is expected to take responsibility for and play an active role in the management of their pain. The assumption is that these programs are "patient-centered" insofar as they acknowledge the patients' roles in their own healing and therefore have the potential to provide more efficient and comprehensive pain management. Interestingly, much of the literature on self-management programs notes that these are relatively safe, cost-effective, and less likely to be stigmatized compared with other treatment approaches, most notably prescription medications, but also behavioral interventions or invasive procedures. Many studies suggest that clinicians should consider self-management programs for pain, given the comorbidity of chronic pain and the complications associated with treating it.

When we speak of the self-care and self-management programs that consumers describe as empowering, healing, transformative, or liberating, we are not usually talking about things that challenge or weaken dominant hierarchies. In fact, much of those industries' products are rooted in concerns about deviancy,

especially in the form of low work productivity, which often leads to the judgment that the relevant workers fail at self-care. The prescriptions for self-care have little or nothing to do with societal transformation; rather they denote the requirements for more productive, efficient, and conforming patients and consumers. In other words, as the demands on people to work and be productive have increased, so we have seen an increase in yoga classes and mindfulness manuals, which for the most part claim to enhance productivity and simultaneously conformity to a rigid moral (not to mention bodily) standard.

Put differently, self-care industries support neoliberal capitalism, both in the pursuit of surplus value and ideological control, that is, by reinforcing its structures, norms, and values and punishing deviations from them. Creating deviant outgroups—from marketing strategies that idealize self-governance and narrow visions of what bodies should look like to research in pain medicine that assumes patients should take responsibility for their chronic pain even when evidence suggests inequitable social structures are at play—and claiming that the members of such groups fail to choose the right interventions to cultivate health, productivity, and self-improvement serve these ends. Self-care commodities are celebrated as good consumer choices, products that lead to better living outcomes. If you are unhappy, unwell, stressed, in pain, or not the proper weight, that is because you are not making the right consumer choices. You are not buying the right stuff.

Gender is central (not peripheral) to self-care industries' operations. Structural transformation is not expected as the solution to gender inequities; rather, resolving those challenges is a burden placed on the shoulders of the disenfranchised, that is, women and other gender and sexual minorities. It should not surprise us then that self-management programs like yoga and mindfulness are increasingly encouraged for sufferers of chronic pain, which affects a higher proportion of women than men around the world. Studies show that women are nonetheless less likely to receive treatment, and this even though they generally experience more recurrent pain, more severe pain, and longer-lasting pain than men. If you are a working mom and experience pain, take a yoga class or study mindfulness. These are the ways to achieve

health and work-life balance, not demanding structural changes, such as better parental leave policies or childcare at the workplace. Studies show that, in addition to gender, class, and racial factors, including a history of Medicaid insurance and lower education levels, being black or Hispanic is also associated with higher incidences of pain.

Put simply, self-care industries individualize what are fundamentally social and political problems in society. This is obviously cohesive with neoliberal capitalism. It follows an ideology that you need to work on yourself, rather than look to social resources for solutions to your problems or demand structural changes.

Neoliberal discourses are nearly ubiquitous in contemporary culture. Given that, it should not surprise us that a neoliberal ethic makes appearances in the literature on pain medicine. For example, Quintner discusses Wesseley's suggestion that clinicians sometimes display sympathy toward their patients "based on their perceptions of whether the illness was acquired through praiseworthy or contemptible means" [5]. As Scheurich observes: "Clinicians struggle with animosity towards patients when the moral attitude contaminates the clinical attitude, that is, when clinicians feel justified in holding patients responsible for some aspect of their illness" [6]. This attitude, that patients are *responsible* for their pain, pervades the literature on and justifications for self-management programs. Quintner also cites literature suggesting that the perception that patients are responsible for their pain could result in societies inflicting sanctions on such people to coerce them toward the "right" way of life in which any benefits obtained are deserved [7].

My concern is not that so-called "patient-centered" self-management programs are not effective in alleviating some of the symptoms certain pain sufferers experience and avoiding some of the complications of other interventions; rather, it is that they stand in place of addressing social stressors related to race, gender, sex, and class, for example, that contribute to lifetime adversity and disadvantage and that are key to increasing our understanding of pain and pain stigma as social phenomena. Pain and

pain stigma affect certain populations more than others, as do other social inequities and inequities in access to care. People who are already socially and economically disadvantaged lack the resources and adequate pain assessment and treatment needed to resist pain's debilitating effects. As Carr points out, this represents an "inversion of the social contract towards persistently impaired members" [1]. The default behavior is to stigmatize "those with the greatest need for help" [1].

Lack of attention to social and economic factors—alongside increased attention to the role of the patient in taking responsibility for their own pain—may increase health inequity among those pain most affects. In fact, Carr suggests, "Identifying and addressing social, emotional, family, and environmental factors can impact the success of the clinical encounter of the patient with pain more effectively than time spent fruitlessly seeking a 'pain generator'" [1]. Likewise, addressing these factors could impact the types of interventions we adopt—including structural interventions that might prevent some of the pain to begin with.

I do not mean to offer just one more voice bemoaning self-care commodities and practices as numbing devices through which consumers ignore the social and structural problems of neoliberal capitalism. Many recent studies have already offered referenda on them, suggesting they merely serve as palliatives or coping mechanisms [8, 9]. These commodities and practices, in their view, function like a fetish that helps consumers feel as if they have escaped reality.

I propose what I hope is a more nuanced analysis by asking what we should make of industry discourses that describe self-care and self-management commodities and programs as "alternatives" to mainstream medical treatments, as more "holistic" and "patient-centered" insofar as they consider the interplay of biological, psychological, social, and cultural factors, and as "empowering" the patients by giving them the opportunity to take responsibility and play an active role in the healing process. I suggest we attend to these through consideration that, rather than a mode through which consumers ignore, escape, or are numbed to the social and structural problems of neoliberal capitalism, many forms of self-care and self-

management, like neoliberal spirituality, represent an area of medicine through which protest against the reigning status quo is simultaneously expressed and contained. The self-care “alternative” programs themselves confront some of the greatest problems with the privatization of medicine—most notably, the neglect of the patient as embedded in larger cultures and structures that can disadvantage them—without impunity for those very problems.

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