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Painscapes

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Pain is imbricated in clinical and experimental histories where the transformation of subjective experience into scientific measure was a form of political physiology.[1] Tracing a history of pain in medicine, Joanna Bourke notes that the application of ether substances in surgical pain relief for surgical applications was not until 50 years after the discovery of this substance, as its widespread use was intertwined with Romantic preoccupations about the democratic distribution of happiness that pushed the pain relief agenda as a legitimate goal during the Enlightenment. Davy's discovery of ether was framed by vitalist concerns about the effect of an under-stimulating gas vis-à-vis pain as an over-stimulant, both seen to put patients at risk.[2] As it became possible to render a person insensible to pain while keeping them alive, the principle of application of pain relief was grounded in forms of calculation of preferable suffering. Pernick's history of anaesthesia demonstrates that the application of pain relief relied on the acceptance of suffering ratios and probabilities of death, and that the 'utilitarian professionalism' that guided the early

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development of anaesthetics was itself rooted in physicians' 'search for a moderate consensus ideology'[3] that would allow them to bridge disciplinary cleavages. Choices between maintaining life and alleviating pain were affectively grounded, as physicians understood their professional duty as 'demanding the unhesitating infliction of extreme suffering in order to save lives'.[4] Social position, race, and gender and age played a major role in this form of calculus, effectively determining who would and would not receive anaesthetics, and to what degree. In some instances, pain was seen as a positive experience that could be beneficial. Physicians counted in their duties to 'bolster the courage of patients',[5] seeking to actively 'develop' their moral qualities through pain management. In contrast, patients were dismissed as responding emotionally while under the influence of anaesthetics, and the encounters between practitioners and patients were seen as dangerous even for practitioners, as the application of anaesthetics was perceived to threaten the social, sometimes also the sexual order between patients and their clinicians. Indeed, as Bourke argues, the development of anaesthesia was enmeshed in wartime logics and logistics, practical barriers that determined the availability of pain relief remedies, as well as defective equipment and incomplete medical training that added up to unequal pain relief provision, grounded in moral anxieties and spiritual dangers.[6]

Turning pain into an object of medical study 'involved separating clinical pain from laboratory pain, and most importantly, separating chronic pain from acute pain'.[7] The history of anaesthetics is based on instrumental correlations that attest to the reality of pain, based on certainties such as the fact that 'a small prick with a needle in the finger causes tolerable pain, whereas a strong blow with a hammer to the same place normally unleashes severe pain'.[8] Correlational measures of pain and tissue damage were predicated on assumptions about the stability of pain as an object of investigation, privileging purely mechanical values of sensation as data since these produced replicable results. Although judgements such as these provided pain with unique characteristics, and its status as research object,[9] these same judgements imbued chronic pain with a problematic status: not only is it a private experience to which no one but the person in pain has direct access, but it resists medical actions and explanations in its persistence. As social, emotional, and psychological domains are brought to bear on the aetiology and definition of pain, clinical research has progressively veered away from early theories of pain that followed the Cartesian model of an isomorphic relation between pain and tissue injury.[10] Yet, as Goldberg has noted, pain without lesion became an object of consistent epistemic stigmatisation in clinical research and practice well into the twenty first century, supported by the rise of a culture of mechanical objectivity and evidence-based practice and backed by historic paradigmatic court rulings.[11]

Definitions of chronic pain have been notoriously difficult to standardise.[12] The long-term effects of chronic pain do not easily map onto prognostic values and indicators.[13] Biomedical health narratives imagined pain through metaphors of survival which depend on the recognition and elimination of pain. Contraposing the pain-free body to the body afflicted by pain, pain is seen to trigger a form of warfare,[14] calling for action-oriented technical responses to tackle its effects and for long-term adaptive approaches to healing. Indeed, 'a good life' should not be painful or difficult, nor lived through the kind of alienated senses of subjectivity and relationality that often arise from anomalous long-term pain.[15] However, although ubiquitous forms of pain transverse religious, cultural, and historical boundaries,[16] social scientists have long known that pain derived from long-term illness is not universal, and neither are its effects.[17] Persistent pain is, rather, anomic,[18] escaping systematisation in a coherent system of meanings or values. Pain may be an event of total loss that fractures any and all notions of totality.[19] It may be a fluid state across patterns of flare and remittance in which, alongside the endurance of pain itself, there is an inability to restore levels of function held prior to pain's inception.

Thinking through emotional and communicational aspects as critical to pain experience, Bendelow and Williams argue for an approach to pain beyond models focused on sensation and based on the Cartesian split between body and mind.[20] Against the medicalised view, Bendelow and Williams recast pain as an experience of being in the world, irreducible to the qualities of sensation, and grounded in communication processes at the intersection between biology and culture. Pain extends beyond individual bodies to inhabit practices, relations of care, regulations, pharmacokinetics and multiple, partially connected practice cultures that normalise notions of health and ability, producing pain no longer only as sensation, but as an epistemological, social, and political ecology. People who live with pain long term trace their pain to personal experiences of misdiagnosis, stigma, and undertreatment, to the extent that, analysing the global patterns that make chronic pain endemic, Manderson and Smith-Morris argue that 'increasingly, chronic, long-term conditions are not naturally occurring ones, but are those for which the political will and economic resources are simply not brought to bear for a given community'.[21] As the prevalence of chronic conditions becomes an increasingly ubiquitous global public health concern,[22] the increased prevalence of chronic pain is linked to factors shaping access to resources, socio-economic status, stress at work, occupational status, race, and education, locating pain across relations between policy and politics. Correlations between pain and disability highlight, furthermore, that feeling pain and being in pain are not co-terminous. People with lower incomes are not only more likely to be more disabled by pain, but research demonstrates that there is a relation between social conditions and the intensification of pain.[23] For Wilkinson and Kleinman, social suffering is now an extension of illness made routine in everyday life by the force of stigma, material deprivation, and compounding forms of epistemic, medical, and political injustice.[24]

In this context, new questions are emerging across academic disciplines about the relation between pain experience and pain expression, which point to complex entanglements between pain epistemologies, the justification and provision of healthcare services, and the dynamics of clinical protocols in lives where pain is present. Addressing pain communication, from this perspective, requires an ongoing dialogue between the humanities, art, philosophy, and the social and biomedical sciences. Combining insights from anthropology, sociology, the medical humanities, and the arts, this volume draws on phenomenological and post-phenomenological approaches to pain communication to enquire about the devices, methods, and artefacts through which pain is known and lived. It focuses on the material, informational, and practical worlds that emerge as pain is made social, and how the endurance of these worlds, their disruptions, and transformative potential pose new questions about the epistemologies and transactional politics of pain and method. Using multiple devices such as stories, poetry, photographs, concepts, and relational aesthetics, contributors reimagine pain through intersubjective, temporal, and material and knowledge ecologies, *painscapes*. These configurations are meant to be totalising representations of pain experience but map the complexity of pain across physical, social, and intersubjective domains, following key concepts, objects, and methods to conceptualise the ways of knowing, relating, and dwelling that resonate in everyday experiences of pain.

Pain and/*as* Communication

Pain literature in the humanities insistently recounts pain's resistance to language. For Wittgenstein, in Philosophical Investigations,[25] language holds an ambivalent potential, as it betrays the inherently private nature of pain, which makes language liable of misrepresenting pain, at the same language is an extension of pain, makes pain public. Elaine Scarry has clearly illustrated that the experience of pain and language relates only partially. 'Physical pain', she writes, '-unlike any other state of consciousness- has no referential content. It is not "of" or "for" anything'.[26] Scarry argues that the indeterminate location and immersive experience of pain bring about a state prior to language, arguing, against currency of biomedical knowledge, that only those who are not in pain can become the reliable narrators of pain experience. Arthur Frank's work on illness narratives demonstrated how the relation between bodies and narrative reflects both cultural ideals and ethical choices, since, ultimately, through narrative, the body is the moral problem addressed in narratives of self-making.[27] A growing body of literature in the fields of medical humanities and narrative medicine has come to revalue narrative as a transformative device in clinical contexts and beyond.[28] Drawing on Eve K Sedgwick's notion, Jurecic reflects on the value of illness narratives as 'reparative reading'.[29] Exploring the role of illness in professional writers' accounts, Jurecic argues traces a parallel between the emergence of narratives about illness and a new role of everyday experience in literary practice. In the nineteenth century, memoirs by clinicians and their heroic narratives of discovery preceded first-person narratives of illness. Unlike full autobiographies, these narratives were rather 'sanatorium narratives',[30] chronicling an encounter with illness, with medical staff, or with other patients. But as changes in the patient–doctor relationships became pronounced after the 1950s, and then again after population health crises such as the HIV/AIDS, the quest of meaning in illness proliferated in multiple genres. Straddling between the noble act of testimony and the impossible task of speaking about trauma, medical, and public engagement with these narratives produced qualitative changes in how individuals faced illness.[31] Jurecic argues that illness narratives generate productive tensions at interstices, taking from illness narratives their capacity to multiply the presence of illness, to speak 'out of what spaces I may speak of it, or be spoken for' as Sedgwick put it, a place where it is possible to point towards instability and uncertainty. Consider Lochlann Jain's definition of 'living in prognosis',[32] which develops a sense that cancer diagnosis, repeatedly deferred and warped by cognitive dissonances between a lived sense of vitality and a personal sense of cancer imminence, and the 'objective' statistical accounts of symptoms brought forward by medical professionals with no direct experience of cancer. Jain was presented with a calculative process based on probabilities of effectivity of particular treatments. Numbers and statistics waged as a measure of real chances of survival were intentionally devoid of politics, yet measured the politics of knowledge against the process of living. Jain writes that 'the statistics that offer the promise of beating the odds also evacuate the politics of prognoses'.[33] Indeed, being treated as a statistic observation not only clashed with Jain's sense of embodiment, selfhood and aspiration in the diagnostic process, but with her actual progress once a treatment course was approved.[34] Living in prognosis suspended the sense of passing time, and of temporal frameworks such as age, generation, illness stage and lifespan. Jain's testimony attests to how consequences of ineffective or injurious ways of knowing treatment had real consequences, affecting some survivors more than illness itself.

Informational worlds are key to the making of everyday pain and disability worlds.[35] Living in pain implies reinterpretation of what a normal life can be like,[36] as of pain temporalities overlap with poverty, normal practices of care and neglect, imbricating the experience of social and physical pain with social dynamics of care and the failings of bureaucratic and administrative systems. Lauren Berlant offers a compelling reading of their entanglement in the Dardennes Brothers film *Rosetta* (1999),[37] which chronicles the devastating physical effects of social pain through the protagonist's impossible quest for aspirational normativity. For Berlant, the indistinction between physical and 'political, economic and affective forms of existence' relates broad kinds of social dynamics to a critical interrogation of the place of pain in the making of political worlds.[38] From this perspective, pain becomes an environment, rather than an object, whose knowledges, practices and artefacts are, as Berlant suggested, 'themselves normatively mediated'.[39] For example, ethnographic studies of pain management[40] evince how dominant ways of knowing pain affect how pain is perceived. Anthropologist Jean Jackson has argued that distinctions between experiences of pain, the emotional states that come with it, and pain behaviours is ambivalent, and the credibility of self-reports of pain can diminish over time. Cultural or collective meanings of illness can work counterintuitively to delegitimise certain forms of pain experience, which are understood as 'meaningless', lacking cultural appraisal or contestation.[41] Jackson's study focused on how interactions at a pain clinic, characterised by a disconnection between patient reports and medical terminology, suggest that forms of address actually impact the perceived reality of pain, its nature, and the perceived responsibilities associated with stigma. During the course of one year, Jackson developed a methodology of 'cognitive restructuring' to track how changes in how pain was thought correlated with self-reports of pain improvement. At this clinic, 'real pain' became notoriously difficult to standardise. While it was agreed that pain 'performed a function' in most cases, whether the nature of this function could be considered authentic was routinely made an object of contention. Jackson reports that "clinicians' understandings of pain are complex and varied, depending on their medical specialty and on the specifics of a given case (…) the clinicians' debate focuses on the extent to which chronic pain is due to psychogenic, rather than physical aspects, causes, and the consequent implications for treatment'.[42] Indeed, the focus on pain's aetiology derived a distinction between 'real' pain—organic, and pain for which the patient is not responsible and 'unreal' pain—involving somatisation and possible gains for the patient, such as access to medication or an assumed ability to derive social gains from 'performing' pain. Combinations of 'real' and 'unreal' pain were the most common for patients. For Jackson, patients were 'placed on a bind: on one hand, some hope is being offered in the form of pain relief, on the other, the suggestion is clear that their notions about their own pain are wrong'.[43] Compounding the notion that unreal pain can be willed away by psychological therapy or non-medical therapies has far reaching implications, as patients began to resist the pain clinic's message because it was seen to perpetuate stigma. Jackson, therefore, became suspicious that self-reports of improvement—that were used to compile improvement indices—reflected actual improvement. Rather, her ethnography suggests that patients routinely changed their understanding of pain, and how they communicated about it, as their own pain measures were broken down and rewritten over the course of the programme to fit with the clinic's prognostic indicators.

The importance of illness narratives, from this perspective, would not least be the capacity of the story to be read, and of a reader to construct the time-bound causal patterns that relate sense-making to primary experience. Placing a teller and a reader at the centre of a narrative process highlights how stark objectivity may not be possible in the realm of human interactions. For Morris,[44] fiction provides a bedrock for a 'post-modern' illness model, understood beyond dualistic, mechanistic, and reductive definitions of body versus mind. At the crossroads of biology and culture, this new approach 'acknowledges the emergence of powerful cultural forces from mass media and government subsidies to multinational drug companies', revealing 'how illness can be crucially modified or wholly reconstructed by its contact with narrative'.[45] For Morris, the implications of the clash between individual and cultural narratives are primarily ethical. Indeed, a narrative ethics must be willing to pose difficult to answer questions about intended and unintended damage to patients, and to face up to the challenge narrative's potential to challenge the decidability of knowledge. For example, in an autoethnographic study of fibromyalgia, Greenhalgh highlights how chronic pain objects, materials and devices have social lives of their own. They can produce disability as an administrative category with recourse to particular policies and regulations,[46] even though, rather than on a physical basis, it depends on social judgements of normalcy, and the measuring of bodies and everyday realities against ideals that characterises disability worlds.[47]

In Greenhalgh's process of being misdiagnosed with fibromyalgia, pain, like disability, was normalised through undemocratic access to technology and the materialities and politics of communication processes. In clinical encounters, her identity was transformed from that of a 'person with arthritis' to a 'fibromyalgic-arthritic patient', a process that involved normalising symptoms and undergoing a course of treatment as part of an erroneous diagnosis.[48] For Greenhalgh, discourses of truth masked as scientific and value neutral put the patient in jeopardy particularly when the complex and chaotic reality of the clinical encounter is denied. However, rather than accept epistemic injustice as an inevitable outcome of clinical relations, a phenomenological and postbiomedical notion of illness must be crucially concerned with values and politics of communication.[49] Greenhalgh calls the doctor's account of the patients' ills a story which draws attention to the moving boundaries between fact and fiction.[50] As a pragmatic tool, narrative can displace questions about who is right or wrong in composing a problem. Crucially, Morris argues, narrative would force medicine 'to confront the recognition that pain is not just a medical or neurological problem but implacably biocultural'.[51] In these sense, illness narratives stage a cultural politics of emotion. Morris draws these politics around encounters 'in the hallway', encounters deeply entrenched in personal experiences of illness that produce new critical agenda for bioethics.[52] Such a programme as this can intentionally replace the ethics of good and evil which hides behind bureaucratic bodies and institutional decisions, linking cultural narratives back to both identities and everyday moralities of the people for whom they matter.

In this context, pain communication becomes a key site of enquiry. Through communication, like illness, as Carel perceptively proposes, can be a phenomenological notion in contrast with the naturalistic definition that accounts primarily for physical fact, it is 'objective (and objectifying), neutral and third-personal'.[53] Carel's first-person-centred epistemology is the basis of a shift to abandon the framework of pathology and bring forward new questions about the social, cultural, epistemological determinants of illness.[54] But more crucially, a focus on communication can become a key site to develop ethical forms of communication concerned with identifying the structures that underpin experience, while taking difference seriously and recognising that others' experiences may be incommensurable.[55] For Carel and Kidd, this process

> involves a transition from an "informational perspective" which sees the speaker as a "potential recipient or source of information" to the 'participant perspective', in which we see the quest for knowledge as a shared enterprise and the patient speaker as "competent to carry out some particular activity that has a fundamental role in carrying out inquiries[56]

Reflecting on clinical experience, Biro has described how a creative practice of listening could transform the clinical encounter with people who 'try to find the right words, but typically come up empty'.[57] It is perhaps the difficulty of finding the right words, he argues, that has tipped clinical assessments of pain from relying on technical assessment protocols, such as the McGill Pain Questionnaire, to instead provide people seeking pain services a basic series of pictures known as the faces pain scale.[58] Biro argues, however, that transcending literal linguistic representations may help clinicians get better at identifying and treating pain. While the rich vocabulary involved in metaphorising the action of pain of the McGill Pain questionnaire goes a long way in making pain representable through language, the simplicity of the faces scale, using pre-linguistic expression, makes it possible to communicate in practice. As Nancy has noted, while hearing has multiple meanings organised through different combinations of tension, intention and attention, listening, on the other hand, evolves around the word 'entendre', which is linked to 'comprendre'—'understanding'.[59] To listen, unlike hearing, does not relate to sensation but seeks to achieve a presence in the 'resonance of a return'.[60] Through listening, a listener opens to the world a field of relational ethics.[61]

Biro's patients spoke of living across two worlds, a sense that the depth and elusive presence of pain is indistinguishable from its significance. Here the metaphorical and contextual nature of pain communication becomes a crucial site of enquiry where new questions about the relational and ecological form of pain can be formulated, drawing on the ways in which different media can draw multiple emotional, aesthetic, political and sublime responses, and not, like in language, directly through it.[62]

Painscapes

This volume aims to interrogate intersections between pain and communication to ascertain in what contexts and to what effects pain becomes known.[63] Much like Veena Das' methods compose the problem of pain from a vernacular,[64] the chapters in this collection present a series of contexts as 'scenes of instruction', presenting particular assemblages of media, context, and critique as key interfaces of ordinary ethics. Advocating a descent into ordinary practice, cultivating the sensibilities of the everyday.[65] In a broad cultural discussion of modernity, Arjun Appadurai argued that the suffix—scape captured a new role of imagination in social life. Not only that the tensions between cultural homogenisation and heterogenisation demanded a dynamic framework 'where an array of empirical facts could be brought to bear on [the] argument', but a sense that theoretical tools, even models and flexible theories, come short of addressing the complexity of global cultural flows. The suffix—scape, as Arjun Appadurai (1996) proposed to understand it, brings into relationship multiple dimensions of complex phenomena, describing landscapes which may be fluid and irregular, and which do not take an objective form from every point of view. Rather, painscapes are perspectival constructs, inflected by the situatedness of multiple actors, who form part of other landscapes, and who both constitute and experience these landscapes in the process of imagining their capacities and shortcomings.

Imagining painscapes brings contributors to map socio-material formations connected with ways of knowing pain, refracting pain through the lines that entangle medical, psychosocial and political domains of pain experience. Navigating these domains opens up a transsensible space that brings into focus transits and exchanges between multiple modalities of perception and technologies of capture in the making of pain worlds. Focusing on the multiple *relations* between experience and expression brings forward a practice of witnessing that takes pain beyond the dominant visualism paradigm in philosophy and in science, bearing witness in ways that exceed vision: just as there is no eyelid to protect from hearing, sound demands to be brought into experience in ways that surrender attention and elicit an affective, conceptual and emotional response. Critical to this new focus on pain communication, then, is the notion of attunement as a critical outcome of communication. This notion brings to a relation context, media and message, and it calls into question the idea that communication must aim to generalise experience, seeking, instead, a capacity to sense, figure, amplify, attend, sensitise, and translate the complexity of the material forces that structure sensation. Tone and tendency are fundamental to the transformation of physical qualities into working concepts, since connecting thinking and feeling foregrounds the critical role of the encounter as a generative, not representative time-space.[66] Crossing human and non-human boundaries, attunement involves locking in qualities, frequencies and vibrations in a communicative event, and connecting capacities of perception to capacities of understanding and intervention, involving the elements assembled in the process of communication.

Bending opens the collection by reflecting on the historical underpinnings of the difficulty of communicating pain. Focusing on the American Civil war, Bending follows the claims to pain's incommunicability to Army Assistant Surgeon J.J Woodward and army doctor Silas Weir Mitchell, who observed that it is only when a person *performs* pain, by verbally admitting to its existence, that the *foreignness* of pain, its signs and symptoms, can be translated. Focusing on how these doctors learnt to listen to 'the sad language of pain', Bending opens up the power of language, and its limitations, to translate 'real' pain worlds. Mitchell advocated a professionalisation of pain medicine not only as a means of recognising the unprecedented forms of pain soldiers encountered during the war but also of grappling with entanglements of word and symptom—real and imagined—as well as with their social and emotional effects. Bending chronicles how in this period, *seeing* pain, rather than *listening to* pain, became the gold standard of diagnostic procedures, constructing the ways in which the 'compelling, more truthful' character of the body's somatic responses was preferred over words by doctors, until it is the doctor himself who is doubted in his capacity to accurately translate pain. For Bending, Mitchell's story brings pain back into moral sets of relationships, and the practical historicity that provides symptoms truth value to ways of knowing in scientific and clinical relations. At the other end of this story, the presence and immediacy of a Crohn's disease diagnosis, Rosen newly engages history and poetry to bear on her experience of chronic pain. Using poems as devices that connect temporalities of pain and clinical pain cultures, Rosen casts the practice of writing as a generative form of resistance to cultural debilitating narratives of chronic pain, using writing to open up in between spaces where people, organs, and drugs, social living and cultural representations share a common temporality. Rosen strings these temporal thresholds through the long persistent temporalities of chronic pain, mirroring memory through the momentous difference of poetic effect, and marking the space of writing as a space of transformation 'outside' of pain. Entangled in this space, writing and sensation unfold multiple tensions between pain and identity, intentionality and indeterminacy, creativity and rupture. The point of pain, Rosen speculates, might be to let the interface of a poem extend the political boundaries of the body beyond the self, in the process making 'the unbearable funny, and hence, bearable'.

Challenging clear-cut binaries between subjective and structural forces, public and private domains, the performance of pain is bound by the recognition of authenticity. Goldingay delves into the mutually constitutive roles of performing doctors and patients in chronic pain related clinical encounters. Her chapter interrogates the cultural fragility associated with the figure of chronic pain patients as they approach the clinical environment, and particularly, the contrast that emerges between this fragility and the coping strategies a person in pain necessarily deploys in everyday living. Goldingay analyses the medical encounter to tease out the expectations, procedures, and experiences that compose patient and doctor roles in the chronic pain drama. Drawing on the inherent dynamism of these roles, and their reliance on conflict, Goldingay unpacks how medical training and performance afford particular cultural constructions of both pain and patient roles, and how, inverting doctor–patient roles and taking non-verbal communication seriously when interpreting pain communication might deeply destabilise the epistemological structures of pain. Taking pain further beyond the limits of modern subjectivity through a reading of autoimmunity, Andrews draws on a close reading of Derrida's philosophy as well as cybernetics to conceptualise autoimmunity. Although autoimmunity refers to self-infliction by etymology, Andrews rethinks this notion in connections across biomedical, political, and philosophical realms. Autoimmunity is at the heart of the modern paradox that understands the self in opposition to a hostile environment. Radically reworking the connections that engineer the I, the authority of scientific discourses, one's autobiography, and healthcare system, Andrews undoes the gap between 'the one who writes and the one who is written', the autonomous one and the one who is 'marked violently, painfully, by that which "one" is not'. Following the logic of autoimmunity, its endurance and destructive quest, Andrews proposes a deconstructive move that focuses directly on pain as a double bind, 'where one is not only put in question but is put to the question'. Andrews offers a new lexicon to navigate pain as an aporia, which produces, at the same time, pain as a form of communication and the information pathways of self-creation. Autoimmunity, from this point of view, is based on a contradiction, which, in Andrews' words 'is just as likely to maintain a system as it is to deconstruct it'.

Interrogating the theme of pain's visibility in popular culture, Morcate explores how experiences of pain confront us with an existential abyss that destabilises notions of truth and presence, since it is only in an effort of remembering and communicating that pain is given form. The artworks she presents instantiate the past to engender multiple futurities—a practice of listening to images' resonances to tune in to what has not been said.[67] Sensing worlds through and beyond the site-specificity of artworks leads Morcate to conceptualise the role artworks might play as vehicles of grief. Morcate tracks significant shifts in pain art worlds around changes in conventional representations of pain across the twentieth century, fuelled by changes in biomedicine and by the rise of photography as a medium to explore life and death. Morcate explores artworks where the quality of detachment—between artist and pain—provides an almost analytic approach to pain, as well as a new political way into pain. By opening up pain controversies, and detaching pain from the individual experience of suffering, these artworks expose often-patronising cultural discourses of pain, particularly at a time when digital technologies and social media platforms have made it possible for artists to develop new contexts and media forms to communicate about pain, newly involving publics and media in feedback loops that transform both pain experience and expression.

As pain communication finds its way into public, networked spaces, shared ordinary experiences of pain become powerful connective and transformative interventions. Newhouse, Atherton, and Ziebland track pain communication in social media platforms and online forums. Their contribution follows how chronic pain patients in these platforms have become health prosumers—active contributors to the production of health communication as well as informed consumers. Using online worlds to find experiential information, these internet users find new ways of understanding their condition, and develop and maintain supportive relations that have a direct effect in how they live with pain. Further, these platforms are significantly transforming interfaces of exchange between clinicians and patients. The key to understanding the success of these platforms, particularly their capacity to transform experiences of pain, lies in the capacity of storytelling—a process of making visible that exposes pain communication beyond factual biomedical language. Yet the increased visibility of chronic pain online, as Pardo perceptively argues in her contribution, can also become a vehicle for stigmatising some forms of chronic pain, particularly those deriving from mental health conditions. Pardo recasts the stigma of invisible pain by interrogating the role of photography and photojournalism in social perception of illness and pain. Using photographic media to call into question the objectivity of scientific pain images, Pardo approaches photographic practices as systems that connect artists, users, and issues through culturally specific aesthetic and moral frameworks, articulating around themselves real and imagined practices and communities. While early in the medical history of pain, photographs classified mental illness traits and symptoms, clinical photography focusing on literal representations of individual conditions became the standard for the representation of mental illness, yet failed to make pain related to mental health visible. Later, approaches in photojournalism followed the critical voices in psychiatry and the social sciences to contest these representations through critical, often highly social images where the photographer's neutrality was radically called into question. The current shift towards online sharing of pain images, mixing self-referential and critical accounts, points to a gradual shift towards a 'domestication' and democratisation of pain images, signalling the beginning of new ways of communicating about pain in ever growing series published in platforms that offered more control and ethical sharing options to users.

The last three chapters reflect on the relation between pain and representation through the perspective of practice. These chapters illuminate aspects of pain that highlight the need to develop a post-phenomenological framework, concerned with the experience of pain in contexts of practice.[68] Thinking through the practice of listening, O'Shea, Wilkinson, and Jones present the results of Adjoin, a collaborative project that brought them to reflect on the experience of living with arthritis. Using photography to explore the experience of pain and to share it in the clinical encounter with Wilkinson, O'Shea reflects on how the practice of photographing, O'Shea's art project brings collected images, dialogues, reflections, and information resonances to constitute the experience of pain as itself multiple, anchored in the juxtaposition of scales, instruments, technologies of representation, the kinds of knowledge, identities, and patient journeys they afford. While O'Shea asks how the language of pain may be depicted and presented to others, Padfield and Zarkrzewska interrogate the potential of images in clinical consultations to improve diagnostic outcomes. Padfield and Zarkrzewska demonstrate how the mechanic specificities of the photographic medium might be particularly suited to be deployed in chronic pain consultations, making the experience of pain present in the consultation room, visible and actionable. Advocating a broad definition of pain across biomarkers and emotional and social pain domains, Padfield and Zarkrzewska present an integrative approach that brings to the fore the inherently narrative character of medicine. Not only do images facilitate doctor–patient dialogue allowing patients to communicate pain in a language of their choice, but working with pain patients at different stages of their journey can help people living with long-term conditions break away with the paralysis that is often experienced as a result of pain. Padfield and Zarkrzewska demonstrate how through a co-creative process, participants in their research were able to project a plastic image of identity, where the practices of observation, witness, and analysis were key to developing new understandings of identities of people living in long-term pain as flexible rather than static.

Finally, Tarr's conclusion brings into focus the relation between pain and method. Drawing on research across a range of projects, Tarr demonstrates the multiple capacities of method to generate pain as a multiple reality. As a mode of addressing pain's shifting constitution, marked by perspective as it is by knowing practices and imagination, Tarr frames painscapes as assemblages that work through the productive and limiting capacities of method—methods that tease out and enclose, reify and reveal, and ultimately produce the contrasts, transferences, and dialogues needed to compose the problem of pain.

Notes

1. Cf. Meloni, Maurizio. *Political Biology: Science and Social Values in Human Heredity from Eugenics to Epigenetics* (Basingstoke, Hampshire; New York, NY: Palgrave Macmillan, 2016).
2. Bourke, Joanna. *The Story of Pain: From Prayer to Painkillers* (New York, NY: Oxford University Press, 2014), 282.
3. Pernick, Martin S. *A Calculus of Suffering: Pain, Professionalism, and Anesthesia in Nineteenth-Century America* (New York: Columbia University Press, 1985), 105.
4. Pernick, *A Calculus of Suffering*, 109.
5. Ibid., 288.
6. Bourke, *The Story of Pain*, 285.
7. Baszanger, *Inventing Pain Medicine*, 2.
8. Moscoso, Javier. *Pain: A Cultural History* (Basingstoke: Palgrave Macmillan, 2012), 173.
9. Baszanger, Isabelle. *Inventing Pain Medicine: From the Laboratory to the Clinic* (New Brunswick, NJ; London: Rutgers University Press, 1998).
10. The biopsychosocial model of pain, the gold standard of pain diagnosis, proposes a heuristic model of the interrelation between biological, psychological, and social and cultural factors. See Gatchel, Robert J., Yuan Bo Peng, Madelon L. Peters, Perry N. Fuchs, and Dennis C. Turk. "The Biopsychosocial Approach to Chronic Pain: Scientific Advances and Future Directions". *Psychological Bulletin* 133, no. 4 (2007: 581–624). Gate control theories such as the allostatic load hypothesis situate social environments as determinants at the core of not only pain prevalence, but thresholds of pain mortality. Brunner, E., and M. Marmot. "Social

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33. Jain, *Malignant*, 66.
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37. Berlant, Lauren. "Nearly Utopian, Nearly Normal: Post-Fordist Affect in La Promesse and Rosetta". *Public Culture* 19, no. 2 (March 20, 2007): 273–301.
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39. Berlant, "Nearly Utopian, Nearly Normal," 296. See also Strathern, Marilyn. "The Whole Person and Its Artifacts". *Annual Review of Anthropology* 33, no. 1 (2004): 1–19.

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41. See Tabor, Abby, Mark J. Catley, Simon Gandevia, Michael A. Thacker, and G. Lorimer Moseley. “Perceptual Bias in Pain: A Switch Looks Closer When It Will Relieve Pain Than When It Won't”. *PAIN®* 154, no. 10 (Oct. 2013): 1961–1965. This experimental study, involving 18 naïve individuals, demonstrates that pain is perceived differently according to constantly updated contextual information, but that the environment is differently perceived at different stages of pain onset.
42. Jackson, “After a While, No One Believes You”, 140.
43. Ibid., 149.
44. Morris, David B. “Narrative, Ethics and Pain: Thinking with Stories”. In *Stories Matter: The Role of Narrative in Medical Ethics*, edited by Rita Charon and Martha Montello (New York; London: Routledge, 2002).
45. Morris, “Narrative, Ethics and Pain,” 200.
46. Kleinman et al., *Pain as Human Experience*.
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50. Greenhalgh, *Under the Medical Gaze*, 23.
51. Ibid., 206.
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53. Carel, Havi. *Illness: The Cry of the Flesh* (Stocksfield: Acumen, 2008), 8.
54. Carel suggests: 'Instead of viewing illness as a local disruption of a particular function, phenomenology turns to the lived experience of this dysfunction. It attends to the global disruption of the habits, capacities and actions of the ill person' Ibid., 8–9.
55. Carel and Kidd, "Epistemic justice and Healthcare".
56. Ibid.
57. Biro, David. *Listening to Pain: Finding Words, Compassion, and Relief* (New York; London: W.W. Norton, 2011), 3.
58. See http://www.iasp-pain.org/Education/Content.aspx?ItemNumber=1519
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61. Ihde, *Listening and Voice*, 200.
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67. See Campt, Tina. *Listening to Images* (Durham: Duke University Press, 2017).
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