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The Deserving Patient: Blame, Dependency, and Impairment in Discourses of Chronic Pain and Opioid Use

Maureen Nickerson
Antioch University Seattle

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THE DESERVING PATIENT: BLAME, DEPENDENCY, AND IMPAIRMENT IN DISCOURSES OF CHRONIC PAIN AND OPIOID USE

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Maureen Nickerson
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THE DESERVING PATIENT: BLAME, DEPENDENCY, AND IMPAIRMENT IN DISCOURSES OF CHRONIC PAIN AND OPIOID USE

This dissertation, by Maureen Nickerson, has
been approved by the committee members signed below
who recommend that it be accepted by the faculty of the
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Dissertation Committee:

____
Mary Wieneke, Ph.D.
Chairperson

____
Phil Cushman, Ph.D.

____
Elin Bjorling, Ph.D.

____
Date

ABSTRACT

THE DESERVING PATIENT: BLAME, DEPENDENCY, AND IMPAIRMENT IN DISCOURSES OF CHRONIC PAIN AND OPIOID USE

Maureen Nickerson

Antioch University Seattle

Seattle, WA

Negative stereotypes about people with chronic pain pose a barrier in the delivery of care; contribute to worsening symptoms of physical and psychological distress; and play a role in policy decisions that adversely affect patients and providers. Pain-care seekers may be accused of malingering, laziness, mental aberration, attention seeking, and drug seeking. The propagation of stigmatizing attitudes was explored in this Critical Discourse Analysis of online-reader-comments responding to a series of pain-care policy articles published by a large metropolitan newspaper. Results suggest that framing pain patients as legitimate and deserving can inadvertently reproduce the inequities advocates seek to redress. Ascriptions of deservingness were associated with the locus of choice and agency. Assignments of blameworthiness were used to distinguish the legitimate pain patient from the illegitimate care seeker. Motivation for seeking pain care, as much as the effects of opioids, provided crucial determinants in evaluating legitimacy claims and blame ascriptions. Evaluations of deservingness were predicated on the valence of social regard. Compassion, empathy, respect and believability were rewards of positive social regard. The subjects of addiction and drug abuse were maligned to the detriment of people with pain and people with opioid addiction alike. The disease-entity model of chronic pain was associated with psychiatric discourses of mental illness through a narratives inaccurate reality perception. Loss of independence, rationality, and respectability were semantically linked to negative stereotypes of pain patients, drug addicts, and mentally ill groups. Medical discourses drawing on empirical materialist traditions assert taken-for-granted population categories (e.g. chronic noncancer pain patient) with little acknowledgment of confounding variables, lack of evidence, or their social impact. For the benefit of people seeking care, there is a critical need for moral, logical, and empirical analyses of predicating factors in education and care giving decision-making. The electronic version of this dissertation is at AURA: Antioch University Repository and Archive, http://aura.antioch.edu/ and OhioLINK ETD Center, https://etd.ohiolink.edu/etd

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An acquaintance who works in office administration for a large urban clinic inquired as to the topic of my research. I replied, "stigma and chronic pain patients." Her immediate response was to interrupt further explanation to recount stories she had heard from the clinicians with whom she worked. Stories of their difficulties in handling drugs seekers and malingering patients. She concluded her tale by confirming the difficulty providers have in determining who amongst their patients is "just trying to get drugs" and who is in "real need" of pain relief. Another colleague, a practicing psychologist, informed me that the patients of pain clinics were not actually people with physical pain conditions, just personality disorders.

These are only two examples of a recurring experience in discussions about this research project. These reflexive and simplistic responses are demonstrations of the problem at the heart of this paper: The automaticity of the association between the label, chronic pain patient, and socially undesirable behaviors (e.g., manipulation), motivations (e.g., attention/drug-seeking), and identities (e.g., addict, or mentally ill).

Introducing the Problem

"Relations between pain patients and health care deliverers are considered the worst in medicine" (Jackson, 2005, p. 338).

The Patient Experience

There is a body of research covering several decades in Western countries attesting to patients' experience of being shamed, humiliated, invalidated, rejected, and discounted when seeking medical care for chronic pain (e.g., Hakanson, Sahlberg-Blom, & Ternestedt, 2010; Holloway, Sofaer-Bennett, & Walker, 2007; Lillrank, 2003; Marbach, Lennon, Link, & Dohrenwend, 1990; Nettleton, O'Malley, Watt, & Duffy, 2004; Slade, Molloy, & Keating, 2009; Walker, Holloway, & Sofaer, 1999; Werner, Isakesen, & Malterude, 2004; Young, Park, Tian, & Kempner, 2013). The people in these studies hale from different countries associated with Western cultures, yet the findings were strikingly similar across studies.

Participants reported a history of contentious and distressing interactions with various members of the medical establishment. They indicated frequently feeling as though they were not taken seriously; that their symptom reports were received with overt skepticisms, derision, or accusations of malingering; that they were viewed as disinterested in improvements; or that they were only seeking drugs, attention, or financial compensation. Some reported that they were ridiculed by health care professionals in the presence of others, and/or treated with disdain and callous disregard in private consultation. Patients described feelings of fear, mistrust, anger, resentment, shame, disillusionment, and a sense of wounded pride arising from their reception in medical and social circles.

The questions posed to participants in the studies cited above were not designed to elicit stories of discrimination, per se. Lillrank's (2003) Finnish participants, for example, were asked only to recount "past and present experiences of back pain and how it affects their lives" (p. 1046). Neither did researchers always set out to study the experience of stigma. Regarding their English participants, Walker et al. (1999) expressed their "shock" at finding such a high prevalence of negative experiences with medical providers amongst people who "shared nothing more in common than seeking help" (p. 627).

With so many similar stories across studies conducted in different cultural settings, it does beg the question: What is happening on a social level to make these narratives so common? While this study cannot hope to provide a definitive answer to this question, it is intended to contribute to the dialogue already under way.

The Professional Role

It has been observed that pain patients can engender strong feelings of hostility in caregivers (Jackson, 2005). There is as yet little research exploring the experiences and feelings of health care professionals (HCP, as an aggregate reference to the professional community in its broadest sense, including clinical workers, insurance workers, health policy-makers, program directors, etc.). One exception found in the literature affirmed the patient perceptions reported in the previous section, from the providers' perspective. The providers described feeling pressured to prescribe opioid medications; wonderment about the veracity of patient reports; worry about secondary gain, and concern abuse of medications (Matthias et al., 2010). These North American providers expressed feelings of frustration and guilt, as well as finding their work with chronic pain patients to be generally ungratifying.

HCPs occupy social roles in which they are tasked with performing gate-keeping functions for patient access to treatment providers, technologies, and products. As gate-keepers, professionals are asked to fill difficult, ambiguous, and conflicting responsibilities. To different degrees, professionals occupying different roles within the health care community are asked to determine patient veracity; assess the safety and efficacy of treatment modalities; uphold the war on drugs; protect the economic interests of their employers; and base treatment decisions on patient economic resources over and above medical indication, all while maintaining an ethical focus on patient care (Sullivan & Main, 2007; M. Taylor, 2011; Turk, 2002).

For providers working with patients being prescribed opioid medications, concerns about over-dose and addiction, and fear of criminal allegations resulting in encumbered licenses or even prison sentences compound the already difficult situation of treating patients who may be desperate for pain relief but for whom no cures exist (Højsted & Sjøgren, 2007; Richard & Reidenberg, 2005). What is more, general medical education programs have been criticized for lack of attention to pain and pain treatments in their core curriculum, leaving many providers unprepared to address the complexities involved (Mezei, Murinson, & Johns Hopkins Pain Curriculum Development Team, 2011; Watt-Watson et al., 2009).

While these can certainly be stressful conditions for professionals to work under, is this situation really so different from other complex health concerns facing the medical industry? Is there something about the intractability of chronic pain, or the ambiguity of its etiology that leads to negative attitudes toward those who complain of it? Are pain patients the real problem? Or is it the meaning of pain in the grand narratives of our societies that underlie the negativity with which these patients are frequently regarded?

The Partial Solution—A Critique

In an effort to promote a solution to the problems facing patients and providers, the Institute of Medicine (IOM) has called for increased education for patients, providers, and the public that "promote a transformation in their expectations, beliefs, and understandings about pain, its consequences, its management and its prevention" (Institute of Medicine [IOM], 2011, p. 209). What they fail to mention is the need for increased research into the prevailing “ill-informed attitudes” that have been identified as contributing factors in the under-treatment of both chronic and acute pain (IOM, 2011, p. 9). Such an endeavor is necessary in order to address the concern that abiding negative stereotypes will undermine the goals of improved patient care. It is hoped that this study will go some way toward filling this gap.

The implication in the IOM (2011) report is that additional education about pain and related factors will largely address the impact of stigma on health care practices. At first glance, such a position appears almost a truism: Unwarranted negative assumptions can be replaced with objective knowledge; unwanted negative associations can be neutralized by substituting a palatable descriptor for one that has become provocative. Research into the stigma of mental illness (Mann & Himelein, 2008; Pescosolido et al., 2010), intellectual disability (Danforth, 2002; Jordan, 2005), and HIV/AIDS (Finn & Sarangi, 2009) suggests that this process is far from straight forward.

Facts do not “float free;” they are attached to beliefs and values, and are applied on the basis of individual judgment (Cassell, 1991, p. 24). Advocates may attempt to invoke a particular frame in the belief that it will reduce widespread negative attitudes only to find through empirical research that it does no such thing, and may actually reinforce negative social attitudes (e.g., Danforth, 2002; Finn & Sarangi, 2009; Jordan, 2005; Mann & Himelein, 2008; Pescosolido et al., 2010). Stigma is sustained in complex and non-obvious ways that can defy well-intentioned efforts by anti-stigma campaigners to re-label and (re)frame the issues, relationships or identities involved (Pescosolido et al., 2010).

Not only does it matter *what* is taught, it also matters *how* it is framed, and these are far from intuitive (Parker, 1992). On the first point, as it relates to pain management, the *what* is an unknown quantity. There is no existing consensus regarding the definition of pain or the line demarcating acute from chronic; or as to what constitutes best practices in pain management; or the safety and efficacy of opioid medications in chronic pain management (Jackson, 2005). Nor is there consensus with regard to what constitutes a real diagnosis (e.g., Erlich, 2003).

This is not to suggest that consensus should be a goal of science or clinical practice, because that would be anathema to the scientific paradigm of progress (Holmes, Murray, Perron, & Rail, 2006). It does mean, however, that there are many overlapping and conflicting pools of information from which pain educators could draw, and which may or may not achieve the stated ends. It also means that the field could benefit from additional research critiquing, synthesizing and clarifying existing knowledge claims informing the development of large scale public educational interventions.

Knowing what frames to use in presenting pain in educational materials is equally problematic. As a review of the literature will show, the existing frames in dominant medical discourses are quite varied and sometimes contradictory. Pain is a debated construct within medicine and the larger societies in which we live. It is conceived as, among other things, a disease; a symptom; a function; an effect; an emotion; a biopsychosocial phenomenon; something deserved; something random; a thing to endure; or a thing to control. Medicine is thought to serve a palliative role in care of the suffering, or not so much. Opioid medications are thought to be a boon to chronic pain management, or they are seen as more dangerous than useful, especially in cases of long-term use. All of these positions have some support in the literature and could therefore be used to fill the IOM mandate of increased education, but to what end?

Rather than believe there are definitive answers to these questions, this study highlights the importance of attending to the intersection of medical/scientific and lay discourses pertaining to chronic pain if we are to understand, or affect, the negative attitudes toward chronic pain sufferers.

Study Aims

The purpose of this project was to explore the intersecting medical/scientific and lay discourses as well as their implications for the treatment of chronic pain patients in practice and policy. The data for this analysis was obtained in the context of a public debate about evolving state policies on opioid medications in the management of chronic pain. The research is undertaken for the purpose of informing efforts by patient advocates to increase access to respectful, client-centered, effective and affordable care for patients who live with chronic pain.

Organization of This Dissertation

The dissertation begins with an overview of chronic pain, patients frames, and treatment issues found in the literature. It will then proceed to a discussion of stigma in chronic pain and the centrality of discourse in the organization of social and material reality. The third chapter will present an overview of critical realism, the philosophy of science upon which the study is predicated, as well as the methodology of critical discourse studies. This third chapter will also address researcher subjectivity. The final two chapters will present the results and discussion of the analysis of pain-related discourse as it appeared in the online responses to the Seattle Times investigative Politics of Pain article series. Clarification of intended use of common terms are interspersed with the results and discussion sections.

Background and Context: Pain, Stigma, and Discourse

Pain

Persistent or recurring pain is a reality for millions of people around the globe. In a 2004 press release, the World Health Organization (WHO) reported statistics released by the International Association for the Study of Pain (IASP) suggesting that one in five people worldwide suffer from moderate to severe chronic pain (World Health Organization [WHO], 2004). The IOM, a congressionally appointed think tank, has estimated that one in three adults in the United States are affected by chronic pain (2011). According to the same report, the national cost of chronic pain is estimated between $560–$635 billion annually. This figure includes both treatment costs and work-place productivity lost to sick days and disability. Qualitative research attests to the profound impact of chronic pain on the lives of those who experience it (Ojala et al., 2014; Thomas, 2000).

The problems associated with inadequate pain management in the United States were considered to be of such magnitude that advocates successfully prevailed upon Congress to take action. In the year 2000, the United States Congress declared a Decade of Pain Control and Research, an act signed into law by then President Clinton (Lippe, 2000). Ten years later, in 2010, Congress directed the department of Health and Human Services (HHS) and the IOM to examine pain as a public health problem (IOM, 2011). The hope of both undertakings was that increased attention and elucidation of the problem would lead to increased efforts in research and medical education for advancing pain care, prevention, and palliation.

From these sources, it is made clear that chronic pain is a problem of staggering proportions with a considerable economic burden for patients and society. What is less clear is who and what are being referenced with the use of these terms.

Pain conditions and pain patients. The health conditions that can lead to a life of chronic pain are myriad (Banning, Sjøgren, & Henriksen, 1991; Breivik, Collett, Ventafridda, Cohen, & Gallacher, 2006; Tsang et al., 2008). Chronic Pain Conditions (CPC) can arise from developmental conditions (e.g., Ehlers-Danlos Syndrome), injury (e.g., spinal fracture), disease (e.g., multiple sclerosis), infection (e.g., HIV/AIDS), metabolic disorders (e.g., diabetes), and treatment after-effects (e.g., neuropathy subsequent to chemo-therapy). Chronic pain is also common sequelae for torture survivors (Thomsen, Eriksen, & Smidt-Nielsen, 2000). (See Table 1 for a partial listing of medical diagnoses associated with chronic pain.)

The source of patient's chronic pain may remain enigmatic to medical science (e.g., phantom limb syndrome or chronic muscular pain). CPCs may be characterized by episodic pain (e.g., recurring migraine headaches), or the pain may be experienced as a constant companion (see Thomas, 2000). Some CPCs produce observable physical signs; the severe spinal curvature resulting from advanced ankylosing spondylitis, for example. Often, however, CPCs have no outwardly observable manifestation; we may only know if someone has Crohn's disease or osteoarthritis if we are given that information.

Table 1

Partial List of Diagnoses Associated With Persistent or Recurring Pain

- Ankylosing spondylitis
- Arachnoiditis
- Arthritis (rheumatoid, psoriatic, osteo)
- Behcet's disease
- Bursitis
- Cancer
- Carpal Tunnel Syndrome
- Chronic Fatigue Syndrome
- Complex Regional Pain Syndrome/ aka Reflex Sympathetic Dystrophy
- Diabetic Neuropathy
- Disc degeneration
- Ehlers-Danlos syndrome
- Endometriosis
- Fibromyalgia
- Frozen Shoulder (joint capsule)
- Glaucoma
- Gout
- Guillain-Barre syndrome
- Hemophilia
- Headache disorders
- HIV/AIDS
- Inflammatory Bowel Disease
- Injury to PNS or CNS
- Interstitial Cystitis
- **Irritable Bowel Syndrome**
- Multiple Sclerosis
- Muscular scar tissue
- Myofascial Pain
- Oncological Complication
- Pelvic Inflammatory Disease
- Post-Herpetic Neuralgia
- Sacroiiac joint dysfunction
- Sciatica
- Scleroderma/systemic sclerosis
- Sickle Cell Disease
- Sjøgren's syndrome
- Spinal fracture
- Spinal Stenosis
- Spondiliosis
- Spondylolisthesis
- Stroke induced neuropathy
- Systemic Lupus Erythematosus
- Temporomandibular joint dysfunction
- Tendinitis
- Trigeminal Neuralgia
- Vulvodynia
- Whiplash

Given the multitude of health conditions, psycho-social factors, and wide variation in the availability of effective treatments, it should come as no surprise that the life circumstances of people who develop CPCs are equally diverse. People with CPCs may be adults, senior citizens, or children and adolescents (Ramage-Morin, 2008; Ramage-Morin & Gilmour, 2010). They may be employed or unemployed, financially independent or recipients of public benefit programs (see Marbach et al., 1990).

People with chronic pain may or may not be receiving or pursuing pain care (see Slade et al., 2009). They may describe treatment as efficacious or report that nothing has yet led to desired improvements. Some disorders and injuries are more frequently diagnosed in particular subpopulations. For example, epidemiological research has found that women are approximately twice as likely to be diagnosed with fibromyalgia then are men (Weir et al., 2006).

Some people with CPCs experience debilitation from their pain while others do not. Variations in individual reports of pain severity, longevity, and impact on functioning have been noted between and across diagnostic categories (McCracken, Matthews, Tang, & Cuba, 2001). Genetic (Williams et al., 2012), hormonal (Wiesenfeld-Hallin, 2005), social (Andersson, 2004), ethnocultural (Bates, Edwards, & Anderson, 1993) and psychological (Pincus, Burton, Vogel, & Field, 2002) factors have all been offered by way of explaining the distinctive manifestations of pain in individual patients.

Little in the way of cross disciplinary scholarship examines whether or how these explanatory hypotheses may be resolved into an integrated phenomenology of pain. Rather, the inherent variance of subjective experience is seen to present a problem of categorization: To what sphere does the report pertain, the physical or the mental, the objective or subjective? Is the complainant in need of physical interventions to redress pathological processes, or does their situation require a different response? These questions are hardly academic. How they are answered carries profound implications for how people with CPCs are received and responded to, particularly when treatments are not as successful as providers or patients would hope.

Definitions and taxonomies of pain. Pain is often given as the primary reason that people consult health care providers (IOM, 2011). Nevertheless, operational and conceptual definitions of pain are in a surprising state of disarray. Lay dictionaries provide biomechanical and metaphorical definitions of pain (see Miriam-Webster dictionary online). Meanwhile, scientists and practitioners debate the properties by which pain can be subdivided into categories of prognostic value; the extent to which pain correlates with structure; and whether it is, at its base, a purely psychological state (see International Association for the Study of Pain [IASP], 2012).

There is even an argument being made that, as neurological phenomena, emotional and physical pain are "ontologically identical" (Fields, 2007, p. 43). The idea that physical and emotional pain are experienced synonymously has also been the subject of psychology research and theorizing (G. MacDonald & Leary, 2005). The idea is supported with some experimental data from animal studies in which affiliative neurochemicals (e.g., oxytocin) administered to rats was shown to reduce sensitivity to physical pain (Uvnäs-Moberg as discussed in G. MacDonald & Leary, 2005).

Pain in a clinical context may be considered acute, chronic, chronic cancer/malignant, chronic non-cancer/malignant, neuropathic, inflammatory, and/or psychogenic (arising in the psyche). Pain is sometimes considered to be a symptom of some underlying pathology; at other times it is conceived as a disease entity in its own right (Siddall & Cousins, 2004; Tracey & Bushnell, 2009). Pain is also described in the professional literature as a biopsychosocial phenomenon (Roy, 2001).

The biopsychosocial conceptualization has been criticized for lack scientific validity, and for ostensibly ignoring the biological components of chronic pain (Manchikanti, Boswell, et al., 2009). The literature using the biopsychosocial language has been criticized for ignoring the social-environmental factors associated with pain reports (Blyth, Macfarlane, & Nicholas, 2007). It would seem that psychological factors are receiving greater focus in medical explanations of chronic pain. The fact that patients may hold a primarily biomedical view of their pain experiences, in contrast to the profession's focus on psychological factors, has been cited as a source of contention in medical encounters (Roy, 2001).

Medical taxonomies of pain usually begin with two super ordinate classifications: chronic or acute (Ferrell, 2003). Chronic pain is further divided into categories of cancer and non-cancer pain (IASP, 2012). The way in which pain is assigned to these different categories is not without problems. While these terms convey a temporal relationship, and are vaguely suggestive of etiology, the situation is considerably more nuanced.

Acute pain—nature's alarm system. Acute pain is frequently identified as having a "distinct onset, obvious cause, and short duration" (Ferrell, 2003, p. 323). It is this type of pain that is associated with sudden and/or damaging changes in physical structures. A minority of individuals are, through congenital factors, disease, or injury, unable to perceive pain and may live forshortened lives as a result (Nagasako, Oaklander, & Dworkin, 2003). This has contributed to a conceptualization of pain as having an evolutionary advantage: Pain alerts us to the presence of potentially life threatening conditions and motivates behavioral responses designed to preserve our physical integrity (Woolf & Ma, 2007). Such a function must, logically, follow form.

Nociceptive fibers in the peripheral nervous system are attributed with being the structure through which the alarm system functions. These stratified nerve cells transmit signals to the central nervous system in response to mechanical (e.g., inflammation), chemical (e.g., capsaicin), or thermal irritation (Woolf & Ma, 2007). The activation of these fibers creates a neuronal chain reaction that includes interpretation of the stimulus as painful, assessment of degrees, and initiation of response—not necessarily in that order

(Fein, 2012). As with any structure, damages and glitches in the system are potential sources of disrupted function.

Chronic pain—the convoluted designation. Definitions of chronic pain are rather more convoluted; and inconsistent in the literature. It begins with the distinction between cancer and chronic non-cancer pain (CNCP). In the first case, it is simply unrelenting pain in the context of malignancy. In the second, persisting pain is not associated with an active cancer diagnosis. The distinction is not academic—it is translated into policies and treatment guidelines that directly impact the types of pain care a patient may receive (Jovey et al., 2003).

The utility of sorting CPCs into broad categories of malignant and nonmalignant is rarely addressed in the context of its use. It appears to be deployed primarily in discussions of opioid therapies for long term pain management (e.g., Kalso, Edwards, Moore, & McQuay, 2004). This is the question that does not seem to have been asked by researchers: Does the etiological diversity of CPCs confound empirical research into opioid responsiveness in an undifferentiated sample of CNCP patients?

People with CPCs represent a heterogeneous group of people that defies reductionist classifications and stereotypes. Yet such pathological diversity in the sources of persistent or recurring pain, as well as the divergent manifestations of pain experiences, is erased with the reductionist terminology that is used to denote and delimit pain related-constructs. As a taxonomical label from the treatment literature that is used in policy-making discourse, CNCP suggests a population homogeneity that simply does not exist.

Chronic non-cancer pain is . . . everything else? A widely accepted definition of Chronic non-cancer pain (CNCP) is that which persists past a time of expected healing, or as “pain that continues when it should not” (IOM, 2011, p. 278). The delimitation of expected healing time, however, is rather difficult to determine, given the wide variance in clinical presentations (Apkarian, Baliki, & Geha, 2009). As these authors point out, different injuries or illnesses have different expected healing times. This is something that is not always acknowledged in discussions of patient presentation, pain research, or treatment guidelines and decisions.

The International Association for the Study of Pain (IASP), Task Force on Taxomony (1994), frequently cited as the authoritative definition in the literature, states that including the specifier of healing time in the definition of chronic pain is traditional (citing a 1953 article by Bonica). They acknowledge that healing periods vary as a function of injury and context and suggest it would be simpler to conceptualize chronic pain as that which “persists for a given length of time” (p. xi). Therefore, three months is offered as “the most convenient point of division” but they suggest a *preference* for six months in the context of research (p. xi). This trifurcated, and seemingly arbitrary, definition is inconsistently translated into the professional literature.

Citing the IASP’s 1994 taxonomy, Apkarian et al. (2009) use a definition in which chronic pain is understood simply to be “pain that persists past the healing phase following an injury” (p. 82). A 1986 definition from the IASP is quoted by Denisco, Chandler, and Compton (2008) as “pain persisting more than 90 days beyond the period of injury” (p. 7). They do not mention healing time.

Ferrell (2003) cites the IASP definition simply as a duration of three months, with no mention of initiating injury. Researchers in a study of CPC prevalence in Australia specified only that the pain must occur "*every day* [emphasis added] for three months" (Blyth et al., 2001, p. 128). Breivik et al. (2006) cite a definition credited to the IASP as pain "without apparent biological value that has persisted beyond the normal tissue healing time, usually taken to be 3 months" (p. 309).

The IASP (1994) has suggested that chronicity may be established earlier for cancer pain then for CNCP. They state that in the case of cancer pain, "three months is sometimes too long to wait before regarding [it] as chronic" (p. xi). It is tempting to suppose this delineation arises from the presence of an observable nociceptive source of sensation. Yet this distinction ignores the existence of CPCs attended by nocioception, effectively collapsing such apparently distinct disorders as rheumatoid arthritis, post-herpetic neuralgia, and musculoskeletal pain.

Categorizing chronic pain. Confounding efforts to deploy pain terms with any specificity, various CPC diagnoses can fall into different categories depending upon which proposed taxonomies are in use. Costigan, Scholz, and Woolf (2009), for example separate nocioception from chronic pain, even for conditions associated with inflammation. Ferrell (2003), on the other hand, subsumes the latter into the former in delineating nociceptive from neuropathic chronic pain. Other authors have distinguished between functional somatic syndromes, characterized by "medically unexplained symptoms" (e.g., Irritable Bowel Syndrome), and CPC diagnoses of "a clear medical origin" (e.g., Inflammatory Bowel Disease) (Looper & Kirmayer, 2004, pp. 373, 374).

Some chronic health conditions which can lead to persistent or recurring pain may not be included under the rubric of chronic pain at all. Sickle Cell Disease and hemophilia provide two examples which did not appear in literature searches using key words of chronic pain. Yet it would appear that patients with these chronic and potentially painful conditions are also vulnerable to under-treatment of pain arising from misunderstandings and negative attitudes about pain and palliative care (Labbe, Herbert, & Haynes, 2005; Witkop et al., 2012).

Pain—the disease. Historically, medical science has conceived of pain as a symptom of underlying disease/injury processes (Siddall & Cousins, 2004). The goal of physicians, according to this view, is to rectify the underlying cause, thereby alleviating the pain. When the underlying cause cannot be remedied, or when it is unknown, pain becomes the primary focus of medical attention and symptom management interventions. Perhaps this is one reason that the conceptualization of chronic pain as a diagnostic entity in its own right—a disease of the central nervous system rather than a symptom of other distinguishable pathologies—is gaining ground (Tracey & Bushnell, 2009).

The central thesis of this disease model of chronic pain holds that the experience of chronic pain is due to identifiable changes in neural structures and their function (Tracey & Bushnell, 2009). These authors report, support for this hypothesis is based on neuroimaging research demonstrating hyperactivity in brain regions associated with processing strong emotion and physical pain. The idea arises from an understanding of pain as nature's alarm, which in the case of chronic pain has sorely malfunctioned. The problem left unstated, of course, is the confounding variance of CPCs. Can osteoarthritis and fibromyalgia, to name a mere two, be reduced to the same underlying condition—malfunctioning neuronal activity in the brain?

Chronic pain, in a temporal sense, may have an obvious biological cause, and, when arising in the context of chronic disease processes, e.g., multiple sclerosis, may not have a healing time at all. For this reason, some researchers have noted a need for more precise nomenclature. Giordano (2011) takes up the relatively uncommon but seemingly useful term, maldynia to denote a "*wild-type* chronic pain" that is characterized by its "nonpurposivenss" and escalating severity (p. 1). It is this wild-type of pain that some now consider to be its own disease entity.

Similarly, Manchikanti, Singh, Datta, Cohen, and Hirsch (2009) explicitly distinguished "chronic pain syndrome" from other forms of chronic pain in the definition used in their research: "Pain that persists 6 months after an injury *and* [emphasis added] beyond the usual course of an acute disease or a reasonable time for a comparable injury to heal . . . that may continue in the presence or absence of demonstrable pathologies" (p. E35). They contrast chronic pain syndrome as "a complex condition with physical, psychological, emotional, and social components" (p. E35). How these definitions are understood as distinctive and contrasting is not clearly articulated.

Some writers specify neuropathic disorders as the intended referent of the disease model of chronic pain (Costigan et al., 2009). Others, such as Siddall and Cousins (2004), argue in favor of the disease conception of chronic pain even in conditions of chronic or recurrent nociceptive pain. These authors explain that "continuing nociceptive inputs" lead to pathological changes in nerve function as well as disruptions in mood, cognition, and social domains (Siddall & Cousins, 2004, p. 510).

In less technical works these ideas are interpreted for popular consumption in the metaphor of a malfunctioning alarm system (Thernstrom, 2010). The common thread amongst all is the tendency to perpetuate the trend of collapsing CPCs into a single category of "chronic pain." The question unasked is whether or how treatment decisions are compromised through ignoring the existence of etiological, mechanistic, or other distinctions.

It is unclear how definitions of acute, chronic cancer and CNCP in professional circulation can account for the diversity of patient presentations, prognoses, and treatment options. What is clear, however, is that these classifications do not provide a consistent signifier that can aptly signify the spectrum of painful chronic conditions for which people may seek medical management of pain. And while it is acknowledged that no consensus understanding exists, the definitions and taxonomies themselves do not appear to be the focus of controversy or debate within the literature. Existing controversies relate to other pain-related topics.

Pain controversies: Ambiguity, opioids, and socioeconomics. Scientific disagreements about pain categorization, the validity of particular diagnoses or the legitimacy of patient reports of pain intensity are another source of complexity (Lillrank, 2003; Looper & Kirmayer, 2004; Walker et al., 1999). In some cases (e.g., fibromyalgia syndrome), the medical community has not arrived at a consensus regarding the ontological status of the diagnostic label (Ehrlich, 2003). Other objectively diagnosable conditions, such as degenerating vertebral discs, are controversial in another way. Some in the medical community are dubious of the view that compressed or disintegrated discs are the source of patients' subjective reports of pain, largely because not all individuals with visible degeneration provide corresponding reports of pain (Negrini & Zaina, 2013).

It is probably unsurprising that these controversies impact provider's attitudes and treatments regarding patients with debated diagnoses (Asbring & Narvanen, 2003). These epistemological and ontological debates within the health science community, however, also have an impact on the way people with CPCs are viewed in non-medical settings. For example, in a qualitative study, Nettleton et al. (2004) reported that psychological explanations of pain were associated with a lack of family support for the person with chronic pain. Moreover, the atmosphere of disbelief that can result contributes to patients' psychological distress; dissatisfaction with the health care community; and self-doubt (Nettleton et al., 2004; Roy, 2001).

The opioid debate. On-going controversies about the safety and efficacy of continuous opioid therapy (COT) are factors in both treatment practices and policy decisions (e.g., Breivik, 2005; Rosenblum, Marsch, Joseph, & Portenoy, 2008). Public health concerns related to the risk of addiction and overdose, and high black market demand have led to regulatory practices that can appreciably obstruct patient access to these medications (Gilson, Maurer, & Joranson, 2005). The situation is made more complicated by the wide variation in reports of opioid efficacy for CPCs.

Different authors make conflicting claims about the efficacy of opioid medications in treating CNCP. Compare the following assertions from two published research reports. "Opioid medications alleviate nociceptive and neuropathic pain but trials reported large individual variation" (Kalso et al., 2004, p. 378). Alternatively, "Neuropathic pain is an anomaly because it is insensitive to morphine as well as other opioid drugs" (Stucky, Gold, & Zhang, 2001, p. 11846). HCP consumers of this research are left to decide for themselves which of these mutually exclusive truth claims is more true.

In clinical practice, concerns of addiction and drug tolerance may deter the use of these substances for pain, whether from acute, chronic, or cancerous conditions (Albrecht et al., 2013; Labbe et al., 2005). Literature reviews of addiction research with pain patients found wide variation in the incidence of addiction following COT (see Fishbain, Cole, Lewis, Rosomoff, & Rosomoff, 2008; Højsted & Sjøgren, 2007). Højsted and Sjøgren (2007) included patients with both CNCP and cancer pain in their review. Fishbain and colleagues (2008) focused specifically on people with CNCP in a study of incidence of abuse and addiction in patient populations.

Local clinics have sometimes made blanket policies proscribing opioid medications for chronic pain management (see American Pain Foundation [APF], 2011). Some pharmacists have admittedly refused to stock opioid medications, citing fears of robbery as well as patient safety (Greenwald & Narcessian, 1999; Morrison, Wallenstein, Natale, Senzel, & Huang, 2000). Pharmacy and clinical policies of this nature are especially problematic for low income patients who are presented with limited options for accessing needed clinical services and pharmaceutical products (Morrison et al., 2000).

Reluctance to prescribe opioid medications has also been credited to a fear of regulatory scrutiny and the possibility of legal sanctions. To assess the statistical risk of this outcome, Jung and Reidenberg (2006) examined legal records of providers who were subjected to DEA investigations related to opioid prescribing. They found that when medical documentation was adequate, legal actions subsequent to an investigation were infrequent. This may not alleviate concerns for providers who doubt the consistency with which “adequacy” is defined by oversight committees.

Disparate treatment of pain patients. Available treatments for chronic pain differ significantly, as do individual responses within and across diagnostic categories (Cipher & Clifford, 2003; Světlík, Hronová, Bakhouche, Matoušková, & Slanař, 2013). Some treatments aim to alter the structural or functional sources of pain: knee, back, and hip surgeries, for example. In many cases, however, medical, psychological and self-management strategies for treating CPCs serve a wholly palliative function, to ease the suffering of those who may one-day return to health (e.g., cancer patients), or whose ailments are presently incurable, e.g., multiple sclerosis (Brennan, Carr, & Cousins, 2007; Roy, 2001). Existing treatments differ according to costs, risks, effectiveness ratings, and their reimbursement status within the economy of medical benefits. For these reasons and more, the full range of treatment options are not routinely available to everyone.

Many writers, providers, researchers, ethicists, patients, family members, as well as agencies such as the IOM have decried the widespread under-treatment of acute, chronic, and malignant pain in medical practice (Albrecht et al., 2013; IOM, 2011). Yet this is not a claim that goes unchallenged within the field. Deyo, Mirza, Turner, and Martin (2009) argue that chronic back pain is over treated and under studied. This raises questions about the medicalization of back pain without attending to sociological factors that may contribute to the experience of pain.

Ethical dilemma of under-treatment. Notwithstanding the objections to the claims of under-treatment, noted above, it is widely accepted that pain, in all its variation, is woefully undertreated the world over (IOM, 2011; Lohman, Schleifer, & Amon, 2010;

Ward et al., 2004). The term conjures an image of an identifiable bar demarcating appropriate from deficient and excessive care, but this not an operational construct.

Under-treatment, as it is used in the literature cited throughout this section, is a general term referencing a set of problems affecting the delivery of care and resulting in absent or ineffective attempts to alleviate pain. These include inconsistent assessment of pain; withholding of interventions for any number of reasons; ignorance of available treatment options; and lack of available resources. This among other social factors related to physical and financial access to clinical care, such as geographical availability and/or poverty (see IOM, 2011). Yet even if everyone had physical and financial access to medical care, vast differences would still exist in HCP understandings of what constitutes *adequate* pain care. Pain care is not merely a scientific question for medical practitioners; it is also an ethical dilemma for people in the health care profession.

Socio-demographic factors. Several writers have reported disparities in treatment for pain-related conditions based upon demographic variables such as race and gender (e.g., Balsa & McGuire, 2003; Green, Anderson, et al., 2003; Sabin & Greenwald, 2012). This too has been challenged. At least one study reported that patient gender and race were not significant factors in clinical treatment decisions (Weisse, Sorum, & Dominguez, 2003). It is interesting to note that, while these authors interpret these results as a challenge to the disparity hypothesis, their findings are considerably more complex. The gender and race of their physician-participants was found to be an influential factor in treatment decisions. In the final analysis, demographic variables were still significant albeit in unexpected ways.

The multiple identified reasons people are living with pain that is not well-controlled are socially complex and ethically loaded (Rich, 2000). There is a well-documented disparity in access to medical care for many, including people of color, immigrants, and those of low SES (Anderson, Green, & Payne, 2009; Balsa & McGuire, 2003; Mor, Zinn, Angelelli, Teno, & Miller, 2004). Considered research about the course and prognosis of specific pain conditions may not be available to guide diagnostic and treatment decisions (Deyo et al., 2009).

Treatment decisions can be influenced by demographic stereotypes (Burgess, van Ryn, Crowley-Matoka, & Malat, 2006; Green, Wheeler, & LaPorte, 2003; Sabin & Greenwald, 2012), as well as attitudes toward pain and diagnostic labels (Ansted, 2009; Asbring & Narvanen, 2003). Available options are likewise limited by financial considerations at the point of delivery (Balsa & McGuire, 2003). Beliefs, access, and policies about opioid medications also play a role (Cherny, Baselga, de Conno, & Radbruch, 2009; Labbe et al., 2005).

Institutional practices. General practitioner education programs do not always provide courses in assessment or management of pain of any type (Mezei et al., 2011). It has been observed that the curriculum for veterinarians contains five times the number of hours devoted to pain care in some university training programs (Watt-Watson et al., 2009). Reimbursement policies encourage clinical practices that limit the time professionals can or will devote to understanding and meeting the needs of individual patients (IOM, 2011). In addition, there are politics of government, including cost-saving priorities and drug related concerns, which affect current clinical practice and research priorities (Gilson, 2010; Gilson et al., 2005; Turk, 2002).

Competing masters. Existing treatments for CPCs vary according to posed risk, cost, and effectiveness (Turk, 2002). Compounding this fact is the subjective nature of the pain experience and its ambiguous relationship with visible markers of pathophysiology. Together, these realities have created complex medical, economic, and regulatory pressures on clinical understanding and decision-making in the treatment of CPCs (M. J. L. Sullivan & Main, 2007).

The oft-times competing social agendas of diverse stakeholders can hamper the scientific and social understanding of CPCs, effectively creating barriers to the development, production, and distribution of treatment technologies (IOM, 2011). The barriers listed above are presumably augmented by the impact of stereotypes and implicit biases on individual decisions and social arrangements (Burgess et al., 2006; Meghani et al., 2012)

Stigma

Stigma theory has been criticized for its focus on the individual being discriminated against rather than those engaging in the discrimination (Sayce, 1998). While such a myopic view of stigma is admittedly problematic, it is not a necessary component of the construct. Stigma can also be understood as a social process, unfolding in ways that are highly context dependent, that normalizes discrimination (including self-directed negativity), and naturalizes the social order (Blommaert, 2005; Goffman, 1963; Scambler, 2009). The problem that Sayce (1998), and others, have identified may reside in the lack of attention being paid to the social contexts and normalizing discourses whereby stigma receives its meaning and its sustenance (Goffman, 1963).

Stigma is inextricably linked to perceptions of social norms, including those associated with the socially acceptable responses to people who fall outside those norms (Norman, Sorrentino, Windell, & Manchanda, 2008). Moral judgments and blame allocation can be part and parcel of stigma, which is ultimately attached to normative expectations of what it means to be a good and desirable human being in one's social context (Goffman, 1963; Yang et al., 2007).

Stigma can also be attached to a perceived inferiority or imperfection without an attendant sense of blame directed toward the stigmatized (Scambler, 2004). In either case, political domination of stigmatized groups is justified through widespread endorsement of negative stereotypes which allows for the exercise of power in excluding those of lesser social status (Goffman, 1963; Link & Phelan, 2001). All of these elements feature in the discourse of chronic pain.

Chronic pain as stigma. Stigma is a recurrent theme in the discourses surrounding pain. As a reference to a particular set of discourses regarding the enactment of social power relationships, it deserves to be held to the same degree of scrutiny as any other invocation in the discourse. This is beyond the scope of this study, however; an existing body of literature has aligned with this construct which this project is intended to connect with and build upon.

The existence of noxious views about people with CPCs is incontrovertible, as is the distress these views engender, and their political consequences. Stigma is one possible conceptual matrix for making sense of these social phenomena. The researchers in the qualitative studies of patient experiences cited in the introduction invoke the concept of stigma as their explanatory model for the existence, enactment, and impact of negative stereotypes in the narratives provided by participants (Hakanson et al., 2010; Holloway et al., 2007; Lillrank, 2003; Marbach et al., 1990; Nettleton et al., 2004; Slade et al., 2009; Walker et al., 1999; Werner et al., 2004; Young et al., 2013).

Pervasive negative expectations and stereotypes regarding pain patients represent the quintessence of social stigma: To have a chronic pain condition (CPC) is to have a deeply discrediting attribute that has led to a widespread view that those who suffer from or complain about chronic pain may be discountable, illegitimate, tainted members of society (applying the definition of stigma provided by Goffman, 1963).

Stigma, as a mark of shameful or blameworthy deviance, (Scambler, 2009) can create an atmosphere in which disrespect, disregard, and disenfranchisement may be viewed (by those with and without CPCs) as socially expected and acceptable responses toward people with CPCs (drawing from Norman et al., 2008). The intersection of multiple stigmatized identities (e.g., female, person of color, disability status, etc.) are identified as contributing factors in disparate reports of pain severity and pain care practices (Burgess et al., 2006; Green, Anderson, et al., 2003).

On a personal level, repeated exposure to negative stereotypes and stigmatizing interactions can have deleterious effects on people’s social relationships, mental and physical health, and their general sense of wellbeing and quality of life (Allison, 1998; Quinn & Chaudoir, 2009). Enacted in the context of unequal social power (such as those involving patients and the gate keepers of medical care—health professionals, payors, and policy-makers), stigma involves acts of individual and institutional discrimination that can effectively limit life options and access to resources (Link & Phelan, 2001). Stigmatizing attitudes influence social relationships, roles and expectations; and directly impact distribution of resources through clinical, policy, and regulatory decision-making (IOM, 2011).

Felt stigma. Felt stigma refers to stereotype awareness and incorporates both a sense of shame for being one of the tainted, as well as the "fear of encountering enacted stigma" (Scambler, 2004, p. 33). Participants in qualitative studies indicate that perceptions of stigmatization contributed to reduced compliance with treatment recommendations. A Hong Kong study of patients with diabetes found that stigma was a barrier to implementing symptom management strategies (Tak-Ying, Kwan, & Wong, 2003).

The unpleasant experiences of stigmatization have reportedly led some individuals to avoid seeking medical care for their CPC or even other health conditions that may have arisen (Slade et al., 2009). Pain-related stigma may also disrupt relationships with family, co-workers, employers, and others within patients' social networks (Roy, 2001). This has reportedly led some people to conceal their health conditions for fear of the consequences to their social standing (Slade et al., 2009).

These effects, including delayed help-seeking, have been described in research with patients who experience stigmatization for attributes other than those explicitly associated with chronic pain. Similar health impacts were identified in patients who present with obesity (Rogge, Greenwald, & Golden, 2004), lung cancer (Chapple, Ziebland, & McPherson, 2004), and mental illness (Corrigan, Larson, & Rusch, 2009). Stigma associated with potentially painful conditions, such as HIV/AIDS and multiple sclerosis, has posed similar problems for these patients in contexts other than pain care (Grytten & Maseid, 2005; Vanable, Carey, Blair, & Littlewood, 2006). This research suggests that the experience or expectation of stigma, and not solely issues related to pain conditions, play a significant role in patients' dissatisfaction with the health care community.

Patient perceptions of stigma have also been assessed in quantitative survey analyses using scales for assessing stigma in chronic illness (see Rao et al., 2009). It has been suggested that some pain patients may experience greater stigma then do people with other stigmatized health conditions, such as epilepsy (Young et al., 2013). The migraine sufferers in this study were also grouped according to whether their migraines were chronic or episodic in nature; the analysis suggested that chronicity was a factor in the experience of felt stigma. Looper and Kirmayer's (2004) study suggested that felt stigma may vary as a function of diagnostic controversy.

Enacted stigma. Enacted stigma refers to "episodes of discrimination… on the grounds of their social and cultural unacceptability" (Scambler, 2004, p. 33). Previous research has documented negative attitudes and beliefs of health care professionals toward chronic pain patients (Asbring & Narvanen, 2003; Dobscha, Corson, Flores, Tansill, & Gerrity, 2008; Matthias et al., 2010; Phelan, Van Ryn, Wall, & Burgess, 2009). A smaller body of research has examined the influence of HCP attitudinal variables on pain management decisions, usually through vignette studies or surveys (Byrne, Morton, & Salmon, 2001; Green, Wheeler, et al., 2003; Labbe et al., 2005; McCaffery, Ferrell, & Pasero, 2000; Sabin & Greenwald, 2012).

Given the plethora of studies finding felt stigma amongst chronic pain patients reviewed in previous sections, it may be tempting to conclude that stigma's influence on pain treatment is a problem relegated to the world of chronic pain. With the exception of

Labbe and company, however, most of the studies cited in this section were exploring the under-treatment of acute pain. At least one article has explored oppressive dynamics in medical encounters with general patient populations, and that from the HCP's perspective (Malterud & Thesen, 2008), but most studies were associated with opioid treatment options. Opioids are socially controversial and medically complicated, whether discussing chronic or acute pain conditions.

Stigma and opioid medications. While debates rage in the literature about the efficacy of COT (see Ross, Jamison, & Edwards, 2011), the point has been made that constrictive opioid regulatory and hesitant prescribing practices are more a product of "opiodophobia and opioignorance" than scientific knowledge (Brennan et al., 2007, p. 209). These are terms frequently deployed by those who are sympathetic to the use of opioid medications in pain management, tied to a psychological discourse of undesirable mind-states.

Many writers from this perspective have expressed concern that a significant factor in the general problem of under-treatment is the negative attitudes about opioid substances endorsed by both patients and providers, even for pain control in end of life care (see Rukhadze & Kordzaia, 2011). These authors characterized palliative care in their native Georgia as one based on "overwhelming opioidophobia" (Ruhkadze & Kordzaia, 2011, p. S159). Others caution authors to avoid hyperbolic debate tactics to avoid a "return to opioidophobia," implying that current reasoning is now past the fear of opioid medications, at least in North America (e.g., Ross et al., 2011, p. 508). Yet the discourse of Eastern European and North American pain care does not seem so different.

In an apparent attempt to insulate discussions of patient care from the highly contentious debates about the use of opioid therapies and the motivations of pharmaceutical companies, Goldberg (2010) advocates treating the question of stigma toward pain patients and negative evaluations of opioid use as separable phenomena. Others have framed antipathy toward opioid medications as subordinate to the general problem of misinformation and deficiencies in pain care education within medical training programs (e.g., Rich, 2000). It may be, however, that patient interests will not be served without attending to the association between perceptions of opioid analgesics and attitudes toward pain in the social discourse (Notcutt & Gibbs, 2010).

Discourse

Discourse, language, text, and talk are employed and understood in different ways at different times by different people (Potter, Wetherell, Gill, & Edwards, 1990). In conversational use, they can be treated as (nearly) interchangeable terms, while in academic settings they are delimited on theoretical grounds. Different disciplines within social science have developed professional discourses characterized by subtle semantic variations in the use of designating terms as well as differing conceptualizations of relational significance (Entman, 1993).

To add a layer of complication to the picture, differing philosophies of science are taken up by different scholars within and across fields (e.g., social constructionist and positivist paradigms) which leads to divergent understandings of posited objects (Hardin, 2000). The practical result is that scholars who are operating within different theoretical paradigms can derive competing understandings of what and how to group phenomena under designations such as discourse, language, text, and talk (Wodak & Meyer, 2009).

For the purposes of this study, discourses are understood according to Fairclough's (2009) proposition: "*Discourses* are semiotic ways of construing aspects of the world (physical, social or mental) which can generally be identified with different positions or perspectives of different groups of social actors" (Fairclough, 2009, p. 164). They are meta-narratives that contain and communicate cultural understandings of any given subject.

Power and sense-making. Discourse theory would suggest that our individual and collective attitudes, including stigma and discrimination, are underlain by historically specific, interconnected systems of meaning (Karlberg, 2012). These discourses are culturally coherent, and reflective of shared normative understandings of the physical, social, and moral world. Yet when critically examined, even the most hegemonic discourses appear dynamic, splintered, and contended (Parker, 2002).

All social practices have semiotic elements (i.e., conceptual communications) to which they are dialectically related: Discursive formulations of individuals, roles, and issues informs behavior and social structures which are in turn influenced by how we think and talk about them (Wodak & Meyer, 2009). Discourses shape meanings as they are ascribed to and attended by cognitions, motivations, emotions, and behavior of groups and individuals (Karlberg, 2012). Cultural and social norms are enacted in and through the patterned use of language (Blommaert, 2005).

The way in which we as a society talk about issues, the way in which concepts are positioned relative to one another in discourse, can facilitate or resist available formulations and enactments of social identities and expectations (Parker, 1992). These formulations are informed by moral understandings of the good that influence social practices, power relationships, resource allocation, and individual behavior through processes of normalization (Blommaert, 2005; Hall, 2001; Parker, 1992).

Dominant discourses. Discourses that dominate within particular social groups lead to the privileging of certain roles, identities and ideas over others to the extent that many voices remain unheard and wield little influence (Blommaert, 2005; Gee, 1998). Existing social realities, inclusive of the stratified allocation of privileges in accessing social and material resources, are naturalized as the right and expected order of things (Parker, 2002). Markers of social identity, and their attendant status, can frequently be observed in the way people use language (Blommaert, 2005). They can show up in speech dialects, turns-of-phrase, spelling accuracy, sentence construction, reactions to prompting events, and even in the construction of our identities (e.g., Gee, Allen, & Clinton, 2001).

It is not that we can know definitively who a person is by the way they use language. Rather, these indexical and contextual cues dictate expectations of production (what is said by the speaker/writer) and uptake (what is understood by the listener/reader) (Blommaert, 2005). They serve to orient discourse participants to existing understandings of the stratification of linguistic repertoires, on the basis of which assumptions of are made about the character and qualities of the participants. Poor spelling, for example, may lead readers to deride the writer's intelligence or educational attainment regardless of whether an objective correlation has been or can be established in any given case.

Access to the linguistic repertoires of various social groups, even within a given culture, is itself an object of privilege and an outgrowth of experience (Blommaert, 2005; Gee, 1998). English speakers in the United States, for example, do not all speak the same *language*. Even the knowledge of conventions guiding language use in specific settings is differentially distributed among speakers of the same mother-tongue (Blommaert, 2005; Gee, 1999). The variance in language production (e.g., accents, jargon, etc.) is matched by the variance in its reception (e.g., meanings taken, stereotypes activated, etc.).

An Italian study comparing the descriptive language of doctors and nurses found that linguistic representations of the clinical significance of pain differed according to professional training and norms (Montali, Monica, Riva, & Cipriani, 2011). Patients with different language use practices (e.g., men and women) may take very different approaches to expressing their symptoms (Strong et al., 2009). People with chronic pain who are not members of the medical/psychological/academic communities may not encounter the signifiers or the concepts associated with pain patients in these discourses. In other words, patients and providers may have very different understandings of concepts, phenomenon, and language in how they articulate pain experiences (Kenny, 2004).

These unclarified interpretative confusions can compromise mutual understanding in medical encounters. The differential use of language in expressing, positioning, and understanding one's self and others in the world is an under-appreciated, and confounding, factor in efforts to understand the meanings and implications of discursive practices (see Gee et al., 2001).

The embedded subject. Because discourse precedes and forms our participation in it, most of our talk and actions are enacted outside of conscious awareness and control (Kogler, 1992/1996). In effect, we do not always know why we think or act as we do and neither do we fully apprehend the implications of what we say or how it is said. An ontological hermeneutic understanding of discourse (e.g., Gadamer, 1966/1976; Richardson, Flowers, & Guignon, 1999) would suggest that individuals exist within pre-existing interpretative frameworks for understanding the world. We make sense of the conceptual and phenomenological world by drawing on this “implicit stock of unthematic background assumptions” (Kogler, 1992/1996, p. 198). The accepted utility of broad distinctions between CNCP and chronic cancer pain, for example, operates as unthematized background assumptions in discussions of COT.

In the normal course of our days, we do not usually pause to consider our current historical context or the semantic relationships with which we express our understandings (Gadamer, 1966/1976; Parker, 1992). In day to day interactions between people with even loosely shared socio-cultural references, such intense reflection on the interpretative possibilities within our discourse is not necessary for mutual comprehension (Gadamer, 1966/1976). This is because understanding is often presumed when speakers deploy familiar terms. Whether or not participants hold shared meanings is rarely explored. This assumption of familiarity, while necessary for efficient communication, can and does contribute to misunderstandings of meaning and significance (Gadamer 1966/1976).

The stock of implicit moral, political, and ontological assumptions (or pre-understandings) which make discourses comprehensible arise from cultural practices (including language practices) that precede our existence as individuals (Gadamer, 1966/1976). As such, discourses transcend the consciousness of the individual interpreter who is always embedded in specific socio-historical contexts with access to a repertoire of discourses delimited by social status and personal experience (Blommaert, 2005; Gee, 1999). When we forget this, meanings become more easily misconstrued. It is only when we acknowledge the interpretative nature of our social situation that we think to verify whether our understandings are shared with others in the encounter.

This does not preclude the possibility of change within social discourses, or the possibility of acquiring new understandings and access to new repertoires. It means we are generally unaware that our understandings are situated understandings until our situation is changed through encounters with different others (Gadamer, 1966/1976). As we enter into new situations and adopt new understandings, we come to inhabit a new discourse, complete with new subject positions and interpretative frameworks (Gee, 1998). Through mutual encounters, assumptions (on opioid use, for example) can be challenged and changed only if participants are open to the existence and credibility of other perspectives (the voice of providers, regulators, and patients).

Changes in understanding and discursive participation happens at an individual level, as when one is inducted into a professional discourse foreign to one's previous experience. The assumptions which are not activated or challenged during these kinds of encounters do not become open for dialogue or influence (Gadamer, 1966/1976). These processes, of encountering and adapting to different ideas and perspectives, are also occurring at a macro level. Social understandings are transformed through the dynamic nature of discursive exchanges between those operating within different situations, from different backgrounds, and with differing ideological frames (van Dijk, 2011).

Contending discourses and changing frameworks. As social understandings change so do the interpretative frameworks (moral, political, and ontological) through which facts are made meaningful (Cassell, 1991). By way of example, pain can be (and has been) viewed as a sign of divine disapproval; an expected or deserved fate that one must simply bear; a pathway to salvation and clarity; an emergent symptom of psychological distress; or a sign of structural pathology, injury or infection, among other things (Thernstrom, 2010; Valadas, 2011).

Each of these frames arises within a culture's wider discourses about the natural order of things (e.g., religious, medical and psychological discourses). Each frame is embedded in a matrix of cultural meanings that elicits different social responses from different social actors (Valadas, 2011). These subjects, and social actors, inhabit different positions within moral hierarchies that are associated with social standing and stigma (Yang et al., 2007).

Awareness of changing representations within discourse is complicated by the observation that terms of reference can remain in common use while conceptualizations of the referent phenomenon are transformed over time and place (Blommaert, 2005). Schizophrenia research provides a prime example of this phenomenon. The word has remained a common reference in research since it entered the psychiatric vernacular in 1908 (Fusar-Poli & Pierluigi, 2008). Operational definitions and categorical criteria, however, can differ to such a degree that referent populations may be incomparable across studies (see Overall & Hollister, 1979).

Thus, accepting definitions without reflection (or implicit assumptions about chronic pain) renders the divergent and contradictory uses of the terms invisible. Taking semiotic devices at face value can lead to a false sense of epistemological and/or ontological continuity that can negate efforts to understand, let alone alter, social reality (Parker, 1992). Attention to the processes by which taken-for-granted social realities are reproduced becomes a necessity, however, when we seek to understand, and particularly when we intend to influence, the social arrangements, moral understandings, role expectations, power relationships, and resource allocations within our society (Wodak & Meyer, 2009). Critical analysis of discursive practices attempts to open this implicit process to explicit observation, reflection, and influence (Parker, 1992).

Medical discourses. Issues of pain, patient care, and policy show up in the social discourse in ways that are both constituted by and constitutive of social and moral attitudes and behaviors toward those who suffer from chronic pain (Wodak & Meyer, 2009). It can be argued, on theoretical grounds, that professional discourses regarding the nature of chronic pain and the chronic pain patient are integral in the propagation of stigmatizing attitudes, and behaviors toward people who suffer with CPCs both within and without the health care field.

Medical and scientific discourses, as “systems of representation” imbued with the socially sanctioned power of authoritative knowledge, are normative in the cultures producing the literature reviewed above (Hall, 2001, p. 73). Truth claims referencing this authority are generally accepted as reflections of the world as it is, which assumption allows the contentious nature and the political implications of the discourse to proceed relatively unobserved and unchallenged (Fischer, 2003).

Medical discourses position people to be particular kinds of subjects (e.g., patients, providers, scientists, sick person, healthy person, etc.). These subjects are expected to have particular sorts of problems, behaviors, and responses, in order to make sense within the frame of discursive exchange—what Davies and Harré (1991) referred to as the subject positions. Would-be clinical providers are enculturated into these discourses through their educational and training experiences. Policy-makers rely on the attestations of people with expert fluency in these discourses in making decisions that have a direct impact on the lives people lead (Fischer, 2003). Patient populations differ widely in their access to, and understandings of these discourses and their associated linguistic repertoires.

Medical, scientific, and pain-specific discussions are nested within dominant discourses of individuality, autonomy, responsibility, and the privileged status of the material sphere that pervade Western understandings of human being and health (Cassell, 1991). These grand narratives are interwoven with local moral and political meanings, and valuations regarding innumerable issues of relevance to the attitudes displayed toward chronic pain suffer (van Dijk, 2011).

Ideological perspectives on gender, sex, race, disability, the physical, and the psychological provide interpretative frameworks through which medical/scientific discourses are taken up by those who encounter them (Radley & Billig, 1996). Anti-stigma discourses that do not consider the ways in which these discursive threads interact can inadvertently compound or at least leave unchanged the stigmatization of their target population (e.g., Finn & Sarangi, 2009). For all of the above reasons, professional discourses about the nature of pain, and its categorization should be subjected to critical analysis, not simply taken to be reflections of the natural order (Blommaert, 2005; Parker, 1992).

Existing critiques of chronic pain stigma. Underlying and intertwining scientific, commercial, and political factors are social attitudes about the moral meanings of pain, pain patients, pain treatments, and pharmaceuticals (Goldberg, 2010). Several writers have explored the moral meaning of pain through the lens of ethnography and philosophical bioethics (e.g., Cassell, 1991; Goldberg, 2010; Jackson, 2005; Rich, 2000). These authors have explored the association between sin and suffering (e.g., Goldberg, 2010); the affront pain poses to expectations of mind-body dualism; and lack of professional consensus regarding diagnosis and treatment (e.g., Jackson, 2005). Cassell (1991) observed the existence of a structural bias in medical science, leading some to discount the subjective experience of patients. The role of opioid stigma and the predominance of a curative (as opposed to palliative) model of medicine have also been a focus of analysis (e.g., Rich, 2000).

These writers, however, have left some of the foundational assumptions in professional discourses unquestioned. What was not found in this literature review was an exploration of how beliefs about American meritocracy and the unproblematic pursuit of life, liberty, and happiness impact patient stigma. Models of medicine (e.g., curative vs. palliative/ functional vs. structural) are subjected to insightful critique (e.g., Cassell, 1991; Rich, 2000). Models and taxonomies of pain, however, are more often cited then critically examined. One glaring example, no one seems to have questioned the confounding effects of variance among the population of CNCP patients in empirical outcomes research.

Opioid medications are acknowledged to be contentious but their (under)use is assumed to represent a lack of education, fear of addiction potential, or fear of legal/ethical sanctions (e.g., Notcutt & Gibbs, 2010). In all the calls for increased provider education into pain care and opioid use, the fact that the peer reviewed literature asserts divergent findings regarding the safety and effectiveness of opioid medications in the treatment of chronic pain has not been critically addressed. The ways in which medical (and lay) discourses of addiction and mental illness intersect pain care has also received scant attention in the literature (for exceptions, see Bell & Salmon, 2009; Looper & Kirmayer, 2004).

Anti-stigma frames in medical discourses of chronic pain. It has been suggested that the cultural connection between sin and suffering contribute to the stigma of chronic pain (Goldberg, 2010). It has also been suggested that the ambiguity of CPCs threatens normative assumptions of the separation of mind and body, which leads to discomfort and hence to stigma (Jackson, 2005). It has also been proposed that (re)conceptualizing chronic pain as a disease entity will lead to reduced stigma (Thernstrom, 2010). There is an assumption in the discourse of the "legitimate patient" that, if people seeking pain care are distinguished from those who have used opioid medications for nonmedical purposes, they will be received with increased empathy and respect. How these frames arise from, interact with, and influence existing beliefs, attitudes and social meanings has not been explored.

Language used in treatment approaches has also been criticized for the negative way they position the patient as a subject. J. MacDonald (2000) noted that psychological approaches to pain management frame patients in patronizing terms that reinforce existing stereotypes of patients, namely that they are motivated by secondary gains; are invested in the sick role; and require paternalistic guidance in letting go of these.

Kendall and Rogers (2007) criticize deployment of the self-management paradigm within psycho-educational programs designed for those with chronic diseases: Self-management and self-care education tend to ignore the social contributions to patients' health, their experiences and their choices. These writers also express concern that these discourses position patients as targets of blame for not taking proper action, according to the dominant medical discourses on what constitutes a healthy life-style.

Patient advocates have embarked upon efforts to counter stigma by drawing attention to the problems faced by patients trying to access medical care. These efforts emphasize the legitimacy of patient reports, and attempting to invoke alternative semantic networks through selective word use. Contemporary attempts include the use of such vernacular as “the legitimate pain patient” (see www.legitimatepainpatients.org). The use of the more erudite “opioid analgesics” is encouraged as a replacement for the common phrase “narcotic pain killers” (van Pelt, 2012, p. 16).

These attempts to rework semantic associational networks represent a move to distance the subject position of pain patient from that of drug abuser/addict. Bell and Salmon (2009) have noted the potential harm this strategy presents to people who been positioned as addicts, especially in the context of pain care for co-occurring health conditions. It is an open question what effect it will have on people with CPCs who are not (yet) identified as addicts.

In addition to a focus on semantic considerations, advocates have attempted to invoke alternative socio-political frames, e.g., pain care as a human right (Brennan et al., 2007). Connecting the issue with an overarching moral discourse, e.g., human rights, is an attempt to build consensus regarding the good, and rally people to the cause (Fischer, 2003). Such frames are intended to display the subject(s) in a more positive light in order to legitimize desired outcomes.

Work in stigma research with other populations suggests that these strategies, in isolation from broader engagement with social norms, are likely to meet with limited success (Bell & Salmon, 2009; Danforth, 2002; Finn & Sarangi, 2009; Harper, 2005; Mann & Himelein, 2008; Norman et al., 2008). This because stigma, like all normative assumptions, does not inhere solely in our words; it lies within the interconnected systems of meaning that frame our understanding of, and attitudes toward, the real and the good (Fischer, 2003). In other words, the problem is not the signifier, but the way in which the signified is related to and functions in service of social norms—the taken-for-granted realities within the discourse.

Without a clear appreciation for the ways in which existent discourses support existing arrangements, would-be educators inevitably draw from what they already know. That is, they draw "on the language, ideas, beliefs, ideologies, metaphors, and representations that are available" in cultural narratives about pain, illness and disability (Nettleton et al., 2004, p. 50). These cultural narratives are infused with dominant discourses, with their moral understandings and political implications, that facilitate stigmatization of people with chronic pain and illness (Radley & Billig, 1996). Unfortunately, these facilitating discourses have received little attention in the literature.

In order to avoid (re)stigmatization of people with CPCs, through well-intentioned efforts to improve their social status, it is necessary to understand how social norms are invoked and deployed within discussions of pain patients, care, and policy. More than this, it is important to explore the moral and political implications of existing and proposed frames, as they are taken up and intersect other discourses and ideologies. This critical discourse analysis was undertaken with the intention of focusing attention on the normalizing factors operating within discourse. A primary aim was the elucidation of interconnected ideas facilitating or resisting stigmatization, and consequent marginalization of people who seek pain care and/or live with chronic pain conditions.

Theory and Method

Discourse Analysis and Discourse Studies

Many books and studies have been published under the rubric of Discourse Analysis (DA) and Critical Discourse Analysis (CDA). In following the example of van Dijk (2009) I am breaking with this tradition in favor of Critical Discourse Studies (CDS/DS). van Dijk proclaimed the term DS to be better able to incorporate the range of activities, theories, and methodologies which make up this multi-disciplinary field of study. Perhaps more to the point, he acknowledged the confusion which results when using a word generally reserved for activities related to methodology: “A widespread misconception” that discourse analysis is *a* method of analysis (van Dijk, 2009, p. 62).

C/DA is not a methodology with a set of prescribed techniques. Rather, as a transdisciplinary concept, various research approaches are associated with the umbrella of discourse studies (van Dijk, 2009). What is offered is a broad theoretical framework (as described in the previous section) for making sense of language as a social practice (Blommaert, 2005).

The study of language-in-use. All discourse studies (DS) draw from linguistic, semantic, and semiotic epistemologies (van Dijk, 2009). The particular properties of discourse that become a focus of attention for the researcher depend in large part upon the researcher’s field of scholarship; the stated purpose of the study; and the specific questions being asked (Gee, 1999; Karlberg, 2012). Ontologically, the meaning of a text, the understandings of the facts within it, is always co-determined by the historical situation of the reader/listener (Gadamer, 1960/1975, pp. 295–296).

Discourses as systems of meaning emerge from the layers of signification that inhere in the ways that language is used: The meaning of an utterance is greater than the sum of the definitions of its constituent elements (Gee, 1998). It is the inter-relationships between these constituent elements (the linguistic, the narrative positions, and the preunderstandings of the authors/readers) that provide the basis for understanding referential meanings and significance for cultural practices (Blommaert, 2005). Analysis in this view involves understanding “the whole in terms of the detail and the detail in terms of the whole” (Gadamer, 1960/1975, p. 291).

van Dijk (2009) proclaimed that discourse studies need to be grounded in linguistic concepts for the simple fact that the fundamental unit of analysis is language-in-use. It is beyond the scope of this project to provide an exhaustive list of linguistic devices that may prove meaningful in the process of analyzing a particular unit of text, but such a list could include semantic denotation and connotation, grammar, syntax, rhetorical devices, argumentations, genre, situational conventions, and contextual cues (aka pragmatics). Any device affecting uptake (i.e., interpretative possibilities).

Blommaert (2005) underscores the importance of including semiotic understandings of the representational aspects of communication in illuminating meanings, both of and for language-as-a-social practice. Semiotics refers to the study of meaning-making processes of communicative exchanges, of which linguistic objects are but one example. Said another way, semioticians seek to understand what words, gestures, images etc. (i.e., “signs”) are meant to signify and how meanings are understood by language users.

DS also incorporates semantic and pragmatic analyses. There are many sub-branches of semantic study, but a unifying theme is the focus on representing meaning through conceptual relationships of referent terms and their referent phenomenon/object (Cruse, 2006, pp. 2–3). Pragmatic branches of semantic studies emphasize the importance of context and embedded social cues for the apprehension of meaning amongst discourse participants (Cruse, 2006, pp. 3–4). Examination of sign deployment within contexts of use may suggest particular conceptual associations, definitions, and understandings of the topical content.

Discursive participants can employ an array of linguistic and non-linguistic devices to signify interpretative intent. These can include the use of gestures, vocal tone, grammatical moods, strategic use of type font, emoticons, pictorial material, as well as word selection and order. Deployment of signs is predicated on (sub)cultural conventions of language use, as well as constraining realities of the medium (e.g., internet) through which communication proceeds (Herring, 2007).

Successful deployment of signs/signifiers renders an utterance comprehensible to particular participants in particular ways. Failed deployment always results in a degree of confusion. Many such failures of understanding are easily remedied but at the most extreme end, they can result in an abrogation of influence through association with lower status and concomitant loss of power and privilege (Blommaert, 2005). People who do not make sense, or have little credibility, are not accorded a say—their Voice is dismissed.

Voice, in this context, refers to the “capacity to accomplish desired functions through language” and “the capacity for semiotic mobility” (Blommaert, 2005, pp. 68–69). To be understood, to influence interpretation of what is said, to influence behavioral responses, these are the capacities of reference. Voice involves the speaker's ability to choose context-appropriate cues (e.g., words, tone, dialect etc.), and to draw from familiar narrative themes, but it also requires that the listening party allow the speaker to influence their understandings. This allowance may be granted or withheld for any number of proffered reasons all of which are based upon assumptions about the speaker's position in the social hierarchy (Blommaert, 2005).

Critical discourse studies. Critical approaches to discourse pay particular attention to power effects within discourse and generally align with an explicit agenda of remediating identified social problems (Blommaert, 2005). Critical theories encourage researchers to engage in the political meanings of knowledge and knowledge production as an ethical stance toward social responsibility (Wodak & Meyer, 2009). Critical studies have their foundations in critical social theory, which has a tradition of tracing its history to the works of the Frankfurt School of Neo-Marxist thinkers like sociologist Max Horkheimer. Extolling the emancipatory aims of social science, Horkehimer (1937) advanced a conception of the researcher not as a neutral observe but as an agent of social change.

Critical approaches to discourse studies are grounded in the theories of Michel Foucault (Hall, 2001). Foucault and those who followed observed that Discourses are more than *just* talk; they are also mechanisms of social control operating through processes of normalization (Hall, 2001; Parker, 2002). Critical discourse studies are often, though not exclusively, associated with post-structuralism, a philosophical movement emphasizing the linguistic construction of experienced reality (Parker, 1992).

While the present study draws upon post-structuralist insights into the constructive nature of language, it is grounded in an alternative paradigm—that of critical realism.

Critical Realism: Ontological and Epistemological Assumptions

Every research program is underlain by a philosophy of science that provides the lens through which objects of study come to be viewed as a legitimate source of inquiry. These theories dictate the manner in which the inquiry must proceed in order to produce knowledge that is viewed as trustworthy (Parker, 1992). Different philosophies of science may overlap in some foundational assumptions, but they often posit exclusive understandings of objects, subjects, practices and ethics (Hardin, 2000).

Assumptions regarding both ontology and epistemology are often left unstated in descriptions of methodology, perhaps due to a (mistaken) assumption that the perspectives on what constitutes *the real* are shared by all. Providing explicit clarification of the philosophy informing a particular research project can aid both the researcher and the reader in their evaluation of the research design and interpretation of the results. Clearly positioning the researcher within an intellectual tradition can also address issues of subjectivity by providing a context for the choices and interpretations made in the course of the analysis.

Ontological foundations. This research is informed by critical realism, a philosophy of science arising from the works of Roy Bhaskar and Rom Harré that posits a dynamic, stratified understanding of social and material phenomena (Gorski, 2013). Inherent in the position of critical realists is the recognition that language and culture play an important and foundational role in the formation of human experience and knowledge, yet the material basis of experience, including oppression, is an acknowledged and accepted aspect of reality (Parker, 1992). In this, critical realism rejects the ontological and epistemological dualism at the heart of the positivist and social constructivist paradigms, respectively (Gorski, 2013).

The ontological assumptions of critical realism are fundamentally dynamic: Things (broadly conceived to include objects, subjects, and practices) with differing properties, existing at different levels of organization within specific contexts, consist of complex interacting subparts which lead to the emergence of other properties (Parker, 1992). Exploring and explaining these emergent properties, and the contexts that give them form and meaning, is understood to be the purview of scientific inquiry in both the physical and social sciences (Gorski, 2013). Differences in the ontological properties of their objects of study necessitate different epistemological considerations in their research programs.

The properties of some things make them at least partially amenable to efforts to isolate variables in predictable ways, e.g., pharmocodynamic and pharmacokinetic properties of medicines. Patterns may be more easily identified when the properties of things are such that systems are closed, or at least containable, and possess limited variability (Parker, 1992). Even in the context of physical science, with its' tangible objects and determinable variance, insights remain incomplete. In the example of pharmacology, complex interactions between variables can impact outcomes (emergent properties) for individual patients in sometimes unpredictable ways (Wilkinson, 2005).

Humans clearly do not exist as or in closed systems—ever (Parker, 1992). Human experience and behavior (inclusive of physiology), cannot be understood in isolation of the contexts in which they occur. This is true not only because social reality gives them meaning, but also because social reality determines the accessibility of material resources underlying the circumstances in which the experiences occur and the behaviors are shaped (Gorski, 2013).

This is not meant to suggest that reality (or knowledge about it) is *merely* a social construction. Simply that in positing either, we are discussing mediated perceptions within a tangled network of meanings that are a fundamental aspect of the human being (Gadamer, 1960/1975, p. 250), which scientific endeavors must both account for and take into account (Gorski, 2013). That these meanings are not consistent across time or universally accepted truths world over is another fundamental aspect of human society: What makes sense to us here today, at this time in history, is not what has or will make sense in cultures across time and space (C. Taylor, 1989, p. 13).

Socially situated not socially determined. Meanings, i.e., theories, ideologies, cultural narratives, etc., contain information regarding the status of, and relationships between posited objects (Cassell, 1991). They frame our conceptual understanding of the description, the described and the describer. These also provide the guiding normative assumptions by which we evaluate things like validity, morality, and desirability (Gorski, 2013). In contrast to post-structuralist/post-modern philosophies of science, it is not assumed that physical realities are simply an outgrowth of interpretation (Parker, 2002).

Social realities may determine whether and how existent phenomena are perceived and responded to (see Hong, Chiu, Dweck, Lin, & Wan, 1999), but not the existence of the phenomena of perception and response per se (see Kearins, 1986). This should not be interpreted as suggesting that any and all concepts imbued with truth-value are, in the empirical sense, actual. For example, it was formerly accepted scientific truth that infants did not feel pain; this does not mean it is, or ever was, the actual case (see Rodkey & Riddell, 2013). Infant pain perception exists or not regardless of whether or how it is described in language. There is a reality outside of our experience (or lack thereof), but “there is no one to one relationship between a description and what it describes” (Parker, 1992, p. 27).

Material and discursive objects. The material and the discursive are viewed as having independent but dynamically related ontological status (Sims-Schouten & Riley, 2007). Material reality is not reducible to discourse but it is made socially meaningful through discourse. Indeed, it has no representation outside of discourse (Gorski, 2013). Concordantly, discourse is understood to have effects on material arrangements through its influence on other practices (Parker, 1992). It is also understood to be constrained by the (im)possibilities inherent in the material world (Sims-Schouten & Riley, 2007). Or, as Parker writes: “The real always lies on the edge of discourse, making some moves in language games impossible” (Parker, 1992, p. 38).

The boundary between the material and discursive is fuzzy, at best and a critical realist approach to discourse analysis has been critiqued on the grounds that there is no clear means of distinguishing between them (e.g., Potter et al., 1990; Speer, 2007). That we have difficulty distinguishing objects, however, does not mean that they are not distinct. It means only that our knowledge should be considered provisional and incomplete, rather than positive or absolute (Parker, 1992). Different theorists within this tradition have offered taxonomies for the purposes of distinguishing different object status and strata of reality (Gorski, 2013). This study was informed by the conceptualization of object status proposed by the critical social psychologist, Ian Parker (1992).

The object status of pain. Parker (1992) suggested conceiving of things (i.e., objects, subjects, and practices) as belonging to one or more of three possible realms of object status: Things which exist (ontological status), things which we talk of knowing (epistemological status), and things which serve as organizing social structures (moral/political status). These are not discrete categories and many things have a place in one, two, or three realms.

In this framework, pain can be seen as a thing with ontological status, something that exists independent of whether or how we talk about it. An ontological property of pain may be that it must be inferred through correlational observations (e.g., pain behaviors). Pain is also a thing with epistemological status. It is a thing that has been delimited on theoretical grounds, and made an object of study and intervention. Pain is also something with a moral/political status: It is a thing that demands response from social actors, responses that will have material and social effects on the lives of those involved.

It would be a mistake to assume that the way in which pain is represented as something known is equivalent to the thing that is experienced. As an object with epistemological status, it is a linguistically conceptualized phenomenon laden with meanings that entwine our experience of it. Social discourses may shape how pain is manifested, perceived, responded to and expressed in different socio-cultural contexts (see Cardosa & Sousa, 2009; Thernstrom, 2010). But conceptions of pain and experience of pain are also constrained by the organic material (aka body) through which pain is brought to light and with which it is intimately associated in language (IASP, 2012).

Summary of theoretical assumptions. Social reality has no physical form outside of discourse, but the physical is not simply a discursive construction. At the same time, the physical is known through discursive constructions, but it should not be taken for granted that our language reflects the world. Discourses are performed by us, but they also hold power over us. Actions are predicated upon the meanings contained in discourses.

Discourses are central to the organization of materials in the social world. The assignment of privileges; access to social and material resources; and the status of social identities are demonstrated and reinforced through discursive positioning. Dominant discourses appear to naturalize the existing social order, but even these are dynamic and contended, making room for resistant formulations. Critical analysis of discursive practices attempts to open this implicit process to explicit observation, reflection, and influence. The next section will outline how these theoretical considerations were applied in this study.

Data, Analysis, and Subjectivity

This section describes the application of the analysis of discourse to the text used in this study. The examination of language-in-use was intended for the purpose of identifying cultural meanings that emerged from readings of the text. This research was predicated upon the ontological assumption that these cultural meanings (theories, ideologies, narratives, associations, etc.) have direct bearing on the experience of discrimination reported by people with chronic pain. In other words, social discourse impacts people in tangible ways.

This analysis was undertaken to increase attention given to understanding the ways in which dominant discourses maintain the status quo (Parker, 1992). It may be particularly relevant to the work of patient advocates who are attempting to (re)frame the subjects involved. Analytic activities focused on interpreting language use, implications of tone, semantic associations, and references to and use of external source material.

Data summarized. In this study, the text of a public exchange carried out via the website of a large metropolitan newspaper in the northwestern United States was subjected to interpretative analysis. The data was derived of 779 units of variable length, individually authored texts. The units of text included articles published by the Seattle Times (the Times) as well as online comments posted to the Times' website by readers or other site visitors. The material was available to anyone with internet access. The data was originally published online in December 2011 and the early months of 2012. It was downloaded during the same time frame [See Table 2 for list of texts used as data in this study].

Table 2

Summary of Source Data

Abbreviated Name	Author(s)	Published	Retrieved	Number of Comments
Politics of Pain Series: State Pushes Drug that Saves Money	Berens & Armstrong	12/10/2011	12/20/2011	185
How We Linked Methadone Deaths to Poverty	Berens & Armstrong	12/10/2011	12/20/2011	7
Politics of Pain Series: State Law Leaves Patients hurting	Berens & Armstrong	12/11/2011	12/22/2011	235
Politics of Pain Series: Vancouver Pain Clinic	Berens & Armstrong	12/12/2011	12/22/2011	75
WA Addressing Deaths (editorial)	Franklin & Thompson	12/20/2011	1/9/2012	22
State Plans Warning for Methadone	Berens & Armstrong	12/21/2011	12/27/2011	45
Rise Above Opiate Wars (editorial)	Myra Christopher	12/22/2011	12/27/2011	31
Preferred pain drug now called last resort	Berens & Armstrong	1/27/2012	4/5/2012	71
Times Win Prize for Series	Seattle Times Staff	3/3/2012	4/5/2012	3
Methadone Series wins Pulitzer	Seattle Times Staff	4/16/2012	4/23/2012	74
Letters to Editor	2	12/12/2011	4/5/2012	5
Letters to Editor	4	12/13/2011	4/5/2012	0
Letters to Editor	2	12/14/2011	4/5/2012	3
Letters to Editor	3	12/16/2011	4/5/2012	0
Letters to Editor	1	12/17/2011	4/5/2012	0
Letters to Editor	1	12/22/2011	4/5/2012	0
Total individual texts: **Combined print and online texts: 779**	**23**			**756**

Note. List of published articles with the number of online reader comments.

The publication of a three-part investigative series sparked the exchange from which this data was derived. The authors of the series were investigative journalists, Mike Behrens and Ken Armstrong, working for the Seattle Times. Published over a three-day period in December of 2011, the trio of articles examined related but distinctive facets of health and policy debates regarding the use of opioid medications in the treatment of chronic pain.

The information presented in the articles was augmented by the inclusion of additional material readers could access via the Times' website. These included links to source documents, a timeline of policy actions, an interactive map of state methadone-related deaths, an explanation of the journalists' methodology, and a video presentation of the stories' primary claims. These items were reviewed and treated as contextualizing documents, "necessary for a situated understanding of some of the things that are in the texts" (Blommaert, 2005, p. 146).

Four follow-up articles appeared in December of 2011, January, March, and April of 2012. The first (12/21/11) and second (1/27/12) of these follow-up articles were substantive reports about governmental actions that were taken subsequent to the initial publications. The third (3/3/12) and fourth (4/16/12) follow-up articles were short pronouncements of recognition and prestige garnered by the original investigation.

Both the original series and each of the follow-up articles elicited editorial responses from readers across the state and elsewhere. Much of the data is derived of text responding to the original series (578). For all articles, the bulk of public responses (756) were posted online using the comment feature available to registered users of the Times' website. Seven of these were appended to the supplementary explanation of methodology used to establish a correlation between methadone, accidental overdose, and government policies. A few (15) of the reader responses were officially published by the paper for print and online consumption as editorials and letters-to-the-editor.

Of the responses published by the Times, two were editorials credited to “Guest Columnists” writing in their professional capacities. The medical directors of two State agencies, the Department of Labor and Industries (L&I) and the Health Care Authority (HCA), wrote in support of existing policies and priorities (Franklin & Thompson, 2011). Although the series focused on local state issues, a patient advocacy position was penned by an out-of-state author, who was a member of the Pain Study Committee of the Institute of Medicine (IOM) and former president of the Center for Practical Bioethics (Christopher, 2011). Thirteen responses were printed as letters-to-the-editor. Some of these letters were also commented upon by readers posting in the online forum.

Contextualizing factors of the online environment. At the time the material was published, news content on the Times’ website was accessible to the public without subscription. As has become an increasingly common practice among media companies (Santana, 2011), the Times’ website included an interactive comment section appended to many of their stories and opinion sections. These forums provided an opportunity for users to respond to the stories’ content, Times’ staff, or other site users. Comment features remained interactive and open to new posts for 72 hours from the date of publication. Any site visitor could peruse the reader comments, but the Times required user registration to access the interactive features, including the ability to make a comment.

Registered users were allowed to leave comments; rate the comments of others; or report an abusive comment to the moderators. Registration consisted of creating an online profile, with a personal moniker and place identifier, which would appear along with the user's posted comments. Users had the option of employing a pseudonym for public display. The creation of a profile provided the Times with the technological capacity to monitor users' interactions and to block accounts associated with habitually problematic posts. Posted comments were subjected to the Times' moderation process—they could be removed if deemed inappropriate, threatening, potentially harmful, offensive or illegal (See Terms of Service, http://www.seattletimescompany.com/notices/notice1-old.html).

Research has explored the impact of user registration and moderating comments on the quality of user posts. It is believed to improve adherence to behavioral norms such as civility and topic maintenance, as well as intelligent sharing, reliability, relevancy, and clarity of posts (Diakopoulos & Naaman, 2011). Moderation has become an integral part of many computer-mediated communication sites and thus plays a role in the evolution of the practices and conventions guiding site users' interactions (Wise, Hamman, & Thorson, 2006).

Moderated posts may demonstrate dominant discourses in action because expressions deemed to be in violation of acceptable norms are deleted from public perception (Hughey & Daniels, 2003). News media outlets contend that the norms being policed through their moderation practices are those governing civility (Diakopoulos & Naaman, 2011). Ostensibly, posts are not deleted for unpopular conceptual content so much as for hurtful words or suggestions of illegal activity.

Of course, in practice it is not as tidy as all that. Norms of enforced civility can serve to silence criticism (particularly expressions of anger) by disenfranchised members of society (West & Olson, 1999). Readers (e.g., moderators) may take offense to posts that were not intended or perceived to be offensive by their authors, or, moreover, that another reader may not find offensive (McKee, 2002). This may be especially salient in discussions of divisive topics and expressions of resistance by those speaking from a stigmatized identity (Hughey & Daniels, 2003) These observations open the way to questions about the impact of moderation on the interpretations made by discourse analysts.

How issues of civility are defined, how moderation practices are enacted, and to what extent ideas and impassioned debates are censored in the drive to ensure civility, are important questions relevant to the topic of this study but outside its scope. Whether inclusion of deleted posts would substantially affect the analysis of stigmatizing discourses intersecting chronic pain may be an important question. It is not, however, one we must necessarily answer in order to observe stigmatizing discourses at work. In this present research, the units of text were treated as a sample of wider social discourses in which it was expected to find that which is ubiquitous in the culture (Parker, 1992).

Analytic practices. In order to preserve the text format as encountered by the public readership, the materials were downloaded from the SeattleTimes.com as a web archive. To secure lexical content from potential alteration during analysis, the materials were also pasted into word documents and saved in pdf format. The text was analyzed using the qualitative research software, Atlas.ti version 7.

Atlas.ti is commercially available software used to examine digitally formatted text files. It provides a tool for creating and organizing codes at different levels of analysis. A memo feature allows researchers to capture reactions, associations, and reminders within the program files. Atlas.ti 7 also includes tools for visual mapping of conceptual relationships between identified codes, and/or source quotes.

The coding process was guided by the following research questions: How are the people, problems and solutions formulated by participants in the exchange? What identities, roles and behavioral expectations are exhibited and/or suggested by participants? How is participant authority and social status established and/or limited within the discourse? What are the ideological value hierarchies offered by participants in determining the relative desirability of identities, roles, and problem solutions? What assumptions appear to be taken-for-granted and what subversive or resistant formulations are presented? Finally, and perhaps most importantly for the aims of this research, the moral understandings and political implications of these discursive formulations were elucidated through analysis and discussion.

With the aim of illuminating contended social meanings (Parker, 1992), the sociolinguistic elements within the text were identified and interpreted (Blommaert, 2005). Indicators of social status, identity, ideology, and language repertoires embedded in reader posts provided indexical markers of authority and influence (Blommaert, 2005). Interpretation of the semantic relationships and pragmatic conditions of, within, and between statements informed my understanding of the taken-for-granted assumptions, common sense understandings, and normative judgments operating within the discourse (Parker, 1992).

Comments were analyzed as they appeared in the online format at the time of download. Grammar and syntax were edited for readability in the final draft; semantic and lexical content were not altered. Analysis proceeded in a step-wise fashion. A first reading identified themes in the topical content of posted comments, with attention to the associations made to the content of the articles (when points were missed, for example). Terms used to identify, define, or describe the people and issues related to pain and pain care were catalogued for ease of categorical analyses.

Additional readings were focused more specifically on semantic and semiotic elements within the text. These included context-dependent conventions guiding communication practices in computer-mediated and moderated forums (Herring, 2007). An example of semiotic devices used in computer-mediated communication is the tactical deployment of type-font as an attempt to influence interpretative uptake in the absence of behavioral cues such as vocal tone and facial expression. The quantity and quality of interaction between participants, as well as use of the site's dichotomous rating feature (Like/Dislike) informed interpretations of the data (per Otterbacher & Hemphill, 2012) but were not the focus of analysis. These and other elements of sociolinguistic analysis were excluded to limit the scope of this study.

In some circumstances, consideration of mechanical construction of written language can provide a window into intentions, meanings, or aspects of a participant's social identity (Blommaert, 2005). Due to emerging conventions governing communication practices within computer-mediated forums (Darics, 2013; Herring, 2007; Przywara, 2012), however, some mechanical forms may be inappropriate signifiers of either intent or language facility. There is no way to know, for example, whether punctuation use reflects the user's degree of knowledge (of the rules of punctuation, typing skills, or computer interface technology). It may simply reflect a disregard of technical conventions in favor of other considerations, such as style, convenience or haste. Therefore, no conclusions were drawn regarding the significance of the non/use of such mechanical devices.

The introduction of tangentially related content (e.g., references to health care reform legislation as "Obamacare"), as well as the use of quotes pulled from the articles and other posts—intertexuality and entextualisation, respectively—informed identification of general themes (Blommaert, 2005). The use of arguments and rhetorical devices, metaphors and analogies received close attention based on the presumption that their presence signified connections between the identified subjects, cultural values, and ideological assumptions (Parker, 1992).

Interpretations of meaning and social significance relied upon the elaboration of semantic associations between signifiers, and the relationships between the concepts and objects being signified. Logical propositions (e.g., "if this then that") within the analyzed texts were highlighted as a window into normalizing and moralizing discourses—those communicating and influencing moral understandings of the normal and the good. At the same time, it must be acknowledged that meanings as apprehended may or may not align with meanings as intended (Blommaert, 2005). Moreover, it is accepted truth that the meanings which are present may have little to do with either the conscious intentions or understandings of discourse participants (Kogler, 1992/1996).

Communicating and understanding are always imperfect processes in which variations amongst participants, their experiences, ideologies, expectations, and uses of linguistic repertoires comingle in unpredictable ways, producing unanticipated effects on production and uptake (Blommaert, 2005). Comments are understood or misunderstood by the interpreter who always stands within a particular horizon of available interpretations (Gadamer, 1960/1975, p. 301). As a researcher engaging in interpretative analysis, I must acknowledge that my understandings of the text are drawn from my own pre-understandings, conscious or otherwise, which may not always be useful or accurate.

The subjective researcher. Research is an inherently subjective endeavor, in that it is always undertaken by a person with subjectively experienced motivations for, and perceptions of, the process (Kogler, 1992/1996). It is naïve to presume that we can know an object by ignoring the fact of our presence in the outcome of our activities (Gadamer discussing Husserl, 1960/1975, p. 241). The researcher has a personal history, is situated in a particular time and place, and possess their own peculiar perspective on every known and speculative aspect of existence (Parker, 1992). In critical research programs, it is not considered possible or desirable to eradicate the subject from research (Kogler, 1992/1996). It is, however, necessary to reflect upon and account for the researcher's subjectivity in making sense of the research process and findings (Wodak & Meyer, 2009).

Competing philosophies of science suggest different tactics in dealing with researcher subjectivity (Gorski, 2013). This research was predicated on the understanding that researchers hold (indeed, cannot avoid holding) cultural assumptions and values, consciously and otherwise, which exert tacit influence on methodological decisions and interpretations of findings (Kogler, 1992/1996). In the present research, no attempt was made to inhabit the untenable positions of objectivity or of bracketing assumptions.

Neither the mechanistic mind engaged in the recording of raw data, unmediated by observation and interpretation, nor the dissociative mind, attempting to by-pass existing assumptions in making unfiltered interpretations, were seen as viable alternatives (cf. Cushman, 2013; Gadamer, 1960/1975; Gorski, 2013).

As the researcher, I acknowledged and challenged my subjective understanding of the text throughout the research process. My own reactions to the material in the data was flagged through the use of memos and a journal for personal review and reflection. Anecdotal experiences or memories of previously encountered texts were recorded in this fashion. All the same, no claim can be made to suggest explicit awareness or accounting of all potential sources of researcher subjectivity.

Unless something contradicts my presumptions, ". . . the fore-meanings that determine my own understanding can go entirely unnoticed" (Gadamer discussing Heidegger, 1960/1975, pp. 270–271). The prejudices of a researcher must be activated by the recognition of difference before they can become conscious. "…our own prejudice is properly brought into play by being put at risk (Gadamer, 1960/1975, p. 299). To facilitate an awareness of existing prejudices, I discussed my research, interpretations, and reactions with colleagues. These strategies of self-reflection and dialogue were intended to facilitate a critical distance between myself as the researcher and the social discourses that were the focus of my research. The purpose of such distanciation is to "make conscious the prejudices governing our understanding, so that the text, as another's meaning can be isolated and valued on its own" (Gadamer, 1960/1975, p. 298) and that I do not find only what I have expected to find (Parker, 1992).

Assumptions of this researcher. I began this study with a conceptualization of pain that I maintained throughout. I hold a view of pain as an experience with both material/physiological, and social discursive/psychological aspects—a complex of interactive biopsychosocial components. It was not the purpose of this analysis to either establish or appraise the facticity of claims regarding the specific properties and inter-relationships of these correlates and components. Therefore, no conclusions are offered regarding the objective truth of explanatory models of things like pain, addiction, or prescribing practices. Questions of adherence to epistemological assumptions are raised in discussing the analysis due to the moral and political implications of authoritative knowledge claims.

I assume pain to be the effect of a wide variety of causative factors, rather than a construct of uniform conditions. The veracity of patient reports of discrimination, of enacted and felt stigma, that has been documented in the myriad qualitative research programs reviewed above is accepted as a reflection of their experience of patient-hood. Conceptualizations of pain and patients found in the data were understood in the context of those found in professional and academic literature. This included exploration of the empirical and phenomenological support, or lack thereof, for assertions and contentions identified in the text.

In service of transparent identification of researcher subjectivity, I am compelled to acknowledge myself as a person who lives with chronic pain. I was given a controversial diagnosis in adolescence that I rarely speak aloud in order to avoid confronting the reactions of my listeners. I am not currently involved with medical systems of pain care, nor have I been a “pain patient” for at least two decades. In my young adult years, I sought medical explanations and interventions for the experience of chronic pain but found it to be an invariably useless and upsetting endeavor. I count myself among the lucky that pain has had less impact on my life and functioning than is true for many people with painful conditions.

I have family, friends, and acquaintances who are identified as chronic pain patients and who seek palliative care from medical providers. Some of these people use opioid medications for palliation and some do not. Some experienced relief through surgeries, acupuncture, or other treatments. I have also known people, some I have called friends and some who were passing acquaintances, who misused prescription opioids. Some of these people would have met criteria for an opioid use disorder as defined in the Diagnostic and Statistical Manual of the American Psychiatric Association (2013). Others used opioids recreationally, reportedly without craving or withdrawal. All of this is to say that this project was personal, political, and academic.

Notes on language use. The following section contains an explanation of how words with a variety of meanings are intended in the body of this project. It is offered to clear up potential sources of confusion or conflation. It is not a necessary component to the analysis per se. It was developed following dialogue with colleagues who expressed confusion regarding the different uses of these common terms.

The distinctions I offer here are pragmatic, rather than technical or conceptual: I wish to simplify communication about complex constructs; and I wish to avoid long discussions of the debates in the broader field of language studies that, while important, are not of central relevance to the aim of this project.

My use of the terms <discourse> and <discursive practices> are as summative devices signifying all forms of meaningful symbolic behavior, or "general mode of semiosis" (Blommaert, 2005, p. 2). Singular and/or plural word forms <discourses> will also be used to reference the particular, historically situated socio-cultural systems of meaning (e.g., Nationalistic Discourses) through which people construe the world (Fairclough, 2009).

I use <ideology> in its most general sense to signify the "coherent and relatively stable set of beliefs or values" that serves to guide evaluations of, and actions within, the social terrain (Wodak & Meyer, 2009, p. 8). I do this in spite of the negative connotations and widespread use of the word to denote those positions which are viewed to be (disagreeably) false to the one employing the term (Wodak & Meyer, 2009). I do so under the assumption that it is necessary to employee a descriptor of the world-framing properties of discourse without regard to affinity for, or affiliation with, the frames being invoked.

In referencing specific examples of discourse, I will use the term <text> to refer to communication that appears in written/typed form and/or as a static image/picture. For ease of communication, I use <talk> as a super-ordinate device to refer to all manner of communication practices, written and spoken. When referring to those who are engaging in talk, I will use the signifiers <reader/author>, <speaker/hearer> and <discursant>. I do not use the more common term <conversant> primarily due to the accepted implication of interactivity signified by its use. Discursants are participating in discursive actions, but they may or may not be engaging in or expecting communicative interchanges in the immediate situation.

In discussions of discourse in the abstract, I will use these terms interchangeably as an aggregate designation in order to maintain grammatical clarity. This should not be understood as an attempt to conflate understandings of communication practices where distinctions remain relevant in other contexts.

Deservingness in Discourses of Chronic Pain

This study utilized the text of a public exchange carried out via an internet news site operated by a large metropolitan newspaper. The exchange was sparked by the publication of a three-part investigative series conducted by Seattle Times' journalists, Mike Behrens and Ken Armstrong. The articles in the series were published on December 10th, 11th, and 12th of 2011. This series of articles, along with follow-up and auxiliary articles, examined related but distinctive facets of health and policy debates related to the use of opioid medications in the treatment of chronic pain.

The final analysis focused on the text of readers' online commentaries and letters to the editor, comprised of 769 individually authored texts of variable length (See Table 2 for list of texts used as data for this study). The text published by the news corporation was treated as stimulus material for the commentaries. The articles offered as a product of the newspaper, are summarized below.

The Politics of Pain Series

Article one: Methadone policy critique. The first article (Berens & Armstrong, 2011a) included a case study in accidental overdose; results of the journalists' analysis of methadone-related death certificates; and selected points of policy discussion that intersect both public health and economic discourses. Starting with the uncontested facts 1) that opioid overdose deaths were on the rise; and 2) that methadone, being less expensive than other long-acting opioids, was the preferred drug in the State's formulary, the investigators advanced several, contested, conclusions.

First, methadone's unique pharmacokinetic properties were responsible for a greater incidence of overdose with this medication than other long-lasting opioids:

Methadone accounted "for less than 10 percent of drugs prescribed and more than half of the deaths" (Berens & Armstrong, 2011a). Second, this information is not readily disseminated amongst prescribers or patient users, resulting in unintentional misuse of the substance. Third, the cost-saving measures enacted by state agencies to privilege reimbursement for the less-expensive methadone over other, ostensibly more predictable opioid medications, resulted in greater incidence of overdose amongst low-income, state-dependent patients. And finally, the authors assert that policy makers and agency leaders chose to ignore the unique dangers of methadone in order to reduce their budgetary expenditures, thereby knowingly putting vulnerable populations at risk for a chance to save money.

The case study presented the face of overdose deaths in the story of a sympathetic character—a young woman who had a respectable job, left disabled and impoverished by the painful sequelae of a blameless injury before her iatrogenic demise. The analysis involved examination of 2,173 death certificates for the casualties of fatal methadone overdoses between the years of 2003–2011. The article reported that "up to 20 percent of the methadone-related deaths involved illicit substances suggesting the overdoses were a byproduct of abuse." The implication of this statement is that 80 percent of the overdose deaths were the unintended consequences of medically sanctioned use by (presumptively) compliant patients.

The article headline and subheading provide a clearly identifiable moral evaluation of the subjects discussed in the article.

> **State pushes prescription painkiller methadone, saving millions but costing lives. To cut costs, State steers Medicaid patients to a narcotic painkiller that costs less than a dollar a dose.** *The state insists methadone is safe. But hundreds*

> *die each year and more than anyone else, the poor pay the price.* (Berens & Armstrong, 2011a; **headline;** *subheading)*

The deaths were undeserved and tragic; blame for these tragic deaths is lain upon the governmental agents responsible for administering public resources. In the body of the article, patients were positioned as the unwitting victim of policies, ignorance, or biochemical interaction effects. Prescribers were either uninformed or impotent to alter course, while policy-makers were cast as willfully shortsighted or negligent. Addicts and addiction were mentioned in relation to heroin, opioid maintenance treatment, and scamming. Addiction was not defined.

Article two: Opioid prescribing law critique. The second article relayed the story of a newly enacted opioid prescribing law focused on the prompting events and potentially deleterious consequences of the State's recently enacted opioid prescribing law (Berens & Armstrong, 2011b). The impetus for the law, according to the policy-makers cited in the article, was the rising tide of accidental overdoses and increasing black market demand for prescription opioids. Policy mandates were expected to guide prescriber's clinical decisions and provide them with an authority to reference in communicating dosage restrictions to their patients.

The article referenced the concerns of patient advocates that the pain management law would encourage caregivers to discontinue, or refuse to initiate, opioid therapy in cases where patients may benefit from it. The law was criticized for creating onerous requirements for providers, and for codifying stigmatizing attitudes toward people with chronic pain. At issue were several points of concern to policy critics.

First, policy-mandated dosing ceilings that were to be based upon a controversial metric purported to calculate morphine equivalent doses for all classes of opioids; a potential problem in the context of the existing variance amongst online calculators (see Shaw & Fudin, 2013). The policy-specified documentation requirements for justifying COT dosage and maintenance with reference to increased functionality and less emphasis on distress reduction alone. Finally, the policy delimited a category of "high risk" patient (people with diagnostic histories positive for psychiatric conditions, including but not limited to substance abuse/dependence and/or mood disorders). The law directed prescribers to flag patients presenting with these historical risk factors for additional documentation and monitoring.

In its coverage, the article was clearly sympathetic to the subject of chronic pain patients whose access to opioid medications was being curtailed by policies and practices predicated on negative evaluations of continuous opioid therapy (COT).

> **New state law leaves patients in pain**
> *It was meant to curb rising overdose deaths. But Washington's new pain-management law makes it so difficult for doctors to treat pain that many have stopped trying, leaving legions of patients without life-enabling medication.*
> (Berens & Armstrong, 2011b; **headline;** *subheading)*

Policy-makers are framed as well-intentioned yet naïve to the plight of patients. In the body of the article, providers were positioned as gatekeepers with a deceptively narrow range of autonomy "to treat pain." Patients were victims of policies, gatekeepers, and stigma that leave them bereft of "life-enabling" pharmaceutical treatments. The article discusses concerns related to addiction and drug diversion and offers supportive claims for the proposition that people with diverse health complaints were being abruptly and arbitrarily withdrawn from opioid therapy for (presumably) non-clinical reasons.

Article three: Negligent prescribing and ineffective oversight. The third article offered a critique of negligent and/or malfeasant opioid-prescribing practices and ineffective governmental responses, purportedly contributing to the health problems of addiction and overdose, and the issue of illegal commerce in prescription opioids (Berens & Armstrong, 2011d). This article focused on a clinic that had operated in a metropolitan area, serving a large population of identified pain patients, many of whom received public benefits. The report claimed that several people had expressed concerns to officials about the unusually high doses of opioids being prescribed at the clinic. The clinic had been associated with multiple overdose deaths, black market distribution, and patients who went on to commit drug-related robberies.

In this third article, people seeking pain relief from the providers at the clinic were sorted into two categories: The unsuspecting, legitimate pain patients and the illegitimate, drug abusers and dealers. The prescribers in this article were framed as criminally negligent, if not nefarious, in their opioid prescribing practice.

> **Vancouver pain clinic leaves behind doubts, chaos and deaths**
> *The clinic's high doses—"Take 10 every 6 hours," one painkiller prescription said—reveal murky regulations and Washington state's anemic response.* (Berens & Armstrong, 2011d; **headline;** *subheading)*

Policy-makers and enforcers were described as "anemic" in their response to this misuse of opioids because they did not investigate or censor the clinicians soon enough. The assumption that this physiological metaphor of systemic dysfunction will be understood in the context of policy discourses is a demonstration of the power and authority of bio-medical discourses. The article suggests that empowered social entities should increase their surveillance and influence over the behavior of other social actors. There is no hint of irony or acknowledgement that previous articles had largely criticized policy-makers' purported attempts to do just that.

Follow-up articles. Two follow-up editorials, penned by “guest columnists,” offered two apparently opposing views on extended opioid use and chronic pain treatment. The first editorial articulated the politically dominant position within the contemporaneous discourses of pain care policy (Franklin & Thompson, 2011). The authors were the medical directors of two State agencies that have social and financial stakes pain care practices. As agencies of public benefit, they are also invested in resolving social problems related to addiction.

In their professional capacity, these officials defend prior committee decisions to support methadone as a preferred medication in their agency formularies, as a safe and cost-effective medication. They emphasize the need to expand the overdose discussion from a narrow focus on methadone to the general class of opioid medications, which they argue are being overused for chronic pain complaints. Use of opioids for chronic pain conditions is thereby positioned to be the principal problem in need of policy intervention.

The second response was published under the name of a prominent advocate for patient voice. This editorial (Christopher, 2011) attempted to focus the discussion away from opioid (mis)use and on to the ethical, sympathetic treatment of people with chronic pain. Here, the pain patient is in a position to deserve empathy and respect; to be accorded a voice (i.e., power of influence). Maintenance of opioids as a viable treatment option for people with pain complaints is inherent in this position of advocacy. Patient voice, by definition, must include those claiming benefit from chronic opioid therapy (COT) as well as those who do not use opioids.

Additional follow-up articles penned by journalists at the Times' reported on the impact these publications had on the subsequent action of healthcare policy-makers. Ostensibly from the analysis of methadone's disproportionate representation in prescription opioid-related deaths, State policy-makers first issued a warning about methadone's specific risks for all prescribers (Berens & Amrstrong, 2011e). A few weeks later, new policy directives were issued that methadone, rather than being a preferred treatment, should be offered as a last resort (Berens & Armstrong, 2012). There was no discussion in these articles of the impact such a ruling may have on patients who were stable on methadone treatment, but it was celebrated as a victory for people whose medical needs would be more safely met through the use of other long acting opioids.

Two briefs related to this series announced that the Politics of Pain series had garnered coveted awards in journalism. The work was honored for its impact on public policy with receipt of the Selden Ring (Seattle Times Staff, 2012a), and for the quality of investigative journalism—the coveted Pulitzer Prize (Seattle Times Staff, 2012b). The reader comments appended to these announcements were included in the analysis.

The quotes presented below were chosen for their exemplification of particular concepts and language use. In an effort to increase readability, quotes were edited for grammar and syntax. Although some socio-linguistic elements of the text are homogenized with this strategy, the topical, literal, and semantic content was not affected by these edits. Use of emphatic font, capitalization, line spacing, and punctuation was left unchanged. To limit the scope of the study, misspellings, idiosyncrasies of expression—all of which affect reader interpretations and responses—were excluded from the final analysis.

In the following section, I first show some of the general, semantic and syntactical language-based, ploys used to influence moral discourse in this cultural moment. I use examples drawn from their application to discourses of chronic pain. In the second section, I analyze these strategies in their application to and implications for the subjects of chronic pain discourses. The quoted text included below is not provided with links to either the source article or personal moniker of the posting author. This was done in an effort to focus on semantic associations within the general discourse.

Reader Commentaries: Positing Deservingness in Categories of Us and Them

Two overarching themes were found emerging throughout reader commentaries: Us v. Them; and Deservingness. These themes wind throughout the data, in comments pertaining to the explicit topics of pain care policies and patient treatment. They are also found in commentaries with apparently tangential content, referencing topics ranging from abortion, climate change, socio economic status, and politico-economic corruption. The common thread connecting them all is the expectation (and assumed necessity) that Us-the-more-deserving should be distinguished from Them-the-less-deserving.

Assignments of deservingness frequently, though not exclusively, hinged on perceptions of blame. The more blameworthy the subject, the less it may be deemed deserving of desirable ends, and the more punishing responses are met with acceptance or encouragement. Aversive consequences are expectations for blameworthy identities—those which are thereby held solely responsible for their undesired and undesirable lot in life (See Figure 1).

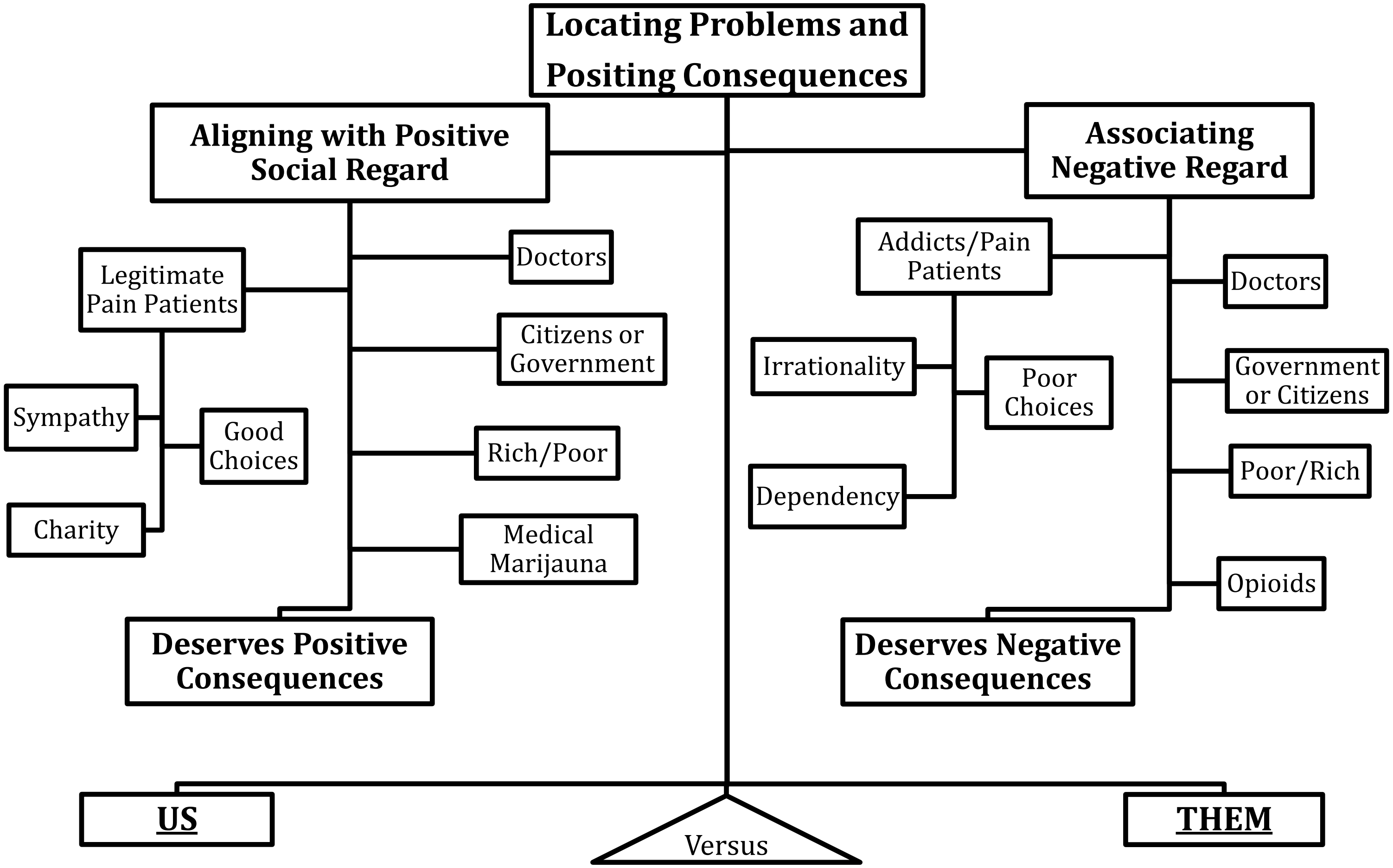

Figure 1. The locus of the problem: Who deserves what. Subjects in discourse are aligned with indexical markers of social regard and positioned in adversarial roles in competition for public opinion, policy benefits, medical resources, respect and credibility.

Commentators position subjects in these adversarial positions, alongside identity qualifiers that may put them in alignment with esteemed positions or push them beyond the pale of social good will (Leerssen, 1995). When the interest of those in one category are in conflict with the interests of those in another, prioritization arguments are predicated upon concepts of deservingness. There are real consequences posited for the people in each category, their just deserts as it were. The actual consequences for any given social actor, however, depends greatly upon the discursive power of their position to influence the flow of resources (Blommaert, 2005).

Qualifying deservingness. Deservingness, as a heuristic, need not convey an inherent endorsement of desirability. It can be a generic reference to a quality possessed of all subjects: They are deserving of something, the question is what, whether blessing or misfortune (Callan, Kay, & Dawtry, 2014). In practical usage, deservingness is explicitly referenced in support of positive consequences—privileges to be earned, or rights to be conferred (see www.oxforddictionaries.com). The word is thereby acceptably positioned to serve as both the value-neutral definition and the positive exemplar of the very concept it has come to designate. It will be used interchangeably in this manner throughout this paper, for reasons of syntax.

Shame and enmity. References to deservingness are sometimes oblique:

> *Let me get this straight…. Your local pharmacist will provide methadone without any moral "compass" (which we now know without doubt is a DEATH SENTENCE)… but refuse to offer "Plan B" birth control? Honestly… you can't make this stuff up.*

This is not the only reference to abortion politics in the comments; it was chosen to demonstrate invocation of deservingness through tangential connections in the discourse. In this comment, birth control is an expectation that is unfairly obstructed by people who have the power to enforce their will over the choices allowed to others. The author emphasizes the responsibility of the pharmacists in the death of opioid consumers, yet it is ultimately an attempt to shame those who refuse to disseminate the "morning after pill"—a form of emergency contraception known by the brand name of Plan B.

This argument only makes sense in the first place if it is an accepted truth that women deserve access to this product more than HCPs deserve to live out the fundamental tenets of their moral lives. Otherwise there is no shame in withholding it.

As a logical proposition, the statement has no inherent merit outside of its ideological argument that women deserve to control the biological reproductive aspect of their lives. Many pharmaceutical products aside from methadone possess potentially dangerous side effects (including Plan B). Moreover, Plan B is considered to be the death sentence in the ideology of the professionals who withhold it. They adhere to an alternative moral ideology where the subject of the potential life of the fertilized ovum—which Plan B effectively flushes from the system prior to implantation in the uterine wall—inhabits a higher moral plane (Rettner, Rachael; Dec 2011; www.livescience.com/1783-morning-pill-plan-controversy-explained.html).

This post is ostensibly a tangent about birth control but it is a defense of patient voice (the woman in search of emergency contraception). As such it is not without implication for the subjects of pain care. If methadone is a "death sentence," then there is no credible defense of medical use. Dismissing any voice claiming benefit becomes ethically defensible, if only for their own good. To advance the interests of patients seeking contraception, they are juxtaposed with patients whose voice need not be heard.

It is not the only time an argument in favor of patient voice in one arena undermines the credibility ascribed to patients in another.

The diminishment of the voice of pain patients occurs even in explicit reference to the deservingness of all patients.

> *This is not a pain-specific issue; this is a health-care access for the poor issue. One that no one has been doing front page articles about until a vocal minority of "relatable" Medicaid patients complained that they couldn't get their Oxy. Do I agree these patients should have access to an educated, informed, responsible pain provider who has every medical option open to him/her? Yes. But I believe every, ANY, kind of patient deserves that, and in WA, poor people have never had that.*

This quote is taken from a longer post expressing sympathy for the needs of the “poor people.” The author claims to have been a hospital social worker. Here, all patients are said to deserve access to educated, informed, responsible medical care. And while pain patients are described as “relatable,” their complaints of lost treatments are secondary to the problems of the impoverished patients. The claims being made by people with pain, that they are experiencing discrimination and lack of care because of attitudes toward pain patients specifically, are herein subsumed rather than compounded by issues of economic class. As a result, the voices of pain patients decrying the stigma of their condition are dismissed as inaccurate reflections of the real problem: class disparity.

There is no authority offered in support of the asserted moral aphorism—that financially impoverished patients deserve to access to medical care—yet the post offers a glimpse of the moral argument playing out in the discourse. The comment provides a clear indictment of the prevailing utilitarian ethic as it is being enacted in a society prizing financial independence: The greatest good for the greatest number, and more for those who can afford it. An ethic of chivalry is the proffered alternative: When interests come into conflict, protect the rights of the vulnerable who have a moral claim to charity.

Dependence and charity. Deservingness was not conceived as a purely dichotomous construct in the text. It was not a simple matter of identifying who deserves rewards and who punishment but rather locating subjects along a continuum of influence, social regard, and legitimacy. As an example, people who relied on charity (e.g., recipients of public benefits) were not quite as deserving of choice treatment as were those with the resources to purchase them, but they were not completely excluded from the circle of positive regard. Their financial dependence led to a concurrent dependence on the charitable will of others and dependency facilitated a limited sphere of influence.

> *I think the real lesson here is that if someone else is footing the bill, then that someone else gets to make the rules.*

This quote is also from a longer comment critical of the journalists focus on the needs of the economic underclass. Previous sentences in the post position medical marijuana as an equivalent alternative to opioids in pain management. The main thesis of the comment, however, is this: People with resources deserve to set standards at the expense of their dependents. When the financial interests of the conferring class conflict with the needs of those in the dependent role, the former has the socially accepted right to benefit at the expense of the latter. It is in fact the quintessential ethic of consumer capitalism. Those with more capital deserve their position of influence over those with less.

> *For all those that believe healthcare is a 'right' and should be "free"; healthcare is a thing, and if you don't pay for it, someone else has to. And like all things, you get what you pay for . . .* (ellipses in original)

In this statement, health care is an object of trade and like other objects of trade must be purchased to be deserved. If one cannot pay for health care they don’t get it, except by philanthropic whim. This system of healthcare delivery is ethically defensible only if it is taken for granted that some people deserve financial profit more than other people deserve to obtain health care. In effect, people who are not paying for services with money received through more valued avenues like inheritance or employment, (i.e., people who are receiving charity) have deservedly less say over the course of their lives than people who have greater economic resources. This accepted truth remains true even when the former group is being harmed.

From this position, suffering is less important in moral decisions of care than is self-sufficiency. It is

> *So let me get this straight, are these patients receiving this care for free? Then complaining it’s not good enough?*

In this post, the patient whose care is subsidized by taxation (e.g., the Medicaid recipient) is not asserted to be wholly undeserving of healthcare. They are, however, expected to appreciate what boon they are granted. Even in cases where the medication offered is dangerously contra-indicated, the dependent patient is expected to accept what is offered without complaint. Any articulation of self-interest by a dependent-patient can be dismissed as self-serving propaganda if it contradicts this maxim.

The dependent-patient is positioned as less deserving—of discursive influence, clinical choices, empathy and respect—than are those who possess the resources to acquire these things through their own efforts. The financially resourced individuals are assumed to deserve more desirable ends than the people receiving charity because they possess value in trade. As an object of sympathy, blamelessness, or duty, the charitable cases are still positioned to deserve a degree of public support. Their excusable deficiencies may yet afford them the power of influence sometimes granted to the weak by the strong (Kunz, 1998).

This does not mean resources will necessarily be made available to individuals, it simply means that the subject may elicit a positive response with potential benefits for individuals. The issue is thereby made one of taxonomy, a question of identifying which, and in what circumstances, people (or other beings) deserve to benefit at the expense of another. Different identities deserve different responses and those responses depend in part on the context in which it appears.

Positioning social identity in discourses of deservingness. Social identities invoke perceptions of deservingness through semantic networks. The identities most deserving of coveted rewards appeared to be the productive, working, taxpaying, law-abiding, rational, intelligent, self-sufficient, independent, free citizen with family connections and a sense of practiced agency. These qualifiers describe qualities that increase positive ascriptions of deserved consequences—whether for material resources, positive regard, or credible influence.

When these ideal qualifiers were invoked, it was to enhance claims of legitimate deserts. The closer one's position is to one (or more) of these identifiers, the greater the expectation of social reward. Citizens, for example, are expected to reap rewards solely because they *are* citizens.

> *It is my (perhaps incorrect) understanding that our federal government negotiates prices at which other countries can purchase prescription drugs from the United States, but WE . . . the citizens of the country . . . pay WAY MORE than people in other countries for EXACTLY the same medications.*

The comment from which this quote is taken begins by setting up an economic argument critiquing current class arrangements in which the government is to blame for the suffering of citizens. Through the use of emphatic capitalization, the post references a fundamental assumption that citizens of the United States deserve valued outcomes solely by virtue of belonging to the category of citizen.

The commentator does not hedge in designating citizens as deserving of positive ends. Whether written with irony or sincerity, the reference to potential factual error results in an assertion that remains true even if the specific facts of the situation are not. In this line of thinking, the citizen deserves affordable medicine even if it is untrue that the federal government negotiates lower prices for citizens of other countries while allowing corporations to charge higher prices in domestic markets. Citizens are distinguished from the population of non-citizens who do not deserve to benefit at cost to them. Citizen is an idealized attribute.

Being accused of lacking in idealized qualities, or alignment with problematized qualities, are clearly intended to diminish the standing of the referenced subject. Markers of diminished standing were readily deployed to support position statements and denigrate those with opposing views.

> *You're all dumb if you don't use marijuana for your pain and use those deadly pain killers instead!!*

It is presented as an established truth that marijuana is safer than opioids. This proposition reflects the assumption that opioids are inherently deadly. In such a worldview, the use of opioids is irrational something only the “dumb” would do. This casting of aspersions on the rationality and intelligence of those who question passionately held beliefs-of-fact reflects the problematic position of the dumb and irrational in the social world.

What is relevant about this post is not the facticity (truth) of the commentator's claims, but the strategy of positioning the assertion relative to the idealized/problematized subject. It is a case of the rational (marijuana user) versus the irrational (opioid user). People claiming medical benefit from opioid pain management strategies are "dumb." Subjects associated with irrational (e.g., crazy, nonsensical, imaginary, etc.) can be defensibly dismissed because, in the dominant positivist framework, only a fool would doubt the truth of reality. Fools are not deemed deserving of influence in social discourse because their claims carry no ontological authority: They know naught of what they speak. Opioids and fools are, in this way, discursively entwined with the idea that the irrational are impaired. They do not deserve a voice.

Deservingness enters the discourse in other ways as well. Valued qualifiers are juxtaposed with more powerful entities to highlight the illegitimacy ascribed to those who block them from what is deserved. That which is deserved is a fundamental expectation attending a subject's moral status. To block what is deserved is, by definition, unfair and unjust. In this way, power relationships are opposed or supported through aligning the sympathetic subject with the qualities of the idealized subject. This tactic is easily identified in statements where the sympathetic subject is the one with less social power or fewer material resources.

> *Wealthy individuals, and their acolytes, wish impoverished citizens to be dead. What do you wish for the wealthy individuals?*

What makes this post meaningful in this context is not the potential to realize class warfare with a call to doom the wealthy at the hands of the impoverished. Rather it is the use of idealized identities in suggesting that the wealthy deserve this fate and the impoverished deserve to deliver it. That the citizen represents the identity most deserving of positive regard remains unquestioned.

The quote is taken from a longer post accusing members of the government of being “happy” that financially dependent patients are dying of methadone overdoses. According to this line of thinking, the idea that the powerful and the wealthy benefit from the death of poor people is contrary to the charitable moral imperatives of chivalry. The powerful are able to benefit from blocking the poor from benefit, but they are not seen to deserve to use this ability. The sympathetic subject is the less powerful player who deserves social benefit. The sympathetic position is marked with the idealized subject of citizen.

Within nationalistic discourses of collective allegiance, the subject of the citizen inhabits a defacto position of positive regard. Members of the economic underclass are here ascribed the citizen’s due while the wealthy are semantically isolated and stripped of their association with the more deserving class of person (e.g., citizen). Since, objectively speaking, the wealthy and the impoverished individuals being referenced are likely citizens of the same body politic, the labels serve a completely ideological function to convince others to align with their position.

Ideological placeholders as links to deserving identities. The idealized identity traits (e.g., citizen, taxpayer, rationality etc.) are a kind of placeholder; they represent the preferred identity role in the dominant discourse though they are not the direct topic of discussion. These ideological placeholders invoke associations that influence evaluation of significance and meaning, of worth and value. What is taken for granted is that these subjects are worthy of sympathetic identification. They deserve attention and consideration. It does not mean that people aligned with these positions (e.g., individual taxpayers) necessarily get the deserts to which it is suggested they are entitled. It is debatable whether that really matters since they are not the actual subject of the discussion. Rather, these subjects inhabit a more metaphorical position in the social discourse.

These placeholders are the qualifiers employed to emphasize what is good or bad in relation to the actual subject of comment.

> *This is the first step in weeding out the chaff. The D's actually had been exposed on this issue on Obamacare. Choosing what and when Grandma and Grandpa get treatment. They want paying members of society not costly ones.*

This quote uses socially venerated identity labels of grandparents to mark the sympathetic position—standing against Obamacare. It is taken from a longer post suggesting that a conspiracy of big government and unions was responsible for increased methadone overdoses amongst the poor. It is not the only example of the idea that policy preferences for methadone were intentional attempts to harm the poor. The imagery employed in this quote is similar to media images created in the partisan campaign against President Obama's Affordable Health Care Act.

In this thread of discourse, reported concerns about pain care and opioid deaths are tied to conspiratorial narratives of totalitarian agendas associated with health care reform (Obamacare). Family members serve an ideological function in this statement, which is really about the demonization of the Democratic Party (D's). To accomplish this, the comment pits the utilitarian ethic of public health initiatives, with its calculated pragmatism that would prioritize resource distribution according to social contribution, against an ethic of family-centered chivalry demanding protection of the venerable and the vulnerable amongst us. Yet beyond this, the intended meaning of the commentator remains ambiguous.

The above post could be a diatribe against existing power relationships, a class conscious frame seeking a face to blame, a face they just happen to name Democrat. It could be a critique of the social practice of restricting health care choices for those in the dependent position, a critique that does not consider the long-standing nature of the problem. Or it could simply reflect an ideological argument about partisan politics in which reference to an exploited and expendable underclass bears no literal meaning at all. All that is clear in the commentator's position is that "the D's" agenda is undeserving of respect or allegiance. This is accomplished with the suggestion that the D's kill grandparents for their own gains.

Influencing evaluations of veracity and righteousness. Semantic associations between the actual subjects and idealized subjects are influential in evaluations of both the veracity and righteousness of the actual topic under discussion. The subjects of citizens, wealthy individuals, acolytes, taxpayers, even family titles can serve as an identity placeholder through which ideological norms are communicated. It is this indexical function of marking positions with idealized and problematized identities that provides a window into the pervasive stigma associated with chronic pain and opioid use.

The government, political parties, policy-makers, health care professionals, pain patients, opioids, and drug addicts/abusers are subjects intersecting with discourses of pain care practice and policy with material consequences for all. Each of these identified subjects has been positioned relative to the idealized subject, the ideological placeholder, in arguments supporting mutually exclusive assertions regarding the social worth of subjects in pain care discourses.

The taxpayer, for example, is an idealized identity role in politico-economic discourses. In the American narrative of meritocracy, in which productivity and financial solvency are idealized qualifiers, the taxpayer inhabits a position of earned rewards. They have purchased a right to be heard by those with the power to spend tax revenue. References to taxpayers were used to support divergent interpretations of whose benefit the ethical imperatives underlying these social systems are meant to serve.

> *So taxpayers should worry greatly as in far too many cases we are not treating people with pain appropriately. Far too many of them go untreated. And the under-treatment of pain, which may affect 116 million people is costly in the truest sense of the word.*

This quote is from a longer post voicing a position of patient advocacy. The alignment of the subject “pain patient” with that of the “taxpayer” is a rhetorical strategy employed to support the call to assign priority to the needs of pain patients over-and-above short term cost saving measures. Yet, it is the taxpayers whose (financial utilitarian) interests most deserve to be honored; not (chivalry for suffering) pain patients per se.

While proponents of this argument may believe that patient interests should be the priority, the argument with which they justify their stance leaves the person with chronic pain to benefit from a trickledown effect: When taxpayer needs are met through treatment of pain patients (through a decrease in long-term expenditure), then should patient needs be served. This means equally well that the taxpayer’s interests should take precedence when patient needs are deemed too costly, which of course they routinely are.

Arguments in opposition to patient advocacy claims invoke the same idealized subject, the taxpayer, using the same logic meeting the interests of tax payers. The difference lies in the identified beneficiaries.

> *Myra J. Christopher is a liar trying to scam money out of the taxpayer. ... "Chronic pain affects an estimated 116 million American adults". Nonsense. The total population of the United States is 313 million.*

This quote is taken from a comment dubious of the claims of patient advocacy discourses. The author claimed to have visited the website of the Institute of Medicine (IOM) cited in the Politics of Pain series. The statement in quotes is interpolated from the body of the editorial by Christopher and is otherwise an oft cited statistic in the pain care world (see IOM, 2011). The taxpayer here is still the most deserving position, but the validity of the statistical claim is challenged directly on the basis of its apparent nonsensicalness. An otherwise legitimating bid for empirical authority (statistical citations) is dismissed as inaccurate propaganda for an improper agenda.

In the first quote above, the cited statistics are accepted proof of urgent need of attention to the plight of people with chronic pain. In the second quote, the suggestion that this experience touches such a large percentage of the population is seen to be so absurd (outside of all expectations) that the author goes so far as to question the integrity of its proponent. In either post affinity with the position of taxpayers is invoked to advance the interests of other subjects. In so doing, the pain patient is positioned not as a member, but as a dependent of the taxpayers. Dependency is a repeated theme attending the problematized subjects of chronic pain and opioid use.

***Positioning patients and opioid users*—Layers of Dependency.** By virtue of the discursive relationship between opioids and pain management, all pain patients fall under the subject of potential opioid user. Opioid use and pain care are discursively entwined to such an extent that seeking the latter regularly invokes reference to the former. This connection was apparent in arguments about prevalence statistics that were initially offered to legitimize the prioritization of patient needs.

> *"Washington has at least 1.5 million people who struggle with chronic or acute pain, the American Academy of Pain Management estimates."*
> *What!!! 23% of the population is in need of pain meds??? 23% REALLY??? Nothing against this particular guy but when 23% of a random ordinary population needs pain meds (implied) something is VERY wrong with this whole picture.*

In this quote, the validity of statistical evidence is questioned largely on the basis of the subject's association with opioid use. While empiricist discourses are commonly referenced to support the authority of a speaker's fact assertions, they are not necessarily accepted if they contradict existing beliefs. These statistics were not viewed as a reflection of the prevalence of pain complaints, or the number of people who may have a stake in the debate to preserve medical access to long-term opioid treatments. Neither was the number understood to include people who may avail themselves of a wide array of non-opioid pain care options, people that clearly claim to exist:

> *I also have a painful medical condition but I work on treating the problem, not the symptoms, because I don't want to live on drugs or in pain.*

When there is not room in the narrative for people claiming a different experience, the voice of pain patients is dismissed if not erased.

The IOM's claims about the prevalence of chronic pain complaints are perceived to (falsely) represent the number of people claiming want/need of opioids. This adjoining of the subjects, seeking pain care with seeking opioids, was displayed in more direct ways as well.

> *Some people just have low pain tolerance and cry to a doctor about every little ache and pain—and want a prescript for it . . .* (ellipses in original)

This quote is from a comment posted in response to those who wrote from a position of patient advocacy, advocating positive regard for patients and medical access to opioid options for pain management. The pain patient in this statement is positioned as weak and drug seeking; they are engaged in irrational behavior for undeserved gain. Seeking pain care for a low pain tolerance suggests that these patients are seen as inviting dependency rather than embracing self-sufficiency in response to potential adversity. In this post and those like it, the irrational, potentially dependent, patient is not someone who deserves to be heard.

Pairing opioid use with weakness rather than necessity is an ascription of illegitimacy that is left for the pain patient to disprove. There is no clear path to proving anyone's credibility, however, when they are speaking from a position of illegitimacy.

> *I was told I was not getting an x-ray; that I am seeking drugs, and I was told it was a simple sprain. I left there angry and I then walked on a broken foot for a month because I was told I'm a drug addict. I'M a drug addict? OOook. I had to go to Covington to be treated like a human and get an x-ray—when I got over my SHOCK of being called a drug seeker by somebody who gets paid to treat illness and injuries.*

This quote is taken from a much longer narrative detailing a humiliating experience at a local Emergency Room. The commentator does not specifically identify as a chronic pain patient but rather someone seeking care for an acute injury whose health benefits were provided through a state welfare program. The author noted that they had been assumed illegitimate because of their welfare status, rather than diagnostic status. The result being that their presenting complaints of pain associated with injury were dismissed as being without merit. Whatever the providers' decision-making process was in this particular situation, an assessment of illegitimacy is a clinically and financially defensible reason to withhold both diagnostic and therapeutic services.

Identified patients rejecting associations with opioid use. It is noteworthy that the commentator above equates the experience of being called a drug seeker with being treated as something other than human. The subject of "abuser" is discursively separated from that of "human." The foundational subject of moral discourse is the being which deserves respect simply because it is a human being (C. Taylor, 1989, p. 14). The addict is plainly not a coveted position, a point that is highlighted elsewhere in the same post when the author preemptively denies that they were using or seeking opioids.

> *My life does not include any drug addiction, never has, and I have never sought a narcotic anywhere.*

This anticipatory rejection of the ascription of opioid [mis]use reflects the importance of opioid use for the issue of Voice. The commentator seeks to retain credibility by inhabiting the identity of a non-opioid using medical patient. That people would reject association with opioid [mis]use signals the diminishing social status of the opioid user. The repetition of this message throughout patient-identified posts is indicative of the patients' close association with opioid use.

Even patients claiming to have utilized opioid treatments may make the case against being categorized as an illegitimate user.

> *I've been on vicodin when needed; I'm not an addict.*

This diminishment of opioid users is demonstrated by the explicit disavowal of association with the subject of opioids and addiction. If the association did not put people with pain in a precarious social position, there would be no particular place in the discourse for statements like these.

I am a pain patient and you would never catch me taking that ride

The above quote is taken from a post that is highly critical of opioids as a treatment modality due to their addictive potential. Addiction, for them, is more concerning than pain suppression. Who can know if this is a reaction to the feared loss of independence, or some similarly idealized quality, that addiction threatens; or if it is a reaction to the feared loss of positive regard that attends identification with opioid use. In the suspiciousness surrounding opioid use and pain patient identities, perhaps foreclosing opioid options can mitigate the suspicions with which care seeking behaviors for chronic pain are met. In any case, addiction is made to seem a more fearsome outcome than unmitigated chronic pain.

These posts speak to the endemic pairing of the subjects, of chronic pain and drug abuse, due in large part to their relationship with the subject of opioid use. The existence of two discrete, objectively identifiable, categories of (even potential) opioid users, the legitimate and the illegitimate, is taken for granted. Legitimate uses for opioids are relegated to the medicinal arena for complaints of a purely physical basis. All other motivations for opioid use have been deemed illegitimate in medical and legal discourses.

Us (pain patients) vs. them (drug abusers). It is not possible to engage in discourses of pain care without encountering a fundamental competition for social benefits between the subjects of pain patient and drug abuse. The identity roles of pain patient and of drug abuser are at fundamental odds in medical and legal discourses and in direct competition for influential social regard.

Legitimate patients are medicinal users whose physical body bears the proof of their suffering. Drug abusers, on the other hand, are those who seek the fruit of the poppy in pursuit of euphoria or escape from mental suffering. The drug abuser inhabits a legally precarious position because, by definition, they must obtain their drugs under suspicious circumstances—through drug diversion or false presentation—for these unsanctioned ends.

Socially, the drug abuser is a blameworthy subject ultimately expendable when their interests conflict with those enjoying a greater claim on the public conscience.

The State and the DEA are treating all of us like junkies and dealers.

For this statement to make sense, one has to assume that Illegitimate users and legitimate users are not expected to receive the same treatment by public agencies, health care providers, or the public-at-large. It is taken for granted, that the two groupings of opioid users deserve differential treatment because they represent distinct and distinguishable classes of people whose lives have earned them different rewards in the existing social system.

The rewards include, but extend far beyond, privileged access to opioid substances through the legally sanctioned medical marketplace. These subjects are also accorded differential expectations of medical care, reception, and social influence (voice), among other intangible attitudinal values, e.g., compassion and respect. All of which are associated with material consequences.

Drug abusers and the illegitimate use of opioids. Within the dominant discourse, there are invalid justifications for opioid use. The illegitimate user consumes opioids without legal or moral sanction, for selfish or psychological reasons. The drug abusers are the idle and the weak who seek euphoria or escape, whose demise is not a surprise.

They overdose because they're trying to deal with the mental strain.

In the context of this post, “they” is a reference to illegitimate users who, though they may be suffering, do not qualify for socially sanctioned access to opioids. This is because suffering of a psychological nature is not a qualifying subject of sanctioned opioid use. Contextually, there is an element of charitable sympathy for the addict position. There is not suggestion that they deserve to die, simply that their death is related to psychological factors not drug properties, as was asserted in the news articles to which they are responding. Overdose is thereby attributed to a blameworthy misuse of opioids; it is an expectable if unfortunate outcome of improper motivation. Such a position renders interventions to offer alternative medications (e.g., OxyContin) unnecessary.

In the grand narratives, abusers are frequently written as villains identified with their actions: They are a “bane”, “crushing idealism” and limiting opportunities for the physician to enact the chivalrous ethic of palliative care.

> *Drug seekers were the bane of our practice—sad in their own right—but also helping to crush physician idealism and any sense of professional satisfaction in what we saw as a calling . . . clogging our waiting rooms while making their rounds for not tens or even twenties of meds—but accumulating hundreds of meds. Many taking our time from legitimately ill patients. They weren't interested in other pain management therapies—they just wanted their narcs.*

It is assumed that drug seekers take what they do not deserve: Physician attention and medical resources are better spent elsewhere. The legitimate patient is clearly positioned more deserving of these things than the drug seekers. What is more, the physician is positioned to deserve job satisfaction more than the maligned deserve medical attention. The position of “drug seekers” in this sentence precludes them from the category of the ill; indeed, they are not even “patients.” Their self-centered choices are causing harm to the interests of more deserving subjects, legitimate patients.

Legitimate patients and the sanctioned use of opioids. People whose access to opioid substances are medically sanctioned are positioned as legitimate users. This would apply, albeit tenuously and not without controversy, to methadone maintenance therapy for opioid addicts. Most centrally, however, the legitimate position reflects medicinal use for the alleviation of intense physical pain.

> *As someone with experience working with pain patients, I can tell you, yes, there are people who abuse pain medicine –probably lots of them. But why is it that they, those who chose to abuse this medicine, get to make the world more difficult for those who depend on the medicine to live their life? And why does the government get to make that decision rather than physicians? I myself am fortunate not to need these types of medications except for when you would expect (i.e., surgery, injury, etc), but far be it from me to tell others they should live their life in pain because some INDIVIDUALS chose to abuse medication. There is no good reason why people should have to suffer in pain when there are inexpensive medications that can help temporarily ease that pain.*

Personal experience is the authority by which this commentator sought to authenticate their knowledge of the subject: They have seen both legitimate need and illegitimate use. They identify as supporters of the patient's position of need, though they report no chronic pain or opioid use. This positions their statement as unbiased, without personal investment, and informed by experience; it is therefore a bid for influence. The position being advanced is the prioritization of (the blameless suffering) patient needs over those of (the blameworthy) addicts who "chose to abuse medication." The patient, as someone who did not choose their lot, should take priority at the gatekeepers' door. The choice to abuse opioid medications renders one abject of their own accord—the abuser has earned their degraded status.

This hierarchical division between the legitimate and illegitimate was frequently articulated in posts aligned with the positions of patient advocacy.

> *Addicts are more important than law abiding chronic pain sufferers. Do you have any idea how warped that is? . . . Preventing addicts from developing a tolerance to their drug of choice seems like a pretty minor issue compared to easing the severe chronic pain of law-abiding citizens.*

Here, restricting access to opioids for the addicted/abusing subject is criticized, not on the basis of presumed efficacy but, on the basis of moral deserts. Restricting opioid access may reduce escalating use by addicts, but that is framed as a secondary concern to the suffering restrictions will cause the blameless. Pain patients are positioned as law-abiding—a subject possessed of earned rewards. Addicts are excluded from the category of deserving law abiders, thereby seen to merit whatever aversive consequences may follow. As such, the drug abuser is less deserving of positive regard than the medicinal user, and is most certainly devoid of legitimacy as the targeted beneficiary of public policy. It is morally nonsensical to think that anyone would consider policy actions aiming to curb drug abuse when these actions could negatively impact more deserving subjects.

For the pain patient-allied position, mitigating pain is considered more important than preventing addiction.

> *Don't make legitimate patients suffer, please reexamine the law and deal with the real issue.*

The “real issue” referenced by this commentator is that of addiction, and by logical extension the people identified with the position of the addict. Their position is that the legitimate patient does not deserve to suffer: If opioids reduce their suffering, then they deserve that option. By implication, the suffering of illegitimate patients is acceptable or, at the very least, irrelevant. Suffering of the legitimate subject is, however, the guiding principle of ethical decision-making invoked by the narrative of patient advocacy.

Suffering, responsibility and blame as markers of interest prioritization. When considered in conjunction with the absence of reference to the suffering of creatures used in medical research, it appears that suffering in and of itself cannot be the dominant legitimizing factor in authorizing positive, compassionate, or charitable regard. In the moral discourse of suffering and chronic pain, the animals used in pain research are non-entities but for human subjects, responsibility and blame appears to be of primary significance in determining whether suffering is deemed deserving of palliation. The existence of agency and choice are integral assumptions in ascriptions of blame. Negative attitudes toward those bearing the addict label are justified through references to their having made a choice in full awareness of their error.

> *What in the world is WRONG with the people in Olympia? Why are they willing to sacrifice the safety, health, and relative comfort of people who are suffering legitimately with horrible pain to "protect" people who have CHOSEN to misuse drugs that weren't even intended for them? Either our legislators are short on brains, or even shorter on compassion.*

This statement emphasizes wrong choice in asserting that pain patients deserve greater consideration than do drug abusers. Rather than being cast as the cause, the patient is afflicted by horrible pain. The abuser is the sole source of their own ill-fortune. Because of the social illegitimacy of their choice—to ingest opioids for recreation or addiction—the abuser has lost their claim to deservingness. They do not deserve access to the drugs they use; the attention of policy-makers; or the sympathy of the public. To think otherwise is seen as a sign of irrationality or stupidity (i.e., “short on brains”). As agents of free-will exercising moral choice, addicts are made blameworthy and shameful.

> *What I will NEVER understand is the state's "mission" to save losers FROM THEMSELVES . . . from their own lifestyle choices . . . while throwing people with legitimate diseases and medical conditions under the bus.*

Again, with choice, the addict is positioned as the cause of their problem, not a victim of unearned calamity, like the pain patient. The social hierarchy is made clear: Though they both may suffer, people associated with painful physical conditions are deserving of opioid access as a compassionate attempt to mitigate their suffering, even at the expense of the "losers" who may be harmed through drug diversion. It is taken for granted that alleviation of withdrawal symptoms or mental strain provides no warrant for opioid use.

Sole responsibility for addiction is clearly located in the identity of the addict, as something inherent to the addicted individuals themselves. Because of this inherency factor, it is not expected that policies and social practices will have any appreciable effect on the population of drug addicts. Pain patients, however, are sufferers deserving of access to pain relieving treatments precisely because they did not choose, and are therefore not responsible for, their need of opioids.

> *When one politician in Olympia can tell me why "saving" a junkie is more important than treating those who didn't choose these drugs, I might change my stance.*

"Junkies" do not deserve to be saved if it harms the interests of more deserving subjects, even if it should mean their death.

> *As usual, probably the best idea is somewhere in the middle. Lose the nanny-state law, but don't have doctors handing out Oxy like M&Ms. Honestly, if a junkie/addict OD's—natural selection at work.*

This post identifies an idealized middle position reducing public involvement in prescribing policies that encourages individual HCPs to make the choice to withhold opioids of their own accord. The reference to "nanny-state" is a rhetorical strategy of partisan politics to mark the problematized subject—dependency. The reference to "natural selection" invokes scientific discourses of ontological inherency. The imperative function in these Darwinian discourses is for the strong to reproduce and the weak to perish, thereby ensuring a thriving future for the species. To benefit the collective, not the individual. In the context of Social Darwinism, assignments of deservingness are predicated upon the belief that exclusion of inferior beings is a just response to a condition of existence (Mackelprang & Salsgiver, 1996).

The ill-fated weak link. The implication that the death of a junkie is "natural selection at work" is that society benefits from the death of the opioid addict. The drug addict is the subject of weakness; they are a being whose life activities threaten the very fabric of society. They are the weak link in a narrative of meritocracy—they cannot earn the right to respect and life if they are not fit to survive.

As the weak link, the death of the illegitimate user should neither be lamented nor prevented. From the moral perspective of personal responsibility and productivity-oriented value systems, death is framed as an earned consequence of their willful choice to engage in wrong action. From the perspective of Social Darwinism, their death represents the protection of society's future. The drug abuser is in dereliction of their duty to collective survival and in so doing are perceived to forfeit their claims on the collective conscience.

> *They took up beds, they took up resources, and they took up medicine, just to get their fix.…and we, the taxpayers, got stuck with the bill, increased wait times for legit ER visits, and higher premiums all because some pathetic junkies needed to have their fix.* [ellipses in original]

Abusers are thus portrayed as parasites, whether by choice or ill-fortune. They drain resources and divert attention from those who are deemed more deserving of these things. With these choices, abusers come to reap what they sow. When they die from the fatal effects of opioid use it is not so sorrowful a thing, because they are to blame for their death.

> *It's like this. People die taking prescription painkillers, because they abuse them, often after buying them on the street.*

This and similar comments were sometimes posted by patient-identified authors or other positions allied with medical opioid use. It is yet another example of support for the voice of one type of patient being asserted at the expense of another: The dead patient is not a patient at all, they are criminals. There is no position in this assertion for people with pain who may overdose while taking medications as prescribed. Suggestions that overdose deaths may result from legitimate use are dismissed outright, because overdosing is itself evidence of abuse (i.e., illegitimacy).

> *It is neither mercurial nor whimsical in its behavior. It only kills those who take it not in accordance with how it is prescribed.*

The thesis that methadone may possess dynamic properties that increase risk of fatal side effects is rejected outright by commentators such as this one. Once again, the dead are drug abusers, the proof rests with the fact that their death was ruled an overdose. Death is in the position of earned reward making it something deserved through the willful actions by individuals who knowingly choose to misuse the drug. It is not clear whether this post is arguing in favor of maintaining access or of restricting opioids, but either way it offers an opportunity to dismiss the voice of any patient who describes a different experience.

Arguments opposing this totalizing view of overdose deaths as the wages of sin do little to counter the underlying assumption that drug abusers are responsible for their own drug-related death.

> *You have no basis for your claim that most overdoses are due to the abuse of illegally obtained methadone. As a result, you are stereotyping victims as irresponsible addicts. That's pretty low.*

This post is a direct response to another commentator, and while it portends to defend the reputation of the dead methadone user, it does little to challenge the assumption that irresponsible addicts inhabit an indefensible position. The author accepts the assertion made in the articles that methadone poses special risks for patients, and that deaths are not necessarily evidence of misuse. The problem, as put forward by this post, is not so much the implicit blame laid on the addicted subject for any overdose related complications they may experience. Rather, the problem lies with linking patients to abuse of drugs.

Patients over addicts. Patients are positioned in adversarial relationships with addicted users when it comes to courting public support for respect, compassion, and blameless access to opioids and other resources. From the competitive dynamic of legitimate patients versus drug abusers, the problem with policies restricting opioid access lies in its impact on the people in the (deserving) patient position.

> *"Druggies will be druggies, no matter what, so it is very dumb to put the "war on drugs" above the suffering of real people with real pain that need effective medication."*

The drug addict, here, is not even accorded the status of a real person: *Real people* deserve respect and medical care, including access to treatment with opioids. The statement positions *Druggies* as people who deserves to be ignored, in part because they are inherently unchangeable. The well-being of humans aligned with the drug addict identity is not even allowed (semantically speaking) to operate as a motivational factor in moral action: Policy-makers are seen to be waging a war on drugs (an object of trade) not trying to reduce the addiction-related suffering of human beings. The subject of the addict is thereby denied moral value as a predicate for beneficent action.

> *Just how twisted and evil are these Washington State lawmakers? Now they will deny or take pain medication away the hard from working, productive and law abiding citizens of this state, and then turn around and use the tax revenue taken from those very people and use it to fund a program that hands out free "clean needles" and free Methadone to heroin addicts down in the "U" district, Tacoma and many other areas.*

Invoking idealized qualifiers in reference to protagonists highlights their desert of a better fate than has befallen them. Pain patients may not get pain care but they deserve it, along with access to financial, material, and social goodwill. Addicts do not deserve care, resources, or goodwill but are seen to receive all at great cost to the more deserving population. Addicts do not even deserve publicly funded clean needle programs to stop the spread of disease. Those who choose to focus on the needs of addicts when it impacts more deserving groups are “twisted and evil”: It is an inexcusable outcome. From this position, whether the addicted subject is suffering from their relationship with opioids is beside the point. Yet, as demonstrated above, the suffering of pain patients is used to legitimize their claim to access to opioids (i.e., the determination that they deserve to have this option).

> *Everyone is worried about money and drug addiction, and then last about your life, as a law-abiding sick person.*

From the stand point of patient advocacy, the idealized qualifiers are invoked to influence perceptions of deservingness in favor of the patient’s position. The law-abiding has earned the privilege of access, the sick deserves compassion as an object of charitable regard. The addicted subject is semantically oppositional to both the law and illness and, hence an inappropriate target for either privilege or compassion.

In arguments about policy, invoking the subject of "law-abiding" to defend a legally debated position is a slippery slope. Policy sets the tone for normative behaviors amongst those who are bound within its parameters (Fischer, 2003). Laws are governing policies. As these change so too will the defining criteria of "law-abiding." What was considered medically legitimate use of opioids may soon be defined as a problem under the law. At that point, and regardless of their actual condition, a pain patient using opioids will have been re-positioned from legitimate to illegitimate. Now, when they speak to their healthcare workers, they do so as someone who is perceived to have a problem with opioids, someone who needs restrictions.

Power and voice: Legitimacy, choice and the good patient script. Different subjects in the discourse inhabit different strata of deserved influence. People who are deemed in need of restriction have substantially less influence than those deciding upon the appropriateness of restrictive actions. They deserve different consequences and enjoy different capacities to exhort their will over their circumstances.

> *I suspect that it is easier and safer for many doctors to simply quit treating chronic pain than it is for them to risk any of the following: 1) Being fooled by a supposed "pain sufferer" who is lying in order to obtain prescription pain meds to feed an addiction, 2) Overlooking some obscure measure in the new regulations that may subject them to fines, censure, lawsuits, and/or all of the above. 3) Having to hire additional staff to make sure that the additional paperwork and reporting required by the new regulations are completed in compliance with the state's dictates . . . I don't blame the doctors . . . I blame the idiots who run this state.*

This post is authored by someone who elsewhere described themselves as sympathetic to the position of pain patients, but as someone without a chronic pain condition themselves. The existence of an ally identity in itself belies the diminishing, but not absent, influence of the patient's voice. Obviously, enough people assume the patient position is both worthy and in need of support that there is an identity role for supporters in the discourse. This patient-allied author accepts the accuracy of the patient experiences described in the article and elsewhere in the comments. The point of the post is to offer an explanation for the negative experience of patient. The one they offer exonerates the immediate gatekeepers of treatment—the providers. The comment also casts aspersions on rationality and cognitive functioning as a means of marking problematized subjects.

The relevance of this post is not so much the portrayal of the health care professional (HCP) as a sympathetic character, but the unstated moral assumptions underlying ascriptions of deservingness, and the implications for the voice of the other subjects. The HCP is a valued position whose pragmatic self-preservation is justified by the utilitarian ethics underlying healthcare delivery. For the HCP, caring for one's own interests preserves one's availability to a larger number of patients. The guidance of a utilitarian ethic is given precedence over the chivalrous regard toward the suffering and vulnerability of any given individual.

If the HCP is under threat of lost social standing for their association with chronic pain and opioid use, then they are imbued with the power to safeguard their position. They can simply refuse to affiliate with patients whose situation may threaten the providers' privileged position. Being fooled, censured, or financially inconvenienced are not consequences that the HCP should have to face (i.e., deserve to deal with). It was, however, accepted as the reality facing providers.

> *It's a tough call sometimes. If more responsibility could be put on the patient, as far as the risks are concerned, and not on the doctor, then maybe the patients who need it can get relief, and the drug seekers can do what they do without jeopardizing the doctor.*

This post is one of the few that acknowledges a difficulty in distinguishing between "patients" and "drug seekers." The proposed solution is the removal of the social mandate to distinguish between them: Let people live and die by their personal choices: This is the quintessence of American Individualism.

The post seems to be suggesting that if prescribers were assigned less responsibility for the consequences of their decision to prescribe opioids, they may feel less apprehensive about prescribing them and people deemed deserving would have access as needed. In considering right action, therefore, accurate distinction between deserving patients or blameworthy drug abusers would become less important. Why? Because the potential good to come of relieving the undeserved suffering of the person with medically explainable chronic pain is greater than the good that would come of restricting users who may be addicted or in danger of overdosing.

Illegitimacy and the loss of voice. People who report medical benefit from opioid pain management strategies fear loss of their choice to access these substances through sanctioned medical channels. In an effort to refute calls for increased prescribing restrictions, the narrative of patient advocacy emphasizes the contribution of opioids to increased quality of life, functionality, productivity, and relief of suffering for "legitimate" patients. All of these are subjective measures; all requiring positive regard for the credibility of the reporting patient to exercise influence. In other words, the provider must believe the patient is truthful and accurate in reporting drug effects.

> *He is alert, can function very well, doesn't feel drugged, and actually doesn't notice anything except some relief from taking the edge off his pain… I hope he can still be prescribed Methadone through his pain clinic like he is now, because I dread that we might have to go through what we used to when he was given other medications before the Methadone. He was like a zombie, and couldn't function at all until the Methadone. Hopefully it will still be available to those who have used it "successfully" for a number of years.*

The author of this quote identifies themselves to be a family member of a depicted beneficiary of opioid therapy. The statements above are taken from a much longer narrative outlining the journey of false starts and setbacks that the patient experienced on their journey toward finding their preferred treatment. What this respondent fears most is the loss of a treatment they credit with increased quality of life for their loved one. This patient-allied commentator agrees with anti-opioid sentiments that losing a sense of rational agency (e.g., being “a zombie”) is an undesirable fate. They argue from experience that not all opioid use results in these negative side effects. Whether their report is taken seriously—whether they are accepted as rational and legitimate or mistaken, manipulative and illegitimate—will depend on the presumptions of the reader.

The consequences of being deemed illegitimate include a loss of voice and restrictions on choice. This diminishing influence is justified on the grounds that people who are illegitimate are poor historians of dubious authority or moral standing. The more denigrated a person’s ascribed identity, the less likely they will be able to successfully convince others they belong in a social category of greater standing. The denigrated patients and opioid users deserves to be ignored more than they deserve to be given heed.

But perhaps the most striking consequence is the ascription of negative consequences to the illegitimate user.

Blame and the assumption of choice. Hateful sentiments and shaming condemnation often attend the subject of illegitimate use, sometimes in stark vitriolic attack.

> *Letting the human garbage that choose to ruin their lives with abuse get in the way of easing the pain of someone whose life has been altered by constant pain is a travesty.*

Since humans are not garbage and drug abuse can be associated with chronic pain, this statement cannot be understood at face value. There are several assumptions necessary to make sense of the statement. The choice to abuse a drug (to use it for illegitimate reasons) renders the subject blameworthy for their circumstances. If they are dying, it is their fault. If they are treated with disdain, it is a natural consequence of poor choice. The individual is wholly responsible for their position in society. It is a travesty to consider the needs of those addicts who are to blame at the expense of the blameless, the stricken patient who is befallen by their circumstances.

Ultimately, patient identified subjects are deemed more deserving of consideration than drug abusing subjects. When the interests of both come into conflict, the needs of the patient-identified subject are expected to trump those of the drug abuser. Taking this as truth renders nonsensical any decisions by gatekeepers, providers and policy-makers that do not act in accord with these foundational assumptions. Any contrary action can be decried as a miscarriage of justice because as a decisional outcome, they contravene the expectations of deservingness that attends each subject position.

It was socially acceptable to give voice to assertions that [people labeled] drug addicts should be left to die of their own vices.

> *I'd rather that the loser addicts out there die from their addictions as long as people who are trying to lead productive lives while suffering from chronic pain can have the medicine that helps them do it.*

This statement supports a view that addicts are expendable because they are unproductive "losers" as opposed to people who want to be productive and deserve to have their suffering alleviated. Controlling opioids is therefore an illegitimate goal, not because it lacks necessity, but because drug abusers are both undeserving and immovable targets of intervention:

> *The sad truth is some people abuse drugs, and some people die, which will happen regardless of what people want so let's stop judging people with pain as somehow deserving of extreme distrust. I can say from personal experience I have never gotten high or had any euphoric feelings from pain medication because I take it for pain, and when you take medication as prescribed you don't get high. Lastly no legitimate pain patient likes taking medication for pain, the side effects aren't fun and nothing would make me happier than not to need anything for the pain.*

This post contains examples of several strategies employed to influence perceptions of deservingness. Personal experience is the identified epistemological authority by which it is expected that veracity will be measured. Legitimate patients are linked to qualities of the good subject, deserving of positive rewards (e.g., being trusted, sympathized with, and granted sanction for their use of opioids). Illegitimate users are devalued; their deaths are sad, maybe, but inevitable in any event. In the end, legitimate patients deserve resources and positive regard more than do abusers. Legitimate equals good and here legitimacy is communicated here through lack of desire for opioids and their side-effects.

Creating the good patient script. The proffered means of distinguishing between abusers and patients involves both motive for and effect of opioid use. There are legitimate and illegitimate examples of both. Patients may be recognized by their need for opioids to increase quality of life accompanied by the desire to cease opioid intake. Legitimacy is also signified by the absence of the opioids' euphoric effects (the one effect—not coincidentally—believed to motivate the addict's quest). Legitimate users supposedly do not experience the symptoms of illegitimacy. As seen above, getting "high" is not associated with a side effect of the drug itself, but rather the consequences of the user's motivation.

> *Patients that have chronic pain don't take their meds to get high. We take meds because it is the only way we can get out of bed in the morning. If I had my choice, I'd never need to take another pill.*

In the good patient script, opioids are necessary evils; they are sought as a last resort and are not desired outright.

> *I hate the pills. They reduce the pain while also reducing my thinking ability, slow the gut (constipation), interfere with good sleep, taste bad, and cause severe dry-mouth and bad breath. And yet, they can make the difference between my choosing to live—or not.*

Even with these unpleasant side effects, opioids are seen as preferable to the alternative of living with unbearable physical pain. While loss of cognitive clarity is not a desirable end, it is for some an unfortunate but worthwhile price to pay for a life worth living. This is in contrast to those commentators prizing rationality and intellectual functioning over pain suppression.

Some comments gave voice to a sense of helplessness ascribed to systemic issues in pain care funding allocations. Removing the option of opioid for chronic pain could leave people with no other fundable options for relief.

> *IF I HAD MORE MONEY OR INSURANCE THAT WOULD COVER OTHER FORMS OF TREATMENT, I WOULD ACTUALLY BE ABLE TO TAKE LESS MEDICATION IN ORDER TO FUNCTION ON A DAILY BASIS. The medical world seems hell-bent on trying to characterize us as drug addicts—when we are not—but won't look at helping us manage pain using many other kinds of tools, as well.*

Again, opioid use and the patient position is legitimated through reference to functionality—the ability to maintain idealized quality of productivity is the defense of its use. A claim that is given no heed by those voices (professional and otherwise) advancing the idea of inevitable opioid-induced impairments of function. Another point being made here, that received little attention in the articles or the literature, is the issue of funding for treatment. If people are dependent upon third-party payers (whether welfare or corporate insurance) to access health services, their selection of treatments are limited to those that are reimbursable under policy.

In this narrative, opioids are not chosen for their preferential effects, but out of economic necessity. This is a very different motivation for use than is attributed to the drug abuser, who is said to be seeking “a high.” In this, and many other posts with an explicit allegiance to patient advocacy, the subject of pain patient is distanced from the subject of drug abuse on the basis of motivational variables.

Ease of distinction and the object-status of group identity. The identity roles of pain patient and of drug abuser are at fundamental odds in medical and legal discourses and in direct competition for influential social regard. The former is provided sanctioned access to opioid substances while the latter is targeted for restrictions. The pain patient is an object of some sympathy, while the drug abuser is an object of derision. The question being debated is not whether these categories exist, but rather upon what grounds they can be distinguished.

There is record of a clear assumption, particularly from the standpoint of patient advocates, that the patient identity is demonstrably separate from that of the addict.

> *You'd think I acted and looked like a junkie.*

That these subject identities represent discrete objects with distinctive features that ought to be recognizable to outside observers is taken for granted.

> *My doctor tells me there are 2 kinds of abusers she watches for: those who always want medications for this week's complaint and those who want to sell the medications for profit. Each of those is easy to spot and avoid.*

It makes no sense to this patient-identified commentator that they should be mistaken for a drug abuser, because it is so clear to them that they are not abusing the drug. They assume it should be equally obvious to others. The necessary presumption being, observable characteristics can reliably distinguish between the deserving (legitimate medicinal user) and the blameworthy (illegitimate drug abuser).

> *A simple urine analysis told the attending physician if the patient needed pain treatment or drug treatment.*

This commentator self-identified as a chronic pain patient and made repeated posts in defense of easy access to opioids for legitimate patients seeking treatment for chronic pain. This sentence occurred within a larger critique of new prescribing policies for chronic opioid therapy. The irony of this, and similar posts, should not be lost. The law they criticize specified the need for monitoring drug use through urine analysis. In other words, to treat patients as potential abusers which the patient advocate otherwise decries. Even as these patient-identified commentators argue against the law, they articulate the same position: Drug abusers are observably, measurably, and discretely separable from medicinal users and it is the task of health care providers to accurately distinguish the two.

Drug abusers and medicinal users may both require medical care, but they have distinct needs that cannot be met by the same treatment programs.

> *90% of our problems can be solved with a pre-screening prior to opioid therapy to separate and place the addicts into programs they desperately need, but differ from the needs of the "clean" patient.*

Addicts (aka abusers) are linked with desperate need (an indictment of dependency) and are juxtaposed to cleanliness. “Clean” being a word used extensively in discourses of addiction to denote the absence of psychoactive substances in the body of [former] drug users. The semantic consequence of categorizing subjects with reference to a quality (clean/legitimate) is the automatic positioning of excluded subjects into a category identified by its opposite (unclean/illegitimate). Employment of the word clean to describe non-drug use automatically positions users as unclean, by definition. This, by virtue of the fact that categorical qualifiers are just that—categorical. Either one is or is not a member of the clean (or legitimate) category.

Being clean (of disease, dirt or drugs) is the socially preferenced position—there is an expectation that most people will think it better to be clean than not. People in the clean category benefit from the positive social regard in which cleanliness is held. If systemic absence of opioids is the only qualifier for inclusion in the category of clean subjects, then it is an impossible goal for the patient-user who is dependent upon opioids to manage pain. Hence, the enclosure of “clean” in quotation marks: If drug users are not clean (i.e., dirty) by definition, then patient-users can be “clean” only in the sense that their dependence is not viewed as addiction. Cleanliness is thereby clarified as a reference to legitimized opioid use allowing for the inclusion of patient users within the preferred subject group.

As noted above, the importance of distinguishing between them arises from the assumption that members of each category deserve different consequences and responses from other social actors. The subject of the pain patient is deemed deserving of some degree of positive response to care seeking, but as pain patients they must argue the case against being (re)classified as abusers. If unsuccessful, they stand to lose access to all that is accorded to the pain patient. Not only do they stand to lose access to opioid treatments but moreover, the expectation of being treated with compassion, trust, and respect.

The patient users are distinguished from the addict/abuser on the basis of their motivation for use; locus of responsibility for their circumstances; and their relationship with identified qualities of the idealized subject.

> *Drug seekers can be so manipulative and convincing it is difficult for even a professional to distinguish their true needs. But government needs to stop trying to protect people from themselves—people who need the drugs should never suffer, and people who are addicts and don't want help, well that's their problem I guess.*

In this quote, the drug seeker is someone who should not be believed but who tricks others into believing them, and while this is understandably difficult for prescribers, it should carry less significance in policy decisions. The drug seeker remains associated with the subject of “people” and are therefore granted what consideration is held for the human being. Their life is of less value than that of the legitimate patient, however, and their descent into disregarded social positions is inevitable. What they don’t deserve is to benefit at the expense of legitimate users, nor do they deserve the respect to be offered to the honest (implied) patients in pain.

> *Those that suffer have more vested in making sure that abusers are culled out of the system than the abusers [do]. All abusers are looking for is a 'high' or a "quick buck"; we are looking for pain control sufficient to allow us to have lives.*

Abusers are not included in “those that suffer”; they are to be “culled,” a word pulled from discourses of production/farming that provides a conceptual link to unwanted objects with little or no value. Here the object of culling is an unwanted person with little or no value in the social world; a subject whose motivations are unworthy of respect. “We” patients, however, deserve “to have lives” and are not looking for more than what is sufficient to fulfill the pursuit of life.

The patient is positioned to have greater social value (as reflected in the expectation of a more positive reception) than the abuser. This hierarchical distinction, made on the basis of motivational purity, is necessitated by the stark realization that the needs of patients (access) and the needs of addicts (restriction) are diametrically opposed in the discourse of opioid policy.

> *Instead of the easy fix of denying care to all, they need to work harder on weeding out the addicts and treating them.*

This author asserts that denial of care for *all* is not the answer; rather denial of care should target those few who should be treated instead. Patients are the “all” deserving of “care” (a word imbued with positive sentimentality). Addicts are the few who should be weeded out, and “treated” (a word communicating clinical detachment).

This post does not advocate abandoning the drug abuser to their fate, as some other posts have. Treatment, as an undefined signifier clearly associated with medical discourses, is being advocated for the subject of drug abuse. Yet the subject is simultaneously denigrated through semantic linkage to weeds. Weeds are unwanted plants. Plants are organisms which are generally treated like senseless objects, not as experiencing subjects, weeds all the more so. The verb, to weed, refers to the act of ending the lives of unwanted plants, usually to make room for other developments.

Addicted subjects are like weeds, to be removed for the sake of more desirable crop. Their lives are expendable; no one really wants a weed.

The illegitimate (ab)users may be culled or weeded from the legitimate patient group only upon identification. To this end, commentators posit distinctive features of each subject position that can be assessed and measured through physical means, or behavioral observations.

Ontological attributions of group identity. In a worldview privileging material ontological explanations, it is logical to conclude that an object of verified existence mandates responsiveness. The privilege granted material ontology is seen in its frequent invocation as authorizing arguments. Yet, it is oft times employed in support of a priori assumptions in logically contradictory ways.

> *I for one am glad they are cracking down on handing those pills out. If your medical record proves you have chronic pain then you should have no problem getting your pain management pills but if there is a question in a dr.'s mind. Sorry I'm siding with the doc.*

This commentator invokes reference to the authority of physical science (observable, documented medical proof) to enhance the claim to represent objective reality in their words. The patient is an abuser until proven legitimate. Yet in the same moment, this post undermines all faith in the practitioners' capacity to objectively identify proof of legitimacy. The author is not denying the existence of people who require opioids as medicinal treatments. They are, however, dubious of the pain experience of those claiming it. They are equally dubious of the prescribers' ability to use appropriate caution when prescribing opioids for pain complaints. If not, they would not need be so welcoming of new of policies increasing restrictions and oversight of prescribing practices.

The “crack down” by government is ethically supportable because it slows the entry of opioids into the consumer market. The crackdown is necessitated by the fact that HCPs have not been sufficiently conservative when “handing out” medicinal opioids. Yet the author will side with these same untrustworthy doctors if they deny the validity of a pain complaint. The professional role is ceded influence only when their understanding of the physical evidence supports their a priori conclusion that opioids are undesirable, ineffective, and, unnecessary.

The ideological role of materialism is also manifest in its use by patient advocates with an opposing agenda: References to physical reality are used to legitimize subjectively reported experiences of pain, rather than undermine them.

> *Baseline information of before injury, after injury blood pressure, etc. systemic measurements can accurately provide information on the status of pain and thresholds. Let us fund studies. Let us encourage that highest level of care. Pain is NOT mental illness. Enduring pain can cause complications. We have the ability to improve our health care. Ignoring pain is abandoning the injured. Pain drugs can complicate the healing, but use with alternate (acupuncture and physical therapy) can be used as tools to allow the injured to heal.*

Legitimate users are identified as those that experience injury, and do not cause, through the willful misuse of opioids, the circumstances of their pain-filled physical suffering. Pain patients may be distinguished from drug abusers on the basis of physiological signs. These signs are understood to reflect material disturbance that can be enumerated through technological means. These observable signs are presented as the preferred barometer of truth in support the validity of the reported pain because it is assumed that they exist as expected. Ironically, a potentially detrimental assumption for the voices of people with different experiences.

Physical malformation of some nature is nevertheless the suggested distinction between a legitimate and illegitimate applicant for pain care. The more closely the observed phenomenon approximates accepted understandings of these cause and effect relationships, the more validity is ascribed to the subjective complaints, the more likely their request for medicinal intervention will be granted.

When pain is attributed to material reality, belief in the rightness of patients' access to caring attitudes and therapeutic options has sufficient currency to be given voice as an expectation. The fact that patient identified subjects may not receive these things is seen as a problem to be remedied through appeal to public sympathies.

> *RESPECT and COMPASSION for those in unrelenting chronic pain is what is lacking in our health care system today. Negative Attitudes around addiction, abuse and chronic pain (addiction, abuse, and chronic pain are NOT synonymous) stand in the way of truly caring for these unfortunate individuals. We need a paradigm shift . . . we need more respect, more compassion and we need more EDUCATION for those whose job it is to care for person with chronic pain. Vulnerable persons with chronic pain are the most discriminated against group in the state of WA at the moment . . . this needs to change.*

Respect and compassion are what is lacking, and education is the solution. Education to inculcate positively valued attitudes about the identified subject (i.e., pain patients). Withholding respect, compassion, and any options for pain care represents an act of discrimination against the patient subject. Discrimination, as it is used here, provides a social reference infused with moral authority: In emphasizing the resistance to unfounded, negative prejudicial attitudes toward the subject of pain patients, the word "discrimination" links this population with discourses of civil rights, social marginalization and stigma.

In this context, the patients are the truly unfortunate ones. They are suffering; they are deserving of respect and compassion, which, contrary to idealistic expectations of fairness, they do not readily receive. In associating them with “vulnerable persons” patients become the deserving and needy subject of the chivalrous imperative: Protect the weak and the blameless. Yet what of the addict position in this comment?

While there is no explicit reference to what the addict may deserve, the patient subject is purposely and emphatically distanced from the addicted subject. They inhabit different spheres of social regard. The addicted subject bears ironic mention in reference to harmful negative attitudes, but their exclusion from consideration in the main is so complete that it does not register as a form of discrimination. The absence of the voice of the addict in this debate is taken for granted.

Disability status and conditional sympathy. Health conditions with material status that are associated with disability are expected to elicit sympathetic responses. Thus references to disability are a potential means of influencing perceptions of deservingness. Disability, when people are not held responsible for the conditions leading to need for opioids, is expected to generate sympathetic identification. The disabled deserve care.

> *Finally, a reasoned thought on pain meds. Thank goodness I do not need them, but my disabled son needs them and is faced with "we do not treat pain patients" policies. So what is a father to do? Become a criminal and traffic in illegal substances or stand by and watch my son suffer?*

This commentator draws upon the moral arguments of chivalry to support the legitimate user’s claim to opioids. The idealized subject is the law-abiding, family-oriented, reasoned individual for whom familial obligations to ease the suffering of kin would prevail in case these ends should conflict with unjust legal mandates. The perceived irrationality of more powerful actors (policy-makers who deny pain care to disabled patients) leaves the devalued subject (criminal drug dealer) more attractive than it should, or otherwise would, be. To traffic in illegal substances preserves at least some, albeit diminished, power to choose for one's self.

When the course of one's life is the undeniable result of choices made by distant others, an acute awareness of dependence emphasizes one's distance from the idealized subject of independence.

> *We penalize hundreds of doctors and thousands of patients who WILL enter the disability rolls when they could have been living productive lives.*

The loss of access to pain relief for legitimate users is attributed to the position of opioid use, because prescription and consumption of opioids are punishable acts. Patient advocates argue that opioids can be effective in allowing patients to approximate the qualities of the ideal subject (e.g., productive worker). Penalizing regulations unfairly relegate patients to disabled lives they may otherwise avoid. The patient's disability becomes the responsibility of policy-makers and gatekeepers who have refused them access to medical treatments, including long-term opioid use.

Arguments against use of opioids for treating chronic pain also reference disability in terms of sympathetic identification. It is not the notion that disability earns charitable deserts that is questioned, but rather the legitimacy of one's claim to it.

> *You guys are insane. No normal person takes these drugs but addicts do everything they can to preserve their drugs.*
>
> *They are extremely dangerous as taken and everyone gets that they do a terrible job of taking care of pain long term (that is why EVERYONE escalates their dose).*
>
> *Very, Very few people on these drugs are able to continue to work full time and most become "Disabled" and unemployed.*
>
> *I met a guy who was disabled with only wrist pain. Give me a break.* [spacing in original]

In this line of thinking, people who use opioids over the long-term are, for the most part, bereft of positive regard, but the notion that the subject of disability deserves a respectful and caring response is a shared assumption. The subject of disability retains its status as an object deserving of charity, even if individual claims of disability may be shown fraudulent. It is the source and legitimacy of the disability claim that is being criticized: Disabled pain patient is an illegitimate identity claim if it is made in service of addiction or laziness. This post is an assertion of fact in relaying the homogeneity of the population of pain patients. As a statement of fact, the patient is left with the responsibility to refute the accuracy of the claim to homogeneity. They must defend their claim to legitimacy against ascriptions of irrationality and sloth.

The fool as problematized subject in discourses of brain dysfunction. Several quotes used above reference loss of rationality, cognitive impairment, and similar designations in their denigration of contrary subject positions. This includes variants such as “zombie”, “numb”, or “mindless.” Words and phrases drawn from psychological discourses have become common-place references to negatively valued subjects. The insane, mentally aberrant are problematized subjects, although in colloquial, metaphorical use, the words are not understood literally to signify someone with an actual mental or brain disorder. Yet the association remains paramount in its ascription of irrationality.

The author of the post immediately above emphasizes that “EVERYONE” (or at least most people) in the category of opioid-using-chronic-pain-patients is “insane,” abnormal, and making false claims in a bid for charitable regard (“Disabled”). They are thus dismissed as unproductive, unemployed, irrational (“insane”), drug dependent (“addicts”) malingerers (“everyone gets they do a terrible job of taking care of pain”). All of these qualities are antithetical to the idealized subject—good and deserving—subject.

> *It's enlightening to read the comments from folks that obliviously have dysfunctional brain chemistry from years of high dose narcotics. As with any addiction procuring drugs and rationalizing its use becomes a central part of their personality. Having the government cut them off is the correct course of action because it's highly improbable that they would attempt that themselves.*

To contextualize the significance of this comment, it is necessary to understand that only the patient-aligned-subjects gave voice to concerns about maintaining access to opioids. Therefore, this author’s response must logically be read as an indictment of patient authenticity. The so-called patient in this narrative is an addict with a dysfunctional brain. Not without significance, the ascension of a disease model of chronic pain is a model of brain dysfunction (see Tracey & Bushnell, 2009). Something also used to describe subjects within discourses of mental illness that has been found to correlate with increased stigmatization of that population (Mann & Himelein, 2008).

Dysfunctional brain chemistry, whether it is identified with pain, addiction, mental illness, or acute drug effects is invoked to undermine a subject’s believability and generally devalues their position in the discourse.

> *Anyone who, because of chronic pain or mental illness, is required to take massive dosages of narcotics in order to survive is already dead. Laying on your couch doped up into a catatonic state is not living.*

In this assertion, pain and mental illness share the distinction of being lives not worth living. Ergo, anyone advocating continued use of opioids is automatically suspect. There is no logical ground upon which opioid users can claim benefit if opioid users are already dead. Or if opioid-induced impairments inevitable. Or if opioids are ineffective for the task at hand—mitigating pain of a chronic nature.

It is not insignificant that these modifiers of the irrational arise from psychiatric discourses of mental aberration. Loss of ascribed rationality inevitably results in a loss of voice, even if one holds sympathetic views of the subject. Affixing subjects with adjectives such as “crazy,” “nuts,” “mindless,” or the like results in an inherently dismissible position. One may pity the “crazy” person, even wish to help them, but that does not mean the so-called crazy person knows what they need regardless of what they say.

When a person is positioned as a chronic pain patient, the assumption is that the pain has no predicted end and, at best, a tenuous relationship with proximal causation. These are subjects of debated ontological and social status: Whether they deserve positive social regard is as much a question as their right to access opioids through medical channels. The chronic pain patient thus resides at the edge of deservingness, fighting to maintain the status of medical patient while frequently being positioned as drug abusers and/or mental patients quite against their will.

Patients as drug abusers. Whether an opioid user will be conversing from the position of patient or abuser is wholly dependent upon the assumptions of their interlocutor and little to do with their own powers of persuasion.

You guys are addicts. ALL of these medicines are extremely dangerous.

This comment addresses the many patient-identified commentators who were defending the efficacy of continuous opioid therapy on the basis of their personal experience. Anyone defending opioid use is derided as a drug addict because the danger is seen to inhere in the medicines, not the way they are used. Once the drugs are positioned as uniformly dangerous (read addictive) than any argument in support of continued access is automatically suspect.

The medicine loses it pain relieving effects after using it for a few weeks.

The medicinal user of chronic opioid therapy is rendered illegitimate because the drugs are "known" to be ineffective. Only an addict would continue to take an addictive substance with no medicinal value and inevitably disabling side effects.

> *Those opiates are making it worse on you due to the fact that they decrease muscle mass and take your inhibition and throw it out the window. Making for a lazy drug addict who would rather drug themselves up and numb their minds than actually figuring out what is really going on.*

This quote is taken from a longer post that posits conditional sympathy for opioid use in cases of cancer and injury all while using totalizing language to suggest that by taking opioids one is made an addict. The quote exemplifies how opioid use weakens association with idealized qualities of productivity, self-sufficient independence, and rationality. The patient user is made illegitimate as a function of the inherent properties of opioid substances. It is inevitable. Pain patients (most especially those who use opioids) must argue the case against being (re)classified as abusers.

Absolute propositions such as the one below leave little room for justifiable dissent without first successfully challenging the claims of asserted facts.

> *Across the country, tens of thousands of people are dying and millions are becoming addicted because pharm industry marketing and pharma-funded pain groups convinced docs to prescribe aggressively for conditions where opioids harm more than they help, like chronic pain. And these same groups are fighting public health efforts to bring the epidemic under control.*

This HCP-identified author is a critic of opioid use in treating chronic pain, and of people who defend their use. The post is appended to a profile name of a publicly identifiable proponent of restrictive opioid prescribing practices. The use of a personal moniker aligned with an HCP identity establishes a personal connection with the professional knowledge base of medical discourses of pain care and opioid therapy. It confers a degree of authority on fact assertions that demonstrates the existing influence of this position.

So what is the message of this authoritative voice? On the face of it, this post advocates for the drug addict who is in a position to benefit from public health interventions aimed at restricting opioid access to reduce addiction-related suffering. On another level, the writer has made de facto addicts of chronic pain patients who utilize continuous opioid therapy. They may have been led into addiction by well-meaning professionals who bowed to the pressure of a greedy pharmaceutical industry, but they are still misusing opioid substances.

In their exploitation by more powerful interests, the patient-become-addict in this scenario is rendered less blameworthy—they do not bear sole responsibility for their predicament. This may be the means by which the subject retains their position of legitimacy as a target of compassionate intervention: It would be ethically righteous to prevent otherwise deserving people to fall into such despair and disrepute. “Pain groups” are credited with exploiting chronic pain to create an acceptable subject (the chronic pain patient) for targeted opioid sales. These same greedy actors are then accused of blockading the patient-addict’s salvation by blocking well-meaning policy-makers from restricting access to the addict-victim’s drug of choice. Well-meaning as it may be, this statement exemplifies the complete erasure of the legitimate patient position by banishing the supportive ally to the role of cynical villain.

When opioids are perceived inherently ineffective and addictive, then negative results are a foregone conclusion. It becomes a matter of moral imperative for providers to restrict their use if they are to live up to the code of their professional oath. If opioids invariably lead to addiction and misuse, then advocating continued access is morally indefensible from the ethical stance of utilitarianism *and* of chivalry. The implication, only the cynical profiteer would do such a thing, which is the position left for patient advocates and treatment production companies. If true, their message would deserves no attention and they no converts to their cause.

But if opioids are assumed to always harm chronic pain patients more then they help, how does one make sense of the claims of those who have reportedly used opioids to effectively manage pain, sometimes for years?

> *I was injured in 2000 and I take oxycontin, I have for ten years plus and I'm alive, and just fine, how are you going to say that narcotics hurt in situations of chronic pain more than they help ?? seriously with that, you clearly have no idea what debilitating pain is, and I'm sure glad you're not my doctor, you wouldn't be for long, you clearly have no compassion!!!*

This patient-identified post was made in response to the physician-identified comment that had proclaimed the inevitable harm of continuous opioid therapy. The author passionately refutes the claims of the professed medical authority on the basis of their lived experience. Yet any sway the assertion may exert must first be granted by more powerful others who may or may not ascribe merit to the patient's narrative. When the health care professional espouses attitudes dismissing the credibility of patient reports, or eliminate any position of legitimacy for the use of opioids in chronic pain management, is there really anything an opioid user can say to convince them otherwise?

Summary of Interpretive Findings

The data used for this critical discourse study included over 779 individually authored texts. The authors ranged from paid investigative journalists, to policy-makers and advocates, to unidentified members of the news reading public. Commentators claimed origins from around the country, though the majority identified as residents of the geographic readership of the Seattle Times newspaper. There were comments by those claiming to be medical professionals, pain patients, and opinionated by-standers.

The sixty-four quotes included above were drawn from comments that were credited to fifty-three different profile names. This was interpreted as a probable indication that the comments had been authored by different individuals. The decision to draw quotes from so many differently authored comments was intentional, and based on an assumption that prevalence communicates something of significance. It was a pragmatic effort to illustrate the dominance of deservingness and the us-vs-them competitiveness that seems to characterize much of the social discourse of our current historical moment.

Throughout the texts used for this project, social problems were discussed in hyperbolic terms of the good/deserving versus the bad/undeserving. This was not true for every individual comment, and alternative conceptualizations of role relationships did exist in the data. These positions were, however, commonly encountered in comments about a wide variety of topics and oppositional assertions. This commonality of deservingness across a spectrum of social positions is indicative of its dominance in discourses of resource allocation and attitudinal regard.

Such hyperbolic and exclusionary discourses posed a challenge to continuing attempts at constructive dialogue about problems, solutions, and compromises. Complex social problems, like chronic pain treatment and opioid addiction, among others, were reduced to simplistic aspersions of character and ascriptions of blame. The negative consequences ascribed to those in unpopular positions was sometimes extreme, including social ostracization and even death.

Reinforcing this dichotomous positioning did little to alleviate the problems associated with problematized identities. Neither could it address the problems facing those people who are (mis)identified with them. Vilifying drug addicted people did not improve the position of pain patients, nor did it result in proposed solutions for preventing addiction in the first place. If anything it reinforced the arguments in favor of increasingly regulated access to opioid medications, contrary to the interests of people with CPC's who have or may benefit from them.

Pain patients inhabit a tenuous position in this discourse of deservingness. They are potentially objects of chivalrous attitudes toward blameless suffering, but they also inhabit a position of dependence. Dependency lead to a reduction in the influence of the dependent person's voice in the social discourse. The claims of those deemed dependent were dismissed, rejected or ignored by numerous respondents to the Times' articles, including some who self-identified as medical professionals who may hold positions of power over the lives of prospective patients.

The assumption of physical and financial dependence, especially of disabled, state-dependent patients, was compounded by an association with opioid dependence. Opioid users are split into categories of descending legitimacy. The pain patient, the patient of addiction treatment, the manipulating pseudo-patient, and the criminal user. Those who abuse opioids are maligned across the board; it was not an identity that was ever willfully adopted in the text.

The hyperbolic, adversarial context of the wider social discourse facilitated extreme conclusions about pain patients and opioid users, perhaps the most troubling being that opioid users deserved to die for their presumed “choice” to (mis)use the drugs. It is not that all commentators made such a claim that makes this part of the dominant discourse. It’s that the assertion was common to arguments in support of maintaining patient access to opioids and those in support of blanket restrictions on opioid prescribing alike.

Opioid substances were argued for and against in relation to their assumed impact on idealized qualities such as agency, self-sufficiency, and productivity, among others. The highly undesirable side effects of opioids, namely addiction and overdose potential, were tied to the subjects of dependency, irrationality, and sloth. Commentators with diverse identity claims articulated the idea that these effects are inherent and inevitable or arose from improper motivation and use. These idealized and problematized subjects were common to statements favoring oppositional positions, e.g., those advocating more or less restrictions for opioid prescribing practices.

The position of opioid side-effects had profound effects on patient voice. People who dismissed opioid efficacy also dismissed patients claiming benefit. People who dismissed the risks of opioid use as side effects of misuse dismissed people with pain who suffered from these negative side-effects. People who dismissed concern for opioid users who developed addictions inevitably dismissed concern for people who may be (mis)labeled as drug addicted.

For patient-identified participants to maintain their right to access the consideration and influence accorded to the human subjects of medical discourses, they must convince others that they are deserving of the right to choose their course, to use or not to use opioids. Contributing to the reification of an illegitimate patient identity undermines this attempted advocacy of the patient's position.

For one, it contributes to stigmatization of another group of suffering people (addicts) with potentially fatal consequences. For another, pain patients have little say over whether they are ultimately labeled as addicts/drug abusers by their HCP, family members, or other members of society. This is particularly true for those who have become dependent upon opioids to maintain functional quality of life, but it is also reportedly true for those who seek care for acute injuries as well as those with chronic conditions who do not seek opioids.

As seen in the analysis above, deservingness and out-grouping infuse discussions of social problems ranging from abortion, climate change, socio-economic conditions, partisan politics, and more. Discourses of pain care, opioid use, and addiction are entwined with these dominant discourses which underlie moral decision making. The idealized position of the law-abiding, independent, self-sufficient, rational citizen is implicated in stigmatizing attitudes toward pain patients, opioid users, and addicts alike.

Losing Voice with Pain, Addiction, and Opioid Use

This critical discourse analysis examined texts from the reactive commentary of news readers that were posted to a series of articles on the website of a large metropolitan newspaper. The frames of legitimacy and deservingness used in patient advocacy appeared to inadvertently reproduced the inequities they sought to redress. Pain Patients were discursively positioned as potential or actual opioid users. Opioid users were positioned as actually or potentially addicted. Addiction and drug abuse were maligned to the detriment of people with pain and people with opioid addictions alike. Perceived loss of independence and rationality underscored negative attitudes toward both groups.

Why This Study?

The original stated purpose of this project was to explore moral discourses intersecting with the subject of chronic pain, specifically to expound the potential implications for the social, personal, and medical treatment of people with chronic pain. The data for this analysis was obtained in the context of a public debate about evolving state policies pertaining to opioid medications in the context of chronic pain management, but this project was not undertaken with a focus on opioid use. As the researcher, I initially undertook this study with the explicit intent of informing efforts by patient advocates to decrease stigma and facilitate access too respectful, client-centered, effective and affordable care for people who live with chronic pain irrespective of etiology.

The need for anti-stigma work in pain care has been well-supported by existing research into the experiences of people seeking medical care for pain of diverse etiological and chronicity factors (e.g., Hakanson, et al., 2010; Holloway et al., 2007; Lillrank, 2003; Marbach, et al., 1990; Nettleton et al., 2004; Slade et al., 2009; Walker et al., 1999; Werner et al., 2004; Young et al., 2013).

In keeping with the findings of these earlier studies of patient experiences, the public commentaries analyzed for this project contained obvious examples of stigmatizing attitudes and beliefs related to chronic pain and people seeking pain care. As would be expected of stigmatized identities, whatever could be said on behalf of pain patients was repeatedly challenged, ignored, or readily dismissed as the ramblings of the naïve, overly-sensitive, or the drug addicted.

From a sociolinguistic standpoint, patterns of language use stand to complicate mutually comprehensible encounters between people of different language-use communities (Blommaert, 2005; Gee et al., 2001). In the instant case, differences in narrative style and content were observably associated with explicitly claimed indices of social identity. Patient-identified commentators, for example, were frequently associated with the use of detailed anecdotal narratives to establish their authority and demonstrate the legitimacy of their claims. Their authority was based on lived experience, rather than knowledge of aggregated data points. This is a sociolinguistic register that may not be well heeded by those steeped in the succinct precision of academic jargon, privileging an assumption of disembodied aggregation over individual reports, as medical practitioners and policy-makers are wont to become.

While any of these artifacts of linguistic expression would have made an apt object of articulation for the stated aims of the study, in the end what stood out was the overall adversarial tone of the discourse in positioning subjects in categories of us-the-more-deserving versus them-the-less-deserving. This is a tone that seems to permeate much of contemporary social discourse and has certainly erupted with vehemence in the 2016 election cycle (Pew Research Center, 2016). Subjects in the analyzed text were positioned as contenders in a fatalistic competition for social and material rewards. Contended rewards included the influence of voice (Blommaert, 2005) and any sense of dignity available to one's social identity (C. Taylor, 1989), as well as access to medical resources.

This adversarial positioning is a theme observed to wind throughout reader commentaries. It is apparent in tangents ranging from abortion arguments to global warming to politico-economic corruption and partisan political propaganda. It is a feature characteristic of many comments directly related to the topics of pain care, including the discourse of safe marijuana vs. deadly opioids. The interests and goals of those individuals who are identified with these subjects are presented as being in direct opposition.

It was suggested, in both the public comments and the medical source material, that legitimate pain patients and drug abusers would be best served by mutually exclusive policy decisions. The pain patients claimed benefit from policies facilitating access to a wide variety of medical treatment options, including opioids. The drug abusers were in a position to need policies restricting general access to opioid substances. Within the commentary, these two categories of opioid users are dichotomously positioned to be deserving or not deserving of respect, compassion, medical resources, palliative responses, and in some cases, life itself.

This competitive dynamic was borne out in regard to the subjects of chronic pain and opioid use by pitting the interests of certain subjects against less deserving others. The humans against non-humans; the good blameless against the blameworthy; the government and/or the corporate powers against the citizen consumer. Perhaps most explicitly associated with the stigma of chronic pain and the voice of care seekers was the division setting the “legitimate patients” against the “drug abusers”.

There seemed to be an expectation (and assumed necessity even) that the-more-deserving subjects should be distinguished from the-less-deserving. Entwined withal were understandings of the real and the good underlying the moral status of these subjects (Parker, 2002). On one level, this is a debate about opioid use between those advocating restriction to reduce addiction and overdose rates and those advocating for the maintenance of medical access to opioid treatments for people with chronic pain conditions. On a more fundamental level, it is about separating the kind of people who deserve to be heard from those who can be justifiably dismissed.

A discourse of deservingness must answer fundamental questions about identity roles, relationships and consequences. Who deserves to be held in esteem? Whose voice deserves influence over the interpretations and actions of their listeners? Who deserves access to or control of material resources? Who is worthy of being respected, empathized with, or beheld with compassion? And who deserves to shoulder the mantle of blame? For whom is exclusion, restriction, derision, or even death considered a justifiable desert? And, perhaps most urgently, how are these distinctions made justifiable? These questions are answered in conflicting, contradictory ways in discussions of chronic pain; patients; addiction; drug abusers; prescribers; policy-makers; and opioid use.

Subjects in discourses of deservingness. It may first be necessary to clarify the use of the word <subject>, which carries such a variety of connotations across academic traditions that the meaning here could become easily lost to confusion. In language studies, the subject is that which is the topic of discussion. In grammar classes, we are taught that “the subject is the person, place, idea or thing that is doing or being something” (http://grammar.ccc.commnet.edu/grammar/subjects.htm). In social science research, <subject> has become a common means of signifying a <being>—a seat of perception and awareness—who is under study, or is a world observer. From this, <subject> can just as easily represent <person> in any number of sentence constructions. Hence, the potential for confusion.

In the realm of social discourse, all subjects (even those referencing material things and/or living beings) are simply ideas, topics of discussion. Here the word <subjects> may be understood as the shadows in Plato’s Cave: We necessarily assume that the subjects are reflections of an actual world where the objects/concepts under discussion have discernible taxonomical distinctions. It would not do, however, to mistake the sign for that which it signifies.

The subjects of interest in this study relate to specific social identities available for living beings, e.g., health care professional, pain patient, drug addict, or research animal. It is understood that people (beings) are discussing these subjects and inhabiting the roles being discussed; however, the paragraphs below offer an examination of the consequential potential of the relationship between Ideas, not the actual individual beings (human or animal). Thus, statements about the subject of pain patients (a social identity role) should not be read as a stand-in for the person of the pain patient, whose individual experience is their own.

The idea of the <pain patient> and the person who is identified as a pain patient may coincide on a regular basis, but they cannot be equated. A person may have chronic pain but not identify as a patient, yet should they communicate about their experience of chronic pain they become semantically associated with the subject of the pain patient. Someone with an observable physical ailment complaining of chronic pain can be perceived an illegitimate claimant to opioid access. Thus a given person with pain may be identified with different (even exclusive) identity labels which can limit the responses available to them in subsequent communications.

Once labeled, the living subjects are discursively positioned relative to a set of expectations and assumptions that are linked to specific socio-moral standards. These are the standards by which they will be judged by other people, and themselves (Link & Phelan, 2006). Individuals are received and responded to according to the prejudices associated with the labels they are given and held by those they encounter (Major, Mendes, & Dovidio, 2013). These standards and prejudices are interpolated with Modern-era views of suffering, individuals, responsibilities, and obligations that become the moral predicates of deservingness and dignity (C. Taylor, 1989, pp. 14–15).

Subjects are allotted their right to culturally valued responses, such as respect, empathy, or privileges on the basis of their moral status within historically specific discourses (Parker, 2002). These allotments are based upon implicit ontological assumptions that are rarely subjected to logical analysis (C. Taylor, 1989, Chapter 1). The same qualities that may mark subjects as deserving objects of moral discourses are the same qualities that can provide individuals with a sense of dignity, as a being worthy of respect (C. Taylor, 1989).

Deservingness and the Moral Status of Objects: Who Deserves What and Why

Subjects are made into the objects of moral discourse whenever they are positioned as potential recipients of moral choices or consequences. The Hippocratic Oath, for instance, makes an object of the patient whose care is the action by which the physician shows themselves to be good, ethical beings. Accusations that one is not living up to this oath amount to aspersions on one's ethical character. Of course the power and social influence of the accuser is paramount in determining the consequences of any accusation that one may be less than ethical. The opinion of a professional ethics board carries more weight than the complaints of a disgruntled pain patient.

Choices made in accordance with ethical imperatives or values are predicated on understandings of both the needs and deservingness of the action's direct object. Yet it may be that, in the final analysis, the latter trumps all. Callan et al.'s (2014) reviewed articles "highlight the role that a concern for deservingness plays in people's reactions to the fates of others" (p. 143). The perception of choice and control were central to the ascription of deservingness in the work of Petersen, Slothuus, Stubager, and Togeby (2010). In exploring opinions about social welfare policies, these authors found deservingness to be more predictive of endorsed actions than were the ethical values identified by their participants. The importance of deservingness attribution has also been seen in researching pain care decisions in clinical encounters (see Hinze, Webster, Chirayath, & Tamayo-Sarver, 2009).

It has been argued that a deservingness heuristic guides an individual's selection of actions on the basis of what is deemed right and wrong in a given circumstance (Petersen et al., 2010). Judgments of right and wrong always imply consequences that are both justified and expected within their ideological frames (C. Taylor, 1989, Chapter 1). Ends are justified when they are believed to be morally right; when they are deserved. Ends are expected when they are assumed inevitable within the chain of events; when they are an effect of causal reality. It is expected and accepted that the good, sympathetic, legitimate subject should be rewarded in social currency while the bad, expendable, illegitimate subject should reap their bitter harvest.

These are supposed real things—the legitimate and illegitimate—they are afforded ontological status in the discourse (Parker, 1992). The issue is ultimately made out to be one of demarcation: The desirable social identities can be, indeed must be, distinguished from the derided and accorded their moral deserts (C. Taylor, 1989, Chapter 1). These positions are taken-for-granted. The only thing that is contended is the means by which they are to be accurately identified and explained. The decision-making process (the who, what, when, and why) of assigning moral status to different subjects and identity roles is questioned only to the degree in which it is a personal choice, an artifact of socio-cultural conditions, or an inherent condition of being. This debate was something seen in the text analyzed above and in the literature authored by researchers of deservingness. (e.g., Petersen, Sznycer, Cosmides, & Tooby, 2012).

When referring to social identities, different classes of people (other beings) are deemed deserving of different personal, social and material consequences, to include life and justice, depending on the position of their associated qualities within moral arguments (Kittay, 2005). The goodness or desirability of any given identity is defined in ways that are wholly context dependent (Goffman, 1963). When it comes to accessing sanctioned markets, and the respect of those aligned with dominant cultural influences, certain identities (e.g., blameworthy illegitimate users) are clearly beyond the pale of social goodwill.

Beyond the pale: In-group vs. out-group. In medieval Ireland the English ruled over regions known as the "Pale," where English laws, customs, and moral dictates held sway over the Anglicized denizens. Outside of these boundaries, the "wild Irish" carried on their fantastical and uncivilized lives under colonial occupation (Leerssen, 1995, p. 30). It was an accepted understanding that those who were beyond the borders of the Pale did not behave in proper fashion and could not expect the same moral or legal consideration as those who resided within the geographic boundary. They were literally, geographically, beyond the Pale of social goodwill extended by the ruling classes.

The continued idiomatic use of this antiquated point of English law reflects an enduring tendency to express the morality of social arrangements in starkly competitive terms: Us (within the pale) vs. Them (beyond the pale). Once people are placed outside the bounds of positive social regard, they become inapt objects of moral benefit (C. Taylor, 1989, Chapter 1). Subjects are positioned in these adversarial roles with the use of indexical qualifiers resulting in alignment with esteemed ideas or pushing them beyond the pale of social goodwill.

Discursively speaking, those who are grouped with "us" propose to speak from the righteous position, expecting the benefit accorded to the good. The "we" may be conceived to be the problem solvers who clearly recognize truth where others may not; or "we" may be the deserving supplicant for charitable endowments. Those grouped as "them" are, of course, conceived to be unworthy, the misguided others, or the morally bankrupt agents of inflicted suffering. These outsiders are the presumed seat of social ills; they are the blameworthy others who have earned their positions of derision or exclusion (Yang et al., 2007).

Stigma as reductive othering. Not coincidentally, the process of stigma involves the demarcation, identification, and categorization of people and subjects into these groups—the valued and the devalued—in the context if unequal social power (Link & Phelan, 2001). According to these authors, "substantial oversimplification is required to create groups" that effectively ignores the "enormous variability within the resulting category." (p. 367). These observations have profound implications not only for the subjects of addiction and pain care, but the social landscape as a whole.

In the analyzed commentaries, there are examples of this reductive othering that are drawn from political narratives on a macro scale: Pitting Democrats against Republicans as enemies and/or defenders of the common decency, and the rights of deserving subjects. There are class-conscious expressions of resistance to existing and suggested allocations of power and privilege from competing ideological positions. Then there is the so-called legitimate patient who is set against the illegitimate user in a contest for morally and legally mandated consequences. These deserved ends are beseeched of and bequeathed by those outside of, and with more social power than, either people in the legitimate or illegitimate group. Seekers of medical care are ascribed diagnoses, motivations, needs, and deserved consequences by those to whom they submit their request, however else they may identify these for themselves.

Inhabitable and ascriptive identities in discourses of pain and opioid use. Blommaert (2005) distinguished between inhabitable and ascriptive identity positions in social discourse. Inhabitable identities are those that people would choose, or at least acquiesce to adopt. Among their reference groups, these will have at least some claim to positive regard, however tenuous. Through this, individuals in these groups maintain a degree of influence over their position within a discourse of privileges and allowances. Ascriptive identities, on the other hand, are those ascribed to an individual, either by virtue of their discursive role (e.g., seeking care from a medical provider results in an ascription of patient identity) or by those with the power to do so. It matters not whether people sought to be identified by the ascriptive label of addict, for example, or even if they freely choose to retain it. It is the person who named them that has decided what they are and will treat them as they believe they should be treated.

Inhabitable identities in medical discourses include the researcher, physician, policy-maker, and patient—these all have some claim to legitimacy. Individual discursants may willingly identify with, and support the interests of these subjects albeit in unequal measure. Within the text used for this study, authors readily adopted the positions of independently resourced, opioid-free members of the collective public. When circumstances warranted, they inhabited (adopted/claimed) the identities of health care providers, policy-makers, people with pain, chronic pain patients, medical opioid user, and on rare occasion, a past abuser of drugs.

It is noteworthy that no one acknowledged themselves to be a current drug addict, or recreational opioid user. The drug addict, the lazy, the free-loader, the criminal, the greedy and the negligent, these were ascriptive identifiers in the commentaries. They were names one may be called, not identities to be claimed nor subjects any one respectable would want to align with. These identities represented the loss of one's claim to dignity as a being worthy of respect by self or others.

The idealized and problematized subjects as markers of social value. Ideal subjects can be idealizations to strive for, or problems to avoid and resolve, depending on their position in moral discourse (Parker, 2002). Idealized and Problematized subjects inhabit a metaphorical position in the commentary in that any reference to them is a marker of social valence for the identified subjects under discussion. It is through this indexical function that ideals come to exert their discursive influence over behaviors and resource allocations (Blommaert, 2005). Ideal subjects invoke discourses of deservingness that become part and parcel of the decision-making of social actors (see Hinze et al., 2009).

As a point of reference, idealized subjects highlight valued traits and social positions. In this sense, they exemplify the concept of Centering Institutions (Silverstein as discussed in Blommaert, 2005). They represent the ideals under which subjects are deemed deserving of consideration or exclusion. The idealized social identities are those viewed most deserving of coveted rewards, including life sustaining resources (Kittay, 2005).

Indexical markers of deservingness in the dominant discourse. As articulated in the reader commentaries, markers of the idealized subject position were the productive, working, taxpaying, law-abiding, rational, intelligent, self-sufficient, independent, free citizen with family connections. These individuals are further imbued with a sense of agency, responsibility, and are expected to demonstrate concern for the deserving other.

There is no case where one of these qualifiers is used as a negative descriptor in an attempt to diminish the standing of the associated subject. There is also no case wherein they are applied to the subjects of drug abusers or addicts—these illegitimate users were invariably problematized.

Problematized subjects are identified as something in need of resolution. Subjects can be thus positioned through explicit declaration, as when referencing the public health problems posed by drug addiction. The notion of public health renders these socially undesirable behaviors into objects of medicalized discourses for the purpose of directing social resources toward behavioral change efforts. It appears to be a category reserved for those behaviors that are perceived to pose a burden on the functioning of the collective.

The markers indexing problematic subjects can provide a window into dominant discourses of power, privilege, and the moral good (Blommaert, 2005). This is particularly evident when subjects are problematized through oppositional juxtaposition with idealized subjects. For example, when opioid use is described as a threat to rationality and productivity the social value placed on these qualities is emphasized. Likewise, when patients and/or opioid users are described as dependent (whether on social welfare or chemical substance) the negative evaluation of dependency becomes definitive.

Chronic pain is a problematized subject, as is its treatment, but the possibility of aligning with idealized subjects remains open for the individuals identified with the subject of chronic pain. Not so for the addict. Once assigned such a label, one can be justifiably excluded from consideration as the beneficiary of social action—no one is expected to listen to the drug abuser rationalizing their drug use. To do so is a mark of exceptionality (e.g., practitioners of “addiction medicine”) or of gullibility (e.g., “prescription happy” providers).

Subjects that are set in opposition to the idealized cannot simultaneously offer exemplification of that ideal. This is not a question of truth, but of the inherent logic of a given statement. Identifying drug addicts as “human garbage” means that the drug addict cannot simultaneously inhabit a respectable identity in that narrative. A subsequent statement could effectively argue that respectable people may also be drug addicts, or that drug addicts are people to pity rather than discard. But if one accepts the parameters of the original argument, then there is no reason to hear what an addict might say in their own defense. If the addict is garbage, then they are someone with no value, no dignity and no voice. Why would anyone heed the requests of garbage, human or otherwise?

Obviously, it is in the interest of any supplicant to find a means of aligning with idealized subjects to increase positive responses to their supplication. The closer one’s position is to one, or preferably more, of the idealized role identifiers the greater the expectation of social reward. These rewards can be attitudinal or material. In the context of medical discourses of pain care, these rewards include respect, compassion, understanding, credibility, and discursive influence. They may also include privileged access to resources, including medical treatments, alternative therapies, assistive devices, and of course prescription opioids. Those who do not or cannot demonstrate alignment with the idealized subjects (e.g., law-abiding) face sanctioned social exclusion, exploitation, and restrictions on allowed access to desired resources (see Hinze et al., 2009; Petersen et al., 2010).

Living subjects as moral objects in discourses of chronic pain. The identified subjects specific (though not exclusive) to conversations about pain care include pain, policy, opioids, medical marijuana, addiction, disability, corporate interests, state welfare, public health, medical patients, drug addicts, providers, veterinarians, and animals as pets or chattel. These subjects are directly related to the actual topic of the conversation (pain care) and are positioned relative to the qualities of idealized subjects (e.g., rational, blameless), legitimacy claims (e.g., materially real and morally good), and posited social consequences (e.g., respect and access).

In medical discourses of deservingness, the subjects of central concern are those objects of cultivated and lived experiences—beings (human, animal, and plant). These beings have an experiential stake, acknowledged or otherwise, in the consequences of social discourse and the position of the subjects therein. Their existence and function, as objects in the world, are directly impacted by discursive actions which influence behavioral choices of other social beings.

The beings identified with idealized or problematized subjects may be positioned as something that merits earned recompense; can claim charitable rewards; must face social exclusion; or merely serve a means to an end (Kittay, 2005). The position in which they will ultimately come to rest in this discourse is based upon the (de)merits ascribed to them; their assumed characteristics; the social standing of the subject with which they are identified; and the needs/interests of other (more deserving) beings (Hinze et al., 2009; McMahan, 1996; C. Taylor, 1989).

Moral relativism and the subject of plants and animals. Discussing the place of plants, and even animals for some, may seem like a tangential topic to some readers.

Perhaps this is because plants are so rarely referred to as living beings in common parlance. They are identified primarily with the ends to which they are but a means. Aside from questions of the experiential potential of plant-based lifeforms, the subject position of specific plants and plant-based derivatives (e.g., opioids) can carry profound implications for the lives of the humans associated with them.

Plants are the subject of pain care discourses in their status as objects of trade and consumption. As agents, they may be potential sources of treatment, recreation, or toxin in their effects. As commodities, they may be available for acquisition in politically sanctioned markets or the illicit black-market trade. As consumables, they may be positioned as medicinally (i.e., legitimately) useful, or as a potentially dangerous form of entertainment and/or pathological coping strategy (i.e., illegitimate). As products, thousands of humans owe their economic livelihood to producing, investigating, confiscating, or otherwise controlling these plants and their derivatives. Other animals, particularly laboratory subjects, are made to ingest these substances for perceived benefit for human beings.

Plants as objects. In the current data, the plants of reference were opium poppies and cannabis. Opium as a “natural” pain reliever, harvested directly from poppy plants, was sometimes invoked similarly to medical marijuana. The proponents of medical marijuana, few of whom identified as people with chronic pain, were vociferous in their support of its use and dissemination. Even here the discourse was adversarial in tone: These “safe and effective” and “natural” forms of treatment were pitted against the “dangerous and deadly” synthetic agents of “greedy” corporate manufacturers. Some patient identified commentators rejected medical marijuana for being ineffective or for effecting greater cognitive impairment than their opioid prescriptions.

In the interest of increasing the social standing of their identified object, medical marijuana supporters were observed to dismiss pain patient narratives if the latter claimed cannabis was ineffective for pain management. The subject of pain patients served an indexical function in these cases, it was not the actual subject of worth. Rather the pain patient was valued only as a backdrop for the elevation of marijuana's position in medical discourses as a therapeutic agent.

Opium was more frequently an indirect subject in posts related to its derivatives. The opioid substances named in the text were, by-and-large, the synthetic concoctions of laboratory science. The plant itself was mentioned infrequently in reference to pure opium or in association with the black-market product—heroin. Despite having a place as diamorphine in the medical formularies of the United Kingdom, heroin is a substance with no legally sanctioned use in the United States (www.deadiversion.usdoj.gov). It is perceived to serve no purpose beyond the hedonistic pursuit of an undeserved euphoria. It is assigned no acceptable instrumental value and is allowed no commercial outlet within the politically sanctioned marketplace. Heroine, and to an extent opium itself, served as an indexical marker of illegitimacy and expendability for its users.

Prescription opioids—misused or not—bear the stamp of legitimacy as the utilitarian objects of medical discourse. As products made available on the open consumer market, they are objects of socially sanctioned use. As consumable objects of medicinal use, their safety and effectiveness is hotly debated in the commentaries analyzed above and in the professional literature (see Kalso et al., 2004; Ross et al., 2011). Medical patients enjoy privileged access to opioid substances, whether as pain treatments or agents of supportive withdrawal from opioid dependency, but even the medical use of opioids is a contentious topic.

Opioids, and by extension would-be opioid users, inhabit a contended space in discourses of deservingness. When illegitimate use is perceived inherent to the plant or its synthetic derivatives, there are few language moves available to users of the substance to justify continued use. If it is inherent to personal variables within the body of the user, it becomes an expectation that these can and should become the basis of restricting access to opioids. When opioid use is perceived to be a free choice or the result of addiction rather than medically necessitated and a last resort, the deservingness of the user to access either opioids or public sympathies is called into question. And when humans forfeit their dignity and abdicate their free-will (e.g., in choosing addiction), they become “weeds” to be “culled” as a means to an end for more deserving subjects (legitimate patients).

Animals as objects. Pain care discourses include the concept of suffering. Subjects suffer, from untreated pain or addiction or stigma and discrimination. This suffering is frequently cited as a moral predicate for medical and policy decisions. Within the discourse, there is an invisible subject whose suffering seems to warrant no notice. Non-human animals are not so visible in the data used for this study, at least not by explicit mention.

Animals feature in the text as unstated indirect objects in posts referencing medical research into painful conditions and their treatments. It is simply an unacknowledged fact of our existence that animal “models” of painful conditions are created as a means of increasing humans' knowledge base. Of course "animal models" is itself a euphemism for the intentional induction of pain, disease, and disorder in non-human creatures for the sake of researching it (e.g., Schiller et al., 2015). The animal, as a being, is secondary to the interests of those who are deemed deserving to benefit from the products of their cultivated experiences, painful or otherwise.

The most direct reference to animal subjects is in the reference to the claimed superior pain management training received by veterinary physicians over those caring for human patients. This is a stance with some support in at least one study (see Watt-Watson, et al., 2009). These assertions seem to be used to shame care providers who are accused of failing to relieve the suffering of human clients. This is ironic because it can only be shaming if it is taken for granted that humans deserve greater pain management than animals, *and* the suffering of animal research subjects is ignored. The animals in these kinds of statements are not the actual subject of interest or significance, but rather a means to prove a point. They are otherwise invisible.

The fact that the suffering of individual animals forms the backbone of the medical industry's knowledge base and production practices is not even a topic of conversation in the text of this analysis or the literature on palliative care. The fact that animal research subjects must certainly be subjected to extremely stressful and painful experiences to create opportunities for the benefit of pain patients (both humans and their chosen animal companions) is never acknowledged. The "rightness" of their subjugation in service of more deserving subjects is taken for granted. If some participants held different views on the subject of animals in pain research, they did not give them voice in this forum.

There may be little room in medical discourses of disease and suffering for the minority views of animal sympathizers. Discursively speaking, the suffering of humans retains a high degree of persuasive power in medical discourses of deservingness. Yet, from a logical standpoint, the exclusion of animal suffering from the discourse serves to undermine the moral arguments of palliative care for any pain patient.

Models of palliative care are predicated upon the assumption that suffering is to be avoided and/or mitigated to the greatest extent possible given the material circumstances of the medical encounter (Cassell, 1991). If only certain beings (e.g., "legitimate patients") deserve a palliative response to suffering, then the moral axioms dictating these responses are inescapably relative. Suffering, by itself, is no longer a tenable predicate for compassionate choices. The being who is suffering must have specified qualities in order to activate assignments of deservingness (McMahan, 1996).

Human beings—objects of ethical privilege. The subject (indeed the whole idea) of beings as a locus of perception, interpretation, and volition reflects notions of self at the heart of moral consideration (C. Taylor, 1989, Chapter 2). The human being is deemed deserving of posited consequences on the basis of belonging to a category of foundational value, a sentient human creature (McMahan, 1996). While some controversial lines of thought extend this value to other sentient creatures their subordination to human interests remains the dominant discourse (C. Taylor, 1989). Humans (particularly those with idealized qualities) are the deserving recipient of ends to which these others (e.g., animals) are but a means.

This is not to suggest that all human beings inhabit an equivalent space in discourses of deservingness, or that categorical exclusion of the "other" from moral consideration is a fate reserved only for animals or the non-sentient. Different humans are clearly differentiated by identity status, e.g., disabled, welfare recipients, tax-payers, and gatekeepers. These are associated with differential assignments of deservingness (see Petersen et al., 2010). They deserve different consequences in response to their circumstances based in no small part on ascriptions of belonging, blame and/or capacity (McMahan, 1996; Petersen et al., 2010; C. Taylor, 1989). It seems logical to question how this relates to the maligned identities of the drug abuser and the contested identity of the pain patient.

For people with pain and opioid users, the self-sufficient, productive, independent ideal is a questionable attainment. A problematic dependence—on taxpayers, family, or addictive substances—along with a concomitant loss of productivity and increased irrationality become their assumed characteristics. Loss of rationality, particularly when this is seen as a voluntary dependence upon opioids, can lead to questions of one's deservingness as a sentient being. The centrality of sentience to the concept of deservingness is so entrenched that the proper place of severely cognitively impaired humans is a subject of philosophical debate (see Kittay, 2005; McMahan, 1996).

In the event of semantic distantiation from idealized subjects (e.g., inability to align with productive, rational, citizen), claims to the social and material rewards of positive regard must be based upon factors. Modern-era conceptions of the deserving self are associated with the position of suffering as something individuals should be allowed to avoid or alleviate (C. Taylor, 1989, p. 13). The beings in this situation must become the objects of charitable action, a boon granted by social superiors, if they are to be the subjects of respect and dignity. In this they may exercise a paradoxical influence over the actions of more powerful others (Kunz, 1998).

Identity roles and power relationships. These discursive processes can ultimately be thought of as reflection, creation, and creator of the social and material circumstances in which individuals exist (Parker, 2002). People may be identified with any number of available subject positions in discourses of deservingness but that does not mean their lives are definitively impacted by negative ascriptions. Semantic indications of blame and deservingness pair negative consequences with identified problem actors, making certain behaviors more likely than others. The actual consequences for a given individual and/or identity role will depend upon pre-existing power dynamics and the ability to influence the flow of resources (Goffman, 1963; Yang et al., 2007).

Existing power relationships will bear heavily on the outcome of any attempted categorization of a subject: A Medicaid patient may harbor negative stereotypes about their physician, but it is the physician's beliefs that carry the weight of authority. Because of existing power relationships and social authority, a patient's negative attitude is unlikely to affect the physician's social standing. The physician's stereotypes about pain or pain patients can, however, stand as an impediment to accessing medical care. That this is actually occurring has some support in empirical research. Hinze et al. (2009) reported findings suggesting that physician opioid prescribing decisions were related more to patient's characteristics (whether they were socially stigmatized or acceptable) than to presenting complaints (regardless of whether pain stemmed from injury, illness, or nonspecific source).

Identity roles in pain care discourses are enacted within politico-economic power structures that operate through relationships between regulators, providers, and consumers. Individuals may serve in positions of policy-makers and enforcers, financiers, producers, retailers, practitioners, and consumers—both the legitimate and illegitimate. These categories include, among others, patients; drug abusers; prescribers; doctors; acupuncturists; researchers; purveyors of therapeutic merchandise (e.g., manufacturers and distributors of treatment products); agents of insurers; public or private policy-makers; people with or without pain; family-members; or observers.

In the analyzed commentaries, the government, political parties, policy-makers, health care professionals, pain patients, opioid users, and addicts have all been positioned in opposition to the idealized, deserving subject. That is, they have all been the identified problem set in opposition to the interests of more deserving subjects. All of these subjects, save for that of the addict/drug abuser, have also been aligned with idealized subjects and present inhabitable identities in medicalized discourses. The subject of the addict was sympathetic only in their potential as victims of naive or malfeasant prescribing and marketing. The absence of any examples of idealized associations with the subject of addiction, or defense of the rights or dignity of addicts demonstrates the extreme marginalization of this identity and the subject of non-medical use of opioids.

In the hierarchical power structure of regulator, provider, and consumer, there are those with limited power to advance their interests or influence others to meet their requests. Some are empowered through their access to resources, e.g., people with money, or associates who will readily provide them their needs. Some have been allotted privileged influence over the behavioral choices of other social actors, e.g., rule makers and enforcers, or lobbyists for corporate or practitioner interests. HCPs are obligated, through socially sanctioned traditions, to function as gatekeepers to other resources—including treatment modalities.

Medical consumers are in the position of supplicants to these higher authorities. If they ask, they do so knowing they may not receive. Some may lay claim to positive regard or resource allocation only through charitable appeals. This includes people with chronic pain conditions who may have few financial resources, or suffer significant loss of self-sufficiency. If these consumers are deemed illegitimate by those with more social power (e.g., HCPs, policy-makers), they are not likely to receive the treatments they seek—be it opioid prescriptions or anything else. In the legal, medical discourses of pain care, the position of illegitimate drug user and care seeker are not inhabitable identities—they are ascribed and undesirable.

The Role of Medical Discourses in Stigmatizing Pain and Opioid Use

Pain is a common experience of living beings. It may be mild or severe enough to impair functioning or even threaten physiological existences. It may be relatively brief or become a never-ending saga. According to the IOM (2011) report, pain is a leading cause of care seeking behaviors. However, as seen in the text of this study, not all people who experience pain will seek medical intervention for that experience, or wish to inhabit medicalized identities. Hence it would be misleading to refer to everyone with chronic pain as “pain patients.”

People with pain—patient and non-patient. People with pain become “pain patients” when they adopt the label, or when it is ascribed by virtue of their relationship with a pain care provider in seeking to mitigate the impact of pain in their lives.

Regardless, pain is a subject of medical discourses and as such people with pain are always potential pain patients. People with pain must therefore contend, to some degree, with the ascriptions associated with the pain patient identity role. For a person to inform another of their experience with persistent or recurrent pain, regardless of medical status, is to encounter stereotypes about pain patients—these include ideas of materiality, psychological dysfunction, and pursuit of opioids all of which affect assignments of deservingness.

Pain patients are further subdivided according to assumptions of duration and etiology. People seeking care for physical pain are categorized as acute pain patients, cancer patients, chronic pain patients (aka chronic non-cancer pain patients; IASP, 1994), or addicts and people with malingered disability. Assigning a patient to any of these categories is predicated upon vague notions of temporality and materiality regarding the attributed source of, and ascribed motivation for, reporting pain. Both the ascribed source of pain as well as the assumed motivation for reporting it have implications for how people will perceive and respond to people who report pain.

Treatment of subjectivity in a material worldview. Pain, particularly chronic pain, presents a challenge to accepted understandings of both the real and the good that underlie medical discourses (Cassell, 1991). It is neither consistently tangible to measurement nor consistently responsive to treatment efforts. As a subjectively reported experience, pain is not readily verifiable by external measures. Yet pain, especially severe and disruptive pain, is oft considered an experience worthy of palliation. In this, it is an apt object of chivalrous moral action.

Addiction in medical discourses is a costly and distressing "disease" thought best treated through supported withdrawal (Roux et al., 2013). When addiction is the targeted object of palliative care, opioid abstinence is seen as the means of managing, if not curing, the medicalized condition of addiction. And when overdose reduction is the direct object, restricting prescribing practices is the life-saving objective by which health care actors enact their moral code to decrease iatrogenic distress. Thus the subjects of pain and addiction are positioned to benefit from mutually exclusive actions predicated upon the same chivalrous and utilitarian ethics of relieving the suffering of individuals and protecting the interests of the collective.

The HCP is the gatekeeper tasked with the responsibility to distinguish the legitimate from the illegitimate positions amongst supplicants for products, services, and positive regard. Acceptance of some degree of personal culpability for the consequences of the professional decisions is also an expectation for those in these roles. This is the situation of health care providers who are tasked with the authority and responsibility to determine whether or what services to provide to those who may request them. And they do so while receiving mixed messages from the research community as to what constitutes scientifically and morally sound predication for their chosen actions.

Population oversimplification as reductive othering. The fact that so many studies of patient experiences of pain care include references to both felt and enacted stigma (as defined by Scambler, 2004) while provider-oriented articles on pain care do not is indicative of this power dynamic. The HCP has the privilege of discussing the "continuous or escalating doses of opioids at the expense of worsening function and quality of life" as do Ballantyne and Sullivan (2015, p. 2098).

The claims of opioid-using pain patients, such as those articulated in the commentaries—that their functioning and quality of life are improved by COT, or that they do not require dosage escalation—are rendered invisible to the readers of such articles. And while there may be cases wherein COT is more harmful than helpful, definitive claims of the ineffectiveness of COT are being made without sufficient evidentiary support (Dowell, Haegerich, & Chou, 2016; Ross et al., 2011). There is no discussion of a how these discrepant reports are to be reconciled. It seems not to have been a question that has been asked. Perhaps these voices are not deemed credible in the first place. Or perhaps it is a discrepancy that has yet to be acknowledged.

This is only one of many examples to be found in professional discourses of chronic pain of the oversimplification of group similarities and ignorance of intragroup variation that lies at the heart of stigma perpetuation (as articulated by Link & Phelan, 2001). The editorial by Ballantyne and Sullivan (2015) include two other examples of this process as it has been applied to people with chronic pain. In the first, the decision to use opioids is attributed solely to prescriber assessments of patient reports of pain severity. While this is no doubt true in some situations, there is no mention of the possible sociological factors influencing the treatment related decisions being made by both patients and prescribers.

One such factor, expressed with apparent frustration in the commentaries, is a lack of funding for different treatment options (e.g., physical therapy for musculoskeletal pain). Working conditions may induce and/or exacerbate musculoskeletal conditions over the lifespan (Cassou, Derriennic, Monfort, Norton, & Touranchet, 2002). Yet the economic necessities that sometimes dictate available options for lifestyle, activity, and treatment choices are rarely examined at length in the professional literature (Holloway & Haw, 2013). It is likely that the palliative therapy of opioids may be an attractive option where removing noxious stimuli, or accessing alternative therapies is not.

The second oversimplification that is found in Ballantyne and Sullivan (2015), and elsewhere, is their interpretation of the data from neuro-imaging studies with chronic pain patients—a group with ill-defined inclusion criteria and immense (unmentioned) variability. Advancing claims made in other studies and venues, these authors report that "over time pain intensity becomes linked less with nociception and more with emotional and psychosocial factors" (p. 2098). Never mind that they do not mention social factors in the article, they still invoke the apparently popular but ill-used concept of the biopsychosocial model of human experience (Manchikanti, Boswell, et al., 2009).

These authors are not alone in contending that chronic pain is a condition of an emotional and/or neuronal feedback loop (e.g., Thernstrom, 2010; Tracey & Bushnell, 2009). What is being advanced is a conceptualization of chronic pain as a singular construct, a disease or disorder of the central nervous system, regardless of causative onset. "The factors leading to the disorder of structure or function might vary, as is the case with cancer, but the end result must be a disordered system" (Tracey & Bushnell, 2009, p. 1114). This reductive interpretation of correlational brain-imaging studies is contributing to the conflation of diagnostic etiologies, including cancer, without mentioning the fundamental diversity of physical conditions associated with persistent or recurring pain.

It is logical to ask whether this hypothesis, that diagnostic discrimination is unimportant because chronic pain reflects a particular disorder, is positively true or false.

Without including comparative studies of diagnostic subpopulations, and sociological analyses of life conditions and pain experiences, it cannot be said to have been truly put to the test (Holloway & Haw, 2013). There are clinically pressing questions to be answered in accepting this formulation of chronic pain. Is it possible that some chronic pain is the result of on-going, or recurrent nociceptive input which ought to be addressed or at least acknowledged? And what of the opioid using patients with neuropathic and/or myelopathic conditions that assert positive response to COT? Are these complainants to be discredited at the fore, and if so on what grounds?

Collapsing diagnostic distinctions in COT research. As reviewed in the second chapter, numerous diverse health and life conditions may lead to an experience of persisting or recurring pain, generally referred to as chronic pain. This etiological diversity is effectively erased in deploying catch-all labels, such as “pain patients” or “chronic non-cancer pain” (CNCP). This latter is particularly deceptive as its use appears almost exclusively in relation to opioid treatments. More to the point, it is a concept defined and measured by what it is not rather than what it is.

CNCP does not demarcate a population that can be studied as a whole because the people in this category have only one thing in common: Their pain complaints are not attributed to cancer. As a semantic marker, it combines every known cause of persistent and/or recurrent pain other than cancer. It is a category inclusive of pain arising from any number of sources, including congenital disorders, physical malformations, auto-immune disorders, herniated discs, cartilage loss, repetitive motion injuries, conditions affecting the central or peripheral nervous system, and somatization of psychological distress.

Surely the distinctions between these source conditions are important for developing targeted intervention strategies, whether that is opioid analgesics or some other.

Some authors in the professional literature are careful to acknowledge that chronic pain “may or may not be driven by tissue injury” (Rosenblum et al., 2008, p. 5). It is telling that the section from which this quote is extracted did not use the term “CNCP.” Rather, this label was reserved for an earlier section of the same paper reviewing opioid efficacy studies for patients with pain from non-cancer sources. In other words, CNCP seems to be code for assessing the legitimacy of opioid use, not pain care as a general practice.

Diverse health conditions may be associated with chronic pain requiring different treatment approaches, but this does not mean that some patients seeking pain care have a ready diagnosis that can be a treatment target. In some cases, pain is the only target of palliative care. Recognition of this fact has led some authors to suggest new categorical identifiers, e.g., “maldynia” for “a wild-type of chronic pain” that is “non-purposive” (Giordano, 2011, p 1). Manchikanti, Singh, et al. (2009) advanced the term “chronic pain syndrome” to include both medically explained and enigmatic illnesses. They suggest that this phrase would be useful in discussing the complex problems of managing quality of life for patients with chronic pain. Neither of these suggested taxonomical labels has achieved currency in the social discourse.

Conceptualizations of chronic pain, whether as CNCP or as a disease entity unto itself carry significant implications for treatment related decision making. When HCPs encounter patients with pain, accepting the existence of variability in the causes of chronic pain leaves open a variety of treatment options. Such options, depending upon the presenting conditions, may or may not include opioids, exercise, physical therapy, steroidal treatments, surgeries, psychotherapy or any number of other modalities (see Rosenblum et al., 2008; Vowles & McCracken, 2008). If chronic pain is a disease of the brain, there is only one logical treatment choice to make—drugs that target brain function. There is certainly a segment of the medical community who advocate psychopharmacological interventions as preferable to opioid treatment (e.g., Julien, Advokat, & Comaty, 2011). Their blanket ascriptions yet again dismiss or erase the voice of patients who claim a different experience.

It is striking that the empirically obvious questions are not readily identifiable in the literature. Medical researchers, practitioners, and commentators operate in a world of empirical epistemologies and material ontologies. Categorical distinctions are assumed to reflect the objective existence of distinct categories; however, it is an epistemological necessity of empiricism that these taxonomical categories are clearly defined and tested before they are accepted as real (valid). Is this really happening?

The literature reviewed herein did not define the objective, material basis of a categorical distinction between cancer pain and CNCP—they accepted it as foundational. The neural change hypothesis of chronic pain is generated from interpretations of neuro-imaging studies. Are these conclusions equating correlation and causation? Do they successfully address confounding variables within the study populations? The question in need of answering is, how meaningful are the findings from these studies really? Are they truly generalizable or are the explanatory possibilities so numerous as to make any proffered conclusions arbitrary?

It may be that these empirical questions have been addressed elsewhere in the professional literature, but they warranted no mention in the articles reviewed for this project. They have been taken-for-granted as foundational reality upon which to build subsequent understandings. It is one of the many questions arising in the course of this project that would benefit from future research. From the perspective of stigma perpetuation, it is the conflation of numerous pain conditions into a single disease entity that poses the largest threat to patient care. Why? Because attitudes, behaviors, and treatment decisions made in regard to people living with chronic pain will be informed by a conceptualization that renders individual differences irrelevant, or worse—invisible.

Personal characteristics, social conditions, diagnostic presentation, and/or treatment responsiveness all but disappear when the primary focus of medical attention becomes the disordered neuronal feedback loop of people complaining of chronic pain. This point was aptly made by M. D. Sullivan, Cahana, Derbyshire, and Loeser (2013) who also expounded the potential benefits of this disease model of chronic, as a bid for legitimization of chronic pain as an apt object of medical action. Yet this frame can increase ascriptions of inherency that preclude assumptions of variability and change, as indicated in studies of mental illness stigma (e.g., Mann & Himelein, 2008).

The concerning issue is that, not only does categorical collapse narrow the treatment options that will make sense to providers, it also creates an oversimplified category of easily stereotyped and dismissed people (Link & Phelan, 2001). If this is the box for people with pain, then negative stereotypes and attitudes toward the problematized subjects are applicable to all. If this becomes the all-inclusive understanding of chronic pain, then there is no path for an individual patient to move from a derided or negated category to less stigmatized category and still carry the identity of pain patient.

It would seem that highlighting the diversity and complexities of pain complaints is a position of patient advocacy. If this diversity is accepted ontology in discussions of pain care, subsequent actions could be predicated upon an accepted need for safeguarding access to diverse treatment options. The question of whether an individual supplicant is deemed deserving of treatment, or perceived as credible is another question altogether.

Opioid Use and the Denigration of Users

Discussions of pain care and people with pain eventually connect with the subject of opioid use—be it actual or potential. In the analyzed texts, complaints of pain were associated with pursuit of opioids and the value of the human subjects was often associated with the nature of their relationship with opioids. This discursive entwinement of opioids, addiction, and pain care intersects moral discourses of competitive individualism, chivalry, utilitarian ethics, and pragmatic necessities.

The moral dilemmas posed by these intersecting discourses are of such social significance that political responses are being mobilized nationwide. Policy, whether voluntary or mandated, offers decision-makers a guided instantiation of consensus reality; it tells us what is normative and acceptable within its scope of influence (Fischer, 2003). In a sense, opioid prescribing policies represent an attempt to mitigate responsibility for the potentially harmful outcomes associated with the decision to prescribe or withhold opioid medications from requesting parties. The policies inform providers what is acceptable risks and can be referenced when and if prescriber decisions are questioned (Dowell et al., 2016).

Thus opioid users are the living embodiment of a moral dilemma: To provide palliative substances to ease physically generated suffering that is not amenable to tangible measurement; or to withhold an addictive substance associated with dependence, criminality, and death. The crux of the argument seems to lie with the answer to a single question: In regard to opioid selection or restriction for patient-identified supplicants, which—addiction or pain—is the greater price to pay? Unfortunately, the question is complicated by the risk of accidental overdose and the widespread practice of polypharmacy treatments for various pain-related health complaints (Dowell et al., 2016).

Legitimate and illegitimate identity roles in discourses of opioid use. The cast of players in the discourse of opioid use included several identity qualifiers, of varying ideological valence. In producing and marketing opioids, the [“greedy”] pharmaceutical industry is either pushing addiction for profit or providing palliative care for suffering patients. In directing opioid prescribing practices, policy makers are either offering ignorant interference or needed policy guidance to providers in need of decisional predication—to prescribe or not to prescribe opioids. HCPs are potential allies for patients, but they are also cast as potentially uninformed or uncaring figures willfully withholding palliative care; or as the frightened middle-man who must comply with legal mandates of their social superiors (e.g., DEA) regardless of clinical judgment.

Opioid use is conceptually entwined with the subjects of drug abuse, addiction, and the person of the “druggie.” Within the commentaries, this semantic affinity was not affected by deployment of alternative lexemes (e.g., substituting “pain medication” for “narcotic painkillers”). The same words were used interchangeably by people propounding starkly different positions, the advocates of medical access to COT, as well as those ascribing addict status to the majority of opioid users.

The associations involved are topical (opioids, addiction, and pain) as much as they are semantic (e.g., narcotics and crime). For multiple millennia, opioid substances have been used for pain relief and euphoric effect, and were associated with overdose, and addiction (Thernstrom, 2010). Centuries of association must leave little hope for the immediate discursive separation of these topics in modern bioethical analyses of patient stigma, as much as some patient advocates would, understandably, like to see done (e.g., Goldberg, 2010). The pain care debate would seem to be as much a debate about the place of opioids in our society as it is about the place of pain in our lives.

Moral categorization of opioid users. Pain patients are caught at this intersection of discourses on pain, opioids, addiction, criminality, and medicine. To the extent that people who use opioids are able to maintain ties with the identity of medical patient they may still openly vie for social reward and access to material resources. Where the patient identity is revoked, so too is the subject's status as a medical object. In the dominant discourse, opioids and opioid users are sanctioned only in their role as the direct objects in medical discourse.

Although opioids have enjoyed a variety of sanctioned uses throughout history, currently there is only one sanctioned outlet for opioid use: It is a palliative measure to alleviate suffering from physical malfunctions or the physical symptoms of addiction withdrawals (Thernstrom, 2010). People who consume opioids are either legitimate or illegitimate users. They are categorized as either people who are granted sanctioned access to opioids as medicine or those who use them—without warrant—for any other purpose.

The existence of discrete, identifiable categories of opioid-using subjects was never questioned in the commentaries, or the literature. Rather, it was the properties and their ease of distinction that was the subject of contention. The legitimate users included patients, providers, and the pharmaceutical industry. The illegitimate users were "druggies" and "pushers," potential pretenders to patient-hood, or the unethical professionals with limited motivation to enforce existing restrictions.

In medical discourses of care, only the real (i.e., legitimate) medical patient is positioned with a moral claim to sympathetic social responses, and with it the potential to access opioids through sanctioned markets. The pretender (i.e., illegitimate patient) is anathema to all; in one way or another, their outcast position is a justifiable consequence of blameworthy choices, motivations, and behaviors. The illegitimate patient receiving opioids is one who is misusing both the health care system and the drugs. In short, they are a drug abuser.

Drug abusers are those who use opioids without legal or moral sanction. According to the designations of dominant discourse, they seek opioid substances for invalid reasons. Their opioid use is viewed as evidence of their degenerate state: These are the idle and the weak who seek primarily euphoria and escape. They may be seeking hedonistic recreation, or their lives may be governed by the singular quest for the fruit of the poppy, to stave off the shock of withdrawal as much as to experience its euphoric properties. Regardless of how they got here, whether they were victims—of prescriber malpractice, industry conspirators, or of an inherently addictive substance—or the agents of free-will. Once they are ascribed this identity and motivation, they are accorded little dignity or voice in the discourse.

None of these motivations are met with particularly positive regard and the most compassionate position one is expected to take toward such an unfortunate wretch is the desire to free them from the influence of drugs. This is obviously contrary to the identified interests of chronic pain patients seeking continued access to opioid substances. It may also be contrary to the wishes of the “addict” or recreational user who want the ability for safe, affordable, easy access to opioids, but their desires are hardly given serious consideration in the text.

In the commentaries, illegitimate users are portrayed as parasites, whether by choice or ill-fortune. These subjects may be positioned within a narrative of the troubled naiveté of tragic desperation; the fatalistic devolution of unsuspecting middle class opioid users; or the devious machinations of a self-centered depravity. People who were ascribed this identity were frequently positioned as simply reaping what they had sewn—they had earned their position in society and were held blameworthy for their sad ends. When they died of overdose it was not so sorrowful a thing. This is a dangerous position to be in because once someone is posited to deserve their own death, there is little reason to pity them or endorse steps to reduce future incidents.

The subject of addiction was frequently positioned with one or more of the following qualifiers: irrational, unproductive, criminal, pathetic, dependent, garbage. In any case, they were perceived unable to safeguard their own physical, psychological, and moral integrity by abstaining from drug use. They are accused of draining resources and diverting attention from those seen to be more deserving of these things, to wit legitimate patients, and care providers. And overdose was too frequently seen as proof of illegitimacy by both patient-identified and patient critical commentators. This results in the discursive exclusion of whole classes of opioid users from discourses of deservingness.

Resisting the position of identified problem. The pain patient, as a subject of discourse, is both disparaged and defended in the commentary. It was also an identity that numerous commentators claimed outright, as a point of authority born of experience, and as an appeal to moral sensibilities. The addict was maligned, vilified, and devalued pretty much across the board. No one claims the voice of the truly excluded: There was no self-identified addict amongst the commentators arguing for greater consideration, more resources, or privileged access to opioids. Neither attitudes of compassion, respect, or derision, nor arguments favoring access or restriction were given voice from the position of addict-hood.

By and large, the position of the addict was outside any consideration of positive regard or socially supportive responses. They were presented as expendable if not downright villainous individuals who present a problem to the public welfare, or threats to social evolution. Legitimate patients, on the other hand, were framed as blamelessly suffering in mind and body. They were deserving of compassionate and palliative responses. It is clearly the preferable position for opioid users, both in terms of their access to prescriptions but also in terms of their access to personal dignity. If they lose this identity, they become one of the maligned. Unfortunately, whether someone is positioned as an addict or a legitimate pain patient is not something over which the categorized person has the ultimate say.

One can accept or resist classification as illegitimate user, but successfully convincing others to reclassify one as another kind of person is wholly dependent upon the extent to which one's arguments are granted credence by the interlocutor. A person may claim, even believe themselves, to be a legitimate pain patient but convincing another person that they are not an addict is another matter entirely. For this, a supplicant's position must be associated with some degree of positive social regard. The person identified as an [potential] opioid addict has none. At least not until such time as they encounter a person who does not believe they are one.

The predilection of patient advocacy commentators to reinforce the maligned traits of the illegitimate user serves to undermine their own claim to social currency. If addicts deserve their fate, if they chose their fate, if they refuse to change their fate, then they are discursively aligned with negative social regard.

The currency of positive regard in discourses of deservingness. The regard in which a subject is held has direct consequences for ascriptions of deservingness and public support for the subject's social influence. Positive regard extends benefits such as ascriptions of credibility and deservingness. These ascriptions are necessary for people to influence their position in the communicative situation. Their ability to willfully influence interpretative uptake of, or evoke behavioral responses to, their communicative attempts requires some degree of positive regard.

The accordance of influence is a direct reflection of the subject's position with the preconceived notions of trait desirability (Goffman, 1963). In relationships of differential power dynamics, loss of voice and choice are feared consequences of negative social regard. To diminish one is to diminish the other. Someone speaking on behalf of a discredited subject, from the position of a devalued identity, has limited means by which to influence their reception or the behavior of their interlocutor.

If the subject of opioid use is generally associated with an absence of productivity, or rationality, then it is the individual opioid user who must show themselves an exception to the rule. But how is this to be accomplished if expression of need or desire for opioids is perceived indicative of illegitimacy by gatekeepers and policy makers? If addicts are assumed to be deceptive in pursuit of opioids, then why should anyone accept protestations of legitimacy from a presumptive addict?

Distancing from ascriptions of illegitimacy and negative regard. When people were positioned as addicts by other discursants it was not a position that was willingly accepted. Quite to the contrary, the result was generally a furious attempt to distance oneself from everything associated with the addict label. One semantic strategy for achieving this was through the intensified denigration of the unwanted position. In effect, the message became: Addicts are bad, they are the problem actors who deserve their unpleasant fate. Patients are not like addicts; they are better people with more value who deserve palliative care.

In adopting this frame, the maligned identity of the illegitimate user is reified by advocates of medically sanctioned opioid access and the existing semantic associations with negative regard are strengthened. Ultimately, it is a strategy that undermines the patient's own position because whether they are perceived as legitimate or illegitimate is not within their power. This defense of the worthiness of pain patients to access positive social regard and medically sanctioned access to opioid substances does not reflect the power of the patient position. Rather, the implication here is that chronic pain is associated with a loss of status.

People who are [perceived] unable to earn their own way in a society prizing [the appearance of] financial and physical independence are positioned as dependent. When a patient relies upon opioid substances to lessen the disruptive influence of pain, their claim to respectability is made increasingly tenuous by the perception of increasing layers of dependence and assumed incapacities. Dependency and incapacity are deemed charitable positions at best, and parasitic at its worst. They are assumed to lead to loss of productivity and/or rationality,

Apart from accusations of drug abuse, chronic pain carries ascriptions of illegitimacy in other ways. Personal experience enjoyed a privileged position in the truth assertions associated with the subject of pain patients and opioid use. The medical discourse of patient care is, however, predicated upon the assumptions of material positivism. This philosophy of science leads to certain assumptions and expectations on the part of physicians and the general public: That which exists to be treated by physicians should be consistently tangible. Material existence is a requirement for the subject to be considered a real object amenable to manipulation and deserving of intervention. In a results oriented value system, the cure is a material demonstration of utility (the good) of medical intervention. Pain offers none of these things—it is personal, intangible; it is a perception of the experiencing being not an object perceptible to the observing being.

Loss of social currency for pain patients and opioid addicts. Patient identity is experienced under a pall of suspicion that questions the person’s motivation, capacity, rationality, and credibility. Pain patients have limited voice in determining the course of their journey through the medical community, much less the position they will be made to inhabit in discursive interchanges—whether it be legitimate or otherwise. The repetitious assertion that people living with chronic pain can also be associated with idealized subjects, e.g., productive, independent, and credible, belies an assumption that they are not. If one must argue the right to be included in any social category, then the default position would be one of exclusion. That their arguments for inclusion are perceived believable to any but the most marginalized listener is evidence of at least some tenuous connection to positive social regard.

Whether and to what extent an actual subject may be negatively impacted by being ascribed a problematic identity will depend more upon the influence of the positions they and their accusers inhabit within discourses of power and control than it will on the problems with which they are being associated. Certain identity positions are imbued with moral, legal, and/or scientific authority (e.g., health care providers, policy-makers, and agents of law enforcement). When the role of a given social actor is to arbitrate the real and/or the good, it is their reality ascription that matters most in a contest of competing truth claims. Policy-makers are tasked with dictating the practices of their subordinates. Health care professionals act as gatekeepers for medical practices; their decisions are influenced by policy guidelines, but are ultimately based upon their own understandings of the problems and values at play.

Sociolinguistics, social regard, and ontological authority. As demonstrated in the reader comments, patient-identified agents may harbor ontological assumptions about their ailment that differ from those of their physician caretakers. Patients may ascribe symptoms to physical malformations while their providers ascribe them to emotional stressors. Patients can also communicate their symptoms and experiences in a linguistic register that may exert little, or even negative, influence over the behavior of health care providers.

People without medical training may engage in narrative styles of communication using metaphorical descriptions in hyper-detailed, tangential anecdotes privileging personal experience over aggregate data. The professional register of the physician privileges succinct expression in the language of empirical science and calculated probabilities. Even phrases, such as “I need pain medications” are potential sources of misunderstood meanings and misattributed intentions.

Regardless of the feelings and beliefs of the patient, in these interactions it is the physician’s judgment of what is real and good that bears most pressing on the treatment the patient will receive. The patient may harbor negative stereotypes about their physician’s competence, though they have little recourse but to accept whatever treatment they receive, regardless of whether they find it oppressive. It is the physician’s stereotypes about the patient that will determine the type of medical services the patient will be offered. If the provider believes the patient is reporting pain symptoms for secondary gain, they may see no medical necessity to engage in the diagnostic or therapeutic endeavors patients may be seeking.

The person who seeks opioids from a health care provider may view themselves as legitimate patients, with a legitimate, verifiable physical claim to need. The provider may share this interpretation, or they may perceive the seeker to be after secondary gains. What is more, the provider may perceive opioids to be unsafe or ineffective as a long-term treatment, or they may endorse COT as a viable, affordable option. In the end, the patient's perception of their pain or the efficacy of opioid management strategies has little bearing on whether they retain the position of legitimacy or are reassigned the label of illegitimate user.

Speaking from a position of illegitimacy. A person who inhabits the identity of pain patient who is accused of misusing opioids is ascribed the identity of an illegitimate patient. Requests for opioid prescriptions are unlikely to be granted by a provider who is responding to a position of illegitimacy. Moreover, any arguments made by the patient in defense of their medical legitimacy can be summarily dismissed as vain pretense, or misguided exaggeration. This, regardless of whether or not they seek opioids, may impact how their symptom complaints are responded to, if they are to be accorded any serious attention by a care provider at all. To be positioned as illegitimate is to be diminished of both voice and choice; as well as removed from one's source of dignity—the possibility of aligning with multiple idealized subjects.

Whatever the actuality of the patient, or the objective existence of a causative source, the associational networks of the physician is ultimately decisive. If, for example, the physician perceives that observable spinal stenosis is not sufficient to account for the reported pain severity, then alternative explanations for the pain (e.g., hyperactive "pain centers" in the brain) are adopted by the practitioner. Whether the patient accepts these is irrelevant in the physician's final analysis. The actions taken by the provider are guided by their own ascription of the patient's complaint. The veracity of the consumer is assigned by the provider—a socially sanctioned performance of power and obligation.

Trapping the consumer with the language of illegitimacy. Pain patients who are unhappy with the care they receive, and who seek to change providers, may be derided for "doctor shopping," a charge of illegitimacy rather than empowered agency. To the patient, changing providers may be perceived as the appropriate consumer response to dissatisfaction. In the world of consumerist discourses, giving or taking one's resources to competitor businesses is the power allotted the consumer. Unfortunately for the person with pain, seeking another provider may be deemed proof of their illegitimate consumption rather than a legitimate exercise of their socially sanctioned power as consumers.

For the illegitimate user there is neither consideration given to their interpretations nor reverence allotted to their position. Their access to opioids may be curtailed through regulatory practices, or relegated to the most unsavory of underworld markets. More to the point, they are moving beyond the pale of positive social regard. Their options for aligning with idealized subjects to maintain respect and dignity, to say nothing of influence, are increasingly limited. Everyone who may be identified with this position is forced to endure a derisive barrage of contempt enough to undermine any sense of dignity that they may, in vain, try and defend. These messages can lead to the adoption of a negative self-evaluation in line with social messages of unworthiness, what stigma researchers have termed self-stigma (Corrigan et al., 2009).

Earning our fate through social regard. In a society prizing its assumption of meritocracy, one's social identity is not viewed a casted lot, but rather something that can be gained or lost through the actions of individual agents (C. Taylor, 1989). In a hierarchical social system, desirable social identities are associated with greater privileges, influences, and worth (Blommaert, 2005). Therefore, subjects are positioned and repositioned within discursive exchanges in an attempt to increase positive regard and influence over social responses. When the social interests of one identified group conflicts with those of another the result is a competitive dynamic in which public opinion, personal dignity, and resource allocations are the contested rewards (Fischer, 2003). The ultimate aim of these policy debates is to shift the moral predication of socially sponsored actions (Fischer, 2003).

Enacting values of independence, self-sufficiency, and self-definition, people at the border of deservingness are understandably trying to show themselves to be the kind of person who deserve to be granted rights, protections, resources, and some modicum of influence in directing the course of their lives. If their words are going to be given any heed, their identities and their claims must be associated with positive social regard—they must be respectable in some way. Failing this means losing the influence of one's voice to argue in support of their own repositioning. (Blommaert, 2005).

Without voice, there is little social pressure on those with more privileged social standing to acquiesce to any request for respect or valued ends. This can leave people without social support, without pain care; without credibility; without a claim on the moral conscience not even that reserved for the tragic blend of blameless suffering and bearing endurance. Truly, what efforts can you be expected to take in alleviating the suffering experienced by people who deserve their ill-fate?

Those arguing from (or on behalf of) these less desirable (i.e., deserving) positions attempt to increase perceptions of deservingness through legitimating strategies—aligning with more deserving qualifiers and/or appealing to sympathetic ideals. Commentators may have voiced support for opioids or denigrated those who use them, but if they aligned with the subject of chronic pain experiences (whether as medical patients or no), they did so as productive and independent, or at least as blamelessly dependent and unproductive as their circumstances allowed.

Degrees of denigration and shared qualifiers. People allied with the pain patient identity role engaged in discursive attempts to increase their authoritative influence in the discussion because their position requires this response: The pain patient, and all the more so the opioid user, are distanced from the idealized subject positions and from credibility's authorizing source. As a result, people complaining of pain are not automatically granted credibility by their interlocutor. Rather, their motivations, their intentions, even their capacities are rendered suspect by virtue of their proximal associations with increasingly problematized subjects: dependency, irrationality, laziness, and criminality.

By definition, pain patients and opioid users both have lost an element of their claim to independence. They inhabit a position of undeniable dependence, relying on medical systems, family support, and/or social welfare. For opioid users, this negative evaluation is compounded by their dependence upon a drug associated with highly undesirable subjects (e.g., overdose, erosion of free-will, loss of moral reasoning, crime, and poverty). Yet, in both cases, to the extent their dependency can be named blameless, and so long as its costs remain acceptable to the giver, the subject of chronic pain maintains some appeal to positive regard as an object of sympathy and charitable reward.

Patients are positioned as someone who must prove their capacity, or at least their attempt, to fulfill the social expectations of the idealized subjects. Illegitimate users, on the other hand, have no real means of aligning with these idealized subjects because, by definition, they are the embodiment of the problematized subject—the irrationally dependent, willful agent of their own destruction whose behavior harms more deserving others. The greater the denigration of the addict position, the less influence is accorded to those who have been identified as addicts, and the less credence is given to their protestations. It becomes easy to dismiss the claims of those who are defined by their self-serving manipulations and criminogenic immorality.

When addiction or overdose are identified as inevitable, or as being of greater concern than unmitigated pain, any advocate of continued use becomes suspect. Who would willingly argue for continued use of a dangerous substance, except people who are addicted to it? If addiction is inevitable it becomes easier to dismiss the voice of people who claim their lives are better for the aid of opioids. Medical patients (legitimate users) become drug abusers (illegitimate users) in all cases. Illegitimate users are a problem in need of elimination. Thus opioid using patients must defend the legitimacy of their position. Such a defense is successful only to the extent that the listener assumes the truth of their assertions and for this they must be deemed credible.

Suggestions for Future Studies

At the outset of this undertaking, I perceived the problems related to chronic pain management to be “multifactorial, and infinitely complex.” Yet for all, I was still narrowly focused on the position of pain patients in medicalized discourses. This was clear by the quote I selected to open the literature review: “Relations between pain patients and health care deliverers are considered the worst in medicine” (Jackson, 2005, p. 338). Indeed, this should be far from surprising. Pain patients and providers are caught at the intersection of discourses on pain, opioids, addiction, criminality, and medicine. There can be nothing easy about obtaining harmony in a relationship characterized by the conflicting agendas these subjects must necessarily evoke.

Moral analyses. The identities of pain patient, opioid user, and drug abuser are thus entangled in a nexus of medico-moral discourses centrally concerned with distinguishing right perception and action from the wrong. Use of opioids is deemed to be either legitimate or illegitimate, making it necessary to sort people by their purpose and motivation in needing, seeking, using, and or rejecting opioids. The provider, on the other hand, has been tasked with the dual role obligations of offering medical care to the legitimate patient and repudiating the illegitimate seeker.

For the patient-identified subject, aligning with the legitimate position is the only means of retaining some degree of dignity, respect, and influence. As a medical patient, a person becomes a moral object of palliative care discourses. They may become the recipient of palliative measures but only at the behest of the HCP who is ethically charged with selecting the appropriate treatment in every circumstance. Yet medical treatment for opioid seekers is mutually exclusive dependent upon whether one is identified as a person in need of opioid access or withdrawal—i.e., whether one is a patient of pain care or addiction care.

Whether they are a pain patient, brain disordered patient, or a patient of addiction medicine, as long as they are identified as a patient, they have some claim to influence over those who may regard them with some, albeit varying degree of, sympathy. Of course these different categories of patient do not enjoy the same rewards of status, choice, or even preservations of dignity. Yet where the legitimacy of their patient-hood is revoked, so too is the subject's status as a medical object and any residual credibility for medical palliation, including the use of opioid substances.

In a world of finite resources, and/or restrictive allocation, it is a clear fact of life that conflicts of interest must be settled. Within medical discourses of patient care and opioid use, not everyone or everything can serve the position of suffering object for the palliative provider. Like it or not, utilitarian decisions must be made for the simple fact that some claims are in direct opposition one to another. We are sometimes forced by exigencies to choose one at the expense of the other. Ultimately this is the existential situation underlying the scientific use of animals: For some to live others must die. To be compassionate may be viewed as *good* but some subjects (ailing humans; legitimate patients) are seen to deserve a greater share than others (research animals; the humans addicted to drugs; or malingering; or criminally motivated).

The same person can be named addict or pain patient. The considered medical treatment for the former is opioid restriction while for the latter—regimented opioid consumption. Yet, the restriction of opioids can be a utilitarian decision as well as a medical one. Addiction is costly, in terms of health care costs, family and individual distress, and criminal justice involvement. Criminal involvement is costly not only in terms of incarceration expenditures but also in terms of the ripple effect of victimizing assaults, robberies, and neglect that are associated with opioid addiction.

Life with chronic pain is also costly, in terms of health care costs, family and individual distress. There are people living with chronic pain who report finding an increased capacity to participate in life activities with the use of opioid medications, with mitigating effects on subjective distress. But if they are described as human garbage, or even pitiable victims of drug addiction, they will not receive the care of the pain patient but rather the treatment reserved for the identified addict. If people develop an addiction to the medication used to palliate their pain, they will be subjected to the derision reserved for the drug addicted. Rejecting this categorization may be as much about maintaining access to respect and dignity as it is to retaining access to prescribed opioid substances. Depending upon how they are categorized, people may be left without pain care, compassion, respect or dignity.

It is for this very reason, for the sheer gravity of potential consequences, that I argue the necessity of applying a moral lens to the analysis of conditional subject positions and predicating arguments within our discourses. Decisions of such magnitude should *not* be based on tacit assumptions (about patient legitimacy) or the vague impressions left by widely used but poorly defined jargonese (e.g., chronic non-cancer pain). Rather, examination of the underlying assumptions *and* potential consequences of our discursive formulations must be incorporated into educational programs and anti-stigma advocacy efforts if we are to avoid reification of existing strategies of marginalization facing pain patients *and* addicted persons alike.

Continuous opioid therapy: Studies of effects and outcomes. Concepts like Chronic non-cancer pain as much as the idea of the legitimate patient should be the subject of both scientific and discursive analysis. Their assumed truth value needs to be questioned both from an epistemological standpoint and from the pragmatic analysis of how they effect and are affected by social behaviors. As a population, CNCP patients should be subdivided in research programs according to more explicit inclusion criteria to address potential confounds for explaining the meaning of findings of statistical analyses.

If it was a population of established empirical validity at some point in history, that point should be referenced in more recent publications to aid modern readers in interpreting the significance of COT research.

The use of opioids for chronic pain management deserves real assessment, with clearly delineated inclusion criteria. Policies are being set based upon an urgent need to reduce overdose deaths, but they are not built on ample evidentiary claims of problematic or ineffective use. In fact, it is an admitted dearth of empirical information regarding the efficacy of COT alongside a surfeit of overdose statistics that make wholesale restriction of opioid prescribing not only logical but an ethical imperative.

In explaining recent CDC guidelines preferencing non-opioid treatments for chronic pain, the limitations of evidentiary analysis were described thus, “Meta-analysis was not attempted due to the limited number of studies, variability in study designs and clinical heterogeneity, and methodological shortcomings of studies” (Dowell et al., 2016, abstract). This is an unacceptable—not to mention mysterious—state of affairs given both the stakes for patient lives and company profits.

Opioid using pain patients should receive greater attention in the pain care literature. Their claims of safe and efficacious use of opioids with and without dosage escalation should be taken seriously by medical researchers and practitioners. To validate or discredit these claims through empirical research can only benefit patients and providers in making informed treatment decisions related to long-term palliative pain management. There may yet be sound reasons that some patients have claimed COT facilitates continued productivity or improved quality of life through mitigation of pain related suffering. Understanding what these reasons might be can inform decisions related to targeted interventions for individual care seekers.

The voices of people living with pain who do not seek medical intervention are strikingly absent from the discourse of chronic pain and patient care. Yet they existed in the commentary, albeit as a minority. This is a population that may be hard to research because they do not rise to the attention of providers, advocates, or researchers. It is an open question whether their choices to forego medical services are a result of their own attitudes toward pain or an outgrowth of social attitudes about people who seek pain care. Similarities and differences in the experiences of those who seek care and those who do not may be informative for anti-stigma work as well as identification of potentially useful interventions for care seeking patients.

Professional roles, attitudes, and needs. Healthcare professional's (HCP) have been tasked with identifying appropriate interventions within the economic means of their patients. They have also been tasked with acting as gatekeepers, sorting the legitimate from the illegitimate care seekers. With a dearth of studies as identified above, this task must be accomplished with little by way of empirical guidance. Moreover, few contemporary studies have directly examined HCP attitudes about chronic pain patients and opioid prescribing. More frequently HCP attitudes are inferred from the studies of patient experiences of care seeking. This is an unhelpful situation for clinical educators, practitioners, and patients alike.

For these reasons, it would seem imperative to conduct research exploring HCP's needs and attitudes. Such a research program may help to determine what the HCP would find helpful in carrying out their task of gatekeeping opioids, and identifying appropriate interventions. These results can then be used in developing provider education materials and inform more targeted research into patients' medical needs. Such research may also be used to inform patient advocacy work toward stigma reduction.

Stigma in chronic pain and addiction. Future studies of stigma in pain care, and addiction medicine, may find value in exploring the correlation between dominant ideological values and attitudes toward specified groups associated with pain, opioid use, and addiction. In conducting this analysis, I was led to the question of whether high valuation of independence/self-sufficiency would correlate with increasingly negative attitudes toward people identified with the pain patient and/or label. It also occurred to me to ask whether such values predicted the likelihood of ascribing devalued motivations for care-seeking behavior among people complaining of pain.

Development of attitudinal measures for patients, providers, and general population respondents may be another fruitful avenue of study. This could explore the question of whether high valuation of individual responsibility may correlate with increased negative evaluations of identified addicts. Is the assumption of victimhood a moderator of ascriptions of blame when determining whether pain patients and addicts are deemed deserving of different outcomes?

Are stigmatizing attitudes toward people with pain affected by assumptions of uniformity amongst pain sufferers? Is this potentially changed if diagnostic, etiological and prognostic distinctions are provided? What bearing does this have on attitudes toward those whose pain is deemed unexplained or ascribed to controversial syndromes? Questions such as these may be answered with the use of vignette studies, the results of which may inform pain management education. They may also inform educational efforts targeting the provision of psychological services to people with history of chronic pain.

Psychotherapy with stigmatized patient populations. While stigma and anti-stigma efforts receive a great deal of attention in psychological research, the role of therapists in working with people who live stigmatized identities does not. Therapists will undoubtedly encounter people touched by the stigma of chronic pain or opioid use. Regardless of whether this occurs in the context of providing pain management care, chemical dependency treatment, or merely serving clients in other contexts who have these histories. Studies have indicated that stigma has a negative impact on health and well-being (Allison, 1998; Quinn & Chaudoir, 2009). Moreover, ascriptions of deservingness can result in negative evaluations of ones' self (Callan et al., 2014). From the perspective of therapeutic work with stigmatized populations, there appears to be little information for therapists and advocates.

The questions not being asked are myriad. How can therapists benefit people whose interpersonal world is significantly impacted by stigma? How do they refrain from reinforcing instances of felt stigma in their interactions with stigmatized patients? What are the needs of patients whose psychological existences is punctuated not only by the experience of physical distress but also the denial of material explanations for their pain? How can therapist support the well-being of patients whose stigmatized identity carries with it ascriptions of extreme denigration, e.g., the opioid addict?

These are questions in dire need of examination because the reality of our social lives entails stigma. In every society, some forms of action, physicality, or accident of birth are celebrated while others are maligned (Goffman, 1963). This is inescapable, whether or not activists want to acknowledge the futility of their valiant endeavor to de-stigmatize their chosen target. If anti-stigma work is taken seriously, advocates must be careful not to transfer negative attitudes from one marginalized group to another, as seems to be the case with setting the legitimate pain patient against the drug abusing person. To contribute to the marginalization and denigration of one group for the perceived benefit of another is to perpetuate a culture of discrimination and oppression that benefits no one.

Concluding Remarks

Negative stereotypes about people with chronic pain pose a barrier in the delivery of care; contribute to worsening symptoms of physical and psychological distress; and play a role in policy decisions that adversely affect patients and providers. People with pain experience this stigma through accusations of malingering, laziness, mental aberration, attention seeking, and drug seeking. These attitudes are propagated through discourse in obvious and non-obvious ways that can defy well-intentioned change efforts.

Assumptions of choice and agency were associated with ascriptions of blame and deservingness. Assignments of blameworthiness were used to distinguish the legitimate pain patient from the illegitimate care seeker. Motivation for seeking pain care as much as the effects experienced by the user provided crucial determinants in evaluating legitimacy claims and blame ascriptions.

Evaluations of deservingness were predicated on the valence of social regard. Compassion, empathy, respect and influence were the rewards of positive social regard. Proposals for resolving perceived conflicts of interests between groups were predicated by one or more pragmatic, utilitarian, objectivist, or chivalrous moral arguments. In medicalized discourses, ontological materialism along with empiricist epistemologies were applied in support of untested truth claims.

The disease entity model of chronic pain and the population category of chronic non-cancer pain were both offered as taken-for-granted realities with little attention to confounding variables in research design. Particularly in light of the potential impact these medical and social frames on the lives of people and animals, these confounds cannot be left as they are—implicit and unquestioned. There is a critical need for moral, logical, and empirical analysis of predicating factors in care giving decisions for both people identified with pain and/or addiction.

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Appendix A

List of Abbreviations

Appendix A

List of Abbreviations

CNCP	Chronic Non-cancer pain
COT	Continuous Opioid Therapy
CPC	Chronic Pain Condition
HCP	Health Care Professionals
IASP	International Association for the Study of Pain
IOM	Institute of Medicine
WHO	World Health Organization

Appendix B

Seattle Times Source Material

Appendix B

Reference List of Copyrighted Source Material

Berens, M., & Armstrong, K. (2011a, December 10). State pushes prescription painkiller methadone, saving millions but costing lives. *The Seattle Times.* Retrieved from http://seattletimes.com

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