

Negotiating (dis)ability:

Challenges in patient– practitioner interaction in the context of chronic pain rehabilitation

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Baukje Stinesen, Dr. Petra Sneijder & Prof. dr. Rob Smeets



Chronic pain rehabilitation

- Helping patients to increase their functioning, despite being in pain
- Regain control over their lives and cope with their pain more actively and resiliently
- Biopsychosocial approach/
interdisciplinary approach



Challenges in patient-practitioner interaction

(Pr)

Exploring social and psychological factors,
increasing the patient's functioning



(Pa)

Receiving a clear biomedical explanation,
treatment aimed at pain relief



Research aim

To explore how the patient's health situation, and particularly the patient's disabilities, are constructed and negotiated in interaction by patients with chronic pain and their practitioners

Theoretical & analytical framework

- (Critical) disability studies: A growing concern for the role of discourse (Goodley 2019)

“What is understood or accepted to be a ‘disability’ is socially and culturally located and constructed via discourse” (Lupton & Seymour, 2003).

- Discursive psychology (Potter, 1998, Edwards & Potter, 2005)
 - ✓ Talk as social practice → social action
 - ✓ Mind-world relations → mind-*body* relations
 - ✓ ‘Discursive bodies’ (Wiggins, 2014): how (the features, functions and limits of) people’s material bodies are produced in interaction to achieve particular interactional goals



Pain-related disability as being constructed and managed in interaction

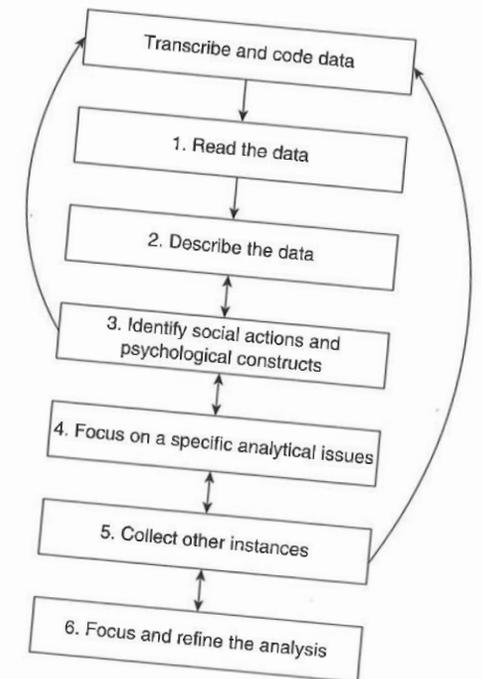
Methods

Data

- Audio recordings of 9 admission interviews to chronic pain rehabilitation (7,5 hours)
- Participants: 9 patients with chronic (musculoskeletal) pain, 6 practitioners (written informed consent)
- Approval by accredited research ethics committee

Procedures

- Transcription: Full corpus at word-level accuracy, relevant sections according to Jefferson's methods (Jefferson, 2004)
- Analysis according to the analytical and validating procedures for discursive psychological research (Wiggins, 2017; Wiggins & Potter, 2017)



(Wiggins, 2017)

Analysis

Willing but unable

1. Pr: (a) and if you then have that so ba:dly,
 2. (0.2)
 3. what can you then do about it to make it less,=
 4. have you got an idea about that yourself,
 5. Pa: .hh yes hh
 6. (1.3)
 7. °I° (.) I'll always try not to
 8. call in sick unless there is no other way,
 9. Pr: hmhm
 6. Pa: if it is ↑this bad that I cannot walk,
 7. (1.0)
 8. then I cannot walk ↑and then I am forced to-
 9. (1.7)
 10. and then it depends on how much pain I have
 11. (0.7)
 12. or else I just lie down in bed.

- Disposition-implicative descriptions reinforce patients' willingness of mind
- Patients construct their inability to perform certain actions as factual and as consequential to their pain
- Patients construct themselves as having limited control
- Patients present adjusting their behaviour as an inevitable outcome of their pain

Potentially unfavourable inferences (malingering, exploiting his health situation) are being countered

Willing but unable

Body/mind distinctions as an interactional resource for building up the **authenticity** of the patient's pain and disabilities



Practitioners' challenges to the self-evidence of a patient's disability

- Practitioners do not always take patients' body-oriented accounts for granted
- They may undermine the inevitability of the patient's adjusted behaviour:
 1. They construct the patients' behaviour as insufficiently accounted for
 2. They propose treatment directions that imply that patients could – despite being in pain – become more active
- Such actions are at odds with patients' interactional efforts to present themselves as willing but unable
- Practitioners orient to these actions as **delicate**

Proposing to become more active

Hedging, pauses repairs and hesitations mark the practitioner's talk as delicate

Both willingness and limited ability/control are made relevant in response

1. Pr: e:hm (0.8) suppose that we would say to you
2. ehm (2.4) pai- 'r eh ↑well ↓moving does no harm?
3. (1.5)
4. just [go do it.]
5. Pa: [hmhm.
6. Pr: what would that-,
7. what would then (0.8) ↓happen what eh
8. Pa: then I would eh yes (d) in any case=eh,
9. as ↑far as possible e::h, =°yes°.
10. Pr: hmhm,
11. (1.3)
12. Pa: (say) that's what I try to do no:w.
13. do keep try to anyhow (.)
14. ↑yes every time e:h to anyhow ↑push the limit

The inference that the patient could just start moving is being countered

Conclusion & Discussion

- Patients' pain-related disability is being negotiated in interaction (rather than static, separate from discourse, ► Lupton & Seymour, 2003)
- The authenticity of chronic pain and pain-related disability is oriented to as delicate, by both patients and practitioners (► Ong, Hooper, Dunn, & Croft, 2004; Snelgrove & Lioffi, 2009)
- By drawing on certain aspects of their character (reinforcing their willingness), patients also manage their *personal accountability* for their health situation (► Horton-Salway, 2001, talk about CFS):
 - Patients' moral identity as sufferers from a condition that is difficult to explain on the basis of biomedical evidence seems to be at stake
- Insights in interactional dilemma's can help practitioners to reflect on their communication practices

Thank you for your attention

baukje.stinesen@hu.nl

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