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## PAIN AS A MULTIDIMENSIONAL EXPERIENCE: FROM BODY AND MIND TO SOCIETY<sup>1</sup>

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### Abstract

This study argues that pain should be understood not only as a physiological or psychological phenomenon but as a multidimensional experience encompassing the social dimension. The aim of the research is to comparatively analyze objective, subjective, and social approaches to the definition of pain, contributing to a more inclusive conceptualization. The study was conducted through literature review, analyzing philosophical texts, medical studies, sociological insights, and contemporary definitions. Data were evaluated using descriptive analysis, with a particular focus on critiques of the International Association for the Study of Pain (IASP) definition. The main finding reveals that current

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objective definitions center primarily on the biological aspects of pain, overlooking its psychological, ethical, and social dimensions. The research demonstrates that pain cannot be properly evaluated when subjective expressions and social contexts are ignored. In conclusion, the paper advocates for the development of comprehensive approaches that recognize the multidimensional nature of pain and its entanglement with individual experience and societal structures.

**Keywords:** Definition of Pain, Political Philosophy, Sociology of the Body, Ethics, Social Pain.

## **Çok Boyutlu Bir Deneyim Olarak Acı: Beden ve Zihinden Toplumsal Yaklaşım**

### **Öz**

Bu çalışma, acının yalnızca fizyolojik bir deneyim olarak ele alınmasının yetersiz olduğunu, onun aynı zamanda öznel ve sosyal bir olgu olarak da değerlendirilmesi gerektiğini savunmaktadır. Araştırmanın temel amacı, acının tanımlanmasına yönelik objektif, subjektif ve sosyal yaklaşımları karşılaştırmalı biçimde analiz ederek daha bütüncül, kapsayıcı ve adil bir anlayış geliştirmektir. Literatür taraması yöntemiyle yürütülen çalışmada felsefi metinler, tıbbi araştırmalar, sosyolojik incelemeler ve güncel tanımlar temel alınarak kavramsal bir analiz gerçekleştirilmiştir. Veriler betimsel analiz yoluyla değerlendirilmiş; Uluslararası Acı Araştırmaları Derneğinin (IASP) tanımı ve bu tanıma yöneltilen eleştiriler ayrıntılı biçimde incelenmiştir. Bulgular, mevcut objektif tanımların acının yalnızca biyolojik yönünü merkeze aldığını, bu nedenle de bireyin yaşadığı acının psikolojik, etik ve toplumsal boyutlarını dışladığını ortaya koymaktadır. Oysaki acı, yalnızca ölçülebilir fiziksel belirtilerle sınırlı değildir; aynı zamanda bireyin duygusal durumu, toplumsal konumu, kültürel geçmişi ve yaşadığı çevresel koşullar tarafından da şekillenir. Bu nedenle, yalnızca biyomedikal verilere dayalı tanımlar, özellikle çocuklar, yaşlılar, engelliler ya da marjinal topluluklar gibi kırılgan grupların acısını görünmez kılabilir. Çalışma, acının doğru ve etik bir biçimde değerlendirilmesi için öznel beyanların ve toplumsal bağlamların mutlaka hesaba katılması gerektiğini vurgulamakta;

bireysel deneyim ile toplumsal yapılar arasındaki ilişkiyi kuran çok boyutlu ve disiplinlerarası yaklaşımların geliştirilmesini önermektedir.

**Anahtar Kelimeler:** Acı Tanımı, Siyaset Felsefesi, Beden Sosyolojisi, Etik, Toplumsal Acı.

## INTRODUCTION

Pain is one of the most universal, yet least understood aspect of human life. Despite its universality, a final, clear and comprehensive definition of it has not yet been established. The objective definition of pain, which is dominant in the biomedical fields, generally treats pain as a sensory experience, a physical condition associated with tissue damage, prioritizing what can be observed, measured, and classified. Even though this approach ensures diagnostic consistency, it largely excludes painful experiences that lack visible physiological markers, experiences that are shaped by psychological and social effects. Psychological theories on the other hand emphasize lived experiences, but this time the subjective nature of pain challenges standardization. However, recent interdisciplinary research has shown that social exclusion, discrimination, and structural inequality activate neural pathways similar to physical pain, expanding the field towards “social pain”. Yet this dimension remains underrepresented in both theory and clinical practice as it has become increasingly visible in the fields of medical sociology, cultural anthropology and social psychology particularly in the last couple decades. Pain cannot be defined as a merely a biological sensation. It is a relational experience shaped by social norms, cultural codes, social roles, and institutions (Bendelow & Williams, 1995). It is determined by social categories, specifically, gender, class, and disability, that extend beyond the body (Jackson, 2011). The ways in which pain is expressed and recognized vary according to interpersonal and cultural contexts (Craig & Fashler, 2014). Despite this, existing studies demonstrate that physical pain is socially expressed, interpreted, and legitimized through cultural and interpersonal contexts (Bendelow & Williams, 1995; Jackson, 2011a);

while social pain, produced by structural mechanisms such as exclusion, discrimination, and stigma, is often considered a secondary phenomenon. As a theoretical analysis, this article bridges these two literatures by arguing that the same social mechanisms that shape the meaning of physical pain can also generate a distinct form of suffering: social pain. Thus, the social dimension is not merely an influence on physical pain but an independent definitional category that must be incorporated into the conceptualization of pain. Taking a critical approach to this limited nature of the current dominant definitions, this article argues that a more comprehensive and multidimensional framework that includes social pain as a constitutive element of the concept, asking the main question of how can pain be defined comprehensively in a way that incorporates its objective, subjective, and social dimensions? The originality of this study lies in the integrating social pain into definitional debates, traditionally dominated by biomedical and lately psychological paradigms. This article posits that social pain as a fundamental dimension, distinguishing it from existing literature that regards it merely as an emotional correlate, thereby altering the understanding, recognition, and management of pain. The following sections will examine pain across objective, subjective and social dimensions, providing both their strengths and limitations and will argue for a multidimensional definition of pain that encompasses social dimension.

## **OBJECTIVE DEFINITION OF PAIN**

Biomedical approach has long dominated pain studies. Within this approach, pain is defined in relation to tissue damage, measurable biological responses, and standard diagnostic categories. Focusing mainly on objectivity, this approach seeks to transcend individual variation and ensure a common, reproducible understanding that is crucial for diagnosis, treatment, and healthcare communication (Podsakoff, MacKenzie, & Podsakoff, 2016).

The objective approach relies on empirical data and shared frameworks, classifies pain by duration, origin, or sensation, underpinning evidence-based medicine and interdisciplinary collaboration, offering clarity and consistency in research and practice (Wager et al., 2013; Turk & Melzack, 2011, pp. 3–19; Dworkin et al., 2005).

While objectivity is vital for treatment and knowledge-sharing, it cannot fully encompass pain's multidimensional nature. It cannot account for the pain without injury, chronic pain that persist independent of nociception, the influence of emotion, memory, and expectation, sociocultural variations in pain expression and systemic biases affecting whose pain are believed. Moreover, biomedical definitions largely remain individualistic and do not address how gender, age, race, disability, or poverty, that would shape the perception and recognition of pain and access to treatment.

### **IASP Definition of Pain**

The most widely accepted clinical definition of pain is that of the International Association for the Study of Pain (IASP), which was introduced in 1979 first: "An unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage", and revised in 2020: "An unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage" (IASP Task Force on Taxonomy, 1994, p. 210). First definition became a global standard for healthcare and research, endorsed by institutions like the World Health Organization (IASP Task Force on Taxonomy, pp. 209–214; Morris, 1991, pp. 31–56), and later tried to reflect the multifaceted nature of pain and includes cases without physical injury. Still, it remains controversial.

Critics argue that the definition inadequately accounts for mind-body interactions (Morris, 1991, pp. 152–173). Rooted in Cartesian dualism (Descartes, 1989, 1996), the separation of body and mind fails to capture pain's emotional and cognitive dimensions (Johnson, 1987; Leder, 1984,

pp. 255–266). Pain is more than a physical signal; it involves psychological and experiential layers often absent in this framework. It also overlooks pain without visible tissue damage—such as neuropathic or chronic pain—which can be more severe than minor injuries like paper cuts (Wright, 2011; Williams & Craig, 2016, pp. 2420–2423; Melzack, 1973, pp. 59–67; Olivier, 2008, pp. 59–67).

Another concern is the lack of inclusivity. Populations like the elderly, infants, and people with disabilities are not clearly addressed (Bodfish et al., 2006, pp. 398–403; Anand, 2017, pp. 1438–1444; Stevens, 2021). A more inclusive definition would better reflect differences across age, ability, and developmental stages.

Furthermore, the IASP definition neglects the social, ethical, and cultural aspects of pain (Anand & Craig, 1996, pp. 3–6; Williams & Craig, 2016, pp. 2420–2423; Skevington & Mason, 2012, pp. 78–100; Peacock & Patel, 2008, pp. 6–9). Pain management involves moral choices—especially in healthcare, yet these are absent from the definition (Anand et al., 1999, pp. 64–73; Cunningham, 1999, pp. 93–99; Sullivan, 2001, pp. 205–207; Ferrell et al., 2001, pp. 30–36; Carvalho et al., 2018, pp. 205–211; Morris, 1991, pp. 174–197).

Ultimately, the IASP’s definition, while foundational and widely accepted; reflects a biomedical, individualistic model that underrepresents pain’s relational, structural, and social dimensions. Therefore, there is a need to move beyond it to fully understand the complex nature of pain, encompassing both subjective and collective approaches.

### **Physiological Approach**

Understanding pain through a physiological lens within biomedicine has been central to discuss pain as an objective phenomenon. After all, pain has always been there for human beings, it is often approached as a universal biological condition (Dekkers, 2017), and shared not only

among humans but also across all other animal species. Its alleviation remains a fundamental task of medicine (Collier, J., 2018, pp. 43-52; Meldrum, 2003; Rey, 1998, pp. 177-185, Cassell, 1998), and a duty for physicians to treat it (Cassell, 1998).

Two primary theories—specificity theory and pattern theory—shaped early biomedical perspectives. Descartes' specificity theory conceptualized pain as a distinct sense transmitted via dedicated pathways, while pattern theory emphasized pain as an interpretive response to stimulus patterns, linking it to cognition and emotion (Cervero, 2009, pp. 15–35; Rey, pp. 95–105; Noordenbos, 1959). These were expanded by gate control theory, which proposed that spinal mechanisms modulate pain signals before reaching the brain (Melzack & Wall, 1973). Melzack later developed the neuromatrix theory, emphasizing the brain's role in generating pain independently of peripheral input (Melzack, 1996). Integrating these ideas, Loeser (2000) and Melzack (1999) proposed a biopsychosocial model recognizing nociception, perception, suffering, and behavior as interconnected components. These models advanced understanding but also highlighted challenges in measuring and managing pain. Classification plays a key role in treatment, distinguishing nociceptive (e.g., from injury), neuropathic (e.g., diabetic neuropathy), somatic (sharp, localized), visceral (diffuse, organ-related), and complex types like cancer pain (Woessner, 2006, pp. 219–223; Ahles et al., 1983; Cervero, 1999; Goldberg & McGee, 2011). While classifications offer clinical utility, they do not eliminate subjectivity. Pain remains shaped by perception, language, and context (Scarry, 1985, pp. 3–30; Melzack & Torgerson, 1971, pp. 50–59), reminding that even in its most physiological form, pain is never fully separable from its psychological and social dimensions.

Importantly, pain's evolutionary function as a warning mechanism should not be overlooked. Discussions on the definition of pain surrounds the "usefulness of pain" within the broader context of health issues, institutional problems, methods of medicine, and understandings of healthy and ill (Rey, 1998, pp. 18-30). A child who touches a hot stove

learns through pain to avoid harmful stimuli, illustrating pain's adaptive and educational role in survival and behaviour regulation (Fine, 1993, pp. 3–15). In this sense, pain is not only a biological sensation but also a vital component of an individual's development and a mechanism for preventing future harm (Aldrich & Eccleston, 2000). It often serves as a warning sign, an educator, an imperative alerting individual to potential threats or issues within the body prompting individuals to seek medical attention, leading to the diagnosis and treatment of underlying health condition (Klein, 2007, pp. 55-67; Hall, 2008, pp. 595-610).

Pain, therefore, has a clear physiological basis. Medical science has advanced our understanding of it as a biological signal and complex sensory experience. However, challenges in measuring and treating pain reveal the limits of a purely biomedical view. Even physical pain is shaped by perception, language, and context, and has a role in perceiving the world around us, learning what to do, and acting upon it. Then, while the physiological model is vital, it is not enough. Pain must be understood as a multidimensional phenomenon that also involves psychological and social dimensions.

### **Strengths and Limitations of Objective Pain**

While the physiological model of pain offers a scientifically grounded and clinically practical framework, it faces conceptual and ethical challenges. This section explores the strengths of objective definitions, especially in standardizing diagnosis and treatment, while highlighting their limitations in capturing the full complexity of pain.

The IASP definition serves as a clinical standard. By recognizing "experiences resembling that associated with tissue damage," it legitimizes chronic, idiopathic, and neuropathic pain even without visible injury, facilitating recognition and appropriate care (Aydede, 2019). Objectivity enables consistency in treatment and communication, supporting tools and diagnostics that guide effective interventions. Pain,

understood as a biological signal, prompts care-seeking and targeted therapy.

However, the IASP definition still rests on a dualistic, individualistic framework that abstracts pain from its personal and collective contexts (Aydede, 2019). This limits the understanding of pain's broader causes. Physiological models cannot explain all types of pain, such as phantom limb or neuropathic pain without clear injury (Wilgen & Keizer, 2012), and sometimes overlook functional or positively interpreted pain (Bain, 2011). Language, culture, and memory also shape how pain is expressed and perceived (Scarry, 1985, pp. 3–30), yet this definition does not account for them.

Pain responses vary widely depending on psychological state, trauma history, and cultural background (Melzack & Torgerson, 1971; Scarry, 1985), complicating objective assessment and risking misdiagnosis when physiology is the sole criterion. Marginalized groups often face under-recognition of pain, with gender and racial biases affecting care (Jackson, 2011a, 2011b; Bendelow, 1993). These disparities reveal how institutional and cultural biases shape medical judgment. Pain also communicates need, protest, or vulnerability, but the biomedical model treats it as a private symptom to suppress. This ignores pain's relational and ethical dimensions, particularly in socially excluded contexts (Craig & Fashler, 2014; Anand & Craig, 1996). Addressing such pain requires ethical and social engagement, not only clinical solutions.

Limitations necessitate moving beyond objective approach to consider how pain is felt and communicated. While objective models remain essential, they must be complemented by interpretive, patient-centered, and culturally responsive approaches. A pluralistic, reflexive framework is necessary to validate pain beyond what can be measured and to ensure pain is understood and addressed justly.

## **SUBJECTIVE DEFINITION OF PAIN**

While medicine often treats pain as a measurable physiological signal, psychological approach highlights its subjective nature, focusing mainly on pain as a lived, phenomenal experience, uniquely felt, interpreted, and expressed by each person. This perspective shifts attention from what pain is to how it feels, how it's communicated, and how it's shaped by personal context.

Defining subjective pain is difficult because it defies external validation. As Scarry (1985, pp. 3–4) argues, pain is “unsharable,” a deeply internal experience. Individuals struggle to convey it in language, which often proves inadequate. Biro (2010, pp. x–10) describes this as a cognitive and linguistic gap that frustrates both sufferers and caregivers. Yet, the subjective model offers crucial insights by affirming that pain is shaped by personal psychology, cultural background, and past experience. Tesarz et al. (2012, pp. 636–638) show that emotional and cultural factors influence how pain is perceived. McCaffery (1968, p. 95) famously stated, “pain is whatever the experiencing person says it is.” Language, memory, and expectation shape pain narratives, while nonverbal cues like facial expressions also reveal suffering (Kunz et al., 2020, pp. 2062–2064). These aspects emphasize the relational and communicative nature of pain.

Though empathy may arise in witnessing pain, it remains deeply individual and hard to share (Kono, 2023, pp. 57–60). It is influenced by a complex web of biological, psychological, cultural, and environmental factors (Bueno-Gomez, 2017, pp. 5–7; Geniusas, 2020, pp. 251–255), as well as social identity markers like class, gender, and ethnicity (Jackson, 2011a, pp. 360–364). Psychological pain can rival physical injury, persisting even after the body heals. This underscores both the value and the challenge of the subjective model: it broadens understanding, highlighting personal interpretation, emotional and cognitive components, and pain's relation with memory, expectations, and cultural scripts but resists clinical standardization.

### **Psychological Approach**

The psychological approach to pain offers vital insights into how cognitive, emotional, and behavioral factors shape the experience of suffering. Rather than treating pain solely as a physiological response or subjective report, this perspective emphasizes how mental processes mediate, amplify, or diminish pain. Rooted in fields such as health psychology, cognitive neuroscience, and behavioral medicine, this approach bridges the divide between biology and lived experience.

A foundational contribution to psychological pain theory is Melzack and Wall's (1965) gate control theory, which challenged the linear link between injury and pain by proposing that the spinal cord modulates pain signals based on psychological factors like mood, attention, and experience. This explained why similar injuries result in different pain experiences. Subsequent research highlighted the role of interpretation and emotional regulation: catastrophizing increases pain intensity and disability (Sullivan et al., 2001), while coping strategies like mindfulness and reappraisal can reduce it (Garland et al., 2012).

Emotion plays a central role in the psychological experience of pain. Negative affect, including anxiety and depression, is closely correlated with increased pain reports. In chronic pain patients, psychological disorders often exacerbate suffering, creating a feedback loop where pain intensifies distress, and distress intensifies pain (Gatchel et al., 2007). This bidirectional relationship underscores the need for integrated treatment approaches that address both physical and emotional dimensions.

Furthermore, memory and anticipation shape pain responses. Studies have shown that individuals who recall painful experiences with heightened negativity are more likely to experience future pain more intensely. Similarly, fear of pain can lead to avoidance behaviours, social withdrawal, and increased disability, a pattern encapsulated in the fear-avoidance model (Vlaeyen & Linton, 2000).

Psychological research shows that traits and early experiences influence pain vulnerability. Trauma or insecure attachment can heighten threat

perception and amplify pain (Lumley et al., 2011), while high self-efficacy and secure attachment are linked to better pain tolerance and recovery.

The psychological framework has practical implications for diagnosis and treatment. Cognitive-behavioral therapy (CBT), for example, has been widely adopted as an effective intervention for managing chronic pain. It helps patients reframe maladaptive beliefs, regulate emotions, and develop healthier behavioral patterns (Turk et al., 2011). Similarly, acceptance and commitment therapy (ACT) and mindfulness-based stress reduction (MBSR) have gained traction as evidence-based strategies to promote psychological flexibility and reduce suffering (McCracken & Vowles, 2014).

Pain is also fundamentally intertwined with identity. Chronic pain can alter a person's self-concept, leading to feelings of helplessness, loss, and stigma. Patients may struggle to reconcile their current limitations with past identities, particularly if pain disrupts professional, familial, or social roles. This identity disruption is not merely psychological; it has existential dimensions that complicate recovery and adaptation (Eccleston et al., 2008).

Psychological approaches extend beyond individual therapy to shape healthcare systems and policy. Training clinicians to recognize psychological aspects of pain improves outcomes and reduces unnecessary interventions. Including psychological screening in assessments helps identify at-risk individuals early for more effective care.

Still, the model faces critique. It may individualize pain and downplay social determinants, implying that patients are responsible for their suffering. In neoliberal systems, this can obscure structural barriers to care (Bendelow, 2013). Psychological explanations may also be dismissed as "all in the head", especially in stigmatized conditions, undermining the legitimacy of pain.

Yet the psychological model is essential. It shows pain as a dynamic interaction between mind, body, and environment. By integrating it with

physiological and social insights, we approach a fuller understanding of pain. This integrative view advances both theory and care, promoting empathy and recognizing the diverse realities of suffering.

### **Strengths and Limits of Subjective Pain**

The subjective approach defines pain as a personal, emotional, and interpretive experience. Unlike the physiological model that seeks measurable indicators, this perspective sees pain as felt and narrated by context, culture, and language.

A core strength lies in valuing personal testimony. Without objective markers, the patient's report becomes central. Melzack and Torgerson (1971) highlight our reliance on metaphor, while Scarry (1985, pp. 3–30) notes pain resists language yet depends on it to be acknowledged. Terms like "burning" or "sharp" attempt to express something inherently private but are shaped by culture and memory. This approach challenges medical authority. Conditions like fibromyalgia or chronic fatigue syndrome, lacking visible signs, have struggled for legitimacy. The subjective model gives precedence to patient voice over diagnostics. Yet it has limits: reports vary by personality, emotion, and culture, complicating diagnosis and standardization. Doubt often falls on subjective claims, especially from marginalized groups, raising issues of credibility and bias.

Pain's privacy further complicates verification. If pain is wholly internal, how can it be fairly assessed or treated? While the model validates all expressions, it struggles with confirming authenticity when external signs are absent. Nevertheless, this model deepens our understanding. Pain becomes not just a symptom but a story—entwined with memory, emotion, identity, and trauma. Approaches like narrative medicine and trauma-informed care are grounded in these insights.

In sum, the subjective model redefines pain as a moral and relational phenomenon. Despite challenges in verification, in variability across individuals and cultures, in disbelieving those whose expressions diverge

from cultural norms, and in its potential for psychological reductionism: it fosters empathy, and centers care around lived experience, pushing back against the dominance of biomedical objectivity. Still, even though subjective framework enriches our understanding of pain, it cannot alone address social and structural aspects of pain. The shortcomings of both objective and subjective models reveal a missing dimension: the collective dimension: social pain.

### **THE MISSING DIMENSION: SOCIAL PAIN**

Despite advances in understanding pain's physiological and psychological dimensions, a crucial aspect remains underexplored: the social. Traditional definitions largely present pain as individual, internal, and private, whether medical or mental. Yet, recent studies show pain is shaped by context and connection; it is socially and culturally situated, embedded in relationships, identities, and structures (Sturgeon & Zautra, 2016, pp. 63–64; Schleifer, 2014, pp. 22–26). This growing field urges us to consider a missing dimension in dominant conceptions: social pain.

Defined in early research (MacDonald & Jensen-Campbell, 2011; MacDonald, Kingsbury, & Shaw, 2005), social pain refers to emotional distress caused by actual or potential social disconnection or cultural exclusion. It includes poverty, racism, gender inequality, political violence, stigmatization marginalization (Williams & Coveney, 2023), rejection, loss, loneliness, and events tied to identity and belonging, like the pain felt when a sports team loses (Eisenberger, 2015; Anderson & White, 2018, pp. 104–106; Klugman, 2009).

Pain is not only internal; it is relational and shaped by history and culture (Sessle, 2012, p. 3). A social pain framework shifts focus from bodily injury to fractured ties, community breakdown, and cultural displacement. Concepts like intercorporeality (Käll, 2013) reveal how pain is shared, witnessed, and intensified in collective spaces. Social pain does not oppose physical or psychological pain — it often compounds them.

Crucially, social pain often escapes medical or psychological recognition. There are no clinical tools for pain from exclusion, stigma, or cultural marginalization, yet such pain leaves lasting physiological and psychological effects. Individuals from disadvantaged groups consistently report that their pain is being underestimated, their pain testimonies are being doubted, and they have limited access to treatment (De Ruddere, 2021). This transforms pain into a political and ethical issue (Jackson, 2021; Thompson, 2022). Without a clear conceptual category encompassing these, pain is misclassified, medicalized incorrectly, or dismissed. This is not a call to medicate all social pain, such as the distress of being a minority, but a call to recognize and act upon it. Personal, social, and political responses are necessary. Without acknowledgment, intervention seems unnecessary, and the pain deepens.

This section will establish the need to integrate social pain into broader frameworks of understanding. As we move toward collectivist and structural perspectives, it becomes clear: to grasp pain fully, we must look beyond the body—into the social worlds where meaning, identity, and suffering are co-produced.

### **Collectivist and Structuralist Approach**

To fully understand social pain, it is necessary to move beyond the individual subject and adopt a collectivist and structural lens that sees pain as shaped, shared, and amplified through relational, historical, and institutional conditions (Cutter, 2017, pp. 78–105; 5, 2017, pp. 271–278). In this sense, pain becomes shareable through the concept of intercorporeality, which views bodies as inherently relational (Käll, 2013, pp. 23–38). Rather than denying the subjective authenticity of pain, this approach situates it within networks of power, identity, and culture that give it meaning (Rey, 1998, pp. 214–233).

Pain is shaped on both micro and macro levels. Micro-level elements, language, expressions, and interpersonal dynamics, highlight how social neuroscience explains pain communication. Macro-level factors like

culture, ethnicity, economics, and politics shape how pain is interpreted and managed through societal norms and institutions (Hadjistavropoulos et al., 2011, pp. 910–911, 920–925; Cleary, Husain, & Maurer, 2016, pp. 324–326). Cultural meanings of pain vary; in some traditions, it is seen as a spiritual trial or a source of growth, which can strengthen endurance by aligning with shared narratives (Rey, 1998, pp. 226–230). Thus, pain is personal but also culturally constructed.

Craig's (2018, pp. 41–58) social communication model of pain bridges psychological, biological, and social dimensions, showing how contexts influence not only expression but also treatment (Craig & Fashler, 2014, pp. 335–353). Empirical studies further emphasize cultural and individual variability in pain. Differences in focus, belief, and social environment affect how pain is perceived and reported (Blitz & Dinnerstein, 1971; Buss & Portnoy, 1967; Kanfer & Goldfoot, 1966; Leventhal et al., 1979; Sternbach & Tursky, 1965; Zborowski, 1952).

Structurally, pain is unequally distributed. Economic deprivation, political violence, racial injustice, and systemic neglect produce chronic social pain with no straightforward remedy. Pain in this context reflects not personal pathology but societal dysfunction. It becomes a symptom of broken systems (Morris, 2001, p. 27). For example, the pain of a mother caring for a sick child cannot be reduced to back pain alone—it is interwoven with caregiving duties, economic stress, and gendered expectations. This kind of pain eludes medical solutions and reveals the moral and political dimensions of suffering. Disabled people, racial minorities, and women often report untreated or disbelieved pain not due to lack of legitimacy, but due to social misrecognition (Siebers, 2010, pp. 74–76; Bendelow, 1993).

The collectivist view also foregrounds the reparative potential of social life. Just as pain can be socially inflicted, it can be socially alleviated. Support from friends, family, and communities can buffer distress and foster healing. Empathy and relational care positively affect both emotional and physical responses to pain (Thoits, 2011, pp. 145–146, 158–159). Research highlights the relationship between social identity and

mental well-being. Soldiers with strong army identification show lower depression levels (Sani et al., 2012, pp. 781–790), and similar patterns are observed in students connected to their schools (Bizumic et al., 2009, pp. 183–187; Brook, Garcia, & Fleming, 2008, pp. 1595–1597; Iyer et al., 2009, pp. 720–725). After collective traumas such as natural disasters, social belonging and trust are key to resilience (Kaniasty, 2012, pp. 27–30; Cruwys et al., 2015, pp. 219–223).

Conversely, social exclusion harms not only mental health but also physical well-being (MacDonald & Leary, 2005, pp. 204–215). Those living in isolation face increased risks of illness compared to those embedded in social networks (Argyle, 1987, pp. 113–118; Cacioppo, Hawkley, & Berntson, 2003, pp. 71–72; Kiecolt-Glaser et al., 1984, pp. 8–12; Lynch, 1979, pp. 87–94; Myers, 1992, pp. 126–130).

Social pain also serves an adaptive function. Just as physical pain protects the body, social pain—like exclusion, loneliness, or identity threat—signals harm to social integrity. Since humans are social beings, disruption in relational ties compromises both psychological and physical survival (Sturgeon & Zautra, 2016, pp. 64–66).

In sum, the collectivist and structuralist approach expand our understanding of pain beyond individual experience. It interprets pain not just as a biological response, but as a reflection of institutional, relational, and cultural dynamics. Through this lens, pain becomes a diagnostic tool for evaluating the health of social systems—and a moral call for collective care.

### **Discussion: The Necessity of an Integrated Understanding of Pain Encompassing Social Approach**

While the collectivist and structuralist approach enrich the understanding of suffering, social pain remains analytically elusive. Unlike physical or

psychological pain, it is diffuse, systemic in origin, and lacks standardized markers (Sturgeon & Zautra, 2016, pp. 64–67; Käll, 2013, pp. 510–514). Its source, either exclusion, structural violence, or internalized stigma, is often hard to isolate.

A key limitation is empirical verifiability. Although neural overlaps between physical and social pain exist, lived experiences are context-dependent and culturally variable (MacDonald & Leary, 2005, pp. 204–208). Lacking physiological indicators, social pain is difficult to diagnose or address institutionally, risking its dismissal as metaphor (Price, 2015, p. 270). Abstraction presents another challenge. Describing pain through social injustice may obscure individual suffering. While poverty or racism cause pain, its experience varies across individuals (Siebers, 2017, pp. 2–6, 35–42, 131–135; Bendelow, 1993, pp. 273–294), and generalizations risk flattening these differences (Rey, 1998, pp. 221–223; Morris, 2001, pp. 195–200).

The term “social pain” may lack emotional precision. For instance, calling a refugee’s isolation or an elderly person’s loneliness “social pain” captures only part of the experience unless embedded in narrative and context (Schleifer, 2014, pp. 45–46; Kaniasty, 2012). Yet despite these limits, the concept is essential. It exposes dimensions that biomedical models overlook, relational, historical, and institutional (Craig & Fashler, 2014; Cleary, Husain, & Maurer, 2016). It reminds us that exclusion causes harm, and belonging supports well-being (Baumeister & Leary, 1995; Bakan, 1968, pp. 37–39, 57–59). Social pain fosters interdisciplinary engagement across neuroscience, psychology, sociology, and public health, connecting private distress to public conditions and collective healing (Riva et al., 2014; Thoits, 2011). Though complex, it is ethically indispensable. It compels us to ask not just what hurts, but who is hurting, under what conditions, and why. Its ambiguities are not grounds for rejection but calls for deeper conceptual clarity and moral attention in understanding human suffering.

Therefore, a comprehensive definition of pain must integrate physiological signals, subjective interpretations, and social contexts. The

objective model ensures diagnostic precision, the subjective model captures phenomenological depth, and the social model reveals relational and structural determinants. The integration of these three is necessary because none of the models can stand alone as the physiology without subjectivity reduces people to biological machines, subjectivity without social contexts risks individualizing structural suffering, and social frameworks without physiological grounding risk conceptual vagueness. A comprehensive definition has implications for research and practice because it would lead healthcare to account for gendered, racialized, and classed experiences of pain, would lead politics to address inequalities that produce chronic social pain, and would lead mental health frameworks to incorporate social belonging as a fundamental need.

Arguing for a need for a comprehensive approach, this study offers such contributions of a tripartite model that conceptualizes pain as objective, subjective, and social; a reconceptualization of social pain as a definitional category, not merely an emotional correlate; a social-theoretical expansion of pain studies linking suffering to recognition, justice, and structural inequality; and a justice-oriented definitional framework that exposes how current biomedical models make certain forms of suffering invisible.

## CONCLUSION

Pain is not a fixed or isolated phenomenon; not merely a sensory event or a private emotion: it is a complex human experience as it moves across body and mind, self and society, biology and culture. Objective, subjective, and social models each reveal essential aspects of suffering, none is sufficient alone. While biomedical models have aided diagnosis and treatment, they remain incomplete. Pain is more than a physiological signal or subjective feeling: it is also a social experience shaped by language, culture, norms, history, and power.

This article critiques both objective and subjective models, highlighting their value but also their limitations, especially in terms of measurement,

communication, and legitimacy. Repositioning social pain not as an emotional correlate but as a constitutive and definitional component of pain. Proposing a multidimensional conceptual framework offering a more comprehensive, ethical, and socially relevant understanding of pain, this article integrated social pain into the conceptual debate, expanding the scope of pain theory beyond biomedical and psychological paradigms and demonstrated that suffering cannot be understood or addressed without acknowledging the social structures that shape, intensify, or negate it. The inclusion of social pain broadens our view, reframing pain not as a private pathology but as a relational, cultural, and political experience.

To build ethical and inclusive responses to suffering, we must adopt an interdisciplinary framework, one that listens to the body, psyche, and society together. Understanding pain as a shared but unequally distributed condition calls for not only better care but greater solidarity. Easing pain becomes not just clinical work, but also a civic and moral responsibility.

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## Pain as Multidimensional Experience: From Body and Mind to Society

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### EXTENDED ABSTRACT

This article investigates the concept of pain as a multidimensional experience, with a particular focus on its objective, subjective, and social dimensions. While traditional definitions, such as those provided by the International Association for the Study of Pain (IASP), have anchored pain primarily in biomedical and individualistic frameworks, this study challenges such reductionism. It argues that pain is not solely a physiological sensation but a mental and social phenomenon that requires integrative conceptualization. The objective of this article is to critically evaluate existing definitions of pain, especially the dominant biomedical paradigm, and propose a broader framework that includes social exclusion, injustice, and collective suffering as essential components of the experience of pain. This study employs an interdisciplinary, qualitative approach grounded in political theory, philosophy of mind, medical anthropology, and sociology. The article is conceptual and theoretical in nature, based on an extensive literature review of clinical definitions, neuroscientific findings, and

socio-political critiques. Through comparative conceptual analysis, the article examines how different traditions construct the meaning of pain. It traces the shift from physiological definitions to more inclusive models that account for emotional, existential, and social suffering. Each section of the article explores a particular aspect of pain: the objective definition, the subjective nature of pain as lived experience; and the emergence of the social pain framework. The analysis reveals that while objective definitions of pain offer clinical clarity, they are insufficient in explaining phenomena such as chronic pain without tissue damage, the moral urgency of suffering, or the impact of social exclusion on health. The IASP's revised definition (2020) marks progress by recognizing pain beyond physical injury, yet it still omits social and ethical dimensions. Subjective approaches, while valuable for validating individual reports, struggle with standardization and communicability. The concept of social pain, supported by fMRI studies and psychological research, bridges this gap by showing that social rejection activates similar neural pathways to physical pain. However, this approach also faces limitations, including empirical vagueness and the risk of abstraction. Nevertheless, it brings collective relevance to pain studies by naming the harm caused by marginalization, injustice, and inequality. The article concludes that none of the three approaches—objective, subjective, or social—can fully capture the experience of pain in isolation. An integrative framework is necessary, one that acknowledges pain as a complex interplay between body, mind, and society. Pain is not only something to be treated by clinicians but also something to be understood by citizens, scholars, and policymakers. By expanding the definition of pain, it is possible to open new possibilities for justice-oriented healthcare, collective healing, and more inclusive public policies. This reconceptualization challenges epistemological hierarchies in medicine and invites interdisciplinary collaboration. The study contributes to pain definition by proposing a more comprehensive model that places it at the intersection of clinical, emotional, and social life.

## GENİŞLETİLMİŞ ÖZET

Bu makale, acının çok boyutlu bir insan deneyimi olduğunu ileri sürerek, onu yalnızca bedensel bir uyarı ya da biyolojik bir tepki olarak değil; aynı zamanda öznel, ahlaki ve toplumsal bir olgu olarak ele almanın gerekliliğini savunmaktadır. Günümüzde hâkim olan tanımlar —özellikle Uluslararası Acı

Araştırmaları Derneği (IASP) gibi kurumların benimsediği biyomedikal çerçevede yapılan tanımlar – acıyı genellikle fiziksel doku hasarına bağlı olarak değerlendirmekte, bireyin içsel deneyimini ve sosyal bağlamını göz ardı etmektedir. Bu yaklaşım, her ne kadar klinik uygulamalarda standardizasyon ve tedavi açısından fayda sağlasa da acının karmaşık yapısını tam olarak yansıtamamaktadır. Bu makale, acının yalnızca bir nörolojik belirti olmadığını; aynı zamanda adaletsizlik, dışlanma ve kolektif travmalarla örülmüş bir toplumsal gerçeklik olduğunu ortaya koymaktadır. Makalenin temel amacı, acıya dair hâkim tanımları eleştirel bir süzgeçten geçirerek daha kapsamlı, çok disiplinli ve toplumsal boyutları içeren bir anlayış önermektir. Bu bağlamda çalışma; siyasal teori, zihin felsefesi, tıp antropolojisi, nörobilim ve sosyoloji gibi çeşitli disiplinleri bir araya getiren kavramsal bir çerçevede yürütülmüştür. Literatür taraması yöntemiyle gerçekleştirilen analiz, hem tarihsel hem de güncel kaynakları dikkate alarak, acının çeşitli boyutlarını felsefi, tıbbi ve sosyal perspektiflerden ele almaktadır. Çalışma, üç temel düzlemde yapılandırılmıştır: birincisi, objektif ve biyomedikal tanımların kapsamı ve sınırları; ikincisi, öznel deneyimin çeşitliliği ve ifadesi; üçüncüsü ise toplumsal acı kavramı. Birinci bölümde, objektif tanımların özellikle tanı koyma ve tedavi planlamasında önemli katkılar sunduğu kabul edilmektedir. Ancak bu yaklaşım, kronik acı, fantom ağrılar, travma sonrası stres gibi durumlarda olduğu gibi, doku hasarı bulunmaksızın deneyimlenen acı türlerini açıklamakta yetersiz kalmaktadır. 2020 yılında IASP'nin tanımında yapılan güncellemeler, acının yalnızca fiziksel değil, aynı zamanda duygusal bir deneyim olduğunu kabul etmek açısından olumlu bir gelişme olarak değerlendirilse de, hâlâ toplumsal ve etik boyutlar tanımın dışında bırakılmıştır. İkinci bölümde, öznel yaklaşımlar ele alınmakta; bireyin kendi deneyimini aktarmasının, acının tanınması ve anlaşılması açısından vazgeçilmez olduğu vurgulanmaktadır. Ancak bu yaklaşımlar, ölçülebilirlik ve karşılaştırılabilirlik gibi bilimsel gereklilikler açısından bazı sınırlamalar taşımaktadır. Öznel beyanlar, kimi zaman tıbbi otoriteler tarafından yeterince ciddiye alınmamakta; bu da özellikle kadınlar, çocuklar, yaşlılar ve engelliler gibi grupların acılarının görünmezleşmesine neden olmaktadır. Üçüncü bölüm ise, acının toplumsal bağlamda nasıl şekillendiğine odaklanır. Burada sosyal acı kavramı devreye girer: Sosyal dışlanma, ayrımcılık, ekonomik eşitsizlik ve politik baskı gibi deneyimlerin de nörobilimsel düzeyde fiziksel acıyla benzer sinirsel tepkiler yarattığına dair araştırmalara yer verilir. fMRI çalışmaları, beynin anterior singulat korteks gibi acıyla ilişkili bölgelerinin sosyal dışlanma sırasında da aktive olduğunu göstermektedir. Bu bulgular, toplumsal

deneyimlerin yalnızca psikolojik değil, biyolojik olarak da acı üretici olduğunu ortaya koymaktadır. Toplumsal acı yaklaşımı, bireysel acının ötesine geçerek yapısal eşitsizliklerin, tarihsel travmaların ve siyasal şiddetin acı üretimindeki rolünü analiz eder. Sonuç olarak makale, acının objektif, öznel ve toplumsal tanımlarının her birinin kendi içinde belirli katkılar sunduğunu; ancak hiçbirinin tek başına yeterli olmadığını savunur. Acı, beden, zihin ve toplum arasında kurulan çok katmanlı ilişkilerle şekillenen bir deneyimdir. Bu nedenle, acıya dair daha adil, etik ve işlevsel politikalar geliştirebilmek için, çok boyutlu bir tanım çerçevesine ihtiyaç vardır. Acının bu şekilde yeniden kavramsallaştırılması, yalnızca tıbbi pratiklerde değil; aynı zamanda etik, hukuk, siyaset bilimi ve sosyal hizmet alanlarında da dönüştürücü bir rol oynayabilir. Bu yaklaşım, sağlık hizmetlerinin daha kapsayıcı hale getirilmesini, kırılgan grupların görünür kılınmasını ve acının toplumsal nedenleriyle mücadeleyi mümkün kılar. Son tahlilde bu makale, acıyı yalnızca bir belirti değil, bir adalet ve temsil meselesi olarak konumlandırarak literatüre özgün bir katkı sunmayı hedeflemektedir.

Bu araştırma için etik kurul izni gerekmemektedir.

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