

## CHAPTER ONE

# Pain as Human Experience: An Introduction

*Arthur Kleinman, Paul E. Brodwin, Byron J. Good,  
Mary-Jo DelVecchio Good*

Pain is a ubiquitous feature of human experience. Acute pain, lasting minutes or hours, is reported at some time by virtually all adults in North American society, across the span of ethnic groups and social classes, of age and gender. It is the single most frequent complaint brought to the offices of physicians in North America (Osterweis et al. 1987). Pain is also a focus of serious attention in the literate medical traditions of China, India, and Islamic cultures (Brihaye et al. 1987). Ethnographers, physicians, and public health experts describe pain complaints for a great variety of societies. Neuroscientists regard pain as a salient feature of the nervous system.<sup>1</sup> It is thus reasonable to assume that pain is a universal feature of the human condition.

At the same time, the cultural elaboration of pain involves categories, idioms, and modes of experience that are greatly diverse. Ohnuki-Tierney, for example, describes complaints among Sakhalin Ainu of Japan as including “bear headaches” that “sound” like the heavy steps of a bear; “deer headaches” that feel like the much lighter sounds of running deer; and “woodpecker headaches” that feel like a woodpecker pounding into the trunk of a tree (Ohnuki-Tierney 1981:49). Ots (1990) describes a common experience of headache among Chinese as characterized by a painful dizziness or vertigo—a complaint that is an embodiment of the traditional Chinese medical category of imbalance as the proximate cause of ill health. Abad and Boyce (1979:34) report that Latinos in North America distinguish *dolor de cabeza* (headache) and *dolor del cerebro* (brainache) as two distinctive experiences and disorders. Headache is a common complaint of Latino patients who suffer *nervios*, a core idiom and syndrome of distress in Latin American cultures (Guarnaccia and Farias 1988). Ebigo (1982) indicates that Nigerians complain of a wide range of specific pains, using language that would

be considered potential indicators of psychosis in this country: "it seems as if pepper were put into my head," "things like ants keep on creeping in various parts of my brain," or "by merely touching parts of my brain it hurts."

Medical anthropologists frequently cite Zborowski's (1952, 1969) studies of the role of ethnicity in the stylization of pain expression—studies conducted in a veterans' hospital in New York state—as the *locus classicus* of serious scholarly anthropological interest in the relationship of pain and culture. While this claim may not be historically accurate—W. H. R. Rivers, Erwin Ackerknecht, and others preceded Zborowski with inquiries into this topic—it is appropriate with respect to magnitude of influence. Zborowski drew upon differences in worldview, including orientation to time, to explain the reactions of "old Yankees," Irish, Jews, and Italians to bodily pain. Nowadays, his writing seems like a quaint anachronism. The cultural stereotypes, elaborated from a study of male veterans, are elevated above particularities of person, gender, and situation. They are ahistorical and unchanging. The peculiar qualities of the sting and throb of pain affecting a particular person—with a unique story, living in a certain community and historical period, and above all with fears, longings, aspirations—are washed away in the ethnic stereotype: Yankees are continent; Jews and Italians are expressive; Jews are more concerned with the future significance of their pain; Italians, focused on the present, are simply relieved that the pain has gone away.

We blush to read these descriptions today. They create cardboard characters instead of describing real people. For all their good intentions and the residuum of group differences they may (or may not) capture, these ethnic caricatures hold little interpretive value; they are even dehumanizing (see Migliore 1989; Lipton and Marbach 1984; Craig and Wyckoff 1987). Zborowski's important accomplishment was to open the study of pain to cultural comparisons and to illustrate ways by which meanings shape behavior; however, his work led a generation of social scientists and health professionals into a conceptual and methodological cul-de-sac. The problem is more than an inadequate conception of ethnicity and the acceptance of a superficial level of understanding. His approach to cultural analysis fails to address pain as an intimate feature of lived experience of individuals in the context of their local social world and historical epoch.

Fabrega and Tyma (1976*a*, 1976*b*), by contrast, recreate the relationship of pain and culture as a greatly complex knot of bodily, psychological, and philosophical conundrums. Using evidence from neurobiology, hermeneutics, psychosomatic medicine, and ultimately epistemology, they portray the ramifying connections between peripheral pain fibers transmitting messages from sensory receptors to the central nervous system, where they are modulated by hormonal, affective, and perceptual processes—all influenced by cultural categories and social relations. Fabrega and Tyma thereby create a

subject matter so densely interrelated and multileveled and of such astonishing complexity that the reader (social scientist or health scientist) must despair at ever grasping the processes that mediate a pounding headache or that transform a social stigma into the nauseating cramping of abdominal distress. With such a vast network of "variables," whose resonances and results are so poorly charted, it is not surprising that researchers have defined (or created) a subject matter they can actually study with available conceptual and methodological approaches. Thus arises the recent interest in chronic pain and the diverse disciplinary approaches to its study.

### CHRONIC PAIN

Unlike acute pain, chronic pain (lasting months or years) is not a ubiquitous experience. Nor has it been shown to be universal, crossing cultures and historical epochs. But it is not infrequent either. In the United States, chronic pain is among the most frequent reasons for disablement (Osterweis et al. 1987). A substantial portion of disability payments goes to those with chronic pain complaints. While only approximately 7 percent of individuals who experience low back pain in the workplace go on to develop chronic symptoms that impair family functioning and work performance, those individuals who do develop chronic pain syndromes occupy much of the time and receive a disproportionately large percentage of the funds of disability programs (*ibid.*).

Chronic pain syndromes highlight the fault lines of society. Patients with chronic pain on the Social Security Administration's (SSA) Disability Insurance Program are more likely to be relatively unskilled workers with limited education from poor, inner-city ethnic groups than middle-class professionals. While the former probably experience greater biomechanical stress in their workaday world, social factors also significantly affect both their pain and disability. Increasing unemployment, for example, is directly correlated with increasing disability claims and numbers of claimants who enter the disability rolls (Berkowitz 1987). As a result, chronic pain has become associated with income redistribution (Stone 1984). Social forces influence not only who develops chronic pain and who is disabled by it but also who responds to treatment and rehabilitation and who becomes permanently disabled. Local conditions in the workplace, for example, turn out to be better predictors of who among the disabled will return to work than biomedical indexes (Yelin et al. 1980). Heretofore, the largest share of social science research on chronic pain has focused on working-class samples for whom work disability was the central issue. With expenditures of public funds going to more than forty-two million noninstitutionalized adults in the United States in 1977 as a source of family income, more than twelve million of whom were disabled, and with one out of four of the severely disabled suffering from a job-related condition,

it is not all that surprising that this has been the emphasis (Work Disability in the United States 1980).

What is surprising is the uncertain status of chronic pain in biomedicine and in the biomedically oriented disability system in the United States. The concept is so poorly defined that chronic pain syndromes lack official status within the standard biomedical taxonomy. The American Psychiatric Association's *DSM-III* category of "Psychogenic Pain"—subsequently dropped in *DSM-III-R*—was unacceptable because physicians and psychologists find relatively few cases of pain in which the etiology is clearly and solely psychological. What one does find is a profusion of discrete conditions—low back pain, chest pain (without heart or lung pathology), functional bowel syndrome, headaches, and so on—without agreement on a unifying rubric. Although chronic pain is one of the most frequent conditions brought to the SSA's Disability Insurance Program, that program does not list it as an official category with specific diagnostic criteria. All of this evidence suggests that chronic pain represents a special case, one that is different from standard biomedical disorders, such as diabetes or asthma, and also from official psychiatric diseases, such as depression. Rather, like chronic fatigue syndrome, chronic pain syndrome is a widely used clinical category without official sanction, an anomalous category, only partially legitimized as disease.

Chronic pain has an anomalous status in biomedicine largely because it is so baffling to clinicians and academic physicians. The pain is seldom adequately accounted for by physiological lesions; its course and outcome do not conform to any known biochemical or mechanical process. Although researchers have advanced competing neurological models, there is still no consensus on a unified conceptual framework for the diverse types of pain. In the absence of known physiological mechanisms, attention has turned to uncovering the social and psychological determinants of pain. Psychosocial factors are widely acknowledged as important influences in all chronic illness, and their role in chronic pain has received extensive study in diverse settings by researchers from various distinct traditions.

Psychologists and family therapists have studied the close association of chronic pain with social, psychiatric, and interpersonal problems. Psychologists, for example, have explored family patterns—emotional "enmeshment," rigidity, and overprotectiveness—which predispose individual members to chronic pain (Minuchin et al. 1978; Meissner 1974; Bokan et al. 1981). Some families may seize upon one member's pain symptom in order to detour conflict and maintain the household's emotional stability. Moreover, the family's response can strongly affect the disability and duration of chronic pain syndromes once established. Sympathy, increased attention, and nurturance positively reinforce such pain-related behaviors as use of medications and time spent in bed (Sternbach 1968; Fordyce 1976).

Psychiatric researchers have focused on the interrelations of depression, anxiety, and chronic pain disorders. Not only major depression but also less serious depressive symptoms and feelings of irritability or annoyance afflict patients with a wide range of pain complaints (Pilowsky and Spence 1976; Blumer and Heilbronn 1982; Pelz and Merskey 1982; Swanson 1984). Severe anxiety has been linked to specific pain disorders, including migraine headaches and temporomandibular joint disorders (examined in chaps. 2 and 5) (Henryk-Gutt and Rees 1973; Salter et al. 1983). However, critical readers should suspect these findings for two reasons. These studies report on patients already in treatment—a distinct (and distinctive) minority of all chronic pain sufferers (Chapman et al. 1979; Crooks, Rideout, and Browne 1984). Moreover, they beg the question of whether these psychological patterns help cause the pain or rather represent a common human response to the suffering of pain (see Merskey 1987).

These studies do, however, support the interpretation that chronic pain is a common idiom for communicating personal and interpersonal problems (Katon et al. 1982). Depression and anxiety, serious family tensions, conflicted work relationships—all conduce to the onset or exacerbation of chronic pain conditions and, in turn, may be worsened by chronic pain. Physical pain complaints therefore express painful relations and experiences. Psychiatrists and psychologists describe a range of meanings routinely expressed in complaints of chronic pain, from anger and loss to failure and fear (Engel 1959; Fordyce 1976; Melzack 1973; Sternbach 1974; Szasz 1959). At a societal level, Kleinman (1986) found that survivors of the devastating effects of China's Cultural Revolution articulated political disaffiliation in an idiom of complaint that made this crossover between bodily pain and existential pain.

Hilbert (1984), a sociologist, argues that chronic pain, because it is atypical or undiagnosable, escapes successful cultural construction. It defies the conventional meanings that patients try to place upon it. This renders pain a quintessentially anomic condition: no coherent system of values and beliefs emerges from the pain experience or survives its morally corrosive effects. The condition of chronic pain thus creates powerful double binds, explored by literary critic Elaine Scarry (1987). Pain is an inner experience, and even those closest to a patient cannot truly observe its progress or share in its suffering. Patients thus have no means to establish its validity as an "objective" part of the world for health professionals or society at large. Absolute private certainty to the sufferer, pain may become absolute public doubt to the observer. The upshot is often a pervasive distrust that undermines family as well as clinical relationships.

Pain can drive a wedge not only between the sufferers and those closest to them but also within pain sufferers themselves. The patient often experiences pain as an intrusive foreign agent: an unwelcome force producing great

physical distress as well as moral and spiritual dilemmas. Others, however, see the patient as the agent, who somehow produces the pain as a response to social and psychological conditions. This approach implies that pain is at least partially willful, voluntary, and hence under the patient's control. This outsider's approach informs much of the psychological and psychosocial research on chronic pain (as described above) and stands at the basis of the ideology operative in certain treatment settings (see chap. 6). But it directly contradicts the immediate, unquestionable physical experience of most pain sufferers.

The National Academy of Sciences Institute of Medicine's report on *Pain and Disability* (Osterweis et al. 1987) concluded that there is no objective measure of pain—no “pain thermometer”—nor can there ever be one, because the experience of pain is inseparable from personal perception and social influence. Chronic pain thus challenges the central tenet of biomedical epistemology: namely, that there is objective knowledge, knowable apart from subjective experience (Kleinman 1988*b*; Good and Good 1981*b*; Gordon 1988). For this reason, the subject of chronic pain draws the researcher toward a cultural critique of biomedicine and of the societal values that are embedded deep within its concepts and practices.

#### WHY CHRONIC PAIN IS AN APPROPRIATE TOPIC FOR ANTHROPOLOGISTS

The theoretical resonance and practical salience of the study of chronic pain surely are reasons why anthropologists should be attracted to this subject. There are other reasons as well. Chronic pain is an important health problem that biomedicine has handled with astonishing lack of success. Medical care has more often than not compounded the suffering as a result of iatrogenic effects of powerful but dangerous surgical and pharmacological treatments and of costly and at times equally dangerous tests. Health professionals are widely viewed by chronic pain patients and their families as insensitive to the patient's needs and disaffirming of the illness experience, and—the ultimate irony—the relationships with health professionals are seen as untherapeutic (see Corbett 1986). By pointing to a source of systematic failure in the health-care system, chronic pain focuses the gaze of the anthropologist on serious weaknesses in the way health professionals are trained and health care is “delivered” in the United States. The ambiguity of chronic pain opens for analysis a site in American medicine where the relations of power and professional knowledge and the potential for exploitation residing in power relations are unusually visible.

Professional biomedical care is not the only culprit. Chronic pain is addressed, often with equally little success, by alternative professional practices, folk healing, and self-care as well. Chronic pain patients and their fami-

lies are dissatisfied, often vehemently so, with the health-care system, every component of which has failed them. Thus, the study of chronic pain leads the researcher to examine a dimension of American medicine that is as much a part of the problem as the solution, offering anthropologists the occasion for critical analysis. Chronic pain not only exposes basic contradictions of medical ideology and care to analysis but also suggests the importance of more systematic criticism of efforts to contain and manage fundamental aspects of human suffering through technical mastery and instrumental rationality.

Anthropological concern with chronic pain arises also from the impressive social problems it indexes: the noxious effects of environmental hazards and power structures in the workplace (Susser 1988), the crisis in the disability and welfare system, the negative consequences of medicalization, and the growth of a "market" for pain products, pain professionals, and pain institutes. We are witnessing the political economic transformation of pain and its treatment—a small but particularly telling feature in the immense transformation of the American health-care enterprise in our times. Medical anthropologists interested in political economy research (see Morgan 1987 for a review) will thus find the potential here for important investigations.

Even more, however, the study of chronic pain seems appropriate to the growing interest in medical anthropology in embodied experience (e.g., Csordas 1990). Anthropologists concerned with the anthropology of everyday experience and the embodiment of cultural categories of distress are drawn to pain in order to understand how the bodily experience itself is influenced by meanings, relationships, and institutions (Kleinman 1988*a*; Devisch 1983; Csordas 1990; Good and Good 1981*b*; Kaufman 1988). These medical and psychological anthropologists are frustrated with the "business as usual" examination of suffering which subsumes personal experience within local cultural categories. They recognize that human conditions such as pain are not adequately appreciated if the analysis begins and ends with the exploration of linguistic terms and cultural taxonomies. Pain itself poses an obdurate resistance to cultural categories. It is an experience that simply cannot be avoided, an experience that sets limits to the meanings given it by cultural beliefs, discourses, or practices. Something is at stake, frequently desperately so, in the lives of pain patients. Pain can be a massive threat to the legitimacy of the everyday world. Viewed in these terms, the anthropological study of chronic pain addresses the sources, varieties, and consequences of human suffering.

#### MONISTIC PAIN/DUALISTIC MEDICINE

Pain, as Scarry (1985) writes, defies language. It occurs on that fundamental level of bodily experience which language encounters, attempts to express, and then fails to encompass. Perhaps more than other somatic experiences,

pain resists symbolization. Language and categories may rework and reshape pain, but they cannot remove or avoid it. Nonetheless, while pain appears at one moment as an unmediated and unmistakable fact, the next moment it seems produced by a dialectic interaction of biological and social processes (see Buytendijk 1974). The experience of chronic pain includes much more than raw physical sensation: pain creates problems of control and meaning-making. It demands enormous energy in the search for relief (see Kotarba 1983; Fagerhaugh and Strauss 1977; Baszanger 1989). These activities incorporate the contradictions of the health-care system into the life world of sufferers and their families. These personal and social responses to pain thus remake the everyday worlds of patients and their families.

Most social scientists studying chronic pain recognize the gap between lay worlds of pain and the world of pain constituted in health-care settings (e.g., Kotarba 1983; Murphy 1987; Zola 1982). The core conflicts between pain patients and health professionals involve many factors—frustration on both sides over the inadequacy of therapeutic interventions, distrust over the assessment of pain and its implications for disability determinations, and disagreement over the influence of voluntary control over symptoms and on the question of accountability. Yet one conflict is so fundamental it has preoccupied social science students of pain. However complicated to articulate and difficult to interpret, the patient's experience of pain is lived as a whole. Perception, experience, and coping run into each other and are lived as a unified experience.<sup>2</sup> When reconstituted as a medical problem, however, that experience is fragmented into a series of dichotomies that represent the deep cultural logic of biomedicine. Physiological, psychological; body, soul; mind, body; subjective, objective; real, unreal; natural, artificial—these dichotomies, so deeply rooted in the Western world and its profession of medicine, are at the heart of the struggle between chronic pain patients and their care givers over the definition of the problem and the search for effective treatment.

In Gordon's analysis (1988) of a series of "tenacious assumptions in Western medicine," the idea of the autonomy of nature is central. In Western medicine, nature (biology to practitioners) is opposed to spirit; it is autonomous from human consciousness (subjective experience); each of its parts is atomistic, independent from the whole; and it "stands not only independent from culture but prior to it" (Gordon 1988:27). Furthermore, nature is a realm separate from morality and society (Taylor 1989). Nature, so isolated, is regarded as universal. It is not dependent upon the parameters of space and time. Nature—biology—is the basis for truth itself. To know nature is to see it: in the body, in the test tube, under the microscope (Good and Good 1989). The order of nature is rational, and human rationality provides the means for explaining natural phenomena. (And, we might add, rationality is usually self-defined as the expert's set of thoughts.)



Gordon (1988) identifies a second category of tenacious assumptions in Western-rooted biomedicine. The individual is a sovereign being, a distinct unit, prior to society and culture, and *autonomous* from them (see Taylor 1985). The knower, the subject of knowledge, is the rational individual whose cognitive states reflect an image of the natural world. The human actor is an individual agent who uses instrumental reason to accomplish goals in the everyday world. Individual orientation is as much part of biomedicine as it is part of Western culture. Sickness is resident in the individual, in individual physiology, and diagnosis and therapy focus exclusive gaze upon the individual body. Suffering is the private response of the subject, and as long as that subject is competent, the moral responsibility of the physician is limited to the individual sufferer.

Now think what egregious influence these values exert on medical practice with patients suffering chronic pain or other chronic illness (see Kleinman 1988*a*, 1988*b*). The experience of chronic pain is fundamentally intersubjective. Chronic pain profoundly affects the lives of the family, intimate friends, co-workers, and even at times the care giver, and such persons in turn shape the experiential world of the sufferer. To regard pain as the experience of an individual, as it is regarded in standard biomedical practice, is so inadequate as to virtually assure inaccurate diagnosis and unsuccessful treatment. Yet this is only the tip of the iceberg.

For the biomedical researcher, pain is the result of change in “material” structures: sensory receptors, afferent neuronal relays, way stations in spinal-cord, mid-brain, or higher cortical modulating systems. The paradigm of investigation—on either the molecular or physiological level—is reductionistic. It reduces the experience of pain to etiological “mechanisms”: biological processes that are measured in “objective,” quantitative terms, most valid when most material. Thus, tissue pathology is more valid than electrophysiological pathology. But this value formulation directly eschews what is most essential to the experience of pain—namely, the relationship between neurobiological and social psychological processes.

Complex processes transform painful relationships and pained feelings into chest pain and, vice versa, transform chest pain into a painful world. These “sociosomatic” processes, processes that inscribe history and social relations onto the body, simply cannot be reduced to biological terminology without distorting in the most fundamental way what pain or, for that matter, experience *per se* is about.

Biological reductionism also fails to illuminate what constitutes chronicity and disability. From the perspective of biomedical research and orthodox clinical practice, chronic illnesses have a “natural course,” which is in essence the unfolding of a predetermined plan of development within the diathesis, the disease as an elemental, natural phenomenon. Disability, in the same discourse, is the impairment that results from the “natural

course" of the disorder. Now these assumptions are curiously at odds with the everyday world of pain patients.

For when the latter, unable to continue working, encounter the disability system, they quickly learn that disability is an administrative category established by the SSA based upon congressional regulations (Osterweis et al. 1987). In this sense, disability is a political category to a much greater extent than it is a biological one (Stone 1984; cf. Warner 1985). Because of the often powerful influence of unemployment, perceived quality of work and work relationships, family, ecology, and mood on the outcome of pain, chronicity cannot be construed as the "natural course" of a particular pathological condition (see McQueen and Siegrist 1982; Turner and Noh 1988; Egan and Katon 1987).

Individuals with the same pathology may develop vastly different disabilities because pain has different meanings for their lives (Lipowski 1969; McHugh and Vallis 1986). The site of the pathology may be precisely the same, yet the course is likely to be quite different, depending on the meaning of the pain, the life world of the sick person, and his or her relationship to family, health-care and disability systems, and the resources available to treat pain. The case studies in this volume vividly demonstrate that inasmuch as pain is always lived as a particular kind of human experience, there can be no "natural course" of a chronic pain syndrome.

Psychological studies claim to challenge this type of biological reductionism. Instead of grounding pain in the objective condition of the body, they regard pain as produced or maintained according to known psychological principles. This psychological literature, however, often reproduces the same conventional categories underlying the medical approach. By focusing exclusively on the psychological sources of pain, such studies scrupulously respect the categorical distinction between body and mind. The medical literature privileges objective somatic processes, and it enshrines them as the agent that produces pain. The psychological literature takes the opposite position: it imputes agency to the subjective mind (as affected by specific behavioral contingencies and family dynamics); these mindful processes then produce physical pain. The Cartesian dichotomy remains unquestioned. Both traditions tend to ignore how a person's immediate experience of pain unites its bodily, psychological, and social origins (see Brodwin and Kleinman 1987).

Much psychological research begins with the notion of "secondary gains" and the behaviorist principles of operant conditioning. This model predicts that the rewards provided by a patient's environment will act as the prime incentive for chronic pain disorders. For example, the responses of family members can significantly affect the disability caused by chronic pain. Sympathy, increased attention, and nurturance may reinforce pain behaviors (Sternbach 1968; Fordyce 1976). Hudgens (1979) lists other secondary gains secured by chronic pain: controlling others, justifying dependency, earning rest, avoiding sex, gaining attention, punishing others, controlling anger, and

avoiding close relationships. These secondary gains may have destructive effects, and Menges (1981) describes the manipulative "pain games" of patients who use their symptoms to dominate other family members or escape responsibilities.

Minuchin et al. (1978) shifts the psychological focus from individual behavior to family systems. He examines how "psychosomatic families" seize upon a child's physical symptom in order to detour conflict and maintain the family's stability. When negative feelings remain unexpressed, focusing on the chronic pain in a vulnerable family member, especially a child, is less threatening than revealing an emotional problem (Meissner 1974; Liebman et al. 1976; Hughes and Zimin 1978).<sup>3</sup>

In addition to these behaviorist and psychodynamic studies, psychologists have investigated how social learning and modeling influence chronic pain. Pain patients have often witnessed similar suffering among their kin; chronic pain is more common among family members of such patients than among families of persons with other chronic illnesses (Violon and Giurgea 1984). The influence of available family models may even be symptom specific. Headache patients have a disproportionate number of family members who also suffer from headaches (Turkat et al. 1984). The rate of abdominal pain in parents of children with chronic abdominal pain is six times higher than in a control group (Apley 1975). Pain patients may thus have "familial pain models" that influence the onset of chronic pain as well as its disability (Edwards et al. 1985).

The dichotomy between mind and body upheld by both medical and psychological research is invalid and unavailing. Yet it is the viewpoint of many practitioners, most researchers, and not a few patients. Patients are mortified and angered to find their experience discredited as "not real" or "functional" pain (see Jackson, chap. 6). Families must struggle to empathize with the effects of pain on a loved one, while at the same time they are told the pain is "a psychological, not a medical, problem." Practitioners with "psychosomatic" orientation must continually remind themselves that biological and social psychological processes interrelate, in spite of reading research literature that overwhelmingly decries the significance of such interrelationships and of encountering clinical colleagues who denigrate a "biopsychosocial" viewpoint as "soft" and quaintly unbiomedical.

Historical and psychiatric evidence attests to the widespread adoption of a psychological idiom of distress by the middle class in Europe and North America. Clinicians today rarely encounter the classic hysteria and conversion symptoms of late nineteenth-century Vienna. But have well-educated "psychologically-minded" individuals abandoned a somatic idiom entirely? Does the somatic presentation of psychological and social distress appear only in nonwhite ethnic groups and lower social classes, social groups that lie outside the mainstream of the therapeutic state (Leff 1981)?

One of the chief findings presented in this book is a resounding no to both

questions. The case studies portray middle-class white Americans who readily and profoundly exploit physical symptoms to communicate personal distress. For many of us, somatization—an idiom of physically painful signs and symptoms—has become stabilized alongside the reigning discourse of emotions and inner feelings.<sup>4</sup> The sufferers of chronic pain, in particular, have elaborated these two parallel and interacting languages in their talk about symptoms and their search for relief. The actual prevalence of classic hysterical and conversion symptoms may have decreased. However, these two cultural languages—one indexing the body and the other indexing the self and its social transactions—continue to inform our understanding of chronic pain and chronic illness generally.

That so many individuals have recourse to these complementary discourses proves the inadequacy of the crude Cartesian mind-body dualism described above. This book focuses on both a class of patients and a few unique individuals who communicate their distress simultaneously through symptoms and words. It thereby suggests how modern Americans attempt to transcend the dichotomy of thought and sensation which is inscribed in everyday language, medical jargon, and treatment settings. They do not transcend it entirely, as the following pages make clear through the many examples of failed self-understanding, miscommunication within families, and frustrating impasses between patients and clinicians. But for the discerning reader (and sensitive clinician), the expression of suffering through both words *and* physical symptoms constitutes an understandable and familiar human language.

#### PAIN AND THE NATURE OF HUMAN SUFFERING

In his searching account of the massive brutality and day-to-day inhumanity suffered by the frontline soldier in World War II, Robert Fussel (1989), himself a combat veteran of that grisly “conventional” war, writes of soldiers having to endure the unendurable—horrible wounds, constant fear, the likelihood of death at any moment—without the sense of control or coherence or the possibility of transcendence. That is a description of a particular form of suffering. Primo Levi (1961) describes those who succumbed or survived the systemization of murder at Auschwitz; Haing Ngor (1987) recounts the experience of those who underwent the mind-numbing horrors of the Cambodian genocide; Nien Cheng (1986) speaks for the victims of China’s Cultural Revolution; Veena Das (1989) describes the misery of victims of Bhopal and of the Hindu riots against Sikhs after the assassination of Indira Gandhi. The list of contemporary forms of suffering is despairingly long. Its scope extends from the havoc of war and revolution and other man-made or “natural” disasters to routinization of suffering brought about by dehumanizing poverty, systematic discrimination, community-wide drug or alcohol

abuse and their violent sequelae, or the even more intimate oppression in workplace or family. Looking back over the epochs in the historical record and across the boundaries of greatly different societies, we see so many sources of suffering—plagues, famines, slavery, astonishingly high rates of child and maternal mortality and of child and adult abuse, to name a few of the more notorious—that it would seem that suffering is a defining characteristic of the human condition.

Certainly death, pain, disfigurement, impairment of functioning, humiliating symptoms, the fear of uncertain outcome, the loss of capacity and relationships, and all the other ways that *illness* can assault the person and the group figure as both common and powerful forms of suffering. Much of “traditional” medical care across epochs and societies has centered on the experience of suffering. What do patients most appreciate in the medical care they receive? Arguably, it is the attention that care givers devote to the experience of menacing symptoms and grave loss as much as the technical interventions that improve outcome. *Pain* is often used as a graphic illustration of the suffering caused by illness, of the body or of the mind. Therefore, to relieve pain is to alleviate suffering. When therapy fails, however, or even when it succeeds, the offer of personal and family support in face of the burdens of illness, bearing witness to the moral experience of suffering, providing suffering with a coherent meaning, and preparing for a socially appropriate death and for religious transcendence are universal features of societal responses to suffering.

Suffering is not just expressed but constituted through lay and expert discourses on its sources and consequences. The medieval quest for religious transcendence shaped the responses of whole societies as well as families and individuals to the Black Death. The suffering caused by that plague thus differs dramatically from the societal response to the pain and death from AIDS in our times (Gottfried 1984; Sontag 1989).<sup>5</sup> What is so impressive about current forms of suffering is the relative weakening in the modern era of moral and religious vocabularies, both in collective representations and the language of experts. In their place we see the proliferation of rational-technical professional argots that express and constitute suffering in physiological, public health, clinical, psychological, and policy terms. These secular discourses accomplish what Max Weber predicted early in this century they might achieve: namely, to replace the “looser,” ad hoc, fuzzier talk about sentiment and tradition—for example, talk of yearning, misery, aspirations, and transcendence—with the much more systematic, routinized, quantified talk about biomedical and psychiatric and legal and policy issues. The transformation of language is notable, even within the social sciences, for leaving out the human spirit and the sacred. In the contemporary discourses on pain or other forms of suffering—expert and popular—the idea of suffering has been attenuated, sometimes trivialized, and at times expunged

altogether, although it may remain resonant in the personal and family encounter with suffering. Neither in the biomedical research literature nor in the pain clinic does the *suffering* of pain patients and their intimate social circles receive much attention as such, that is, as a moral burden or a defining existential experience. Pain as human suffering in the dominant institutions that deal with it in our times is a question of therapeutic *means*—analgesia, surgical procedures, rehabilitation, psychotherapy—not of human (or suprahuman) *ends*.

The upshot is that the intricate experience as much as the straightforward treatments of pain are culturally embedded. Moreover, the symbolic processes that interrelate body and self with meanings and relationships change as part of wider societal and cultural transformations (Kleinman 1986). Pain and suffering have thus also changed over time. Charting the causes, features, and implications of this astonishing transformation in the human condition in the West and contrasting it with other societies and other times should be what distinguishes the anthropology of pain from the biology and psychology of pain.

This approach suggests the importance of placing the study of human suffering in a broader historical and civilizational frame. What have been the primary modalities of conceiving, shaping, and responding to suffering across history and society? And how have European and North American traditions compared with those of other civilizations? Is there an “experiential transition” discernible through history, one that parallels the more widely noted demographic and epidemiological transitions?<sup>6</sup> If it exists, does that transition involve similar dimensions of change? Does it vary for different societies and for different groups within societies? What are the consequences of this hypothesized “experiential transition” for pain patients, families, and health professionals in our own society? These are large questions that future studies in the anthropology of pain might profitably address.

#### OVERVIEW OF THE VOLUME

For the purpose of this edited volume, we have set ourselves a more modest agenda. We have developed a set of studies of *experiences of chronic pain*, in the context of American culture and society, which highlight the daily effects of pain, its place in the biography of the pain sufferer, its trajectory through the family and workplace, its treatment, and the effects of cultural and social forces upon each element of the pain experience. Taken together, these studies establish the domain of suffering inhabited by pain patients. They reveal the intimate and shared meanings pain holds for an individual, a family, or care givers, meanings that color patients’ experience of the everyday world.

We have attempted to write an *ethnography of experience* of persons afflicted by chronic pain. Like all ethnographies, this volume explores the crucial

categories that exert a strong but unseen effect on these people's lives: How does pain feel? What is at stake for the sick person and family? What is learned from the encounter with pain by those who undergo it and those who provide care? How is the meaning of pain created, expressed, and negotiated? How are meanings reflected or constituted in stories people tell? What is the relation between such narratives and lived experience? And how do the meanings of pain and suffering emerge from, and then reciprocally influence, particular worlds of pain? If the book clarifies this iterative process of experience lived under bodily constraint, of the making of painful meanings, and of the meanings of painful worlds, if we illustrate that iterative, dialectical process with enough convincing detail, it will have succeeded.

The contributors bring to this book differing questions of social theory, different anthropological preoccupations, even different investigations with different samples of pain patients. Yet we all share participation, at one time or another, in the Harvard Program in Medical Anthropology's "Friday Morning Seminar." That weekly seminar, supported with funds from a training grant from the National Institutes of Mental Health,<sup>7</sup> has both a scholarly and a practical mission. It reviews the methodological developments and conceptual controversies in anthropological studies of health and health care; it also discusses the relevance of these for practical questions confronting patients, clinicians, and policymakers. Since its inception, the seminar has placed great emphasis on studies of the experienced worlds of patients and healers and on the refashioning of research methodologies, especially interpretive ones, to pursue with greater validity our understanding of body-self processes, illness narratives, and the changing social contexts within which illness and clinical practice are enacted.

The Seminar's colloquy is the backdrop for the research projects reported in this volume. These include a study of chronic pain supported by the National Science Foundation, a study of jaw, neck, and back pain, and an NIMH-funded ethnography of a single residential pain clinic. The NSF-supported study, "The Ethnography of Chronic Somatization,"<sup>8</sup> carried out by the editors of this volume, investigated four aspects of chronic pain in working Americans: the experience and meaning of their symptoms, the history of illness and loss in their families, the range of their associated emotional problems, and their social disabilities and work adaptations. Intensive interviews were carried out with thirty-eight patients over two years. The sample differed from many such studies in that participants were employed and working at the time they entered the study. Chapters 3, 4, and 7 depict participants in this study.<sup>9</sup> The study of sufferers of jaw, neck, and back pain was carried out by Linda Garro, Karen Stevenson, and Byron Good. Lengthy interviews were conducted with forty persons, thirty-two of whom suffered jaw joint pain or dysfunction, drawn from volunteers from several chronic illness support groups. Chapters 2 and 5 provide in-depth accounts

of several of these pain sufferers. Finally, chapter 6 reports the results of an ethnographic investigation of a well-known chronic-pain treatment center on the East Coast. This two-year study, conducted by Jean Jackson, was supported by a grant from the NIMH.<sup>10</sup>

The anthropology of experience is the shared conceptual thread uniting these chapters; it is the identifying signature that emerges from the authors' participation in the Harvard seminar. The chapters attempt (1) to provide an authentic representation of the experiences sufferers have been willing to share with us, and (2) to draw generalizations from the analysis of these "microscopic" experiential accounts, or (3) to examine that experience as refigured in diverse treatment contexts.

Chapter 2, by Byron Good, provides a phenomenological analysis of the complex array of pains of a single young man, who ascribes his pain to an underlying temporomandibular joint disorder. The analysis suggests that studies of the pain experience not only should attend to direct reports of experience but might begin with investigation of the experienced world, the "life world." Drawing on Alfred Schutz (a German-American philosopher and sociologist) and Elaine Scarry's volume on pain (1985), the chapter explores the perceptual dimensions through which this young man's life world is constituted, the radical reshaping of that world under the influence of enduring pain, and the constant threat of dissolution of that achieved world for the chronic pain sufferer. In addition, the chapter provides an analysis of the young man's "origin myth," or narrative of the onset and foundation of the pain. A close reading of the text indicates that two conflicting narratives, one of psychological origins and one of physiological sources of the pain, are juxtaposed. But since neither have provided final grounds for therapeutic efficacy, neither provides a final reading of the experience.

Mary-Jo DelVecchio Good, in chapter 3, examines the relationship of work and chronic pain among two women who are part of a special category of pain patients to which many of those who participated in these studies belonged. These are professional women who continue actively working in spite of chronic pain, which many of them experience daily. Unlike pain patients who have been the focus of most research—those who because of chronic pain are unemployed or on the disability rolls—for these two women, work is a haven from pain. Work provides a meaningful way of being-in-the-world, in spite of histories replete with losses, menace, dissatisfaction, and disappointments in their personal and family lives. Work is both a mode of self-realization and an occasion for the purposive control over the intrusiveness of pain, physical and psychological, into the day-to-day world. Through work, these women actively engage the world, attending to their professional activities and demands as opposed to their bodies in pain. This chapter thus suggests a reinterpretation of much of the literature on gender, work, and pain.

In chapter 4, Paul Brodwin depicts a woman whose pain, while neither